STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055064	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Canyon Healthcare Center	1391 Madison Avenue El Cajon, CA 92021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on the interview, and record review, the facility failed to ensure comprehensive resident-centered care plans were implemented for one of two sampled residents (1) when Resident 1 had no bowel movements for three days, and the physician's order was not followed. This deficient practice had the potential to affect resident's health and safety. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm (abnormal tissue growth) of ill-defined sites within the digestive (a group of organs that work together to digest and absorb nutrients from the food that was eaten) system, per the Admission Record. A review of Resident 1's medical record was conducted. Per the Plan of Care, dated 11/21/24, Resident 1 was At risk for complications with bowel regimen due to risk for constipation due to decreased physical mobility, weakness, used of medications, under Interventions/Tasks, the LN was to Administer medications per physician order. Per the Order Summary Report, dated 11/21/24, Resident 1 had the following physician's order:Magnesium Hydroxide Suspension (medication to treat occasional constipation) every 24 hours as needed;Bisacodyl Suppository (medication to treat constipation) every 24 hours as needed if Magnesium Hydroxide was ineffective;Fleet enema every 72 hours as needed if Bisacodyl was ineffective. Per the Bowel Movement Report, dated 11/25/24 at 1:32 P.M., through 11/29/24 at 4:38 A.M., Resident 1 had no bowel movement for three days. Per the Medication and Treatment Administration Record, dated 11/26/24 through 11/28/24, there was no documented evidence that Resident 1 was offered or given medications ordered by the physician. On 12/17/24 at 4:30 P.M., an interview and record review was conducted with the Director of Nursing (DON). The DON stated the LN should have given Resident 1 medication to help with constipation, but they did not. Per the facility's policy and procedure, dated 3/22, titled Care Plans, Comprehensive Person-Centered, . Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure the discharge medication list order from the hospital matched the facility's admission medication list for one of two sampled residents (1) when one tablet of Sennoside (a medication used to treat constipation) was omitted from the order. As a result, Resident 1 did not receive the desired dose of medicine to be effective. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm (abnormal tissue growth) of ill-defined sites within the digestive (a group of organs that work together to digest and absorb nutrients from the food that was eaten) system, per the Admission Record. A review of Resident 1's medical record was conducted. Per the Hospital Discharge Order List, dated 11/21/24, the physician ordered for Sennosides 17.2 milligrams. Per the facility's Order Summary, dated 11/21/24, Resident 1 was to receive Sennosides 8.6 milligrams, take one tablet orally at bedtime for constipation [Instead of two tablets]. Further review of Resident 1's medical record was conducted. No evidence of order change from the physician was noted. Licensed Nurse (LN) 1 was not available for an interview. On 12/17/24 at 4:30 P.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated LN 1 should ensure the orders from the hospital matched their admission order, and any changes would be documented in the medical record. The DON stated that LN 1 did not transcribe the order correctly. Per the facility's policy and procedure, dated 7/17, titled Reconciliation of Medications on Admission, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosage upon admission or readmission to the facility .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure a resident's medical record was complete for one of two sampled residents (1) when the licensed nurse (LN) had incomplete documentation after receiving an order, and the inventory sheet (record of resident's belongings) was not signed. As a result, the facility could not verify a physician's order and Resident 1's inventory sheet when discharged was not completed. Findings Resident 1 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm (abnormal tissue growth) of ill-defined sites within the digestive (a group of organs that work together to digest and absorb nutrients from the food that was eaten) system, per the Admission Record. A review of Resident 1's medical record was conducted. Per the Progress Notes, dated; 11/28/24, LN 1 documented that Resident 1 insisted on going home because the Butalbital/Acetaminophen/Caffeine (a combination of medications to treat tension headaches) was not routine. LN 1 further documented the nurse practitioner was called and changed the order from as needed to routine, and on 11/30/24, LN 2 documented, Received new order for Butalbital/Acetaminophen / Caffeine to be changed from three times a day routinely to as needed. LN 2 did not document who changed the order and how LN 2 received the order. In addition, a review of the Resident Inventory of Personal Effects, under Certification of Receipt on Discharge, the signature to indicate that belongings left with Resident 1 was blank. On 12/19/24 at 4:22 P.M., an interview was conducted with LN2. LN 2 stated she could not remember how she received the order, whether by telephone or in person, and whom she spoke to. LN 2 further stated she could not remember if she talked to Resident 1 about the order change. LN 2 stated she should have documented the event thoroughly, as she could no longer recall it. LN 2 further stated Resident 1 was very upset on 12/6/24 because Resident 1 was not getting the medication routinely and wanted to leave against medical advice. LN 2 stated Resident 1's inventory was not signed before discharge from the facility and should have been. LN 2 further stated she could not verify that Resident 1's belongings were taken home or were missing. On 12/23/24 at 9:09 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that licensed nurses should document the resident's medical record completely and thoroughly. The DON further stated the LNs should have documented the name of the physician or the nurse practition changing the order back to as needed. In addition, the DON stated the resident's belongings should have been reviewed before leaving the facility and the resident should have signed the inventory sheet to acknowledge that the resident took all belongings home. The DON further stated Resident 1's inventory sheet was blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility could not provide a policy and procedure for accountability of resident's belongings. Per the facility's policy and procedure titled Medication and Treatment Orders, .7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, the date and the time of the order .