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	08/11/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement an effective discharge planning process for 1 of 3 sampled residents (Resident 5), who had severe cognitive impairment due to dementia and no family or surrogate decision-maker, when the facility did not document evidence of interdisciplinary team (IDT) meetings or third-party involvement (like conservator or ombudsman) to advocate for Resident 5's needs before her discharge to an assisted living facility on 2/27/25. This failure had the potential to result in an inappropriate placement, compromising Resident 5's safety and well-being.Findings:Resident 5 was admitted to the facility on [DATE] with diagnoses that included dementia (memory problem), per the admission Record. Per the same document, under Contacts, Resident 5 had a bioethics IDT (a group of people that discuss moral, social, and legal issues that may arise).A review of Resident 5's medical record was conducted.Per the Minimum Data Set (MDS - a standardized assessment tool used to evaluate residents' health status and care needs), dated 2/19/25, Resident 5's Brief Interview for Mental Status (BIMS - a measure to track a resident's mental decline or improvements in a long-term care facility) score 2, which indicated Resident 5 had severe cognitive impairment.Per the Progress Notes, dated 1/15/25, the Social Service Director (SSD) documented that a public resident representative (third-party agency) met with SSD and discussed the criteria for a public representative. Resident 5 was under bioethics IDT and cannot make a medical decision. There was no documented evidence that a plan for Resident 5 to have a conservatorship (a court-appointed person, or conservator, for residents who can no longer make decisions).A further review of Resident 5's medical record was conducted. There was no documented evidence that IDTs were conducted to address Resident 5's discharge needs, goals, or the appropriateness of the assisted living facility, or the status of conservatorship.On 2/27/25 at 9:08 A.M., the SSD documented that Resident 5 will be discharged to [address provided]. No evidence was provided on how the decision was made, who authorized it, or whether the facility was equipped to meet Resident 5's dementia care needs.Per the Discharge summary, dated [DATE] at 2 P.M., Resident 5 was discharged to an assisted living facility.On 8/11/25 at 4:10 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the IDT meeting should have been done before discharge and documented in the medical record. Resident 5 should have a conservatorship assigned to assist in making decisions on their behalf to ensure the resident's needs and safety are met.On 8/14/25 at 4 P.M., an interview was conducted with the SSD. The SSD stated Resident 5 used to live in an independent living facility with a family member's oversight, the family member passed away, and Resident 5 had no other family member who could decide for her.Resident 5 was diagnosed with dementia and was walking around and asking to go home. The SSD further stated that she requested the assistance of the placement provider to locate Resident 5's location for transfer, and they found the assisted living facility. The SSD further stated that there was no IDT meeting or a third-party agency decision made for Resident 5 that occurred before discharge.Per the facility's policy and procedure, dated 3/2025, titled Discharge Summary and Plan, .2. The purpose of the discharge plan is to ensure a safe transition from the facility to the post-discharge setting. 3. The discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and the representative .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to attempt to reschedule a resident's shower schedule or find a suitable time for a shower for one of three sampled residents (Resident 4).This failure resulted in Resident 4 not showering for 11 days, which could lead to discomfort and compromised hygiene.Findings:Resident 4 was admitted to the facility on [DATE] with diagnoses that included a fracture (broken) of the left ilium (pelvic bone), per the admission Record.On July 7, 2025, at 2:52 P.M., a complainant reported that Resident 4 had not received a shower at the facility for over ten days. Resident 4 preferred morning showersA review of the Activity of Daily Living (ADL- a set of self-care tasks) Report dated 6/23/25 through 7/7/25, under bathing, Resident 4 indicated that the staff had not assisted Resident 4 with showering from 6/23/25 until 7/4/25. Resident 4 did not receive a shower for 11 days.Per the Shower Schedule, Resident 4's scheduled shower was during the PM shift (a work period that falls in the late afternoon or second shift).On 7/8/25 at 1:15 P.M., Resident 4 was not available for an interview.On 7/8/25 at 2:30 P.M., a joint interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 4 was admitted on [DATE], and had a scheduled shower every Wednesday and Saturday. Resident 4 had refused showers three times. The ADON further said that not showering for 11 days was a long time, and should have involved the family and the physician.The ADON stated there was no documented evidence that the physician or family member was made aware of this or offered Resident 4 alternatives, which the staff should have done. The ADON further stated it was important for a resident to shower to maintain personal hygiene [cleanliness]. Licensed Nurses assigned to Resident 4 were not available for interview.Per the facility's policy and procedure, dated 2/2018, titled Bath, Shower/Tub, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and observe the condition of the resident's skin .