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	02/12/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately code the Minimum Data Set (MDS) to reflect the resident's true injury status following a fall, for one of three sampled residents (Resident 1).As a result, this placed Resident 1 at risk for inaccurate care planning, inappropriate monitoring and follow up, and the transmission of incorrect health information to Centers for Medicare & Medicaid Services (CMS).Cross-reference F689Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated 12/25/25 indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.Resident 1's EHR (Electronic Health Record) progress noted by LN 1 titled Nurse's Note dated 12/25/25 at 20:55 (8:55 P.M.) late entry, indicated, .Walked in to [sic] the room to find resident lying face down and having agonal [an abnormal, reflexive pattern of gasping and labored breaths that occurs when the brain is deprived of oxygen] respirations. Resident also had a bleeding laceration (a jagged cut) on top left of the forehead. Resident breathing had slowed down to the point where he was fully unconscious [a person is not reacting to sound, touch, or pain] by this time. Resident 1's EHR progress noted by LN 2 titled Nurse's Note dated 12/25/25 at 21:00 (9 P.M.) late entry, indicated, .Noted his left side of the head of head [sic] with some bleeding, Some abrasion to bilateral UE [upper extremity-arms and hands]. The residentwas [sic] unresponsive [unconscious] at this time.On 1/27/26 at 12:54 P.M., an interview and record review were conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated Resident 1's MDS dated [DATE] was coded inaccurately, as Section J1900C .Major injury-bone fractures, joint dislocations, closed head injury with altered consciousness. was not coded to reflect a major injury. The MDSC stated record review showed Resident 1 required cervical [neck bones] precautions, had slowed respirations, bleeding to the head and was fully unconscious, which met criteria for a major injury and should have been coded accordingly. The MDSC stated accurate MDS coding is required to ensure reportable falls are correctly captured, appropriate interventions and care planning are implemented, and Centers for Medicare Services (CMS) quality measures accurately reflect the care provided. The MDSC stated the MDS required correction and resubmission to accurately reflect Resident 1's condition.On 1/29/26 at 1:47 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that accurate MDS coding is essential to correctly reflect a resident's clinical status and to guide care planning and clinical decision making. The DON stated that serious events, including major injuries, must accurately be captured on the MDS because the information is submitted to the CMS federal database and is used to determine quality measures, regulatory reporting, and appropriate resident care.A review of Centers (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Medicare and Medicaid Services (CMS, a federal agency) RAI Manual 3.0 October 2025, (Page J-37) Section J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment .Major Injury Includes, but is not limited to, traumatic bone fractures, joint dislocations/ subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries .A review of the facility's policy and procedure titled, Resident Assessments dated October 2023, indicated .Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews .

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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 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** Based on interview and record review the facility failed to develop, revise and implement an individualized, person-centered care plan to address supervision, prevent falls and feeding assistance needs for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for falls, choking, serious injury and delayed emergency response due to the lack of an individualized and implemented care plan that aligned with Resident 1's needs when:1. Resident 1, who was a high fall-risk resident, was left unsupervised, despite requiring close monitoring the comprehensive care plan lacked personalization specific to Resident 1's needs that are clear, specific, and measurable interventions to ensure continuous one on one (1:1) supervision.2. Staff failed to provide feeding assistance to Resident 1 according to the nutritional care plan, even though the resident was identified as requiring 1:1 feeding assistance that required assistance with meals.Cross-Reference F689 and F7261. Fall risk-unsupervisedA review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated 12/25/25 indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On 1/14/26 at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated that upon starting her shift on 12/25/25, she observed Resident 1 independently wheeling himself (using a wheelchair for ambulation -the act of walking or moving place to place) in the hallway. CNA 1 stated she provided Resident 1 with a meal tray, and watched Resident 1 eat independently. CNA 1 stated she was not informed that Resident 1 was a fall risk. CNA 1 reported that Resident 1 remained seated in his wheelchair unsupervised in the hallway until approximately 8 P.M., on 12/25/25. CNA 1 stated that after returning from a bathroom break, she observed nursing staff (LN 2) with Resident 1 who was lying face down on the floor with a bleeding head wound. CNA 1 stated oxygen was applied to Resident 1 who was minimally responsive, moving only his hand, at the time he was found on the floor. On 1/14/26 at 1:51 P.M., an interview and record review were conducted with LN 1. LN 1 stated he was the nursing supervisor on duty when Resident 1 fell (12/25/25). LN 1 stated he had directed the CNA's (assigned to hallway 100 where Resident 1's room was) to closely monitor Resident 1 because Resident 1 had repeatedly attempted to get out of his wheelchair and was seen wheeling himself throughout the hallway. LN 1 stated Resident 1 was a high fall-risk and required close supervision at all times and should be on a one to one [1:1] supervision (one staff supervising one resident) for safety. LN 1 further stated Resident 1 did not have orders for a 1:1 supervision and Resident 1 was not care-planned (plan created by nursing based on an assessment) for 1:1 supervision but should have been because he was a safety risk. LN 1 stated Resident 1's assigned CNA (CNA 1) used the restroom and that CNA 1 had told a registry (temporary or contracted staff) (CNA 3) to watch [Resident Name]. CNA 3 ignored CNA 1's instructions to supervise Resident 1. LN 1 stated Resident 1 had not been supervised and fell. LN 1 stated Resident 1's baseline was alert but not oriented (confused) x [times]3 [person, place, time] and was non-verbal (did not speak). On 1/14/26 2:03 P.M., an interview was conducted with CNA 1. CNA 1 stated she did not ask another nursing staff to supervise Resident 1 because she was unaware Resident 1 was a fall risk. CNA 1 stated LN 1 did not endorse or communicate to her that Resident 1 required close monitoring or supervision. CNA 1 further stated that had she been informed Resident 1 was a fall risk, she would have (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately notified another nursing staff member to supervise Resident 1 to prevent the fall.On 1/14/26 at 2:11 P.M., an interview was conducted with CNA 2. CNA 2 stated Resident 1 was not assigned to her on 12/25/25; however, Resident 1 was located on the same unit throughout her shift. CNA 2 stated she observed Resident 1 sitting alone in his wheelchair and noted Resident 1 appeared confused and not fully oriented, which she believed to be Resident 1's baseline. CNA 2 stated she was not informed that Resident 1 was a fall risk and therefore did not recognize the need for close supervision. CNA 2 stated she later observed nursing staff next to Resident 1 who was found on the floor. CNA 2 stated she observed Resident 1 to have had irregular breathing, which prompted LN 2 to administer oxygen via a non-rebreather mask (medical emergency device used to deliver high concentrations of oxygen). CNA 2 further stated Resident 1 had been observed earlier seated in his wheelchair with a walker positioned in front of him and that no staff member instructed her to monitor or supervise Resident 1 at any time during her shift, including when the assigned CNA 1 left the area to use the restroom.On 1/14/26 at 3:40 P.M., an interview was conducted with CNA 4. CNA 4 stated Resident 1 required maximum assistance (the staff performs approximately 75% or more of the physical work, while the patient contributes 25% or less) for sit-to-stand movements and transfers due to being wobbly and unstable. CNA 4 stated Resident 1 used a walker and had ambulated with a walker during therapy sessions. CNA 4 stated Resident 1 was confused and appeared unable to consistently understand how to use the call light for safety, despite staff encouragement. CNA 4 further stated that due to Resident 1's confusion, and inability to fully verbalize his needs, staff would need to respond promptly to prevent unsafe attempts to stand if Resident 1 needed assistance.On 1/14/26 at 3:47 P.M., CNA 5 was interviewed. CNA 5 stated that when Resident 1 was first admitted to the skilled nursing facility she noticed Resident 1 frequently sat on the edge of the bed without assistance and had difficulty understanding how to safely use the call light. CNA 5 stated Resident 1 often laughed or giggled when attempting to use the call light and continued not to use it, indicating limited comprehension and developmental delay. CNA 5 stated Resident 1 was a known fall risk, as he (Resident 1) could sit up unassisted in bed and attempted to stand or ambulate without assistance. CNA 5 stated she had reported to the LN's that Resident 1 repeatedly sat at the edge of the bed and required ongoing supervision to reduce the risk of a fall. CNA 5 further stated that despite reminders, Resident 1 continued unsafe behaviors and required supervision to prevent falls.On 1/27/26 at 11:48 A.M., CNA 3 was interviewed. CNA 3 stated she was a registry CNA who had worked the night Resident 1 fell. CNA 3 stated she was not the primary CNA assigned to Resident 1 but had observed Resident 1 earlier in the hallway sitting on his (Resident 1) wheelchair making random sounds, not fully verbal, and attempting to stand up from the wheelchair. CNA 3 stated she was informed by the LNs (LN 1 and LN 2) at the start of the shift that Resident 1 was a fall risk. CNA 3 stated she was not instructed by CNA 1 to monitor or supervise Resident 1 prior to CNA 1 using the restroom. CNA 3 stated she heard a nurse call out for help then entered Resident 1's room, where she observed Resident 1 lying on the floor with a bleeding forehead, non-responsive and breathing irregularly. CNA 3 stated after the fall, LN 2 had applied oxygen via a mask, and she observed no rescue breaths or chest compressions had been provided. CNA 3 further stated Resident 1 did not regain consciousness not waking up, and his (Resident 1) body was twitching while on the floor.On 1/27/26 at 12 P.M., an interview and record review were conducted with LN 2. LN 2 stated she did not witness Resident 1's fall that happened in his room because she (LN2) was at the nursing station charting. LN 2 stated she heard somebody called out and his [Resident 1] roommate said somebody fell. LN 2 stated she entered Resident 1's room and observed Resident 1 lying face down on the floor, unresponsive, with visible bleeding around the head. LN 2 stated Resident 1 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had poor safety awareness and had episodes of ambulating without assistance to use the bathroom in his room despite, reminders to use the call light and did not reliably call staff for help. LN 2 stated she was not aware Resident 1 was identified as a fall risk prior to the incident but acknowledged that, given Resident 1's IDD, confusion and communication deficits (difficulty with memory, thinking and controlled impulses) that Resident 1 should have been considered a safety and fall risk. LN 2 stated if she had known Resident 1 was a fall risk, then Resident 1's care plan should have been updated with interventions for Resident 1 to be placed on a 1:1 supervision and not left unattended to prevent the fall. Resident 1's recent transfer documents from the hospital to the skilled nursing facility included a document titled Inpatient Physical Therapy Evaluation dated 12/19/25 at 1:30 P.M., which indicated, .Safety Judgment: Decreased awareness of need for safety, Decreased awareness of need for assistance. Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated 12/25/25 indicated that Resident 1 was rarely or never understood with severe cognitive deficits (a decrease in the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) to understand and make decisions. According to the MDS section J: Resident 1 was assessed as a fall risk and had experienced falls prior to admission to the skilled nursing facility. On 1/28/26 at 3:44 P.M., an interview and record review were conducted with the Director of Staff Development (DSD). The DSD stated Resident 1's fall risk care plan initiated 12/22/25, indicated, .Educate/remind resident to call for assistance .Keep call light within reach.Keep within supervised view as much as possible. was not individualized and specific to Resident 1's cognitive (relating to the mental processes of knowing, learning, thinking, and understanding things) and safety needs. The DSD further stated that if Resident 1 was unable to comprehend or appropriately use the call light for safety, use call light on the care plan does not effectively lessen Resident 1's fall risk because Resident 1 had decreased safety awareness with limited understanding of the purpose of a call light, and dependent on that nursing intervention alone is insufficient. The DSD stated the care plan should instead include direct supervision and staff-initiated monitoring to ensure Resident 1's safety. The DSD stated that 1:1 supervision allows staff to immediately intervene and redirect unsafe movement, which helps prevent falls and injury. The DSD stated Resident 1's fall risk should have been clearly communicated to all licensed nurses and CNAs. The DSD further stated that when a high fall-risk resident is left unsupervised, even briefly, a resident may fall and sustain serious injury caused by delayed staff response for impulsive residents.On 1/29/26 at 12:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was that the LNs (LN 1 and LN 2) involved with Resident 1's care should have completed a comprehensive safety assessment for Resident 1 to update and personalize Resident 1's safety needs based on Resident 1's cognitive impairment and decreased safety awareness and should have implemented structured monitoring every 30 minutes with clearly assigned staff responsibility. The DON stated staff should have used a sensitive or alternative call-light system, as Resident 1 did not comprehend the purpose or safe use of a standard call light. The DON stated that a 1:1 supervision should have been implemented when Resident 1 was observed attempting to stand on the day of the incident. The DON stated 1:1 supervision was critical due to Resident 1's cognitive limitations, impulse behaviors, and fall risk assessment, explaining that Resident 1 was unable to consistently recognize danger or follow safety instructions. The DON stated that 1:1 supervision ensures continuous observation and immediate staff intervention, allowing staff to redirect unsafe movement, attend to Resident 1's needs and prevent accidents before they occur. The DON stated her expectation was that all nursing staff and CNAs are informed of fall risk and supervision needs, particularly for new admissions, and that residents (all (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility residents) are closely monitored during the first 72 hours to determine whether enhanced supervision is required. The DON further stated that delayed staff response for impulsive residents (such as Resident 1) or residents (all fall risk facility residents) unable to recognize danger significantly increases the risk for injury, including fall-related harm and further health decline. The DON acknowledged that failure to clearly communicate a fall risk and lack of supervision placed Resident 1 at risk because the nursing staff were unaware of the level of monitoring required, resulting in inadequate supervision and hospitalization.A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered dated March 2022, indicated .Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change.2. Feeding AssistanceA review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently). Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated 12/25/25 indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On 1/14/26 at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated that upon starting her shift on 12/25/25, she observed Resident 1 independently wheeling himself (using a wheelchair for ambulation -the act of walking or moving place to place) in the hallway. CNA 1 stated she provided Resident 1 with a meal tray, and watched Resident 1 eat independently. CNA 1 stated she was not informed that Resident 1 was a fall risk. CNA 1 reported that Resident 1 remained seated in his wheelchair unsupervised in the hallway until approximately 8 P.M., on 12/25/25. CNA 1 stated that after returning from a bathroom break, she observed nursing staff (LN 2) with Resident 1 who was lying face down on the floor with a bleeding head wound. CNA 1 stated oxygen was applied to Resident 1 who was minimally responsive, moving only his hand, at the time he was found on the floor. On 1/14/26 at 3:47 P.M., an interview was conducted with CNA 5. CNA 5 stated Resident 1 was able to feed self but was on her feeder's list due to difficulty with swallowing and to prevent choking hazards.Resident 1's nutritional care plan with date initiated as 12/22/25 interventions indicated, .1:1 Feeding Assistance. Resident 1's Speech evaluation dated 12/22/25 indicated, .Previous treatment 1:1 feeder.Swallowing Abilities=Severe.Risk Factors: Aspiration [choking].The facility's document labeled Feeding list undated included Resident 1's name.On 1/28/26 at 3 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated staff were required to communicate resident-specific risks and care needs, including cognitive (related to thinking, learning, and understanding) impairment, fall risk and feeding assistance, through shift handoff reports and nurse-led huddles prior to providing care. The DSD stated staff must know this information before assuming resident care (all facility residents) to ensure safe and competent services. The DSD further stated failure to communicate these risks could result in preventable injuries, including falls and choking, due to staff being unaware of Resident 1's supervision and assistance needs.On 1/29/26 at 1:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff were expected to competently assess residents with cognitive impairment and impulsive behaviors, anticipate risks, and implement appropriate interventions to prevent injury. The DON stated Resident 1's assigned staff were required to provide direct assistance to Resident 1 during feeding due to choking risk and not to leave Resident 1 unattended. The DON further stated failure of staff to understand Resident 1's specific risks and care needs placed Resident 1 at risk for injury, further health decline and death.A review of the facility's policy and procedure titled, Care Plans, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Person-Centered dated March 2022, indicated .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate emergency respiratory interventions, including providing rescue breaths or assisted ventilation (movement of air in and out of the lungs), for one of three sampled residents (Resident 1).This deficient practice placed Resident 1 at risk for hypoxia (low oxygen levels), and respiratory arrest.Cross-Reference F726 and F689Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated [DATE] indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On [DATE] at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated that upon starting her shift on [DATE], she observed Resident 1 independently wheeling himself (using a wheelchair for ambulation -the act of walking or moving place to place) in the hallway. CNA 1 stated she provided Resident 1 with a meal tray, and watched Resident 1 eat independently. CNA 1 stated she was not informed that Resident 1 was a fall risk. CNA 1 reported that Resident 1 remained seated in his wheelchair unsupervised in the hallway until approximately 8 P.M., on [DATE]. CNA 1 stated that after returning from a bathroom break, she observed nursing staff (LN 2) with Resident 1 who was lying face down on the floor with a bleeding head wound. CNA 1 stated oxygen was applied to Resident 1 who was minimally responsive, moving only his hand, at the time he was found on the floor. On [DATE] at 1:51 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 1's baseline was alert but not oriented (confused) x [times]3 [person, place, time] and was non-verbal (did not speak). LN 1 further stated after the fall Resident 1 was having agonal breathing (an abnormal, reflex-driven pattern of slow, gasping, or snoring-like breaths that occurs in severe emergencies), but had a pulse. LN 1 further stated the only intervention that we did was oxygenation (the process of supplying, treating, or enriching blood with oxygen), he [Resident 1] still had a pulse we just gave oxygen via non re-breather mask (non-invasive device that delivers high concentration of oxygen) used for acute respiratory distress (life-threatening, a very serious condition and may cause rapid, severe shortness of breath, low oxygen levels, and stiff lungs, often occurring in critically ill patients due to sepsis, pneumonia, or injury). On [DATE] at 2:11 P.M., an interview was conducted with CNA 2. CNA 2 stated she later observed nursing staff next to Resident 1 who was found on the floor. CNA 2 stated she observed Resident 1 to have had irregular breathing, which prompted LN 2 to administer oxygen via a non-rebreather mask. CNA 2 further stated Resident 1 had been observed earlier seated in his wheelchair with a walker positioned in front of him and that no staff member instructed her to monitor or supervise Resident 1 at any time during her shift, including when the assigned CNA 1 left the area to use the restroom.On [DATE] at 11:48 A.M., an interview was conducted with CNA 3. CNA 3 stated earlier on [DATE] she had seen Resident 1 in the hallway sitting on his (Resident 1) wheelchair making random sounds, not fully verbal, and attempting to stand up from the wheelchair. CNA 3 stated she was informed by the LNs (LN 1 and LN 2) at the start of the shift that Resident 1 was a fall risk. CNA 3 stated she was not instructed by CNA 1 to monitor or supervise Resident 1 prior to CNA 1 using the restroom. CNA 3 stated she heard a nurse call out for help then entered Resident 1's room, where she observed Resident 1 lying on the floor with a bleeding forehead, non-responsive and breathing irregularly. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 3 stated after the fall, LN 2 had applied oxygen via a mask, (medical emergency device used to deliver high concentrations of oxygen) and she observed no rescue breaths or chest compressions had been provided. CNA 3 further stated Resident 1 did not regain consciousness not waking up, and his (Resident 1) body was twitching while on the floor.On [DATE] at 8:40 A.M., an interview was conducted with LN 2. LN 2 stated Resident 1's oxygen levels was not registering on the oxygen pulse oximetry (device that measures blood oxygen saturation/levels). LN 2 stated she did not check Resident 1's chest for rise and fall to determine effective breathing and did not provide rescue breaths, despite uncertainty regarding Resident 1's respiratory status. LN 2 stated she provided chest rubs and oxygen via mask, confirmed Resident 1 had a pulse, and acknowledged that chest compressions were documented inaccurately, as they were not performed. LN 2 stated she understood rescue breaths are required when a resident is not breathing adequately to ensure airway patency and oxygen delivery to the brain and acknowledged that delayed or missed rescue breathing can result in serious harm, including brain injury. On [DATE] at 3 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated staff are expected to follow the American Heart Association (AHA) Basic Life Support (BLS) guidelines during emergencies or changes in condition. The DSD stated when a resident (all facility residents) are unresponsive with a pulse and abnormal or ineffective breathing, staff must initiate rescue breathing at a rate of one breath every six seconds (10 breaths per minute) and assess chest rise and fall to confirm airway patency. The DSD stated that supplemental oxygen does not replace rescue breaths, as oxygen alone does not provide ventilation (movement of air in and out of the lungs) or ensure air movement into the lungs. The DSD further stated failure to provide rescue breaths could result in delayed oxygen delivery to the brain, brain injury, respiratory failure and compromised continuity of care during hospital transfer.On [DATE] at 2 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff were required to immediately recognize and respond when Resident 1 was unresponsive or exhibited irregular or ineffective breathing, as failure to do so placed Resident 1's life at risk. The DON stated supplemental oxygen did not replace rescue breaths, because rescue breathing was necessary to assess airway patency, confirm chest rise, and provide effective ventilation. The DON further stated failure to provide rescue breaths could result in inadequate oxygen delivery to the brain and vital organs, leading to coma or death if not promptly addressed.According to the American Heart Association at https:// https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-life-support .For adult patients who are not breathing normally but have a pulse, it is reasonable for rescuers to provide 1 breath every 6 seconds (10 breaths per minute). rescuers can monitor for adequate ventilation by observing chest rise. Ventilation is essential for oxygen delivery and carbon dioxide elimination for a person with a pulse who is not breathing or not breathing effectively. passive oxygen delivery does not ensure sufficient ventilation.A review of the facility's policy and procedure titled, Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support dated [DATE], indicated .Staff are trained to follow current AHA Guidelines and recommendations for the sequence of resuscitation, including: a. Recognition of cardiac arrest; b. Initiation of resuscitation; c. Opening the airway.

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	055064	A. Building B. Wing	02/12/2026

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility left Resident 1 alone with a meal tray and did not provide feeding assistance or supervision to Resident 1 who had been assessed and identified as requiring feeding assistance and supervision (according to the facility's nutritional care plan). The facility also failed to provide adequate (one on one supervision) for Resident 1 who was assessed as a high risk for a fall and did not implement appropriate fall-prevention interventions (based on assessment of Resident 1's individual needs), for one of three sampled residents (Resident 1).As a result, Resident 1 required emergency services, was hospitalized , sustained a head injury, sustained a spinal L4 compression fracture, (break in the fourth lumbar vertebra lower back, the part of your spine with five strong bones that support your upper body's weight) was intubated, (a plastic tube is inserted into a person's windpipe/trachea to open and to deliver oxygen, via a breathing machine called a ventilator) transferred to the ICU, (intensive care unit-a higher level of care within the hospital) experienced seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and required placement of a feeding tube (FT-feeding tube-medical device used to provide nutrition when oral intake is altered or unsafe).Cross-Reference F842, F726, F656 and F678Findings:Resident 1's skilled nursing facility record was reviewed. Per the admission record Resident 1 was admitted to the skilled nursing facility on [DATE] with diagnoses which included difficulty in walking, muscle weakness and a fall history. Resident 1 was also diagnosed with an Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently) and dysphagia (difficulty swallowing).Resident 1's recent transfer documents from the hospital to the skilled nursing facility included a document titled Inpatient Physical Therapy Evaluation dated [DATE] at 1:30 P.M., which indicated, .Safety Judgment: Decreased awareness of need for safety, Decreased awareness of need for assistance. Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated [DATE] indicated that Resident 1 was rarely or never understood with severe cognitive deficits (a decrease in the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) to understand and make decisions. According to the MDS section J: Resident 1 was assessed as a fall risk and had experienced falls prior to admission to the skilled nursing facility. On [DATE] at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated that upon starting her shift on [DATE], she observed Resident 1 independently wheeling himself (using a wheelchair for ambulation -the act of walking or moving place to place) in the hallway. CNA 1 stated she provided Resident 1 with a meal tray, and watched Resident 1 eat independently. CNA 1 reported that Resident 1 remained seated in his wheelchair unsupervised in the hallway until approximately 8 P.M., on [DATE]. CNA 1 stated that after returning from a bathroom break, she observed nursing staff (LN 2) with Resident 1 who was lying face down on the floor with a bleeding head wound. CNA 1 stated oxygen was applied to Resident 1 who was minimally responsive, moving only his hand, at the time he was found on the floor. CNA 1 stated she was not informed that Resident 1 was a fall risk. Record review of Resident 1's nutritional care plan with date initiated as [DATE] interventions indicated, .1:1 (one staff to one Resident) Feeding Assistance. Resident 1's Speech evaluation dated [DATE] indicated, .Previous treatment 1:1 feeder.Swallowing Abilities=Severe.Risk Factors: Aspiration [choking]. The facility's document labeled Feeding list undated included Resident 1's name.On [DATE] at 1:51 P.M., an interview and record review were conducted with LN 1. LN 1 stated he was the nursing supervisor on duty when Resident 1 fell ([DATE]). LN 1 stated he had directed the CNA's (assigned to hallway 100 where (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1's room was) to closely monitor Resident 1 because Resident 1 had repeatedly attempted to get out of his wheelchair and was seen wheeling himself throughout the hallway. LN 1 stated Resident 1 was a high fall-risk and required close supervision at all times and should be on a one to one [1:1] supervision (one staff supervising one resident) for safety. LN 1 further stated Resident 1 did not have orders for a 1:1 supervision and Resident 1 was not care-planned (plan created by nursing based on an assessment) for 1:1 supervision but should have been because he was a safety risk. LN 1 stated Resident 1's assigned CNA (CNA 1) used the restroom and that CNA 1 had told a registry (temporary or contracted staff) CNA, (CNA 3) to watch [Resident Name]. CNA 3 ignored CNA 1's instructions to supervise Resident 1. LN 1 stated Resident 1 had not been supervised and fell. LN 1 stated Resident 1's baseline was alert but not oriented (confused) x [times]3 [person, place, time] and was non-verbal (did not speak). LN 1 further stated after the fall Resident 1 was having agonal breathing (an abnormal, reflex-driven pattern of slow, gasping, or snoring-like breaths that occurs in severe emergencies), but had a pulse. LN 1 further stated the only intervention that we did was oxygenation (the process of supplying, treating, or enriching blood with oxygen), he [Resident 1] still had a pulse we just gave oxygen via non re-breather mask (non-invasive medical device that delivers high concentration of oxygen) used for acute respiratory distress (life-threatening, a very serious condition and may cause rapid, severe shortness of breath, low oxygen levels, and stiff lungs, often occurring in critically ill patients due to sepsis, pneumonia, or injury). On [DATE] at 2:03 P.M., an interview was conducted with CNA 1. CNA 1 stated she did not ask another nursing staff to supervise Resident 1 because she was unaware Resident 1 was a fall risk. CNA 1 stated LN 1 did not endorse or communicate to her that Resident 1 required close monitoring or supervision. CNA 1 stated Resident 1 had confusion and was unable to fully verbalize his needs, communicating primarily through gestures. CNA 1 further stated if she had been informed Resident 1 was a fall risk, she would have immediately notified another nursing staff member to supervise Resident 1 to prevent the fall.On [DATE] at 2:11 P.M., an interview was conducted with CNA 2. CNA 2 stated Resident 1 was not assigned to her on [DATE]; however, Resident 1 was located on the same unit throughout her shift. CNA 2 stated she observed Resident 1 sitting alone in his wheelchair and noted Resident 1 appeared confused and not fully oriented, which she believed to be Resident 1's baseline. CNA 2 stated she was not informed that Resident 1 was a fall risk and therefore did not recognize the need for close supervision. CNA 2 stated she later observed nursing staff next to Resident 1 who was found on the floor. CNA 2 stated she observed Resident 1 to have had irregular breathing, which prompted LN 2 to administer oxygen via a non-rebreather mask. CNA 2 further stated Resident 1 had been observed earlier seated in his wheelchair with a walker positioned in front of him and that no staff member instructed her to monitor or supervise Resident 1 at any time during her shift, including when the assigned CNA 1 left the area to use the restroom.On [DATE] at 3:40 P.M., an interview was conducted with CNA 4. CNA 4 stated Resident 1 required maximum assistance (the staff performs approximately 75% or more of the physical work, while the patient contributes 25% or less) for sit-to-stand movements and transfers due to being wobbly and unstable. CNA 4 stated Resident 1 used a walker and had ambulated with a walker during therapy sessions. CNA 4 stated Resident 1 was confused and appeared unable to consistently understand how to use the call light for safety, despite staff encouragement. CNA 4 further stated that due to Resident 1's confusion, and inability to fully verbalize his needs, staff would need to respond promptly to prevent unsafe attempts to stand if Resident 1 needed assistance.On [DATE] at 3:47 P.M., an interview was conducted with CNA 5. CNA 5 stated that when Resident 1 was first admitted to the skilled nursing facility she noticed Resident 1 frequently sat on the edge of the bed without assistance and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	had difficulty understanding how to safely use the call light. CNA 5 stated Resident 1 often laughed or giggled when attempting to use the call light and continued not to use it, indicating limited comprehension and developmental delay. CNA 5 stated Resident 1 was a known fall risk, as he (Resident 1) could sit up unassisted in bed and attempted to stand or ambulate without assistance. CNA 5 stated she had reported to the LN's that Resident 1 repeatedly sat at the edge of the bed and required ongoing supervision to reduce the risk of a fall. CNA 5 further stated that despite reminders, Resident 1 continued unsafe behaviors and required supervision to prevent falls.Resident 1's skilled nursing facility record was reviewed. Resident 1's History and Physical (H&P) examination by the facility Medical Doctor (MD) dated [DATE], indicated, .This resident.does NOT have the capacity to understand and make decisions. Resident 1's admission fall risk assessment titled, .FALL RISK OBSERVATION/ASSESSMENT. dated [DATE] at 20:37 (8:37 P.M.) indicated, Resident 1's fall risk score was a 20 that identified Resident 1 was a .HIGH RISK. Resident 1's fall risk care plan initiated [DATE], indicated, .Educate/remind resident to call for assistance .Keep call light within reach.Keep within supervised view as much as possible. Resident 1's skilled nursing facility Electronic Health Record (EHR) progress noted by Licensed Nurse (LN) 1 titled Nurse's Note dated,[DATE] at 20:00 (8:00 P.M.), indicated, .Resident spotted one time trying to get out of his wheelchair.Medication nurse for 100 hall instructed all of the CNAs [Certified Nursing Assistant] in the hallway to do visual inspections every 30 minutes and switch with other CNA as needed to keep resident under continuous supervision. Nurse on duty had also instructed CNAs that if resident was to be alone inside of room, to be in the same room with the resident.A record review of Resident 1's progress noted by LN 1 was reviewed. The note titled Nurse's Note dated [DATE] at 20:55 (8:55 P.M.) late entry, indicated, .Heard medication nurse shouting across the hallway to the front nurse's station. Medication nurse requested crash cart (a set of trays/drawers/shelves on wheels used in hospitals for transportation and dispensing of emergency medication/equipment at site of medical/surgical emergency for life support protocols); crash cart taken to her. Walked into the room to find resident lying face down and having agonal (a critical, abnormal reflex characterized by gasping, snorting, or labored, infrequent breaths that occur when the brain is severely deprived of oxygen) respirations. Resident also had a bleeding laceration (a ragged, jagged tear in the skin), on top left of the forehead. Oxygen tank and non-rebreather (a, high-concentration oxygen therapy device featuring a reservoir bag, one-way valves, and a face mask). used C-spine[Cervical-spine refers to neck] to stabilize cervical neck [sic], used a 3 person assist to turn resident to the supine [lying flat on your back with your face, chest, and stomach facing upward] position. Resident breathing had slowed down to the point where he was fully unconscious [a person is not reacting to sound, touch, or pain] by this time. Writer ran out, grabbed treatment cart to control bleeding to the forehead using gauze and bandages.A record review of Resident 1's EHR progress note was conducted. Nurse's Note dated [DATE] at 21:00 (9 P.M.) late entry by LN 2, indicated, .Found the resident lying on the floor .Some abrasion to bilateral UE [upper extremity-arms and hands]. The residentwas[sic] unresponsive [unconscious] at this time. The chest compression (manual technique, life-saving used during CPR to pump blood to a person's heart and brain) initiated [sic] and oxygen with a non re-breather [sic] mask was given. 9-11 was called. arrived at 21:10. Resident is transportation to [Hospital Name] for further eval.Resident 1's hospital record was reviewed. Resident 1's hospital emergency notes titled, H&P(History and Physical) dated [DATE] 9:38 P.M, indicated, .General Appearance: Awake and non-responsive, uncomfortable appearing, hematoma (clotted blood that pools outside of blood vessels, usually after an injury), to forehead.Review of Resident 1's Trauma notes titled, Trauma Tertiary [third in order] Note dated, [DATE] 12:32 P.M., indicated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.presented to [Hospital Name] after being found down. Patient was found to have the following injuries: L4 compression fracture with 30% height loss.Patient is intubated someone who has had a hollow breathing tube (inserted through their mouth or nose into their windpipe (trachea) to maintain an open airway, deliver oxygen, provide anesthesia, or assist breathing with a ventilator, used when patient can not breathe adequately on their own) (.Seizure activity noted overnight.Neurology consulted given seizure activity.Resident 1's hospital discharge notes were reviewed. The document titled, Discharge Summary dated [DATE] 3:05 P.M., indicated, .Diagnosis on discharge Seizure disorder Dysphagia [difficulty swallowing].It was presumed that the patient suffered arrest from acute respiratory failure, in the setting of recurrent aspiration [choking]. Apparently, patient was witnessed to have two generalized TC [tonic clonic-sudden loss of consciousness, body stiffening which is a tonic phase, and rhythmic jerking-clonic phase] seizures after admission. MRI [a magnetic resonance image of the brain] 12/26, which revealed findings concordant [consistent or align with one another] with recent seizure activity.Patient's brother has elected to maintain FC [feeding connection]/FT [feeding tube].Record review of Resident 1's skilled nursing facility and hospital records indicated Resident 1 had no documented history of seizure activity or dependence on a feeding tube prior to the facility-to-hospital transfer on [DATE].On [DATE] at 11:48 A.M., an interview was conducted with CNA 3. CNA 3 stated she was a registry CNA who had worked the night Resident 1 fell. CNA 3 stated she was not the primary CNA assigned to Resident 1 but had observed Resident 1 earlier in the hallway sitting on his (Resident 1) wheelchair making random sounds, not fully verbal, and attempting to stand up from the wheelchair. CNA 3 stated she was informed by the LNs (LN 1 and LN 2) at the start of the shift that Resident 1 was a fall risk. CNA 3 stated she was not instructed by CNA 1 to monitor or supervise Resident 1 prior to CNA 1 using the restroom. CNA 3 stated she heard a nurse call out for help then entered Resident 1's room, where she observed Resident 1 lying on the floor with a bleeding forehead, non-responsive and breathing irregularly. CNA 3 stated after the fall, LN 2 had applied oxygen via a mask, and she observed no rescue breaths or chest compressions had been provided. CNA 3 further stated Resident 1 did not regain consciousness not waking up, and his (Resident 1) body was twitching while on the floor.On [DATE] at 12 P.M., an interview and record review were conducted with LN 2. LN 2 stated she did not witness Resident 1's fall that happened in his room because she (LN2) was at the nursing station charting. LN 2 stated she heard somebody called out and his [Resident 1] roommate said somebody fell. LN 2 stated she entered Resident 1's room and observed Resident 1 lying face down on the floor, unresponsive, with visible bleeding around the head. LN 2 stated Resident 1 had poor safety awareness and had episodes of ambulating without assistance to use the bathroom in his room despite, reminders to use the call light and did not reliably call staff for help. LN 2 stated she was not aware Resident 1 was identified as a fall risk prior to the incident but acknowledged that, given Resident 1's IDD, confusion and communication deficits (difficulty with memory, thinking and controlled impulses) that Resident 1 should have been considered a safety and fall risk. LN 2 stated if she had known Resident 1 was a fall risk, then Resident 1‘s care plan should have been updated with interventions for Resident 1 to be placed on a 1:1 supervision and not left unattended to prevent the fall. On [DATE] at 3 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated staff were required to communicate resident-specific risks and care needs, including cognitive (related to thinking, learning, and understanding) impairment, fall risk and feeding assistance, through shift handoff reports and nurse-led huddles prior to providing care. The DSD stated staff must know this information before assuming resident care (all facility residents) to ensure safe and competent services. The DSD further stated failure to communicate these risks could (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	result in preventable injuries, including falls and choking, due to staff being unaware of Resident 1's supervision and assistance needs.On [DATE] at 3:44 P.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated Resident 1's fall risk care plan initiated [DATE], indicated, .Educate/remind resident to call for assistance .Keep call light within reach.Keep within supervised view as much as possible. was not individualized and specific to Resident 1's cognitive (relating to the mental processes of knowing, learning, thinking, and understanding things) and safety needs. The DSD further stated that if Resident 1 was unable to comprehend or appropriately use the call light for safety, use call light on the care plan does not effectively lessen Resident 1's fall risk because Resident 1 had decreased safety awareness with limited understanding of the purpose of a call light, and dependent on that nursing intervention alone is insufficient. The DSD stated the care plan should instead include direct supervision and staff-initiated monitoring to ensure Resident 1's safety. The DSD stated that 1:1 supervision allows staff to immediately intervene and redirect unsafe movement, which helps prevent falls and injury. The DSD stated Resident 1's fall risk should have been clearly communicated to all licensed nurses and CNAs. The DSD further stated that when a high fall-risk resident is left unsupervised, even briefly, a resident may fall and sustain serious injury caused by delayed staff response for impulsive residents.On [DATE] at 12:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was that the LNs (LN 1 and LN 2) involved with Resident 1's care should have completed a comprehensive safety assessment for Resident 1 to update and personalize Resident 1's safety needs based on Resident 1's cognitive impairment and decreased safety awareness and should have implemented structured monitoring every 30 minutes with clearly assigned staff responsibility. The DON stated staff should have used a sensitive or alternative call-light system, as Resident 1 did not comprehend the purpose or safe use of a standard call light. The DON stated that a 1:1 supervision should have been implemented when Resident 1 was observed attempting to stand on the day of the incident. The DON stated 1:1 supervision was critical due to Resident 1's cognitive limitations, impulse behaviors, and fall risk assessment, explaining that Resident 1 was unable to consistently recognize danger or follow safety instructions. The DON stated that 1:1 supervision ensures continuous observation and immediate staff intervention, allowing staff to redirect unsafe movement, attend to Resident 1's needs and prevent accidents before they occur. The DON stated her expectation was that all nursing staff and CNAs are informed of fall risk and supervision needs, particularly for new admissions, and that residents (all facility residents) are closely monitored during the first 72 hours to determine whether enhanced supervision is required. The DON further stated that delayed staff response for impulsive residents (such as Resident 1) or residents (all fall risk facility residents) unable to recognize danger significantly increases the risk for injury, including fall-related harm and further health decline. The DON acknowledged that failure to clearly communicate a fall risk and lack of supervision placed Resident 1 at risk because the nursing staff were unaware of the level of monitoring required, resulting in inadequate supervision and hospitalization.On [DATE] at 1:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff were expected to competently assess residents with cognitive impairment and impulsive behaviors, anticipate risks, and implement appropriate interventions to prevent injury. The DON stated Resident 1's assigned staff were required to provide direct assistance to Resident 1 during feeding due to choking risk and not to leave Resident 1 unattended. The DON further stated failure of staff to understand Resident 1's specific risks and care needs placed Resident 1 at risk for injury, further health decline and death.A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered dated [DATE], (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	indicated .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.A record review of the facility's policy and procedure titled, Falls and Fall Risk, Managing dated [DATE], indicated .If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure staff assigned to high fall-risk residents were competent, informed, and trained to meet the residents' safety and care needs, for one of three residents sampled (Resident 1) when:1. Cardiopulmonary resuscitation (CPR) rescue breaths was not provided and only oxygen via a non-rebreather mask was administered when Resident 1 was found unresponsive with irregular breathing, and oxygen saturation was not registering on pulse oximetry (device that measures blood oxygen saturation/levels) .2. Resident 1, who was a high fall-risk resident, was left unsupervised, despite requiring close monitoring.3. Staff failed to provide feeding assistance to Resident 1, even though the resident was identified as requiring feeding assistance on a feeding assist list and required assistance with meals.As a result, this placed Resident 1 at risk for harm, including inadequate emergency response, respiratory compromise, falls with injury, choking or aspiration, and unmet care needs due to staff not being competent or informed of Resident 1's required level of care.Cross-reference F689, and F678Findings:1. CPRA review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated [DATE] indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On [DATE] at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 reported that Resident 1 remained seated in his wheelchair unsupervised in the hallway until approximately 8 P.M., on [DATE]. CNA 1 stated that after returning from a bathroom break, she observed nursing staff (LN 2) with Resident 1 who was lying face down on the floor with a bleeding head wound. CNA 1 stated oxygen was applied to Resident 1 who was minimally responsive, moving only his hand, at the time he was found on the floor. On [DATE] at 1:51 P.M., an interview and record review was conducted with LN 1. LN 1 further stated after the fall Resident 1 was having agonal breathing (an abnormal, reflex-driven pattern of slow, gasping, or snoring-like breaths that occurs in severe emergencies), but had a pulse. LN 1 further stated the only intervention that we did was oxygenation (the process of supplying, treating, or enriching blood with oxygen), he [Resident 1] still had a pulse we just gave oxygen via non re-breather mask (non-invasive device that delivers high concentration of oxygen) used for acute respiratory distress (life-threatening, a very serious condition and may cause rapid, severe shortness of breath, low oxygen levels, and stiff lungs, often occurring in critically ill patients due to sepsis, pneumonia, or injury). On [DATE] at 2:11 P.M., an interview was conducted with CNA 2. CNA 2 stated she later observed nursing staff already present with Resident 1 after Resident 1 was found on the floor in his room. CNA 2 stated she assisted with placing Resident 1 in a safe position and observed Resident 1 had irregular breathing, prompting LN 2 to administer oxygen via a non-rebreather mask. CNA 2 stated Resident 1 was non-verbal, moving his fingers, and confirmed that Cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) or chest compressions were not initiated because the resident had a pulse.On [DATE] at 11:48 A.M., an interview was conducted with CNA 3. CNA 3 stated she heard a nurse call out for help then entered Resident 1's room, where she observed Resident 1 lying on the floor with a bleeding forehead, non-responsive and breathing irregularly. CNA 3 stated after the fall, LN 2 had applied oxygen via a mask, and she observed no rescue breaths or chest compressions had been provided. CNA 3 (continued on next page)

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	055064	A. Building B. Wing	02/12/2026

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated Resident 1 did not regain consciousness not waking up, and his (Resident 1) body was twitching while on the floor.On [DATE] at 8:40 A.M., an interview was conducted with LN 2. LN 2 stated Resident 1's oxygen levels was not registering on the oxygen pulse oximetry. LN 2 stated she did not check Resident 1's chest for rise and fall to determine effective breathing and did not provide rescue breaths, despite uncertainty regarding Resident 1's respiratory status. LN 2 stated she provided chest rubs and oxygen via mask, confirmed Resident 1 had a pulse, and acknowledged that chest compressions were documented inaccurately, as they were not performed. LN 2 stated she understood rescue breaths are required when a resident is not breathing adequately to ensure airway patency and oxygen delivery to the brain and acknowledged that delayed or missed rescue breathing can result in serious harm, including brain injury. On [DATE] at 3 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated staff are expected to follow the American Heart Association (AHA) Basic Life Support (BLS) guidelines during emergencies or changes in condition. The DSD stated when a resident (all facility residents) are unresponsive with a pulse and abnormal or ineffective breathing, staff must initiate rescue breathing at a rate of one breath every six seconds (10 breaths per minute) and assess chest rise and fall to confirm airway patency. The DSD stated that supplemental oxygen does not replace rescue breaths, as oxygen alone does not provide ventilation (movement of air in and out of the lungs) or ensure air movement into the lungs. The DSD further stated failure to provide rescue breaths could result in delayed oxygen delivery to the brain, brain injury, respiratory failure and compromised continuity of care during hospital transfer.On [DATE] at 2 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff were required to immediately recognize and respond when Resident 1 was unresponsive or exhibited irregular or ineffective breathing, as failure to do so placed Resident 1's life at risk. The DON stated supplemental oxygen did not replace rescue breaths, because rescue breathing was necessary to assess airway patency, confirm chest rise, and provide effective ventilation. The DON further stated failure to provide rescue breaths could result in inadequate oxygen delivery to the brain and vital organs, leading to coma or death if not promptly addressed.According to the American Heart Association at https:// https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-life-support .For adult patients who are not breathing normally but have a pulse, it is reasonable for rescuers to provide 1 breath every 6 seconds (10 breaths per minute). rescuers can monitor for adequate ventilation by observing chest rise. Ventilation is essential for oxygen delivery and carbon dioxide elimination for a person with a pulse who is not breathing or not breathing effectively. passive oxygen delivery does not ensure sufficient ventilation.A review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing dated [DATE], indicated .Licensed staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas.Identifying and responding to changes in condition.2. Fall risk-unsupervisedA review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated [DATE] indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On [DATE] at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated Resident 1 fed himself and further stated she was not aware Resident 1 required one on one (1:1) feeding assistance and was not informed that Resident 1 was a fall risk. CNA 1 reported that Resident 1 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remained seated in his wheelchair unsupervised and repeatedly refused to return to his room for dinner despite staff encouragement. CNA 1 stated that around 8 P.M., after returning from a bathroom break, she observed nursing staff (LN 2) was with Resident 1 in his room lying face down on the floor with a bleeding head wound. CNA 1 further stated Resident 1 was minimally responsive, moving his hand, at the time he was found on the floor.On [DATE] at 1:51 P.M., an interview and record review was conducted with LN 1. LN 1 stated he was the nursing supervisor on duty. LN 1 stated he had directed the CNA's (assigned to hallway 100 where Resident 1's room was) to closely monitor Resident 1 because Resident 1 had repeatedly attempted to get out of his wheelchair and was seen wheeling himself throughout the hallway. LN 1 stated Resident 1 was a high fall-risk and required close supervision at all times and should be on a one to one [1:1] supervision for safety. LN 1 stated Resident 1 did not have orders for a 1:1 supervision and was not care-planned as a 1:1 supervision but should have because he was a safety risk. LN 1 stated Resident 1's assigned CNA (CNA 1) used the restroom and that CNA 1 had told a registry CNA (CNA 3) to watch [Resident Name] but instead ignored CNA 1's instructions to supervise Resident 1as the reason why Resident 1 was not supervised and fell. LN 1 stated Resident 1's baseline was alert but not oriented x [times]3 [person, place, time] and was non-verbal. On [DATE] 2:03 P.M., an interview was conducted with CNA 1. CNA 1 stated she did not ask another nursing staff to supervise Resident 1 because she was unaware Resident 1 was a fall risk. CNA 1 stated LN 1 did not endorse or communicate to her that Resident 1 required close monitoring or supervision. CNA 1 further stated that had she been informed Resident 1 was a fall risk, she would have immediately notified another nursing staff member to supervise Resident 1 to prevent the fall.On [DATE] at 2:11 P.M., an interview was conducted with CNA 2. CNA 2 stated Resident 1 was not assigned to her; however, Resident 1 was located on the same unit throughout her shift. CNA 2 stated she observed Resident 1 sitting alone in his wheelchair and noted Resident 1 appeared confused and not fully oriented, which she believed to be Resident 1's baseline. CNA 2 stated she was not informed that Resident 1 was a fall risk and therefore did not recognize the need for close supervision. CNA 2 stated she later observed nursing staff already present with Resident 1 after Resident 1 was found on the floor. CNA 2 further stated Resident 1 had been observed earlier seated in his wheelchair with a walker positioned in front of him and that no staff member instructed her to monitor or supervise Resident 1 at any time during her shift, including when the assigned CNA1 left the area to use the restroom.On [DATE] at 3:40 P.M., an interview was conducted with CNA 4. CNA 4 stated Resident 1 required maximum assistance for sit-to-stand movements and transfers due to being wobbly and unstable. CNA 4 stated Resident 1 used a walker and had ambulated with a walker during therapy sessions. CNA 4 stated Resident 1 was confused and appeared unable to consistently understand how to use the call light for safety, despite staff encouragement. CNA 4 further stated that due to Resident 1's confusion and inability to fully verbalize his needs, staff would need to respond promptly to prevent unsafe attempts to stand if Resident 1 needed assistance.On [DATE] at 3:47 P.M., an interview was conducted with CNA 5. CNA 5 stated that when Resident 1 was first admitted she noticed Resident 1 frequently sat on the edge of the bed without assistance and had difficulty understanding how to safely use the call light. CNA 5 stated Resident 1 often laughed or giggled when attempting to use the call light and continued not to use it, indicating limited comprehension and developmental delay. CNA 5 stated Resident 1 was a known fall risk, as he (Resident 1) could sit up unassisted in bed and attempted to stand or ambulate without assistance. CNA 5 stated she had reported to the LN's that Resident 1 repeatedly sat at the edge of the bed and required ongoing supervision to reduce fall risks. CNA 5 further stated that despite reminders, Resident 1 continued unsafe behaviors and required supervision to prevent (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falls.On [DATE] at 11:48 A.M., an interview was conducted with CNA 3. CNA 3 stated she was a registry CNA that worked the night Resident 1 fell. CNA 3 stated she was not instructed and/or endorsed by CNA 1 to monitor or supervise Resident 1 prior to CNA 1 using the restroom. CNA 3 stated she heard a nurse call out for help then entered Resident 1's room, where she observed Resident 1 lying on the floor with a bleeding forehead, non-responsive and breathing irregularly. CNA 3 stated Resident 1 was placed in the hallway because Resident 1 was impulsive, repeatedly attempted to move toward other residents' rooms and was resistant to redirection when his (Resident 1) primary CNA (CNA 1) attempted to return him to bed. CNA 3 further stated Resident 1 did not regain consciousness not waking up and his (Resident 1) body was twitching while on the floor.On [DATE] at 12 P.M., an interview and record review was conducted with LN 2. LN 2 stated she did not witness Resident 1's fall that happened in his room because she was at the nursing station charting. LN 2 stated she heard somebody called out and his [Resident 1] roommate said somebody fell. LN 2 stated she entered Resident 1's room and observed Resident 1 lying face down on the floor, unresponsive, with visible bleeding around the head. LN 2 stated Resident 1 had poor safety awareness and had episodes of ambulating without assistance to use the bathroom in his room despite, reminders to use the call light and did not reliably call staff for help. LN 2 stated that had she known Resident 1 was a fall risk, that Resident 1‘s care plan should have been updated with interventions for Resident 1 to be placed on a 1:1 supervision and not left unattended to prevent the fall. Resident 1's record was reviewed. Resident 1's safety evaluation per acute hospital health records titled Inpatient Physical Therapy Evaluation dated [DATE] at 1:30 P.M., indicated, .Safety Judgment: Decreased awareness of need for safety, Decreased awareness of need for assistance. Resident 1's History and Physical (H&P) examination by the facility Medical Doctor (MD) dated [DATE], indicated, .This resident.does NOT have the capacity to understand and make decisions. Resident 1's admission fall risk assessment titled, .FALL RISK OBSERVATION/ASSESSMENT. dated [DATE] at 20:37 (8:37 P.M.) indicated, Resident 1's fall risk score was a 20 that identified Resident 1 was a .HIGH RISK. Resident 1's fall risk care plan initiated [DATE], indicated, .Educate/remind resident to call for assistance .Keep call light within reach.Keep within supervised view as much as possible. Resident 1's Electronic Health Record (EHR) progress noted by Licensed Nurse (LN) 1 titled Nurse's Note dated,[DATE] at 20:00 (8P.M.), indicated, .Resident spotted one time trying to get out of his wheelchair.Medication nurse for 100 hall instructed all of the CNAs [Certified Nursing Assistant] in the hallway to do visual inspections every 30 minutes and switch with other CNA as needed to keep resident under continuous supervision. Nurse on duty had also instructed CNAs that if resident was to be alone inside of room, to be in the same room with the resident. Resident 1's EHR progress noted by LN 2 titled Nurse's Note dated [DATE] at 21:00 (9 P.M.) late entry, indicated, .Found the resident lying on the floor in his room next to the bed with half of his body on the landing mate [sic], and left side on a semi prone [lying flat on your stomach, with your face and chest facing downward] to the floor. Noted his left side of the head of head [sic] with some bleeding, Some abrasion to bilateral UE [upper extremity-arms and hands]. The residentwas [sic] unresponsive [unconscious] at this time.On [DATE] at 3:44 P.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated Resident 1's fall risk care plan initiated [DATE], indicated, .Educate/remind resident to call for assistance .Keep call light within reach.Keep within supervised view as much as possible. was not individualized and specific to Resident 1's cognitive (relating to the mental processes of knowing, learning, thinking and understanding things) and safety needs. The DSD further stated that if Resident 1 was unable to comprehend or appropriately use the call light for safety, use call light on the care plan does not effectively lessen Resident (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's fall risk because Resident 1 had decreased safety awareness with limited understanding of the purpose of a call light and reliance on that intervention alone is insufficient. The DSD stated the care plan should instead include direct supervision and staff-initiated monitoring to ensure Resident 1's safety. The DSD stated that 1:1 supervision allows staff to immediately intervene and redirect unsafe movement, which helps prevent falls and injury. The DSD stated Resident 1's fall risk should be clearly communicated to all licensed nurses and CNAs. The DSD further stated that when a high fall-risk resident is left unsupervised, even briefly, the resident (all fall risk facility residents) may fall and sustain serious injury caused by delayed staff response for impulsive residents (all fall risk facility residents) or residents (all fall risk facility residents)unable to recognize danger results in missed redirection opportunities and increased risk for falls and harm.On [DATE] at 12:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations was that the LNs (LN 1 and LN 2) involved with Resident 1's care should have completed a comprehensive safety assessment for Resident 1 to update and personalize Resident 1's safety needs based on Resident 1's cognitive impairment and decreased safety awareness and should have implemented structed monitoring every 30 minutes with clearly assigned staff responsibility. The DON stated staff should have used a sensitive or alternative call-light system, as Resident 1 did not comprehend the purpose or safe use of a standard call light. The DON stated that a 1:1 supervision should have been implemented when Resident 1 was observed attempting to stand on the day of the incident. The DON stated 1:1 supervision was critical due to Resident 1's cognitive limitations, impulse behaviors and fall risk assessment, explaining that Resident 1 was unable to reliably recognize danger or follow safety instructions. The DON stated that 1:1 supervision ensures continuous observation and immediate staff intervention, allowing staff to redirect unsafe movement, attend to Resident 1's needs and prevent accidents before they occur. The DON stated her expectation was that all nursing staff and CNAs are informed of fall risk and supervision needs, particularly for new admissions and that residents (all facility residents) are closely monitored during the first 72 hours to determine whether enhanced supervision is required. The DON further stated that delayed staff response for impulsive residents (such as Resident 1) or residents (all fall risk facility residents) unable to recognize danger significantly increases the risk for injury, including fall-related harm and further health decline. The DON acknowledged that failure to clearly communicate fall risk and supervision needs placed Resident 1 at risk because the nursing staff were unaware of the level of monitoring required, resulting in inadequate supervision and hospitalization.A review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing dated [DATE], indicated .Licensed nurses and certified nursing assistants are available 24 hours a day, seven(7) days a week to provide co competent resident care services including: a. assuring resident safety. 3. Feeding AssistanceA review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated [DATE] indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions.On [DATE] at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated she provided Resident 1 with a meal tray, which she placed on a bedside table for Resident 1 while Resident 1 sat on his wheelchair in the hallway to eat independently. CNA 1 stated Resident 1 fed himself and further stated she was not aware that Resident 1 required one on one (1:1) feeding assistance and was (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not informed that Resident 1 was a fall risk.On [DATE] at 3:47 P.M., an interview was conducted with CNA 5. CNA 5 stated Resident 1 was able to feed self but was on her feeder's list due to difficulty with swallowing and to prevent choking hazards.Resident 1's record review was conducted on [DATE]. Resident 1's nutritional care plan date initiated [DATE] interventions indicated, .1:1 Feeding Assistance. Resident 1's Speech evaluation dated [DATE] indicated, .Previous treatment 1:1 feeder.Swallowing Abilities=Severe.Risk Factors: Aspiration [choking]. The facility's document titled: Feeding list undated included Resident 1's name.On [DATE] at 3 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated staff were required to communicate resident-specific risks and care needs, including cognitive (related to thinking, learning, and understanding) impairment, fall risk and feeding assistance, through shift handoff reports and nurse-led huddles prior to providing care. The DSD stated staff must know this information before assuming resident care (all facility residents) to ensure safe and competent services. The DSD further stated failure to communicate these risks could result in preventable injuries, including falls and choking, due to staff being unaware of Resident 1's supervision and assistance needs.On [DATE] at 1:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated staff were expected to competently assess residents with cognitive impairment and impulsive behaviors, anticipate risks, and implement appropriate interventions to prevent injury. The DON stated Resident 1's assigned staff were required to provide direct assistance to Resident 1 during feeding due to choking risk and not to leave Resident 1 unattended. The DON further stated failure of staff to understand Resident 1's specific risks and care needs placed Resident 1 at risk for injury, further health decline and death. A review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing dated [DATE], indicated .Licensed nurses and certified nursing assistants are available 24 hours a day, seven(7) days a week to provide co competent resident care services including: a. assuring resident safety.

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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** Based on interview and record review the facility failed to maintain accurate, complete and reliable medical records that reflected the actual care provided during an emergency event, for one of three residents (Resident 1).This deficient practice placed (Resident 1) at risk for delayed or inappropriate medical treatment, misinformed clinical decision-making and compromised continuity of care.Cross reference F689Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of Intellectual Developmental Disability (IDD-is a condition that limits intelligence and disrupts abilities necessary for living independently).A record review of Resident 1's Minimum Data Set (MDS-nursing facility assessment tool) dated [DATE] indicated that Resident 1 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory and perception) deficits to understand and make decisions.On [DATE] at 1:40 P.M., an interview was conducted with CNA 1. CNA 1 stated that upon starting her shift on [DATE], she observed Resident 1 independently wheeling himself (using a wheelchair for ambulation -the act of walking or moving place to place) in the hallway. CNA 1 stated she provided Resident 1 with a meal tray, and watched Resident 1 eat independently. CNA 1 stated she was not informed that Resident 1 was a fall risk. CNA 1 reported that Resident 1 remained seated in his wheelchair unsupervised in the hallway until approximately 8 P.M., on [DATE]. CNA 1 stated that after returning from a bathroom break, she observed nursing staff (LN 2) with Resident 1 who was lying face down on the floor with a bleeding head wound. CNA 1 stated oxygen was applied to Resident 1 who was minimally responsive, moving only his hand, at the time he was found on the floor. On [DATE] at 1:51 P.M., an interview and record review was conducted with LN 1. LN 1 stated Resident 1's baseline was alert but not oriented x [times]3 [person, place, time] and was non-verbal. LN 1 further stated Resident 1 was having agonal breathing but had a pulse. LN 1 further stated the only intervention that we did was oxygenation not chest compressions he [Resident 1]still had a pulse we just gave oxygen via non re-breather (a mask that delivers a high concentration of oxygen) and what was documented on his [Resident 1] medical record was not true we did not do chest compressions cause [sic] he still had a pulse. I don't know why the med nurse [LN 2] charted that. On [DATE] at 2:11 P.M., an interview was conducted with CNA 2. CNA 2 stated she later observed nursing staff already present with Resident 1 after Resident 1 was found on the floor. CNA 2 stated she assisted with placing Resident 1 in a safe position and observed Resident 1 had irregular breathing, prompting LN 2 to administer oxygen via a non-rebreather mask. CNA 2 stated Resident 1 was non-verbal, moving his fingers and confirmed that Cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) or chest compressions were not initiated because the resident had a pulse.On [DATE] at 11:48 A.M., an interview was conducted with CNA 3. CNA 3 stated she was a registry CNA that worked the night Resident 1 fell. CNA 3 stated she was not the primary CNA assigned to Resident 1 but had observed Resident 1 earlier in the hallway sitting on his (Resident 1) wheelchair making random sounds, not fully verbal and attempting to stand up from the wheelchair. CNA 3 stated she was informed by the LNs (LN 1 and LN 2) at the start of the shift that Resident 1 was a fall risk. CNA 3 stated she was not instructed and/or endorsed by CNA 1 to monitor or supervise Resident 1 prior to CNA 1 using the restroom. CNA 3 stated she heard a nurse call out for help then entered Resident 1's room, where she observed Resident 1 lying on the floor with a bleeding forehead, non-responsive and breathing irregularly. CNA 3 stated Resident 1 was placed in the hallway because Resident 1 was impulsive, repeatedly attempted (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to move toward other residents' rooms and was resistant to redirection when his (Resident 1) primary CNA (CNA 1) attempted to return him to bed. CNA 3 stated after the fall, LN 2 had applied oxygen via a mask and she observed no rescue breaths or chest compressions were provided. CNA 3 further stated Resident 1 did not regain consciousness not waking up and his (Resident 1) body was twitching while on the floor.On [DATE] at 12 P.M., an interview and record review was conducted with LN 2. LN 2 stated she did not witness Resident 1's fall that happened in his room because she was at the nursing station charting. LN 2 stated she heard somebody called out and his [Resident 1] roommate said somebody fell. LN 2 stated she entered Resident 1's room and observed Resident 1 lying face down on the floor, unresponsive, with visible bleeding around the head. LN 2 stated she attempted to reposition Resident 1 and placed Resident 1 on her knee. LN 2 stated she instructed staff to obtain the crash cart and oxygen. LN 2 stated she performed chest rubs [a technique where a person's chest bone is rubbed hard with knuckles to see if an unconscious person reacts to pain] for stimulation, not chest compressions and confirmed Resident 1 had a pulse. LN 2 stated she initially applied portable oxygen and then placed Resident 1 on a non-rebreather mask. LN 2 acknowledged that documentation indicating chest compressions were performed was inaccurate and stated it should have reflected chest rubs only, explaining the medical record must accurately describe care provided for continuity of care during hospital transfer. LN 2 stated Resident 1 had poor safety awareness and had episodes of ambulating without assistance to use the bathroom in his room despite, reminders to use the call light and did not reliably call staff for help.Resident 1's record review was conducted on [DATE]. Resident 1's Electronic Health Record (EHR) .Resident 1's (EHR) progress noted by Licensed Nurse (LN) 1 titled Nurse's Note dated,[DATE] at 20:00 (8:00 P.M.), indicated, .Resident spotted one time trying to get out of his wheelchair.Medication nurse for 100 hall instructed all of the CNAs[Certified Nursing Assistant] in the hallway to do visual inspections every 30 minutes and switch with other CNA as needed to keep resident under continuous supervision. Nurse on duty had also instructed CNAs that if resident was to be alone inside of room, to be in the same room with the resident.Resident 1's record was reviewed on [DATE]. Resident 1's EHR progress noted by LN 1 titled Nurse's Note dated [DATE] at 20:55 (8:55 P.M.) late entry, indicated, .Heard medication nurse shouting across the hallway to the front nurses station. Medication nurse requested crash cart, crash cart taken to her. Walked in to the room to find resident lying face down and having agonal [an abnormal, reflexive pattern of gasping and labored breaths that occurs when the brain is deprived of oxygen] respirations. Resident also had a bleeding laceration on top left of the forehead. Oxygen tank and nonrebreather[an oxygen mask that delivers high concentrations of oxygen] brought and setup , infiated [sic] and fixed to face at 10-15 liters per minute. Used C-spine[Cervical-spine refers to neck] to stabilize cervical neck [sic], used a 3 person assist to turn resident to the supine [lying flat on your back with your face, chest and stomach facing upward] position. Resident breathing had slowed down to the point where he was fully unconscious [a person is not reacting to sound, touch, or pain] by this time. Writer ran out, grabbed treatment cart in order to control bleeding to the forehead using gauze and bandages. As per medication nurse [LN 2], she checked for carotid [the rhythmic throbbing felt in the carotid arteries on either side of the neck, reflecting blood flow from the heart to the brain] pulse, pulse was too faint to be identifiable. Compressions [use your hands to push down hard and fast in a specific way on the person's chest] were briefly initiated by on duty medication nurse as she initially thought resident had no pulse. After 5 minutes with the nonrebreather mask, resident breathing briefly stabilized and chest rise and fall was noted, compressions at this time were stopped and carotid pulse was noted to be present.Resident 1's record review was conducted on [DATE]. Resident 1's EHR (continued on next page)

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	02/12/2026

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

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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	progress noted by LN 2 titled Nurse's Note dated [DATE] at 21:00 (9 P.M.) late entry, indicated, .Found the resident lying on the floor in his room next to the bed with half of his body on the landing mate [sic], and left side on a semi prone [lying flat on your stomach, with your face and chest facing downward] to the floor. Noted his left side of the head of head [sic] with some bleeding, Some abrasion to bilateral UE [upper extremity-arms and hands]. The residentwas [sic] unresponsive [unconscious] at this time. The chest compression initiated [sic] and oxygen with a non re-breather [sic] mask was given. 9-11 was called. arrived at 21:10. Resident is transportation [sic] to [Hospital Name] for further eval.Resident 1's record review was conducted on [DATE]. Resident 1's EHR Interdisciplinary (IDT) note titled IDT Fall dated [DATE] 14:46 (2:46 P.M.) .The resident was unresponsive at this time. The chest compression initiated and oxygen with a non re-breather mask was given.On [DATE] at 3:27 P.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated that nursing documentation must be accurate, complete and reflect exactly what care was provided, particularly during emergency events. The DSD stated staff are expected to document the actual interventions performed follow established emergency protocols and avoid documenting interventions that did not occur, such as recording chest compressions when only chest rubs were performed. The DSD stated that documenting care inaccurately is not acceptable, emphasizing that the medical record is a legal document and must truthfully reflect the resident's (Resident 1) condition and the care delivered. The DSD stated the IDT Fall dated [DATE] was inaccurate. The DSD further stated the IDT was responsible for reviewing and validating documentation, not merely reading nursing notes at face value, because inaccurate documentation can misrepresent the Resident 1 clinical status and the underlying cause of the event and negatively impact continuity of care during hospital transfer.On [DATE] at 1:02 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that nursing documentation must be timely, accurate, complete and objective, particularly during emergency events. The DON stated staff are expected to document only what they directly observed and the care that was actually provided and documentation must truthfully reflect what occurred. The DON stated staff should not document interventions that were not performed, specifically noting that chest compressions should not have been documented on Resident 1's health record when compressions were not performed. The DON further stated that inaccurate documentation placed all residents at risk, explaining that incorrect information in the medical record can mislead medical providers, delay appropriate treatment and monitoring and negatively Impact continuity of care during hospital transfer. The DON stated that inaccurate documentation may result in delayed or inappropriate medical decision-making, placing Resident 1 at risk for further health decline.A review of the facility's policy and procedure titled, Charting and Documentation dated [DATE], indicated .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .