

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Cottonwood Canyon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe use of mechanical lift equipment (Hoyer lift) for resident transfers for one resident (Resident 1). This deficient practice had the potential to affect all residents requiring mechanical lift transfers. Findings: A review of Resident 1's admission record indicated, he was admitted on [DATE] with a diagnosis that included Osteitis Deformans (a chronic disorder that disrupts the normal recycling process of bone tissue) and Hemiplegia and Hemiparesis (hemiplegia indicated by partial or total paralysis and hemiparesis indicated by weakness on one side of the body). A review of Resident 1's care plan dated, 2/10/26 indicated, use Hoyer lift with appropriate sling for all transfers, lock brakes, position patient safely, and monitor during transfers. On 4/15/26 at 10:40 A.M., an observation and interview was conducted with Resident 1. Resident 1 stated an incident occurred on 12/15/25 when he landed on the floor during a transfer from the Hoyer lift to a wheelchair. Resident 1 stated he was strapped in the Hoyer lift when certified nursing assistant (CNA) 1 attempted to move him over the wheelchair arm rest; the Hoyer lift tilted over, hitting CNA 1 on the head and shoulder, causing Resident 1 to land on the floor. Resident 1 stated he complained of back pain. Resident 1 stated staff came to assist and 911 was called. Resident 1 further stated the 911 Paramedics placed a neck collar on him, and he was taken to the general acute care (GACH) for evaluation. On 4/15/26 at 12:25 P.M., a telephone interview was conducted with certified nurse assistant (CNA 1). CNA 1 stated she attempted to transfer Resident 1 from shower chair to a wheelchair, but the Hoyer lift tilted forward. CNA 1 stated she attempted to hold Resident 1 while CNA 2 used remote to lower the resident to the floor. CNA 1 stated the base of the Hoyer lift should have been opened wide but could not recall if the base of the Hoyer lift was opened. CNA 1 stated she should have done a safety check before moving the patient. On 4/15/26 at 12:20 P.M., a telephone interview was conducted with CNA 2. CNA 2 stated when she walked into the room she observed Resident 1 was already in the Hoyer lift and strapped in. CNA 2 stated she used the remote to start the transfer when the Hoyer lift tilted forward. CNA 2 stated CNA 1 attempted to hold Resident 1 so he wouldn't hit the floor and used the remote to lower him to the floor. CNA 2 stated she could not recall if the base of the Hoyer was opened wide. On 4/15/26 at 3:05 P.M., an interview and record review was conducted with Maintenance Supervisor (MS). MS stated the Hoyer lift was removed from the floor after the incident. MS stated he inspected the Hoyer lift after the incident and did not find any defects. MS stated he cleaned the Hoyer lift and it was put back in service. MS stated that if the base of the Hoyer lift was not opened or opened wide enough, it could have caused the Hoyer lift to tilt forward. On 4/15/26 at 4:40 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was for her staff to follow policy when using the Hoyer lift for the safety of the residents and staff. A review of the facilities policy titled Lifting Machine, Using a Mechanical, dated 2001, indicated .7. Make sure the lift is stable and locked.13. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution.A review of the manufacturer's guidance titled Battery Operated Patient Lift, revised 8/10/16, indicated .while lifting or lowering a patient maintain the base (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>unit legs spread to the widest position and ensure that the casters are unlocked. keep the patient centered over the base and facing the operator/caregiver.</p>		