

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	
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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's Quality Assurance Agency (QAA) failure to identify, monitor, and address problem areas identified by the State Survey team for their Quality Assurance and Performance Improvement (QAPI) plan, during their annual recertification. This failure put all residents at risk for medication errors and equipment failures. (See F-759, F-761, and F-908) An interview was conducted with the Administrator (ADM) and Director of Nursing (DON) on 12/18/25 at 5:31 P.M. The ADM and DON stated they both started at the facility three months ago. The ADM and DON stated they had reviewed last year's recertification and recognized medication administration and medication storage were both issues. The DON stated she began by monitoring, auditing, and educating staff regarding medication storage and they thought they had corrected the issues, so it was dropped from QAPI. The DON stated based on the current medication error rate during this re-certification, and the medication storage issues, they should have identified improvement was needed prior to survey. The ADM stated the Director Maintenance did not attend their quarterly QAA meetings. The DON stated maintenance issues were discussed every morning in their stand-up meetings. The ADM acknowledged equipment safety issues were identified during recertification, which should have been brought to his attention by the Director of Maintenance, or facility's Safety Committee, prior to survey. A review of the facility's QAPI plan dated 9/10/25 through 12/2025, listed no implementation or monitoring of medication administration, medication storage, or equipment maintenance. According to the facility's policy, titled Quality Assurance and Performance Improvement, dated September 2019, .Purpose: The purpose of the QAPI plan and processes is to continually assess the facility's performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individuals highest practicable physical, mental and social well-being.2. QAPI Plan Components.c. Feedback, data systems, and monitoring.e. Systemic analysis and systemic action.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their own Infection Control Program when: 1. There was no documented evidence regarding vaccine refusal, no documented hand hygiene surveillance and no documented evidence regarding antibiotic surveillance, Cross reference F881. 2. Resident 178's oxygen tubing did not have a date, 3. Resident 8's oxygen tubing and nebulizer (liquid medication delivered as a fine mist inhaled into the lungs through a mouthpiece or mask) mask were not dated and stored properly. These failures could potentially contribute to the spread of microorganisms. 2. Resident 178 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (a condition where the lungs fail to adequately exchange oxygen, leading to low oxygen in the blood) according to the facility's admission Record. During an observation on 12/15/25 at 8:47 A.M., Resident 178 was in bed with an oxygen cannula (oxygen tubing with two open prongs placed in the nose) connected to a humidifier bottle (plastic bottle with distilled water that adds moisture to oxygen being inhaled) and concentrator (machine that provides oxygen). The oxygen tubing did not have a date. A joint observation and interview on 12/15/25 at 10:37 A.M., was conducted with Licensed Nurse (LN) 14. LN 14 checked Resident 178's oxygen tubing. LN 14 stated the oxygen tubing did not have a date when it was last changed. LN 14 stated Resident 178's oxygen tubing should be dated when it was first applied to Resident 178 then changed every Wednesday. LN 14 stated it was important to date and change every Wednesday to keep the tubing clean and to prevent infection. 3. Resident 8 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and gastrostomy status (feeding tube in the stomach) according to the facility's admission Record. During an observation on 12/15/25 at 9:15 A.M., a concentrator was observed next to Resident 8's bed. An oxygen cannula was hanging on top of the concentrator. A nebulizer mask connected to a nebulizer machine was on top of Resident 8's bedside table. A review of Resident 8's Order Summary Report indicated, CHANGE OXYGEN NASAL CANNULA and PLASTIC STORAGE BAG EVERY WEDNESDAY NIGHT and PRN [as needed]. A joint observation and interview on 12/15/25 at 10:40 A.M., was conducted with Licensed Nurse (LN) 14. LN 14 checked Resident 8's oxygen tubing and nebulizer mask. LN 14 stated the oxygen tubing and the nebulizer mask were not stored in a plastic bag. LN 14 stated the oxygen tubing and nebulizer mask should be stored in a plastic bag when not in use to keep them clean and prevent resident infection. During an interview on 12/16/25 at 3:54 P.M. with LN 12, LN 12 stated oxygen cannulas and masks were changed every Wednesday and stored in a plastic bag for infection control. An interview on 12/18/25 at 4:50 P.M. was conducted with the Director of Nursing (DON). The DON stated oxygen cannulas and nebulizer masks should be dated when changed and stored in a plastic bag for infection control. A review of the facility's undated policy and procure (P&P) titled, Oxygen Handling and Storage was (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	conducted. The P&P indicated, It is the policy of this facility to provide proper use and handling and storage of respiratory equipment (oxygen tanks, oxygen tubings and nebulizers) in the facility. During a review of the facility's undated P&P titled, Small Volume Nebulizer (SVN) the P&P indicated, Replace and/or clean nebulizer components as per facility guidelines/policy.Tubing may be replaced every week. Findings: 1. On 12/18/25 at 1: 17 P.M., an interview and record review was conducted with the Director of Staff Development (DSD), Director of Nursing in training (DIT), and the Director of Nursing (DON). The DSD stated she started working on April 224 with DSD role and started doing Infection Preventionist (IP) role on 12/11/25. The DON stated we had our transition from 10/16/25. The DSD/IP stated she had no account to California Immunization Registry (CAIR) and she had no access to check residents vaccination status. A random review of resident's vaccination refusals was conducted. There was no documented evidence to indicate a follow up education and care plan related to vaccine refusal. According to the facility's policy titled, Infection Control Prevention and Control Program, revised 11/23/2016 indicated, The Infection Prevention and Control Program is comprehensive in that it addresses detection, prevention and control of infections among resident and personnel.THE MAJOR ACTIVITIES OF THE PROGRAM ARE::SURVEILLANCE OF INFECTIONS AND REPORTING.REPORTING MECHANISMS FOR INFECTION CONTROL.A. The IP completes the Infection Surveillance monthly form and reports.C. Compliance with Infection Prevention Control practices is monitored and documented by: 1. Staff evaluation .2. Observation of Practices i.e. Hand Hygiene.The IP/Director of Staff Development and Director of Nursing review the compliance monitoring and initiate appropriate action. A review of the facility Healthcare-Associated Infections Program Adherence Monitoring for Hand Hygiene was conducted. There were no documented evidence for the months of August, September and October 2025. In addition, there was decline in the from 92% on July 2025 Adherence Monitoring for Hand Hygiene to 73% of November 2025. The DSD/IP and DIT could not verbalize what action was needed to correct decrease adherence in hand hygiene. There was no documented evidence including in -services related to hand hygiene were provided to show appropriate action related to hand hygiene adherence monitoring. Antibiotic surveillance for October 2025 did not match the case map for October 2025. The October 2025 Antibiotic surveillance had 6 cases of community acquired infection (CAI), 6 cases of healthcare associated infection(HAI) and 5 did not meet criteria. The October 2025 case mapping had 8 entries but did not identify whether CAI or HAI. There was no documented evidence to indicate comprehensive tracking measures with data analysis, length of antibiotic use, appropriate use of antibiotic use and communication with Medical Director and Pharmacist to discuss opportunities of improvement.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance for 6 of 6 dependent residents with their Activities of Daily Living (ADLs, activities related to mobility and personal care) when: 1. Resident 23 was not assisted in getting up and out of bed. Cross Reference F-679. 2. Two residents (Resident 71 and Resident 163) who were cognitively impaired were not cued to perform hand hygiene before meals. 3. Routine nail care was not provided to three residents (Residents 90, 6 and 112). As a result, the residents were at risk for skin injury, infection and overall quality of life. Findings: 1. Resident 23 was readmitted to the facility on [DATE], with diagnoses which included multiple sclerosis (MS, a disease that causes breakdown of the protective covering of nerves, can cause numbness, weakness, trouble walking, vision changes and other symptoms), per the facility's admission Record. On 12/15/25, a review of Resident 23's minimum data set (MDS, a federally mandated resident assessment tool) dated 11/27/25, indicated Resident 23 could make independent reasonable decisions. The MDS of Resident 23's functional abilities indicated he had lower extremities impairment and that he was dependent on staff for his activities of daily living (ADLs, like transferring). On 12/15/25, a review of Resident 23's care plan indicated Resident 23 required total assistance with transfers. On 12/15/25 at 9:06 A.M., an observation and an interview was conducted with Resident 23 in his room. Resident 23 was lying in bed with his legs elevated. Resident 23 stated he had MS and was unable to walk. Resident 23 stated he stayed in bed and no one got him up from bed. On 12/15/25 at 4:55 P.M., a follow-up observation and an interview were conducted with Resident 23 in his room. Resident 23 stated, I want them to get me out of here. Resident 23 stated he could not stand and or walk and needed assistance to get up. On 12/16/25 at 3:20 P.M., another follow-up observation, and an interview were conducted with Resident 23 in his room. Resident was lying in bed. Resident 23 stated he had not gotten up from the previous day (12/15/25) until 12/16/25. On 12/16/25 at 3:53 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 23 was alert, could make his needs known and was dependent on staff when transferring. On 12/17/25 at 2:59 P.M., a joint record review and interview was conducted with the Activity Coordinator (AC). The AC stated Resident 23 required two person to assist him with transfers from bed to wheelchair. On 12/17/25 at 3:36 P.M., a joint record review and an interview were conducted with Licensed Nurse (LN) 3. LN 3 stated the staff had gotten up Resident 23 a month ago to attend an activity. LN 3 stated Resident 23 required two person assist to transfer him from the bed to the wheelchair and back to bed. LN 3 stated Resident 23 had been in bed a lot and could cause complications like getting wounds, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	isolation and boredom. On 12/18/25 at 1:19 P.M., an interview was conducted with CNA 3. CNA 3 stated during the time she was assigned to Resident 23, she had not helped Resident 23 get up. On 12/18/25 at 3:19 P.M., a joint review of Resident 23's clinical record and an interview was conducted with the Director of Nursing (DON). The DON stated Resident 23 required assistance from the staff when getting up and out of bed. The DON stated the policy was for the staff to encourage and offer Resident 23 to get up and out of bed to enhance his quality of life. A review of the facility's policy titled, ADL care, revised 11/07, indicated, .2. Residents who are unable to carry out activities of daily living (ADL) will receive assistance as needed. 2a. Resident 71 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities) and required assistance with personal care, per the facility's admission Record. On 12/16/25, a review of Resident 71's history and physical (H&P) dated 2/26/25 indicated Resident 71 had severe dementia and was pleasantly confused. On 12/16/25, a review of Resident 71's MDS dated [DATE], indicated Resident 71's functional abilities was supervision and cueing in performing her personal hygiene. 2b. Resident 163 was admitted to the facility on [DATE] with diagnoses which included dementia and required assistance with personal care, per the facility's admission Record. On 12/16/25, a review of Resident 163's MDS dated [DATE], indicated Resident 163 had a brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12/15 which meant Resident 163 had moderate cognitive impairment. The MDS of Resident 163's functional abilities indicated he required supervision and cueing in performing his personal hygiene. During dining observation on 12/15/25 at 11:26 A.M., Resident 71 sat alone at the fourth dining table and Resident 163 sat at the opposite table with another resident. No hand hygiene was provided to the residents. On 12/15/25 at 11:46 A.M., meal trays were served to the residents. Resident 71 picked up her food, played with her food with her bare hands and licked her fingers. No supervision was provided to Resident 71. Resident 163 spooned his food and licked his fingers every time the food escaped the spoon. No supervision was provided to Resident 163. On 12/15/25 at 12:16 P.M., an interview was conducted with Restorative Nursing Assistant (RNA) 1. RNA 1 stated the staff should have offered hand sanitizer to the residents after they ate their meal. On 12/16/25 at 1:01 P.M., a follow-up interview was conducted with RNA 1. RNA 1 stated Resident 71 and Resident 163 required supervision and cueing to perform hand hygiene. RNA 1 stated the policy was to provide encouragement and offered the residents to perform hand hygiene before and after (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meals. RNA 1 stated, Yesterday (12/15/25), it was chaos. I was busy focused on feeding another resident. RNA 1 stated hand hygiene was important for personal hygiene and infection control. On 12/18/25 at 3:42 P.M., an interview was conducted with the DON. The DON stated hand hygiene should have been offered to the residents before and after meals for infection control. A review of the facility's policy titled, Assisting the Resident with In-Room Meals, revised 12/15, indicated, .8. Be sure the resident is prepared to receive the meal (like.hands washed.) 3a. Resident 90 was readmitted to the facility on [DATE] with diagnoses which included multiple sclerosis (MS) and had contractures (stiffening of joints) of his right and left hands, per the facility's admission Record. On 12/16/25, a review of Resident 90's MDS dated [DATE], indicated Resident 90 had a BIMS score of 5/15 which meant Resident 90 had severe cognitive impairment. The MDS of Resident 90's functional abilities indicated he had upper and lower extremities impairment and that he was dependent on staff with his ADLs (activities of daily living), like personal hygiene. On 12/15/25 at 10:17 A.M., an observation and an interview were conducted with Resident 90 in his room. Resident 90 laid in bed with his right hand in a splint with long and sharp fingernails. Resident stated he was unable to lift his left hand, and the fingernails were long. Resident 90 stated he wanted the fingernails to be trimmed short. On 12/15/25 at 10:28 A.M., a joint observation of Resident 90 and an interview with LN 4 was conducted. LN 4 stated Resident 90's fingernails were long and sharp. LN 4 stated Resident 90 was diabetic (high blood sugar) and LNs were to trim his fingernails. LN 4 stated he would have to trim Resident 90's fingernails short for hygiene and prevent him from getting an infection. On 12/17/25 at 4:38 P.M., an interview was conducted with LN 3. LN 3 stated Resident 90 was totally dependent on staff with his ADLs. LN 3 stated for diabetic residents, LNs were to trim and cut the residents' fingernails. LN 3 stated Resident 90 could dig his hands and caused tears to the skin since he had contracted hands. LN 3 stated nail care was important for hygiene and infection control. On 12/18/25 at 3:51 P.M., an interview was conducted with the DON. The DON stated nail care was important to Resident 90 for hygiene and infection control. A review of the facility's policy titled, ADL care, revised 11/07, indicated, .2. Residents who are unable to carry out activities of daily living (ADL) will receive assistance as needed. A review of the facility's undated policy and procedure (P&P) titled, Nail Care was conducted. The P&P indicated, It is the policy of this facility to promote cleanliness, safety, and neat appearance. 3b. Resident 6 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a chronic autoimmune disease (occurs when the body immune system mistakenly attacks its own healthy cells, tissues, and organ causing inflammation, damage, and dysfunction) affecting the brain and spinal cord causing diverse symptoms like vision problems, numbness, weakness, and balance issues, fatigue, and cognitive difficulties) and need for assistance with personal care according to the facility's admission Record. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/16/25 at 8:36 A.M., Resident 6 stated he had MS. Resident 6 had long fingernails. Resident 6's fingernails had black debris under the nails. Resident 6 stated he would like staff to trim his fingernails because he could not trim them by himself. An interview and joint observation on 12/16/25 at 8:57 A.M. was conducted with Certified Nurse Assistant (CNA) 12. CNA 12 checked Resident 6's fingernails and stated Resident 6's fingernails were long and dirty. CNA 12 stated Resident 6's fingernails should be trimmed for infection control and to prevent Resident 6 from scratching himself. During an interview on 12/16/25 at 3:51 P.M. with Licensed Nurse (LN) 12, LN 12 stated CNAs trimmed fingernails once a week to prevent scratching and the risk of infection. 3c. Resident 112 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) according to the facility's admission Record. During an observation of Resident 112 on 12/16/25 at 9:38 A.M., Resident 112 was in bed with left arm bent at elbow close to Resident 112's left side of his body. Resident 112's left hand was closed in a fist. Resident 112's right thumb was bent toward the palm of the hand. Resident 112's had long fingernails. During an interview on 12/16/25 at 3:41 P.M. with CNA 11, CNA 11 stated nail care for residents were completed on Sundays. CNA 11 stated nail trimming was important to prevent residents from getting hurt and to prevent infection. An interview with the Director of Staff Development (DSD-a licensed nurse certified for staff training) was conducted on 12/16/25 at 4:20 P.M. The DSD stated an in-service was provided regarding filing and keeping residents' fingernails clean during showers and as needed. The DSD stated CNAs can only file and keep residents' fingernails clean and no trimming was allowed. The DSD stated the licensed nurse could trim residents' fingernails. The DSD further stated it was important to keep residents' fingernails trimmed and clean for good hygiene and infection control. A joint observation of Resident 112 and interview was conducted on 12/16/25 at 4:55 P.M. with Licensed Nurse (LN) 13. LN 13 checked Resident 112's left arm and hand. LN 13 could not straighten Resident 112's left arm and was unsuccessful in attempting to open the left hand. LN 13 checked Resident 112's right hand and fingers. Resident 112's right fingers bent with the thumb close to their palm. LN 13 stated Resident 112's right hand fingernails were long. LN 13 stated CNAs can trim residents' fingernails, but LNs trimmed them if residents had contractures to prevent injury. An interview with the DON was conducted on 12/18/2025 4:50 PM. The DON stated residents' long fingernails should be trimmed because it was a quality of care and infection control issue. A review of the facility's undated policy and procedure (P&P) titled, Nail Care was conducted. The P&P indicated, It is the policy of this facility to promote cleanliness, safety, and neat appearance.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. Timely assessment, monitoring and immediate physician notification in response to significant clinical changes, including suspected gastrointestinal (referring to the stomach and intestines) bleeding and ongoing nausea or vomiting for one of three sampled residents reviewed for closed record (Resident 1). Cross Reference F 580. 2. A physician's order was obtained from the attending physician prior to blood sugar checks on a resident (Resident 9) who was on insulin (antidiabetic medication). In addition, blood sugar checks was obtained without proper time interval. This deficient practice resulted in a delay in the resident receiving treatment to address Resident 1's necessary care and services and placed Resident 1's health at risk. In addition, Resident 9 had blood sugar checks without physician's order, without appropriate time interval and caused discomfort to Resident 9. Findings: Resident 1 was readmitted to the facility on [DATE] with diagnoses which included pneumonia (infection of the lungs), per the facility's admission Record. A review of Resident 1's history and physical (H&P) dated [DATE] was conducted. Per the H&P, Resident 1's Computed Tomography (CT scan, a type of imaging that uses X-ray techniques to create detailed images) of his chest, abdomen and pelvis at the general acute care hospital (GACH) indicated Resident 1 had left chest wall large hematoma with active extravasation (a collection of blood in the extra thoracic space). The H&P indicated one of Resident 1's active medications was enoxaparin (anticoagulant, blood thinner medication). On [DATE] at 8:38 A.M., a joint record review and interview was conducted with LN 32. LN 32 stated Resident 1 was transferred to the GACH on [DATE] at 10:50 A.M. after a cardiopulmonary resuscitation (CPR, a life sustaining treatment) was initiated at the facility. LN 32 stated Resident 1 was at GACH when he passed away. LN 32 stated per LN 1's nurses progress notes on [DATE] at 1:36 A.M. Resident 1 vomited large amount of coffee ground emesis (medical term for vomiting). LN 32 stated the progress notes indicated, after Resident 1 vomited a coffee ground emesis, Resident 1 received ondansetron (antiemetic medicine to prevent nausea and vomiting). LN 32 stated there was no documentation indicating Resident 1 was assessed before the antiemetic medications were given. LN 32 stated the progress notes indicated there were no documentation to indicate the physician was notified of Resident 1's change in condition (CIC) until 10:50 A.M. on [DATE]. LN 32 stated Resident 1 had CIC at 1:36 A.M. and that was more than nine hours after LN 1 observed Resident 1 had a CIC. LN 32 stated the LNs should have immediately informed the attending physician because Resident 1 was on anticoagulant and vomited a coffee ground emesis. LN 32 stated there was no monitoring documented for Resident 1. LN 32 stated the purpose of monitoring Resident 1 for further bleeding was to notify the attending physician because coffee ground emesis was a sign of bleeding and could be dangerous to Resident 1's health. On [DATE] 4:08 P.M., a joint review of Resident 1's clinical record and an interview were conducted with the Director of Nursing (DON). The DON stated Resident 1 had been receiving and anticoagulant from GACH. The DON stated the timeline was as follows: -- [DATE], Resident 1 was readmitted to the facility, and was on anticoagulant. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- [DATE] at 3 A.M., the LN progress notes indicated Resident 1 had another large ground coffee emesis around 7:45. The DON stated she did not see documentation if this episode was the first time Resident 1 had coffee ground emesis. -- [DATE] at 11:10 A.M., the LN progress notes was reviewed and indicated, the nurse practitioner (NP, a nurse who has advanced clinical education and training. NPs share many of the same duties as doctors) was notified and NP gave diagnostic orders for Resident 1. The DON stated Resident 1 had CIC on [DATE] at 3 A.M., the LNs did not notify the NP until after eight hours of Resident 1's CIC. -- [DATE] at 1:37 A.M., the progress notes indicated Resident 1 vomited a large coffee ground emesis. -- [DATE] at 10:49 A.M., the progress notes indicated Resident 1 had changed in level of consciousness, the NP was notified, NP recommended to send Resident 1 to GACH, CPR was initiated at the facility and was sent out to the hospital and was placed in intensive care unit (ICU, a special area in a hospital or healthcare facility for people who have a life-threatening illness or injury). Resident 1 expired at the hospital. The DON stated she did not see any documentation of notifying the doctor on [DATE] at 1:37 A.M. when LN 1 observed Resident 1 had coffee ground emesis. The DON stated that ondansetron was given to Resident 1 on [DATE] at 1:52 A.M and at 9:55 A.M., there was no documentation of LN 1's observation of Resident 1's condition. The DON stated the NP was notified on [DATE] at 10:20 A.M. and at that time, CPR was initiated to Resident 1. The DON stated the LNs should have notified the physician immediately, meaning as soon as possible after they (LN) observed the resident's CIC. The DON stated Resident 1 passed away at GACH. A review of the facility's policy titled, Change in Condition, revised 2025, indicated, It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being.Procedure.2. The nurse will perform and document an assessment of the resident and identify need for additional interventions.Routine Medical Change, 1. All symptoms and unusual signs will be communicated to the attending physician promptly. A review of the facility's policy titled, Notification, Physician or Responsible Party, revised 2024, indicated, It is the policy of this facility to promptly notify the resident, his/ her attending physician/ NP.of changes in the resident's condition . 2. On [DATE] at 8:45 A.M., a concurrent observation and interview was conducted with Resident 9 and Licensed Nurse (LN) 23. LN 23 obtained blood from the resident to check Resident 9's blood sugar level. Resident 9 stated the LNs took my blood sugar this morning before breakfast. Resident 9 stated she had a routine blood sugar check before breakfast but LNs did not do it logically. A review of Resident 9's current physician's order did not indicate an order for blood sugar checks. On [DATE] at 8: 14 A.M., a concurrent interview and record review was conducted with LN 24. LN 24 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated there was no physician order for blood sugar checks for Resident 9. LN 24 stated she would notify the physician. On [DATE] at 8: 21 A.M., a concurrent interview and record review was conducted with LN 23. LN 23 stated it was a standard operating procedure for LNs to check resident blood sugar. LN 23 stated when Resident 9 returned to the facility, there was no physician order for blood glucose check. In addition, there was documentation in the electronic Medication Administration Record (eMAR) to enter blood sugar checks or results. LN 23 stated she should have clarified with the LN Supervisor when there was no physician order for blood sugar checks. LN 23 stated Resident 9 did not have a physician order for blood sugar checks. On [DATE] at 10:09 A.M., a concurrent interview and record review of Resident 9's Weights and Vitals Summary report of blood sugar checks on the following dates was conducted with the Director of Nursing (DON) indicated: [DATE] at 9 A.M., blood sugar (BS) = 285 mg/dl [DATE] at 5 P.M., = 283 mg/dl [DATE] at 9:07 A.M., = 196 mg/dl [DATE] at 6:17 P.M., = 132 mg/dl [DATE] at 9:42 A.M., = 230 mg/dl [DATE] at 6: 54 P.M., = 211 mg/dl [DATE] at 9 A.M., = 214 mg/dl [DATE] at 5 :49 P.M., = 306 mg/dl [DATE] at 7:11 A.M., = 238 mg/dl A review of Resident 9's time of blood sugar checks and time intervals indicated the following: [DATE] taken at 11: 15 A.M. and 12: 16 P.M. [DATE] taken at 10: 47 A.M and 11: 57 A.M. [DATE] taken at 7 A.M. and 9 A.M. [DATE] taken at 7: 27 A.M and 8:05 A.M. [DATE] taken at 7 A.M and 9 A.M. [DATE] taken at 7: 15 and 8:42 A.M. [DATE] taken at 7 A.M. and 9: 15 A.M. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] taken at 7 A.M. and 8:35 A.M. [DATE] taken at 7 A.M and 9 A.M. [DATE] taken at 7:33 A.M and 9:16 A.M. [DATE] taken at 7:02 A.M. and 9 A.M. [DATE] taken at 7:04 A.M. and 7: 25 A.M. [DATE] taken at 8:39 A.M. and 8:40 A.M. [DATE] taken at 7 A.M. and 8: 48 A.M. [DATE] taken at 7 A.M. and 9 A.M. [DATE] taken at 7 A.M and 8: 49 A.M. [DATE] taken at 7: 15 A.M. and 8: 51 A.M. [DATE] taken at 7:56 A.M. and 9: 51 A.M. [DATE] taken at 7: 35 A.M. and 9: 10 A.M. [DATE] taken at 7: 29 A.M. and 10: 12 A.M. During a concurrent interview and record review with the DON, the DON stated LNs should notify the physician when there was no order of blood sugar check. The DON also stated LNs should not check blood sugar check without a physician order. The DON stated she did not know why the blood sugar check was taken with close intervals. According to the facility policy entitled Physician Orders, revised 2025, indicated, .Physician's orders shall be obtained prior to the initiation of any medication or treatment.When a licensed nurse has questions about an order, the physician will be contacted to ensure follow up and timely implementation of the order.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from unnecessary medication when a resident (Resident 5) was receiving rivaroxaban (blood thinner that prevents and treat blood clots, one side effect is bruising or bleeding) and was not monitored for five months for signs and symptoms of bruising/ bleeding for one of two sampled residents reviewed for anticoagulant (AC, medicines that help prevent blood clots). This failure could result in AC medication related untoward side effects from inconsistent and poor management of medication therapy for Resident 5. Cross Reference F 756 Findings: Resident 5 was re-admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke, per the facility's admission Record. On 12/15/25, a review of Resident 5's clinical record was conducted. There was a physician's order on 7/31/25 for rivaroxaban (AC) for prevention of stroke. There were no physicians order and documentation of monitoring for signs and symptoms of bleeding or bruising related to rivaroxaban use from 7/31/25 to 12/14/25. On 12/17/25 at 4:02 P.M., a joint review of Resident 5's clinical record and an interview was conducted with Licensed Nurse (LN) 3. LN 3 stated Resident 5 had been receiving rivaroxaban since 7/31/25, the whole month of August, September, October, November, and until 12/14/25. LN 3 stated Resident 5 received the rivaroxaban and she did not see physician's order for monitoring Resident 5 for bleeding and bruising until 12/15/25. LN 3 stated it was five months that there was no documentation of monitoring Resident 5 while on blood thinners. LN 3 stated Resident 5 should have been monitored for bruising and bleeding for resident's safety since the resident was unable to express her symptoms. On 12/18/25 at 4 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the LNs to monitor residents receiving anticoagulants for signs of bleeding and bruising to ensure there were no untoward side effects of the anticoagulant therapy. A review of the facility's undated policy titled, Pharmacy Services/ Medication Management for Anticoagulants, indicated, The facility safely administers and monitors anticoagulant medications based on practitioner orders, resident needs, and accepted standards of practice, using ongoing assessment. Residents are monitored for bleeding.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 19.51%. Eight medication errors were observed out of 41 opportunities, during the medication administration process for one of eight randomly observed residents (Resident 8). As a result, the facility could not ensure medications were correctly administered to all residents. In addition this deficient practice had the potential to affect the resident's health and wellbeing. Findings: Resident 8 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and gastrostomy status (feeding tube in the stomach) according to the facility's admission Record. During medication administration on 12/17/25 at 9:50 A.M. an observation for Resident 8, Licensed Nurse (LN) 14 administered the following medications:-Tylenol (pain medication) 325mg two tablets by mouth-Allopurinol (for high uric acid in the blood) 100mg one tablet by mouth-Carvedilol (heart medication) 12.5mg one tablet by mouth-Hydralazine hydrochloride (for high blood pressure) 25mg one tablet by mouth-Metformin hydrochloride (for high blood sugar) 850mg one tablet by mouth-MVI (multivitamin) with mineral (supplement) one tablet by mouth-Geri-Kot (for constipation) 8.6mg two tablets by mouth-Juven (nutrition powder) nutrition support 1 packet by mouth, mixed in eight ounces of water by mouth During a review of the Order Summary Report for Resident 8, the Order Summary Report indicated: -Tylenol tablet 325mg give two tablets via G-Tube (gastrostomy tube- tube in the stomach) three times a day-Allopurinol 100mg give one tablet G-Tube one time a day-Carvedilol 12.5mg give one tablet G-Tube two times a day-Hydralazine hydrochloride 25mg one tablet G-Tube two times a day -Metformin hydrochloride 850mg one tablet G-Tube two times a day-Multiple Vitamins-Minerals give one tablet enterally (via feeding tube) one time a day -Senna oral tablet 8.6mg give two tablets via G-Tube one time a day-Juven oral packet give 1 packet enterally two times a day During an interview on 12/17/25 at 3:47 P.M. with Licensed Nurse (LN) 34, LN 34 stated the medication administration record (MAR) should be checked prior to medication administration. LN 34 stated the MAR should be checked to ensure the correct medication, resident, dose, time and route for resident's safety. An interview and joint record review was conducted on 12/18/25 at 10:16 A.M. with LN 14. LN 14 stated the five rights of medication administration were: checking for the right resident, time, medication, route and dose. LN 14 checked physician's orders for Resident 8 in the electronic medical record. LN 14 acknowledged that the physician's orders for the tablets were to be given via Resident 8's G-tube. During an interview on 12/18/25 at 4:50 P.M. with the Director of Nursing (DON), the DON stated she expected nurses to follow the five rights of medication administration. The DON stated it was important to follow the five rights to ensure that physician's orders were followed. A review of the facility's undated policy and procedure (P&P) titled, Medication Administration was conducted. The P&P indicated, It is the policy of this facility to accurately prepare, administer and document oral medications. Verify medication with medication order. The policy did not provide guidance regarding the five rights of medication administration.		

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Centers for Medicare & Medicaid Services

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to follow its own policy and procedure to establish an antibiotic stewardship program when the Infection Preventionist (IP) did not comprehensively track and monitor appropriate use of antibiotics. This failure had the risk to affect the residents in the facility due to lack of oversight and monitoring that could lead to increased infections and preventable deaths from resistant infections. Cross reference F880 Findings: On 12/18/25 at 1: 17 P.M., an interview and record review was conducted with the Director of Staff Development (DSD), Director of Nursing in training (DONIT), and the Director of Nursing (DON). The DSD stated she started working on April 224 with DSD role and doing Infection Preventionist (IP) role on 12/11/25. The DON stated we had our transition from 10/16/25 and the designated IP was no longer working in the facility. The October 2025 Antibiotic surveillance had 6 cases of community acquired infection (CAI) and 6 cases of healthcare associated infection (HAI). The October 2025 case mapping had 8 entries but did not identify whether a CAI or an HAI cases. The Antibiotic surveillance for October 2025 did not match the case map for October 2025. There was no documented evidence to indicate comprehensive tracking measures for antibiotic use to include data analysis, length of antibiotic use or number of days of therapy, and reason of using the antibiotic. In addition, there was no evidence of communication with the Medical Director and Pharmacist to discuss opportunities of improvement. The DSD/IP, the DIT and the DON could not discuss the Infection Control Program. The DON stated the facility should have done accurate and complete infection surveillance to prevent infection. According to the facility's policy, titled Antibiotic Stewardship, revised 9/2017 indicated, .It is the policy [facility name] to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections. Nursing home ASP activities should include, at a minimum. leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improvement.		

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Centers for Medicare & Medicaid Services

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident equipment in a safe, functional manner for 57 of 159 residents, located in the secured unit, (specialized, secured area for residents with dementia or mental illness, who are prone to wandering), when:1. Handrails in the hallway, (Station 3), had peeling paint, and;2. A bed remote control had exposed wires.These failures had the potential for peeling paint to be ingested by confused residents and the wires from the bed's remote control to pierce the skin of a resident.Findings:During initial tour on 12/15/25 at 10:07 A.M., an observation was conducted of the handrails outside room [ROOM NUMBER]. The handrails contained numerous layers of paint, and the white paint was peeling off in different areas.An observation and interview was conducted with Director of Maintenance (DM) on 12/16/25 at 3:50 P.M. of the hallway handrails outside Station 3's activity room. The DM was observed removing patches of white peeling paint from the handrails, with attempts of smoothing out the peeling paint patches. The DM stated he tried to check the handrails daily because of the peeling paint. The DM stated the peeling paint could be ingested by confused residents, which could cause harm. An observation was conducted of Station 3's handrails on 12/17/25 at 9:25 A.M. All the handrails on Station 3 had been painted lime green overnight. An observation and interview was conducted with Licensed Nurse 33 (LN 33) on 12/17/25 at 11:30 A.M., of Station 3's handrails, near the nurse's station. LN 33 stated the handrails were painted last night, because the previous paint kept peeling. LN 33 stated the green paint was starting to peel already, because too much paint had already been added. LN 33 stated the harm with the peeling paint was residents could ingest the peeling paint. An observation was conducted of Station 2's hallway handrail on 12/17/25 at 12:11 P.M. The handrail near the nurse's station was painted tan, with a small area of chipped wood exposed. 2. Resident 4 was admitted to the facility on [DATE], with diagnoses which included paranoid schizophrenia (a mental illness marked by intense paranoia, delusions [false beliefs, often persecutory], and auditory hallucinations [hearing voices], per the facility's admission Record. An observation was conducted with Resident 4, while lying in bed on 12/16/25 9:04 A.M. The bed control remote was wrapped around the upper right side rail. The coiled cord to the bed remote was frayed with exposed wires, approximately 6-7 inches down the length of the cord.An observation and interview was conducted with Certified Nursing Assistant 33 (CNA 33) on 12/16/25 at 9:06 A.M., of Resident 4's bed remote control. CNA 33 stated the cord should be replaced, because wires were exposed. CNA 33 stated the exposed wires were a safety issue and could poke the resident. A record review was conducted of Station 3's maintenance book on 12/16/25 at 9:06 A.M. Resident 4's frayed cord for the beds' remote control had not been reported by staff and was not documented in the unit's maintenance book. An interview was conducted with the Director of Maintenance (DM) on 12/16/25 at 9:12 A.M. The DM stated he conducted monthly inspections of resident rooms, to identify issues needing repairs. The DM stated he retrieved his monthly maintenance log to see when Resident 4's room was last inspected.An interview was conducted with CNA 34 on 12/16/25 at 9:39 A.M. CNA 34 stated if equipment issues were identified, she would inform the charge nurse and document the issue in the facility's maintenance book, so repairs could be made. A follow-up interview was conducted with the DM on 12/16/25 at 10:11 A.M. The DM stated he could not identify when Resident 4's room was last inspected in his monthly room maintenance log. The DM stated he was informed today of the exposed wires in Resident 4's room by staff. The DM stated the exposed wires on the bed remote could poke the resident or break her skin.An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 8:50 A.M. The DON stated she expected all resident equipment to be regularly inspected to be safe and functional.According to the facility's policy, titled Physical Environment-Equipment Maintenance, dated May 2007, It is the policy of this facility to establish procedures for routine and non-routine care of equipment and to ensure that equipment remains in good working order for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents and staff safety.Procedures: .3. Electrical. equipment will be inspected.on a routine basis. 5. Routine inspections and maintenance will be recorded using TELS and equipment .		

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Centers for Medicare & Medicaid Services

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No. 0938-0391

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity for two of six residents (Resident 4 and Resident 177) when:1. Resident 177 had an uncovered urinary collection bag (when urine drains from the bladder into a clear plastic drainage bag); and,2 . A staff member stood over Resident 4, while assisting with a meal.These failures had the potential for Residents 4 and 177 to feel exposed and undignified. Findings:1. Resident 177 was readmitted to the facility on [DATE], after a hospital diagnosis of bacteremia (a bacterial infection in the bloodstream), per the hospital discharge records, dated 12/11/25.During initial tour on 12/15/25 at 9:42 A.M., Resident 177's bed was empty. According to Licensed Nurse 31 (LN 31), Resident 177 was outside the secured unit (a specialized, controlled environment within a facility, for residents with mental illness or memory loss) attending a physical therapy session.An observation was conducted of LN 32 on 12/15/25 at 2:34 P.M., as she was administering Resident 177 an intravenous antibiotic (medication administered directly into a patient's bloodstream through a vein) in the resident's room. Resident 177 had a urinary collection bag hanging from the right bedframe. The collection bag was a milliliter cylinder type (usually utilized in a hospital setting for closely monitoring the urine output) and was uncovered. The urine was visible in the collection bag. A dignity bag (a dark colored bag utilized to cover urine collection bags) was not covering the collection bag or attached to the resident's wheelchair, which was used earlier to transport Resident 177 to physical therapy. A joint observation and interview was conducted with LN 32 while inside Resident 177's room on 12/15/25 at 2:54 P.M. LN 32 observed visible urine within Resident 177 urine collection bag and stated the drainage bag should have a dignity bag covering it, and there was not one present. LN 32 stated dignity bags were important to protect the resident's privacy and to provide dignity.An interview was conducted with the Director of Nursing (DON) on 12/18/25, at 8:50 A.M. The DON stated she expected all urinary collection bags to be covered with a dignity bag, to promote a resident's privacy and dignity. According to the facility's policy, titled Resident Rights, Dignity and Respect, dated October 2015, .4. Residents shall be examined and treated in a manner that maintains privacy of their bodies.2. Resident 4 was admitted to the facility on [DATE], with diagnoses which included paranoid schizophrenia (a mental illness characterized by intense paranoia, distrust, and suspicion, often leading to delusions (believing others want to harm you) and auditory hallucinations-hearing voices), per the facility's admission Record.An observation was conducted of Certified Nursing Assistant 31 (CNA 31) on 12/17/25 at 8 A.M., as she assisted Resident 4 with her breakfast within the resident's room. Resident 4 was in bed with the head of the bed elevated. CNA 31 was standing next to the bed, with a spoon in her hand and a meal tray on the bedside table. CNA 31 was observed standing over Resident 4's head, by approximately 2 feet. An interview was conducted with CNA 31 on 12/17/25 at 8:04 A.M. CNA 31 stated, Yes, I know I should not have been standing over her while assisting with her meal, because it was a dignity issue An interview was conducted with Licensed Nurse 31 (LN 31) on 12/17/25, at 8:08 A.M. LN 31 stated staff should be sitting or maintaining eye level while assisting residents with their meals. LN 31 stated if staff were standing, it could be assumed by the resident they were looking down on the residents or standing over them. LN 31 stated it was important to maintain eye level while feeding residents, to show respect and encourage socialization. An interview was conducted with the Director of Nursing (DON) on 12/17/25 at 8:11 A.M., as she entered the secured unit. The DON stated staff should always maintain eye to eye level when assisting residents with their meals. The DON stated staff could sit next to the bed or raise the bed up to obtain an eye to eye level. The DON stated by maintaining eye to eye level, it promotes dignity and respect.According to the facility's policy, titled Assisting the Impaired Resident with In-Room Meal, dated September 2013, .Steps in the Procedure: 1. Place the tray on the overbed table.3. If you are going to be seated during the feeding, position a chair (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	where it will convenient for you and the resident. According to the facility's policy, titled Resident Rights, Dignity and Respect, dated October 2015, it is the policy of this facility that all residents be treated with kindness, dignity and respect.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a Licensed Nurse (LN 1) notified the physician immediately, when a resident who was on anticoagulant therapy (medicines that help prevent blood clots) experienced episodes of vomiting large amount of coffee ground vomit (coffee ground vomit indicates upper gastrointestinal bleeding), for one of three sampled residents (Resident 1) reviewed for closed record. This deficient practice resulted in a delay in the resident receiving treatment to address Resident 1's significant change in condition and placed Resident 1's health at risk. Cross Reference F 684. Findings: Resident 1 was readmitted to the facility on [DATE] with diagnoses which included pneumonia (infection of the lungs), per the facility's admission Record. A review of Resident 1's history and physical (H&P) dated [DATE] was conducted. Per the H&P, Resident 1's Computed Tomography (CT scan, a type of imaging that uses X-ray techniques to create detailed images) of his chest, abdomen and pelvis at the general acute care hospital (GACH) indicated Resident 1 had chest wall large hematoma with active extravasation (a collection of blood in the extra thoracic space). The H&P indicated one of Resident 1's active medications was enoxaparin (anticoagulant). On [DATE] at 8:38 A.M., a joint record review and an interview was conducted with LN 32. LN 32 stated Resident 1 was transferred to the GACH on [DATE] at 10:50 A.M. after a cardiopulmonary resuscitation (CPR, life sustaining treatment) was initiated at the facility. LN 32 stated Resident 1 was at GACH when he passed away. LN 32 stated per LN 1's nurses progress notes on [DATE] at 1:36 A.M. Resident 1 threw up large amount of coffee ground emesis (medical term for vomiting). LN 32 stated the progress notes indicated she did not see any notes indicating the physician was notified of Resident 1's change in condition (CIC) until 10:50 A.M. LN 32 stated Resident 1 had CIC at 1:36 A.M. and that was more than nine hours after LN 1 observed Resident 1 had a CIC. LN 32 stated the LNs should have had informed the attending physician immediately because Resident 1 was on anticoagulant and threw up coffee ground emesis. LN 32 stated coffee ground emesis was a sign of bleeding and could be dangerous to Resident 1's health. On [DATE] at 4:08 P.M., a joint review of Resident 1's clinical record and an interview were conducted with the Director of Nursing (DON). The DON stated Resident 1 had been receiving an anticoagulant from GACH. The DON stated the timeline was as follows: - - [DATE], Resident 1 was readmitted to the facility, and was on anticoagulant. - - [DATE] at 3 A.M., the LN 1 progress notes indicated Resident 1 had another large ground coffee emesis around 7:45. - - [DATE] at 11:10 A.M., the LN progress notes indicated the nurse practitioner (NP, a nurse who has advanced clinical education and training and share many of the same duties as doctors) was notified and NP gave diagnostic orders for Resident 1. The DON stated Resident 1 had CIC on [DATE] at 3 A.M., the LNs did not notify the NP or the attending physician until after eight hours of Resident 1's CIC. - - [DATE] at 1:37 A.M., the progress notes indicated Resident 1 threw up a large coffee ground emesis. - - [DATE] at 10:49 A.M., the progress notes indicated Resident 1 had changed in level of consciousness, the NP was notified, NP recommended to send Resident 1 to GACH, CPR was initiated at the facility, was sent out to the hospital and was placed in intensive care unit (ICU, a special area in a hospital or healthcare facility for people who have a life-threatening illness or injury). Resident expired at the hospital. The DON stated she also did not see any documentation of notifying the doctor on [DATE] at 1:37 A.M. when LN 1 observed Resident 1 had coffee ground emesis. The DON stated the NP was notified on [DATE] at 10:20 A.M. The DON stated the LNs should have notified the physician immediately meaning as soon as possible after they (LN) observed the resident's CIC. A review of the facility's policy titled, Notification, Physician or Responsible Party, revised 2024, indicated, It is the policy of this facility to promptly notify the resident, his/ her attending physician/ NP. of changes in the resident's condition .		

Department of Health & Human Services
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Printed: 07/18/2026
Form Approved OMB
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NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to ensure a thorough investigation was conducted for an allegation of abuse for one of one resident (Resident 162), when Resident 162 reported a male staff (RNA- restorative nursing assistant 1) inappropriately touched her. This failure had the potential to negatively affect Resident 162's psychosocial wellbeing and the potential to expose all residents in the facility to abuse. Findings: On 12/2/25, the Department of Public Health (CDPH) received a facility reported incident for an allegation of RNA 1 inappropriately touched Resident 162's breast. On 12/15/25 at 9:25 A.M., a concurrent observation and interview was conducted with Resident 162 in her room, curled up in bed. Resident 162 stated RNA 1 touched her breast in her room, but could not recall the date and time it happened. Resident 162 stated there were two unwitnessed incidents with the same staff (RNA 1). Resident 162 stated she informed her roommate (Resident 9) about the second incident. On 12/15/25 at 9:36 A.M., an interview was conducted with Resident 9. Resident 9 stated the incident happened a couple of weeks ago after breakfast in the room. Resident 9 stated she heard Resident 162 saying it is not happening. Resident 9 stated she did not witness the incident. On 12/17/25 at 8:55 A.M., a concurrent interview and a review of Resident 162's clinical records and RNA 1's record was conducted with the Director of Nursing (DON). The DON stated Resident 162's physician History and Physical (H&P) dated 11/3/25 indicated Resident 162 did not have the capacity to understand and make decisions. The DON stated Resident 162's Brief Interview of Mental Status (BIMS - ability to recall) score dated 11/7/25 was 5/15 which meant Resident 162's cognitive level was severely impaired. The DON stated RNA 1 did not have any previous allegations of abuse, was not previously suspended, had no disciplinary actions prior, and he was up to date with his in-services and trainings. On 12/18/25 at 10:30 A.M., a follow up interview and record review was conducted with the DON. The DON stated there were no date and time Resident 9 and Resident 162 were interviewed during the facility investigation. The DON stated there were no date and time when RNA 1 was interviewed. The DON stated there were no other residents interviews to whom RNA 1 provided care or services. The DON stated she should have interviewed other residents and staff members to have a more understanding of the abuse allegation and the investigation would have a more definitive conclusion to make the investigation thorough and complete for prevention and safety of all residents. According to the facility policy entitled Administration, revised 6/2025, indicated .The investigation will include the following: An interview with staff members (on all shifts) who may have information regarding the alleged incident; Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; An interview with staff member (on all shifts) having contact with e accused employee; and A review of all circumstances surrounding the incident.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide a written notice of transfer and its bed hold policy to a resident and his Responsible Party (RP) at the time of his hospital transfer for one of three residents (18) reviewed for closed record. As a result, Resident 18 and his RP were not fully informed of Resident 18's bed hold rights. Findings: Per the facility's admission Record, Resident 18 was readmitted to the facility on [DATE] with diagnoses to include end stage renal disease (End Stage Renal Disease-irreversible kidney failure). On 12/17/25, a review was conducted of Resident 18's medical record. Resident 18's history and physical dated 6/24/25 indicated Resident 18 did not have the capacity to understand and make decisions and the resident's family member (FM) was the RP. Per the facility's Progress Note, dated 11/24/25 at 12 A.M., Resident 18 was transferred to an acute care hospital for a change in condition. There was no documentation on 11/24/25 or 11/25/25 that Resident 18's RP was provided with a written notice of Resident 18's transfer and the facility's bed hold policy. Per the facility's Bed Hold Notification, signed by Resident 18's RP on 10/6/25 (at the time of admission), the portion of the form titled, Confirmation of Transfer & Bed Hold Provision was not completed. The form was blank for the sections indicating the acute care hospital to which Resident 18 was transferred, the day and time he left, who notified him or his RP of the bed hold option, when he and his RP were notified, and the location for staff to sign. The section of the form that indicated 24-hour notification to Resident 18 and his RP was left blank. On 12/18/25 at 3:58 P.M., a joint review of Resident 18's bed hold notification form and an interview was conducted with the Director of Nursing (DON). The DON stated there was no signature when Resident 18 was transferred out to the hospital. The DON stated written notice of transfer and bed hold should have been provided to Resident 18 and his RP because that was their right. Per the facility's policy, titled Bed Hold, revised 1/22, It is the policy of this facility to inform the resident or resident's representative in writing of the right to exercise the bed hold provisions of (7) days upon admission, before transfer to a general acute care hospital.the duration of the state bed hold policy.that the resident's bed will be held for the duration of (7) days, during which time the resident is permitted to return and resume residence in the facility.		

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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 observation, interview, and record review, the facility failed to accurately assess and code two of six residents (130 and 9) for Restorative Nursing Services (RNA-a specially training certified nursing assistant who provides range of motion exercises with residents, in order to maintain mobility and flexibility) on their Minimum Data Set (MDS-a mandated reporting assessment tool) used to inform Centers for Medicare and Medicaid Services (CMS), of residents' current status reviewed for MDS accuracy. This failure resulted in CMS not being informed of Resident 130's and Resident 9's current health status and services being provided. Findings: 1. Resident 130 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke - a medical emergency where blood flow to part of the brain is suddenly blocked or a blood vessel bursts, depriving brain cells of oxygen and nutrients causing them to die within minutes) affecting the left side (weakness of the left extremities), per the facility's admission Record. During initial tour 12/15/25 at 10:53 A.M., an observation and interview was conducted with Resident 130 as he laid in bed. A wheelchair was positioned near the foot of the bed. Resident 130 stated he wanted physical therapy, because he could not walk and he felt he was getting weaker every day. Resident 130 stated he really wanted to walk again. Resident 130's medical record was reviewed on 12/17/25. According to the physician's order, dated 10/22/25 indicated, Program for passive range of motion, left lower extremity, all planes, 10 repetitions, two sets, three times a week as tolerated. According to the quarterly Minimum Data Set (MDS-a clinical assessment tool), dated 12/11/25, Resident 130 had a cognitive score of 15, indicating cognition was intact. The quarterly MDS for Special Treatments, Section O, listed no Restorative Nursing Programs had been provided in the past seven days. A care plan, titled Resident at Risk for decline in Range of Motion, undated, listed RNA services being provided three times a week. The Weekly Restorative Nursing notes were present in the facility's Progress notes. An interview was conducted with certified nursing assistant 32 (CNA 32) on 12/17/25 at 9:58 A.M. CNA 32 stated it was important to recognize and identify residents with deteriorating range of motion, so a referral to physical therapy could be made and an assessment completed. An interview was conducted with Restorative Nursing Assistant 1 (RNA 1) on 12/17/25 at 12:06 P.M. RNA 1 stated Resident 130 was receiving RNA services three times a week to the lower extremities. An interview and record review was conducted with the Minimum Data Set Nurse (MDSN), regarding Resident 130's RNA services. The MDSN stated when reviewing and assessing residents for services, she reviews the physician's orders, nurses' notes, care plans, and administration records. The MDSN reviewed Resident 130's current physician orders, which indicated RNA services were being provided. The MDSN reviewed the 12/11/25 MDS, section O for RNA services which indicated no services were being provided. The MDS then checked the RNA administration record, which had no documented services. The MDSN left to get RNA 1, in order to confirm if RNA services were being provided or not. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with RNA 1 on 12/17/2025 at 12:30 12:23 P.M., with the MDSN being present. RNA 1 stated he documented his services in the nurses' progress notes and he never used the RNA Administration Record. The MDSN stated she completely missed it, by not checking the nursing progress notes for confirmation. The MDSN stated she should have checked with RNA 1 to confirm services were being provided and where they were documented. The MDSN stated that by missing the RNA assessment, CMS was unaware of the resident's current condition and services being provided. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 8:50 A.M. The DON stated she expected MDS data to be correct and completed in a timely manner. The DON stated CMS needed to be aware of all services being provided to residents. According to the Resident Assessment Instrument, dated October 2019, Section O-0500, .Steps for Assessment; 1. Review the restorative nursing program notes and/or flow sheets in the medical record. 2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period. 3. The following criteria for restorative nursing programs must be met in order to code O-0500: Measurable objective and interventions must be documented in the care plan and in the medical record. 2. According to the facility's admission Record, Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE], was sent out and return to facility on 12/8/25. On 12/17/25 at 3: 27 P.M., a concurrent observation, interview, and record review was conducted with Licensed Nurse (LN) 21. Resident 9 had hemiplegia (paralysis or severe weakness affecting one side of the body [arm, leg, and sometimes face] due to brain damage, often from a stroke, injury, or congenital condition) on the left side of body. Review of the admission notes indicated: On 1/31/24 Resident 9 had history of stroke with left sided hemiplegia (loss of muscle function). The questions were answered with: yes to weakness present, yes to left arm and left leg, yes to paralysis, left side weakness and ROM in arm, hand, leg and foot with limitation on one side. On 5/24/25 readmission assessment for Resident 9 questions were answered: Resident 9 had no weakness, paralysis, and did not indicate any limitation or loss of ROM. On 12/8/25 readmission assessment for Resident 9, the questions were answered: paralysis was marked with a check and ROM impairment on one side. During an interview with LN 21, LN 21 stated Resident 9's record was not accurate. LN 21 stated Resident 9's admission on [DATE] did not indicate any weakness or paralysis on the left side and the License Nurse Initial admission Record did not indicate ROM limitation or loss. On 12/17/25 at 3: 47 P.M., a concurrent observation, interview, and review of the LN initial admission notes was conducted with LN 22. Resident 9 had hemiplegia on the left side. Review of the LN initial admission notes dated 1/31/24 indicated: Resident 9's question were answered with yes to weakness present, yes to left arm and left leg, yes to paralysis and left side weakness and ROM in arm, hand, leg and foot with limitation on one side. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/24/25, the admission assessment, Resident 9 no weakness, paralysis and did indicate any limitation on ROM or loss. On 12/8/25, the assessment were answered on Resident 9 questions: paralysis was marked with a check and ROM impairment on one side. During this interview with LN 22, LN 22 stated Resident 9's assessment record was not accurate. LN 22 stated the License Nurse Initial admission Record on 5/24/25 did not indicate ROM limitation or loss. LN 22 stated it was important to have an accurate description of Resident 9. On 12/17/25 at 4: 25 P.M., an interview and record review of Resident 9's MDS (minimum data set-assessment tool) section G was conducted with Minimum Date Set Nurse (MDSN) 21. MDSN 21 stated Resident 9 was assessed today and confirmed Resident 9 had left sided weakness on upper and lower extremity. MDSN 21 stated the MDS assessment was not accurate. MDSN 21 stated Resident 9's records should be accurate to provide accurate care. On 12/18/25 at 10:09 A.M., an interview and review of the LN initial admission assessment and MDS assessment was conducted with the Director of Nursing (DON). The DON stated Resident 9's records was not coded accurately. The DON stated we need accurate MDS coding to provide accurate care. According to the facility policy entitled Resident Assessment Instrument, updated 10/1/19, indicated .The results of the assessment, which must accurately reflect the resident's status and needs.'		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASSAR 2-a federally mandated process that ensures individuals with serious mental illness (SMI), intellectual disabilities (ID), developmental disabilities (DD), are not inappropriately admitted to Medicaid-certified nursing facilities (NFs) if they can be served in a more integrated, community-based setting) was completed in a timely manner for one of three residents (Resident 129) reviewed for PASSAR. The failure had the potential for Resident 129 to be improperly placed or to miss out on additional services offered for PASSAR II residents. Findings: Resident 129 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), per the facility's admission Record. An observation and interview was conducted with Resident 129 on 12/16/2025 at 8:15 A.M., in his room. Resident 129 was dressed and neatly groomed. Resident 129 stated he was admitted to the facility a few months ago and has made one or two friends since admission. Resident 129's medical record was reviewed on 12/17/25. A PASARR I was completed on 11/10/25, which was listed as, positive and triggered for a PASSAR II to be conducted by a State official. There was no documented evidence a PASARR II had been completed. On 12/17/25, the Minimum Data Set Nurse (MDSN) was asked to provide proof a PASSAR II had been completed. A review of Resident 129's PASARR II was reviewed on 12/17/25 at 8:16 A.M. The document dated 11/14/25 indicated, Unable to complete evaluation for serious Mental illness. Staff were unresponsive on 2 or more attempts to schedule within 48 hrs. Case close. An interview and record review of Resident 129's PASARR II was conducted with the MDSN on 12/17/25 at 8:30 A.M. The MDSN stated she arranged and scheduled the PASARR II interviews with State evaluators. The MDSN stated once Resident 129's PASARR II document was requested and reviewed, the MDSN realized Resident 129's PASARR II was never completed. The MDSN stated she could not recall ever receiving any calls from the State to schedule the evaluation or ever receiving the PASARR II letter, indicating the case was closed due to being unable to reach the facility to schedule it. The MDSN stated since the PASARR II was never completed it had the potential for a delay in Resident 129 receiving additional services and to ensure he was appropriately placed at the facility. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 8:50 A.M. The DON stated PASSAR II's were important so staff could properly care for the resident and provide all recommended services. The DON stated she expected all PASARR I and PASSR II's to be completed in a timely manner. According to the facility's Policy, titled Resident Assessment: PASRR, dated December 2021, .1 A PASRR shall be completed on every resident upon admission. 3. After admission, IDT members will review the assessment for accuracy and the need for PASRR Level II referral. 4. Based on the assessment, the facility will ensure proper referral to appropriate State agencies for the provision of specialized services to residents with ID/RC (Intellectual Disability or Related Condition) or SMI (Serious Mental Illness) .		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide individualized therapeutic and or social activities that promote the residents' highest physical, mental, and psychosocial well-being, according to their plan of care for one of three reviewed residents (Resident 23). This deficient practice placed Resident 23 at risk for decreased emotional well-being, social isolation, and reduced quality of life due to the lack of meaningful engagement. Cross Reference F 677. Findings: Resident 23 was readmitted to the facility on [DATE], with diagnoses which included multiple sclerosis (MS, a disease that causes breakdown of the protective covering of nerves, can cause numbness, weakness, trouble walking, vision changes and other symptoms), per the facility's admission Record. On 12/15/25, a review of Resident 23's minimum data set (MDS, a federally mandated resident assessment tool) dated 11/27/25, indicated Resident 23 could make independent reasonable decisions. The MDS also indicated Resident 23's functional abilities included lower extremities impairment and that he was dependent on the staff on his activities of daily living (ADLs, like transferring). On 12/15/25, a review of Resident 23's care plan indicated Resident 23 will participate in group activities of choices including playing bingo. On 12/15/25 at 9:06 A.M., an observation and an interview was conducted with Resident 23 in his room. Resident 23 was laying in bed with his legs elevated. Resident 23 stated he had MS and was unable to walk. Resident 23 stated he stayed in bed and no one got him up from bed. Resident 23 stated he wanted to join activities but was unable to get up on his own. On 12/15/25 at 4:55 P.M., a follow up observation and an interview were conducted with Resident 23 in his room. Resident 23 stated he had not gone to the activity and would like to play Bingo. Resident 23 stated the staff had not offered any activities to him and it was boring. Resident 23 stated, I want them to get me out of here. Resident 23 stated he could not stand and or walk and needed assistance to get up. On 12/16/25 at 3:20 P.M., another follow up observation, and an interview were conducted with Resident 23 in his room. Resident 23 was laying in bed. Resident 23 stated he had not gotten up from yesterday (12/15/25) until 12/16/25. Resident 23 stated he wanted to attend activities and it would be great if he could be get up and attend activities. On 12/16/25 at 3:53 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 23 was alert and could make his needs known. CNA 2 stated Resident 23 was dependent on the staff when transferring. CNA 2 stated Our sup (supervisor) tells us to ask them (residents) to have social activities unless bedbound. On 12/17/25 at 2:59 P.M., a joint record review and an interview was conducted with the Activity Coordinator (AC). The AC stated Resident 23 required two person to assist him to transfer from bed to wheelchair. On 12/17/25 at 3:12 P.M., a joint observation and interview of Resident 23 with the AC was conducted in Resident 23's room. Resident 23 stated to AC, he would love to attend the activity and it would be nice. The AC stated Resident 23 was so happy and he is now smiling. On 12/17/25 at 3:36 P.M., a joint record review and interview were conducted with Licensed Nurse (LN) 3. LN 3 stated the staff had gotten up Resident 23 a month ago to attend an activity. LN 3 stated Resident 23 required two person assist to transfer him from the bed to the wheelchair and back to bed. LN 3 stated Resident 23 had been in bed a lot and could cause complications like getting wounds, isolation and boredom. On 12/18/25 at 11:36 A.M., a follow-up interview and record review of Resident 23's activity quarterly evaluation was conducted with the AC. The AC stated Resident 23 was in the one-on-one activity program from November to December 2025. The AC stated Resident 23 likes bingo. The AC stated bingo was a group activity and contradicted Resident 23's activity quarterly evaluation that indicated Resident 23's activity goal was met when he could not join bingo which Resident 23 liked. The AC stated Resident 23 had no wheelchair to attend the group activity and the information was communicated to nursing. The AC stated she could not locate the documentation indicating Resident 23 needed a wheelchair to attend the group activity. The AC stated Resident 23's evaluation was not accurate; the goal was not met. On 12/18/25 at 1:19 (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M., an interview was conducted with CNA 3. CNA 3 stated during the time she was assigned to Resident 23, she had not gotten up Resident 23 to attend group activity. On 12/18/25 at 3:19 P.M., a joint review of Resident 23's clinical record and an interview was conducted with the Director of Nursing (DON). The DON stated Resident 23 required assistance from the staff when getting up and out of bed. The DON stated there was no documentation of an attempt to encourage Resident 23 to attend activities of choice. The DON stated the policy was for the staff to encourage and offer Resident 23 to attend activities of choice to enhance his quality of life. A review of the facility's policy titled, Quality of Life, Activities Program, revised 3/19 indicated, .It is the policy of this facility to implement an ongoing resident centered activities program that incorporates the resident's interests.which is integral to maintaining and/ or improving a resident's physical, mental, and psychosocial well-being.Procedures, 1. Activities are planned according to the resident's preferences, needs and abilities.		

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NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	
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F 0689 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to complete post fall assessments for one of one resident (Resident 57) reviewed for accidents according to the facility's policy and procedure. This failure had the potential for not identifying the root cause of Resident 57's falls and maintain Resident 57's safety. Findings: Resident 57 was admitted to the facility on [DATE] with diagnoses including vascular dementia (brain damage affecting thinking, memory, judgment and walking), unspecified severity according to the facility's admission Record. During an observation of Resident 57 on 12/15/25 at 9:30 A.M., Resident 57 was in bed with a floor mat on the right side of the bed. An interview and concurrent record review on 12/17/25 at 3:08 P.M. was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 57 used to walk independently using a front wheel walker but had declined and preferred to stay in bed most of the day. LN 11 reviewed Resident 57's progress notes from September 2025 and stated Resident 57 has had multiple fall incidents. LN 11 stated Resident 57 fell on 9/3/25, 9/16/25, 10/11/25, 11/5/25, 12/8/25 and on 12/11/25. LN 11 stated a fall risk assessment was completed upon a resident's admission and after each fall. LN 11 reviewed fall risk assessments for Resident 57. LN 11 stated the fall risk assessment completed on 9/16/25, 10/11/25 and on 12/11/25 indicated, Resident 57 was high risk for falls. LN 11 stated there was no fall risk assessment completed for the Resident 57's fall incidents on 9/3/25 and 11/5/25. LN 11 stated a fall risk assessment should have been completed to assess the resident's functionality and if fall preventive measures were working. During an interview on 12/17/25 at 3:25 P.M. with Certified Nurse Assistant (CNA) 13, CNA 13 stated Resident 57 had episodes of unsafely getting up from bed unassisted and was a fall risk. CNA 13 stated Resident 57 required one on one monitoring for safety. An interview was conducted on 12/18/25 at 4:50 P.M. with the Director of Nursing (DON). The DON stated post fall assessments were needed to check for the root cause of a fall and to have appropriate interventions. A review of the facility's policy and procedure (P&P) titled, Fall Best Practice Guidelines, dated 7/2016 was conducted. The P&P indicated, It is the policy of this facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional fall and minimize potential for injury. Identify the residents who are at risk for fall. Fall risk assessment will be completed within 24 hours of admission, post fall, with the MDS [Minimum Data Set- a clinical assessment tool] required assessment, and quarterly. A Post Fall Assessment including recommendations and care plan changes will be completed for all residents who experienced a fall. Findings: Resident 57 was admitted to the facility on [DATE] with diagnoses including vascular dementia (brain damage affecting thinking, memory, judgment and walking), unspecified severity according to the facility's admission Record. During an observation of Resident 57 on 12/15/25 at 9:30 A.M., Resident 57 was in bed with a floor mat on the right side of the bed. An interview and concurrent record review on 12/17/25 at 3:08 P.M. was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 57 used to walk independently using a front wheel walker but had declined and preferred to stay in bed most of the day. LN 11 reviewed Resident 57's progress notes from September 2025 and stated Resident 57 has had multiple fall incidents. LN 11 stated Resident 57 fell on 9/3/25, 9/16/25, 10/11/25, 11/5/25, 12/8/25 and on 12/11/25. LN 11 stated a fall risk assessment was completed upon a resident's admission and after each fall. LN 11 reviewed fall risk assessments for Resident 57. LN 11 stated the fall risk assessment completed on 9/16/25, 10/11/25 and on 12/11/25 indicated, Resident 57 was high risk for falls. LN 11 stated there was no fall risk assessment completed for the Resident 57's fall incidents on 9/3/25, 11/5/25 and on 12/8/25. LN 11 stated a fall risk assessment should have been completed to assess the resident's functionality and if fall preventive measures were working. During an interview on 12/17/25 at 3:25 P.M. with Certified Nurse Assistant (CNA) 13, CNA 13 stated Resident 57 had episodes of unsafely getting up from bed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unassisted and was a fall risk. CNA 13 stated Resident 57 required one on one monitoring for safety. An interview was conducted on 12/18/25 at 4:50 P.M. with the Director of Nursing (DON). The DON stated post fall assessments were needed to check for the root cause of a fall and to have appropriate interventions. A review of the facility's policy and procedure (P&P) titled, Fall Best Practice Guidelines, dated 7/2016 was conducted. The P&P indicated, It is the policy of this facility to. Investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional fall and minimize potential for injury. Identify the residents who are at risk for fall. Fall risk assessment will be completed within 24 hours of admission, post fall, with the MDS [Minimum Data Set- a clinical assessment tool] required assessment, and quarterly. A Post Fall Assessment including recommendations and care plan changes will be completed for all residents who experienced a fall.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 5) was positioned properly while tube feeding (TF-nutrition in liquid form through a tube) was ongoing per the resident's plan of care for one of two residents reviewed for TF. As a result, Resident 5 was at risk for aspiration (back up of fluid from the stomach to the lungs) and other TF complications. Findings: Resident 5 was re-admitted to the facility 7/29/25 with diagnoses which included dysphagia (difficulty swallowing) and a gastrostomy (opening in the stomach created surgically), per the facility's admission Record. On 12/16/25 at 9:38 A.M., an observation of Resident 5 in the room was conducted. Resident 5 was lying flat on bed while a TF was infusing. On 12/16/25 at 10:40 A.M., a joint observation of Resident 5 and an interview was conducted with Licensed Nurse (LN) 32. LN 32 stated Resident 5's TF would have been completed at 10 A.M. LN 32 stated Resident 5's head of bed was flat and should have been elevated to prevent Resident 5 from aspiration that could have led to pneumonia (lung infection). LN 32 stated for residents with ongoing TF, the head of the bed should have been elevated to 30 to 45 degrees angle to prevent the residents from aspiration. A review of Resident 5's plan of care, titled Enteral Feeding, indicated one of the interventions was to elevate Resident 5's head of bed at 45 degrees angle during and thirty minutes after TF. On 12/18/25 at 4 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated facility's policy for residents with ongoing TF, the residents' head of bed should be elevated at 30-45 degrees angle to prevent from aspiration. A review of the facility's policy and procedure (P&P) titled, Gastrostomy Tube Care and Management, dated 1/22 was conducted. The P&P did not provide guidance regarding proper positioning of a resident with TF.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess respiratory status during a nebulizer treatment (liquid medication delivered as a fine mist inhaled into the lungs through a mouthpiece or mask) for two of two residents (Resident 178 and Resident 8) reviewed for respiratory care. This failure had the potential for residents to receive inappropriate care and treatment to address their respiratory problems. Findings: 1. Resident 178 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (a condition where the lungs fail to adequately exchange oxygen, leading to low oxygen in the blood) according to the facility's admission Record. On 12/17/25 at 8:55 A.M. Resident 178's family member notified Licensed Nurse (LN) 14 that Resident 178 had difficulty breathing. LN 14 informed Resident 178's family member that he will administer a nebulizer treatment to Resident 178 to help with the breathing. LN 14 took a medication in a plastic vial from the medication cart. LN 14 poured the liquid medication into a chamber connected to a mask and a machine, placed the mask on Resident 178 and then turned on the machine. LN 14 did not listen to Resident 178's lung sounds, checked respiratory rate and heart rate prior to, during or after the nebulizer treatment. During a review of Resident 178's Order Summary Report, the Order Summary Report indicated, Ipratropium-Albuterol Solution.3 ml [milliliter] inhale three times a day for Acute respiratory failure. An interview was conducted with LN 11 on 12/18/25 at 8:31 A.M. LN 11 stated for nebulizer treatments, the resident's lung sounds, respirations and heart rate should be checked before and after the nebulizer treatment. LN 11 stated an assessment should be conducted in case there was a change in the resident's condition. 2. Resident 8 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and gastrostomy status (feeding tube in the stomach) according to the facility's admission Record. A medication administration observation for Resident 8 was conducted on 12/17/25 at 9:52 A.M. with Licensed Nurse (LN) 14. LN 14 stated Resident 8 was due for a nebulizer treatment. LN 14 took a liquid medication in a small plastic vial from the medication cart, poured the medication into a chamber connected to a mask and a machine, applied the mask to Resident 8 then turned on the nebulizer machine. LN 14 did not check Resident 8's lung sounds, respiratory rate and heart rate before, during or after the nebulizer treatment. A review of the Order Summary Report for Resident 8 indicated, Budesonide [a steroid medication used to reduce inflammation] Inhalation Suspension.2 ml [milliliter] inhale orally via nebulizer two times a day for COPD (Chronic Obstructive Disease- lung diseases that block airflow and make it difficult to breathe) Nebulizer treatment. During an interview on 12/18/25 at 10:16 A.M. with LN 14. LN 14 stated he was not instructed to check a resident's respiratory rate and pulse prior to, during or after a nebulizer treatment. An interview on 12/18/25 at 10:29 A.M. with LN 34 was conducted. LN 34 stated the resident's respirations, breathing and pulse should be checked before and after a nebulizer treatment. LN 34 stated it was important to check the resident's heart rate if it was normal after a nebulizer treatment and if the treatment was effective. An interview on 12/18/25 at 4:50 P.M., was conducted with the Director of Nursing (DON). The DON stated she expected nurses to stay with the resident during breathing treatment. The DON stated nurses should check the resident's respirations, listen to their lungs and check heart rate because some medications could increase heart rate. The DON stated an assessment should be done to check for abnormality and effectiveness of the nebulizer treatment. A review of the facility's undated policy and procedure (P&P) titled, Small Volume Nebulizer was conducted. The P&P indicated, Nebulizer treatment is done to improve and promote coughing, to improve distribution of ventilation [process of moving air in and out of the respiratory system], to open up alveoli [air sacs in the lungs], to decrease carbon dioxide [waste product expelled upon breathing out] and to deliver medication [s]. The policy did not provide guidance regarding resident assessment to verify effectiveness of the nebulizer treatment.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address and implement the Consulting Pharmacist's (CP) recommendation during a monthly Medication Regimen Review (MRR) regarding a psychotropic medication (a medication that affects brain function), for one of five residents (Resident 99), for Medication Review. In addition, the CP did not identify monitoring of untoward side effects of anticoagulant (AC, blood thinner medication) for one of two residents (Resident 5) reviewed for AC (Cross Reference F 757). This failure had the potential for Resident 99 not to be monitored appropriately by staff for exhibiting specific behaviors. In addition, Resident 5 was not monitored for untoward side effects of AC for five months. Findings: Resident 99 was admitted to the facility on [DATE], with diagnoses which included paranoid schizophrenia, (a mental illness marked by intense paranoia, delusions [false beliefs, often persecutory], and auditory hallucinations [hearing voices]), according to the facility's admission Record. Resident 99's medical record was reviewed on 12/17/25. According to the physician's order, dated 5/23/24, Ativan 1 milligram tablet, (a medication use to treat anxiety), three times a day by mouth, for anxiety. Monitor episodes of anxiety as exhibited by restlessness every shift. According to undated care plan, titled Anti-Anxiety medication use related to anxiety disorder as exhibited by anxiousness, included an intervention of: Monitor/record occurrences of target behavior. A review of the MRR for October 2025 was conducted on 12/17/25. The CP made the recommendation for Resident 99's Ativan use indicated: Restlessness is vague and subjective, it is not measurable, please change or correct. There was no documented evidence that the recommendation was addressed or acted on. An interview and record review regarding Resident 99 was conducted with Licensed Nurse 33 (LN 33) on 12/18/25 at 8:27 A.M. LN 33 stated to administer a psychotropic medication, there needed to be a physician's order, a consent signed by the resident or their responsible party, and a specific behavior to monitor for. LN 33 reviewed Resident 99's physician order for Ativan behavior monitoring, which listed a behavior of restlessness. LN 33 stated the behavior was too vague and subjective. LN 33 stated the behavior should be more specific like, repeatedly pacing. getting up and down from bed. LN 33 stated the behavior of restlessness should have been captured sooner by staff and changed to a specific targeted behavior. An interview and record review was conducted regarding Resident 99 with LN 31 on 12/18/25 at 8:34 A.M. LN 31 stated specific behaviors needed to be listed by the physician for staff to monitor for, when receiving a psychotropic medication. LN 31 reviewed Resident 99's physicians' order for Ativan behavior monitoring. LN 31 stated the behavior of restlessness was too vague and was unacceptable for monitoring. LN 31 stated the behavior needed to be very specific such as yelling and/or screaming at staff. An interview and record review regarding Resident 99's MRR was conducted with the Director of Nursing (DON) on 12/18/25 at 8:50 A.M. The DON stated specific behavior monitoring should be documented, so staff were aware of what behavior they were monitoring for. The DON reviewed (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 99's October 2025 MMR and the CP's recommendation regarding the vague behavior of restlessness. The DON stated the recommendation should have been implemented, once it was received and it was not. The DON stated she did not follow through and make the recommended changes. An interview was conducted with the Consulting Pharmacist (CP) on 12/18/25 at 9:51 A.M. The CP stated he made recommendations on a monthly basis and he expected staff to follow the recommendations or offer a written explanation of why they are not being followed. The CP stated if he made a recommendation in October 2025, he expected staff to acknowledge it and make the needed changes that same month. According to the facility's policy, titled Care and Treatment-Medication Regimen Review, dated May 2007, .Procedure: .4. Pharmacist review considers factors such as; Whether the physician and staff have documented objective findings, diagnoses, and/or symptoms to support indications for use. 5.The use of medication without evidence of adequate monitoring.6.B. Nursing Documentation Review: Nursing personnel provide a written response to the review after the report is received. 2. Resident 5 was re-admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following a stroke, per the facility's admission Record. On 12/15/25, a review of Resident 5's clinical record was conducted. There was a physician's order on 7/31/25 for rivaroxaban (AC) for prevention of stroke. There were no physicians order and documentation of monitoring for signs and symptoms of bleeding or bruising related to rivaroxaban use from 7/31/25 to 12/14/25. On 12/17/25 at 4:02 P.M., a joint review of Resident 5's clinical record and an interview was conducted with Licensed Nurse (LN) 3. LN 3 stated Resident 5 had been receiving rivaroxaban since 7/31/25, whole month of August, September, October, November, until 12/14/25. LN 3 stated Resident 5 received the rivaroxaban, and she did not see physician's order for monitoring Resident 5 for bleeding and bruising until 12/15/25. LN 3 stated it was five months that there was no documentation on monitoring Resident 5 while on blood thinners. LN 3 stated Resident 5 should have been monitored for bruising and bleeding for resident's safety since the resident was unable to express her symptoms. On 12/18/25 at 9:46 A.M., a telephone interview was conducted with the facility's CP. The CP stated Resident 5's physician's order for rivaroxaban was received on 7/31/25. The CP stated the medication regimen review (MRR) for Resident 5's AC therapy should have been done monthly to look for discrepancies. The CP stated there was no monitoring for the untoward side effects like bleeding, for Resident 5's AC therapy from July 2025 to December 2025. The CP stated, It should have been captured during the MRR. I did not capture it. On 12/18/25 at 4 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the LNs to monitor residents on anticoagulant for bleeding and bruising to ensure there was no untoward side effects of the anticoagulant therapy. A review of the facility's undated policy titled, Pharmacy Services/ Medication Management for Anticoagulants, indicated, The facility safely administers and monitors anticoagulant medications (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based on practitioner orders, resident needs, and accepted standards of practice, using ongoing assessment.Residents are monitored for bleeding.Anticoagulants therapy is reviewed monthly by the consultant pharmacist, with follow-up documented as appropriate. A review of the facility's policy titled, Medication Regimen Review (MRR), revised 5/07, indicated, .1. The pharmacist must review each resident's medication regimen at least once a month.to identify clinical significant risks and or adverse consequences resulting from or associated with medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications had proper storage and labeling when:1. Two tablets were found loose and unlabeled inside a medication drawer,2. Expired medications were stored inside the medication refrigerator These failures had the potential for medications to be incorrectly administered and decrease medication potency (medication strength) that could compromise the therapeutic effectiveness of stored medications.Findings: 1. A medication storage observation was conducted on 12/17/25 at 7:52 A.M., at station 1. Licensed Nurse 14 (LN 14) opened the second drawer of the medication cart which contained medication cards for residents. A small orange and small white tablet were found loose and unlabeled at the bottom of the drawer. LN 14 stated he was unsure why there were loose tablets in the medication drawer. LN 14 stated the medication cards listed residents' names and drug names. LN 14 stated there should not be any loose and unlabeled medications in the medication cart because staff would not know what the medications were used for. 2. A medication storage observation was conducted on 12/17/25 at 11:56 A.M. at the facility's medication storage room. During a joint observation of the medication refrigerator with LN 32, three bisacodyl suppositories (medication for constipation) were inside the refrigerator. LN 32 checked the expiration dates for each suppository and stated the suppositories had an expiration date of 11/2025. LN 32 stated the suppositories should not be in the refrigerator because they were expired. LN 32 stated expired medications were no longer effective. An interview with the Director of Nursing (DON) on 12/18/25 at 4:50 P.M., the DON stated there should be no loose and unlabeled medications in the medication drawer because it was a safety issue and infection control concern. The DON further stated if a medication was expired, the medication was no longer effective. A review of the facility's policy and procedure (P&P) titled, Labeling and Storage, dated 2/2025 was conducted. The P&P indicated, It is the policy of this facility that medications and biologicals are labeled in accordance with facility requirements, state and federal laws.Drugs shall be stored in appropriate temperatures.Discontinued drug container shall be marked.Discontinued drugs shall be disposed of within ninety (90) days of the date the drug was discontinued, unless the drug is reordered within that time The policy did not provide guidance regarding expired medications.		

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure the kitchen staff carried out the tasks of the food and nutrition services department in accordance with the standard of practice for the following kitchen competencies: 1. [NAME] (CK) 1 did not demonstrate how to conduct spoon tilt tests (food must hold its shape on a spoon and when tilted, it should fall off with little residue) of pureed food. 2. CK 2 did not know how to calibrate food thermometers. These failures had the potential to expose all residents who consumed food from the kitchen to contract a food-borne illness. Findings: 1. On 12/17/25 at 10:16 A.M., a joint observation of CK 1 performing spoon tilt test of pureed food with the Dietary Services Supervisor (DSS) and the Registered Dietitian (RD) present; and an interview with CK 1 was conducted. CK 1 took the pureed brussels sprouts in a metal bin off the heating rack, took a spoon filled of the pureed brussels sprouts, performed spoon tilt test, returned the spoon filled to the puree, mixed the puree, took another scoop or pureed brussels sprouts, returned it back to the bin and did the process four times. CK 1 stated she was looking for a pudding consistency. CK 1 stated she should have done the spoon tilt testing on a plate instead of the whole bin of the pureed food. On 12/18/25 at 10:16 A.M., a joint review of CK 1's in-service training and an interview was conducted with the DSS. The DSS stated CK 1 had an in-service training in August and September 2025. The DSS stated CK 1 should have performed the spoon tilt test in a plate prior to serving to maintain the texture of the whole container of the pureed food. The facility did not provide policy and procedure regarding spoon tilt test of pureed food. 2. On 12/17/25 at 11:43 A.M., a joint observation of CK 2 calibrating the food thermometer with the DSS and the RD present, and an interview with CK 2 was conducted. CK 2 put three thermometers in a metal bin with ice and water and left the thermometers submerged with the probes touching the bottom of the metal bin. CK 2 stated she will start the tray line. CK 2 calibrated the thermometer every time she checked the temperature of the cooked food items. The DSS stopped CK 2 and told CK 2, You don't have to calibrate the thermometer every time you check the temperature. On 12/18/25 at 10:16 A.M., a joint review of CK 2's in-service training and an interview was conducted with the DSS. The DSS stated CK 2 had an in-service training on how to calibrate a food thermometer on 11/7/25. The DSS stated CK 2 did not demonstrate the calibration of the food thermometer properly. The DSS stated the probes of the thermometer should not touch the bottom or the sides of the bucket because it affects the temperature and the calibration would not be accurate. A review of the facility's policy titled Thermometer Use and Calibration, dated 2023, indicated, .Checking the Accuracy and Calibrating.1. Fill a large glass with crushed ice and add clean tap water until slush is formed. Stir the mixture well, 2. Put the thermometer's stem into the ice water so that the sensing area is completely submerged.Do not let the stem touch the bottom or sides of the glass. The thermometer sensor or probe must remain in the ice water one minute and during calibration process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	
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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain written consents and educational proof that residents and their responsible persons (RPs-a person assign to make medical decisions on behalf of the resident) were informed of the risk and benefits for receiving or declining pneumococcal (an immunization protecting against streptococcus pneumoniae bacteria, which causes severe infections) and influenza vaccines (prevents the seasonal flu, a contagious respiratory illness) for two of five residents (Resident 14 and 121), reviewed for vaccinations. As a result, Residents 4 and 121, along with their RPs were not informed of the risks and benefits, if the vaccine was received or declined.1. Resident 121 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought). Resident 121 also had a documented Durable Power of Attorney for medical consent only, according to the facility's admission Record. On 12/18/25 at 9:39 A.M., Resident 121's clinical record was reviewed for immunizations. According to the immunization record, Resident 121 received an influenza vaccine on 12/4/25, and declined to receive a pneumococcal (PCV 20), which was undated. There was no documented evidence Resident 121 or the RP ever consented to influenza vaccination, or the risk were explained by declining the pneumococcal vaccination. 2. Resident 14 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (like hallucinations, delusions, disorganized thinking) with major depressive). Resident 14 had a documented Durable Power of Attorney for medical consent only, according to the facility's admission Record. On 12/18/25 at 9:43 A.M., Resident 14's clinical record was reviewed for immunizations. According to the immunization record, Resident 14 refused the influenza and the pneumococcal (PCV 20) vaccine, both documentations were undated for when refused. There was no documented evidence Resident 14 or the RP ever consented to vaccinations, or that the risk were explained by declining the vaccinations. An interview was conducted with the acting Infection Control Nurse (ICN) on 12/18/25 at 2:40 P.M. The ICN stated the previous ICN left on 12/18/25, and she was asked to step into the position temporarily to assist. The ICN was asked to provide proof on vaccination consents which were stored in a large binder, within the ICN office. The ICN stated she could only locate three of the five requested consents. The ICN stated by not having signed consent, you do not know if the risks or benefits of vaccinations were explained to the residents and their RPs. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 3:01 P.M. The DON stated by not having a signed consent, you do not know if the RP agreed to vaccinations or if the risks and benefits were explained to them and the resident.According to the facility's policy, titled Immunizations-Residents, dated 2021, .Procedure: 1.a. Residents will be screened annually during the flu season.2. Before offering any vaccine and to ensure a resident's right to choose, each resident or their resident representative receives education regarding the benefits and potential side effects of the immunization. a. Provide the resident and/or their representative with the vaccine Information Statement .and document that the education .was provided.		

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NAME OF PROVIDER OR SUPPLIER Lemon Grove Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8351 Broadway Lemon Grove, CA 91945	
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain written consents and educational proof that residents and their responsible persons (RPs-a person assign to make medical decisions on behalf of the resident) were informed of the risks and benefits for receiving or declining the SARS-COV-2 vaccine (prevents severe COVID-19 illness, a highly contagious respiratory virus), for two of five residents (Resident 14 and 121), reviewed for vaccinations. As a result, Residents 4 and 121, along with their RPs were not informed of the risks and benefits, or if the vaccine was received or declined. Findings: 1. Resident 121 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought). Resident 121 also had a documented Durable Power of Attorney for medical consent only, according to the facility's admission Record. On 12/18/25 at 9:39 A.M., Resident 121's clinical record was reviewed for immunizations. According to the immunization record, Resident 121 received the SARS-COV-2 vaccination on 12/4/25. There was no consent or documented evidence the resident or RP received education as to the risk and benefits for accepting or declining the vaccine. 2. Resident 14 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (like hallucinations, delusions, disorganized thinking, with major depression). Resident 14 had a documented Durable Power of Attorney for medical consent only, according to the facility's admission Record. On 12/18/25 at 9:43 A.M., Resident 14's clinical record was reviewed for immunizations. According to the immunization record, Resident 14 refused the SARS-COV-2 vaccination, which was undated. There was no documented evidence the resident or RP received education as to the risk and benefits for accepting or declining the vaccine. An interview was conducted with the acting Infection Control Nurse (ICN) on 12/18/25 at 2:40 P.M. The ICN stated the previous ICN left on 12/18/25, and she was asked to step into the position temporarily to assist. The ICN was asked to provide proof of vaccination consents, which were stored in a large binder, within the ICN office. The ICN stated she could only locate three of the five requested consents. The ICN stated by not having signed consents, the facility was unsure if the risks or benefits of vaccinations were explained to the residents and their RPs or if they consented to being vaccinated. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 3:01 P.M. The DON stated by not having a signed consent, you do not know if the RP agreed to vaccinations or if the risks and benefits were explained to RP and the resident. According to the facility's policy, titled Immunizations-Residents, dated 2021, .Procedure: .5. Each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated or the resident is already immunized. 7. The resident or the resident's representative has the opportunity to decline any and all immunizations. 8. Information related to education provided regarding the benefits and risks of the immunization and administration or refused will be documented in the resident's medical record .		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the requirement for the accommodation of no more than four residents per resident room. This affected two of 65 resident rooms (room [ROOM NUMBER] and 112). rooms [ROOM NUMBERS] were occupied by five residents in each room. This failure had the potential for residents to feel crowded. Findings: On 12/15/25 through 12/18/25, multiple observations were conducted of the five male residents who occupied room [ROOM NUMBER] and the five female residents who occupied room [ROOM NUMBER]. There were no observed problems with the provision of care for the residents. Residents were observed using wheelchairs and Certified Nursing Assistants (CNAs) were able to wheel the residents in and out of the rooms without difficulty. On 12/18/2025 at 10:57 A.M., interviews were conducted with residents in room [ROOM NUMBER]. There were no complaints from the residents regarding the number of residents occupying the room or concerns regarding space. 12/18/2025 11 A.M., interviews were attempted with the five Residents in room [ROOM NUMBER]. All the residents were non-verbal and did not respond to questions. The five female residents looked comfortable and uncrowded. On 12/18/25, the ADM provided the square footage for room [ROOM NUMBER] and room [ROOM NUMBER] in the Square Footage Study, dated December 2025, indicating no changes were present for square footage since 2019. room [ROOM NUMBER] contained 504 total square feet and five beds. The square footage per resident was 100.8 square feet. room [ROOM NUMBER] contained 504 total square feet and five beds. The square footage per resident was 100.8 square feet. There were no indications of adverse effects on the quality of care, the quality of life, or health and safety of the residents. rooms [ROOM NUMBERS] were found to be in accordance with the special needs of the residents occupying the two rooms. A continued waiver for number of residents per room was recommended.		