STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055975	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Manor Sanitarium	1889 National City Blvd. National City, CA 91950

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to staff a Registered Nurse (RN) for at least eight hours a day for 19 days from July 1, 2025, through September 30, 2025. This failure may have prevented residents from receiving advanced care or having their complex medical needs managed effectively. Findings: A review of the PBJ (Payroll-Based Journal) Staffing Date Report and CASPER Report 1705 D, which help Skilled Nursing Facilities identify areas for improvement, showed that in Quarter 4 of 2025 (July 1-September 30), the facility triggered a No RN hours alert. This indicated there were at least four days in the quarter without any RN hours. On 2/11/25 at 10:45 A.M., an observation of the current staffing was posted at the nurse's station.A review of the PBJ report indicated that on 7/3/25, 7/4/25, 7/8/25, 7/9/25, 7/10/25, 7/18/25, 7/28/25, 8/8/25, 8/29/25, 9/1/25, 9/17/25, 9/18/25, 9/21/25, 9/24/25, 9/25/25, 9/26/25, 9/28/25, 9/29/25, and 9/30/25, there was no RN hours. On 2/12/25 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON) and the administrator (ADM). The DON stated that they were hiring registered nurses but had not been able to retain them. The ADM stated they do not have a staffing waiver, and she could not say how many days they do not have an RN. The DON stated that the full-time RN left them and they were hiring. The DON further stated they are trying to staff the floor, but it was challenging. The DON further stated it was important to have an RN to ensure oversight with patient care and safety. The DON also said that the RNs could conduct and assess during a complex change of conditions. Per the facility's undated policy and procedure, titled Nursing Services, indicated, It is the policy of the facility to assure that there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet residents' needs safely and in a manner that promotes each resident's rights, physical. mental, and psychological well being .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to (1) check the consistency of the pureed (blended to a smooth and creamy consistency) foods for a resident and (2) ensure the beef patties were cooked according to the manufacturer's guidelines for 48 of 48 residents who received the beef patties. These failures could lead to food that was not palatable and texture that was not safe for a resident to consume. In addition, residents who consume the beef patties could contract food-borne illness.Findings: 1. On 2/11/26 at 11 A.M., an observation during a puree preparation and interview with [NAME] (CK) 1 was conducted. CK 1 poured water into the container of the blender, an amount not measured, and four scoops of thickener into the container of the blender. CK 1 stated they will be serving burgers with baked beans on the side, and she needed to puree the vegetables for one resident. The container was observed with shredded lettuce, diced tomatoes, diced onions, water, and thicker. CK 1 then covered the container and blended the items. CK 1 got a brown cup, poured the blended items into it, and placed it inside the metal container. CK 1 did not check for the consistency and texture of the pureed food. A second puree food observation was conducted. CK 1 got the container of the blender, opened the oven, and took a scooper with a white handle. CK 1 scooped the baked beans, drained the sauce, and put the baked beans into the blender container. CK 1 then scooped two and a half scoops of the baked bean sauce and poured it into the blender. CK 1 put three scoops of the thickener into the container and blended the items. CK 1 then got a brown cup, poured the blended items into the cup, and placed it inside the metal container. CK 1 did not check for the consistency and texture of the pureed food.CK 1 stated she did not follow instructions for pureeing food. CK 1 further said she just knew to put about three to four scoops of thickener without measuring or assessing for the consistency. On 2/11/26 at 11:45 A.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated they did not have instructions on how to puree food, but the cooks were expected to follow the facility's policy on proper food food pureeing. The DS stated the CK blended the food, but could not explain how the CK should check the consistency and texture of the food prior to serving, to ensure that the pureed food was safe and had a proper texture. On 2/12/26 at 11:15 A.M., an interview was conducted with the Registered Dietitians (RD). The RD stated to ensure the pureed food meets the proper consistency and texture, the CK should have performed a fork test (to check if the food will hold shape) and a spoon tilt test (to check for correct consistency) to ensure the pureed food meets the proper consistency and texture. Per the facility's undated policy and procedure, titled Textures, indicated For starches and vegetables: Place cooked items in the food processor or blender and blend until smooth. Add 1/4 - 1/2 slice bread or thickener if necessary . 2. On 2/11/26 at 11:00 A.M., CK 2 was observed grilling the beef patties on the flat grill and transferring the cooked beef patties into the metal container without checking the temperature. CK 2 continued to do the same process until all the beef patties were cooked, covered them, and set them aside. On 2/11/26 at 11:25 A.M., CK 1 was observed tempering the food items and delivered the food in the dining area. A follow-up interview and record review were conducted. CK 1 stated she had tempered the beef patties while in the kitchen area, and the temperature was 155 degrees Fahrenheit. CK 1 stated it was a safe temperature for the residents to eat. Per the manufacturer's guidelines for the Fresh Beef Patties, the recommended cooking was to an internal temperature of 160 Fahrenheit for a well-done product. On 2/11/26 at 11:45 A.M., an interview was conducted with the Dietary Supervisor (DS). The DS stated she agreed with CK 1 and that the beef patties were safe to be served to the residents. On 2/12/26 at 3:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the staff did not follow the manufacturer's guidelines for cooking the beef patties. Per the manufacturer's guidelines for the Fresh Beef Patties, the recommended cooking was to an internal temperature of 160 Fahrenheit for a well-done product.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents(Resident 40) reviewed for psychotropic (a drug or substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medication had specific behavior monitoring in place for the use of antipsychotic (a class of drugs that treat symptoms of mental disorder by altering brain function). This failure had the potential to result in unnecessary use of psychotropic medication. Findings: Resident 40 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition characterized by a mix of mood problems and thinking problems), per the facility's admission Face Sheet. On 2/9/26 at 10:21 A.M., Resident 40 was observed walking in the hallway with a walker. A review of Resident 40's clinical record was conducted on 2/11/26. Per the Physician's Order, dated 1/25/26, the physician wrote an order to give haloperidol (a medication used to treat certain mental and mood disorders) five milligrams as needed. On 2/3/26, the physician ordered to discontinue the haloperidol and change it to chlopromazine (a medication to treat mental and mood disorders) 25 milligrams every PM (afternoon shift). The order did not indicate the diagnosis, medical symptoms, or behavior monitoring. In addition, there was no documented evidence that the care plan was developed for chlorpromazine, and consent was signed by the responsible party. On 2/11/26 at 10:17 A.M., a joint interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 40 had an order for haloperidol because Resident 40 had aggressive behavior. Resident 40 asked the physician to change the haloperidol because, according to Resident 40, he was allergic to it. LN 1 further stated that there was no behavior monitoring or diagnosis written, and that it should have been. On 2/12/26 at 9:05 A.M., a joint interview and record review was conducted with the Director of Nursing (DON) stated Resident 40 should have a care plan, diagnosis, and behavior monitoring for the use of the antipsychotic medication routinely, and it was not developed. The DON further said it was important to have a care plan to ensure the residents receive consistent care from the staff, and monitoring of the antipsychotic medication to ensure the effectiveness of the drug. Per the facility's undated policy and procedure, titled Psychotropic Medication Use, indicated that Each resident shall receive the necessary care and services to attain and maintain the highest level of physical, mental and psychosocial well-being .If a psychotropic medication is ordered, include in the order the dosage, frequency, route of administration, related diagnosis and medical symptoms .Behavior monitoring shall be initiated .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive resident-centered care plan were developed and interventions were implemented for three of 19 sampled residents (2, 1, 40) when:1. A care plan for an anticoagulant monitoring of side effect for Resident 2 was not developed.2. A care plan for dementia was not developed for Resident 1.3. A care plan for antipsychotic medications for Resident 40 was not developed. These failures had the potential for the residents not to receive care and services specific to the residents' needs.Findings: 1. A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis that included unspecified atrial fibrillation (Afib- irregular, often fast, and chaotic heart rhythm). On 2/12/26 at 11:06 A.M., an interview and record review was conducted with the Infection Preventionist (IP). The IP reviewed Resident 2's medical records. The IP reviewed Resident 2's physician's order. The Physician's order indicated Eliquis 5 milligrams (mg) one tablet by mouth twice a day for Afib. The IP stated there was no care plan for the anticoagulant. The IP stated the importance of a care plan was to meet resident care needs. The IP stated there should have been a care plan for Resident 2's anticoagulant. 2. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis that included dementia due to traumatic brain injury (a decline in memory, thinking, behavior, and language). On 2/12/26 at 11:26 A.M., an interview and record review was conducted with the IP. The IP stated Resident 1 did not have documentation of a care plan for dementia. The IP stated there should be a care plan for Resident 1's diagnosis of dementia to have a person-centered care plan in place to meet resident needs. On 2/12/26 at 4:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated a resident that is on an anticoagulant should have a care plan developed. The DON stated Resident 1 should have had a care plan for a diagnosis of dementia. The DON stated her expectation was for care plans to be in place to meet residents' specific needs. 3. Resident 40 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition characterized by a mix of mood problems and thinking problems), per the facility's admission Face Sheet. On 2/9/26 at 10:21 A.M., Resident 40 was observed walking in the hallway with a walker. A review of Resident 40's clinical record was conducted on 2/11/26. Per the Physician's Order, dated 1/25/26, the physician wrote an order to give haloperidol (a medication used to treat certain mental and mood disorders) five milligrams as needed. On 2/3/26, the physician ordered to discontinue the haloperidol and change it to chlorpromazine (a medication to treat mental and mood disorders). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that a comprehensive resident-centered care plan was developed for haloperidol and chlorpromazine. On 2/11/26 at 10:17 A.M., a joint interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 40 had an order for haloperidol because Resident 40 had aggressive behavior. LN 1 stated Resident 40 asked the physician to change the haloperidol because he was allergic to it. LN 1 further stated the care plan should have been developed. On 2/12/26 at 9:05 A.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 40 should have a care plan for the use of the antipsychotic medication and it was not developed. The DON further said it was important to have a care plan to ensure the residents receive consistent care from the staff. Per the facility's undated policy and procedure, titled Care Plans, .The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess a resident's respiratory status for one of 19 sampled residents (Resident 40). These failures had the potential to delay care and cause Resident 40's condition to worsen. Findings: Resident 40 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition characterized by a mix of mood problems and thinking problems), per the facility's admission Face Sheet. On 2/9/26 at 10:21 A.M., Resident 40 was observed walking in the hallway with a walker. Resident 40 stated I've been coughing, and that staff had not done anything about it. A review of Resident 40's clinical record was conducted on 2/11/26. Per the Physician's Order, dated 2/10/26, the physician wrote an order to give guaifenesin dextromethorphan (medication for cough) as needed for 10 days. A further review of Resident 40's clinical record was conducted. The Nurse's Notes, dated 2/9/26, contained the first documentation of Resident 40's cough with phlegm; however, the respiratory assessment was not documented. In addition, there was no documented evidence of respiratory assessment was found in subsequent nursing notes on that date, 2/9/26. On 2/11/26 at 10:17 A.M., a joint interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 40 had a cough for 2 days, but Resident 40 thinks he had a respiratory infection. LN 1 stated Resident 40 smokes and has shortness of breath. This could be why Resident 40 was coughing. LN 1 stated she had not listened to Resident 40's lung sounds. On 2/11/26 at 10:30 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 40 had been coughing for five days. He told the nurse that, and the nurse handed him a cough drop. CNA 1 further stated he gave the cough drop to Resident 40. On 2/12/26 at 9:05 A.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated per the documentation, Resident 40 had complained of a cough on 2/9/26, and the licensed nurses did not perform a thorough lung assessment. The DON further stated that when a resident complains of a cough, the LNs should conduct a thorough lung assessment to identify normal or abnormal lung sounds to ensure proper treatment for Resident 40. Per the facility's undated policy and procedure, titled Change of Conditions, .1. Assess the resident's condition .2. Document what, where, symptoms, assessment, treatment, notifications .

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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 interview and record review the facility failed to ensure a smoking assessment was completed for one of nine residents (Resident 5).This failure had the potential for Resident 5 to be at risk for burns when smoking.Findings:A record review of Resident 5's admission Record indicated Resident 5 was admitted on [DATE] with a diagnosis which included paranoid schizophrenia (intense, irrational delusions and auditory hallucinations) and syncope (fainting or passing out). On 2/10/26 at 4 P.M. an observation and interview was conducted with the Patio Monitor (PM) in the smoking area. The PM stated resident s who smoke were at risk for burns. The PM stated all residents were required to have a smoking assessment before they could go out to the smoking area to smoke. On 2/12/26 at 11:13 A.M., an interview and record review was conducted with the Infection Preventionist (IP). The IP reviewed Resident 5 medical records which indicated Resident 5 was a smoker. The IP stated there was no smoking assessment documented in Resident 5's medical records. The IP stated a smoking assessment was required to ensure patient safety while smoking. The IP stated there should have been a smoking assessment in Resident 5's medical records. On 2/12/26 at 4:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated smoking assessment was important to identify risk related to smoking. The DON stated a smoking assessment should have been in the resident medical records. A review of the facility policy titled Cigarette Smoking and Distribution of Cigarettes, undated, indicated .1. Upon admit, the resident will be assessed for smoking capacity by admitting nurse. 2. Smoking assessment shall be completed annually and as needed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and respond to unplanned significant (noticeable) weight loss for one of two sampled residents (Resident 33) who experienced unplanned weight loss. This failure could affect their health and well-being.Findings: Resident 33 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental health condition that affects the way a person thinks, feels, and behaves) per the admission Face Sheet. Per Resident 's Care Plan Report, dated 8/30/25, indicated Resident 33 had altered nutrition less than body requirements related to meal refusals and had a potential for dehydration. The goal was for Resident 33 to avoid further weight loss, tolerate the prescribed diet without additional loss, and not exhibit any signs or symptoms of dehydration. Resident 33's goal weight range (GWR) was 170 to 185 pounds. The Interventions included honoring food and fluid preferences and referring Resident 33 to the registered dietitian (RD) for dietary recommendations as needed. Per the Vital Signs & Weights Flow Sheet, dated 8/30/25 through 2/2/26, Reident 33's weights were:On 8/30/25 was 181.2 lbsOn 8/31/25 was 180.4 lbsOn 9/1/25 was 179.8 lbsOn 10/2/25 was 180.6 lbsOn 11/1/25 was 183.2 lbsOn 12/2/25, Resident 33 was 189.4 lbs [Resident 33 gained 6.2 lbs] On 1/1/26, Resident 33 was 182.0 lbs [Resident 33 lost 7.2 lbs from 12/2/25 to 1/1/26]On 2/2/26, Resident 33 was 167.8 lbs [Resident 33 lost 14.2 lbs from 1/1/26 to 2/2/26.] There was no documented evidence that an assessment was performed for the unplanned significant weight loss, and there were no further weight recordings to verify that the weight on 2/2/26 was correct. Per the Nutritional Progress Notes, dated 12/12/25, indicated IDT (Interdisciplinary Team) weight variance, indicated that Resident 33's weight gain was not significant. Then on 1/20/26, the Registered Dietitian (RD) documented Resident 33 lost 7.2 lbs. and indicated, it was not significant. On 2/9/26 at 10:03 A.M., Resident 33 was observed in bed wearing a red jacket with an episode of coughing. On 2/11/26 at 10:40 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 33 does not like to eat and frequently refuses breakfast and lunch. On 212/26 at 3:36 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated when there was a significant weight loss, the physician should have been notified, and the RD should have been notified to ensure the resident was assessed and proper treatment would be ordered. The DON further stated Resident 33 had a significant weight change and was not assessed in a timely manner. Per the facility's undated policy and procedure, titled Change of Conditions, To assure that appropriate care and documentation occurs when residents experience a change of condition .1. Assess the resident's condition .4. Document what, where, symptoms, assessment, treatment, notification .Weight (+ [greater than] or - [less than] 5 pounds in a month).

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician completed the initial visit in a timely manner for one of 19 sampled residents (Resident 40). These failures had the potential to compromise the quality and safety of resident care.Findings: Resident 40 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental health condition characterized by a mix of mood problems and thinking problems), per the facility's admission Face Sheet. On 2/9/26 at 10:21 A.M., Resident 40 was observed walking in the hallway with a walker. Resident 40 stated I've been coughing, and that staff had not done anything about it. A review of Resident 40's clinical record was conducted on 2/11/26. Per the History and Physical, dated 1/9/26, the Physician Assistant (PA) saw Resident 40. On 2/12/26 at 9:05 A.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated the physician (PA) alternates visits with the residents, and the initial visit should happen within 72 hours of admission, no later than one week. The PA saw Resident 40 on 1/9/26, which was late. The DON stated it was important that the physician or the PA do their initial visit to ensure their resident was adjusting well to their new environment, review and confirm the orders were correct, and perform their assessment. Per the facility's undated policy and procedure, titled admission Procedure, .Primary physician's documentation of first visit within 3 days (72 hours) of admission and no later than 7 days .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one out of one sampled resident (Residents 2) was free of unnecessary medications when Resident 2 received an anticoagulant (blood thinner) medication without staff monitoring for signs and symptoms of side effects.This deficiency had the potential to cause harm due to lack of monitoring for negative side effects of anticoagulant therapy, including excessive bleeding or bruising.Findings:A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis that included unspecified atrial fibrillation (Afib- irregular, often fast, and chaotic heart rhythm). On 2/12/26 at 11:30 A.M., an interview and record review was conducted with the Infection Preventionist (IP). The IP reviewed Resident 2's physician's order. Physician's order indicated, Eliquis 5 milligrams (mg) one tablet by mouth twice a day for afib. The IP stated there was no documentation for monitoring the negative side effects of the blood thinner for Resident 2 and that there should have been. The IP stated it was important to monitor negative side effects for patient safety. On 2/12/26 at 4:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated negative side effects of an anticoagulant were abnormal bleeding and bruising. The DON stated licensed nurses should have monitored and documented negative side effects for residents on a blood thinner. The DON stated there was no policy on an anticoagulant at this time. A review of the facility's policy did not have a policy that addressed monitoring side effects of an anticoagulant. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Eliquis (apixaban), dated 4/17/25, retrieved from DailyMed, indicated, .Increased Risk of Hemorrhage [bleeding]. can cause serious, potentially fatal .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055975	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Manor Sanitarium	1889 National City Blvd. National City, CA 91950

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the medication storage room was free of expired Tuberculin PPD (purified protein derivative) testing solution (used in a skin test to help diagnose tuberculosis infection). This failure had the potential for testing solutions and/or medications to be ineffective and could have had inaccurate results.Findings: On [DATE] at 9:55 A.M., an observation and interview was conducted with Licensed Nurse (LN) 1. LN 1 reviewed Tuberculin PPD, 5 units per 0.1 ml (milliliters) solution had an open date of [DATE]. LN 1 reviewed the manufactures guidelines that indicated, .vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. LN 1 stated the vial had been open for more than 30 days and should have been discarded. On [DATE] at 11:15 A.M., an interview was conducted with the Infection Preventionist (IP). The IP stated once the Tuberculin PPD solution, it was valid for 30 days and should not be used past the 30 days. The IP stated using the solution after 30 days could decrease its effectiveness, and could have had inaccurate results. The IP stated the Tuberculin PPD solution should have been disposed of. On [DATE] at 4:30 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated a vial of Tuberculin PPD after it was opened was good for only 30 days. The DON stated the vial of Tuberculin PPD should have been removed from the refrigerator and disposed of. The DON stated using the Tuberculin PPD after the expired use by date could have lessened the potency and lead to inaccurate readings. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for Aplisol (tuberculin PPD, diluted) updated [DATE] retrieved from DailyMed, indicated, .Failure to store and handle Aplisol as recommended may result in a loss of potency and inaccurate test results.Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.A review of the facility's policy titled Medication Administration Guidelines undated, indicated .Refrigerator: Expired and DC's meds should be removed.

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	055975	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Manor Sanitarium	1889 National City Blvd. National City, CA 91950

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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 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 ensure five of 25 resident rooms (Rooms SWD 1, SWD 2, SWD 3, SWD 4, and room [ROOM NUMBER]) accommodated no more than four residents. This failure had the potential to limit the freedom of movement for the residents that occupied those rooms, which may place them at risk for injury.Findings:During initial tour on 2/9/26, five of the 25 resident rooms accommodated more than four residents:a. Room SWD 1- 5 Residentsb. Room SWD 2- 5 Residentsc. Room SWD 3- 5 Residentsd. Room SWD 4- 5 Residentse. room [ROOM NUMBER]- 5 ResidentsDuring the course of the survey, those rooms did not impose any safety hazards. There were no complaints about space or room issues from the residents occupying these rooms. There were no quality of care or quality of life concerns identified that negatively affected the residents residing in those rooms.The survey team recommends the approval of the written room waiver continuum request, dated 2/12/26, for the rooms listed in this deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055975	A. Building B. Wing	02/12/2026

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to provide a minimum of 80 square feet (sq. ft.- unit of measurement) of livable space per resident for four of 25 resident rooms. This failure had the potential to affect the resident's health and safety and prevent the residents from maintaining their highest level of well-being by limiting the movements of those residents in their rooms.Findings: During initial tour, dated 2/9/26, four of the 25 residents' room were observed to be less than 80 sq. ft. per resident. The residents' rooms and their measurements of livable space were noted as follows:a. Room SWD 1 (5 beds) measured: 385.5 sq. ft. (77.1 sq. ft. per resident)b. Room SWD 2 (5 beds) measured: 391.3 sq. ft. (78.2 sq. ft. per resident)c. Room SWD 3 (5 beds) measured: 394.5 sq. ft. (78.9 sq. ft. per resident)d. Room SWD 4 (5 beds) measured: 390.2 sq. ft. (78 sq. ft. per resident) These four rooms were not crowded and did not impose any safety hazards. There were no complaints about space or room issues from the residents occupying these rooms. During an interview with the Administrator, on 2/12/26, the Administrator (ADM) confirmed the measurements for 25 of the 25 residents' rooms and four of those rooms did not meet the required 80 square feet per resident requirement. The survey team recommends the approval of the written room waiver continuum request, dated 2/12/26, for the rooms listed in this deficiency.