

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Stillwater Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 510 E. Washington Avenue El Cajon, CA 92020	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not develop a patient centered care plan for one resident reviewed for care planning (Resident 4). This deficient practice had the potential for Resident 4 to not meet her needs for safety and well-being. Findings: Resident 4 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (a brain disorder that causes uncontrollable movements and difficulty with balance and coordination) and anxiety disorder (a mental health disorder characterized by worry or fear that interferes with daily functioning) according to the facility's admission Record. An interview on 3/19/26 at 9:55 A.M. was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 4 was discharged to a board and care on 3/17/26 but had complained about a Certified Nurse Assistant (CNA) on 3/11/26. LN 1 stated Resident 4 observed with a purplish, quarter sized discoloration on top of Resident 4's hand between the forefinger (2nd finger) and the thumb. LN 1 stated Resident 4 made the report to the Assistant Director of Nursing (ADON) for the unit. An interview on 3/19/26 at 10:15 A.M. was conducted with ADON. The ADON stated Resident 4 was at the nursing station by the snack bin when he observed a quarter sized, dark purplish discoloration on Resident 4's right top of hand between the forefinger and thumb. During an interview on 3/19/26 at 12 P.M. with the Director of Nursing (DON), the DON stated Resident 4 had the tendency to tightly hold and rub her hands when Resident 4 was upset. The DON demonstrated with her hands how Resident 4 repeatedly held her hands tightly and rubbed them. The DON stated there was no documentation or care plan to reflect Resident 4's behavior of tightly rubbing her hands. During an interview on 3/24/26 at 2:02 P.M. with the DON, the DON stated there should have been a care plan regarding Resident 4 squeezing her hand when upset or when spoken to. The DON stated it was important to have a care plan to observe and monitor Resident 4. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022 was conducted. The P&P indicated, The interdisciplinary team [IDT- team members with various areas of expertise who work together toward the goals of their residents), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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