STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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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** 43518 Based on observation, interview, and record review the facility failed to maintain the dignity of one resident out of thirty-seven sampled residents (Resident 227) when she was asked by staff to have a bowel movement in her brief. This failure had the potential to affect this Resident 227's dignity and mental health. Findings: Review of Admission Record for Resident 227 indicated resident was admitted on [DATE] for diagnoses which included Cervical(relating to the neck) Disc Disorder with Myelopathy (disease of the spinal cord), Spinal Stenosis (condition where the spinal canal narrows, causing compression of the spinal cord), Chronic Kidney Disease (a condition where the kidneys are damaged and cannot effectively filter waste and fluid from the blood), Congestive Heart Failure (a condition where the heart can't pump enough blood to meet the body's needs), and Respiratory Failure (condition where the lungs struggle to transfer enough oxygen into the blood). Review of Minimum Data Set (MDS-a standardized assessment tool used in nursing homes) section C-Cognitive (thinking processes) Patterns indicated that Resident 227 had a Brief Interview for Mental Status (BIMs-a quick assessment tool used to evaluate cognitive function) score of 14, which indicated intact cognitive abilities. Review of MDS section GG-Functional Abilities, indicated Resident 227 was dependent for self-care, independent for Self-Cognition (thinking processes), and dependent for toileting hygiene. On 4/15/25 at 10:18 A.M., an observation and interview with Resident 227 was conducted during initial pooling. Resident 227 was observed to be very pleasant and alert and oriented x4 (a person is fully alert and oriented to person, place, time, and event). Resident 227 stated that she was bedbound with leg strength at time of interview. Resident 227 stated that she was constipated and that before she was hospitalized , she could use the commode, but probably could not at this time because of the weakness of her legs. Resident 227 further stated that she was feeling, backed up and that the night staff had told her to move her bowels in the diaper, and they would clean her up after. Resident stated that staff did not offer her a bedpan. (continued on next page)

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

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	555076	A. Building B. Wing	04/18/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 8:45 A.M., an interview with Resident 227 was conducted. Resident 227 stated she had still been constipated and they had been putting her on the bedpan mostly, but night shift staff still asked to have a bowel movement in her diaper and did not offer her a bedpan. On 4/17/25 at 9 A.M., an interview with Certified Nursing Assistant (CNA 11) was conducted. CNA 11 stated Resident 227 was alert enough to ask for a bedpan when she had to move her bowels. CNA 11 stated the expectation for alert residents who cannot use commode, or bathroom should be offered a bedpan to maintain the resident's dignity. On 4/17/25 at 9:20 A.M. an interview with Licensed Nurse 12 (LN 12) was conducted. LN 12 stated that Resident 227 was alert enough to ask for bedpan when she had to move her bowels. LN 12 stated the expectation for alert residents who cannot use commode, or bathroom should be offered a bedpan. LN 12 stated the importance was to maintain the resident's dignity. On 4/17/25 at 9:30 A.M., an interview with Charge Nurse 13 (CN 13) was conducted. CN 13 stated that Resident 227 was alert enough to ask for bedpan when she had to move her bowels. CN 13 stated the expectation for alert residents who cannot use commode, or bathroom should be offered a bedpan. CN 13 stated the importance was to maintain the resident's dignity and allow for resident's right to choose. On 4/18/25 at 9:45 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation for alert residents who cannot use commode, or bathroom should be offered a bedpan to maintain the resident's dignity and allow for resident's right to choose. Review of facility policy titled QUALITY OF LIFE, dated 2020, indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of wellbeing, level of satisfaction with life, feeling of self-worth and self-esteem .11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example .b. Promptly responding to a resident's request for toileting assistance . Review of facility policy titled RESIDENT RIGHTS, dated December 2016, indicated Employees shall treat all residents with kindness, respect, and dignity .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: 1. a dignified existence; b. be treated with respect, kindness, and dignity .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on observation and interview, the facility failed to provide a blanket after showering to one of 37 sampled residents (148). As a result, Resident 148 felt cold. Findings: Per the facility's Admission Record, Resident 148 was admitted to the facility on [DATE] with diagnoses to include heart failure and absence of right ankle. On 4/15/25 at 10 A.M., an observation and interview was conducted with Resident 148. Resident 148 was observed lying on his bed wearing only a disposable brief, and was not covered by any linens. Resident 148 stated, when Certified Nursing Assistant (CNA) 3 brought him back to his bed at 9 A.M. after his shower, he asked her to cover him with a blanket. Resident 148 further stated, CNA 3 told him she would come back to give him a blanket, but he had been waiting an hour for her to return. Resident 148 stated he was cold. On 4/15/25 at 12:54 P.M., an interview was conducted with CNA 3. CNA 3 stated, she finished providing a shower to Resident 148 at about 9 A.M., and returned him to his room. CNA 3 further stated, she was delayed in bringing him his blanket because she was busy. On 4/18/25 at 9 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, the blankets should have already been ready when CNA 3 returned Resident 148 to his bed, and he should not have had to wait for his blanket after returning from the shower. Per the facility's policy, titled Homelike Environment, revised February 2021, .Residents are provided with a safe, clean, comfortable and homelike environment .clean bed and bath linens .comfortable and safe temperatures .

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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** 39448 Based on interview and record review, the facility failed to complete a mental health screening accurately for one of 37 sampled residents (17). As a result, Resident 17 may not have received necessary mental health services. Findings: Per the facility's Admission Record, Resident 17 was admitted to the facility on [DATE] with diagnoses of bipolar disorder (a mental health disorder with mood swings). Per the facility's Preadmission Screening and Resident Review (PASRR) Level 1 screening, dated 11/30/24, the screening was negative and a level 2 mental health evaluation was not required. The document also directed the facility to resubmit a new level 1 screening in 31 days. On 4/17/25 at 10 A.M., a concurrent interview and record review was conducted with the Minimum Data Set Nurse (MDSN). The MDSN stated, Resident 17's latest PASRR was completed on 11/30/24, and it indicated Resident 17 had bipolar disorder, but it did not direct them to complete a level 2 PASRR evaluation. The MDSN stated the 11/30/24 PASRR was inaccurate and it should have triggered a level 2 PASRR evaluation. The MDSN further stated, a new PASRR screening should have been completed within 30 days of the screening on 11/30/24. On 4/18/25 at 9 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, if a resident had bipolar disorder, then the PASRR should have triggered a level 2 PASRR evaluation. The DON further stated, the facility should have submitted a new level 1 PASRR within 30 days of the evaluation completed on 11/30/24. Per the facility's policy, titled Admission Criteria, revised March 2019, .If the level I screen indicates that the individual may meet the criteria .he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to initiate an initial activities care plan within 48 hours for one of 11 reviewed new admitted residents (Resident 570). This deficient practice placed all newly admitted residents at risk for depression (a mood disorder that causes a persistent feeling of sadness) and missed opportunities to take part in enjoyable activities that supported their emotional and mental well-being. Findings: A review of Resident 570's Admission Record indicated Resident 570 was admitted to the facility on [DATE] with diagnoses which included a history of depression. A clinical chart review of Resident 570's initial Activities assessment dated [DATE] indicated, Resident 570 was alert and oriented x1 [only oriented to person] with severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 4/15/25 at 11:52 A.M., an observation and interview was conducted with Resident 570, in Resident 570's room. Resident was non-verbal and was unable to answer simple yes or no questions. Resident 570 was frowning and a bit teary eyed while lying in bed with a startled-like appearance while clenched on her blanket. On 4/16/25 at 9:12 A.M., an observation and attempted interview was conducted with Resident 570, in Resident 570's room. Resident 570 was lying in bed and was unable to verbalize. Resident 570 just stared and looked confused to verbal communication and was unable to answer simple yes or no questions. On 4/16/25 at 1:26 P.M., a clinical chart review was conducted on Resident 570's initial care plan. Resident 570's initial care plan for activities was initiated on 4/14/25. Resident 570's activities care plan indicated . Encourage participation during group programs .Inform and offer out of room activities . On 4/18/25 at 8:20 A.M., an interview was conducted with Licensed Nurse (LN) 26. LN 26 stated Resident 570 does not talk to me but according to the family she was just real scared of being in the facility and if you get too close, she can get reactive (e.g. physically hit someone). LN 26 stated Resident 570 was verbal and understood English and Spanish according to a staff interview. On 4/18/25 at 9:51 A.M., an interview and clinical chart review was conducted on Resident 570, with the Activities Director (AD). The AD stated that there was always someone representing the activities department on the weekends that did initial evaluations for new admissions. The AD stated Resident 570's activities care plan was initiated on 4/14/25. The AD stated they evaluated and documented under ACTIVITIES-Initial Assessment in Resident 570's electronic clinical chart (e-chart) to initiate the activities care plan that included how Resident 570 communicated (e.g. verbal, non-verbal methods) and preferred language to provide proper activities. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 9:58 A.M., an interview and record review was conducted with Activities Assistant (AA) 1. AA 1 stated they were responsible to put in a baseline care plan within 48 hours for all new admissions. AA 1 stated Resident 570 was admitted on Friday (4/11/25) and that she was working on Sunday (4/13/25). AA 1 stated she did not evaluate Resident 570 until 4/14/25 as the reason why she did not initiate the activities care plan for Resident 570. AA 1 stated Resident 570 can say bad words only when she wants but had not heard Resident 570 verbally talk to her. AA 1 stated Resident 570's care plan was not initiated timely and further stated we would not be able to provide resident [Resident 570] activities and delay her care. She would be in her bed doing nothing. On 4/18/25 at 10:02 A.M., an interview was conducted with the AD. The AD stated that the baseline care plan should have been initiated by the activities department regarding Resident 570's status to avoid delaying activities that Resident 570 likes to do because that's important. The AD stated if Resident 570 was unable to verbalize her preference with activities that they [activities department] should have communicated with the family and make sure communication preferences were updated with the baseline care plan to better communicate with Resident 570 if she was not able to verbalize her needs. The AD further stated the baseline care plan helped to communicate with other staff involved with Resident 570's care on her activities preferences and communication. On 4/18/25 at 2:45 P.M., an interview with the Director of Nurse (DON) was conducted, in the conference room. The DON stated her expectations was for all members of the interdisciplinary team (IDT) to include the activities department's input with Resident 570's immediate care needs should include communication preferences, and activities preferences that promotes participation with activities and overall psychosocial well-being. A review of the facility's policy and procedure titled CARE PLANS BASELINE, revised 2016 indicated, .The Interdisciplinary Team will review the healthcare practitioner's orders .and implement a baseline care plan to meet the resident's immediate care needs .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39448 Based on observation, interview, and record review, for four of 37 sampled residents (148, 163, 92, 141) the facility failed to: 1. Notify the doctor of high blood sugar readings, 2. Develop a careplan for a palm guard splint, 3. Develop a careplan for supervision during dining, and 4. Ensure a care plan was implemented for foot care. As a result, there was not a consistent approach by staff to address residents' care needs. Findings: 1. Per the facility's Admission Record, Resident 148 was admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes Mellitus (abnormal blood sugar levels). Per the facility's Medication Administration Record, dated April 2025, Resident 148 had an order to notify the physician if his blood sugar (BS) was greater than 350 milligrams per deciliter (mg/dl). The following BS readings in April 2025 were greater than 350 mg/dl: 4/4 6:30 A.M., BS 356 mg/dl. 4/5 6:30 A.M., BS 380 mg/dl. 4/8 11:30 A.M., BS 517 mg/dl. 4/13 11:30 A.M., BS 410 mg/dl. 4/16 11:30 A.M., BS 378 mg/dl. On 4/17/25 a review was conducted of Resident 148's medical record. There were no progress notes on 4/4, 4/5, 4/8, 4/13, or 4/16 regarding high BS or notifying the physician of high BS. On 4/17/25 at 1:16 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated, she did not always document when she notified the physician of high BS. LN 2 was not available for interview. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/25 at 9 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, the LNs should have notified the physician of the high BS readings for Resident 148, and they should have documented the notification. The DON further stated, if notifying the physician was not documented, then the notification did not happen. Per the facility's policy, titled Change in a Resident's Condition or Status, revised May 2017, .The nurse will notify the resident's Attending Physician .when there has been .specific instruction to notify the Physician of changes in the resident's condition . 48263 Cross-Reference F688 2. A review of Resident 163's Admission Record indicated Resident 163 was readmitted to the facility on [DATE] with diagnoses which included a history of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (brain attack known as stroke when the blood flow to part of the brain is interrupted) of the left side. A record review of Resident 163's minimum data set (MDS - a federally mandated resident assessment tool) dated 1/16/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 13 points out of 15 possible points, which indicated Resident 163 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 4/17/25 at 8:15 A.M., an observation and interview was conducted with Resident 163, in Resident 163's room. Resident 163 had on a palm guard splint (medical device that stabilizes a part of your body and holds it in place to protect from injury) on his left hand. Resident 163 stated he was only able to move his right hand. On 4/17/25 at 8:31 A.M., an observation and interview was conducted with Resident 163, in Resident 163's room. Certified Nursing Assistant (CNA) 25 stated she did not know the care for Resident 163's palm guard splint and was not sure when Resident 163's palm guard splint was supposed to be taken off. On 4/17/25 at 8:35 A.M., an interview was conducted with Resident 163, in Resident 163's room. Resident 163 stated he wore his palm guard splint on his left hand because he was unable to move it due to contractures (the shortening of muscles). Resident 163 stated he had his palm guard splint on the whole day yesterday and the other day. Resident 163 stated he could not remember when they took off his palm guard splint. Resident 163 stated there was no set time when they removed his palm guard splint. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25 at 8:38 A.M., an interview and clinical chart review was conducted with Restorative Nurse Assistant (RNA) 27 of Resident 163's RNA charting. RNA 27 stated that he was involved with RNA programs for all residents that had splints. RNA 27 stated that he documented under RNA FOR ADL (activities of daily living) and WEEKLY RNA SUMMARY in the facility's electronic chart [e-chart]. RNA 27 stated Resident 163's palm guard splint was usually removed at the end of the shift about four hours and documented. RNA 27 stated he was unable to find documentation when Resident 163's palm guard splint to his left hand was removed or when care instructions were provided. RNA 27 stated it was important to provide the proper care on Resident 182's left hand with the palm guard splint to stretch his mobility and trying to prevent from further contracture. RNA 27 further stated you wanna [sic] take off the palm protector to check for skin care and any changes and having the palm protectors [palm guard splint] can cause skin breakdown. On 4/17/25 at 8:51 A.M., an interview and clinical chart review was conducted with Licensed Nurse (LN) 21. LN 21 stated she was not aware Resident 163 had a palm guard splint to his left hand. LN 21 stated there was no care plan in place for the palm guard splint to communicate with the nursing staff for when it should be on and off and/or additional instructions for monitoring. LN 21 further stated without proper physician's (MD) orders and a care plan for Resident 163's palm guard splint could lead to improper care and complications of Resident 163's left hand contracture. On 4/17/25 at 9:01 A.M., an observation, and interview was conducted with LN 21 and Resident 163, in Resident 163's room. Resident 163 stated he had been using the palm guard splint for a while about three months. Resident 163 stated RNA 26 was the one who put the palm guard splint on his left hand. On 4/17/25 at 12:57 P.M., an interview and clinical chart review was conducted with Licensed Nurse (LN) 23. LN 23 stated it was important that we monitor the use of Resident 163's palm guard splint to prevent skin breakdown and provide skin care and to include the frequency of when it should be on and off. LN 23 stated that a care plan for Resident 163's palm guard splints were just put in today in the in the care plan [sic] but did not indicate further instructions with frequency. On 4/17/25 at 1:11 P.M., an interview and clinical chart review was conducted with Assistant Director of Nursing (ADON) 3. ADON 3 stated Resident 163's care plan was updated today with a new intervention dated 4/17/25 that indicated .May use palm protector for prevention of skin breakdown and contracture . ADON 3 stated Resident 163's care plan was not personalized to the care and monitoring of Resident 163's palm guard splint and should have been focused on Resident 163's comprehensive care plan during the time Resident 163 started using the palm guard splint to prevent improper care and complications. On 4/17/25 at 1:46 P.M., a record review was conducted on Resident 163's clinical chart. Resident 163's MDS dated [DATE] section GG, indicated Resident 163 had an upper side impairment to one side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25 at 4:18 P.M., an interview and clinical chart review was conducted with the Minimum Data Set Nurse (MDSN). The MDSN stated she updated Resident 163's care plan today after finding out from RNA 27 that Resident 163 was using hand protectors [palm guard splint] and not hand rolls (hand towels rolled) that did not need an MD order. The MDSN stated Resident 163's care plan should have been updated and screened by the rehab team from when Resident 163 started using the palm guard splint (three months ago). The MDSN stated a care plan for the use of the palm guard splint was a way to communicate to the staff on the proper use and monitoring of Resident 163's palm guard splint. The MDSN further stated improper care and monitoring of Resident 163's palm guard splint could lead to complications such as skin breakdown and the worsening of contractures. On 4/18/25 at 2:33 P.M., an interview was conducted with the Director of Nursing (DON), in the conference room. The DON stated Resident 163 should have been screened two to three months ago to get the proper MD order if indicated and care planned personalized to include the use of the palm guard splint. The DON stated RNA 27 should not have put on Resident 163's palm guard splint without an MD order because the nursing staff would not have known that they should be providing the proper care and monitoring for the use of the device. The DON stated complications to not providing the proper care and monitoring of the palm guard splint could have resulted in skin injuries, pain and worsening of contractures. A review of the facility's policy and procedure titled CARE PLANS, COMPREHENSIVE PERSON-CENTERED revised 2016 indicated, .Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to .Participate in determining the type, amount, frequency and duration of care . 51452 3. Resident 92 was readmitted to the facility on [DATE], with the diagnosis which include Parkinson's Disease (a progressive neurological disorder characterized by gradual loss of movement-related symptoms like tremors, slowness of movement, and stiffness), Dysphasia (Difficulty with swallowing), a stroke causing left non-dominant side hemiplegia and hemiparesis (weakness and paralysis of one side of the body) per facility's Admission Record. On 4/17/25 at 1:23 P.M., an observation and interview with Resident 92 and Certified Nursing Assistant (CNA) 54 was conducted. The resident was eating his lunch in his bed, the meal ticket indicated chopped meat and soft fruit plate. The resident was observed to be eating without dentures but stated, I'm fine without them. CNA 54 stated that he was from another unit and was supervising the resident during mealtime to help the resident reach drinks and chop meat into smaller pieces if needed. CNA 54 stated this was his second time to supervise the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/25 at 8:29 A.M., an observation was conducted in the hallway outside of Resident 92's room. Resident 92 was heard attempting to cough loudly. Resident 92 was in his bed with his breakfast tray on the bedside table in front of him. The breakfast tray had scrambled eggs, cubed potatoes, fruit cup, cream of wheat and thin beverages. Resident 92's head of bed was up, and he was slightly slanted over to his left side. His face was red. Resident 92 was asked if he was choking and the resident nodded while trying to breathe and cough. No staff were present in the room. Licensed Nurse (LN) 53 and Assistant Director Of Nursing (ADON) 66 were called to the resident's room. The nurses were observed assisting the resident. ADON 66 stated she had assigned a CNA to supervise the resident for his breakfast. ADON 66 stated the CNA should have been there. ADON 66 stated Resident 92 required RNA (Restorative Nursing Assistant) DINING (a trained nursing staff to supervise a resident with meals while focusing on aspiration risk) and she was going to discuss it with the physician. On 4/18/25 at 10:22 A.M., an observation was conducted at the nurses' station. There was a white board that indicated, 4/17/25 Feeders [Resident 92] (supervision). On 4/18/25 at 10:30 A.M., an interview and record review with ADON 66 was conducted. ADON 66 stated CNA supervision was required during mealtime for Resident 92 because the resident was identified as at risk for aspiration, and he coughs with food and drinks. ADON 66 stated the Resident 92 was known to inhale food and gulp as he drank. ADON 66 reviewed Resident 92's clinical record and stated she did not find a care plan related to aspiration, swallowing precautions, or providing supervision during mealtime. ADON 66 stated there should have been a care plan that addressed providing supervision to Resident 92 during meals to prevent aspiration and choking. On 4/18/25 at 3:15 P.M., an interview with the Director Of Nursing (DON) was conducted. The DON stated if LNs identified residents at risk for aspiration, they could initiate meal supervision without orders. The DON stated Resident 92 should have been supervised during meals when ADON 66 identified the concern for aspiration. DON stated care plan for aspiration/swallow precaution should have been developed at the time the problem was identified, because it was important to communicate the resident's required supervision to all staff. A review of the facility's policy titled Care Plans, Comprehensive Person - Centered revised December 2016, indicated, .8. The comprehensive, person-centered care plan will . b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, ad psychosocial well-being . g. Incorporate identified problem areas 51541 4. Resident 141 was admitted to the facility on [DATE] with diagnoses which included peripheral vascular disease (having to do with the blood vessels and circulation), hereditary and idiopathic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and insulin dependent diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During an interview and observation on 4/15/25 at 8:55 A.M., Resident 141 stated he had long toenails and a fungal condition, and had been on a list to see the podiatrist (healthcare provider specializing in foot care) for months. Resident 141 was observed to have long, thick toenails that were approximately a quarter inch in length. Resident 141 also had dry, cracked feet. (continued on next page)

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	555076	A. Building B. Wing	04/18/2025

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Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 4/18/25 at 9:50 A.M., the assistant director of nursing (ADON) 66 reviewed Resident 141's care plan for podiatry dated 6/1/24. The care plan indicated, Podiatry care every other month and PRN (as needed). The ADON 66 stated the last time Resident 141 was seen by Podiatry was on 9/5/24. The ADON 66 stated Resident 141's care plan was not followed. During an interview on 4/18/2025 at 3 P.M., the Director of Nursing (DON) stated Resident 141's care plan should have been followed and implemented for podiatry care. A review of the facility's policy and procedure, titled Care Plan, Comprehensive Person-Centered, revised December 2016, indicated, .Receive the services and/or items included in the plan of care

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47956 Based on interview and record review, the facility failed to create a comprehensive care plan for one of 37 sampled residents (Resident 183). This failure caused Resident 183's medication to be unmonitored. Cross Reference F757 and F881. Findings: Resident 183 was admitted to the facility on [DATE] with a diagnosis of aftereffects of a cerebral infarction (Stroke- lack of blood flow to the brain). Additional diagnoses included metabolic encephalopathy (brain dysfunction due to the body's inability to filter toxins). During a concurrent interview and record review on 4/18/25 at 1:55 P.M., with the Director of Nursing (DON), the DON stated, Care plans drive the resident care, they should be resident specific. The DON further stated, if it [a resident's care plan] is not specific, the resident might not get the appropriate care. Resident 183's care plans were reviewed. The DON stated there is no care plan for antibiotic monitoring. There should be one. During an interview on 4/18/25 at 2:10 P.M., with the Infection Preventionist (IP), the IP stated Resident 183 has been on this medication since admission. The IP further stated Yes, the care plan is not specific to this medication. It should be. During a review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised December 2016, the document indicated .8. The comprehensive, person-centered care plan will aid in preventing or reducing decline in the resident's functional status and/or functional levels .

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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** 48263 Based to observation, interview and record review, the facility failed to provide individualized therapeutic and/or social activities according to their plan of care for one of seven reviewed residents (Resident 67) that promotes their highest physical, mental, and psychosocial well-being. This deficient practice placed Resident 67 at risk for decreased emotional well-being, social isolation, and reduced quality of life due to the lack of meaningful engagement. Findings: A review of Resident 67's Admission Record indicated Resident 67 was readmitted to the facility on [DATE] with diagnoses which included a history of adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and dementia (a progressive state of decline in mental abilities). Observations were conducted during the following days in Resident 67's room: - 4/15/25 at 9:49 A.M., Resident 67 was in bed resting with a blanket wearing a facility gown and was not verbal staring blankly at the ceiling. - 4/15/25 at 3:48 P.M., Resident 67 was in bed resting wearing a facility gown and was not verbal staring blankly at the ceiling. - 4/17/25 at 8:29 A.M., Resident 67 was in bed asleep. - 4/17/25 2:21 P.M., Resident 67 was in bed resting wearing a facility gown and was not verbal staring blankly at the ceiling. - 4/18/25 8:29 A.M., Resident 67 was in bed resting wearing a facility gown and was not verbal staring blankly at the ceiling. On 4/16/25 at 7:54 A.M., a record review was conducted on Resident 67's Activities care plan with activities. The Care plan initiated on 4/5/24 indicated, .will have 1:1 room visits activities to reduce BPSD [Behavioral and Psychological Symptoms of Dementia (loss of mental abilities)] episodes 3x [three times] per week . On 4/16/25 at 2:03 P.M., a record review was conducted on Resident 67's Activities participation tasks documentation for the month of January 2025-April 2025. Resident 67's activity participation task for individual and social activities conducted 3x per week indicated: - 1/1/25 thru 1/7/25: Activities conducted two times on 1/4/25 and 1/6/25. - 1/8/25 thru 1/14/25: Activities conducted two times on 1/9/25 and 1/13/25. - 1/22/25 thru 1/31/25: No activities conducted. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/1/25 thru 2/28/25: No activities conducted. - 3/1/25 thru 3/7/25: Activities conducted one time on 3/6/25. - 3/8/25 thru 3/14/25: Activities conducted one time on 3/13/25. - 3/15/25 thru 3/21/25: Activities conducted two times on 3/18/25 and 3/21/25. - 3/22/25 thru 3/28/25: Activities conducted one time on 3/23/25. - 3/29/25 thru 3/31/25: Activities conducted one time on 3/31/25. - 4/1/25 thru 4/6/25: Activities conducted two times on 4/5/25 and 4/6/25. - 4/8/25 thru 4/14/25: Activities conducted two times on 4/9/25 and 4/12/25. On 4/18/25 at 10:17 A.M., an interview and record review was conducted with the Activities Director (AD). The AD stated Resident 67 liked music and would sing with her when they did a music activity. The AD stated Resident 67 would also enjoy participating with lotion massage, listening to music on the radio and participate with balloon toss. The AD stated she was aware that resident was not getting activities three times a week within the last month and stated she was on leave at the beginning of the year to audit. The AD stated she planned on training one of the Activities Assistant (AA) to help her when she was unavailable to help with audits and do more initial evaluations and care plans. The AD stated Resident 67 did participate in social events in the past and stated they should try and have Resident 67 participate more with social events. The AD stated if Resident 67 did not engage with activities according to his plan of care that Resident 67 could have declined and became more depressed (mental disorder with continuous sadness) and lonelier. On 4/18/25 at 2:52 P.M., an interview with the Director of Nursing (DON) was conducted, in the conference room. The DON stated for dependent residents like Resident 67 they should have been visited regularly per their plan of care because it was their right to participate with activities. The DON stated not engaging with activities according to their [facility residents] plan of care could have caused depression that did not promote their highest physical, mental and psychosocial well-being. A review of the facility's policy and procedure, titled ACTIVITIES ATTENDANCE, revised June 2018 indicated, .Records are reviewed on a regular basis, and at least quarterly, to determine any changes in resident participation that might indicate a change in condition and lead to reassessment and care plan review .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51541 Based on observation, interview, and record review, the facility failed to ensure one of 37 sampled residents (Resident 141) received foot care and treatment as ordered by the physician. This failure resulted in missed appointments and treatment aimed to prevent complications from conditions such as diabetes, peripheral vascular disease, or immobility Findings: Resident 141 was admitted to the facility on [DATE] with diagnoses which included peripheral vascular disease (having to do with the blood vessels and circulation), hereditary and idiopathic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During an interview and observation on 4/15/25 at 8:55 A.M , Resident 141 stated he had long toenails and a fungal condition and had been on a list to see the podiatrist (healthcare provider specializing in foot care) for months. Resident 141 was observed to have long, thick toenails that were approximately a quarter inch in length. The resident also had dry, cracked feet. A record review was conducted on 4/16/25. Resident 141's physician's order dated 2/9/24, indicated podiatry every 2 months and PRN (as needed) for mycotic (something related to, caused by, or of a fungus), hypertrophic (excessive growth) nails, corns and calluses (thickening of or a hard thickened area on skin). During an interview on 4/18/25 at 8:20 A.M , Certified Nursing Assistant (CNA) 69 stated CNAs could not cut or file toenails. CNA 69 stated CNAs could only clean the residents' feet in the shower or in bed with a towel, and clean between the toes. CNA 69 stated CNAs had to let the nurse know about residents' toenails when they were long. During an interview on 4/18/25 at 8:20 A.M., CNA 68 stated toenail care included cleaning between the residents' toes and using a cuticle stick to clean under the nail. CNA 68 stated CNAs were not allowed to cut or file the residents' toenails. CNA 68 stated if the residents' nails needed to be cut, it had to be reported to the nurse. During a concurrent interview and record review on 4/18/25 at 8:50 A.M., Assistant Director of Nursing (ADON) 66 stated if the residents' toenails were long, the CNA would need to report it to nurse. ADON 66 stated the nurse would contact Social Worker (SW) 65 in person or by phone to let them know to put the patient on the list to be seen by podiatry. ADON 66 stated the podiatrist came once a month to the facility. ADON 66 stated the last time Resident 141 was seen by Podiatry was on 9/5/24. ADON 66 went into Resident 141's room and assessed the resident's feet. ADON 66 came out of Resident 141's room and stated, Yeah, that's bad and [Resident 141] should have been seen immediately and placed on list [for podiatry]. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/25 at 9:15 A.M., SW 65 stated she handled the referrals for podiatry and had a spreadsheet with every resident on the list that was to see podiatry. SW 65 stated that was a rolling schedule that cycled every 90 days. SW 65 stated she was not aware Resident 141 had an order to be seen every two months or as needed and did not have him on the rolling schedule to be seen by the podiatrist. SW 65 stated Resident 141 should have been seen regularly as his orders indicated. During an interview on 4/18/25 at 3 P.M., the Director of Nursing (DON) stated Resident 141's order for podiatry care every two months should have been followed and implemented. A review of the facility's policy and procedure, titled Foot Care, revised October 2022, indicated, .5. Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review, the facility failed to evaluate the use of palm guard splints for one of four reviewed residents (Resident 163) according to professional standards of practice. These deficient practices placed Resident 163 at risk for improper care and worsening of hand contractures (a shortening of muscles). Cross-Reference F656 Findings: A review of Resident 163's Admission Record indicated Resident 163 was readmitted to the facility on [DATE] with diagnoses which included a history of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (brain attack known as stroke when the blood flow to part of the brain is interrupted) of the left side. A record review of Resident 163's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/16/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 13 points out of 15 possible points which indicated Resident 163 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 4/17/25 at 8:15 A.M., an observation and interview was conducted with Resident 163, in Resident 163's room. Resident 163 had on a palm guard splint (medical device that stabilizes a part of your body and holds it in place to protect from injury) on his left hand. Resident 163 stated he was only able to move his right hand. On 4/17/25 at 8:31 A.M., an observation and interview was conducted with Resident 163, in Resident 163's room. Certified Nursing Assistant (CNA) 25 stated she did not know the care for Resident 163's palm guard splint and was not sure when Resident 163's palm guard splint was supposed to be taken off. On 4/17/25 at 8:35 A.M., an interview was conducted with Resident 163, in Resident 163's room. Resident 163 stated he wore his palm guard splint on his left hand because he was unable to move it due to contractures. Resident 163 stated he had his palm guard splint on the whole day yesterday and the other day. Resident 163 stated he could not remember when they took off his palm guard splint. Resident 163 stated there was no set time when they removed his palm guard splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 8:38 A.M., an interview and clinical chart review was conducted with Restorative Nurse Assistant (RNA) 27 of Resident 163's RNA charting. RNA 27 stated that he was involved with RNA programs for all residents that had splints. RNA 27 stated that he documented under RNA FOR ADL (Activities of Daily Living) and WEEKLY RNA SUMMARY in the facility's electronic chart [e-chart]. RNA 27 stated Resident 163's palm guard splint was usually removed at the end of the shift about four hours and documented. RNA 27 stated he was unable to find documentation when Resident 163's palm guard splint to his left hand was removed or when care instructions were provided. RNA 27 stated it was important to provide the proper care on Resident 182's left hand with the palm guard splint to stretch his mobility and trying to prevent from further contracture. [sic] RNA 27 further stated you wanna [sic] take off the palm protector to check for skin care and any changes and having the palm protectors [palm guard splints] can cause skin breakdown. On 4/17/25 at 8:51 A.M., an interview and clinical chart review was conducted with Licensed Nurse (LN) 21. LN 21 stated she was not aware Resident 163 had a palm guard splint to his left hand. LN 21 stated Resident 163 did not have Physician's (MD) orders for a palm guard splint for his left hand. LN 21 stated there was no care plan in place for the palm guard splint to communicate with the nursing staff for when it should have been on and off and/or additional instructions for monitoring. LN 21 further stated without proper MD orders and a care plan for Resident 163's palm guard splint could lead to improper care and complications of Resident 163's left hand contracture. On 4/17/25 at 9:01 A.M., an observation, and interview was conducted with LN 21 and Resident 163, in Resident 163's room. Resident 163 stated he had been using the palm guard splint for a while about three months. Resident 163 stated RNA 26 was the one who put the palm guard splint on his left hand. On 4/17/25 at 12:57 P.M., an interview and clinical chart review was conducted with LN 23. LN 23 stated there was no MD orders in place for Resident 163's palm guard splint to his left hand. LN 23 stated that any splints required MD orders because these were medical devices that could cause immobility issues if not properly monitored or cared for. LN 23 stated it was important that we monitored the use of Resident 163's palm guard splint to prevent skin breakdown and provide skin care and to include the frequency of when it should have been removed. LN 23 stated that a care plan for Resident 163's palm guard splints were just put in today in the in the care plan [sic] but did not indicate further instructions. On 4/17/25 at 1:11 P.M., an interview and clinical chart review was conducted with Assistant Director of Nursing (ADON) 3, at station three nursing station. ADON 3 stated that the RNA supervisor which was the Minimum Data Nurse (MDSN) stated they did not need an order for a palm guard splint. ADON 3 stated that Resident 163 did not have an order for a palm guard splint. ADON 3 stated an MD order was needed for their [Resident 163's] care and to know how to care for them. ADON 3 stated Resident 163's palm protector splint should have had a frequency to the MD order to be removed to check for skin injury cause it can cause device related pressure injuries and skin tears. ADON 3 was unable to find documentation by the RNA charting for the proper care and monitoring of Resident 163's palm guard splint. ADON 3 stated Resident 163 had an updated intervention in place dated 4/17/25 that indicated .May use palm protector for prevention of skin breakdown and contracture . ADON 3 stated Resident 163's care plan was not personalized to the care and monitoring of Resident 163's palm guard splint and should have been focused on Resident 163's comprehensive care plan during the time Resident 163 started using the palm guard splint to prevent improper care and complications. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1:46 P.M., a record review was conducted on Resident 163's clinical chart. Resident 163's MDS dated [DATE] section GG, indicated Resident 163 had an upper side impairment to one side. On 4/17/25 at 4:18 P.M., an interview and clinical chart review was conducted with the MDSN. The MDSN stated that RNA 27 thought it was a hand roll [rolled hand towel] and not a palm guard splint (hand protector) and the reason I said we did not need an order but when I looked at Resident 163's left hand it was a hand protector [palm guard splint] and not a hand roll. The MDSN stated Resident 163 did not have an MD order for the palm guard splint and that an order was indicated for the use and monitoring of the medical device. The MDSN stated RNA 27 should not have applied the palm guard splint without an MD order. The MDSN stated an MD order and a care plan for the use of the palm guard splint was a way to communicate to the staff on the proper use and monitoring of Resident 163's palm guard splint. The MDSN further stated improper care and monitoring of Resident 163's palm guard splint could have lead to complications such as skin breakdown and the worsening of contractures. On 4/18/25 at 2:33 P.M., an interview was conducted with the Director of Nursing (DON), in the conference room. The DON stated Resident 163 should have been screened three months ago to get the proper MD order if indicated and care planned personalized to include the use of the palm guard splint. The DON stated RNA 27 should not have put on Resident 163's palm guard splint without an MD order because the nursing staff would not know that they should have been providing the proper care and monitoring for the use of the device. The DON stated complications to not providing the proper care and monitoring of the palm guard splint could result in skin injuries, pain and worsening of contractures. A review of the facility's policy and procedure, titled SPLINTS and POSITIONING DEVICES, revised July 2017 indicated, .any resident with a need to be screened by the Rehab team including a qualified specialist in Rehab devices .if a device is ordered other than a simple hand roll, an in-service will be given to the RNA and any other appropriate staff on the use of the device, to ensure proper application .This device will be applied daily as ordered and documented on the resident Care plan and daily RNA notes .

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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** 51452 Based on interview, observation, and record review, the facility failed to provide adequate supervision to prevent choking during mealtimes for one sampled resident (Resident 92). As a result of this deficient practice, the resident experienced a choking episode while eating breakfast without supervision (cross reference F656 #3). Findings: Resident 92 was readmitted to the facility on [DATE], with the diagnosis which include Parkinson's Disease (a progressive neurological disorder characterized by gradual loss of movement-related symptoms like tremors, slowness of movement, and stiffness), Dysphasia (Difficulty with swallowing), a stroke causing left non-dominant side hemiplegia and hemiparesis (weakness and paralysis of one side of the body) per facility's Admission Record. On 4/17/25 at 1:23 P.M., an observation and interview with Resident 92 and Certified Nursing Assistant (CNA) 54 was conducted. The resident was eating his lunch in his bed, the meal ticket indicated chopped meat and soft fruit plate. The resident was observed to be eating without dentures but stated, I'm fine without them. CNA 54 stated that he was from another unit and was supervising the resident during mealtime to help the resident reach drinks and chop meat into smaller pieces if needed. CNA 54 stated this was his second time to supervise the resident. CNA 54 also stated that although the resident could answer questions appropriately, he noticed the resident was confused at times. On 4/18/25 at 8:29 A.M., an observation was conducted in the hallway outside of Resident 92's room. Resident 92 was heard attempting to cough loudly. Resident 92 was in his bed with his breakfast tray on the bedside table in front of him. The breakfast tray had scrambled eggs, cubed potatoes, fruit cup, cream of wheat and thin beverages. Resident 92's head of bed was up, and he was slightly slanted over to his left side. His face was red. Resident 92 was asked if he was choking and the resident nodded while trying to breathe and cough. No staff were present in the room. Licensed Nurse (LN) 53 and Assistant Director Of Nursing (ADON) 66 were called to the resident's room. The nurses were observed assisting the resident. ADON 66 stated she had assigned a CNA to supervise the resident for his breakfast. ADON 66 stated the CNA should have been there. ADON 66 stated Resident 92 required RNA (Restorative Nursing Assistant) DINING (a trained nursing staff to supervise a resident with meals while focusing on aspiration risk) and she was going to discuss it with the physician. On 4/18/25 at 10:22 A.M., an observation was conducted at the nurses' station. There was a white board that indicated, 4/17/25 Feeders [Resident 92] (supervision). On 4/18/25 at 10:30 A.M., an interview with ADON 66 was conducted. ADON 66 stated CNA supervision was required during mealtime for Resident 92 because the resident was identified as at risk for aspiration, and he coughs with food and drinks. ADON 66 stated the Resident 92 was known to inhale food and gulp as he drank. ADON 66 stated she told CNA 55 before breakfast that Resident 92 needed supervision with meals. ADON 66 stated she handed Resident 92's breakfast tray directly to CNA 55 and instructed her to supervise Resident 92 because he coughs with food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 10:53 A.M., an interview with CNA 55 was conducted. CNA 55 stated she was from the registry (nursing staff provided by an agency) and Resident 92 was eating fine without supervision last time she worked at the facility. CNA 55 stated that she was not aware of Resident 92's need for mealtime supervision and did not remember ADON 66's instruction to supervise the resident for breakfast. CNA 55 stated she wasn't focused. CNA 55 stated it was very important to listen to the direction of the nurses because a resident's condition could change at any time. On 4/18/25 at 3:15 P.M., an interview with the Director Of Nursing (DON) was conducted. The DON stated it was important to provide supervision for Resident 92 when CNA 55 was instructed to do so. The DON stated if LNs identified residents at risk for aspiration, they could initiate meal supervision without orders. The DON stated it was important for all CNAs to follow the LN's instructions to avoid an incident like this. The DON stated Resident 92 should have been supervised during meals when ADON 66 identified the concern for aspiration. A review of the facility's policy titled Accidents and Incidents - Investigating and Reporting revised July 2017, did not provide guidance related to providing supervision to prevent aspiration/choking. A review of the facility's policy titled Assistance with Meals revised July 2017, indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident

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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** 48263 Based on observation, interview, and record review, the facility failed to follow nutrition orders for two of 37 sampled residents (Resident 82, Resident 208) with tube feedings (TF: nutritional intake via tube) when: 1. Resident 82's TF was not started timely. 2. Resident 208's TF was not ran at the ordered rate. These deficient practices placed all residents on TFs at risk for malnutrition. Findings: 1. A review of Resident 82's Admission Record indicated Resident 82 was readmitted to the facility on [DATE] with diagnoses which included a history of protein calorie malnutrition (the body does not get enough calories and protein from their diet). A record review of Resident 82's MDS (Minimum data set: nursing facility assessment tool) dated 2/7/25 indicated that Resident 82 was rarely or never understood with severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to understand and make decisions. On 4/15/25 at 12:07 P.M., an observation, and interview, was conducted with Resident 82, in Resident 82's room. Resident 82 was unable to verbalize clearly but was able to answer simple yes or no questions. Resident 82 pointed to his TF when asked if he ate breakfast. Resident 82's TF was stopped and a bag of TF formula was still hung on the TF pole with 100 ml (milliliters) remaining labeled 4/14/25. On 4/15/25 at 3:35 P.M., a clinical chart review was conducted on Resident 82's diet/nutrition orders. Resident 82's orders indicated .(Brand name of TF) 2.0 at 55 cc[ml]/hr [per hour] x 20 .TURN ON AT 1400 [2 P.M.] & OFF AT 10:00 [10 A.M.] OR AFTER THE DOSE IS COMPLETED . On 4/15/25 at 4:14 P.M., an observation was conducted in Resident 82's room. Resident 82 was in bed asleep. Resident 82's TF was not turned on and the same bag of TF dated 4/25/25 with 100 ml remaining was still hung on Resident 82's TF pole. On 4/17/25 at 9:03 A.M., an interview and clinical chart review was conducted with LN (Licensed Nurse) 21, on Resident 82's diet orders. LN 21 stated Resident 82's TF orders indicated, .(Brand name of TF) 2.0 at 55 cc/hr x 20 .TURN ON AT 1400 & OFF AT 10:00 OR AFTER THE DOSE IS COMPLETED . LN 21 observed pictures of Resident 82's TF taken at 12 P.M. and 4:13 P.M. with Resident 82's name and remaining 100 ml TF bag still hung on Resident 82's TF pole. LN 21 stated that the TF should have been discarded and should have been re-hung as ordered at 2 P.M. on 4/15/25. LN 21 stated it was important to follow Resident 82's physician's (MD) orders to prevent malnutrition and weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 9:10 A.M., an interview and clinical chart review was conducted with LN 22, on Resident 82's diet orders. LN 22 stated Resident 82 was NPO [no intake by mouth]. LN 22 stated Resident 82's TF orders indicated, .(Brand name of TF) 2.0 at 55 cc/hr x 20 .TURN ON AT 1400 & OFF AT 10:00 OR AFTER THE DOSE IS COMPLETED . LN 22 stated at 10 A.M., Resident 82's TF bag should have been stopped and discarded. LN 22 stated that Resident 82's TF should have been started at 2 P.M. and not late (given at 4:15 P.M.) per the Medication Administration Record (MAR). LN 22 stated Resident 82 had a history of malnutrition and was at increased risk of malnutrition. LN 22 stated Resident 82 required a TF to get all his nutritional needs because that was his food and giving the TF late could have been harmful for Resident 82 because he was not getting sufficient nutrition that could have lead to weight loss. On 4/18/25 at 2:27 P.M., an interview with the Director of Nursing (DON) was conducted, in the conference room. The DON stated it was her expectations that the LN's followed Resident 82's diet order for his TF intake. The DON stated that complications for not giving Resident 82's TF timely could have caused complications with weight loss, especially for dependent residents. A review of the facility's policy and procedure, titled ENTERAL FEEDINGS-SAFETY PRECAUTIONS, revised May 2024 indicated, .The facility will remain current in and follow accepted best practices in enteral nutrition . 39448 2. Per the facility's Admission Record, Resident 208 was admitted to the facility on [DATE] with diagnoses of malnutrition (not enough nutrients), dementia (mental and physical decline), and dysphasia (difficulty swallowing). On 4/15/25 at 10:48 A.M., an observation was conducted of Resident 208's TF. The TF was running at 50 Milliliters per hour (ml/hr). On 4/16/25 a review was conducted of Resident 208's record. There was an order for TF at 65 ml/hr. On 4/16/25 at 1:02 P.M., an observation and interview was conducted with Licensed Nurse (LN) 5. LN 5 stated, she refilled Resident 208's TF that morning and it was her responsibility to ensure the TF was running as ordered. LN 5 stated, Resident 208 had an order for the TF to run at 65 ml/hr. The TF was observed to be running at 50 ml/hr and LN 5 stated, that it was incorrect and should have been running at 65 ml/hr. On 4/17/25 at 2:10 P.M., an interview was conducted with the Registered Dietician (RD). The RD stated, if a TF was ran at the incorrect rate, it could potentially have contributed to weight loss. On 4/18/25 at 9 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, the LNs should have checked the order to ensure the TF was running at the correct rate. The DON further stated, running a TF at a lower rate than ordered could have contributed to weight loss. A review of the facility's policy and procedure, titled ENTERAL FEEDINGS-SAFETY PRECAUTIONS, revised May 2024 indicated, .The facility will remain current in and follow accepted best practices in enteral nutrition .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on observation, interview, and record review, the facility failed to label and change a peripheral intravenous access (IV, location to administer medication into the blood stream) for one of 37 sampled residents (179) based on professional standards of practice. As a result, Resident 179 was placed at an increased risk of infection and medical complications. Findings: Per the facility's Admission Record, Resident 179 was admitted to the facility on [DATE] with diagnoses of Amyotrophic Lateral Sclerosis (a nerve disorder causing loss of movement). On 4/15/25 at 10: 38 A.M., an observation and interview was conducted with Licensed Nurse (LN) 4 of Resident 179. The IV to Resident 179's right hand was observed to be unlabeled. Resident 179 stated that the IV had been in his right hand for one week. LN 4 stated the IV needed to be changed. On 4/17/25 a review was conducted of Resident 179's medical record. There were no orders to monitor or change the IV prior to 4/15/25. There was an order on 4/8/25 (seven days before the observation of the unlabeled IV) for Resident 179 to have gentamycin (an antibiotic) IV. On 4/18/25 at 9 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, the LN should have dated Resident 179's IV, and they should have entered an order to insert the IV and an order to change the IV at a specific frequency. The facility's policy, titled Peripheral and Midline IV Catheter Flushing and Locking, revised March 2022, did not direct staff to label their IVs, or change them at a specific frequency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48263 Based on observation, interview, and record review, the facility failed to provide the minimum required staffing to adequately care for all 248 residents to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident This deficient practice placed all residents at risk for unmet care needs, including delayed assistance, missed treatments and potential harm due to insufficient nursing staff. Findings: A review of the facility's Payroll Based Journal (PBJ) fiscal year (FY) quarter (QTR) one 2025 (October 1, 2024 - December 31, 2024) indicated, .Excessively Low Weekend Staffing . Survey team observations conducted on 4/15/25 included: - 9:00 A.M., Sometimes there is a long wait. Roommate stated he had poop since 7:30 A.M. - 11:15 A.M., Soiled diapers were changed about an hour ago. - 3:05 P.M., Waits for staff for over an hour every time he called then yelled out. Waited for pain management for a long time. - 9:55 A.M., 3-11 shift that it takes a long time to answer call light due to not having enough staff - 10:58 A.M., Don't answer call lights for hours. On 4/17/25 at 9:47 A.M., an interview was conducted with the Staffing Coordinator (SC). The SC stated there were weekend shortages during the holidays along with the month of January and February and staff call offs due to sickness. On 4/17/25 at 1:30 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 22. CNA 22 stated during staff shortage that this definitely affected resident care. CNA 22 stated the facility residents would complain about getting changed and yell out. On 4/18/25 at 7:45 A.M., an interview was conducted with Resident 37, in Resident 37's room. Resident 37 stated there aren't enough staff that run the facility which stressed the nursing staff having to fill in for the shortage. Resident 37 stated she did not think the facility scheduled enough people to care for residents because they had nursing staff who floated from other sections and were overworked to cover a shortage. Resident 37 stated that influenced how the care was unmet when she waited hours to get changed. Resident 37 stated meals were always given an hour late and thought the kitchen staff may also have been short staffed. Resident 37 stated that happened on all shifts and all days. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/25 at 7:51 A.M., an interview was conducted with Resident 47, in Resident 47's room. Resident 47 stated she had fallen out of bed twice because there was no one by her bedside to help her when she needed it. Resident 47 stated the first time she fell her physician (MD) told her she required two person to assist her with transfers and mobility. Resident 47 stated that the second time she fell was in the middle of being changed while she was in bed and fell to the floor that required four people to help her from the fall. Resident 47 stated that she had not been changed all night and further stated they assume that I don't need to be changed. Resident 47 stated this had affected her care and other residents care due to call lights not being answered because they [nursing staff] call in sick, no show or whatever and that's just detrimental for them [nursing staff] and neglect for us[residents]. On 4/18/25 at 8:33 A.M., an interview was conducted with CNA 23. CNA 23 stated he worked when they were short-staffed and when they were short-staffed we have more work to do. CNA 23 stated they were more short during the weekends with staff calling out. CNA 23 stated he helped out when he could by doing double shifts but also had another CNA job elsewhere. On 4/18/25 at 8:37 A.M., an interview was conducted with CNA 24. CNA 24 stated that residents would complain about night shifts not providing care that they needed. On 4/18/25 at 10:41 A.M., an interview was conducted with Resident 21, in Resident 21's room. Resident 21 stated that a certain CNA during night (NOC) shift did not care to answer call lights. Resident 21 stated staff called in sick during the weekends and it had been difficult for CNA's picking up more work. Resident 21 stated that being short-staff had affected her care because she was not turned every two hours when she needed to be turned for skin maintenance, does not get changed timely and meals delivered late. Resident 21 stated during NOC shift her roommate stinks because she was unable to advocate for herself when she needed an incontinent change. On 4/18/25 at 10:45 A.M., an interview was conducted with the SC. The SC stated being short-staff could have affected resident care and increased complaints by residents with their call lights. The SC stated they used registry but some complaints from residents were due to registry staff either missing or late or taking long to answer lights. On 4/18/25 at 2:13 PM an interview with the Director of Nursing (DON) was conducted, in the conference room. The DON stated that when they were short-staff, they would use registry as a last resort. The DON stated her expectations were for the Director of Staff Development (DSD) and the SC to work together to communicate with the call-ins and communicate this with the Administrator (ADM). The DON stated wait times for call lights could increase and necessary care could be delayed, compromising the care given for the residents. A review of the facility's policy and procedure titled STAFFING revised October 2017 indicated, .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39111 Based on observation, interview, and record review, the facility failed to ensure medications were administered according to professional standards of practice for three of seven residents (37, 81, 92) reviewed for pharmacy services when: 1. Resident 81's pantoprazole (a prescribed medication to treat acid reflux) was dispensed and left at the resident's bedside for the resident to self-administer. 2. The manufacturer's instructions for Advair Diskus (an inhaled steroid medication) were not followed when the medication was administered to Resident 92. 3. A controlled medication (drugs with high abuse potential) prescribed to Resident 37 could not be accounted for. As a result: -Resident 81 self-administered his pantoprazole at the wrong time and not according to the physician's order. -Resident 92 was at risk of developing thrush (a fungal infection). - The facility was unable to readily identify potential loss and/or drug diversion (illegal distribution or abuse of prescription drugs). Findings: 1. A review of Resident 81's Admission Record indicated the resident was readmitted to the facility on [DATE]. A review of Resident 81's physician orders dated 7/28/24, indicated the resident was to receive pantoprazole 40 milligrams once a day before breakfast. The medication was scheduled to be administered at 6:30 A.M. A review of Resident 81's medication administration record (MAR) indicated the resident's pantoprazole was administered to the resident on 4/15/25 at 6:30 A.M. On 4/15/25 at 9:45 A.M., an observation and interview was conducted with Resident 81 while inside the resident's room. Resident 81 was observed in bed. There was a yellow, oblong tablet in a medication cup next to the resident on the resident's overbed table. Resident 81 was asked about the observed medication in the medication cup. Resident 81 quickly self-administered the tablet and then stared at the wall without answering the question. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 10:29 A.M., a joint observation, interview, and record review was conducted with licensed nurse (LN) 52. LN 52 stated he was the nurse currently assigned to Resident 81. LN 52's medication cart was inspected and Resident 81's medication cards were observed. Resident 81's pantoprazole matched the tablet in the medication cup which was observed at 9:45 A.M. LN 52 stated he just dispensed and administered Resident 81's medications that were scheduled for 9 A.M. LN 52 stated he did not give the resident pantoprazole. LN 52 stated Resident 81's pantoprazole was a medication that the night shift nurse gave to the resident at 6:30 A.M. LN 52 stated he did not work the night shift. LN 52 reviewed Resident 81's clinical record and stated the resident did not have an order to self-administer medications. LN 52 stated Resident 81 ate breakfast approximately an hour ago, and when the resident self-administered his pantoprazole, it was not taken at the correct time and before breakfast as was ordered. On 4/18/25 at 3:10 P.M., an interview was conducted with the director of nursing (DON). The DON stated pantoprazole should not have been left at Resident 81's bedside for the resident to self-administer. The DON stated Resident 81 did not have an order to self-administer his medications. The DON stated the pantoprazole was administered late and not according to physician's order. The DON stated her expectation was for LNs to stay with residents until the residents took all their medications. The DON stated LNs should be checking the residents' mouths to ensure medications were swallowed. 2. A review of Resident 92's Admission Record indicated the resident was readmitted on [DATE]. On 4/17/25 at 9:50 A.M., a medication administration observation was conducted with licensed nurse (LN) 53. LN 53 was observed preparing and dispensing medications for Resident 92. At 10:05 A.M., LN 53 was observed administering an oral inhalation of Advair Diskus to Resident 92. LN 53 then had Resident 92 drink water and take oral medications. The Advair Diskus packaging indicated, .Instructions for using ADVAIR DISKUS .Step 3. Inhale your medicine .Put the mouthpiece to your lips. Breathe in quickly and deeply through the DISKUS .Step 5. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it On 4/17/25 at 10:13 A.M., an interview and record review was conducted with LN 53. LN 53 reviewed the Advair Diskus packaging (for Resident 92's Advair). LN 53 stated he did not follow the manufacturer's instructions when administering the Advair to Resident 92. LN 53 stated he should have instructed the resident to rinse his mouth with water and spit it out. On 4/18/25 at 3:10 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 92's Advair Diskus manufacturer's instructions should have been followed. The DON stated LN 53 should have instructed the resident to rinse his mouth with water and spit it out. The DON stated this was to prevent oral thrush. A review of Patient Information Advair Diskus for oral inhalation use, revised January 2019, indicated, .Advair Diskus can cause serious side effects, including: fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Advair Diskus to help reduce your chance of getting thrush 51541 (continued on next page)

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	555076	A. Building B. Wing	04/18/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 37 was admitted to the facility on [DATE] per the facility's Admission Record, with diagnoses to include femur (upper leg bone) fracture. During a record review on 4/17/25, Resident 37's physician's order, controlled drug record (CDR), and medication administration record (MAR) was reviewed. Resident 37's physician's order dated 1/14/25, indicated the resident was to receive hydrocodone-APAP 5/325mg (medication used to relieve pain) one tab every four hours as needed for pain. A review of Resident 37's CDR indicated two doses of the resident's hydrocodone-APAP 5/325 had been removed from the locked supply on 2/8/25 and 2/28/25. Resident 37's MAR for hydrocodone-APAP 5/325mg had blank entries on 2/8/25 and 2/28/25 and it could not be determined if the medication had been given to the resident. During an interview on 4/18/25 at 7:40 A.M., Licensed Nurse (LN) 64 stated LNs had to sign controlled medications out on the CDR and document on the MAR when the medication was given to the resident. LN 64 stated that it was important to keep track of controlled medications so that other LNs knew when the medication was given. During an interview on 4/18/25 at 7:45 A.M., the Director of Nursing (DON) stated Resident 37's hydrocodone-APAP 5/325mg was not documented on the resident's MAR on 2/8/25 and 2/28/25. The DON stated her expectation was for the LN to sign the CDR when controlled medications were removed from the locked drawer and then for the LN to document on the resident's MAR once the medication was given to the resident. During another interview on 4/18/25 at 3:15 P.M., the DON stated the Assistant Directors of Nursing (ADON) were supposed to conduct weekly random audits of controlled medications for five random residents. The DON stated these weekly audits had to be documented and submitted to the DON. The DON stated the weekly audits of controlled medications were not being done. The facility's policy and procedure, titled Medication Reconciliation, revised July 2017, did not provide guidance related to reconciling and accounting for controlled medications.

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	555076	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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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 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** 48263 Based on observation, interview, and record review, the facility failed to complete a monthly medication reconciliation (reviewing and creating an accurate list of all medications a resident is taking if appropriate to continue, hold or stop) review (MRR) for one of 20 sampled residents (Resident 183) receiving antibiotics. This deficient practice placed residents at risk for unnecessary medication use, side effects, and harm due to lack of proper review. Cross-Reference F881 and F657. Findings: A review of Resident 183's Admission Record indicated Resident 183 was admitted to the facility on [DATE] with diagnoses which included a history of metabolic encephalopathy (a brain disorder that causes problems with the body's chemistry due to lack of oxygen, blood sugar level and essential nutrients). On 4/15/25 at 2:46 P.M. a clinical chart review was conducted on Resident 183's physician's order sheet (POS). Resident 183 was taking Rifaximin (an antibiotic medication that worked by killing the bacteria and preventing its growth) for encephalopathy ordered 3/4/24. On 4/18/25 at 7:06 A.M., a record review was conducted on Resident 183's MRR. There was no MRR conducted on Resident 183's medication for Rifaximin for the month of January 2025-March 2025. On 4/18/25 at 8:49 A.M., an interview and record reviews were conducted on Resident 183's clinical chart and MRR with the Infection Control Prevention Nurse (ICPN). The ICPN stated Resident 183 was no longer on antibiotic. The ICPN stated she tracked the infection control log/antibiotic tracking to determine which residents were on antibiotics. The ICPN reviewed Resident 183's POS and stated Resident was on Rifaximin for encephalopathy ordered on 3/4/24. The ICPN reviewed the MRR for the month of January 2025-March 2025 and stated Resident 183's Rifaximin was not reviewed. The ICPN stated that she only kept track on residents with infections as part of her antibiotic stewardship log as to why Resident 183's antibiotic was not tracked. The ICPN stated Resident 183's Rifaximin should have included routine monitoring for the medication use and appropriateness to be included monthly. The ICPN stated antibiotics (such as Rifaximin) were used for bacterial infections but Resident 183 was using the medication for encephalopathy and that there was no stop date for the medication. The ICPN stated she was unable to find any side effect monitoring or documentation in Resident 183's clinical chart for Rifaximin. The ICPN stated we should have been monitoring the side effects for Resident 183's antibiotic use and indications so that the physician could have reassessed with the information gathered to determine appropriateness of long term use. The ICPN stated complications from taking antibiotics for long term use could have lead to antibiotic resistance and caused other infections. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 2:55 P.M., an interview with the Director of Nursing (DON) was conducted, in the conference room. The DON stated that her expectations was for the ICPN to track all antibiotics short term and long term and be reviewing all antibiotics for indication of use and be included in the care plan. The DON stated, the ICPN should have followed up with the MRR and recommendations with antibiotic appropriateness and continued use monthly. The DON stated complications to include antibiotic resistance to infections, disease progressions, and multi-drug resistance organisms (MDRO: germs that have evolved to survive against multiple antibiotics) complications A review of the facility's policy and procedure, titled MEDICATION REGIMEN REVIEWS, revised May 2019 indicated, .The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example .potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences .

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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 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** 22383 Based on observation, interview, and record review, the facility failed to ensure one of 37 sampled residents (321) and one unsampled resident (59) had medications that were labeled and stored appropriately when: 1. Resident 321's intra venous antibiotic was labeled incorrectly. 2. Resident 59's prescribed medicated ointment was kept in a bowl at the resident's bedside. As a result, there was the potential for a medication errors. Findings: 1. Resident 321 was admitted to the facility on [DATE], with a diagnosis of cellulitis (bacterial infection of the skin). On admission Resident 321 had a physician's order for vancomycin (a strong antibiotic a treatment for patients with cellulitis) q (every) 12 hours, 1.5 grams intravenous to infuse at 250cc/hr (cubic centimeters per hour) over 2 hours On 4/17/25 at 8:31 A.M., an observation was made to Resident 321's bedside and there was an empty IV (intravenous) bag and tubing. The empty IV bag was not labeled correctly. The IV bag had 2 pieces of tape with handwritten information. The label was difficult to understand. The DON was interviewed on 4/17/25 at 9:30 A.M. The DON stated the IV should have had a label from the pharmacy. The IV should not have had a handwritten label using tape. 39111 2. A review of Resident 59's Admission Record indicated the resident was admitted to the facility on [DATE]. On 4/15/25 at 10:07 A.M. an observation and interview was conducted while in Resident 59's room. Resident 59 had a small bowl on his bedside table that contained several sachets of hydrocortisone 1% External Gel. Resident 59 stated the medication sachets in the bowl were for his rash and that the medication did not seem to work. On 4/15/25, Resident 59's clinical record was reviewed. The resident's physician order dated 2/1/25, indicated, Hydrocortisone External Gel 1% . Apply to generalized topically every 8 hours as needed for itching Resident 59 did not have a physician order to self-administer any medications. On 4/17/25 at 3:25 P.M., an interview was conducted with licensed nurse (LN) 51. LN 51 stated hydrocortisone 1% ointment was a medication and should be stored in the locked treatment cart. LN 51 stated the hydrocortisone 1% ointment should not have been kept at a resident's bedside because nursing would not know if the resident was using the medication or how frequently it was being applied. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 3:10 P.M., an interview was conducted with the director of nursing (DON). The DON stated hydrocortisone 1% ointment was considered a medication and it should not have been kept at Resident 59's bedside. The DON further stated that Resident 59 did not have an order to self-administer medications. A review of the facility's policy titled Storage of Medications revised November 2020, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner . 1. Drugs and biologicals used in the facility are stored in locked compartments . Only persons authorized to prepare and administer medications have access to locked medications

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43518 Based on observation, interview and record review, the facility failed to ensure food served to all residents was in a palatable, flavorful manner that maintained the nutritional value of the menu items served when they: 1. Did not take resident's preferences and tastes into account for meals, 2. Did not follow recipe for pureed garden meat loaf, 3. Did not follow recipe for garden meat loaf. This failure had the potential to decrease residents' meal intake and contribute to weight loss. The facility census was 248. Findings: 1. During a dining observation and interviews with residents on 4/15/25 from 9:00 A.M. to 12:45 P.M., residents' food concerns included: . I don't eat the food, sometimes I don't get food I like . . Food sucks. Alternates suck . . Food is lousy .Small Portions .No seasoning .No variety . . Always chicken .always dry . . Calls it Slop, poured lots of gravy . Food-sometimes too salty, sometimes no flavor . . Food is bland . . Does not like Asian food . . No variety in meals .always chicken .always dry . . Food is not good, so-so . .Too many sandwiches .repeated meals over and over again . food bland On 4/16/25 at 10:29 A.M., a meeting of the Resident Council was conducted. Six out of six residents at the Resident Council Meeting complained about food. Food complaints during Resident Council included: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Sometimes run out of snacks . . No coffee at dinner time . . Breakfast this morning was Ice Cold . More variety and more vegetables; vegetables were 'mushy', overcooked . . Menu most time is not being followed . . Alternative menu sometimes items not available due to ordering . . Fresh eggs not available, eggs are usually scrambled . . More dessert variety . Review of the facility's menu dated 4/16/25 indicated the regular diet meal for lunch was, Garden Fresh Meatloaf, Mashed Potatoes, Spinach Augratin, and Garlic Bread. The Pureed Diet was served pureed versions of regular diet. On 4/16/25 between 11:45 A.M. and 2:05 P.M. an observation of trayline was conducted. Resident tray distribution was observed on last unit (Unit 4). On 4/16/25 at 2:09 P.M., an observation of two test trays (Pureed and Regular) and interview with the Registered Dietician (RD) was conducted. Test tray items temperatures were taken by the RD prior to sampling. The RD and surveyor sampled all items on test trays. The following were the surveyor's observations of the test trays: Regular Tray - visually: test tray items appeared appetizing, but lots of gravy. Meatloaf- 128 F.Taste: well seasoned, slightly salty, warm. Mash Potatoes 134.6 F.Taste: well seasoned, slightly salty, warm. Spinach Au Gratin- 130.F.Taste: bland, no cheese tasted, slightly mushy Puree Tray - visually multiple large scoops of pureed food, covered in gravy. Meatloaf 146.9 F. Taste: well seasoned, slightly, salty warm. Mashed Potatoes 146.5 F. Taste: well seasoned, slightly salty, warm. Spinach Au Gratin-140.4 F.Taste: bland, no cheese tasted, did not look appetizing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25 at 3:30 P.M., an interview with Registered Dietician (RD) was conducted. The RD stated that the expectation was that optimal temperature for food served off tray line for residents should be close to holding temperature of 140 F. The RD stated the importance of having hot palatable meals was to encourage residents to eat their meals and promote good nutrition. The RD stated that it was important for residents to have their preferences met to encourage them to eat their meals and meet nutrition goals. Review of policy titled FOOD PREPARATION, dated 2023, indicated .7. Hold foods prior to service for as short time as practical. A maximum 1 hour holding time is recommended. Hot food should be held prior to service at 140 F or above . Review of facility policy titled FOOD PREFERENCES, dated 2023, indicated Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group . Food preferences can be obtained from the resident, family or staff members. Updating of food preferences will be done as the residents' needs change . 2. On 4/16/25 at 9:17 A.M., an observation of [NAME] 14 and [NAME] 15 preparing meatloaf puree was conducted. [NAME] 14 was observed cooking ground beef and other ingredients for meatloaf on a tilt skillet (a large, shallow pan with a tilting mechanism that allows for easy tilting to pour out contents) prior to making Garden Meatloaf puree. [NAME] 15 moved the ingredients cooked by [NAME] 14 to a large food processor. [NAME] 15 stated that the puree recipe indicated to, Complete regular recipe prior to pureeing. [NAME] 15 stated that cooking the meatloaf ingredients in the tilt skillet prior to pureeing was not the same as baking the meatloaf by provided recipe. Review of recipe titled, RECIPE: GARDEN FRESH MEATLOAF, dated 2024, indicated Directions: .4. Add sauteed vegetables and herbs to meat mixture, and press into loaves. 5. Bake 1 1/2 to 2 hours at 325 F . Review of recipe titled, RECIPE: PUREED (DDSI-LEVEL 4) MEATS, dated 2024, indicated .Directions: 1. Complete regular recipe On 4/17/25 at 3:30 P.M., an interview with Registered Dietician (RD) was conducted. The RD stated that the expectation was that the cooks should follow the recipe to ensure meal quality and to meet residents' nutritional needs. Review of policy entitled FOOD PREPARATION, dated 2023, indicated .1. The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. 2. Recipes are specific as to portion, yield, method of preparation, quantities of ingredients, and time and temperature guidelines . 3. On 4/16/25 at 9:45 A.M., an observation of [NAME] 14 preparing meatloaf and interview was conducted. [NAME] 14 was observed mixing ground beef and breadcrumbs in a large bowl. [NAME] 14 was observed pouring breadcrumbs directly into bowl from container without measuring. The recipe book was observed closed on the table and multiple containers of breadcrumbs were open. [NAME] 1 refused to answer when asked if he had measured the breadcrumbs. [NAME] 14 refused to answer when asked if he was following the recipe for Garden Meatloaf he was preparing. [NAME] 14 continued to mix unmeasured breadcrumbs into bowl with meat loaf ingredients. [NAME] 14 stated that it was important to follow the recipe, so the residents get the nutrition from the dish as per recipe. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of recipe titled, RECIPE: GARDEN FRESH MEATLOAF, dated 2024, indicated Directions: . Ingredients: .Serves 120 .Soft bread crumbs 2 Qts(Quarts) 2 cups . On 4/17/25 at 3:30 P.M., an interview with Registered Dietician (RD) was conducted. The RD stated that the expectation was that the cooks should follow the recipes to ensure meal quality and to meet residents' nutritional needs. Review of policy titled FOOD PREPARATION, dated 2023, indicated .1. The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. 2. Recipes are specific as to portion, yield, method of preparation, quantities of ingredients, and time and temperature guidelines .

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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. 43518 Based on observation, interview, and record review the facility failed to ensure: 1. Frozen biscuits, hash brown potatoes, and chicken breast were in a sealed, labeled, and dated container in facility's walk in freezer. 2. One food services worker wore a beard restraint not completely over his full beard and mustache during tray line service. These failures had the potential for food borne illness related to poor quality food or contamination by facial hair. Findings: 1. On 4/15/25 at 7:45 A.M., during initial tour of the kitchen, an observation of the walk-in freezer and interview with Registered Dietician (RD) was conducted. Frozen biscuits, potato hash browns, and chicken breast were observed in unsealed, unlabeled, and undated plastic bags. The RD stated that this was, Unacceptable, and that she would in-service dietary staff about proper food storage in the freezer. On 4/17/25 at 3:30 P.M., an interview with the RD was conducted. The RD stated that food in the freezer should be sealed, labeled and dated. The RD stated the importance of proper food storage was for maintaining food quality and preventing contamination of residents' food. Review of facility policy titled, PROCEDURE FOR FREEZER STORAGE, dated 2023, indicated .5. Store frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. 6. All frozen food should be labeled and dated . 2. On 4/16/25 at 11:55 A.M., an observation of tray line service was conducted. Dietary Supervisor (DS) was observed with a full beard and mustache not completely covered by beard restraint. The DS was about to plate the first tray and the beard restraint was covering just his chin and not the upper beard and mustache. The tray line service was paused until the DS fixed beard restraint. The DS stated that the expectation was that facial hair should be completely covered with beard restraint. The DS stated that facial hair falling into food can be unsanitary and could contaminate food. On 4/17/25 at 3:30 P.M., an interview with the RD was conducted. The RD stated any facial hair needs to be covered completely. The RD stated that the importance of beard restraints was to prevent contamination of residents' food by facial hair. Review of facility policy titled DRESS CODE, dated 2023, indicated .8. If applicable, beards and mustaches (any facial hair) must wear a beard restraint . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled PREVENTING FOODBORN ILLNESS-EMPLOYEE HYGIENE AND SANITARY PRACTICE, dated November 2022, indicated .15 .Beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263 Based on observation, interview, and record review the facility failed to implement their Antibiotic Stewardship policy and procedures to evaluate and monitor the ongoing use of a long-term antibiotic for one of 20 sampled residents receiving antibiotics. This deficient practice placed residents at risk for antibiotic overuse, potential side effects, and the development of antibiotic-resistant infections. Cross-reference F757 and F657 Findings: A review of Resident 183's Admission Record indicated Resident 183 was admitted to the facility on [DATE] with diagnoses which included a history of metabolic encephalopathy (a brain disorder that caused problems with the body's chemistry due to lack of oxygen, blood sugar level and essential nutrients). On 4/15/25 at 2:46 P.M., a clinical chart review was conducted on Resident 183's physician's order sheet (POS). Resident 183 was taking Rifaximin (an antibiotic medication that worked by killing the bacteria and preventing its growth) for encephalopathy ordered 3/4/24. On 4/18/25 at 7:06 A.M., a record review was conducted on Resident 183's MRR. There was no MRR conducted on Resident 183's medication for Rifaximin for the month of January 2025-March 2025. On 4/18/25 at 8:49 A.M., an interview and record reviews were conducted on Resident 183's clinical chart and MRR with the Infection Control Prevention Nurse (ICPN). The ICPN stated Resident 183 was no longer on antibiotic. The ICPN stated she tracked the infection control log/antibiotic tracking to determine which residents were on antibiotics. The ICPN reviewed Resident 183's POS and stated Resident was on Rifaximin for encephalopathy ordered on 3/4/24. The ICPN reviewed the MRR for the month of January 2025-March 2025 and stated Resident 183's Rifaximin was not reviewed. The ICPN stated that she only kept track on residents with infections as part of her antibiotic stewardship log as to why Resident 183's antibiotic was not tracked. The ICPN stated Resident 183's Rifaximin should have included routine monitoring for the medication use and appropriateness to be included monthly. The ICPN stated antibiotics (such as Rifaximin) were used for bacterial infections but Resident 183 was using the medication for encephalopathy and that there was no stop date for the medication. The ICPN stated she was unable to find any side effect monitoring or documentation in Resident 183's clinical chart for Rifaximin. The ICPN stated they should have been monitoring the side effects for Resident 183's antibiotics use and indications so that the physician can reassess with the information gathered to determine appropriateness of long-term use. The ICPN stated complications from taking antibiotics for long term use can lead to antibiotic resistance and cause other infections. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/25 at 2:55 P.M., an interview with the Director of Nursing (DON) was conducted, in the conference room. The DON stated that her expectations was for the ICPN to track all antibiotics short term and long term and be reviewing all antibiotics for indication of use and be included in the care plan. The ICPN should have followed up with the MRR and pharmacy recommendations with antibiotic appropriateness and continued use monthly. The DON stated complications to include antibiotic resistance to infections, disease progressions, and multi-drug resistance organisms (MDRO: germs that have evolved to survive against multiple antibiotics) complications. A review of the facility's policy and procedure, titled ANTIBIOTIC STEWARDSHIP, revised May 2001 indicated, .The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51452 Based on observation, interview, and record review, the facility failed to ensure call lights were functioning in three residents' rooms (401, 405, 406). As a result, the residents in rooms [ROOM NUMBER] had the potential to not have their needs met in a timely manner. Findings: On 4/15/25 at 3:05 P.M., an observation and interview was conducted with a resident in room [ROOM NUMBER]. The resident stated he waited over an hour every time he used the call light to request help. On 4/15/25 at 3:35 P.M., a joint observation and interview with Certified Nursing Assistant (CNA) 56 was conducted. CNA 56 turned on the bedside call light in room [ROOM NUMBER]. CNA 56 went to the hallway to observe the call light outside the room [ROOM NUMBER]. The call light did not turn on. CNA 56 stated the call light should have been on and visible above room [ROOM NUMBER]'s door. CNA 56 then went to room [ROOM NUMBER] and turned on a bedside call light in the room. CNA 56 went into the hallway to observe the call light outside of room [ROOM NUMBER]. The call light did not turn on. The bedside call light was then turned on in room [ROOM NUMBER]. The call light did not come on above room [ROOM NUMBER]'s door. On 4/16/25 at 7:49 A.M., an observation was conducted in the hallway outside of room [ROOM NUMBER]. The restroom call light in room [ROOM NUMBER] was activated. The restroom door was closed. The restroom call light was not visibly turned on above room [ROOM NUMBER]'s door. CNA 59 was observed going into room [ROOM NUMBER]. CNA 59 did not check the call light in the restroom nor verify if there was a resident inside the restroom. CNA 59 exited room [ROOM NUMBER] at 7:57 A.M. On 4/16/25 at 8:03 A.M., the restroom call light in room [ROOM NUMBER] was activated. The restroom door was closed. The call light above room [ROOM NUMBER]'s door did not light up. On 4/16/25 at 8:05 A.M., an observation and interview with Licensed Nurse (LN) 52 was conducted. LN 52 was observed checking the call light panel at the nurses' station. LN 52 stated the call lights were lit up on the panel in the nurses' station for rooms [ROOM NUMBERS] and the lights should be on above the doors. On 4/16/25 at 8:14 A.M., an observation and interview with Assistant Director of Nursing (ADON) 66 was conducted. ADON 66 was observed entering room [ROOM NUMBER] and checking on the residents inside the room. ADON 66 did not check the restroom. The restroom door was still closed. ADON 66 stated the call light above room [ROOM NUMBER]'s door was not on. ADON 66 stated that room [ROOM NUMBER]'s call light was showing as activated on the panel in the nurses' station. ADON 66 stated that she did not check room [ROOM NUMBER]'s restroom. ADON 66 stated staff should always check the restroom because a resident could be calling from there. ADON 66 was observed going into room [ROOM NUMBER] and turning off the call light in the restroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue El Cajon, CA 92020

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 8:19 A.M., the maintenance director (MTD) was observed telling the nursing staff in the hallway that he would fix the call lights. On 4/16/25 at 8:25 A.M., an interview with CNA 59 was conducted. CNA 59 stated it was really important for staff to be able to see the call lights turned on above the resident room doors. CNA 59 stated nursing staff needed to be able to see if the call lights in the hallway were on in order to help the residents right away. CNA 59 stated staff could not always be at the nurses' station to watch the call light panel. CNA 59 also stated it was important to check the call lights coming from the restrooms when the doors were closed. CNA 59 stated there could be a resident who needed help inside the restroom. On 4/18/25 at 2:21 P.M., an interview and record review with MTD was conducted. MTD reviewed Room Call Light Log dated 4/4/25. The Room Call Light Log indicated room [ROOM NUMBER], 405, and 406 were checked for the temperature. The Room Call Light Log did not indicate call lights were checked. MTD stated the Room Call Light Log was the same log used to check room temperature. MTD stated he checked random call lights above the entrance doors on the first day of each month and they were last checked on 4/4/25. MTD stated he did not routinely check the functionality of bathroom call lights. MTD stated he only checked the bathroom call lights if notified of an issue. MTD stated he was not aware of any issues with the call lights until the morning of 4/16/25. MTD stated CNA 56 was a registry staff (staff provided by an agency) and he should have reported the malfunctioning call lights to the maintenance department on the day it was observed (4/15/25). MTD stated call lights had to be fixed immediately so residents could ask for help. On 4/18/25 at 3:15 P.M., an interview with the Director Of Nursing (DON) was conducted. The DON stated call light issues must be entered in the maintenance log, or the maintenance director must be notified immediately. The DON stated the facility should have utilized bells until the call light issue was resolved. The DON stated that all staff including registry CNAs needed to be educated on the process for reporting malfunctioning call lights because resident safety was a priority. A review of the facility's policy titled Call System, Resident revised September 2022, indicated, .3. The resident call system remains functional at all times . If visual communication is used, the lights remain functional