

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Country Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1580 Broadway El Cajon, CA 92021	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on interview and record review, the facility failed to investigate an allegation of staff to resident abuse for one of two residents (Resident 2) when reviewed for Resident Abuse.</p> <p>This failure had the potential for all resident's to be at risk of staff to resident abuse.</p> <p>Findings:</p> <p>Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), with agitation, per the facility ' s Admission Record.</p> <p>On 2/21/25, Resident 2 ' s clinical record was reviewed:</p> <p>According to the Minimum Data Set, (MDS-a clinical assessment tool), Resident 2 had a cognitive score of 9, indicating cognition was moderately impaired. According to the Functional Abilities section, Resident 2 could ambulate without any assistive devices.</p> <p>According to the facilities SBAR (Situation-Background-Assessment-Recommendation communication tool used between staff members about a resident's change in condition), Communication Form, dated 1/31/25 at 10 A.M., Patient sustained a skin tear to right lateral heel when being assisted in room by (certified nursing assistant 1 [CNA 1]) .Excused (CNA 1) from providing care for patient at this time until further investigation. Supervisor (LN 3), notified.</p> <p>An interview was conducted with the Director of Staff Development (DSD) on 2/21/25 at 11:45 A.M. The DSD stated he became aware of an incident on the morning of 1/31/25, when he arrived at work. The DSD was informed by CNA 4, that CNA 1 was sent home during the night shift regarding an incident of Resident 2's foot being injured. The DSD stated he was informed Resident 2 became agitated while he was being assisted back to his room by CNA 1 when a bedside table tipped over inside the resident ' s room, resulting in a cut to the resident's heel. The DSD was told by CNA 4, that licensed nurse 1 (LN 1) insisted CNA 1 be sent home. The DSD stated the Director of Nursing (DON) was on vacation at the time, so he went to the Social Services office to ask if they were aware of the incident. The DSD stated he spoke with Social Services Aide 1 and 2 (SSA 1 and SSA 2) and they were not aware of any abuse allegation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DSD provided a printed copy of an internal text message, which he stated was sent to all nursing staff on the morning of 1/31/25, by LN 1.</p> <p>A document review was conducted of the facility's internal text message with the DSD on 2/21/25 at 11:50 A.M.</p> <p>According to an internal text message, sent to all nursing staff, dated 1/31/25 at 6:57 A.M., LN 1 documented, At approximate 0430 am .CNA 1 hooked his right arm under pt (patient) left arm and escorted him to his room .Pt was yelling and cussing stating you are hurting me .loud commotion and pt yelling that his foot was hurt. This nurse intervened .a deep horseshoe shaped laceration (cut) to right lateral heel .Sorry. Hooked right arm under pt right arm .I instructed (CNA 1) to be nicer to the patient . as his approach was aggressive before he made in the bedroom which was causing the resident to be agitated . The text was followed by another, undated but timed at Today 6:53 P.M. Hey. (smiley face emoji) I have been waiting for state to call me about this, I will give them a call tomorrow. I'm sure it was an oversight. The DSD's interview continued, stating he interpreted the event as an accident and not as an allegation of abuse.</p> <p>An interview was conducted with the Social Services Director (SSD) on 2/21/25 at 11:56 A.M. The SSD stated she was never informed of an allegation of staff to resident abuse.</p> <p>An interview was conducted with the Assistant Director of Nursing 1 (ADON 1) on 2/21/25 at 11:57 A.M. The ADON stated she was never informed of an abuse allegation involving Resident 2 and CNA 1.</p> <p>A record review was conducted of CNA 1's employment file on 2/21/25 at 11:59 A.M. CNA 1 was hired on 9/20/22, and there was no documented evidence a criminal background check was completed prior to hire. CNA 1's last abuse training was conducted in June 2024.</p> <p>An Interview was conducted with the DON on 2/21/25 at 12:35 P.M. The DON stated he just sent a text to the Administrator (ADM), the facility ' s Abuse Coordinator this morning and asked if the incident was ever reported to the ADM, which the ADM replied no, he was not aware of any staff to resident abuse allegation. The DON stated any abuse allegation needed to be reported to the Abuse Coordinator and needed to be thoroughly investigated. The DON stated the allegation was never elevated up to the department heads, and it should have been reported and investigated. The DON stated the ball was dropped and all residents were at risk for potential harm and abuse.</p> <p>A follow-up interview was conducted with the DSD on 2/21/25 at 1:13 P.M. The DSD stated he could not recall the entire conversation with CNA 4 and LN 1, but he could not recall if the word, abuse was mentioned or not. The DSD stated he did not hear any more about the incident that day (1/31/25) and he assumed someone else was looking into it. The DSD stated the ball was dropped by several staff and the event should have been investigated to clarified as to what really happened.</p> <p>An interview was conducted with LN 3 on 2/21/25 at 1:34 P.M. LN 3 stated she was the charge nurse on the night shift 1/31/25., and she was notified by LN 1, that CNA 1 was being sent home. LN 3 stated she did not inquire as to why LN 1 was sending CNA 1 home, but she was told about the injury on Resident 2's heel. LN 3 stated she instructed LN 1 to document what occurred and to let other staff know what happened, and to also inform the DSD.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with CNA 3 on 2/25/25 at 8:02 A.M. CNA 3 stated she was working in the secured unit (a unit in the facility that houses patients who need a high level of supervision to prevent them from harming themselves or other) on the 1/31/25. CNA 3 stated she was responsible for watching a confused resident in the room next to Resident 2. CNA 3 stated she heard CNA 1 trying to direct Resident 2 back to his room. CNA 3 stated she could hear CNA 1 telling Resident 2 to sit down on his bed, and Resident 2 was yelling stop or something like that. CNA 3 stated she did not hear a crash or any other commotion inside</p> <p>Resident 2 's room. CNA 3 stated the next thing CNA 3 heard was CNA 1 asking LN 1 to check Resident 2's foot, because it was bleeding. CNA 3 stated she did not see anything, because she was focused on her own resident, in the room next door.</p> <p>An interview was conducted with LN 4 on 2/25/25 at 8:13 A.M. LN 4 stated she was working on the early morning of 1/31/25. LN 4 stated she was sitting at the nursing station with LN 1 and it was getting close to the end of her shift around 4 A.M. LN 4 stated Resident 2 was awake and walking around. LN 4 stated Resident 2 was observed fondling himself and then touching the medication cart. LN 4 stated LN 1 asked Resident 2 to stop touching her medication cart. LN 4 stated CNA 1 approached and was trying to re-direct Resident 2 back to his room. CNA 1 grabbed Resident 2 and walked him back to his room, while Resident 2 was resisting. LN 4 stated she next heard a loud noise, so she turned around and saw Resident 2 sitting on his bed. CNA 1 came out of the room minutes later and asked LN 1 to look at the resident because he noticed blood on the floor of the resident ' s room. LN 4 stated a few minutes later, she heard LN 1 say to CNA 1 to Step away, you just abused this patient, and CNA 1 replied, No I didn't. LN 4 stated CNA 1 looked confused and LN 1 ordered CNA 1 to leave the unit immediately. LN 4 stated the loud noise she heard sounded like a door slamming and she had never seen CNA 1 being aggressive or inappropriate with the residents.</p> <p>An interview was conducted with CNA 1 on 2/25/25 at 9:08 A.M. CNA 1 stated Resident 2 came out of his room and was next to the medication cart. CNA 1 stated Resident 2 started to fondle himself and then he was touching the medication. CNA 1 stated both LN 4 and R-LN 1 were sitting at the nurse's desk, opposite of the medication cart. CNA 1 stated he put his left hand on Resident 2's mid-section and started to walk the resident backwards towards his room. CNA 1 stated once in the room, it was a tight area trying to maneuver the resident past the main door and the bathroom door, and CNA 1 slipped, but caught himself before falling and the bathroom door slammed shut. CNA 1 stated once the bathroom door slammed, he believed Resident 2 got startled, because the resident started to yell, Help, help. CNA 1 stated he directed Resident 2 on his bed and then noticed blood on the floor. CNA 1 asked LN 1 to come into the room to assess the resident. When LN 1 came into the room she said to CNA 1, Why can't you be nice to the residents? You can just leave now. CNA 1 stated he was confused, and he clarified with LN 1 what she wanted, and she instructed him to leave the unit. CNA 1 stated he left the secured unit and called the lead CNA on the night shift, (CNA 4). CNA 1 stated he was instructed by CNA 4 and LN 3 to go to the lobby and to write a statement about what happened, which he did.</p> <p>A follow up interview was conducted with LN 1 on 2/25/25 at 2:05 P.M. LN 1 stated she clearly mentioned in the nursing note and in the nursing text message that there was abuse. LN 1 stated prior to the text message she had phoned the DSD and informed him of the staff to resident abuse. LN 1 stated she kept waiting for someone from the facility to contact her as part of the facility's investigation, but no one ever did, so she notified the State. LN 1 stated she felt CNA 1 was rough and impatient with the resident, which resulted in his injury. LN 1 stated as a mandated reporter she felt by documenting the event and informing the DSD, the incident would be investigated and reported.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the facility's policy, titled Abuse, Neglect, Exploration or Misappropriation-Reporting and Investigating, dated 2001, 1. If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or individual making the allegation immediately reports to his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying licensing the facility; .3. Immediately is defined as: a. within two hours of an allegation involving abuse .or b. within 24 hours of an allegation that does not involve abuse or a result of serious bodily injury.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess, document, and transmit Minimum Data Set (MDS-a clinical assessment tool), information to the Center for Medicare and Medicaid Services (CMS-A federal agency that oversees health insurance) regarding the preferred language for one of two residents (Resident 1), when reviewed for MDS Assessments</p> <p>As a result, CMS was uninformed of Resident 3 ' s language preference.</p> <p>Findings:</p> <p>Resident 1 was readmitted to the facility on [DATE], with diagnoses which included Parkinson ' s disease, (a progressive neurological disorder that affects movement, balance, and other bodily functions), per the facility ' s Admission Record.</p> <p>An observation was conducted of Resident 1 in her room on 2/21/25 at 10:52 A.M. Resident 1 was in bed, with the head of the bed slightly elevated. Resident 1 padded her mattress and stated No bueno, .mucho delore, no bueno (No good . much pain, no good). Resident 1 did not understand questions in English and a Spanish communication board was not present on her wall or in her dresser drawer.</p> <p>On 2/21/25, Resident 1 ' s clinical record was reviewed:</p> <p>According to the facility ' s quarterly Minimum Data Set, (MDS-a clinical assessment tool), dated 1/9/25, Section A, titled Identification Information, A1110-Language, listed Resident 1 with a preferred language of, English. The cognitive assessment score was 9, indicating moderately impaired cognition.</p> <p>According to the facility ' s care plan, titled Primary language is Spanish, revised 12/19/24, listed interventions to include, Staff to provide 1:1 room visit utilize Language line for communication to promote socialization .</p> <p>An observation, interview, and record review was conducted with the Minimum Data Set Nurse 1 (MDSN 1) on 12/21/25 at 12:27 P.M. The MDSN 1 reviewed the facility ' s quarterly MDS for Resident 1, dated 1/9/25, and stated, the assessment indicated the resident spoke English, which was incorrect because the care plan indicated the resident was Spanish speaking. The MDSN went to Resident 1 ' s room, which was empty and stated she could not find a Spanish Communication board, which the resident could use to communicate with staff.</p> <p>The MDSN interview continued stating the facility ' s quarterly MDS assessment, dated 1/9/25, was incorrect and she will need to modify the assessment immediately to correct it. The MDSN stated the harm for an incorrect assessment was that CMS did not have accurate information on the resident at the current time.</p> <p>An interview was conducted with the Director of Nursing (DON) on 2/21/25 at 12:35 P.M. The DON stated he expected all MDS information to be accurate.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record was reviewed on 2/21/25. According to the CMS Resident Assessment Instrument (a tool that helps nursing home staff assess a resident for MDS coding) Version 3.0 [NAME], dated October 2019, .Section A1110-Language: .Steps for Assessment: 1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff .</p>		