STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555431	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Hills Post Acute	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review the facility failed to correctly administer medications for one of six residents reviewed for competent nursing staff. (Resident 1) As a result of this deficient practice, the facility could not ensure medications were accurately and safely provided to residents. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included sequelae (after effect) of cerebral infarction (disrupted blood flow to the brain) and hypertension (high blood pressure) according to the facility's Admission Record. Resident 2 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction according to the facility's Admission Record. On 4/7/25 at 9:05 A.M., an unannounced onsite visit to the facility was conducted related to a medication error. During an interview on 4/7/25 at 9:05 A.M. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 received her roommate's (Resident 2) medications on 3/23/25. The ADON stated Resident 2 was no longer in the building and she had been discharged from the facility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/7/25 at 2:27 P.M. was conducted with LN 3. LN 3 stated she was the assigned medication nurse for Resident 1 on 3/23/25. LN 3 stated she was orienting LN 4 for medication pass on 3/23/25. LN 3 stated Resident 1 was in room [ROOM NUMBER], bed B and Resident 2 was in bed A. LN 3 stated she prepared medications for Resident 2 and labeled the medication cup with Resident 2's name. LN 3 stated she gave Resident 2's medication cup to LN 4 to give to [NAME] (Resident 2). LN 3 stated when she (LN4) was about to administer Resident 1's medications, LN 4 told LN 3 that she (LN 4) already gave Resident 1's medications. LN 3 stated LN 4 misunderstood her when she instructed LN 4 to give the medications to [NAME]. LN 3 stated LN 4 told her that she (LN 4) had heard to give medications to Bed B (Resident 1). LN 3 stated LN 4 gave Resident 1 the medications that she (LN 3) prepared for Resident 2. LN 3 further stated she should not give the cup of medications that she had prepared for another nurse because the medications could be given to the wrong resident. LN 3 stated she herself usually did not administer medications prepared by other nurses, but she had seen other nurses do it and thought it was the process at the facility. An interview on 4/7/25 at 3:39 P.M. was conducted with LN 4. LN 4 stated she was a new graduate nurse, and the facility assigned her to train for medication pass with a registry nurse (LN3) on 3/23/25. LN 4 stated, It was not really training, it was give this and give that. LN 4 stated, I didn't think of it at the time when she gave me the meds to give. LN 4 stated LN 3 instructed her to take Resident 1's vital signs (temperature, heart rate, blood pressure) and then to give the cup of medications . LN 4 stated, I heard, this is for bed B (Resident 1), and then I administered the medications to Resident 1. LN 4 stated LN 3 then gave her another cup of medications which she (LN 4) thought was for Resident 2. LN 4 stated during the medication pass Resident 2 told her that the medications in the cup were not her (Resident 2) medications, and the pain medication was not in the cup. LN 4 stated LN 3 then told her (LN 4) that she had given the wrong medications to Resident 1. Resident 1's record was reviewed on 4/7/25. Progress notes for Resident 1 was reviewed. A change in condition note dated 3/28/25 at 9:48 A.M. indicated Resident 1 was given her roommate's (Resident 2) medications. The progress notes indicated medications administered to Resident 1 were: Amlodipine [for blood pressure]10mg [milligrams], Carvedilol [for blood pressure] 25mg, Enoxaparin [blood thinner] 40mg, Losartan [for blood pressure]100mg, Levetiracetam [for seizures] 1500mg, Multivitamin, Valproic Acid [for seizures] 250mg, Acetaminophen-Codeine [strong pain medication] 300-30mg, Carvedilol 12.5mg, Lisinopril [for blood pressure] 40mg, Baclofen [muscle relaxant] 5mg, Oxycodone-Acetaminophen [strong and addictive pain medication] 5-325mg, Famotidine [for stomach acid] 40mg, Clopidogrel [blood thinner] 75mg, Pregabalin [for nerve pain and seizures] 75mg, Senna [stool softener]17.2mg, Vitamin D 5000 units . A total of 17 medications were incorrectly administered to Resident 1. Resident 1's care plan dated 3/23/25 indicated Resident 1, .was given medications not prescribed for her . An interview was conducted on 4/9/25 at 9:59 A.M. with LN 6. LN 6 stated she was the supervisor at the facility on 3/23/25. LN 6 stated the charge nurse (LN 5) notified her of the medication error. LN 6 stated LN 3 prepared 12 medications for Resident 2 and gave them to LN 4 to administer. LN 6 stated there were two residents in the room and LN 4 administered the medications to the wrong resident (LN 1). LN 6 stated LN 3's process of passing medications was not correct because LN 3 did not follow the five rights (the right resident, right drug, right dose, right route and right time) of the resident. An interview with the facility's Consultant Pharmacist (CP) was conducted on 4/10/25 at 3:03 P.M. The CP stated the nurse should never prepare a resident's medication then have another nurse administer them. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Assistant Director of Nursing (ADON) on 4/11/25 at 3:13 P.M. The ADON stated she expected licensed nurses to check for the right resident, right medication, right time and right dose to ensure accuracy of medication administration. The ADON further stated LNs should not give another nurse medications that he or she prepared because the other nurse would not know what was being given to the resident and it would be a medication error. A review of the facility's policy and procedure (P&P) titled, Administering Medication, dated April 2019 was conducted. The P&P indicated, .Medications are administered in a safe and timely manner .Medications are administered in accordance with prescriber orders .The individual administering medications verifies the resident's identity before giving the resident his/her medications .The individual administering medications checks the label THREE [3] times to verify the right resident, right medication, right dosage, right time and right method [route] .Medications ordered for a particular resident may not be administered to another resident .

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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 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** 46235 Based on interview, and record review, the facility failed to ensure medications were correctly administered according to the physician's order for one of six residents (Resident 1) reviewed for pharmacy services. As a result of this deficient practice, the facility could not ensure pharmaceutical services were safely provided to its residents. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included sequelae (after effect) of cerebral infarction (disrupted blood flow to the brain) and hypertension (high blood pressure) according to the facility's Admission Record. Resident 2 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction according to the facility's Admission Record. On 4/7/25 at 9:05 A.M., an unannounced onsite visit at the facility was conducted related to a medication error. During an interview on 4/7/25 at 9:05 A.M. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 received her roommate's (Resident 2) medications on 3/23/25. The ADON stated since then Resident 2 has been discharged from the facility. An interview on 4/7/25 at 10:27 A.M. was conducted with Licensed Nurse (LN) 2. LN 2 stated to ensure medication administration accuracy, he checked the resident's electronic medical record (EMR) for the medication list, dosage and directions. LN 2 stated he then checked the EMR for the correct resident's name, room number and the medication cards. LN 2 stated prior to administering the resident's medications he checked the resident's ID bracelet and/or asked the resident his or her name. An interview on 4/7/25 at 11:05 A.M. was conducted with LN 1, LN 1 stated prior to medication administration, she checked the name of the drug, dosage and scheduled time. LN 1 stated she checked the resident's ID wrist band for resident identification prior to giving medications to the resident. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/7/25 at 2:27 P.M. was conducted with LN 3. LN 3 stated she was the assigned medication nurse for Resident 1 on 3/23/25. LN 3 stated she was orienting LN 4 for medication pass on 3/23/25. LN 3 stated Resident 1 was in room [ROOM NUMBER], bed B and Resident 2 was in bed A. LN 3 stated she prepared medications for Resident 2 and labeled the medication cup with Resident 2's name. LN 3 stated she gave Resident 2's medication cup to LN 4 to give to [NAME] (Resident 2). LN 3 stated when she (LN4) was about to administer Resident 1's medications, LN 4 told LN 3 that she (LN 4) already gave Resident 1's medications. LN 3 stated LN 4 misunderstood her when she instructed LN 4 to give the medications to [NAME]. LN 3 stated LN 4 told her that she (LN 4) had heard to give medications to Bed B (Resident 1). LN 3 stated LN 4 gave Resident 1 the medications that she (LN 3) prepared for Resident 2. LN 3 further stated she should not give the cup of medications that she had prepared for another nurse because the medications could be given to the wrong resident. LN 3 stated she herself usually did not administer medications prepared by other nurses, but she had seen other nurses do it and thought it was the process at the facility. An interview on 4/7/25 at 3:39 P.M. was conducted with LN 4. LN 4 stated she was a new graduate nurse, and the facility assigned her to train for medication pass with a registry nurse (LN3) on 3/23/25. LN 4 stated, It was not really training, it was give this and give that. LN 4 stated, I didn't think of it at the time when she gave me the meds to give. LN 4 stated LN 3 instructed her to take Resident 1's vital signs (temperature, heart rate, blood pressure) and then to give the cup of medications . LN 4 stated, I heard, this is for bed B (Resident 1), and then I administered the medications to Resident 1. LN 4 stated LN 3 then gave her another cup of medications which she (LN 4) thought was for Resident 2. LN 4 stated during the medication pass Resident 2 told her that the medications in the cup were not her (Resident 2) medications, and the pain medication was not in the cup. LN 4 stated LN 3 then told her (LN 4) that she had given the wrong medications to Resident 1. Resident 1's record was reviewed on 4/7/25. The progress notes for Resident 1 was reviewed. A change in condition note dated 3/28/25 at 9:48 A.M. indicated Resident 1 was given her roommate's (Resident 2) medications. The progress notes indicated medications administered to Resident 1 were: Amlodipine [for blood pressure]10mg [milligrams], Carvedilol [for blood pressure] 25mg, Enoxaparin [blood thinner] 40mg, Losartan [for blood pressure]100mg, Levetiracetam [for seizures] 1500mg, Multivitamin, Valproic Acid [for seizures] 250mg, Acetaminophen-Codeine [strong pain medication] 300-30mg, Carvedilol 12.5mg, Lisinopril [for blood pressure] 40mg, Baclofen [muscle relaxant] 5mg, Oxycodone-Acetaminophen [strong and addictive pain medication] 5-325mg, Famotidine [for stomach acid] 40mg, Clopidogrel [blood thinner] 75mg, Pregabalin [for nerve pain and seizures] 75mg, Senna [stool softener]17.2mg, Vitamin D 5000 units . A total of 17 medications were incorrectly administered to Resident 1. Resident 1's care plan dated 3/23/25 indicated Resident 1, .was given medications not prescribed for her . An interview was conducted on 4/9/25 at 9:59 A.M. with LN 6. LN 6 stated she was the supervisor at the facility on 3/23/25. LN 6 stated the charge nurse (LN 5) notified her of the medication error. LN 6 stated LN 3 prepared 12 medications for Resident 2 and gave them to LN 4 to administer. LN 6 stated there were two residents in the room and LN 4 administered the medications to the wrong resident (LN 1). LN 6 stated LN 3's process of passing medications was not correct because LN 3 did not follow the five rights (the right resident, right drug, right dose, right route and right time) of the resident. (continued on next page)

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Country Hills Post Acute	1580 Broadway El Cajon, CA 92021

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the facility's Consultant Pharmacist (CP) was conducted on 4/10/25 at 3:03 P.M. The CP stated to ensure medication administration accuracy, the nurse should check the electronic medical record (EMR) against the medication card for the right resident, right medication, right route and the right time. The CP further stated the nurse should never prepare a resident's medication then have another nurse administer them. A review of the facility's pharmacy policy and procedure (P&P) manual dated July 2022 was conducted. The P&P indicated, .MEDICATION ADMINISTRATION . Drug Administration refers to the act in which a single dose of prescribed drug .is given to a resident by an authorized person .The complete act of administration involves removing an individual dose .verifying the dose with the prescriber's orders and promptly giving the dose to the proper resident .

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on interview and record review the facility failed to correctly administer medications for one of six residents reviewed for medication errors. (Resident 1) This failure has the potential affect Resident 1's health and wellbeing. In addition, this failure has the potential to place other residents at risk for medication errors. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses which included sequelae (after effect) of cerebral infarction (disrupted blood flow to the brain) and hypertension (high blood pressure) according to the facility's Admission Record. Resident 2 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction according to the facility's Admission Record. On 4/7/25 at 9:05 A.M., an unannounced onsite visit at the facility was conducted related to a medication error. During an interview on 4/7/25 at 9:05 A.M. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 received her roommate's (Resident 2) medications on 3/23/25. The ADON stated Resident 2 had been discharged from the facility since the incident had occured. Resident 1's record was reviewed on 4/7/25. During a review of the MDS (a clinical assessment tool) dated 3/25/25 for Resident 1, the MDS listed a cognitive (thinking, reasoning, or remembering) score of 14, which indicated that Resident 1's cognition was intact. An observation and interview was conducted on 4/7/25 at 9:43 A.M. with Resident 1 in her room. Resident 1 was in bed and stated she was sleepy. Resident 1 stated she was not aware of receiving her roommate's medications. Resident 1 stated her mother was involved in her care and did not inform her about receiving her roommate's medications. Resident 1 stated she had not had any change in her condition in the last two weeks and she was fine. Resident 1 then closed her eyes. An interview on 4/7/25 at 10:27 A.M. was conducted with Licensed Nurse (LN) 2. LN 2 stated to ensure medication administration accuracy, he checked the resident's electronic medical record (EMR) for the medication list, dosage and directions. LN 2 stated he then checked the EMR for the correct resident's name, room number and the medication cards. LN 2 stated prior to administering the resident's medications he checked the resident's ID bracelet and/or asked the resident his or her name. An interview on 4/7/25 at 11:05 A.M. was conducted with LN 1, LN 1 stated prior to medication administration, she checked the name of the drug, dosage and scheduled time. LN 1 stated she checked the resident's ID wrist band for resident identification prior to giving medications to the resident. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/7/25 at 2:27 P.M. was conducted with LN 3. LN 3 stated she was the assigned medication nurse for Resident 1 on 3/23/25. LN 3 stated she was orienting LN 4 for medication pass on 3/23/25. LN 3 stated Resident 1 was in room [ROOM NUMBER], bed B and Resident 2 was in bed A. LN 3 stated she prepared medications for Resident 2 and labeled the medication cup with Resident 2's name. LN 3 stated she gave Resident 2's medication cup to LN 4 to give to [NAME] (Resident 2). LN 3 stated when she (LN4) was about to administer Resident 1's medications, LN 4 told LN 3 that she (LN 4) already gave Resident 1's medications. LN 3 stated LN 4 misunderstood her when she instructed LN 4 to give the medications to [NAME]. LN 3 stated LN 4 told her that she (LN 4) had heard to give medications to Bed B (Resident 1). LN 3 stated LN 4 gave Resident 1 the medications that she (LN 3) prepared for Resident 2. LN 3 further stated she should not give the cup of medications that she had prepared for another nurse because the medications could be given to the wrong resident. LN 3 stated she herself usually did not administer medications prepared by other nurses, but she had seen other nurses do it and thought it was the process at the facility. An interview on 4/7/25 at 3:39 P.M. was conducted with LN 4. LN 4 stated she was a new graduate nurse, and the facility assigned her to train for medication pass with a registry nurse (LN3) on 3/23/25. LN 4 stated, It was not really training, it was give this and give that. LN 4 stated, I didn't think of it at the time when she gave me the meds to give. LN 4 stated LN 3 instructed her to take Resident 1's vital signs (temperature, heart rate, blood pressure) and then to give the cup of medications . LN 4 stated, I heard, this is for bed B (Resident 1), and then I administered the medications to Resident 1. LN 4 stated LN 3 then gave her another cup of medications which she (LN 4) thought was for Resident 2. LN 4 stated during the medication pass Resident 2 told her that the medications in the cup were not her (Resident 2) medications, and the pain medication was not in the cup. LN 4 stated LN 3 then told her (LN 4) that she had given the wrong medications to Resident 1. Resident 1's record was reviewed on 4/7/25. Resident 1's progress notes were reviewed. A change in condition note dated 3/28/25 at 9:48 A.M. indicated Resident 1 was given her roommate's (Resident 2) medications. The progress notes indicated medications administered to Resident 1 were: Amlodipine [for blood pressure]10mg [milligrams], Carvedilol [for blood pressure] 25mg, Enoxaparin [blood thinner] 40mg, Losartan [for blood pressure]100mg, Levetiracetam [for seizures] 1500mg, Multivitamin, Valproic Acid [for seizures] 250mg, Acetaminophen-Codeine [strong pain medication] 300-30mg, Carvedilol 12.5mg, Lisinopril [for blood pressure] 40mg, Baclofen [muscle relaxant] 5mg, Oxycodone-Acetaminophen [strong and addictive pain medication] 5-325mg, Famotidine [for stomach acid] 40mg, Clopidogrel [blood thinner] 75mg, Pregabalin [for nerve pain and seizures] 75mg, Senna [stool softener]17.2mg, Vitamin D 5000 units . A total of 17 medications were incorrectly administered to Resident 1. Resident 1's care plan dated 3/23/25 indicated Resident 1, .was given medications not prescribed for her . An interview was conducted on 4/9/25 at 9:59 A.M. with LN 6. LN 6 stated she was the supervisor at the facility on 3/23/25. LN 6 stated the charge nurse (LN 5) notified her of the medication error. LN 6 stated LN 3 prepared 12 medications for Resident 2 and gave them to LN 4 to administer. LN 6 stated there were two residents in the room and LN 4 administered the medications to the wrong resident (LN 1). LN 6 stated LN 3's process of passing medications was not correct because LN 3 did not follow the five rights (the right resident, right drug, right dose, right route and right time) of the resident. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Assistant Director of Nursing (ADON) on 4/9/25. The ADON stated LN 3 did not properly communicate to LN 4. The ADON stated to prevent medication errors, the nurse who prepared the medication should administer the medications and not give them to another nurse to administer. An interview with the facility's Consultant Pharmacist (CP) was conducted on 4/10/25 at 3:03 P.M. The CP stated a nurse should never prepare a resident's medication then have another nurse administer them. The CP further stated Resident 1 was at risk for significant low blood pressure and increased sedation which placed the resident at increased risk for falls. A review of the facility's policy and procedure (P&P) titled, Administering Medication, dated April 2019 was conducted. The P&P indicated, .Medications are administered in a safe and timely manner .Medications are administered in accordance with prescriber orders .The individual administering medications verifies the resident's identity before giving the resident his/her medications .The individual administering medications checks the label THREE [3] times to verify the right resident, right medication, right dosage, right time and right method [route] .Medications ordered for a particular resident may not be administered to another resident .