

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 03/03/2026
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** Based on observation, interview, and record review the facility failed to ensure timely reporting of an injury of unknown origin to the California Department of Public Health (CDPH), Ombudsman, and/or law enforcement (LE) in accordance with the facility's abuse reporting policy and procedures, for one of three sampled residents (Resident 1). This deficient practice placed one resident (Resident 1) at risk for uninvestigated abuse, neglect, or mistreatment and delayed protective oversight by the appropriate authorities. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). A record review of Resident 1's MDS (Minimum data set: nursing facility assessment tool) dated 1/27/26 indicated that Resident 1 was rarely or unable to understand others or make self-understood and had severe cognitive (the mental processes that take place in the brain, including thinking, attention, language, learning, memory, and perception) deficits to make decisions. On 3/2/26 at 9:21 A.M., a telephone interview with the complainant ECPD (El Cajon Police Department) Officer was conducted. The ECPD Officer stated Resident 1, a non-verbal resident, had a bruise on the left eye of unknown origin. The officer confirmed ECPD responded to a call for service at the skilled nursing facility on 1/30/26 and notified CDPH (California Department of Public Health) and the Ombudsman (a patient advocate who investigates and helps to resolve complaints and concerns for long term care facilities) about the incident. The ECPD Officer stated there was suspicious documentation, and staff was unable to explain how the injury occurred. On 3/2/26 at 11:40 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated they (the facility) had not called the ECPD. The DON verified that the ECPD Officer was at the facility because they (ECPD) had received a report that Resident 1 had an injury of unknown origin. The DON stated the facility had identified Resident 1 with a bruise to the left eye as an injury of unknown origin and had conducted an internal investigation. The DON stated staff believed the bruise may have occurred when Resident 1's head leaned against the bed rail. The DON stated the injury was unwitnessed and of unknown origin, but the facility did not report the incident to the required entities (CDPH, Ombudsman and/or ECPD) and/or submitted a required report because staff believed the ECPD Officer did not identify wrongdoing. The DON further stated the incident should have been reported to all required entities (CDPH, Ombudsman and/or ECPD). On 3/2/26 at 11:45 A.M., an interview was conducted with the Administrator (ADM), in the DON's office. The ADM stated the facility did not report Resident 1's injury of unknown origin to the required entities because the responding ECPD Officer had indicated there was no evidence of abuse. The ADM stated the facility relied on the officer's conclusion and did not complete the required reporting to all required entities. On 3/2/26 at 4:07 P.M., an observation was conducted in Resident 1's room. Resident 1 had padded bed rails on both sides of her bed. Resident 1 was non-verbal and was unable to be interviewed. On 3/2/26 at 4:10 P.M., an interview and record review were conducted with Licensed Nurse (LN) 1, in the third-floor nursing station. LN 1 stated Resident 1 had a change in skin condition with discoloration to the left eye identified on 1/29/26. LN 1 stated injury was unwitnessed, (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

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 03/03/2026
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>and it was unknown how Resident 1 was injured. LN 1 stated Resident 1's injury should have been reported to all required entities within 24 hours to initiate an investigation and ensure Resident 1's safety. LN 1 stated she did not see documentation indicating the incident had been reported to the required entities. On 3/3/26 at 3:25 P.M., an interview was conducted with the Social Service Director (SSD), in the ADM's office. The SSD stated staff identified discoloration to Resident 1's face on 1/29/26. The SSD stated nursing staff believed the bruise may have occurred when Resident 1 leaned her head against the bed rail. The SSD stated the injury appeared to be a yellow bruise and Resident 1 was at baseline with no signs of distress when observed. The SSD further stated injuries of unknown origin should be reported to CDPH, law enforcement, and the Ombudsman within 24 hours, or immediately within two hours if serious injuries were sustained to ensure all resident safety and initiate an investigation. On 3/5/26 at 5:30 P.M., an interview was conducted with ECPD Officer, by telephone. ECPD Officer stated he and another officer observed discoloration to Resident 1's left eye (1/30/26) which appeared as a light-yellow bruise that was fading. On 3/5/26 at 5:48 P.M., an exit interview was conducted with the DON, by telephone. The DON stated injuries of unknown origin and suspected abuse should be reported to ensure resident (all facility staff) safety and to allow an investigation to be conducted in accordance with reporting requirements. A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated December 2017, indicated .1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law</p>		