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 03/18/2026
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)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one of three residents reviewed for discharges (Resident 1) to return to the facility following a hospitalization for aggressive verbal and physical behavior.This failure had the potential for Resident 1 to not receive continuity of care, violated her right to return to the facility per behold agreement, and extended Resident 1's hospital stay unnecessarily.Findings:According to the facility's admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses which included psychotic disorder (a mental health condition causing a loss of contact with reality) with hallucinations due to known physiological condition (related to the function of the body or parts of the body, such as the brain), and dementia (loss of memory, problem-solving, and other thinking skills).During a record review, the Minimum Data Set (MDS- a federally mandated assessment tool), dated 1/29/26, indicated Resident 1 had a Brief Interview For Mental Status (BIMS- a tool to assess cognition of 6, which indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 was dependent on staff for all Activities of Daily Living (ADL's- activities such as eating, dressing, toileting, and bathing) as well as bed mobility (rolling to the left and right side, changing position from sitting to lying and vice versa).During an interview with the Director of Nursing (DON) on 3/13/26 at 4:32 P.M., the DON stated on 2/4/26, during resident care, Resident 1 swung at Certified Nursing Assistant (CNA) 1 and was sent to the hospital for physically aggressive behavior. The DON stated Resident 1 had psychiatric diagnoses, however she was unaware of any other incidents of physically aggressive behavior prior to 2/4/26.During an interview with Certified Nursing Assistant (CNA) 1 on 3/18/26 at 11:54 A.M., CNA 1 stated Resident 1 had been on 1:1 monitoring (one staff assigned to stay with the resident at all times) since admission and required two staff members' assistance with all ADL's. CNA 1 stated on 2/4/26, during toileting assistance, Resident 1 swung her fist at CNA 1 and hit her in the face. CNA 1 stated I was pulling up her brief, and she got me pretty good. She punched me with a closed fist. When I stepped back, she came at me. CNA 1 stated Resident 1 was Coming at us.she was mad saying ?Get out of the room.' CNA 1 stated staff did not leave the room because Resident 1 required 1:1 monitoring for safety. CNA 1 stated she provided 1:1 supervision for Resident 1 multiple times, and stated there were no prior incidences of Resident 1 having assaultive behaviors towards her or any other person.During an interview with the Social Services Director (SSD) on 3/18/26 at 1:22 P.M., the SSD stated Resident 1 was confused due to dementia, and exhibited impulsive behavior, such as yelling at staff and attempting to stand up unassisted. The SSD stated the incident of Resident 1 hitting a staff member on 2/4/26 was Resident 1's first incident of physical assault at the facility. The SSD stated, That was her first time being assaultive. There was no indicator that she was assaultive, but she has exhibited impulsive behavior.During a follow-up interview with the DON on 3/18/26 at 3:33 P.M., the DON stated the last known communication she had with the hospital was on 2/5/26. The DON stated the facility refused to accept Resident 1 back to the facility on 2/5/26, because they did not believe her behaviors had been stabilized at the hospital. The DON stated she gave her cell phone number to the hospital contact and .once she's stable, we will take her back. The DON stated Resident 1 did not (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555431	A. Building B. Wing	03/18/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return to the facility because, We never received any call [from the acute care hospital]. The DON stated since 2/5/26, she does not know if anyone at the facility attempted to call the hospital for an update on Resident 1's status.During a telephone interview with the Administrator (ADMIN) on 3/27/26 at 2:23 P.M., the ADMIN stated sending Resident 1 to the hospital was a transfer to stabilize the resident, and not considered a discharge. The ADMIN acknowledged the facility did not allow Resident 1 to return to the facility because of the assaultive behavior on 2/4/26, but stated the facility did not have any documented attempts at contacting the hospital to see if Resident 1 had been stabilized and/or was ready to return to the facility. The ADMIN stated his expectation was for the facility to follow its policy regarding transfers and bedholds to ensure residents rights to return to the facility.During a review of the facility's policy titled Bed-Holds and Returns, revised 10/22, the policy indicated, Following a hospitalization, residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred.

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 03/18/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three of five sampled residents were free from significant medication errors (an error which causes the resident discomfort or jeopardizes his or her health and safety) when: 1. Resident 1 received a fentanyl patch (a potent pain medication) which belonged to another resident (Resident 2) without a physician's order. 2. Resident 2 was not administered a fentanyl patch by nursing staff as ordered by the physician. 3. A fentanyl patch was administered to Resident 2 without verification that the previously administered fentanyl patch was removed. 4. A Licensed Nurse (LN) 3 did not properly identify (establish or indicate who someone is) Resident 3 prior to administering medications. As a result of these failures, Resident 1 was placed at risk for adverse reactions (an undesired effect of a drug) due to receiving a potent opioid (a type of drug used to reduce moderate to severe pain) without a physician's order. In addition, these failures placed Resident 2 at risk for experiencing increased pain and discomfort due to not receiving prescribed medications. Furthermore, Resident 2 was placed at risk for experiencing increased effects of Fentanyl. These failures had the potential to cause serious injury, harm, impairment, or death for Resident 1 and Resident 2.Findings: On 3/13/26 at 4:25 P.M., an unannounced onsite visit was conducted to investigate an anonymous complaint regarding a medication error in which a Fentanyl Transdermal (a route of medication administration in which the drug is delivered through the skin) Patch was administered to the wrong resident.1.Review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (a lung disease which makes it difficult to breathe), dependence on renal dialysis (a procedure that removes toxins from the lungs when the kidneys have failed), and Alzheimer's disease (a disease that affects memory, thinking, and behavior).A review of Resident 1's Minimum Data Set (MDS- a standardized assessment tool) dated 3/4/26 indicated Resident 1 was unable to complete a Brief Interview for Mental Status (BIMS- a tool to assess cognition -acquiring knowledge mentally or thinking skills). The MDS indicated Resident 1 had a memory problem and severely impaired cognitive skills.During an interview with the Director of Nursing (DON) on 3/13/26 at 4:35 P.M., the DON stated on 3/4/26 at approximately 7 A.M., Resident 1 had a change in condition and was transferred to an acute care hospital via 911 for difficulty breathing. The DON stated the facility was informed by the hospital that a Fentanyl Transdermal Patch was found on Resident 1. The DON further stated the fentanyl patch was intended for a different resident (Resident 2) and that Resident 1 did not have an order for a fentanyl patch. The DON stated an investigation was initiated, and the facility determined on 3/3/26, Licensed Vocational Nurse (LN) 1 administered the fentanyl patch to Resident 1 without a physician's order.During a telephone interview with Licensed Nurse (LN) 1 on 3/17/26 at 12:08 P.M., LN 1 stated on 3/3/26 he was on duty as the medication nurse for Resident 1 and Resident 2. LN 1 stated while providing care for Resident 1, he placed a Fentanyl Patch on her chest. LN 1 stated on 3/4/26, he received a call from the Director of Nursing (DON) and was informed he administered the fentanyl patch to the wrong resident. LN 1 stated his employment with the facility was terminated on 3/5/26 due to the medication error. During a record review of Resident 1's Electronic Health Record (EHR), a Respiratory Note dated 3/4/26 a 7:10 A.M. indicated, Nurse notified writer to assess pt [patient] due to increase [sic] WOB [Work of Breathing- energy expended by the respiratory muscles to move air in and out of the lungs]. Upon assessment pt was found on 2L [a flow rate of oxygen] NC [nasal cannula- plastic tubing placed in the nostrils used to deliver oxygen] in semi-Fowlers position [a position where an individual is laying on their back, with the head raised at an angle between 30 and 40 degrees], spo2 [a percentage of oxygen] 83% RR [respiratory rate] 40 HR [heart rate] 115. Crackles auscultated bilateral lobes. Oral sx [suction] performed with mod [moderate] amount of white, frothy secretions obtained. Ptnoted [sic] to have weak cough effort.During a record review of (continued on next page)

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 03/18/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 1's EHR, a progress note dated 3/4/26 at 7:15 A.M. titled Nurse's Note indicated, Upon report resident was noted with labored [sic] breathing, desaturating 83%, and diaphoretic [sweating]. RT [Respiratory Therapist] assessed resident placed on non-rebreather [an emergency medical device used to deliver high-concentration oxygen to patients experiencing respiratory distress] , MD [Medical Doctor] notified with orders to have resident sent out via 911 for further evaluation.During a record review, the SBAR [Situation, Background, Assessment, Recommendation] Communication Form dated 3/4/26 at 9 A.M. indicated, This writer received call from [Acute Care Hospital] and was notified the upon admission [Resident 1] had Fentanyl [a potent opioid medication used to treat chronic pain] patch w/o [without] order. PCP (Primary Care Physician), DON (Director of Nursing), ADMINISTRATOR, AND RP NOTIFIED.During a record review, the Progress Note dated 3/12/26 at 10 A.M. indicated, Placed call to [Hospital Name] to obtain status update on patient, Transferred to MICU [Medical Intensive Care Unit- a specialized hospital department providing 24/7 care for critically ill patients].spoke with RN and was notified patient had expired on 03/10/2026 due to respiratory failure.During a concurrent telephone interview and record review with the Pharmacy Consultant (PC) on 3/25/26 at 3:58 P.M., the PC stated Resident 1 had only been prescribed acetaminophen (a non-opioid, over the counter medication pain medication) at the facility. The PC stated Resident 1 was assessed to be opioid naive (an individual who had not used opioid medications regularly, and whose bodies were not accustomed to opioid medications). The PC stated, You don't want to give the fentanyl patch to anyone who hasn't taken any other opioids.it's the last line of medication to give. The PC further stated as an opioid naive individual who was given fentanyl, Resident 1 was placed at higher risk for respiratory depression, sedation, and confusion.During a review of the facility provided drug reference sheet for Fentanyl Transdermal System, the document indicated, Schedule 2 opioid substances which include fentanyl.have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression.Since the peak fentanyl concentrations generally occur between 20 and 72 hours of treatment; prescribers [licensed healthcare professions who are authorized to prescribe medications] should be aware that serious or life threatening hypoventilation [breathing at an abnormally slow rate] may occur, even in opioid-tolerant patients [patients whose bodies have adjusted to receiving opioids on a regular basis] during the initial application period. The drug reference sheet further indicated, [Fentanyl Transdermal Patch] should be used with extreme caution in patients with significant chronic obstructive pulmonary disease.In such patients, even usual therapeutic doses of [Fentanyl Transdermal Patch] may decrease respiratory drive to the point of apnea [temporary cessation of breathing].Chronic Pulmonary Disease.Because potent opioids can cause serious or life-threatening hypoventilation, [Fentanyl Transdermal Patch] should be administered with caution to patients with pre-existing medical conditions predisposing them to hypoventilation. In such patients, normal analgesic [pain relieving] doses of opioids may further decrease respiratory drive to the point of respiratory failure.During a review of the Medication Guide for Fentanyl Transdermal System, revised 2009, provided by the facility, the guide indicated, Fentanyl is a very strong opioid narcotic pain medicine that can cause serious and life threatening breathing problems can happen because of an overdose or if the dose you are using is too high for you.A [Fentanyl Transdermal Patch] must be used only on the skin of the person for whom it was prescribed.During a review of the facility's undated policy titled Administering Medications, the policy indicated, Medications are administered in accordance with prescriber orders.The individual administering mediations 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) of administration before giving the medication.Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services.2. During a record review, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which (continued on next page)

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 03/18/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	included traumatic subarachnoid hemorrhage (a life-threatening emergency bleeding into the space surrounding the brain), and fall.During a record review, the History and Physical dated 5/16/25 indicated Resident 2 had a diagnosis of pain.During a record review, the MDS dated [DATE] indicated Resident 2 had a BIMS of 3, which indicated severe cognitive impairment.During an interview with the Director of Nursing (DON) on 3/13/26 at 4:35 P.M., the DON stated Resident 2 was on hospice services and received Fentanyl for pain management and comfort. The DON stated on 3/3/26 Resident 2 was scheduled to receive a Fentanyl Patch. The DON stated the Fentanyl Patch was mistakenly given to Resident 1.During a telephone interview with Licensed Nurse (LN) 1, on 3/17/26 at 12:08 P.M., LN 1 stated on 3/3/26 he was the medication nurse assigned to Resident 1 and Resident 2. LN 1 stated on 3/3/26 during the morning shift, he was replacing Resident 1's gastrostomy tube (GT- a tube inserted into the stomach to administer food and/or medications) dressing, and he had Resident 2's Fentanyl Patch with him. LN 1 acknowledged he did not administer the Fentanyl Patch to Resident 2 as ordered by the physician.During an interview with LN 2 on 3/18/26 at 12:14 P.M., LN 2 stated on 3/4/26 she was informed that Resident 2 did not receive a Fentanyl Patch on 3/3/26. LN 2 stated a skin check was conducted on Resident 2 to see if she had a Fentanyl Patch on. LN 2 stated on 3/4/26, a Fentanyl Patch could not be located on Resident 2. LN 2 stated, it was a medication omission when [Resident 2] didn't receive the patch. and it was important to ensure Resident 2 received all medications as ordered to manage her pain and keep her comfortable.During a review of the facility's undated policy titled Administering Medications, the policy indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders.Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.3. During a medication administration observation on 3/17/26 at 9:42 A.M., Licensed Vocational Nurse (LN) 3 was observed preparing medications for Resident 2. LN 3 stated one of the medications was a Fentanyl Transdermal Patch. LN 3 stated per the Electronic Medication Record (EMAR), the previously applied patch was on Resident 2's right arm. LN 3 stated he needed to remove the previously applied patch prior to administering the new patch.On 3/17/26 at 10:06 A.M., LN 3 was observed administering the Fentanyl Transdermal Patch to the right side of Resident 2's chest. LN 3 stated he could not locate the previously applied patch on Resident 2's right arm. LN 3 was observed lifting Resident 2's left arm, and he stated he did not see a Fentanyl patch on the left arm either. LN 3 made no further attempts, such as a full body/skin check, to locate the previously applied Fentanyl patch.During a record review of Resident 2's Physician's Orders dated 3/5/26, indicated, fentanyl Transdermal Patch 72 Hour 12 MCG/HR Apply 1 patch transdermal every 72 hours for pain/comfort and remove per schedule.On 3/17/26 at 10:25 A.M. an interview was conducted with LN 3. LN 3 stated the purpose of removing the previously applied Fentanyl Transdermal Patch was to ensure Resident 2 did not receive too much of the medication. LN 3 stated if the previously applied patch was still on Resident 2's skin, and a new patch was applied, we don't want her to get too much of it.During an interview with the Director of Nursing (DON) on 3/17/26 at 10:40 A.M., the DON stated there was no system in place to monitor the placement of a transdermal patch every shift. The DON stated her expectation was for the medication nurse to do a thorough body check for the previous patch, prior to applying the new Fentanyl Transdermal Patch. The DON stated it was important to try to locate the previously applied patch to prevent the resident from becoming overmedicated.During a review of the Medication Guide for Fentanyl Transdermal System, provided by the facility, the guide indicated, Do not wear more than one [Fentanyl Transdermal System] at a time, unless your doctor tells you to do so.During a review of the facility's policy titled Administering Medications, the policy did not provide guidance on the removal and/or application of transdermal medications. 4. According to the admission Record, Resident 3 was admitted on [DATE] with diagnoses which included chronic pain and type 2 diabetes.A review of Resident 3's Minimum Data Set (MDS- a federally mandated assessment tool) dated 2/17/26 indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to measure (continued on next page)

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 03/18/2026
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)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cognition) of 15, which indicated intact cognition.On 3/17/26 at 8:50 A.M., a medication administration observation was conducted with Licensed Vocational Nurse (LN) 3 for Resident 3. Resident 3 was observed without an identification band on her arms. LN 3 proceeded to administer eye drops (brimonidine-a medication used to treat glaucoma, an eye disease) to Resident 3. LN 3 then handed Resident 3 a plastic cup of medications. Resident 3 was observed consuming her medications. LN 3 did not confirm Resident 3's identification prior to administering her medications. The following medications were administered to Resident 3:-iron (mineral supplement) 65 mg (milligrams- a unit of measurement) , 1 tablet-baclofen (muscle relaxant) 5mg, 1 tablet-Eliquis (blood thinner) 5mg, 1 tablet-duloxetine (a medication to treat depression and/or nerve pain) 30 mg, 1 capsule-gabapentin (a medication used to treat nerve pain) 100 mg, 1 capsule-multivitamin with minerals, 1 tablet-vitamin b12 1000 mcg (micrograms- a unit of measurement) 1 tablet-lidocaine patch 4% (a medication used to treat pain) 1 patch to each knee-brimonidine (medication primarily used to lower high eye pressure) 1 drop in the right eye-dorzolamide 2% (a medication used to treat glaucoma) 1 drop in both eyes.On 3/17/26 at 9:20 A.M., an interview was conducted with LN 3. LN 3 stated prior to administering medications, he should have identified the resident. LN 3 stated one of the identification methods was to check Resident 3's arm band and birthday, and to compare to the Electronic Health Record. LN 3 stated since Resident 3 did not have an identification band, he should have checked her picture in the Electronic Health Record and offer an ID band to Resident 3. LN 3 stated it was important to identify residents prior to administering medications to avoid any medication errors. LN 3 stated, it's one of the rights of med pass.During an interview with the Director of Nursing on 3/17/26 at 10:40 A.M., the DON stated it was her expectation that licensed nurses identify residents prior to administering medications. The DON stated methods of identification included checking the residents' identification bands for the name and date of birth , then comparing against the electronic health record. The DON stated if the resident did not have an identification band, the licensed nurse should use their picture in the EHR. The DON further stated if the resident did not have a picture in the EHR, two staff members should identify the resident. The DON stated it was important to identify the correct resident prior to administering medications to avoid medication errors.During a review of the facility's policy titled Administering Medications, the policy indicated, The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel.On 3/17/26 at 3:08 P.M., a meeting was conducted with the Administrator (ADM), the Director of Nursing (DON) and Area Lead (AL). The California Department of Public Health (CDPH) Pharmacy Consultant (PC) was also present. The CDPH District Office Manager and Supervisor were present via telephone. The facility was notified of Immediate Jeopardy (IJ- is the highest-level deficiency citation in healthcare, occurring when a provider's noncompliance causes or is likely to cause serious injury, harm, impairment, or death to a patient. It triggers mandatory, urgent corrective action, with potential Medicare/Medicaid termination within 23 days if not resolved). The (IJ) related to the facility's failure to identify the correct resident prior to administering a Fentanyl Transdermal Patch on 3/3/26, and the facility's failure to verify the location of a previously administered Fentanyl Transdermal Patch prior to applying a new patch on 3/17/26. This resulted in placing Resident 1 at risk for serious effects due to receiving a medication that was not ordered for her. Additionally, this failure placed Resident 2 at risk for becoming overmedicated from a potent opioid medication. The IJ Template was provided to the ADM and DON via email. The facility initiated a plan to remove the IJ. On 3/17/26 at 4:25 P.M., the ADM and DON provided a removal plan. The removal plan was reviewed and was not acceptable.On 3/17/25 at 4:52 P.M., the ADM and DON re-submitted a removal plan. The removal plan was reviewed and was not acceptable.On 3/17/26 at 5:43 P.M., the ADM and DON re-submitted a removal plan. The removal plan was reviewed and was not acceptable.On 3/17/26 at 6:23 P.M., the ADM and DON re-submitted a removal plan. The removal plan was reviewed and accepted. The IJ was removed. (continued on next page)

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 03/18/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.Immediate Protective ActionsMedical records did a sweep of all residents who were receiving narcotic pain patches. The Assistant Director of Nursing conducted a visual check to ensure narcotic pain patches were applied as ordered.The Medical Records Department did a facility-wide sweep for residents' identification bands on 3/17/26. Residents who did not have an identification band were provided with one, with the following resident information: Name, date of birth , doctor's name, facility address and phone number. 2. Corrective Measure for the Affected ResidentResident 1 was transferred to an acute care facility on 3/4/26 and had expired on 3/10/26. 3. Facility-Wide Systemic ChangesAn extra check was added for residents who had an order for narcotic pain patches. Licensed nurses are now required to check for the location of the patches every shift to ensure missing patches were identified prior to the next administration date.All licensed nurses were required to attend an in-service prior to administering any medications.

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 03/18/2026
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain accurately documented records when Licensed Nurse (LN) 1 documented he removed a fentanyl (a potent medication used to control pain) patch (a medication that is applied to the skin) although Resident 2 did not have a fentanyl patch to be removed at that time.This failure resulted in inaccurate documentation in Resident 2's medical record and had the potential to negatively affect her treatment and assessment.Findings:During an interview with the Director of Nursing (DON) on 3/17/26 at 3:16 P.M., the DON stated that LN 1 documented he removed Resident 2's fentanyl patch on 2/28/26 on Resident 2's February 2026 Medication Administration Record (MAR, an official legal document that has a complete and accurate record of all medications administered to a resident to ensure patient safety). The DON stated there was an order to start the fentanyl patch on 2/25/26, but the medication was not delivered until 2/28/26. The DON stated Resident 2 did not have a patch to be removed on 2/28/26.A review of Resident 2's medical record indicated she had an order for fentanyl transdermal (through the skin) patch 72 hour (left on for 72 hours, or 3 days) 12 mcg (micrograms, unit of measure)/hr (hour, unit of measure for time) - apply 1 patch transdermally every 72 hours for pain/comfort and remove per schedule, initiated 2/25/26. Resident 2's February 2026 MAR indicated 9 on 2/25/26 at 12:24 P.M. for the fentanyl patch. The MAR legend for codes indicated, 9 = Other/ See [sic] Nurses Notes. A progress note dated 2/25/26 at 12:25 by LN 4 indicated, .awaiting delivery. Resident 2's February 2026 MAR also indicated a fentanyl patch was removed on 2/28/26 at 11:56 A.M.During an interview with the DON on 3/18/26 at 3:46 P.M., the DON stated Resident 2 did not receive a fentanyl patch on 2/25/26. DON stated there was nothing to remove on 2/28/26, based on the controlled drug record (CDR, count sheet used to track controlled medications). The DON stated the fentanyl patch was not applied to Resident 2's skin on 2/25/26, which meant there was no patch to remove on 2/28/26. The DON confirmed documentation on Resident 2's February 2026 MAR on 2/28/26 at 11:56 A.M. by LN 1 indicated that the fentanyl patch had been removed. The DON stated the documentation was not accurate.A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised July 2017, indicated, .3. Documentation in the medical record will be objective.complete, and accurate.