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	04/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff adhered to proper infection control practices for one of four residents sampled residents (Resident 1) when:Resident 1's leaking/overflowing urinary catheter (a tube inserted into the bladder to aide in urine flow) was placed in a fracture pan (a device used to hold urine) and a urine-soaked towel were left on the floor.Certified Nursing Assistant (CNA) 1 did not wear Personal Protective Equipment (PPE- gown, gloves) prior to providing direct patient care.These failures had the potential for cross contamination (spread of germs and bacteria) and infection to residents, staff and visitors.Findings :1.According to the admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses which included obstructive and reflux uropathy (a blockage in the body that makes it urinate) and resistance to multiple antibiotics (occurs when antibiotics are no longer effective, making infections difficult to treat).A review of Resident 1's Physician's Orders indicated, SUPRAPUBIC [an area below the abdomen and above the pubic area] CATHETER #FR [French- a unit of measurement] 18 WITH 10CC [Cubic Centimeters- a unit to measure volume] BULB TO GRAVITY DRAINAGE BAG [a device to collect urine].During an observation on 4/23/26 at 10:53 A.M., a bed pan (a device used to collect urine or feces for people who are unable to leave their bed to use the bathroom) was observed on the floor, next to Resident 1's bed. A foley catheter bag (a bag which is attached to a urinary catheter, used to collect urine) was placed inside the bed pan. There was a hand towel observed on the floor, next to the bedpan. The hand towel was soaked with a liquid. There was a strong smell of urine inside the room.During an interview with Resident 1 on 4/23/26 at 10:55 A.M., Resident 1 stated his foley catheter bag had a hole in it and needed to be replaced. Resident 1 stated the urine from the catheter bag had leaked onto the floor, so he tossed a hand towel on the floor to soak the urine. Resident 1 stated his catheter bag had been leaking since the night shift, and he was still waiting for a nurse to replace it.On 4/23/26 at 1:27 P.M., an interview was conducted with the Infection Preventionist (IP) 1. IP 1 stated foley catheter bags should be emptied right away when full, and changed immediately if there was any leakage or holes. IP 1 further stated a foley catheter bag should have been hanged on the bed frame, and should never be placed on the floor. Per IP 1, bacteria could travel to the catheter tube into Resident 1's body and placed Resident 1 at a higher risk for infection.During an interview with the Assistant Director of Nursing (ADON) on 4/23/26 at 1:40 P.M., the ADON stated it was his expectation that a catheter bag be replaced when leaking. The ADON stated a catheter bag and tubing should be kept off the floor to prevent the possibility of introducing microorganisms to Resident 1.During a review of the facility's policy titled Catheter Care, Urinary, revised August 2022, the policy indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.Be sure the catheter tubing and drainage bag are kept off the floor.2. During an observation on 4/23/26 at 10:30 A.M., a purple sign which indicated Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce transmission of bacteria by wearing gown and gloves during high contact care) was posted on the wall, outside Resident 1's bedroom.During an observation on 4/23/26 at 10:53 A.M., a bed pan (a device used to collect urine or feces for people who are unable to leave their bed to use the bathroom) was observed on the floor, (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	next to Resident 1's bed. A foley catheter bag (a bag which is attached to a urinary catheter, used to collect urine) was placed inside the bed pan. There was a hand towel observed on the floor, next to the bedpan. The hand towel was soaked with a liquid. There was a strong smell of urine inside the room.During an observation on 4/23/26 at 11:09 A.M., Certified Nursing Assistant (CNA) 1 was observed entering Resident 1's bedroom. CNA 1 donned (put on) gloves but did not don a gown. CNA 1 proceeded to empty Resident 1's urinary catheter bag into a urinal (a plastic device used to hold urine). CNA 1 then emptied the urine into the toilet. During an interview with CNA 1 on 4/23/26 at 11:27 A.M., CNA 1 stated the EBP sign posted indicated staff needed to wear gloves and a gown when providing direct care to Resident 1. CNA 1 stated emptying the catheter bag was considered direct care, but she was in a hurry to empty the bag and forgot to wear PPE. CNA 1 stated it was important to follow the EBP sign to protect the resident, and herself from contamination.During an interview with the Infection Preventionist (IP) 1 on 4/23/26 at 1:27 P.M., IP 1 stated it was her expectation that staff wear the appropriate PPE while providing direct care to residents on Enhanced Barrier Precaution. IP 1 stated it was important to prevent infection, especially for Resident 1 since he was more prone to infection.During a review of Resident 1's Care Plan Report, the care plan dated 12/26/25 indicated, Enhanced Barrier Precautions: Resident requires enhanced barrier precautions during high-contact resident care activities due to the presence of.Suprapubic catheter.Utilize PPE (gown and gloves; face-shield as indicated) during high-contact resident care activities (e.g.device care.). During a review of the facility's policy titled Enhanced Barrier Precautions, revised December 2024, indicated, Enhanced barrier precautions apply when.a resident.has a wound or indwelling medical device.EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply.Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.device care or use.