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	05/20/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to accurately code a stage IV (4) pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the Minimum Data Set (MDS-a federally mandated resident assessment tool) after a [NAME] Ulcer (nonhealing skin sore that may form when you're dying) was reclassified as a Stage IV pressure ulcer, for one of three sampled residents (Resident 1). These deficient practices placed Resident 1 at risk for inaccurate assessment data, inappropriate care planning and misrepresentation of the resident's health status to Centers for Medicare Services (CMS).A review of Resident 1's admission Record indicated Resident 1 was re-admitted to the facility on [DATE] with diagnoses which included history of Pressure Ulcer of Sacral (lower back/tailbone) Region and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 4/30/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 0 points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) impairments. On 5/19/26 at 2:07 P.M., an interview was conducted with the Wound Nurse (WN). The WN stated that pressures typically occur over boney prominences (an area where a bone is close to the surface of your skin and sticks out. e.g. back/tailbone, hip bone, back of your head, shoulder blades, elbows and knees) and may be staged from Stage I through Stage IV based on the extent of tissue involvement. The WN further stated wound assessment includes visual inspection, palpation (touch), evaluation of tissue characteristics, and consultation with the physician and wound care team to determine appropriate wound classification and staging. A record review of Resident 1's progress notes dated 4/24/2026 at 14:27 (2:27 P.M.), titled IDT [intradisciplinary team- groups of healthcare professionals from different specialties]- Skin Management indicated, .Resident re admitted with previous Kennedy ulcer that was re-classified as stage IV pressure injury to sacrum area. A record review of Resident 1's MDS Section J1400 Prognosis (prospect of recovery) dated 4/30/26 indicated, .Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation). was coded no. A record review of Resident 1's MDS Section O0110 K1. Special Treatments, Procedures, and Programs dated 4/30/26 indicated Resident 1 was not in hospice care. On 5/20/26 at 1:28 P.M., an observation, interview and record review was conducted with the WN. The WN stated that Resident 1 had a Stage IV Pressure ulcer to the sacral area that had previously been identified as a [NAME] Ulcer and later reclassified as a Stage IV pressure injury (4/27/26). The WN further confirmed there were no physician orders indicating that Resident 1 had received hospice or end-of-life care services. On 5/20/26 at 1:46 P.M., an observation was conducted with the WN and Certified Nursing Assistant (CNA) 2. CNA 2 repositioned Resident 1 to the left side, provided peri-care, and removed the incontinent brief. The WN cleansed the sacral wound with wound cleaner, applied collagen sprinkles to the wound, followed by calcium alginate, and packed the undermining area with gauze before covering the wound with a foam dressing. Observation of the sacral wound revealed a circular Stage IV pressure ulcer approximately t he size of a golf ball, (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with noted depth and undermining. The wound be appeared bright red with light drainage and without slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds) or eschar (dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound and over time falls off). The WN pressed on the surrounding sacral skin and observed no color change (non-blanchable tissue). A review of Resident 1's skin notes titled, SW - Skin Issues dated 4/27/2026 at 14:07 (2:07 P.M.), indicated, .Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure - Kennedy terminal ulcer / End of Life. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. On 5/20/26 at 1:52 P.M., an interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 1's MDS 4/30/26, Section M0210, was inaccurately coded and should have reflected a Stage IV pressure ulcer to the sacrum after the wound had been reclassified from a Kennedy terminal ulcer to a Stage IV pressure injury. The ADON stated that Resident 1 was receiving ongoing Stage IV pressure ulcer treatments. The ADON stated accurate MDS coding was required to ensure the facility submitted correct resident (all facility residents)assessment data to Centers for Medicare and Medicaid Services (CMS-a federal agency). The ADON stated Resident 1's MDS required correction and resubmission to CMS. On 5/20/26 at 2:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the MDS coordinator did not code Resident 1's stage IV pressure ulcer assessment reference date (ARD) 4/30/26 MDS because the wound had previously been identified as a Kennedy terminal ulcer. The DON stated Resident 1was not receiving hospice or end-of-life services and acknowledged Stage IV pressure ulcer should have been accurately coded on the MDS in accordance with the Resident Assessment Instrument (RAI) Manual. The DON stated accurate MDS coding was necessary to ensure resident assessment information submitted to CMS and Quality Measures (QM) reflected Resident 1's actual clinical status and care needs. The DON further stated Resident 1's MDS required correction and resubmission to CMS. A review of Centers for Medicare and Medicaid Services RAI Manual 3.0 October 2025, (Page M-5) M0210: Unhealed Pressure Ulcers/Injuries .Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days . A review of the facility's policy and procedure titled, Resident Assessments dated October 2023, indicated .Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews .