

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/21/2025
NAME OF PROVIDER OR SUPPLIER  Hillcrest Heights Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4033 Sixth Avenue Ext San Diego, CA 92103	

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36471</p> <p>Based on interview and record review, the facility failed to develop an effective discharge plan that ensured residents' discharge goals were identified and addressed for one of three sampled residents (Resident 2).</p> <p>As a result, Resident 2 felt rushed, unheard, and unprepared to transition to the next care setting, which affected the continuity of care.</p> <p>(Cross-reference: F-655, Baseline Care Plans)</p> <p>Findings:</p> <p>Resident 2 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body), per the Admission Record.</p> <p>A record review of the facility's census and list of residents scheduled for discharge was conducted. The facility indicated that Resident 2 will be discharged today [5/8/25].</p> <p>On 5/8/25 at 12:35 P.M., Resident 2 was observed holding a cell phone and sitting on the transport wheelchair. Resident 2 stated that yesterday [5/7/25], he was told by the Social Service Director (SSD) that he would be discharged today [5/8/25]. Resident 2 stated he indicated his concerns [like finance and wheelchair], and the SSD did not seem to want to listen to him. Resident 2 stated that the SSD appears to have decided that he will leave, regardless of the circumstances. Resident 2 further stated that he did not know where he was going and was told that transportation would pick him up by 2 P.M. on 5/8/25. Resident 2 further said he tried to call his family members to let them know.</p> <p>On 5/8/25 at 12:44 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that the process for discharging a resident involved the licensed nurse (LN) informing them of who would be discharged at the beginning of their shift so that they could prepare the resident's belongings. CNA 1 stated the LN did not inform her of Resident 2's discharge today and received the information through Resident 1. CNA 1 stated that Resident 2 was upset, looking for his belongings, and she was doing her best to gather them all.</p> <p>(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
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/8/25 at 12:55 P.M., a joint interview and record review was conducted with LN 1. LN 1 stated the SSD would provide them with a copy of the resident's name and the day of discharge. LN 1 stated Resident 2 was not scheduled to be discharged today. However, when LN 1 reviewed Resident 2's medical record, the SSD documented that Resident 2 would be discharged today with transport scheduled. In addition, Resident 2 did not have a care plan or a physician's order for discharge.</p> <p>On 5/8/25 at 1:15 P.M., an interview was conducted with the SSD. The SSD stated that Resident 2 had agreed to leave on that day, and she found a placement for him. The SSD denied having knowledge of Resident 2's concerns. The SSD stated she should have created a discharge care plan for Resident 2 and ensured the resident's preference was considered for placement.</p> <p>On 5/8/25 at 1:30 P.M., an interview with the Administrator (ADM) was conducted. The ADM stated that a care plan should have been created to ensure residents' needs were prepared before discharge.</p> <p>Per the facility's policy and procedure, dated 12/2016, titled Transfer or Discharge, Preparing a Resident for, . Resident will be prepared in advance for discharge .A post-discharge plan is developed for each resident prior to his or her transfer or discharge .</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36471</p> <p>Based on observation, interview, and record review, the facility failed to ensure the care plan for discharge (leaving the facility) was developed and implemented for two of three sampled residents (Resident 1 and Resident 2).</p> <p>This failure increased the risk that the residents' wishes would not be honored.</p> <p>Findings:</p> <p>1. Resident 1 was admitted to the facility on [DATE] with diagnoses that included aftercare following surgery, per the Admission Record.</p> <p>On 5/8/25, a review of Resident 1's medical record was conducted. Resident 1 was discharged from the facility on 4/18/25. There was no evidence that a discharge care plan was developed.</p> <p>On 5/8/25 at 11 A.M., an interview was conducted with the Social Service Director (SSD). The SSD stated that a care plan should have been done on admission. Resident 1 did not have a discharge care plan and the facility should have ensured the resident was discharged according to the plan.</p> <p>On 5/08/25 at 12:55 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that the discharge care plan should have been developed to meet residents' needs.</p> <p>2. Resident 2 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body), per the Admission Record.</p> <p>On 5/8/25 at 12:35 P.M., Resident 2 was observed sitting on the transport wheelchair. Resident 2 stated that he was discharged today at 2 P.M. and did not know where he was going.</p> <p>On 5/8/25, a review of Resident 2's medical record was conducted. There was no evidence that a discharge care plan was developed.</p> <p>On 5/8/25 at 1:15 P.M., an interview was conducted with the SSD. SSD stated that Resident 2 did not have a discharge care plan and should have had one in place.</p> <p>Per the facility's policy and procedure, reviewed 1/2023, titled Care Plans - Baseline, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission .The baseline care plan will be used until the staff can conduct the comprehensive assessment .</p> <p>Per the facility's policy and procedure, reviewed 1/2023, titled Care Plans, Comprehensive Person-Centered, .A comprehensive. person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36471</p> <p>Based on an interview and record review, the facility failed to (1) Notify the physician of the change of condition [rashes on the head] and monitor skin changes for one of three sampled residents (Resident 3) and (2) Thoroughly assess and document Resident 3's condition following an unwitnessed fall.</p> <p>As a result, Resident 3 experienced delayed care, and the medical record did not accurately reflect the resident's condition, potentially impacting their health and safety.</p> <p>Findings:</p> <p>Resident 3 was admitted to the facility on [DATE] with diagnoses that included hypertension (abnormal blood pressure), per the Admission Record.</p> <p>A review of Resident 3's medical record was conducted. Per the Shower Sheet, dated 1/25/25, Licensed Nurse (LN) 2 documented Resident 2 had rashes on top of the head and above the forehead. There was no documented evidence that the physician was notified of the rashes or monitoring.</p> <p>Per the Progress Notes, dated 1/26/25 at 12:48 P.M., LN 2 documented that Resident 3 reported falling over a month ago and hitting her head. Resident 3 also stated she had a wound on top of the head. LN 2 further documented that Resident 3 had no change in level of consciousness, and no signs or symptoms of bleeding were noted. However, there was no documented evidence of the wound description, including its appearance or size, before the hospital transfer.</p> <p>A further review of Resident 3's medical record was conducted. There was no fall incident documented.</p> <p>LN 2 was not available for an interview.</p> <p>Per the hospital report, titled General Medicine History and Physical, dated 1/26/25, Resident 3 went to the emergency department with purulent (pus) drainage from the a wound on the scalp.</p> <p>On 5/21/25 at 1:15 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated any change of condition [such as fall, rashes or wound] should have been reported to the physicians and documented. The ADON further stated the LNs should have document detailed observations of the wound.</p> <p>Per the facility's policy and procedure, revised 5/2017, titled Change in Resident's Condition or Status, .Our facility should promptly notify .attending physician .Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider .</p>		