

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 01/09/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess and code one of three residents (Resident 50) on their annual Minimum Data Set (MDS-a clinical assessment tool which is a Federal requirement to be submitted to Centers for Medicare and Medicaid Services {CMS}) who was identified as a smoker, when reviewed for Comprehensive Assessments.</p> <p>This failure had the potential for CMS to be unaware of Resident 50's current health status.</p> <p>Findings:</p> <p>Resident 50 was admitted to the facility on ,d+[DATE]//23, with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record.</p> <p>An observation was conducted of Resident 50 on 1/6/25 at 10:10 A.M. Resident 50 was sitting outside in the smoking area with four other residents and a smoking monitor (a person who supervises smoking residents and hands-out smoking material). Resident 50 was wearing a protective smoking apron and holding a cigarette in his right hand.</p> <p>An observation was conducted of Resident 50 on 1/7/24 at 8:10 A.M. Resident 50 was outside smoking with three other residents and a smoking monitor was present. Resident 50 was not wearing a protective smoking apron and was holding a lit cigarette in his right hand.</p> <p>Resident 50's clinical record was reviewed On 1/7/25:</p> <p>According to the annual Minimum Data Set (a clinical assessment tool), dated 10/25/24, Resident 50 had a cognitive score of 5, which indicated severe impaired cognition. The Health Condition section indicated Resident 50 was not a user of tobacco products.</p> <p>According to the facility's Smoking Safety Evaluation, dated 10/21/24, Resident 50 was identified as a smoker, who consumed 2-5 cigarette a day. Resident 50 was required to wear a smoking apron for protection and staff were required to extinguish the resident's cigarette.</p> <p>According to the care plan, titled Resident at risk for smoking related injury, revised 12/11/24, interventions included: Supervise resident per Smoking Assessment.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 1/7/25 at 3:01 P.M., of Resident 50's annual MDS dated [DATE]. The MDSN stated when Resident assessments were completed for MDS, he reviewed the physician orders, nursing notes, assessments, and care plans first. The MDSN stated if a resident was identified as a smoker, it would be listed in Section J, Health Condition in MDS. The MDSN reviewed Resident 50's annual MDS, dated [DATE], and stated Resident 50 was listed as a non-smoker, which was incorrect. The MDSN stated he missed it, and the annual MDS was incorrect. The MDSN stated the harm to the inaccurate MDS assessment was CMS was not informed of the resident's smoking status.</p> <p>An interview was conducted with the Director of Nursing (DON) on 1/8/245 at 4:30 P.M., The DON stated she expected the MDS's to be accurate, so CMS had an accurate picture of what was currently going on with the resident.</p> <p>According to the Resident Assessment Instrument (RAI-a tool used by the MDSNs to code and submit accurate MDS data) dated October 2019, .Section J1300, Health-related Quality of Life: The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident safety for one of three residents (Resident 50), identified as requiring a smoking apron while smoking, when reviewed for accidents.</p> <p>This failure had the potential for Resident 50's clothing to catch fire when smoking.</p> <p>Findings:</p> <p>Resident 50 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's Admission Record.</p> <p>An observation was conducted of Resident 50 on 1/6/25 at 10:10 A.M. Resident 50 was sitting outside in the smoking area with four other resident's, including a smoking monitor (a person who supervises smoking residents and hands-out smoking material). Resident 50 was wearing a protective smoking apron and holding a cigarette in his right hand.</p> <p>An observation was conducted of Resident 50 on 1/7/24 at 8:10 A.M. Resident 50 was outside smoking with three other residents and a smoking monitor was present. Resident 50 was not wearing a protective smoking apron and was holding a lit cigarette in his right hand.</p> <p>An interview was conducted with the Smoking Monitor (SM 1) on 1/7/25 at 8:11 A.M. SM 1 stated there was only one resident who required a protective apron while smoking which was identified as Resident 1.</p> <p>Resident 50's clinical record was reviewed On 1/7/25:</p> <p>According to the annual Minimum Data Set (a clinical assessment tool), dated 10/25/24, Resident 50 had a cognitive score of 5, indicting severe impaired cognition. The Health Condition section indicated Resident 50 was not a user of tobacco products.</p> <p>According to the facility's Smoking Safety Evaluation, dated 10/21/24, Resident 50 was identified as a smoker, who consumed 2-5 cigarette a day. Resident 50 was required to wear a smoking apron for protection and staff were required to extinguish the resident's cigarette.</p> <p>According to the care plan, titled Resident at risk for smoking related injury, revised 12/11/24, interventions included; Supervise resident per Smoking Assessment.</p> <p>A follow-up interview was conducted with SM 1 on 1/7/25 at 2:45 P.M. SM 1 stated his supervisor had communicated to him that Resident 50 needed a smoking apron. SM 1 stated Resident 50 was upset with him one day about wearing the apron, so SM 1 stopped putting the apron on Resident 50. SM 1 stated Resident 50 could be harmed when not wearing the apron, because his clothing could catch on fire. SM 1 stated he knew he should have put the apron on Resident 50. SM 1 stated there were three residents who required smoking aprons and Resident 50 was one of them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Licensed Nurse 6 (LN 6) on 1/7/25 at 2:50 P.M. LN 1 stated Smoking Assessments were completed by Licensed Nurses. LN 1 stated if LNs determined a smoking apron was required for safety reasons, then the resident should always wear an apron while smoking. LN 6 stated if a required smoking apron was not put on, the resident could be at risk of burns if their clothing caught fire. LN 6 stated their job was to keep the residents safe.</p> <p>An interview was conducted with the Director of Nursing (DON) on 1/7/25 at 2:56 P.M. The DON stated if the Smoking Assessment indicated a protective apron was required, then she expected staff to ensure the apron was in place when the resident was smoking.</p> <p>According to the facility's policy, titled Safe Smoking-Resident, dated August 2022, .2. Resident's will be assessed by the IDT (Interdisciplinary Team) .The assessment is to determine if the Resident is ale to smoke safely and not harm themselves . 3. As identified by the Safe Smoking Assessment', Residents who require assistance and/or monitoring for smoking safety are not allowed to smoke unaccompanied/unsupervised .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49613</p> <p>Based on observation, interview, and record review, the facility failed to ensure the accountability of controlled medications (those with high potential for abuse and addiction) and failed to accurately and timely administer resident medications, when:</p> <ol style="list-style-type: none"> 1. The Controlled Drug Records (accountability records) for four out of seven randomly selected residents (Residents 91, 86, 81, and 11) did not reconcile with the Medication Administration Records (MAR). This failure resulted in inaccurate accountability of controlled medications and the potential for accidental duplicate medication administration; and 2. The pharmacy did not provide Resident 30's Creon (brand name for pancrelipase, a medication for the pancreas) for 13 days. This failure could result in ineffective management of Resident 30's pancreatic insufficiency (inability to properly digest food due to pancreas dysfunction); and 3. Nursing staff failed to administer one medication as ordered by the prescriber for one out of seven residents (Resident 3). This failure resulted in Resident 3 receiving a dose of metformin (a medication for diabetes) without food which could cause side effects such as diarrhea and upset stomach. <p>Findings:</p> <p>1a. Resident 91 had a physician order, dated 11/24/24, for oxycodone (a controlled narcotic medication for pain) 10 milligrams (mg), one tablet by mouth every four hours as needed for severe pain.</p> <p>During a concurrent interview and record review on 1/7/25 at 10:24 A.M. with licensed nurse (LN) 1, Resident 91's oxycodone 10 mg Controlled Drug Record (CDR) and December 2024 MAR were reviewed. LN 1 confirmed the CDR indicated the nursing staff signed out one tablet on the following date and time but did not document the administration on the MAR (total of one dose):</p> <p>- 12/7/24 at 12 A.M.</p> <p>1b. Resident 86 had a physician order, dated 10/12/24, for hydrocodone with acetaminophen (a controlled narcotic medication for pain, generic for Norco) 10-325 mg, one tablet by mouth every four hours as needed for moderate to severe pain.</p> <p>During a concurrent interview and record review on 1/7/25 at 10:24 A.M. with LN 1, Resident 86's Norco 10-325 mg CDR and January 2025 MAR were reviewed. LN 1 confirmed the CDR indicated the nursing staff signed out one tablet on the following date and time but did not document the administration on the MAR (total of one dose):</p> <p>- 1/3/25 at 2:30 P.M.</p> <p>1c. Resident 81 had a physician order, dated 7/29/24, for oxycodone 5 mg, one tablet by mouth every six hours as needed for severe pain.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/7/25 at 11:19 A.M. with LN 2, Resident 81's oxycodone 5 mg CDR and January 2025 MAR were reviewed. LN 2 confirmed the CDR indicated the nursing staff signed out one tablet on the following date and time but did not document the administration on the MAR (total of one dose):</p> <ul style="list-style-type: none"> - 1/2/25 at 9 A.M. <p>1d. Resident 11 had a physician order, dated 7/4/24, for Norco 5-325 mg, one tablet by mouth every six hours as needed for moderate and severe pain.</p> <p>During a concurrent interview and record review on 1/7/25 at 11:19 A.M. with LN 2, Resident 11's Norco 5-325 mg CDR and January 2025 MAR were reviewed. LN 2 confirmed the CDR indicated the nursing staff signed out one tablet on the following date and time but did not document the administration on the MAR (total of one dose):</p> <ul style="list-style-type: none"> - 1/3/25 at 8:30 A.M. <p>During a concurrent interview and record review on 1/7/25 at 1:37 P.M. with the Assistant Director of Nursing (ADON), the Controlled Drug Records and MARs for Residents 91, 86, 81, and 11 were reviewed. ADON acknowledged the following controlled medications were unaccounted for:</p> <ul style="list-style-type: none"> - Resident 91: one tablet of oxycodone 10 mg - Resident 86: one tablet of Norco 10-325 mg - Resident 81: one tablet of oxycodone 5 mg - Resident 11: one tablet of Norco 5-325 mg <p>The ADON stated the nursing staff need to document the administration of pain medications in the MAR.</p> <p>During an interview on 1/9/25 at 9:27 A.M., the DON verified she was aware of the discrepancies in the controlled drug medical records for Residents 91, 86, 81, and 11. The DON stated the expectation is that every time the nurse administers a narcotic medication, the nurse documents the administration in the CDR and the MAR. The DON stated documentation in the MAR is important as proof that the resident received the medication. The DON also stated a concern of inaccurate MAR documentation is accidental duplicate administration of narcotic pain medications.</p> <p>A review of the facility's policy and procedure titled, Preparation and General Guidelines IIA5: Controlled Medication, dated April 2008, indicated:</p> <p>.When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): .Date and time of administration .Amount administered .Initials of the nurse administering the dose on the MAR after the medication is administered .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an interview on 1/7/25 at 11:40 A.M., Resident 30 stated she had been discharged from the hospital two weeks ago with a new medication to take with meals for her pancreas. Resident 30 stated someone at the facility told her that her insurance would not cover the pancreas medicine and she could not afford to pay for the medication herself. Resident 30 verified she had not received this medication since her re-admission to the facility on [DATE].</p> <p>Resident 30 had a physician order, dated 12/24/24, for Creon 24,000-76,000 units, Give 2 capsule by mouth with meals for PANCREATIC INSUFFICIENCY.</p> <p>During a telephone interview on 1/7/25 at 3:24 P.M., the Consultant Pharmacist (CP) stated the pharmacy delivered Resident 30's Creon to the facility on [DATE] at 7:04 P.M. During a follow up telephone interview on 1/7/25 at 3:41 P.M., CP verified this was the first delivery of Creon for Resident 30.</p> <p>During a telephone interview on 1/8/25 at 12:48 P.M., Pharmacist 1 (PH 1) stated the pharmacy received orders for Resident 30's Creon on 12/24/24. PH 1 stated the first time the pharmacy filled and delivered Resident 30's Creon was on 1/6/25. PH 1 stated the pharmacy notified the facility that the medication was not covered by insurance and requested a signature on the authorization form, Urgent Notice of Non-Covered/High-Cost Drug, to dispense. PH 1 then stated the pharmacy received the signed authorization form to deliver the medication on 1/5/25. PH 1 verified Resident 30 did not receive Creon from the pharmacy from 12/24/24 until 1/6/25. PH 1 stated the facility has discretion to sign the authorization form. PH 1 stated there is no alternative medication for Creon.</p> <p>During an interview on 1/8/25 at 3:21 P.M., the DON stated Resident 30 received the first Creon dose on 1/7/25 because the first Creon delivery was on 1/6/25. The DON verified Resident 30 did not receive any doses between 12/24/24 and 1/7/25. The DON stated the facility noticed Resident 30's Creon was missing on 1/5/25 and contacted the pharmacy to follow up on the delay. The DON stated she submitted the signed authorization form after talking to the pharmacy on 1/5/25. The DON stated the insurance issue for Creon was identified by the facility on 1/5/25. The DON also stated when resident medications are missing, the nurse should follow up with the pharmacy. The DON stated Resident 30 was supposed to start Creon on 12/25/24 at the facility.</p> <p>During an interview on 1/9/25 at 8:12 A.M., the DON stated she was investigating whether any facility staff had contacted the pharmacy between 12/25/24 and 1/5/25 to follow up on the Creon. The DON did not provide evidence of facility contacting the pharmacy prior to 1/5/25 to the surveyor.</p> <p>A review of the signed authorization form Urgent Notice of Non-Covered/High-Cost Drug, signed and dated 1/5/25 by the DON for Resident 30, indicated:</p> <p>.Option 1: Pay for current medication as per below .Drug Name and Strength: Creon . and</p> <p>.Option 3 - No Covered Alternative (if this option is checked by pharmacy, Facility staff must select option 1 and sign below) .</p> <p>A review of the Consolidated Delivery Sheets, dated 1/6/25 at 12:52 P.M., indicated delivery confirmation of 100 capsules of Creon for Resident 30 to the facility.</p> <p>A review of the Creon Administration Notes for Resident 30, dated 12/24/24 to 1/9/25, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - 12/25/24 at 9:55 A.M.awaiting for delivery . - 12/25/24 at 1:26 P.M.not covered with insurance awaiting for dlivery [sic] . - 12/26/24 at 7:48 A.M.awaiting delivery from pharmacy . - 12/26/24 at 12:31 P.M.f/u with pharmacy . - 12/26/24 at 4:45 P.M.med unavailable. pharmacy notified . - 12/27/24 at 9:46 A.M.Awaiting pharmacy to delivery . - 12/27/24 at 2:45 P.M.No med awaiting for pharmacy to deliver [sic] . - 12/29/24 at 8:36 A.M.Med unavailable, waiting for pharmacy delivery. Will administer when arrived . - 12/29/24 at 11:44 A.M.Med unavailable, waiting for pharmacy delivery. Will administer when arrived. MD aware . - 12/30/24 at 9:15 A.M.Med unavailable, waiting for pharmacy delivery. Will administer when arrived. MD (medical doctor) aware . - 12/30/24 at 11:39 A.M.Med unavailable, waiting for pharmacy delivery. Will administer when arrived. MD aware . - 1/1/25 at 8:07 A.M.not covered by insurance . - 1/1/25 at 4:22 P.M.no meds available. pharmacy notified . <p>A review of the facility's policy and procedures titled Medication Ordering and Receiving from Pharmacy IC3: Ordering and Receiving Medications from the Dispensing Pharmacy, dated January 2022, indicated:</p> <p>.Medications and related products are received from the dispensing pharmacy on a timely basis . and</p> <p>.New medications .are ordered as follows: If needed before next regular delivery, inform pharmacy of the need for prompt delivery . and</p> <p>.New Admission/Re-admission Orders .Facility .indicates whether a new supply of medication is needed from the pharmacy . and</p> <p>.A licensed nurse .Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor .Assures medications are incorporated into the resident's specific allocation prior to the next medication pass .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Creon, dated 2/6/12, retrieved from DailyMed, indicated:</p> <p>.CREON is indicated for the treatment of .pancreatic insufficiency in adult and pediatric patients .</p> <p>3. During a concurrent medication pass observation and interview on 1/6/25 at 11:34 A.M., LN 3 was observed preparing and administering one medication to Resident 3. There was no meal tray observed in Resident 3's room during the medication pass observation. LN 3 stated lunch starts at noon and had not started yet.</p> <p>During an interview on 1/6/25 at 11:56 A.M., Resident 3 stated he had not had his lunch yet.</p> <p>Resident 3 had a physician order, dated 9/20/24, for metformin (a medication to treat diabetes) 500 mg. Give 1 tablet by mouth two times a day for DM [diabetes] Give with meals. Breakfast and lunch only. The orders indicated to hold if the resident refuses to eat or has PO [by mouth] intake under 50%.</p> <p>During an interview on 1/9/25 at 9:29 A.M., the DON stated the expectation when orders indicate to give medication with food is for the nurse to give the medication with a meal or a snack. The DON agreed the expectation is for the medication nurse to follow the prescriber's orders.</p> <p>A review of the Prescribing Information for metformin tablets, dated 9/6/12, retrieved from DailyMed indicated:</p> <p>.Metformin .should be given in divided doses with meals .to reduce gastrointestinal side effects, and</p> <p>.Common side effects .include diarrhea, nausea, and upset stomach .Taking your medicine with meals can help reduce these side effects .</p> <p>A review of the facility's policy and procedures titled Administering Medications, dated December 2012, indicated:</p> <p>.Medication must be administered in accordance with the orders, including any required time frame . and</p> <p>.Medication must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49613</p> <p>Based on interview and record review, the facility failed to ensure one of one resident (Resident 30) was free of a significant medication error when the facility did not give Creon (brand name for pancrelipase, a medication for the pancreas) to Resident 30 for 13 days. This failure resulted in Resident 30 having digestive symptoms and had the potential for worsening of her medical conditions.</p> <p>Findings:</p> <p>During an interview on 1/7/25 at 11:40 A.M., Resident 30 stated she had been discharged from the hospital two weeks ago with a new medication to take with meals for her pancreas. Resident 30 stated the hospital told her that her pancreas is failing and she needs to take a pancreas medication with breakfast, lunch, dinner, and snacks. Resident 30 verified she had not received her pancreas medication since her re-admission to the facility on [DATE]. Resident 30 stated since her re-admission, she noticed her stool had a worsened slimy film (also known as oily stool) than in the hospital. While rubbing her upper abdomen, Resident 30 also stated she noticed more pancreas pain since her return to the facility. Resident 30 stated that on 1/6/25, she had an episode of sudden onset nausea and vomited dark coffee colored liquid into a trash can while with facility staff. Resident 30 also stated she had a bowel movement while vomiting. When she checked afterwards, she noted a bright orange oily glob in her undergarments. Resident 30 stated she was embarrassed by this incident and did not tell facility staff about the orange glob. Resident 30 stated she was scared to walk around in case she had another accident with her bowels. Resident 30 stated she wanted to continue taking the pancreas medication from the hospital.</p> <p>A review of Resident 30's medical record indicated a physician order, dated 12/24/24, for Creon 24,000-76,000 units, Give 2 capsule by mouth with meals for PANCREATIC INSUFFICIENCY (inability to properly digest food due to pancreas dysfunction). Resident 30 had an additional physician order, dated 12/24/24, for Creon 24,000-76,000 units, Give 1 capsule by mouth as needed for PANCREATIC INSUFFICIENCY WITH SNACKS PRN (as needed).</p> <p>During a telephone interview on 1/7/25 at 3:41 P.M., the Consultant Pharmacist (CP) verified the pharmacy first delivered Resident 30's Creon to the facility on [DATE] at 7:04 P.M. The CP stated she did not think the facility would go this long without giving the resident this medication. The CP stated if the resident is not getting the medication, the facility staff need to inform the physician. The CP stated Creon is an enzyme medication. The CP also stated every medication is important and given to residents to improve quality of life. The CP stated if the resident is not getting Creon, the concerns are digestive issues, including poor absorption of nutrients, bloating, and discomfort. When informed Resident 30 reported episodes of oily stool, the CP stated there can be different type of stool if the resident does not get the enzyme medication to break down food.</p> <p>During an interview on 1/8/25 at 11:19 A.M., Resident 30 stated she received the first dose of Creon on 1/7/25. Resident 30 reported continued abdominal pain and oily stool. Resident 30 stated she feels better now that she is getting the medication.</p> <p>(continued on next page)</p>

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 01/09/2025
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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 1/8/25 at 12:48 P.M., Pharmacist 1 (PH 1) stated the pharmacy received orders for Resident 30's Creon on 12/24/24. PH 1 stated the first time the pharmacy filled and delivered Resident 30's Creon was on 1/6/25. PH 1 stated the pharmacy received signed authorization from the facility to deliver the Creon on 1/5/25.</p> <p>During a telephone interview on 1/8/25 at 1:10 P.M., Pharmacist 2 (PH 2) stated 100 capsules of Creon should last 13 days for Resident 30 based on the physician's orders. PH 2 stated he calculated a 13 day supply for Resident 30 assuming she ate three meals and one or two snacks per day. When PH2 was asked the risks of Resident 30 not receiving Creon doses for multiple days, PH 2 stated Resident 30 would not be able to digest food properly and there is a risk of inadequate nutrition. PH 2 stated nausea and differences in bowel movements would be effects of missing doses of Creon.</p> <p>During an interview on 1/8/25 at 3:21 P.M., the Director of Nursing (DON) verified Resident 30 had active orders for Creon with meals and snacks for pancreatic insufficiency. The DON stated Resident 30 received the first dose of Creon on 1/7/25. The DON stated the facility noticed the missed Creon doses on 1/5/25 and notified the physician. The DON stated Resident 30 was supposed to start Creon on 12/25/24 at the facility.</p> <p>During an interview on 1/8/25 at 4:42 P.M., the Medical Director (MD 1) verified he was first informed of the missing doses of Creon on 1/5/25. MD 1 stated if a resident misses one day of medication, the physician needs to be informed. MD 1 stated oily stool could be caused by poor absorption due to the pancreas and means the dietary fat was not broken down. MD 1 verified pancreatic insufficiency is a long-term condition.</p> <p>During an interview on 1/9/25 at 9:06 A.M., Resident 30 stated she has pain in her stomach radiating to her lower back and the pain is an eight out of 10.</p> <p>During an interview on 1/9/25 at 9:29 A.M., the DON stated the expectation when orders indicate to give medication with food is for the nurse to give the medication with a meal or a snack. The DON agreed the expectation is for the medication nurse to follow the prescriber's orders.</p> <p>During a telephone interview on 1/9/25 at 9:54 A.M., Physician 2 (MD 2) stated he ordered Resident 30 to continue the Creon from the hospital. MD 2 stated he was informed a couple days ago about the facility not giving Creon to Resident 30. MD 2 stated resident could have flank pain, vomiting, and loss of appetite due to not getting the medication. When informed of interview with Resident 30 regarding her pain in stomach and lower back, MD 2 stated the pain is concerning for the pancreas and he was not aware. When informed of interviews with Resident 30 reporting oily stools, nausea, and vomiting, MD 2 stated he was not aware of these symptoms. MD 2 stated the presence of pain, nausea, and oily stools could be related to Resident 30 not getting the Creon. MD 2 stated these symptoms are the reason Resident 30 needs Creon.</p> <p>During an interview on 1/9/25 at 10:44 A.M, Resident 30 stated her pain in her lower back is an eight out of 10. Resident 30 stated she informed MD 1 of her pain before the interview. Resident 30 stated the hospital said her pancreas is failing and she wants to take care of herself.</p> <p>A review of the Nurses Notes for Resident 30, dated 1/5/25 at 6:51 P.M., indicated .Resident noted to have missed 3 or more doses of medication Creon .MD/NP (nurse practitioner) aware. Will contact pharmacy for eta (estimated time of arrival) of medication .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Nurses Notes for Resident 30, dated 1/7/25 at 8:26 P.M., indicated .Resident c/o (complained of) abdominal discomfort. Assessment shows hardening of abdomen, loose stool .MD/NP notified .</p> <p>A review of Resident 30's December 2024 MAR for Creon two capsules with meals, dated 12/25/24 to 12/31/24, indicated:</p> <ul style="list-style-type: none"> - 14 out of 21 entries marked 9=Other/See Progress Notes - Two of 21 entries marked 14 = Will administer when available. MD notified - Five of 21 entries incorrectly marked as administered (cross reference F842). <p>A review of Resident 30's January 2025 MAR for Creon two capsules with meals, dated 1/1/25 to 1/9/25, indicated:</p> <ul style="list-style-type: none"> - 14 of 26 entries marked 8 = Medication Not Available .Notify MD . - Four of 26 entries incorrectly marked as administered (cross reference F842) - Six of 26 entries marked as administered. <p>A review of Resident 30's Nutrition Documentation for meal intake, dated 12/26/24 to 1/8/25, indicated Resident 30 ate three meals every day.</p> <p>A review of Resident 30's December 2024 MAR for Creon one capsule as needed with snacks, dated 12/24/24 to 12/31/24, indicated zero administration entries.</p> <p>A review of Resident 30's January 2025 MAR for Creon one capsule as needed with snacks, dated 1/1/25 to 1/8/25, indicated zero administration entries.</p> <p>A review of Resident 30's Nutrition Documentation for HS (bedtime) Snacks, dated 12/24/24 to 1/6/25, indicated Resident 30 ate a bedtime snack on 11 of 14 days.</p> <p>A review of Resident 30's care plans, dated 1/5/25, indicated .Resident missed 3 or more doses of medication Creon . and .Notify MD/NP of missed doses of medication .</p> <p>A review of the facility's policy and procedures titled Administering Medications, dated December 2012, indicated:</p> <ul style="list-style-type: none"> .Medication must be administered in accordance with the orders, including any required time frame . and .Medication must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . <p>A review of the facility's policy and procedures titled Adverse Consequences and Medication Errors, dated April 2014, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders . and</p> <p>.Examples of medication errors include .Omission - a drug is ordered but not administered .</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on observation, interview, and record review, the facility failed to follow the posted menu. In addition, two of 88 residents (Resident 32 and 86) did not receive a fortified (foods with nutrients added to them), meal as ordered, when reviewed for nutritional needs.</p> <p>This failure had the potential for residents' nutritional needs to not be met.</p> <p>Findings:</p> <p>A lunch tray line observation was conducted in the kitchen on 1/8/25 at 12:10 P.M. The lunch meal consisted of oven crisp fish, sweet potato fries or brown rice, seasoned carrots, wheat roll, and cranberry crunch bar for dessert.</p> <p>1. An observation was conducted on 1/8/25 at 1:23 P.M., during lunch tray line service in the kitchen. Some lunch trays contained white rice, in lieu of the sweet potato fries. The posted daily menu listed brown rice or sweet potato fries as being served with the fish. The cook was questioned about the white rice and went to view the posted menu. The cook stated It does indeed say brown rice. The cook stated, I did not look at it closely and made white rice instead. The cook stated the Registered Dietician was unaware white rice was made, instead of brown rice.</p> <p>An interview was conducted with the Food Nutrition Service (FNS) manager on 1/8/25 at 1:50 P.M. The FNS stated when white rice was served instead of brown rice the cook was not following the menu.</p> <p>An interview was conducted with the Registered Dietician (RD) on 1/8/25 at 4:05 P.M. The RD stated brown rice contains more fiber and nutrients than white rice. The RD stated she should have been notified the posted menu was not being followed, to ensure residents were getting all their nutrients.</p> <p>According to the facility's policy, titled Meal Planning, dated 2023, .3. All daily menu changes, with the reason for the change, are to be noted on the back of the kitchen spreadsheet. Only the Facility Registered Dietician or FNS Director can make permanent changes. The FNS Director is to receive the Facility Registered Dietician's approval for any permanent changes. Menu changes should also be noted on the menus on the consumers board and any other menus which may be posted.</p> <p>2a. Resident 32 was admitted to the facility on [DATE], with diagnoses which include moderate protein-calorie malnutrition per the facility's Admission Record.</p> <p>An observation of the lunch tray line was conducted on 1/8/25 at 12:20 P.M. Resident 32's meal was compared to the plate prepared. The meal ticket listed fortified ground consistency with double meat, fish, eggs. The plate contained fish, carrots, and white rice. No fortified additive was noted. The cook was asked what fortified additive was being used. The cook stated, melted butter on the vegetables and rice, if indicated. The cook stated, I forgot to add the melted butter to Resident 32's meal. The plate was returned to the cook prior to putting on the food cart, and additional butter was added.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2b. Resident 86 was admitted to the facility on [DATE], with diagnoses which included displaced fracture of the right lower leg, per the facility's Admission Record</p> <p>An observation of Resident 86's lunch tray was compared to his meal ticket on 1/8/25 at 1:37 P.M., during tray line. Resident 69's meal ticket read, Fortified regular consistency. The plate contained fish, carrots, sweet potato fries, and dessert. No additional butter was added to the carrots. The plate was covered and getting ready to place on the food cart for delivery. The meal ticket was pointed out to staff that no fortified additive was present. The cook added butter to the carrots without commenting.</p> <p>An interview was conducted with the Food Nutrition Service Manager (FNS) on 1/8/25 at 1:50 P.M. The FNS stated fortified foods were required for residents experiencing weight loss. The FNS stated if the fortified additive were not added, they were not meeting the resident's nutritional needs.</p> <p>An interview was conducted with the Registered Dietitian (RD) on 1/8/24 at 4: 05 P.M. The RD stated fortified additives were important to provide residents experiencing weight loss with additional calories. The RD stated if the residents were not getting their fortified additives, it could be contributing to their weight loss.</p> <p>According to the facility's policy, titled Fortification of Foods: Increasing Calories and/or Protein in the Diet, dated 2023, .Identification of residents in need of fortification will be done by the facility's Registered Dietician or the FNS Director. The physician will then order a Fortified Diet. Calories and/or protein will be added to selected food .FNS staff will be familiar with the fortification process for each item chosen to be used at the facility .</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>39220</p> <p>Based on observation, interview, and record review, the facility failed to honor resident food preferences listed on their resident's meal tickets, for five of 88 residents (Residents 1, 11, 49, 75, 151), reviewed for Resident Accommodations.</p> <p>This failure had the potential for resident's wishes, likes, and dislikes to be ignored.</p> <p>Findings:</p> <p>A lunch tray line observation was conducted in the kitchen on 1/8/25 at 12:10 P.M. The lunch meal consisted of oven crisp fish, sweet potato fries or brown rice, seasoned carrots, wheat roll, and cranberry crunch bar for dessert.</p> <p>1. On 1/8/25 at 12:24 P.M., the lunch tray for Resident 1 was viewed and compared to the meal ticket. On the plate was fish, sweet potato fries, carrots, and a wheat roll. Listed on the meal tickets was a dislike for fish. The dislike was pointed out to staff after the plate had been covered and was getting ready to load on the metal wheeled food cart. The fish was removed by the cook and a cooked hamburger patty was place instead of the fish.</p> <p>An interview was conducted with Resident 1 on 1/9/25 at 9:08 A.M., in her room. Resident 1 stated she was told by someone she had been losing weight. Resident 1 stated she did not like some of the food. Resident 1 stated if fish was served to her, she would not eat it.</p> <p>2. On 1/8/25 at 12:48 P.M., the lunch tray for Resident 11 was viewed and compared to the meal ticket. On the plate was a small piece of fish, sweet potato fries, carrots, and a wheat roll. Listed on the meal ticket was a preference listed as Portion: Double meat, fish, eggs. The preference portion was pointed out to the staff, after the plate had been covered and was getting ready to load on the metal wheeled food cart. The plate was given back to the cook, who added another portion of fish.</p> <p>An interview was conducted with Resident 11 on 1/9/25 at 9:11 A.M., in her room. Resident 11 was sitting up in bed, with her breakfast tray covered and untouched on the bedside table. Resident 11 stated she was in pain and did not feel like eating. Resident 11 stated she was aware she was losing weight and was trying not to. Resident 11 stated she liked to have extra meat, fish or eggs on her plate, because it was usually the only thing she ate.</p> <p>3. On 1/8/25 at 1:07 P.M., the lunch tray for Resident 75 was viewed and compared to the meal ticket. A like was listed on the meal ticket as soup, with a dislike of Tomato soup. A covered bowl of tomato soup had been added to the tray, with a package of crackers on top. After the plate had been covered and the tray was getting ready to be added to the metal wheeled food cart, the dislike of tomato soup was pointed out to Kitchen Aide 1 (KA 1). KA 1 removed the soup bowl.</p> <p>On 1/9/25 at 9:20 A.M., an interview was conducted with Resident 75, in her room. Resident 75 stated she loved soup, but she hated tomato soup specifically. Resident 75 stated she would not get upset if it was given to her, she just would not eat it.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 1/8/25 at 1:14 P.M., the lunch tray for Resident 151 was viewed and compared to the meal ticket. The meal ticket listed the diet as Vegetarian, Fortified. The plate was viewed which consisted of a cooked meat patty. The cook was questioned if the patty on the plate was meat or vegetarian. The cook stated he ran out of cooked veggie patty and gave no explanation of the reason meat was served in its place. The cook immediately began to cook a veggie patty, which was later plated.</p> <p>On 1/9/25 at 9:24 A.M., an interview was conducted with Resident 151 in her room. Resident 151 stated she had been a vegetarian since 4 years of age. Resident 151 stated if meat was served to her, she would be able to immediately tell. Resident 151 stated she just would not eat it (meat), and it would not upset her.</p> <p>5. On 1/8/24 at 1:19 P.M. the lunch tray for Resident 49 was viewed and compared to the meal ticket. Served on the tray was a homemade cranberry bar dessert. On the meal ticket, listed a dislike of cranberry sauce. After the plate had been covered and the tray was getting ready to be added to the metal wheel cart, KA 1 was notified of the dislike. The dessert was removed, and vanilla ice cream was added in its place.</p> <p>On 1/9/25 at 9:29 A.M., an interview was conducted with Resident 49, as he laid in bed. Resident 49 stated, No, I don't like cranberry sauce or anything related to cranberries. Resident 49 stated if it was served to him, he just would not eat it.</p> <p>An interview was conducted with the Food Nutrition Service Manager (FNS) on 1/8/24 1:50 P.M. The FNS stated she expected all preferences to be honored and respected.</p> <p>An interview was conducted with the Registered Dietician (RD) on 1/8/25 at 4:05 P.M. The RD stated all resident food preferences should be honored, because it was a resident's right. The RD stated she expected all kitchen staff to review the meal cards and compare them to the plated meal during service.</p> <p>According to the facility's policy, title Food Preferences, dated 2023, Resident food preferences will be adhered to within reason .Procedure: Food preferences will be obtained as soon as possible through the initial resident screen. This screening must be completed within 7 days of admission by the Food Nutrition Services Director .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49613</p> <p>Based on interview and record review, the facility failed to ensure medical records were accurate and concise for two of two residents (Residents 30 and 71), reviewed for medical records accuracy when:</p> <ol style="list-style-type: none"> 1. Resident 30's medication administration records (MARs) for Creon (brand name for pancrelipase, a medication for the pancreas) incorrectly indicated nine doses were administered between 12/25/24 - 1/9/25, when the medication was not administered and was unavailable; and 2. Resident 71's Dialysis Communication Form, post assessment listed a graft, (an internal surgically created connection between an artery and a vein that allows for hemodialysis treatment), instead of a Perma-cath, (a central line inserted into a main vein). <p>These failures had the potential to result in inaccurate documentation of the resident's medical history and response to care.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an interview on 1/7/25 at 11:40 A.M., Resident 30 stated she had been discharged from the hospital two weeks ago with a new medication to take with meals for her pancreas. Resident 30 verified she had not received this medication since her re-admission to the facility on [DATE]. <p>Resident 30 had a physician order, dated 12/24/24, for Creon 24,000-76,000 units, Give 2 capsule by mouth with meals for PANCREATIC INSUFFICIENCY.</p> <p>During a concurrent observation and interview on 1/7/25 at 10:50 A.M. at Medication Cart #4 with licensed nurse (LN) 4, a sealed bottle of Creon 24,000-76,000 units was noted in the top drawer. The Creon bottle was labeled for Resident 30 and indicated a pharmacy fill date of 1/6/25. LN 4 stated Resident 30 will start this medication the following day.</p> <p>During an interview on 1/8/25 at 11:40 A.M., Resident 30 stated she got her first dose of Creon with lunch on 1/7/25. Resident 30 stated she only got one dose of Creon on 1/7/25.</p> <p>A review of Resident 30's January 2025 MAR indicated Resident 30 received a Creon dose on 1/7/25 at 8 A. M., before the observation of the sealed Creon bottle on 1/7/25 at 10:50 A.M.</p> <p>During a concurrent interview and record review on 1/8/25 at 3:21 P.M. with the Director of Nursing (DON), Resident 30's December 2024 and January 2025 MARs were reviewed. The December 2024 MAR indicated Resident 30 received a Creon dose on the following dates and times:</p> <ul style="list-style-type: none"> - 12/25/24 at 5 P.M. - 12/28/24 at 5 P.M. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 12/29/24 at 5 P.M.</p> <p>- 12/30/24 at 5 P.M.</p> <p>- 12/31/24 at 5 P.M.</p> <p>The January 2025 MAR indicated Resident 30 received a dose on the following dates and times:</p> <p>- 1/3/25 at 5 P.M.</p> <p>- 1/4/25 at 5 P.M.</p> <p>The DON stated Resident 30 received the first dose of Creon on 1/7/25. The DON verified Resident 30 did not receive the doses above as documented in the MAR.</p> <p>During an interview on 1/9/25 at 9:27 A.M., the DON stated documentation in the MAR is important as proof that medication was administered to the resident.</p> <p>During a concurrent observation, interview, and record review on 1/9/25 at 1:13 P.M. at Medication Cart #4 with LN 5, LN 5 did a physical count of Resident 30's Creon capsules. LN 5 counted 88 capsules of Creon remaining in the bottle. LN 5 verified the sealed bottle contained 100 capsules. LN 5 verified the January 2025 MAR for Resident 30's Creon indicated a total of 16 Creon capsules had been administered to Resident 30 since 1/7/25 at 8:09 A.M. LN 5 stated the Creon bottle should have 84 capsules remaining based on the entries in the January 2025 MAR.</p> <p>A review of the facility's policy and procedure titled, Charting and Documentation, dated July 2017, indicated:</p> <p>.All services provided to the resident .shall be documented in the resident's medical record .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . and .Documentation in the medical record will be objective .complete, and accurate .</p> <p>39220</p> <p>2. Resident 71 was admitted to the facility on [DATE], with diagnoses which included dependence on renal dialysis (a procedure that removes waste products and excess fluid from the blood when the kidneys are unable to function properly), per the facility's Face Sheet.</p> <p>An observation and interview was conducted with Resident 71 on 1/7/25 at 2:21 P.M. Resident 71 was sitting up in bed, eating lunch. Resident 71 stated she just got back from a dialysis treatment and showed me her Perma-cath (a central line covered with a gauze), located on her upper right chest wall. Resident 71 stated she goes to dialysis three times a week, on Tuesday, Thursday, and Saturday early in the morning.</p> <p>Resident 71's clinical record was reviewed on 1/07/25:</p> <p>(continued on next page)</p>

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 01/09/2025
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.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the physician orders, dated 10/22/24, monitor vital signs pre and post dialysis and right chest Perma-cath (a central line for blood access) for signs and symptoms of bleeding, swelling, redness and pain.</p> <p>According to the care plan, titled Right upper chest Perma cath, undated, interventions listed included: Monitor for signs and symptoms of bleeding, swelling, redness, and pain. Notify medical doctor if observed.</p> <p>The facility's Dialysis Communication book (a form that communicates to dialysis team of resident's vital signs and Perma-cath site, dialysis documentation of what occurred while at dialysis, and a post assessment, once resident returns to the facility of vital signs and Perma-cath site) from 12/3/24 through 1/7/25 was reviewed. Of the 16 communication forms completed during that time frame, five forms were inaccurate. The five forms (dated 12/3/24, 12/27/24, 12/19/24, 12/23/24, and 1/2/25) listed on the post assessment, that Resident 71 had a graft site (an internal surgically created connection between an artery and a vein that allows for hemodialysis treatment), instead of a Perma-cath.</p> <p>An interview and record review was conducted with the Director of Staff Development (DSD) on 1/8/25 at 10:45 A.M. The DSD stated dialysis grafts can only be assessed by checking the bruit (listening) and checking the thrill (feeling) the site, since the graft is internal. The DSD stated Perma-caths were assessed visually by checking for bleeding and signs of infection. The DSD stated she had been at the facility for four months and had not provided any in-services or education to Licensed nurses regarding the dialysis access sites.</p> <p>An interview and record review was conducted with Licensed Nurse 7 (LN 7) on 1/8/25 at 10:53 A.M., regarding post dialysis assessments. LN 7 stated with Perma-caths there is no bruit and thrill, those can only be assessed on dialysis grafts. LN 7 was asked to review the post dialysis form she completed on 12/19/24. LN 7 stated she documented there was a dialysis graft with a bruit and thrill and did not document the resident had a Perma-cath instead. LN 7 stated she knows the difference between the two and she made an error. LN 7 stated it was important to document accurately, so everyone reviewing the record knew what was going on with the resident.</p> <p>An interview and record review was conducted with LN 8 on 1/08/25 at 11:11 A.M. regarding post dialysis assessments. LN 8 stated it was very important to conduct post dialysis assessments to identify potential problems or complications. LN 8 reviewed a post dialysis assessment she completed on 12/23/24. LN 8 stated she documented Resident 71 had a bruit and thrill, which was inaccurate because the resident actually had a Perma-cath.</p> <p>An interview and record review was conducted with the Director of Nursing on 1/8/25 at 11:14 A.M., of Resident 71's Dialysis Communication Forms. The DON stated post dialysis assessments were important to identify early signs of bleeding, infection, or complications. The DON stated she recently presented dialysis training to the nurses, during their annual skills assessment. The DON reviewed Resident 71's five Dialysis Communication Forms, indicating a graft was present. The DON stated the documentation was not accurate and could cause confusion to the reader.</p> <p>According to the facility's policy, titled Dialysis Communication Form, undated, .9. Licensed Nurse will evaluate the resident's condition including but not limited to vital signs, dialysis access site .and skin condition upon return .and will document on the post-dialysis assessment (bottom part) communication form .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Hillcrest Heights Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 Sixth Avenue Ext San Diego, CA 92103	

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the facility's policy, titled Charting and Documentation, dated July 2017, .7. Documentation of procedures and treatment will include care specific details, including: a. The date and time the procedure/=treatment was provided .d. How the resident tolerated the procedure/treatment .</p>