STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555878	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Hills Healthcare & Wellness Centre, LLC	1340 E Madison Ave 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36471 Based on interview and record review, the facility failed to provide a safe environment for one of three residents (Resident 1) reviewed for accidents. Resident 1, who was known to have a history of suicidal attempt (the act of intentionally causing one ' s death), was left unattended during a mealtime, and swallowed part of a metal fork. As a result, Resident 1 was transferred to the hospital to remove the metal fork from her body. Findings: Resident 1 ' s clinical Admission record was reviewed on 4/3/24. Per Resident 1 ' s Admission record, Resident 1 was admitted to the facility ' s secured unit (a specially designed space for residents to have resources they require to live safely) on 2/12/24. Per the same Admission record, Resident 1 ' s diagnoses included personal history of suicidal behavior. A review of Resident 1's hospital clinical record prior to being admitted to the facility was conducted. According to Resident 1 ' s ED (Emergency Department) Note, dated 10/27/23, Resident 1 swallowed the temple (the arms on each side of the frame, extending from the front of the frame to behind the ears) part of a pair of reading glasses. The note indicated that Resident 1 had a history of suicidal ideation and had multiple visits to the hospital due to swallowing foreign objects. According to Resident 1 ' s Hospital Discharge Summary, dated 2/12/24, Resident 1's primary diagnosis was a history of attempted suicide. A review of Resident 1 ' s facility ' s plan of care, initiated on 2/17/24 was conducted. The care plan indicated that Resident 1 had a behavior problem of harming self. According to Resident 1 ' s care plan, one of the interventions, initiated on 3/6/24, was to provide close monitoring of Resident 1 during mealtime. On 3/26/24, per the IDT (Interdisciplinary Team) meeting notes, the Director of Nursing (DON) documented Resident 1 would be closely monitored during mealtime. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident 1 ' s progress notes, dated 3/26/24 at 5:07 P.M., written by licensed nurse (LN) 3, was conducted. LN 3 documented that Resident 1 had shown breaking the plastic and metal forks in half during mealtime. LN 3 further documented that Resident 1 would be closely monitored and one-to-one assistance would be provided to Resident 1 during meals. On 3/28/24 at 4:38 P.M., under System Note, LN 2 documented that Resident 1 continued to be supervised when eating. A record review of Resident 1 ' s progress notes, dated 3/29/24 at 9:29 A.M., written by the Assistant Director of Nursing (ADON) was conducted. The ADON documented that [on 3/29/24] Resident 1 verbalized ending her life and swallowed a fork. The progress note indicated that the staff (CNA 1) found a broken fork with a missing handle, and Resident 1 was transported to the hospital via 911 (emergency responders). On 4/3/24 at 1:15 P.M., an interview was conducted with the DON. The DON stated on 3/29/24 Resident 1 swallowed a metal fork and went to the hospital. Resident 1 was currently in the hospital for the removal of the object. On 4/3/24 at 4:20 P.M., Certified Nursing Assistant (CNA) 2 was interviewed. CNA 2 stated that the LNs told her to stay in Resident 1 ' s room the entire time during meals. On 4/3/24 at 4:30 P.M., an interview was conducted with LN 1. LN 1 stated she was the assigned LN for Resident 1 on the day of the incident (when Resident 1 swallowed the fork) on 3/29/24. LN 1 stated she told CNA 1 in the morning to provide one-to-one supervision and monitor Resident 1 closely, and to not leave Resident 1 with utensils. On 4/4/24 at 4 P.M., an interview was conducted with CNA 3. CNA 3 stated that the LN instructed her to always sit with Resident 1 while eating for safety. On 4/4/24 at 4:14 P.M., an interview was conducted with LN 2. LN 2 stated she documented on 3/28/24 that Resident 1 need to be supervised when eating continued. On 5/7/24 at 1:45 P.M., an interview was conducted with LN 3. LN 3 stated on 3/26/24, he observed Resident 1 bending the plastic and the metal utensils. LN 3 stated, for Resident 1's safety nursing and medical staff accelerated the plan of care, and the intervention was to provide Resident 1 with one-to-one feeding assistance, not to feed Resident 1, but to ensure Resident 1 did not swallow anything that was not meant to be eaten. On 5/7/24 at 3:55 P.M., an interview was conducted with CNA 1. CNA 1 stated she was the assigned CNA to Resident 1 on 3/29/24, and LN 1 told her not to leave Resident 1 alone during mealtime. CNA 1 stated Resident 1 was having breakfast in her bed asked for a blanket. CNA 1 further stated she knew not to leave Resident 1, but she was naive and believed Resident 1 would be okay alone and left to get a blanket. CNA 1 stated she left Resident 1 ' s room for a minute and heard Resident 1 cough when she (CNA 1) was outside of Resident 1 ' s room. When CNA 1 returned to Resident 1 ' s room with a blanket and noticed Resident 1's fork was missing. CNA 1 stated, Resident 1 said she swallowed the fork, and she (CNA 1) called LN 1 and the ADON and DON came in the room, and Resident 1 was transferred to the hospital via 911. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review on 5/15/24 of Resident 1 ' s hospital x-ray (a photographic or digital image of the internal composition of something, especially a part of the body, produced by X-rays being passed through it and being absorbed to different degrees by different materials) report dated 3/29/24, indicated an elongated metallic density (the degree of film darkening) measuring 13.5 centimeters (cm) by 1.5 cm projecting over the left upper abdomen. A record review on 5/15/24 of Resident 1 ' s GI (Gastro-Intestinal-) Procedure Report, dated 3/29/24, indicated Resident 1 had an EGD procedure (Esophagogastroduodenoscopy - a procedure that involves removing foreign objects from the esophagus, stomach or intestine using flexible tube-like instrument into the body to look inside. The report indicated the physician removed the utensil handle from Resident 1's stomach. The facility could not provide a policy about safe environment or supervision during meal time.