

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Granite Hills Healthcare & Wellness Centre, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47956</p> <p>Based on interviews and record review the facility failed to provide a medication as ordered by the physician to one (Resident 1) of three sampled residents. This failure had the potential to elevate Resident 1 ' s ammonia levels.</p> <p>Resident 1 ' s record was reviewed. Per Resident 1's Admission Record, Resident 1 is a [AGE] year-old female admitted to the facility on [DATE]. Resident 1 ' s diagnosis included cirrhosis of the liver (scarring that prevents the liver from working properly) and hepatic encephalopathy (loss of brain function when the liver does not work properly).</p> <p>During a record review of Resident 1 ' s admission orders dated 8/30/24, Resident 1 was admitted with a physician's order for lactulose (a medication used to prevent and treat hepatic encephalopathy) 30 grams by mouth three times a day.</p> <p>During a record review of Resident 1 ' s Medication Administration Record (MAR) for August 2024, the Licensed Nurse (LN) had not initialed or signed (recorded administration) lactulose medication was administered for the morning and midday doses for 8/31/24.</p> <p>During a record review of Resident 1 ' s MAR for September 2024, the recording areas of Resident 1's MAR for the morning dose on September 5, 2024, was left blank and the LN had not initialed or recorded administration of lactulose.</p> <p>During a record review of facility document Preparation and General Guidelines IIA2: Medication Administration-General Guidelines dated October 2017. C. Documentation 1) The individual who administers the medication dose records the administration on the resident ' s MAR directly after the medication is given . 4) The resident ' s MAR is initialed by the person administering the medication in the space provided under the date, and on the line for that specific medication dose administration.</p> <p>During an interview on 9/17/24 at 11:07 A.M. LN1 stated we (licensed nurses) give medications based on the resident ' s conditions and the doctor ' s orders. LN1 stated I mark it in the MAR. LN 1stated, I can tell when a medication was given because a name (of a LN) is next to the time. LN 1 further stated, If a dose is missed, we notify the doctor and see what they want to do. If the medication is missed there will be no licensed nurse name in the MAR.</p> <p>During an interview on 9/17/24 at 11:35 A.M. LN2 stated When medications are missed, the doctor is notified, and a note is added in the computer chart under the Prog Note tab.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Granite Hills Healthcare & Wellness Centre, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 9/17/24 at 12:23 P.M. with the DON, the MARs dated August 2024 and September 2024 for Resident 1 were reviewed. The DON stated according to the Resident 1's MAR the medication was not given. The DON also stated, depending on the medication, a missed dose could be very bad for the resident 's health.</p>