

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 12/27/2024
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 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** 49330</p> <p>Based on observation, interview, and record review, the facility failed to implement its policy and procedure for fall prevention program for two of three sampled residents (Residents 2 and 3) who had incidents of repeated falls.</p> <p>This failure placed Residents 2 and 3 at risk for further falls and injuries.</p> <p>Findings:</p> <p>1) According to the Admission Record, Resident 2 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included history of falling, lack of coordination, and abnormalities of gait and mobility.</p> <p>A review of the facility's Incidents By Incident Type log indicated Resident 2 had unwitnessed falls on 11/1/24 and 12/3/24.</p> <p>On 12/27/24 at 9:55 A.M., Resident 2 was observed in bed. There was a small cut on the left side of Resident 2's forehead. Resident 2's call light was observed plugged into the wall and was missing the cord and button.</p> <p>On 12/27/24 at 10:04 A.M., a concurrent interview and observation was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was the assigned CNA for Resident 2. CNA 1 stated Resident 2 recently had a fall but did not know when or why. CNA 1 stated Resident 1 sustained a laceration (cut) to the forehead during the fall. CNA 1 stated, "[Resident 2] is a fall risk. She can still walk but she's not stable . CNA 1 stated Resident 2 attempts to stand up and walk unassisted. CNA 1 acknowledged Resident 2 did not have a call light cord or button. CNA 1 stated, ".its important for [Resident 2] to have a call light, especially if they need help, if there's an emergency. She could fall again .</p> <p>A review of Resident 2's Electronic Health Record (EHR) indicated an IDT (Interdisciplinary Team-a group of people with different areas of expertise) Meeting was not conducted to address the falls on 11/1/24 and 12/3/24.</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 12/27/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/27/24 at 1:50 P.M., an interview was conducted with the Interim Director of Nursing (IDON). The IDON stated IDT meetings should have been conducted after each fall to determine the root cause. The IDON stated, .we didn't do an IDT. We didn't do a new intervention . The IDON stated it was important to determine the root cause to create a plan of care that would prevent further falls.</p> <p>A review of the facility's policy titled Fall Management Program revised 11/7/16 indicated, .The IDT will initiate a fall investigation .the IDT will summarize conclusions after their review of the fall and circumstances surrounding the fall on an IDT note. The plan of care will also be reviewed, and the care plan will be revised as necessary in an effort to prevent further falls .</p> <p>2) According to the Admission Record, Resident 3 was admitted on [DATE] with diagnoses which included history of falling.</p> <p>According to the MDS (Minimum Data Set-an assessment tool) dated 10/22/24, Resident 3 had a BIMS (Brief Interview for Mental Status-a tool to assess cognition) of 1 indicating severe cognitive impairment.</p> <p>A review of the facility's Incidents By Incident Type log indicated Resident 3 had unwitnessed falls on 11/10/24 and 12/13/24.</p> <p>On 12/27/24 at 10:25 A.M., an observation was conducted in the hallway outside Resident 3's room. The door to Resident 3's bedroom was closed. Resident 3's name was on the wall along with the names of two roommates, without any indication of the residents being a fall risk. Upon entering the room, Resident 3 was observed laying in bed. Resident 3's call light was observed clipped to the wall, out of Resident 3's reach.</p> <p>On 12/27/24 at 10:33 A.M., an interview was conducted with CNA (Certified Nursing Assistant) 2. CNA 2 stated she was Resident 3's assigned CNA. CNA 2 stated Resident 3 was not a fall risk. CNA 2 stated Resident 3's bedroom door is always closed because , [Resident 3's roommate] likes the door closed . CNA 2 stated, .[Resident 3] moves around a lot in bed, all day. I've seen her scoot up, to her left and right . CNA 2 stated it was important for Resident 1 to have access to her call light .just in case something happens. In case they fall .</p> <p>On 12/27/24 at 11 A.M. an interview was conducted with LN (Licensed Nurse) 1. LN 1 stated he was the supervising nurse for the unit. LN 1 stated he did not that Resident 3 had a fall on 12/13/24 and he was not aware that she was a fall risk. LN 1 stated, She [Resident 3] should've had her call light next to her. Especially with her door closed, she could try to get up and we wouldn't see her .</p> <p>During an interview with the IDON on 12/27/24 at 1:50 P.M., the IDON stated the facility did not have any identifying logos or designations to alert staff to residents who were a fall risk. The IDON stated her expectation was for staff to ensure residents were able to easily access their call lights. The IDON stated, . yes they should have the call light to call for help, especially if they're a fall risk .</p> <p>A review of Resident 3's care plans indicated there were no new interventions implemented after the fall on 11/10/24 and 12/13/24.</p> <p>(continued on next page)</p>		

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 12/27/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled Fall Management Program revised 11/7/16 indicated, .A resident who sustains multiple falls .will be considered a high risk to fall .These residents may: i. be identified by a special logo or designation to alert staff to their high-risk activity; ii. May require more frequent observation of activities and whereabouts .These interventions will be documented on the resident's plan of care .</p>