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	02/04/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to prevent accidents for one of five sampled residents (Resident 1) who has left sided hemiplegia (paralysis affecting one side of the body) and hemiparesis (one-sided weakness) when the facility failed to develop an individualized care plan that addressed Resident 1's physical limitation and failed to ensure the staff implemented appropriate interventions when certified nursing assistant (CNA 1) left the bedside table positioned on the resident's left-side, rendering necessary items inaccessible and requiring Resident 1 to reach across the body which posed a risk of Resident 1 falling off the bed. These failures resulted in Resident 1 sustaining an unwitnessed fall on 12/6/2025. Resident 1 went to the hospital and was admitted for a forehead laceration and femoral neck fracture (fractured hip).Findings:On 12/30/2025 at 1:00 P.M., an unannounced onsite visit at the facility was conducted for an abbreviated survey related to a facility-reported incident.On 12/30/25 at 1:30 P.M., A review of Resident 1's undated admission Record was conducted. Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis affecting one side of the body) affecting the movement of the left side of his body (hemiparesis).According to Resident 1's Care Plan Report, dated 12/8/2025, under Focus [Problem], Resident 1 was at risk for falls because of impaired mobility, history of CVA [Cerebrovascular Accident-blood flow to the brain was blocked], under Interventions, it was indicated that staff needed to ensure Resident 1 wore nonskid socks, keep environment clutter free, adequate lighting, maintain fall precautions such as low bed and call light within reach, and reorient Resident 1 as needed due to dementia (a loss in mental functioning). The care plan did not indicate putting Resident 1's belongings or items on the right side for easy access ,safety, and fall prevention.According to Resident 1's Hospital Discharge summary, dated [DATE], the Emergency Department physician repaired the superficial forehead laceration with sutures, and Resident 1 was found to have a femoral neck fracture.Resident 1 returned to the facility on [DATE].On 12/30/2025 at 2:00 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 1's roommate called for help, the staff answered the call light and found Resident 1 on the floor. Licensed Nurse (LN 1) assessed Resident 1 and found that Resident 1 had a bump on the forehead. LN 1 called the physician and ordered them to transfer Resident 1 to the hospital. Later, the hospital called the facility and said that Resident 1 had a left femoral neck fracture.The DON further stated that the facility did their investigation and found out that Resident 1's bedside table was on the affected side of Resident 1, which would make it hard for Resident 1 to reach the item, and Resident 1 fell out of bed. The DON further stated that the fall could have been avoided, and corrective actions were implemented, such as in-service training for the staff and a 1:1 CNA education for CNA 1.On 12/30/2025 at 2:35 P.M., Resident 1 was observed sitting in a wheelchair in the activity room and was not available due to attending activitiesOn 12/30/2025 at 3:35 P.M., an interview was conducted (continued on next page)

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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(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	with LN 1. LN 1 stated she was giving medications to another resident when CNA 1 called her to check Resident 1. LN 1 entered the room and found that Resident 1 was on the floor between the B- bed and the C- bed. LN 1 explained that Resident 1's room had three beds, and Resident 1's bed was the C-bed away from the door. LN 1 further stated the bedside table was tilted and pushed against the B-bed. LN 1 saw Resident 1's right forehead with a bump and a superficial scrape, which had a moderate amount of blood. Resident 1's physician was made aware and asked the facility to transfer Resident 1 to the hospital. LN 1 further stated that Resident 1 told her that he was reaching for the remote control on the bedside table, felt weak, and then fell onto the floor. LN 1 stated the roommate pressed the call light because Resident 1's bedside table leaned against his right side. LN 1 further stated that CNA 1 arrived to answer the call light and saw Resident 1 laying on the floor, and she was called by CNA 1.On 1/8/2026 at 2:10 P.M., an interview was conducted with CNA 1. CNA 1 stated the last time she saw Resident 1 was before she took her 30-minute lunch break. CNA 1 stated she knew Resident 1 had left-sided weakness, and the bedside table should have been placed on Resident 1's right side of the bed. CNA 1 said she could not recall where the bedside table was located when she left Resident 1 to take a break. CNA 1 further stated that Resident 1's fall was unwitnessed, and Resident 1 was not a good historian. CNA 1 further stated that she came back from her 30-minute lunch break, saw the call light was on, and she went to the room. She did not know how long the call light had been on before she responded. CNA 1 further stated she entered the room, the roommate on B-bed said he did not need help and CNA 1 then approached C-bed. CNA 1 saw Resident 1 on the floor, with blood on the face, and called LN 1. CNA 1 said that she did not know how long the call light had been on, but noticed it was on after she came back from her break. CNA 1 stated she told LN 1 she was going to lunch but not the CNA that is going to cover her section. CNA 1 said she only notified LN 1.According to the facility's policy, dated 8/28/25, titled Fall Management Program, The facility will maintain an environment free of accident hazards, provide adequate supervision and assistive devices to prevent avoidable accidents.