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	01/30/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to provide and promote a homelike atmosphere for four of 15 resident rooms (11, 19, 21, 22), within the secured unit (a specialized care unit which is locked and limits residents with memory loss and/or mental health issues from exiting the unit without supervision), when reviewed for Resident Rights. This failure had the potential for residents to feel disrespected and undervalued. Findings: 1. An observation was conducted of the secured unit, room [ROOM NUMBER] on 1/27/25 at 3:03 P.M. The room sink was in the middle of the main room. The sink's faucet was covered on both sides and underneath with lime green calcification. An observation and interview regarding room [ROOM NUMBER] was conducted with the Director of Maintenance (DM) on 1/28/25 at 2:34 P.M. The DM stated he started at the facility in July 2024 and had never performed an inspection of the resident rooms on the secured unit. The DM viewed the sink faucet and stated, That's nasty and the whole sink and faucet needs to be replaced. The DM stated the sink did not present a homelike atmosphere. 2. An observation was conducted of the secured unit, room [ROOM NUMBER] on 1/27/25 at 3:50 P.M. Plastic, cord covers on the wall were broken and hanging downwards next to the TV. The bedside dressers for both bed A and bed B had no knobs attached to the two drawers for opening. The dresser of bed B was leaning to the right, with no metal footrest on the front right dresser leg. An observation and interview regarding room [ROOM NUMBER] was conducted with the DM on 1/28/25 at 2:20 P.M. The DM stated bed B's front dresser leg needed to be replaced. The DM stated he did not see any drawer handles, so it made it hard for residents to open their drawers and the plastic cord covering was broken and splintered. The DM asked the resident of bed A if he would want a door handle for his dresser and the resident stated, That would be nice. The DM exited the room and stated the room did not look neat or homelike. (continued on next page)

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	555878	A. Building B. Wing	01/30/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An observation was conducted of the secured unit, room [ROOM NUMBER] on 1/27/25 at 3:47 P.M. Both bed A and bed B had no door handles or knobs for opening the two-drawer bedside dresser. A cable wire was seen sticking out of the wall and was not attached to anything on the same wall as the TV. The wall thermostat had no covering and the metal mechanism was exposed. An observation and interview regarding room [ROOM NUMBER] was conducted with the DM on 1/28/25 at 2:10 P.M. The DM stated the residents could not open their dresser drawers without handles or knobs. The DM stated the cable cord was sticking out and should not be there, because it served no purpose and the exposed metal thermostat looked tacky. The DM stated the resident's room did not look functional or homelike. 4. An observation and interview was conducted of the secured unit, room [ROOM NUMBER] on 1/27/25 at 4:20 P.M. with Resident 40 in the room. Resident 40 stated she did not like her room and pointed to the area around her sink, stating it had mold and she believed it was making her sick. The sink was in the main room with lots of bumpy plaster patches on the wall, around and under the sink. Blackened areas were noted on the caulking between the wall and the sink. Resident 40 asked if someone could get rid of, that black stuff. An observation and interview regarding room [ROOM NUMBER] was conducted with the DM on 1/28/25 at 2:50 P.M. The DM stated the plaster repair job on the sink wall was sloppy and unprofessional. The DM stated the sink area looked bad and the whole sink and wall should be replaced. The DM stated the room was not homelike and he would not want his family member to look at a wall like that. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated he wanted all residents to feel comfortable with a homelike atmosphere in their rooms. The DON stated with dresser handles missing, it did not present a homelike environment. According to the facility's policy titled, Resident Rooms and Environment, dated January 2012, .The Facility provides residents with a safe, clean, comfortable, homelike environment . 1. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and order; .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to accurately assess, document, and transmit Minimum Data Set (MDS-a clinical assessment tool), information to the Center for Medicare and Medicaid Services (CMS-A federal agency that oversees health insurance) regarding a vision assessment for one of eight residents (Resident 3), reviewed for Resident Assessment. As a result, CMS was uninformed of Resident 3's impaired vision. Cross reference (F-685) Findings: Resident 3 was readmitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive brain disorder that causes nerve cells in the brain to deteriorate, leading to body movement problems), per the facility's Admission Record. An observation and interview was conducted with Resident 3 on 1/27/25 at 12:52 P.M. in his room. Resident 3 was earlier heard telling staff if did not want his lunch tray and to take it away. Resident 3 was observed dressed, lying in bed. Resident 3 stated he did not want his lunch because he could not see it and did not want to eat anything he could not see. Resident 3 yelled, I'm blind and can't see. I keep telling everyone, but no one listens. Resident 3's clinical record was reviewed on 1/28/25: According to care plan, titled Impaired Vision related to Cataracts (a clouding in the lens of the eye, which impairs vision), revised 6/15/24, listed interventions to include, arrange consultation of eye practitioner, and tell resident where you are placing their items. According to the Eye Doctor Consultation report, dated 7/19/24, Resident 3 was diagnosed with bilateral (both eyes) cataracts (a clouding of the eye's natural lens, resulting in vision loss). According to the facility's social service note, dated 8/27/24, a referral to ophthalmologist (physician who specializes in eye and vision care), was documented. There was no additional documentation that an appointment was schedule or a follow up was conducted for an ophthalmology appointment. According to the most recent quarterly MDS, dated [DATE], Section B-1000 listed Resident 3's Vision as Adequate . According to the facility's Registered Dietician (RD) note, dated 1/23/25, Resident 3 said he was having difficulty seeing. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with the Minimum Data Set Nurse (MDSN) on 1/28/25 at 1:42 P.M. The MDSN stated when preparing MDS data for CMS, she reviewed the resident's clinical record, such as the physician assessments, nurse's notes, social service notes, and care plans. The MDSN reviewed Resident 3's quarterly vision assessments, dated 1/16/25, and stated the assessment was inaccurate, because the care plan indicated vision impairment. The MDSN stated because of incorrect coding, CMS was unaware Resident 3 still had impaired vision. The MDSN stated the 1/16/25 quarterly MDS did not give an accurate picture of Resident 3's current visual status. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated he expected MDS assessments, coding, and transmissions to be accurate, so CMS had a clear picture of what was currently going on with each resident. According to the MDS Resident Assessment Instrument (a guide which gives direction to staff of requirements and for MDS coding), dated October 2019, .B-1000 Steps for Assessment: 1. Ask direct care staff over all shifts if possible about the resident's usual vision patterns during the 7-day look-back period (e. g., is the resident able to see newsprint, menus, greeting cards?). 2. Then ask the resident about his or her visual abilities. 3. Test the accuracy of your findings .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review, the facility failed to develop a person-centered care plan to manage combative behavior for one of three residents (Resident 84) reviewed for ADLs (Activities of Daily Living- eating, dressing, showering, grooming and toileting). As a result, there was potential for the resident to not receive individualized care. Findings: According to the Admission Record, Resident 84 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (a stroke), and anxiety disorder. A review of the Minimum Data Set (MDS-an assessment tool) dated 12/16/24 indicated Resident 84 had a BIMS (a tool that measures cognition) of 3 and was cognitively impaired. On 1/28/25 at 4:02 P.M., an observation and interview was conducted with Certified Nursing Assistants (CNA) 13 and 14 in Resident 84's room. CNA 13 was attempting to give Resident 84 a shave while CNA 14 was standing on Resident 84's left side. CNA 14's hand was placed on Resident 84's left arm. Resident 84 was observed moving his head to the left and right. CNA 14 stated, I'm here to make sure [Resident 84] doesn't swing his arm, so that [CNA 13] can give him a shave. CNA 14 stated Resident 84 had a behavior of attempting to hit staff during ADL's. On 1/29/25 at 8:12 A.M. an interview was conducted with CNA 16 in Resident 84's room. CNA 16 stated, .If you do his nails and shave him, he doesn't like that. He'll try to push you away and grab you .he doesn't know what's going on . During an interview with Licensed Nurse (LN) 11 on 1/29/25 at 8:28 A.M., LN 1 stated Resident 84 was confused, but understood Spanish. LN 11 stated, I do something sing-[NAME] .I will say agua, agua and give him a distraction. He'll focus on what I'm saying and listen to my voice so that he is calm .it helps to distract him .to explain things in Spanish even though he's not very alert, it does seem to register when you talk to him in Spanish . A review of Resident 84's records indicated there was no care plan developed to address combative behaviors when receiving care. On 1/30/25 at 12:54 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated it was important for Resident 84 to have an individualized care plan, especially because he is confused, combative and Spanish speaking. The DON stated, .we can meet the needs [of Resident 84] by having the [individualized] care plan in place, and everybody will know what's required to help him . A review of the facility's policy titled Comprehensive Person-Centered Care Planning dated 11/18 indicated, It is the policy of this facility to provide person-centered, comprehensive and interdisciplinary care .to obtain or maintain the highest physical, mental, and psychosocial well-being .

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	555878	A. Building B. Wing	01/30/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to address a residents' visual impairment in a timely manner for one of two residents (Resident 3), reviewed for Quality of Care. As a result, Resident 3 experience weight loss due to being unable to see his food. Cross Reference (F-641 and F-692) Findings: Resident 3 was readmitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive brain disorder that causes nerve cells in the brain to deteriorate, leading to body movement problems), per the facility's Admission Record. An observation was conducted of Resident 3 on 1/27/24 at 9:58 A.M., in his room. Resident 3 had a covered, untouched breakfast tray sitting on his bedside table. An observation and interview was conducted with Resident 3 on 1/27/25 at 12:52 P.M. in his room. Resident 3 was heard telling staff if did not want his lunch tray and to take it away. An unidentified staff returned Resident 3's lunch tray to the food cart. Resident 3 was observed dressed, lying in bed. Resident 3 stated he did not want his lunch because he could not see it and he did not eat anything he could not see. Resident yelled, I'm blind and can't see. I keep telling everyone, but no one listens. An observation and interview was conducted on 1/28/25 at 10:13 A.M., with Certified Nursing Assistant 1 (CNA 1). Resident 3's uneaten breakfast tray 2 was removed by CNA 1. CNA 1 stated Resident 3 does not usually eat breakfast. Resident 3's clinical record was reviewed on 1/28/25. According to the facility's Minimum Data Set, (MDS-a clinical assessment tool) dated 10/18/24, Resident 3 had a cognitive score of 10, indicating moderately impaired cognition. The care plan, titled Impaired Vision related to Cataracts (a clouding in the lens of the eye, which impairs vision) , revised 6/15/24, listed interventions included: arrange consultation of eye practitioner, and tell resident where you are placing their items. According to the facility's Eye Doctor Consultation, dated 7/19/24, Resident 3 had cataracts in both eyes. According to the facility's Social Service note, dated 8/27/24, Refer to an Ophthalmologist (physician who specializes in eye and vision care). (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence Resident 3 was ever referred or seen by an Ophthalmologist, or any follow-up by staff to inquire why he was not seen by the eye specialist. According to the facility's Change of Condition report, dated 1/16/25, Resident 3 had an identified weight loss. According to the facility's Interdisciplinary Team meeting, (IDT-when department heads meet to discuss resident issues and develop interventions to address those issues), titled Weight Variance, dated 1/23/25. There was no documented evidence Resident 3's vision loss was discussed or investigated as to when his last vision exam was. An interview and record review was conducted with the Social Services Director (SSD) on 1/28/25 at 1:54 P. M. The SSD reviewed the eye doctor exam on 7/17/24, and the Ophthalmologist referral dated 8/27/24, The SSD stated she could not find any documentation that Resident 3 ever went to Ophthalmologist for treatment of his cataracts or that a follow-up was conducted to ensure an appointment was made. The SSD stated with no follow-up for Resident 3's vision, his eye sight could have worsened, which would impact his quality of life An interview and record review was conducted with the RD on 1/29/25 at 10:29 A.M. The RD stated during Resident 3's weight variance IDT meeting, she informed the team of Resident 3 complaining of visual problems. The RD stated the vision issue was not explored or investigated, and it should have been. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated he expected all referrals to be completed and followed up on, so resident needs were addressed. The DON stated Resident 3's vision and eye care was not addressed in a timely matter, which could worsen his vision . According to the facility's policy, titled Referrals to Outside Services, dated December 2013, .I. The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility . The facility did not have a policy specific to Vision Care or Services.

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	555878	A. Building B. Wing	01/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39220 Based on observation, interview, and record review, the facility failed to maintain resident rooms from environmental hazards for six of 15 rooms (12, 13, 17, 19, 20, 21), reviewed for accidents. In addition, the facility failed to provide two-person lifting assistance while transferring one of one resident (Resident 29) from a wheelchair to bed using a mechanical lifting device (a hydraulic devices with a sling used for transfers) with one staff, (Two staff always required for mechanical lifts). These failures had the potential for residents to sustain injuries from hazards identified in their rooms and from mechanical lifts or transfers. Findings: 1. An observation was conducted of room [ROOM NUMBER] on the secured unit (a specialized care unit which is locked and limits residents with memory loss or mental health issues from exiting the unit without supervision) on 1/27/25 at 4:02 P.M. A cable wire was protruding from the wall next to the closet area. Plastic cord covers on the wall were brittle and splintered protruding out, away from the wall. An observation and interview was conducted with the Director of Maintenance (DM) of room [ROOM NUMBER] on 1/28/25 at 2:31 P.M. The DM stated he did not know why the cable wire with a center point was sticking out from the wall, since it did not seem to be needed and was not going anywhere. The DM stated the center point was sharp and could hurt someone. The DM inspected the splintered plastic cord covers on the TV wall and stated this was a hazard because someone could walk into it and it was high enough to poke them in the face or eye. The DM stated he was unaware of these hazards and had never inspected the resident rooms within the secured unit. 2. An observation was conducted of room [ROOM NUMBER] in the secured unit on 1/27/25 at 3:57 P.M. A small circular hole was in the middle of the exterior bathroom door. The hole was approximately 2 inch by 2 inches in size and contained splintered wood. An observation and interview was conducted with the DM of room [ROOM NUMBER] on 1/28/25 at 2:28 P. M. The DM stated the hole in the wall was splintered and a resident could cut themselves. The DM stated this should have been reported immediately, so he could have fixed it. 3. An observation was conducted of room [ROOM NUMBER] on 1/27/25 at 8:52 A.M. The bedside dresser of Bed B had a Phillips' screw head protruding from the drawer, where a door handle use to be. An observation and interview was conducted with the DM of room [ROOM NUMBER] on 1/28/25 at 2:26 P. M. The DM observed the protruding screw head when inspecting the dresser and stated, That's a hazard, someone could catch themselves on that and it should be fixed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance book for the secured unit was viewed on 1/30/25 at 8:46 A.M. A staff member documented repair was required in room [ROOM NUMBER] on 1/14/25 for, Toilet seat loose Rm 17. An observation, interview, and record review was conducted with Licensed Nurse 1 (LN 1) of room [ROOM NUMBER]'s toilet seat on 1/30/25 at 8:51 A.M. The toilet seat slid to the right when touched and was not anchored down. LN 1 stated the toilet seat was a hazard, because someone could fall to the floor if they attempted to sit on it. LN 1 stated she will add the repair to the maintenance book. LN 1 stated the toilet seat was already reported in the maintenance log on 1/14/25, it should have been fixed within a day. LN 1 stated 16 days later for a repair was unacceptable for a potential hazard. 4. An observation was conducted of room [ROOM NUMBER] on 1/27/25 at 12:34 P.M. On the TV wall, approximately 4-5 feet from the floor was an area of peeling paint. The area was estimated to be 6 inches by 4 inches in size with loose paint coming off the wall. An observation and interview was conducted with the DM of room [ROOM NUMBER] on 1/28/24 at 2:22 P. M. The DM stated there should not be peeling paint, where residents had access to it. The DM stated some residents on this unit were confused and could ingest the peeling paint, not knowing it could be harmful to them. 5. An observation was conducted of room [ROOM NUMBER] on 1/27/25 at 3:52 P.M. A long cable cord was protruding from the floor of the TV wall, near the sliding glass door, The cord was approximately 4 feet in length. The cord was pulled up and wrapped around the sliding glass door handle. An observation and interview was conducted with the DM of room [ROOM NUMBER] on 1/28/25 at 2:24 P. M. The DM observed the cable cord protruding from the wall and wrapped around the sliding glass door handle. The DM stated this was a tripping hazard and it could also be a choking hazard if a resident got tangled up in it. 6. An observation was conducted of room [ROOM NUMBER] on 1/27/25 at 3:47 P.M. The exterior edge of the bathroom door, near the doorknob had wood exposed, which was splintered and sharp. An observation and interview was conducted with the DM of room [ROOM NUMBER] on 1/28/25 at 2:15 P. M. The DM stated the edges were sharp and the door needed to be sanded down. The DM stated a resident could hurt themselves on the sharp wood if they grabbed or fell against the door. An interview was conducted wit the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated he expected all resident rooms to be safe and free of environmental hazards. The DON stated the sliding toilet seat was a hazard and should have been fixed immediately to avoid a possible fall. According to the facility's policy, titled Resident Safety, dated April 2021, .VII. Any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse . 39449 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. A record review of the facility's Admission Record indicated Resident 29 was admitted to the facility on [DATE] with diagnoses to include complete weakness on one side of the body and partial weakness of one side of the body following a stroke. On 1/28/25 at 3:46 P.M., an observation and interview was conducted with a Certified Nursing Assistant (CNA) 31. Resident 29 was observed on a wheelchair in his room with one CNA. CNA 31 was observed setting the sling of the mechanical lifting device (an equipment to assist in lifting). CNA 31 was observed transferring Resident 29 from the wheelchair to his bed. Resident 29's transfer using mechanical lifting device was conducted by CNA 31 without another CNA. CNA 31 was observed on one side of the mechanical lifting device while transferring Resident 29. There was no other CNA on the other end of the mechanical lifting device. CNA 31 stated she usually did it by herself. CNA 31 stated she did it by herself when other CNAs were not available. CNA 31 stated she had an in-service training for using a mechanical lifting device with two- person assistance. CNA 31 stated it was important to have two-person assist for mechanical lifting device to prevent any accidents and for safety. On 1/29/25 at 8:57 A.M., an interview was conducted with CNA 32. CNA 32 stated mechanical lifting device required two-person assistance, which meant two CNAs must be present to use the mechanical lifting device. On 1/29/25 at 9:14 A.M., an interview was conducted with CNA 33. CNA 33 stated mechanical lifting device required two-person assistance. On 1/29/25 at 10 A.M., an interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated using a mechanical lifting device required two-person assistance which meant two direct care staff like CNAs, licensed nurses or rehabilitation therapy staff would assist using a mechanical lifting device. The DSD stated the facility policy did not indicate two persons are required to use the mechanical lift, but he stated it should be with two-person assistance. A review of Minimum Data Set (MDS- assessment tool) Section GG dated 12/13/2024 indicated Resident 29 had impairment of his upper and lower extremity. Resident 29 was dependent on two or more staff to complete activity. A review of the care plan dated 12/1/21 indicated Resident 29 required mechanical lift with at least two staff assistance for transfers. On 1/29/25 2:41 P.M., an interview and record review was conducted with LN 31. LN 31 stated Resident 29 required a mechanical lifting device with two-person assist, LN 31 stated Resident 29 was a total care and required two person lifting with one staff to operate the sling and another to guide the resident to prevent swinging in the sling or from falling. On 1/29/25 at 3:19 P.M., an interview was conducted with CNA 34. CNA 34 stated a mechanical lifting device required two person, because one person was guiding the resident and the other staff was operating the mechanical lift. On 1/29/25 at 1:31 P.M., an interview and record review was conducted with the DON. The DON stated his expectation was that mechanical lifting of a resident required two person assistance to prevent resident injury. (continued on next page)

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	01/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Transfer of Residents dated 4/27/2023 111 indicated, . Residents who require assistance in transferring may be transferred using . or with a mechanical lift The policy did not provide guidance on the number of staff required when utilizing the mechanical lift.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to investigate and analyze the root cause for recent weight loss for one of one resident (Resident 3) reviewed for nutrition. This failure had the potential for Resident 3 to experience additional weight loss. (Cross Reference F-641, F-685, F-842) Findings: Resident 3 was readmitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive brain disorder that causes nerve cells in the brain to deteriorate, leading to body movement problems), per the facility's Admission Record. An observation was conducted of Resident 3 on 1/27/25 at 9:58 A.M., in his room. Resident 3 had a covered, untouched breakfast tray sitting on his bedside table. An observation and interview was conducted with Resident 3 on 1/27/25 at 12:52 P.M. in his room. Resident 3 was heard telling staff if did not want his lunch tray and to take it away. An unidentified staff returned Resident 3's lunch tray to the food cart. Resident 3 was observed dressed, lying in bed. Resident 3 stated he did not want his lunch because he could not see it and he did not eat anything he could not see. Resident 3 yelled, I'm blind and can't see. I keep telling everyone, but no one listens. An observation and interview was conducted on 1/28/25 at 10:13 A.M. with Certified Nursing Assistant 1 (CNA 1). Resident 3's uneaten breakfast tray 2 was removed by CNA 1. CNA 1 stated Resident 3 does not usually eat breakfast. Resident 3's clinical record was reviewed on 1/28/25. According to the physician's order, dated 5/10/24, Resident 3 required a fortified diet, regular texture with regular to thin consistency. According to the facility's Minimum Data Set, (MDS-a clinical assessment tool) dated 10/18/24, Resident 3 had a cognitive score of 10, indicating moderately impaired cognition. The care plan, titled Impaired Vision related to Cataracts, revised 6/15/24, listed interventions included: arrange consultation of eye practitioner, and tell resident where you are placing their items. According to the facility's Change of Condition report, dated 1/16/25, Resident 3 had an identified weight loss. The facility's Weight Summary was reviewed for Resident 3. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recorded weight on 7/5/24 was 170.5 pounds. Recorded weight on 1/16/25 was 156.5 pounds. The facility's Task for food percentages consumed was reviewed: Staff documented food percentage consumed by Resident 3 on 1/27/25, was 75-100% for breakfast and lunch, which was incorrect. (Observation was no breakfast and or lunch was consumed). According to the Registered Dietician (RD) note dated 1/23/25, Resident 3 experienced a 13.7% weight loss in 6 months. Resident 3 told the RD he was having trouble seeing, but agreed to try Ensure (a nutritional supplement drink designed to help with nutritional needs), with his lunch and dinner. According to the facility's Interdisciplinary Team meeting, (IDT-when department heads meet to discuss resident issues and develop interventions to address those issues), titled Weight Variance, dated 1/23/25. There was no documented evidence Resident 3's vision loss was discussed or investigated as to when his last vision exam was. The recommended interventions were finger foods and supply Ensure with lunch and dinner. The care plan, titled Nutritional problem, revised 1/23/25, included interventions of Ensure with lunch and dinner, provide finger food, and offer snack. A note was added by RD stating resident drinks 2-3 soda's a day and was at risk for weight fluctuation. Resident 3 agreed to be re-weighted by CNA 2 on 1/28/25 at 2:43 P.M., if he was provided a soda. Resident 3's weight was documented as 160.3 An interview was conducted with Licensed Nurse 1 (LN 1) on 1/29/25 at 8:16 A.M. LN 1 stated Resident 3 refused to do things unless he was provided a soda and he would drink 20 sodas a day if staff allowed it. LN 1 stated sometimes Resident 3 will refuse to eat, unless he was provided a soda. There was no documented care plan related to soda consumption or bargaining for a soda. An observation and interview was conducted of Resident 3 in his room on 1/29/25 at 8:29 A.M. Resident 3's breakfast tray remained untouched with no finger food present. The breakfast tray consisted of a bowl of dry cereal, an unopened carton of milk, a cellophane covered bowl of canned fruit, and an unopened container of cherry yogurt. Resident 3 stated he could not see his food, so he was not going to eat it. Resident 3 asked for a banana instead, which was provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with the RD on 1/29/25 at 10:29 A.M. The RD stated during Resident 3's weight variance IDT meeting, on 1/23/25, she informed the team of Resident 3 complaining of visual problems and was informed by the rest of the team of Resident 3's desire for sodas. The RD stated the vision issue was not explored or investigated, and it should have been. The RD stated she was unaware of the soda addiction until the IDT meeting, and no one discussed using the soda as an incentive to encourage eating. The RD stated they had not discussed one to one assistance with eating either. The RD stated she could have been more forceful in IDT to explore the issues and think of better interventions. The RD stated all staff needed to get behind the plan to correct the issue and she was dependent on staff to document the correct percentages of meals consumed. The RD stated based on the items observed on the resident's breakfast tray, those items were not finger foods. The RD stated she could have done better, because nutrition was very important for the resident's overall health. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated he expected the IDT team to be collaborative and to get to the issue of the problem. The DON stated the IDT was supposed to develop and implement meaningful interventions to rectify the issue at hand. The DON stated Resident 3's visual issue should have been identified and investigated as contributing to the root cause of his weight loss. According to the facility's policy, titled Evaluation of Weight Nutritional Status, dated November 2022, 1. The facility will work to maintain acceptable nutritional status for residents by: a. Assessing the resident's nutritional status and the factors that put the resident at risk .b. Analyzing the assessment information to identify .causes and/or problems related to the resident's condition and needs .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on observation, interview and record review, the facility failed to identify triggers related to PTSD (post-traumatic stress disorder- difficulty recovering after experiencing or witnessing a traumatic event) for two of two residents (Resident 27 and 35) reviewed for trauma-informed care. This failure had the potential to result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past traumatic experience) that could lead to severe psychosocial harm and affect the resident's quality of life. Findings: 1.) A record review of the facility's Admission Record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder, anxiety disorder, and schizoaffective disorder (a mental illness that affects thought, mood and behavior). An interview on 1/27/25 at 10:50 A.M., with Resident 27 was conducted . Resident 27 stated the staff here did not know how to handle his PTSD. Resident 27 stated, his mother committed suicide and swallowed a large amount of her pills. Resident 27 further stated, his brother did something to him 5-[AGE] years ago but refused to elaborate further. Resident 27 stated, he heard demons and his mother 's voice and just talking about her, made him anxious and irritated. A review of Resident 27's minimum data set (MDS- a federally mandated assessment tool) dated 1/29/25 indicated Resident 27's, brief interview for mental status (BIMS) score was 15 which meant Resident 27's cognition was intact. An interview on 1/28/25 at 8:43 A.M., with licensed nurse (LN) 12 was conducted. LN 12 stated Resident 27 had behavioral outburst when he did not get his cigarettes or his way and became verbally aggressive . LN 12 stated with regards to his PTSD, she was not aware and did not know of any triggers. LN 12 stated it was important for staff to know Resident 27's triggers to avoid them and at the same time know how to take care of Resident 27. A joint interview and record review on 1/28/25 at 4:04 P.M., with the Assistant Director of Nursing (ADON) was conducted. The ADON stated there was no identified triggers related to PTSD in Resident 27's care plan . The ADON stated it was important to know Resident 27's triggers to meet his needs. An interview on 1/20/25 at 8:01 A.M., with the Social Service Director (SSD) was conducted. The SSD stated her role included arranging referrals to psychologist and psychiatrist for residents that needed their service. The SSD stated Resident 27 did not like people behind him and he did not like people screaming. The SSD stated it was important to identify Resident 27's triggers to prevent psycho- social , emotional issues and to prevent the past event from reoccurring and ensure Resident 27's needs are met. A joint observation and interview on 1/30/25 at 8:17 A.M., with Resident 27 was conducted. Resident 27 was observed holding his coffee cup with his breakfast tray untouched. Resident 27 stated he does not feel good and was not hungry at the moment. Resident 27 refused further comments. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 1/30/25 at 9:35 A.M., with the Director of Nursing (DON) was conducted . The DON stated, we need to determine and implement ways to avoid or at least minimize the triggers and have them in the Resident 27's care plan. 49330 2.) A review of Resident 35's Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder. A review of Resident 35's Minimum Data Set (MDS, an assessment and care-screening tool), dated 10/1/24 indicated Resident 2's cognition was intact. During an interview on 1/27/25 at 8:56 A.M., Resident 35 stated she had PTSD. Resident 35 stated, .my [PTSD] came from abuse when I was a child. It morphed into physical abuse at home, and more as an adult with an alcoholic husband . Resident 35 stated when she was triggered, .I get a physical response in my chest. It gets tighter and tighter . On 1/27/25 at 12:55 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 11. CNA 11 stated she was familiar with Resident 35 and had taken care of her multiple times. CNA 11 stated she was not aware that Resident 35 had PTSD. CNA 11 stated it was important to know about a resident's PTSD diagnosis, .so we can be familiar with what happened .if she has a trigger we can prevent it . On 1/27/25 at 3:40 P.M., an interview was conducted with Licensed Nurse (LN) 12. LN 12 stated she was Resident 35's assigned nurse. LN 12 stated, .[PTSD] is when something traumatic happened previously and you still suffer from that .it can provoke an emotion due to what happened previously .we should know [the resident's] triggers so they don't relive the trauma. LN 12 stated she was not aware that Resident 35 had PTSD. During an interview with the Social Services Director (SSD) on 1/29/25 at 12:50 P.M., the SSD stated knowing a resident's PTSD diagnosis and triggers are important, .to make sure their emotions are managed . to make sure we're tending to their emotional needs . During an interview with Director of Nursing (DON) on 1/29/25 at 12:55 P.M., the DON stated it was his expectation for staff to know a resident's PTSD diagnosis and the accompanying triggers. The DON stated, . its important to determine triggers to minimize the episode. It also gives some control back to the patient .we are trying to prevent harm and mental anguish for the patient . The DON stated it was important to provide trauma-informed care to prevent the resident from harming themselves, or staff. A review of Resident 35's care plans dated 5/25/24 indicated, Review identified triggers with the relevant staff . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Trauma Informed Care ; Screening, Training, and Care Integration Program dated June 28, 2019 indicated .Policy .The facility will ensure residents who are trauma survivors receive culturally competent, trauma informed care; account for resident experience and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident .Trauma assessment and screening .The IDT will meet to discuss the results of the trauma informed screen document and implement a plan of care to address potential trauma triggers and prevent re-traumatization.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interview and record review, the facility failed to monitor behaviors and side effects of a psychotropic medication (a drug to control thoughts and behaviors) for one of five residents (Resident 11) reviewed for unnecessary psychotropic medications. This failure placed the resident at risk for receiving unnecessary medication and having unrecognized adverse reactions. Findings: According to the Admission Record, Resident 11 was admitted on [DATE] with diagnoses which included Tourette's Disorder (a disorder that causes people to make sudden and repeated twitches, movements, or sounds) and dementia. According to the Minimum Data Set (MDS, an assessment tool) Resident 11 had a BIMS (a tool to assess cognition) of 8, which indicated cognitive impairment. On 1/27/25 at 8:46 A.M., an observation was conducted in Resident 11's room. Resident 11 was in bed and repeatedly stated, [NAME]! [NAME]! [NAME]! Resident 11 was observed with an open wound between the upper lip and nose. Resident 11 did not respond to questions by the surveyor. On 1/27/25 at 11:18 A.M., an interview was conducted with Licensed Nurse (LN) 11. LN 11 stated Resident 11 had the open wound due to a behavior of repeatedly hitting himself with a plastic cup. LN 11 stated the behavior was a symptom of Tourette's Disorder. LN 11 stated, .he does it for twenty seconds, and then stops. LN 11 stated Resident 11 was on medication for the Tourette's disorder. A review of Resident 11's Order Summary Report dated 12/4/24 indicated, risperidone (a psychotropic medication) oral tablet 2.5 mg. Give 2.5 mg by mouth two times a day for Tourettes AEB (as evidenced by) tics and skin picking . A review of Resident 11's Medication Administration Record (MAR) did not indicate Resident 11's behaviors of tics and skin picking were being tracked by nursing. There was no evidence in the MAR that Resident 11 was being monitored for side effects of risperidone. On 1/30/25 at 12:54 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated it was important to monitor Resident 11's behaviors because, You want to see if what we're using is effective, or to go to something different, a new medication .we should have monitored the behaviors to see if the medication was working . The DON also stated it was important to monitor Resident 11 for side effects related to psychotropic medications. The DON stated, We need to look for side effects because it could be detrimental for the patients themselves. It might be necessary for a change in medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25, a review of a policy titled Behavior/Psychoactive Drug Management dated 11/18 indicated, .F. Any order for psychoactive medications must include .v. Specific behavior manifested .I. Monitoring for Side Effects .the resident should be observed and/or monitored for side effects and adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39220 Based on observation, interview, and record review, the facility failed to secure one of three treatment carts (East Station) and one of three medication carts (East Station), when reviewed for Pharmacy Services. This failure had the potential for residents, staff, and visitors to have access to unauthorized medications and wound supplies. Findings: An observation was conducted on 1/30/25 at 7:15 A.M., in East Station area near the nurse's station. A treatment cart was up against the wall between the nurse's station and the exit door to the secured unit (a specialized care unit which is locked and limits residents with memory loss or mental health issues from exiting the unit without supervision), and was unlocked. In the top drawer of the treatment cart were prescriptions creams and ointments. The second drawer contained scissors and wound dressing material. No staff were present in the area. An observation was conducted on 1/30/25 at 7:16 A.M., in the East Station area across from the treatment cart. A medication cart was pushed up against the exterior nurse's station and was unlocked. The first and second drawer contained, over-the-counter medications and prescription medications. No staff were present in the area. An observation and interview was conducted with licensed nurse 1 (LN 1) on 1/30/25 at 7:18 A.M., as she exited the secure unit. LN 1 stated she forgot to lock the medication cart when she left the East Station. LN 1 stated with the medication cart being left unlocked, residents, staff, and visitors could have access to medications, which could have caused harm. LN 1 stated she did not know who was responsible for locking the treatment cart, but it also contained prescriptions and equipment that could be harmful to unauthorized people. LN 1 stated the treatment cart should also have been locked when unattended. An interview was conducted with the Director of Staff Development (DSD) on 1/30/25 at 7:30 A.M. The DSD stated treatment carts and medication carts must be locked and secured when not in use to prevent theft. The DSD stated the treatment carts and medication carts contained medications which had the potential to cause harm if accessed by residents, staff, or visitors. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9:00 A.M. The DON stated he expected all treatment carts and medications carts to be locked when not in use. The DON stated when the carts were left unlocked, residents, staff, and visitors had access to unauthorized medications which could cause harm. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to to facility's policy, titled Medication Storage in the Facility, dated April 2008, .B. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39220 Based on observation, intervention, and record review, the facility failed to follow safe food practices when: 1. The ceiling above the kitchen tray line area had peeling and bubbling paint; and, 2. Two staff members entered the kitchen without donning (to put on) hair coverings. This failure had the potential for unsanitary products to fall into resident food or onto kitchen equipment. Findings: 1. An observation was conducted of the ceiling within in the kitchen, over the food tray line area on 1/28/25 at 9:20 A.M. The ceiling had an approximately 5 inch by 5 inch area of peeling paint. Pieces of peeling paint were hanging downwards. North on the ceiling, from the peeling paint area was a large section of bubbling paint estimated at 5 inches by 10 inches in size. An interview and record review was conducted with the Certified Dietary Manager (CDM) on 1/28/25 at 9:55 A.M. regarding the kitchen ceiling. The CDM stated the bubbling paint could start to peel and the peeling paint could flake off and fall down into resident food, which could cause harm. The CDM stated she believed she had reported the peeling paint to the maintenance department and she would check her Dietary Maintenance logbook. The CDM provided copies of documented past report she made for repair of the ceiling. The repairs were requested on 8/8/22, 9/1/22, 11/6/23, and 1/14/24. The repairs were never marked off by maintenance as being completed. An interview was conducted with the Director of Maintenance (DM) on 01/28/25 at 2:15 P.M. regarding kitchen repairs. The DM stated he started working at the facility in July 2024. The DM stated he was unaware of the ceiling issues within the kitchen and just learned about it today. An interview was conducted with the Registered Dietician (RD) on 1/29/25 at 10:13 A.M. The RD stated she reported the ceiling issues on her last kitchen audit to the former Administrator. The RD stated repairing the ceiling was very important to protect residents and kitchen equipment from the contamination of peeling paint. The RD stated it was important to have a clean, functioning kitchen. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated the kitchen ceiling should have been repaired when it was first reported. The DON stated paint could have fallen into resident food, which would be unsanitary. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the facility's policy, titled Sanitation, dated 2023, .5. The dietary Supervisor will report any equipment needing repair to the maintenance man 14. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures and the hood over stove, which will be cleaned by maintenance staff . 2a. An observation and interview was conducted of Kitchen Aide 1 (KA 1) on 1/28/25 at 10:31 A.M. KA 1 was observed re-entering the kitchen area and walking across the kitchen to the handwashing sink. KA 1 was wearing a baseball hat with no hair net. KA 1 had her hair pulled back into a messy bun, with strands of hair hanging down in the back. KA 1 stated she knew she was supposed to have a hair net on and she did not. KA 1 stated her hair could fall into resident food. 2b. An observation and interview was conducted with Dishwasher 1 (DW) on 1/28/25 at 10:33 A.M. The DW was observed entering the kitchen, crossing the kitchen area to speak with the CDM. The DW had on a baseball hat with no hair net. The DW also had a mustache and goatee style beard approximate 1 inch in length that was uncovered. The DW stated he knew he was supposed to have a hair net and beard cover on and he did not. The DW stated his hair could fall onto food and cause cross contamination. An interview and record review was conducted with the CDM on 1/28/25 at 10:48 A.M. The CDM stated she expected all kitchen staff to wear hair and beard guards to prevent cross contamination. The CDM reviewed and provided sanitation/hairnet training, which was provided to KA 1 and DW on 1/22/25. An interview was conducted with the Registered Dietician (RD) on 1/29/25 at 10:13 A.M. The RD stated all kitchen staff were expected to put on hair nets and beard guards before entering the kitchen. The RD stated hair nets, and facial guards were important to prevent hair from falling into food or onto equipment, which would cause cross contamination. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated he expected all staff to cover head hair and facial hair at all times when in the kitchen, because hair could fall into the residents' food. According to the facility's policy, titled Food Service Employee Hygiene Practices, undated, .1. Food Service Staff are to .use appropriate hair restraints to prevent contamination of food .

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	01/30/2025

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on observation, interview, and record review, the facility failed to accurately document: 1. Food intake percentages (how much a resident consumes for each meal) for one of one resident (Resident 3), reviewed for nutrition; and 2. Care given to one of three residents (Resident 84) reviewed for Activities of Daily Living (ADL'S). As a result, resident records were inaccurate and did not give a clear picture of the resident's current status to other care providers. Cross Reference (F-692) Findings: 1. Resident 3 was readmitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a progressive brain disorder that causes nerve cells in the brain to deteriorate, leading to body movement problems), per the facility's Admission Record. An observation was conducted of Resident 3 on 1/27/24 at 9:58 A.M., in his room. Resident 3 had a covered, untouched breakfast tray sitting on his bedside table. An observation and interview was conducted with Resident 3 on 1/27/25 at 12:52 P.M. in his room. Resident 3 was heard telling staff if did not want his lunch tray and to take it away. An unidentified staff returned Resident 3's lunch tray to the food cart. Resident 3 was observed dressed, lying in bed. Resident 3 stated he did not want his lunch because he could not see it and he did not eat anything he could not see. Resident yelled, I'm blind and can't see. I keep telling everyone, but no one listens. An observation and interview was conducted on 1/28/25 at 10:13 A.M. with Certified Nursing Assistant 1 (CNA 1). Resident 3's uneaten breakfast tray 2 was removed by CNA 1. CNA 1 stated Resident 3 does not usually eat breakfast. Resident 3's clinical record was reviewed on 1/28/25. According to the physician's order, dated 5/10/24, Resident 3 required a fortified diet, regular texture with regular to thin consistency. According to the facility's Change of Condition report, dated 1/16/25, Resident 3 has an identified weight loss. According to the facility's Task, certified nursing assistants documented food percentage consumed by Resident 3 on 1/27/25, as 75-100% of breakfast and lunch. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review was conducted with the Registered Dietician (RD) on 1/29/25 at 10:13 A.M. The RD stated she was dependent on staff to accurately document food intake, especially on residents experiencing weight loss. The RD stated if the documentation of food percentages was in inaccurate, she was not provided a clear picture of the resident, and it could cause additional weight loss. The RD reviewed Resident 3's clinical record for food percentages and stated Resident 3 was currently experiencing weight loss and she was monitoring his daily intake. The RD stated his intake for 1/27/25 was documented as 75-100% consumed and based on the surveyor's observation for breakfast and lunch, the documentation was not accurate. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9 A.M. The DON stated documentation of food percentages was very important to staff to prevent weight loss. The DON stated he expected accurate documentation because it directly affects nutrition services. According to the facility's policy, titled Food Intake-Recording Percentage & Nutrition Assessment, dated January 2012, .II. After a resident had completed the meal, the CNA will record the amount eaten on the resident's food intake record after the completion of each meal . IV.A. If more than 50% of the entire meal is refused by the resident .the charge nurse will review the resident's fluid intake, weight stability pattern, presence/absence of acute underlying medical problem . 49330 2. According to the Admission Record, Resident 84 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) affecting the right dominant side, and functional quadriplegia (a condition that causes a person to be completely unable to move). A review of Resident 84's chart indicated Resident 84 received a shower on 1/27/25 at 8:05 P.M. Resident 84's chart indicated the shower was given by CNA 14. During an interview on 1/28/25 at 4 P.M., CNA 13 stated she gave Resident 84 a bed bath on 1/27/25, not a shower. CNA 13 further stated she was unable to access the Electronic Health Record (EHR), and used CNA 14's username and password to document the care given for Resident 84. CNA 13 stated it was important to document under her own username and password to communicate the correct care given. On 1/30/25 at 12:46 P.M. an interview was conducted with the Director of Staff Development (DSD). The DSD stated, .passwords should not be shared because its someone else's name and license. I wouldn't want someone else to make a mistake under my name .its not accurate . The DSD further stated, .its important to be accurate to know what got done, so if there's an issue we know where we go. We can't [initiate] proper interventions if the charting is inaccurate . On 1/30/25 at 12:56 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated it was his expectation for staff to accurately document what care was provided to the residents. During a record review on 1/30/25, a policy titled Medical Record Content dated 1/1/12, did not provide guidance on accuracy of documentation.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 47466 Based on interview and record review, the facility's Quality Assessment Performance Improvement (QAPI-plan developed by the QAA committee to improve conditions in the facility) failed to identify deficient practices prior to to their recertification survey when: 1) The facility did not provide education to staff related to the management of residents with post-traumatic stress disorder (PTSD- a mental condition that's caused by an extreme event - either being part of it or witnessing it) and, 2) Did not identify and correct environmental hazards which could have caused injury. These failures had the potential to negatively affect residents' health and quality of life. Findings. Cross reference : F-584, F-689, and F699. 1) A joint interview on 1/30/2025 at 2:27 P.M., with the Administrator (ADM) and the Director of Nursing (DON) was conducted. The DON stated there was no education provided to staff regarding PTSD and triggers associated. The DON stated the importance of QAA committee was identifying the trends and to maintain residents health condition, prevent possible decline and to promote the highest standard of care for their residents with PTSD. 2) A joint interview on 1/30/25 at 2:27 P.M.,was conducted with the Administrator (ADM) and the Director of Nursing (DON). The ADM stated they were aware of maintenance issues but had not identified the environmental hazards found during the federal recertification survey. The ADM stated she was unaware if the facility had a safety committee, but she would now be initiating one. A record review of the facility's policy titled, Quality Assessment and Assurance Activities undated, indicated The QAA committee will review data from areas the facility believes it needs to monitor on a monthly basis to assure systems are being monitored to achieve the highest level of quality for our facility.