STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555878	A. BUILDING _____ B. WING _____	**04/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 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** Based on observation, interview, and record review, the facility failed to provide a safe environment related to lack of functioning air conditioning. The facility failed to maintain the residents' room temperature as required (71 to 81 degrees Fahrenheit). This failure had the potential to cause decreased mental and physical well-being for Residents in a susceptible population. Findings: On 7/7/17 at 1:50 P.M., a complaint reported event was investigated regarding the facility's air conditioner was not functioning; the temperature in the facility was very warm for residents. The outside temperature was 95 degrees Fahrenheit at 1:45 P.M. A tour of the facility was conducted on 7/7/17 at 2 P.M. with the maintenance director (MD). The MD checked room air temperatures with a digital thermometer. Measurements were in degrees Fahrenheit. The following readings were obtained: room [ROOM NUMBER]: 82 degrees; no airflow through the air vent. Residents' dining room: 82 degrees; no airflow through the air vent. room [ROOM NUMBER]: no airflow through the air vent. room [ROOM NUMBER]: no airflow through the air vent. room [ROOM NUMBER]: no airflow through the air vent. room [ROOM NUMBER]: no airflow through the air vent. The MD stated, The air conditioning is not working. On 7/7/17 (Friday) at 3 P.M., an interview was conducted with the MD. The MD stated, I knew the air conditioning fans were out (of service) 2 weeks ago, (I) had the parts in stock. I didn't get around to it because it is only me here most days. I will do it on Monday. A review of the facility's document, titled shipping confirmation, indicated that the air cooler motors were shipped to the facility on [DATE]. A review of the facility's policy, dated 1/1/12, titled, Resident Rooms and Environment, indicated, Purpose: to provide Residents with a safe .comfortable environment .Procedure: I. facility staff aim to create a homelike environment, paying close attention to the following .F. comfortable temperatures .

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

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.