STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555431	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY HILLS POST ACUTE	**1580 BROADWAY 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.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the conservator for two residents (10, 11) involved in an altercation. This failure had the potential for the conservator to be unaware of the residents' (10, 11) condition and status, in the facility. Findings: 1. Resident 10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 2/11/20 at 1351 (military time = 1:51 P.M.) a report was received from the facility related to an altercation between two residents (10, 11). An unannounced visit was conducted on 2/26/20. On 2/26/20 at 3:40 P.M., an interview with Resident 10 was conducted. Resident 10 stated she knew something had happened, but was unable to recall the incident. On 3/9/20 at 1:18 P.M., a phone interview with CNA 7 was conducted. CNA 7 stated he recalled Resident 10 and Resident 11 fighting in the hallway, in front of the nurse's station. On 3/10/20, at 10:24 A.M., a phone interview with licensed nurse (LN) 5 was conducted. LN 5 stated she received a report from the CNAs about the altercation between Resident 10 and Resident 11. LN 5 stated the resident's conservator had to be notified on the same day of the incident and documented in the nurse's notes. A review of Resident 10's medical record was conducted. The MDS (Minimum Data Set; an assessment tool), dated 2/17/20 indicated the resident had a BIMS (Brief Interview for Mental Status; an assessment tool) score of 4 (13-15 indicated a cognitively intact status). The Admission Record, dated 2/11/20, indicated the resident was conserved. There was no documentation found in the Nurse's Notes, the Social Services Notes, nor the facility's Investigation Report, the Resident 10's conservator was notified. On 3/10/20, at 3:14 P.M., a concurrent record review and phone interview with the director of nursing (DON) was conducted. The DON stated nurses were expected to notify Resident 10's conservator on the day of the incident but it was not done. A review of the facility's policy titled, Change in a Resident's Condition or Status, dated May 2012, indicated, Our facility shall promptly notify .representative (sponsor) of changes in the resident's medical/mental condition and or status . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any .incident . 2. Resident 11 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 2/26/20 at 3:30 P.M., an observation and interview with Resident 11was conducted. Resident 11 was sitting in a chair in the dining room. Resident 11 could not recall the incident. On 3/9/20 at 1:18 P.M., a phone interview with certified nursing assistant (CNA) 7 was conducted. CNA 7 stated he recalled Resident 10 and Resident 11 were already fighting in the hallway, in front of the nurse's station. On 3/10/20, at 10:24 A.M., a phone interview with licensed nurse (LN) 5 was conducted. LN 5 stated the CNAs reported the altercation between Resident 11 and Resident 10 to LN 5. LN 5 stated the resident's conservator had to be notified on the same day of the incident and documented in the nurse's notes. A review of Resident 11's medical record was conducted. Resident 11's MDS (Minimum Data Set; an assessment tool), dated 1/18/20 indicated the resident had a BIMS (Brief Interview for Mental Status; an assessment tool) score of 14 (13-15 indicated a cognitively intact status). Resident 11's Admission Record, dated 2/11/20, indicated the resident was conserved. There was no documentation that Resident 11's conservator was notified, in the Nurse's Notes, the Social Services Notes, nor the facility's Investigation Report. On 3/10/20, at 3:14 P.M., a concurrent record review and phone interview with the director of nursing (DON) was conducted. The DON stated nurses were expected to notify Resident 11's conservator on the day of the incident but it was not done. A review of the facility's policy titled, Change in a Resident's Condition or Status, revised May 2012, indicated, Our facility shall promptly notify . representative (sponsor) of changes in the resident's medical/mental condition and or status . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any . incident .
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** Based on observation, interview, and record review, the facility failed to implement their plan of care related to monitoring of four residents (1, 2, 6, 11) as written. In addition, the facility failed to develop a plan of care related to a behavior of taking other resident's belongings for one resident (3). These failures had the potential for altercations with the involved residents (1, 2, 3, 6, 11). Findings: 1a. Resident 1 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1's MDS (Minimum Data Set, an assessment tool), dated 6/17/19, indicated Resident 1 had a BIMS (Brief Interview of Mental Status, an assessment tool) score of 15 (13-15 indicated an intact cognition). A report was received from the facility, related to a report made by an occupational therapist (OT) of Resident 1's allegation, dated 7/3/19. The report indicated, Resident 1 was hit on the arm by Resident 2 during the night. On 7/12/19, at 12:38 P.M., an observation of Resident 1 was conducted. Resident 1 was having lunch in the dining room, and sitting in her wheel chair. On 3/10/20 at 8:06 A.M., a phone interview with licensed nurse (LN) 1 was conducted. LN 1 stated she remembered hearing of the incident, but could not give details of the incident. A review of Resident 1's care plan was conducted. The care plan, dated 7/3/19, indicated, . Monitor/document . any s/sx (signs and symptoms) of resident posing danger to self and others. There was no monitoring log found in Resident 1's medical record after the incident. A review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring Policy Statement, undated, indicated, . Monitoring . document any improvements or worsening in the individual's behavior, mood, and function On 3/10/20 at 3:14 P.M., a phone interview with the director of nursing (DON) was conducted. The DON stated, it was important to implement the plan of care related to behavioral monitoring but it was not done. 1b. Resident 2 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 2's MDS, (Minimum Data Set, an assessment tool), dated 7/1/19, indicated Resident 2 had a BIMS (Brief Interview of Mental Status, an assessment tool) score of 15 (13-15 indicated an intact cognition). On 7/12/19, at 12:27 P.M., an observation of Resident 2 was conducted. Resident 2 was sleeping and not available for an interview. On 3/10/20 at 8:06 A.M., a phone interview with licensed nurse (LN) 1 was conducted. LN 1 stated she remembered hearing of the incident, but could not give details of the incident. A review of Resident 2's medical record was conducted. The care plan titled, . (Resident 2's name) hit another resident arm ., dated 7/3/19, indicated the intervention, . Monitor/document/report to MD (medical doctor) of danger to self and others . There was no monitoring log found in Resident 2's medical record for the behaviors after the incident. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, .implements a comprehensive, person-centered care plan for each resident In addition, a review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring Policy Statement, undated, indicated, . Monitoring .document any improvements or worsening in the individual's behavior, mood, and function . On 3/10/20 at 3:14 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated, it was important to implement the plan

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.

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COUNTRY HILLS POST ACUTE	1580 BROADWAY EL CAJON, CA 92021

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) of care, related to behavioral monitoring. The DON acknowledged there was no behavioral monitoring for Resident 2. 2. Resident 6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A report was received from the facility, dated 7/10/19 at 8:11 A.M., related to an allegation of Resident 6 inappropriately touching his roommate. On 7/12/19 at 12:32 P.M., an observation of Resident 6 was conducted. Resident 6 was asleep in his bed and not available for an interview. On 7/12/19 at 3:34 P.M., an interview with Resident 5 (former roommate of Resident 6) was conducted with a Spanish translator, certified nurse assistant (CNA) 4. Resident 5 recalled the incident with Resident 6 and stated, in the middle of the night, Resident 6 touched Resident 5's backside, pulled the blanket off, and tried to get into Resident 5's bed. Resident 5 stated he tried to kick Resident 6 and reported to the social worker assistant (SWA). On 3/9/20, at 2:13 P.M., a phone interview with certified nursing assistant (CNA) 5 was conducted. CNA 5 stated, she remembered hearing of an incident with Resident 6 and Resident 5, but could not give details of the incident. A review of Resident 6's medical record was conducted. There was no evidence that monitoring was performed after the incident, for Resident 6's whereabouts, or location, from 7/9/19 to 7/11/19. A Monitoring Sheet, dated 7/12/19, did not indicate Resident 6's location from 12 A.M. to 4 A.M., and at 6 A.M. On 3/10/20, at 8:45 A.M., a phone interview with the Director of Nursing (DON) was conducted. The DON stated he could not find monitoring documentation for Resident 6. The DON stated, if there were behavioral issues, monitoring was required, and the CNAs filled out the monitoring form. The DON stated, there should have been hourly monitoring of Resident 6's behavior and location. The DON acknowledged, there were no Monitoring Sheets for Resident 6 from 7/9/19 to 7/12/19. A review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring Policy Statement, undated, indicated, .Safety strategies will be implemented immediately .to protect the resident and others from harm ., and . Monitoring .document any improvements or worsening in the individual's behavior, mood, and function . 3. Resident 11 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 2/11/20 at 1351 (military time= 1:51 P.M.) a report was received from the facility related to an altercation between Resident 10 and Resident 11. On 2/26/20 at 3:30 P.M., an observation and interview of Resident 11, was conducted. Resident 11 was sitting in a chair by herself with other residents sitting in the dining room. Resident 11 could not recall any incident with another resident. A review of Resident 11's medical record was conducted. Resident 11's MDS (Minimum Data Set; an assessment tool), dated 1/18/20, indicated the resident had a BIMS (Brief Interview for Mental Status; an assessment tool) score of 14 (13-15 indicated a cognitively intact status). On 3/9/20 at 1:18 P.M., a phone interview with certified nursing assistant (CNA) 7 was conducted. CNA 7 stated he recalled the altercation between Resident 11 and Resident 10 fighting in the hallway, in front of the nurse's station. A review of Resident 11's care plan titled, .(physical altercation with peer) ., dated 2/11/20, indicated the intervention, . Monitor, document observed behavior and attempted interventions in behavior log There was no monitoring log found in Resident 11's medical record. On 3/10/20, at 10:24 A.M., a phone interview with licensed nurse (LN) 5 was conducted. LN 5 stated she received a report from the CNAs about the altercation between Resident 10 and Resident 11. LN 5 stated Resident 11 should be monitored hourly, after the incident, due to aggression. LN 5 stated, the resident's activity and location should have been documented. On 3/10/20, at 3:14 P.M., a concurrent record review and phone interview with the director of nursing (DON) was conducted. The DON stated, if there were behavioral issues, monitoring of the behavior was required, and the CNAs filled out the monitoring form. The DON stated Resident 11's behavior and location should have been monitored and documented hourly, but it was not done. A review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring Policy Statement, undated, indicated, . Safety strategies will be implemented immediately .to protect the resident and others from harm . 4. Resident 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The H & P (history and physical) dated 12/18/18 indicated, Resident 3 did not have the capacity to understand and make decisions. A report was received from the facility on 7/8/19 at 11:39 A.M., related to an allegation of Resident 3 taking Resident 4's belongings. On 7/12/19 at 10:53 A.M., Resident 3 was not interviewable. On 7/12/19, at 11 A.M., an interview with Resident 3's former roommate (Resident 4) was conducted. Resident 4 recalled the incident and stated, she received a bottle of lotion as a gift, that went missing for a month. Resident 4 stated, Resident 3 had been stealing from her, and had known her to have this behavior. Resident 4 stated, when she had found her lotion, she could not stay calm because she was tired of the stealing, and had pushed Resident 3 to the floor. On 3/9/20 at 3:20 P.M., a phone interview with licensed nurse (LN) 2 was conducted. LN 2 stated she recalled Resident 3 taking Resident 4's something simple. LN 2 stated a care plan should have been initiated. A review of Resident 3's medical record was conducted. There were no care plans related to Resident 3's behavior of taking belongings from other residents. On 3/10/20 at 8:45 A.M., a phone interview with the director of nursing (DON) was conducted. The DON stated, the purpose of a care plan was to address Resident 3's behaviors. The DON acknowledged there was no care plan for Resident 3's behavior of taking other residents' belongings. A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, .10. Identifying problem areas and their causes, and developing interventions
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform an Interdisciplinary Team (IDT) meeting after an altercation for five residents (1, 2, 3, 5, 6). These failures had the potential for miscommunication among staff members and providers to address the residents' needs and the potential for future altercations. Findings: 1a. Resident 1 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1's MDS (Minimum Data Set, an assessment tool), dated 6/17/19, indicated Resident 1 had a BIMS (Brief Interview of Mental Status, an assessment tool) score of 15 (13-15 indicated an intact cognition). Resident 2 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS of 15. A report was received from the facility, related to a report made by an occupational therapist (OT) of Resident 1's allegation, dated 7/3/19. The report indicated, Resident 1 was hit on the arm by Resident 2 during the night. A review of Resident 1's medical record was conducted. There was no Interdisciplinary Team (IDT) note found in Resident 1's medical records after the incident. A review of Resident 2's medical record was conducted. There was no IDT note found in Resident 2's medical records after the incident. On 3/10/20 at 3:14 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated, it was important to have an IDT meeting for each resident to address the issues and develop corrective actions. The DON stated, the IDT should have been done the next day, but there was no IDT performed for each resident. A review of the facility's undated policy, Interdisciplinary Team Meeting, indicated, . reason for IDT meeting is to meet the changing needs of the patient by using an interdisciplinary system . care planning and updates will be made in a reasonable and timely manner. IDT meetings are usually held daily . 2. Resident 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The H & P (history and physical) dated 12/18/18 indicated, Resident 3 did not have the capacity to understand and make decisions. On 7/12/19, at 10:53 A.M., Resident 3 was non-interviewable. On 7/12/19, at 11 A.M., an interview with Resident 3's former roommate (Resident 4) was conducted. Resident 4 recalled the incident and stated, she received a bottle of lotion as a gift, that went missing for a month. Resident 4 stated, Resident 3 had been stealing from her, and had known her to have this behavior. Resident 4 stated, when she had found her lotion, she could not stay calm because she was tired of the stealing, and had pushed Resident 3 to the floor. On 3/6/20 at 3:25 P.M., a phone interview with the Medical Records Director (MRD) was conducted. The MRD stated there was no IDT note related to the incident for Resident 3. On 3/9/20 at 3:20 P.M., a phone interview with licensed nurse (LN) 2 was conducted. On 3/9/20 at 3:20 P.M., a phone interview with licensed nurse (LN) 2 was conducted. LN 2 stated she recalled Resident 3 taking Resident 4's something simple. A review of the facility's undated policy, Interdisciplinary Team Meeting, indicated, . reason for IDT meeting is to meet the changing needs of the patient by using an interdisciplinary system . care planning and updates will be made in a reasonable and timely manner. IDT meetings are usually held daily On 3/10/20 at 3:14 P.M., a phone interview with the Director of Nursing (DON) was conducted. The DON stated there should have been an IDT meeting after the incident and develop corrective actions but it was not done. 3. Resident 5 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the resident's MDS (Minimum Data Set, an assessment tool), dated 4/14/19, indicated Resident 5 had a BIMS (Brief Interview of Mental Status, an assessment tool) score of 15 (13-15 indicated an intact cognition). Resident 6 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A report was received from the facility, dated 7/10/19 at 8:11 A.M., related to an allegation of Resident 6 inappropriately touching his roommate, Resident 5. On 7/12/19 at 12:32 P.M., Resident 6 was not available for an interview. On 7/12/19 at 3:34 P.M., an interview with Resident 5 was conducted, with a Spanish translator, certified nurse

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) assistant (CNA) 4. Resident 5 stated, in the middle of the night, Resident 6 touched Resident 5's backside, pulled the blanket off, and attempted to get into Resident 5's bed. Resident 5 stated he reported the incident to the social worker assistant (SWA). A review of Resident 5 and Resident 6 medical records were conducted. Both residents' medical records did not indicate that an IDT meeting was conducted after the incident. On 3/10/20, at 8:45 A.M., a phone interview the director of nursing (DON) was conducted. The DON stated there were no IDT notes found in Resident 5 and Resident 6's medical records that IDT meetings were held after the incident. The DON stated there should have been an IDT meeting after the incident to address the issues and develop corrective actions. A review of the facility's undated policy, Interdisciplinary Team Meeting, indicated, . reason for IDT meeting is to meet the changing needs of the patient by using an interdisciplinary system . care planning and updates will be made in . timely manner . IDT meetings are usually held daily .