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 _____	**09/15/2020**

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 -** Few	**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 interview and record review the facility failed to protect resident's belongings from loss or theft and ensure an inventory record containing residents' belongings were documented and signed for 2 of 2 sampled residents (1, 2). As a result, Resident 1's belongings were missing and the facility was unable to verify that Resident 2 received all their belongings. Findings: 1. Resident 1 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 2/11/20, a review of Resident 1's record was conducted. Per the document titled, Inventory of Personal Effects, there was no signature from the family member that the belongings were picked up, or documented evidence of what happened to Resident 1's belongings. On 2/11/20 at 12:24 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 1 was transferred to the hospital and later passed away. LN 1 stated the process when a resident was discharged from the facility was that the certified nursing assistant (CNA) was to put the resident's belongings in a box and ask the maintenance to keep the box in the storage room. LN 1 further stated when the family or responsible party was ready to pick up the belongings, the staff would review the items and have them sign the inventory form. LN 1 stated she was unsure what happened to Resident 1's belongings. On 2/11/20 at 12:45 P.M., an interview was conducted with CNA 1, who was assigned to Resident 1 when transferred to the hospital. CNA 1 stated she did not put Resident 1's belongings in a box and was unsure who did. CNA 1 stated when she returned from her day off Resident 1's belongings were no longer in the room. CNA 1 stated she was unsure what happened to Resident 1's belongings. On 2/11/20 at 1:11 P.M., an interview was conducted with the Social Worker (SW). The SW stated the family member came into the facility and requested Resident 1's belongings sometime over the weekend. The staff were unable to locate Resident 1's belongings, therefore the family member could not sign the inventory form. The SW further stated she attempted to look for Resident 1's belongings but was unsuccessful. The SW stated we do not know what happen to Resident 1's belongings. On 2/11/20 at 1:45 P.M., a joint interview and record review was conducted with the Director of Environmental Services (DES). The DES stated any time staff asked to store resident's belongings in the storage room, he would document it on the Discharge Resident Belongings Log Form, but Resident 1's was not on this log because he never stored the Resident's belongings. The DES further stated he did not know where Resident 1's belongings went. On 2/11/20 at 2 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated residents belongings should have been protected from loss or theft. The DON stated the facility could not locate Resident 1's belongings. On 3/5/20 at 2 P.M., an interview was conducted with CNA 4. CNA 4 stated on 1/21/20, he was told by the LN 2 to put Resident 1's belongings in the box, around 2 P.M., and he had to hurry because his shift was over at 3 P.M. CNA 4 stated he left two boxes of Resident 1's belongings in the room and did not notify DES to store Resident 1's belongings. LN 2 was not available for an interview. On 8/24/20 at 4:27 P.M., an interview was conducted with CNA 5. CNA 5 stated on 1/21/20, she was the assigned CNA that was working on Resident 1's room in the afternoon. CNA 5 stated when she entered Resident 1's room she did not see any box and had no idea where Resident 1's belongings were. On 8/24/20 at 5 P.M., an interview was conducted with the Administrator (ADM). The ADM stated Resident 1's belongings was never found and the facility should have protected it from loss or theft. 2. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 2/11/20, a record review was conducted. Per the document titled, Inventory of Personal Effects, there was no signature from the family member that the belongings were picked up, or any documented evidence of what happened to Resident 2's belongings. On 2/11/20 at 1:11 P.M., an interview was conducted with the SW. The SW stated Resident 2 received his belongings but was unable to explain why the inventory had not been signed by the resident or the representative. On 2/11/20 at 2 P.M., a joint interview and record review was conducted with the DON. The DON stated the staff should have reviewed the items on the inventory list and the items inside the box. The DON further stated the staff should have had the resident or the responsible party sign the inventory form before they left the facility to confirm that the belongings were accepted. The DON stated Resident 1 and Resident 2's inventory forms were not signed. Per the facility's policy and procedure, revised 2/18, titled Discharge and Transfer of Residents, .IV. Resident Inventory A. At the time of discharge from the facility, Facility staff will prepare a Resident Inventory. B. Upon discharge, Facility will provide the resident/resident representative with a copy of the Resident's Inventory and have the recipient sign .

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.