STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055488	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Mesa Healthcare Center	3780 Massachusetts Avenue LA Mesa, CA 91941

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 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 interview and record review, the facility failed to develop a care plan to protect Resident 1 from further claims of lost personal funds when the resident alleged his cash was stolen from his personal locked safe.As a result, Resident 1 was potentially exposed to feeling decreased sense of security.Findings:On 5/5/26 at 12:25 P.M., an onsite investigation was conducted to investigate a Facility Reported Incident (FRI) regarding an alleged stolen cash of $3000 from Resident '1 personal safe. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with PTSD (Post-Traumatic Stress Disorder - a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening event). A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 3/5/26, indicated the resident's BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On 5/5/26 at 1:10 P.M., an observation and interview were conducted with Resident 1. The resident was observed sitting at the edge of the bed, eating lunch. Resident 1 stated he had lost cash a few times at the facility and this time. In response, the facility provided a personal safe with a lock and key for his room. However, despite multiple offers and education from staff about the risks of keeping cash on hand, Resident 1 adamantly refused to use the facility's safe, stating that he did not trust anyone with his money. After receiving his personal safe, Resident 1 stated he went to the bank to withdraw his money and placed them in the safe. Resident 1 pointed out a black box located on the floor between his nightstand and his bed and explained he hid the safe in the nightstand and kept the key in an open-top glass pouch. Resident 1 stated he could not find his key to the safe and discovered the safe was open and empty. Resident 1 stated that this time, he had $2,500 in cash stolen, adding to two previous thefts at the facility. Resident 1 repeatedly stated that he did not trust anyone with his money, yet he did not keep a record of the amount of money kept in his safe. Resident 1 stated stated he could not remember how much money he withdrew prior to placing the cash in his safe or which date he withdrew the money. On 5/5/26 at 2:08 P.M., an interview was conducted with the Certified Nursing Assistant (CNA). The CNA stated he would accompany Resident 1 to his bank to withdraw money using Uber as their transportation. The CNA stated he did not have the knowledge of how much money Resident 1 withdrew each time they visited the bank. The CNA stated the facility's policy for personal funds was to keep it in the facility's safe or to send it home with the family. On 5/5/26 at 3:33 P.M., an interview was conducted with the ADM and the Director of Nursing (DON). The ADM stated Resident 1 was very skeptical of others and would not even let the housekeeping clean his room without his presence. The ADM stated Resident 1 refused to put his money in the facility's safe or count it after returning from the bank, despite multiple educational efforts and being informed of the risks of losing the money. The ADM stated the facility decided to utilize the personal safe for Resident 1 since the resident reported he had lost his cash a few times at the facility but continued to refuse to use the facility's safe. A review of Resident 1's care plan Resident prefer to keep his money and decline to keep it in the safe dated 2/17/26 indicated, Continue to Offer to use safe at social services office to keep his money (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055488	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Mesa Healthcare Center	3780 Massachusetts Avenue LA Mesa, CA 91941

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reeducate resident to risk and consequences of keeping money at bedside. No other care plans were found regarding his personal funds, including his visits to the bank and inventory of the money he withdrew, and his use of the personal safe. On 5/6/26 at 10:37 A.M., an interview and record review was conducted with the Assistant Social Worker (ASW). After reviewing Resident 1's care plans, the ASW stated she failed to develop Resident 1's personalized care plan surrounding his personal funds. The ASW stated the care plan should have been more specific and personalized because she was aware that Resident 1 made trips to the bank to withdraw his money with the CNA, the resident's refusal to count the money and use the facility's safe after his bank visits, and the presence of his personal safe. On 5/6/26 at 10:50 A.M., an interview and record review was conducted with the Licensed Nurse (LN). The LN reviewed Resident 1's care plan. The LN stated the facility should have developed a clear care plan for Resident 1's money withdrawals, inventory of the money, and use of the safe. On 5/6/26 at 11:10 A.M., an interview was conducted with the DON and the ADM. The ADM and the DON acknowledged that the facility did not develop personalized care plans for Resident 1 regarding the use of the personal safe and the expectations surrounding its use, a clear process of Resident 1's trip to the bank with the CNA, and a protocol for after the resident returns with the money from the bank. The DON stated those should have been developed as part of Resident 1's care plan.A review of facility's policy titled Personal Property revised August 2022, did not indicate protection plan for residents after they encounter accidents while out on pass. A review of facility's policy titled Care Plans, Comprehensive Person-Centered revised March 2022, indicated, .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.