STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055806	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Las Palmas Healthcare Center	622 South Anza Street El Cajon, CA 92020

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of sexual abuse for one of three sampled residents (Resident 1) to the Department of Public Health (DPH) within twenty-four (24) hours from the time the facility learned of the allegation.This deficient practice had the potential for Resident 1 to experience continued abuse and negative psychosocial outcomes. Findings:On 12/19/25 at 12:45 P.M., an unannounced visit was conducted at the facility to investigate a complaint regarding an allegation of abuse. During a record review on 12/19/25, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included alcoholic cirrhosis of liver (severe scarring of the liver caused by alcohol abuse), major depressive disorder, anxiety disorder, and unspecified dementia.During a record review on 12/19/25, the Minimum Data Set (MDS-an assessment tool) indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) of 9, which indicated Resident 1 had impaired cognition.During an interview with the Assistant Director of Nursing (ADON) on 12/19/25 at 12:45 P.M., the ADON stated on 12/18/25 around 1 P.M., the police arrived at the facility after Resident 1 called 911 to report an allegation of abuse. The ADON stated she was present during the police's interview with Resident 1. The ADON stated during the interview, Resident 1 stated that a staff member, .asked him, ‘how are you honey' and touched his shoulder and touched his butt. The ADON further stated Resident 1 felt sexually harassed by a staff member. The ADON stated Resident 1 did not report this allegation to any staff member.During an interview with Licensed Nurse (LN) 1 on 12/19/25 at 1:30 P.M., LN 1 stated he was present during Resident 1's interview with the police officer. LN 1 stated, [Resident 1] told the cop his nurse was flirtatious with [Resident 1], [the nurse] was overly nice.[Resident 1] said he felt like it was sexual harassment. LN 1 stated Resident 1 identified Licensed Nurse (LN) 2 as the alleged perpetrator. LN 1 stated Resident 1's comments were an allegation of abuse.During an interview with the Director of Nursing (DON) on 12/19/25 at 2:02 P.M., the DON stated Resident 1 accused LN 1 of harassment and, any type of harassment is abuse. The DON stated the facility did not report the abuse allegation to the State Licensing Agency or the Ombudsman. The DON stated she did not initiate the investigation, or report the incident because she was training the ADON to investigate allegations of abuse. The DON stated, I wanted [the ADON] to train and take initiative over the incident. The DON stated it was her expectation that any allegation of abuse was reported to the State Licensing Agency.During an interview with Resident 1 on 12/19/25 at 3:22 P.M., Resident 1 stated, About 12 days ago, one of the male nurses was flirtatious with me. It started with ‘hey honey, how's it going?' I blew it off and [the flirtatious behavior] increased . Resident 1 further stated, [LN 1] stroked my face and he put his fist in my [vulgar word for buttocks]. Resident 1 stated he called the police, but does not remember whether he told staff about LN 1's actions.During an interview with the Director of Operations (DO) on 12/19/25 at 3:31 P.M., the DO stated he was the designated abuse coordinator for the facility. The DO stated as abuse coordinator, his responsibility was to ensure all allegations of abuse were reported to the State Agency per policy. The DO acknowledged Resident 1's allegations were not reported to CDPH.During a record review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022, the policy indicated, All reports of resident abuse.are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services.e. Law enforcement officials; f. The resident's attending physician; and g. The facility's medical director.Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.