

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2025
NAME OF PROVIDER OR SUPPLIER  Magnolia Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  635 S Magnolia Ave 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to follow their policies and procedures for investigating missing items to protect the personal property for one reviewed resident (Resident 1) during a complaint investigation.</p> <p>This deficient practice placed all 91 residents at risk for loss of personal belongings and potential exploitation (taking advantage of a resident for personal gain), especially those with impaired cognition (memory or thinking).</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of cognitive communication deficit (CCD-understanding what others say and organizing thoughts) and right ear hearing loss.</p> <p>A record review of Resident 1s minimum data set (MDS - a federally mandated resident assessment tool) dated 4/14/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of six points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>On 4/30/25 12 P.M., an interview was conducted with the Quality Assurance (QA) Nurse. The QA nurse stated on 4/4/25 a Facility Reported Incident (FRI) was previously reported due to Resident 1's allegation of missing money. The QA nurse stated Resident 1 was unsure if she had the missing money with her. The QA nurse stated they investigated the missing money which concluded Resident 1 did not have the missing money with her when she came to the facility per Resident 1 ' s personal belongings list.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/30/25 at 12:13 P.M., An interview and record review was conducted with the Social Services Director (SSD). The SSD stated she was informed on 4/17/25 by the nursing staff of the missing gray bag. The SSD stated the nursing staff was not able to place Resident 1 ' s hearing aids in her ear which alerted them [nursing staff] that Resident 1 ' s gray bag was missing because the hearing aids was stored inside Resident 1 ' s gray bag. The SSD stated she spoke with Resident 1 who told her that she had given her gray bag to her personal caregiver (not employed at facility). The SSD stated Resident 1 had told her the contents of the bag which included Resident 1 ' s house keys, phone charger, and hearing aids. The SSD stated Resident 1 ' s personal caregiver had access to her apartment because she had Resident 1's house keys. The SSD stated that she had only met Resident 1 ' s personal caregiver twice because she would come to the facility after hours to visit Resident 1. The SSD stated she did not contact Resident 1 ' s personal caregiver to ask about the gray bag because Resident 1 ' s personal caregiver was not listed on Resident 1 ' s clinical record and only knew her first name. The SSD stated because she lacked Resident 1 ' s personal caregiver ' s information she was unable to ask if the hearing aids could be returned to Resident 1. The SSD stated she had reached out to Resident 1 ' s [SENIOR LIVING FACILITY NAME] to replace Resident 1 ' s hearing aids and further stated it ' s a referral process so it takes a while but provided a fax report on 4/18/25 for an Audiology [hearing] ENT [ears, nose, throat] specialist consult.</p> <p>On 4/30/25 at 12:45 P.M., an interview was conducted with the SSD, QA Nurse and Operations Manager (OM). The OM stated it was important that they obtained [First Name of Resident 1 ' s personal Caregiver] information and question how much involvement she had with Resident 1. The QA stated that there was no further information found on [First Name of Resident 1 ' s personal Caregiver].</p> <p>On 4/30/25 at 12:48 P.M., a record review was conducted on the SSD Missing Items binder. There was no recorded investigation regarding Resident 1 ' s missing gray bag or hearing aids.</p> <p>On 4/30/25 at 12:52 P.M., an interview was conducted with Resident 1, in Resident 1 ' s room. Resident 1 stated she had a missing gray bag and stated [First Name of Resident 1 ' s personal Caregiver] can give you much information about this. Resident 1 stated she did not give her gray bag to [First Name of Resident 1 ' s personal Caregiver]. Resident 1 stated the bag had diapers, wallet and hearing aids was in that purse and it was brand new and another box with a charger. Resident 1 stated her hearing aids have not been used since the day her gray bag went missing (4/17/25).</p> <p>On 4/30/25 at 2:17 P.M., an interview and record review was conducted with the QA Nurse. The QA nurse stated Resident 1 went to the hospital on 4/5/25 and returned on 4/10/25. The QA nurse stated that a new inventory list was made when Resident 1 returned from the hospital. A review of Resident 1 ' s Inventory of Personal Effects dated 4/10/25 included:</p> <ul style="list-style-type: none"> <li>- bag-gray</li> <li>- keys</li> <li>- charger for hearing aids</li> <li>- id [identification] card</li> <li>- two hearing aids checked off.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/30/25 at 4:26 P.M., an interview was conducted with the QA Nurse. The QA Nurse stated his expectations were for the SSD to follow up with [First Name of Resident 1 's personal Caregiver] since Resident 1 has cognitive impairments to verify if the bag was given to her or was still missing. The QA nurse stated Resident 1 has hearing impairments and without the use of hearing aids this could have affected Resident 1 's quality of life to cause communication barriers, and confusion.</p> <p>On 4/30/25 4 P.M., receipt reviewed of generic hearing aids purchased for \$54.11 by OM on 4/30/25.</p> <p>On 5/1/25 at 11:15 A.M., an interview was conducted with the DON. The DON stated Resident 1 has severe cognitive impairments and may forget at times that can affect her memory and may not realize she 's [Resident 1] being taken advantaged of by a person who is supposed to be caring for her. The DON stated it was her expectation that the SSD to follow the facility 's missing items policy and procedures and to protect Resident 1 from risks of exploitation.</p> <p>A review of the facility's policy and procedure titled [Facility Name] POLICY/PROCEDURE SECTION ADMINISTRATIVE SUBJECT THEFT &amp; LOSS undated, indicated, 1. Loss or theft of resident property worth \$25.00 or more will be documented and reported to the administrator (or designee) for investigation, police reporting or other appropriate action .2. Completed Theft and Loss investigation reports will be filed in a binder which will be retained in the Social Service Department Office .</p>