STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055890	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Post Acute Care	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 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 ensure Resident 2's grievance corrective action was followed through when the facility assigned certified nursing assistant (CNA) 4 to the resident after Resident 2 requested not to assign CNA 4 to provide care to her as indicated in her grievance on 7/21/24.As a result of this deficient practice, Resident 2's request to not be provided care by CNA 4 was not honored and the resident was at risk for further abuse by CNA 4. Cross reference F600 and F656.Findings: On 11/26/25 at 10:19 A.M., an onsite investigation was conducted to investigate three Facility Reported Incidents (FRIs) alleging CNA 4 inappropriately touched Residents 2 and two other residents. A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 2's Minimum Data Set assessment (MDS, a comprehensive assessment tool) dated 10/7/25, indicated the resident's brief interview of mental status was 15 out of 15, which indicated the resident was cognitively intact.A review of Resident 2's History and Physical dated 9/30/25, indicated the resident had capacity to understand and make decisions. A review of Resident 2's facility investigative summary dated 11/17/25, indicated, .On 11/13/25 at approximately 2100pm [9 P.M.], a report was received . [Resident 2] alleged that a male staff touched her inappropriately while.changing her brief. [Resident 2] heard the alleged situation of inappropriate behavior with another resident in the building. On 12/9/25 at 12 P.M., an interview was conducted with Resident 2. Resident 2 was asked about the incident with CNA 4 that she had reported to the facility on [DATE]. Resident 2 stated CNA 4 had changed her soiled brief. The resident stated CNA 4 told her that he was going to give her a massage which would make her feel better and help her go to sleep. Resident 2 stated CNA 4 then started massaging her vagina where he should not be rubbing. Resident 2 stated CNA 4 rubbed her vagina outside and inside, then she felt his hand starting to go into her vagina. Resident 2 stated she realized what was happening and told CNA 4, It better be the end of it. Never again do I want a massage, at which point CNA 4 stopped. Resident 2 stated CNA 4's actions made her feel very uncomfortable because no doubt in my mind that the brief change by CNA 4 was different from a normal one. Resident 2 stated the incident made her feel angry and she felt CNA 4 took advantage of her. A review of CNA 4's employee file indicated that there was a grievance filed against CNA 4 by Resident 2 on 7/21/25. The grievance indicated the CNA was a little too friendly and [Resident 2] just wa [sic] the CNA to do her brief change and so she can go to sleep and Resident 2 requested to not have CNA 4 be assigned to her. The grievance did not mention a sexual touch by CNA 4. On 12/11/25 at 10:04 A.M., another interview was conducted with Resident 2. Resident 2 was asked about the grievance she filed against CNA 4. Resident 2 was asked when the incident with CNA 4 had occurred. The resident stated it happened a few days before the grievance was filed (on 7/21/25). Resident 2 stated she did not include the sexual abuse encounter in the grievance. Resident 2 stated she regretted not including the sexual abuse committed by CNA 4 in the grievance because other residents could have been victimized by him, too. The resident stated she was especially worried about the non-verbal, vulnerable residents who could not speak up about abuse. Resident 2 stated when CNA 4 massaged her vagina, it was an unpleasant experience, and it felt sexual in nature. Resident 2 stated after the incident with CNA 4, I was on the edge as to who is going to be the CNA at night, worried that he was going to be my CNA again. Resident 2 stated CNA 4 changed her brief again one night in October. Resident 2 stated CNA 4 did not massage or insert his fingers into her vagina that time because she recognized him when he entered her room and told him, No massages, no nothing, just a change. A review of the CNA assignment for July through October 2025, indicated CNA 4 had provided care to Resident 2 on 7/14/25 and 10/21/25 during the NOC shift (11P.M. to 7A.M.). On 12/18/25 at 10:13 A.M., a phone interview and record review was conducted with the Director of Nursing (DON), the Administrator (ADM), and the facility's Clinical Consultant (CC). The DON stated CNA 4 being assigned to Resident 2 on 10/21/25 was an oversight on her part. The DON stated CNA 4 should not have been assigned to Resident 2 after the grievance indicated the resident refused to be cared by CNA 4. The facility's written form provided to their residents titled Resident Rights dated July 2017, indicated, .Safe Environment. You have a right to a safe.homelike environment. A review of the facility's policy titled Section: Resident Rights Subject: Grievance dated November 2025, indicated, .4. The grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three out of three residents (Resident 1, 2, and 3) were free from sexual abuse when:1. Resident 1 stated certified nursing assistant (CNA) 4 fondled her clitoris and inserted his fingers in her vagina during care.2. Resident 2 stated CNA 4 massaged her vagina during a brief change. 3. Resident 3 stated CNA 4 inserted his fingers into her vagina during a brief change. 4. The facility hired CNA 4 with reference checks that reflected negative past employment performance. As a result of this deficient practice, Resident 1, 2, and 3 experienced psychosocial harm (damage to a person's mental, emotional, and social well-being that was caused by their environment or experiences), stating the incidents with CNA 4 made them feel angry, humiliated, embarrassed, ashamed, and worried. Findings: On 11/26/25 at 10:19 A.M., an onsite investigation was conducted to investigate three Facility Reported Incidents (FRIs) alleging CNA 4 inappropriately touched Residents 1, 2, and 3. 1. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included constipation, difficulty walking, and need for assistance with personal care. A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 11/28/25, 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).A review of Resident 1's History and Physical dated 11/10/25 indicated the resident had capacity to understand and make decisions. A review of Resident 1's facility investigative summary dated 11/16/25, indicated, .According to [Resident 1], during the NOC [night] shift on 11/11/25. [Resident 1] had a large soft stool that needed to be cleaned. The CNA came in, introduced himself as [CNA 4] . and explained that he would change the brief.felt as if something brushed against her vaginal area. On 12/9/25 at 11:13 A.M., an interview was conducted with Resident 1. Resident 1 was asked about the allegation which the resident reported to the facility on [DATE]. The resident stated she told a nurse about her abdominal pain caused by her constipation in the early morning of 11/12/25. Resident 1 stated CNA 4 came into her room and told her he could help with her constipation around 3 A.M. The resident stated CNA 4 then removed the front part of her brief and she felt his fingers rubbing against her clitoris. The resident then stated she felt CNA 4's fingers going into her vagina. Resident 1 stated when CNA 4 rubbed her clitoris and inserted his fingers into her vagina, it felt sexual in nature and was uncomfortable. Resident 1 stated she felt humiliated and ashamed, and she was glad CNA 4 no longer worked at the facility. The resident stated she reported this incident to her husband and the facility later that day. Resident 1 stated she reported the incident because it felt wrong that CNA 4 was taking advantage of people like her sexually. The resident remembered and verbalized CNA 4's name and stated she was worried if there were other residents who had been abused by CNA 4. A review of Resident 1's Care Plan initiated on 11/12/25, indicated, the resident requested to have only female CNA or a female CNA to be present if a male CNA was to give her care. 2. A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 2's MDS assessment dated [DATE], indicated the resident's BIMS was 15 out of 15.A review of Resident 2's History and Physical dated 9/30/25, indicated the resident had capacity to understand and make decisions. A review of Resident 2's facility investigative summary dated 11/17/25, indicated, .On 11/13/25 at approximately 2100pm [9 P.M.], a report was received . [Resident 2] alleged that a male staff touched her inappropriately while.changing her brief. [Resident 2] heard the alleged situation of inappropriate behavior with another resident in the building. On 12/9/25 at 12 P.M., an interview was conducted with Resident 2. Resident 2 was asked about the incident with CNA 4 that she had reported to a CNA on 11/13/25. Resident 2 stated CNA 4 had changed her soiled brief. The resident stated CNA 4 told her that he was going to give her a massage which would make her feel better and help her go to sleep. Resident 2 stated CNA 4 then started massaging her vagina where he should not be rubbing. Resident 2 stated CNA 4 rubbed her vagina outside and inside, then she felt his hand starting to go into her vagina. Resident 2 stated she realized what was happening and told CNA 4, It better be the end of it. Never again do I want a massage, at which point CNA 4 stopped. Resident 2 stated CNA 4's actions made her feel very uncomfortable because no doubt in my mind that the brief change by CNA 4 was different from a normal one. Resident 2 stated the incident made her feel angry and she felt CNA 4 took advantage of her. A review of CNA 4's employee file indicated that there was a grievance filed against CNA 4 by Resident 2 on 7/21/25. The grievance indicated the CNA was a little too friendly and [Resident 2] just wa [sic] the CNA to do her

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 thoroughly investigate and identify sexual abuse in the facility after conducting three investigations when:1. The facility unsubstantiated Resident 1's sexual abuse allegation against certified nursing assistant (CNA) 4.2. The facility unsubstantiated Resident 2's sexual abuse allegation against CNA 4.3. The facility unsubstantiated Resident 3's sexual abuse allegation against CNA 4.4. The facility's investigation into the allegations against CNA 4 indicated the CNA had only favorable pre-employment references when this was not correct. In addition, the facility failed to ask clarifying questions during the course of their investigations to fully understand the residents' allegations. As a result of the facility's failure to identify and substantiate sexual abuse through its own investigative process, residents were placed at risk for abuse. Findings: On 11/26/25 at 10:19 A.M., an onsite investigation was conducted to investigate three Facility Reported Incidents (FRIs) alleging CNA 4 inappropriately touched Residents 1, 2, and 3. 1. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include constipation, difficulty walking, and need for assistance with personal care. A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 11/28/25, indicated the resident's BIMS (Brief Interview for Mental Status) was 15 out of 15, indicating the resident was cognitively intact.A review of Resident 1's History and Physical dated 11/10/25, indicated the resident had capacity to understand and make decisions. A review of Resident 1's facility investigative summary dated 11/16/25, indicated, .According to [Resident 1], during the NOC [night] shift on 11/11/25.she [Resident 1] had a large soft stool that needed to be cleaned. The CNA came in, introduced himself as [CNA 4] . and explained that he would change the brief.felt as if something brushed against her vaginal area. On 12/9/25 at 11:13 A.M., an interview was conducted with Resident 1. Resident 1 was asked about the allegation which the resident reported to the facility on [DATE]. The resident stated she told a nurse about her abdominal pain caused by her constipation in the early morning of 11/12/25. Resident 1 stated CNA 4 came into her room and told her he could help with her constipation around 3 A.M. The resident stated CNA 4 then removed the front part of her brief and she felt his fingers rubbing against her clitoris. The resident then stated she felt CNA 4's fingers going into her vagina. Resident 1 stated when CNA 4 rubbed her clitoris and inserted his fingers into her vagina, it felt sexual in nature and was uncomfortable. Resident 1 stated she felt humiliated and ashamed, and she was glad CNA 4 no longer worked at the facility. The resident stated she reported this incident to her husband and the facility later that day. Resident 1 stated she reported the incident because it felt wrong that CNA 4 was taking advantage of people like her sexually. The resident remembered and verbalized CNA 4's name and stated she was worried if there were other residents who had been abused by CNA 4. 2. A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 2's MDS assessment dated [DATE], indicated the resident's BIMS was 15 out of 15.A review of Resident 2's History and Physical dated 9/30/25, indicated the resident had capacity to understand and make decisions. A review of Resident 2's facility investigative summary dated 11/17/25, indicated, .On 11/13/25 at approximately 2100pm [9 P.M.], a report was received . [Resident 2] alleged that a male staff touched her inappropriately while.changing her brief.[Resident 2] heard the alleged situation of inappropriate behavior with another resident in the building. On 12/9/25 at 12 P.M., an interview was conducted with Resident 2. Resident 2 was asked about the incident with CNA 4 that she had reported to the facility on [DATE]. Resident 2 stated CNA 4 had changed her soiled brief. The resident stated CNA 4 told her that he was going to give her a massage which would make her feel better and help her go to sleep. Resident 2 stated CNA 4 then started massaging her vagina where he should not be rubbing. Resident 2 stated CNA 4 rubbed her vagina outside and inside, then she felt his hand starting to go into her vagina. Resident 2 stated she realized what was happening and told CNA 4, It better be the end of it. Never again do I want a massage, at which point CNA 4 stopped. Resident 2 stated CNA 4's actions made her feel very uncomfortable because no doubt in my mind that the brief change by CNA 4 was different from a normal one. Resident 2 stated the incident made her feel angry and she felt CNA 4 took advantage of her. 3. A review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including need for assistance with personal care. A review of Resident 3's MDS assessment dated [DATE], indicated the resident's BIMS was 15 out of 15.A review of Resident 3's History and Physical dated 12/7/24, indicated the resident had capacity to understand and make decisions. A review of Resident

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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 and implement a person-centered care plan in a timely manner after Resident 2 filed a grievance and requested certified nursing assistant (CNA) 4 to not be assigned to her. As a result of this deficient practice, Resident 2's request to not be provided care by CNA 4 was not honored and the resident was at risk for further abuse by CNA 4.Findings: On 11/26/25 at 10:19 A.M. , an onsite investigation was conducted to investigate three Facility Reported Incidents (FRIs) alleging CNA 4 inappropriately touched Residents 2 and two other residents. A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 2's Minimum Data Set assessment (MDS, a comprehensive assessment tool) dated 10/7/25, indicated the resident's brief interview of mental status was 15 out of 15, which indicated the resident was cognitively intact.A review of Resident 2's History and Physical dated 9/30/25, indicated the resident had capacity to understand and make decisions. A review of CNA 4's employee file indicated that there was a grievance filed against CNA 4 by Resident 2 on 7/21/25. The grievance indicated the CNA was a little too friendly and [Resident 2] just wa [sic] the CNA to do her brief change and so she can go to sleep and Resident 2 requested to not have CNA 4 be assigned to her. The grievance did not mention a sexual touch by CNA 4. On 12/11/25 at 10:04 A.M., an interview was conducted with Resident 2. Resident 2 was asked about the grievance she filed against CNA 4. Resident 2 was asked when the incident with CNA 4 had occurred. The resident stated it happened a few days before the grievance was filed (on 7/21/25). Resident 2 stated she did not include the sexual abuse encounter in the grievance. Resident 2 stated she regretted not including the sexual abuse committed by CNA 4 in the grievance because other residents could have been victimized by him, too. The resident stated she was especially worried about the non-verbal, vulnerable residents who could not speak up about abuse. Resident 2 stated the incident involved CNA 4, and that he had massaged her vagina during care and it was an unpleasant experience. Resident 2 stated the incident felt sexual in nature. Resident 2 stated after the incident with CNA 4, I was on the edge as to who is going to be the CNA at night, worried that he was going to be my CNA again. Resident 2 stated CNA 4 changed her brief again one night in October. Resident 2 stated CNA 4 did not massage or insert his fingers into her vagina that time because she recognized him when he entered her room and told him, No massages, no nothing, just a change. A review of the CNA assignment for July through October 2025, indicated CNA 4 had provided care to Resident 2 on 7/14/25 and 10/21/25 during the NOC shift (11P.M. to 7A.M.). A review of Resident 2's care plan ADL Self Care Performance Deficit related to UTI, Chest pain, pain to left shoulder, weakness, impaired mobility indicated Resident have preference on some CNAs over others without being specific on reasons why she refuse certain CNAs as an intervention. The care plan was initiated on 10/24/25. On 12/17/25 at 3:31 P.M., a record review was conducted with the Medical Record Director (MDR) through emails. The MDR reviewed Resident 2's care plan and stated the facility did not have a care plan developed in response to Resident 2's request to not have CNA 4 assigned to her when the grievance was filed on 7/21/25. On 12/18/25 at 10:13 A.M., a phone interview and record review was conducted with the Director of Nursing (DON), the Administrator (ADM), and the facility's Clinical Consultant (CC). The DON stated the facility did not develop a care plan promptly to honor Resident 2's request to not assign CNA 4 to her as indicated in the grievance filed on 7/21/25. A review of the facility's policy titled Care Planning/Care Conference dated January 2025, indicated, .4. Revision and update of care plan should transpire to accommodate resident needs.where IDT [Interdisciplinary Team, a group of health care professionals that coordinate resident care] will respect resident's decision.