STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056182	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Hill Post Acute	1201 34th St. San Diego, CA 92102

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. (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
	056182	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Hill Post Acute	1201 34th St. San Diego, CA 92102

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure comprehensive resident-centered care plans were revised and implemented for two of 16 sampled residents (Resident 20 and 40) when: 1. Resident 20 had an altercation with his roommate and the care plan was not revised.2. Resident 40's activities care plan was not implemented. These failures had the potential to affect resident's care needs. Cross Reference F 679.Findings: 1. Resident 20 was admitted to the facility on [DATE], per the facility's admission Record. On 8/27/25, a review of Resident 20's clinical record was conducted. Resident 20's progress notes dated 8/21/25 indicated Resident 20 had physical contact with his roommate. The care plan noted in Resident 20's clinical record related to resident's physical contact with his roommate was not revised. On 8/27/25 at 8:40 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 20 was alert and oriented. CNA 2 stated the report was Resident 20 had physical contact with his roommate. CNA 2 stated Resident 20 was taken to the acute care hospital after the incident. On 8/27/25 at 11:20 A.M., a joint review of Resident 20's clinical record and an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 20 was transferred to acute care hospital. LN 2 stated Resident 20's care plan was not revised related to the altercation with his roommate. LN 2 stated the care plan should have been revised. On 8/27/25 at 11:28 A.M., a joint review of Resident 20's clinical record and an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 20's care plan was not revised. On 8/28/25 at 8:04 A.M., a joint review of Resident 20's clinical record and an interview was conducted with the Director of Nursing (DON) 1 with the presence of DON 2. DON 1 stated Resident 20 was alert, confused and would get easily agitated. DON 1 stated Resident 20 became agitated when his needs were not met timely. DON 1 stated Resident 20 had an altercation with another resident prior to the incident with his roommate. DON 1 stated per the LNs report, Resident 20 took the leg of the wheelchair and barricaded himself in his room. DON 1 stated Resident 20's roommate did not know what happened. Per DON 1, Resident 20 was agitated and shut the door until the police officers came to take Resident 20 to the acute care hospital. DON 1 stated the care plan for Resident 20's aggressive behavior was not revised and was not addressed. DON 1 stated the purpose of revising the care plan was to ensure Resident 20's aggressive behavior was addressed. A review of the facility's policy titled, Comprehensive Resident Centered Care Plan, Revised 5/2025, indicated, .4. Care plan will be revised as needed. 2. Resident 40 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like transferring), per the facility's admission Record. On 8/25/25, a review of Resident 40's history and physical (H&P), dated 7/4/25, indicated Resident 40 had the capacity to make decisions. On 8/25/25, a review of Resident 40's minimum data set (MDS - a federally mandated resident assessment tool) dated 7/9/25, indicated Resident 40's brief interview for mental status (BIMS, ability to recall) score was 15/15, which meant Resident 40's cognition was intact. The MDS also indicated Resident 40's functional abilities indicated he had upper and lower extremities impairment and that he required assistance from the staff on his activities of daily living (ADLs, like transferring). On 8/25/25 at 10:56 A.M., an observation and an interview was conducted with Resident 40 in his room. Resident 40 laid in bed watching a television show. Resident 40 stated he had been in the facility for almost two months. Resident 40 stated he was always in his bed and was bored. Resident 40 stated he needed help getting up and out of bed. Resident 40 stated he wanted to attend the activity but, They don't take me out. I wanted to attend. On 8/26/25, a review of Resident 40's care plan related to leisure activity was conducted. Resident 40's care plan indicated, Interventions.Invite to scheduled activities.Needs assistance activity functions. On 8/26/25 at 9:55 A.M., a follow up observation and an interview was conducted with Resident 40 in his room. Resident 40 stated, I just lay here, and they (staff) don't get me up. They don't offer me to attend the activity. Resident 40 stated he received the activity sheet, but staff did not offer him to get up and attend the activity. Resident 40 stated, How can I go there if they don't get me up? On 8/27/25 at 9:19 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 40 was very alert and could make his needs known. CNA 2 stated Resident 40 wanted to get up, but he did not have his own wheelchair. On 8/27/25 at 9:39 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 40 was very alert and oriented. CNA 3 stated Resident 40 required a mechanical lift when transferring from the bed to the