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	02/19/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner for three of three residents (Residents 2, 3 and 4) who filed complaints with the California Department of Public Health (CDPH, an agency responsible for regulatory compliance of healthcare facilities).This failure had the potential to negatively affect the overall health and mental wellbeing of the residents.Findings:Three consumer complaints were filed with CDPH regarding the facility's failure to answer call lights in a timely manner. An onsite investigation was conducted. An interview was conducted on 2/12/26 at 5:15 P.M. with Resident 2. Resident 2 stated she had been in two skilled nursing facilities over the last seven years, and she had never filed a complaint with CDPH prior to this incident. Resident 2 stated she often waited an hour or more for someone to respond to her call light. Per Resident 2, on 2/4/26 she waited 90 minutes for a medication. Resident 2 stated due to her physical issues, the long delay in getting a medication or getting assistance with toileting could cause serious complications to her health. Resident 2 stated she was involved in Resident Council (a meeting for residents to communicate concerns or needs), and call light response was always discussed, but no improvements had been seen. On 2/12/26, a record review was conducted. Resident 2 was admitted to the facility on [DATE] with diagnoses to include quadriplegia (paralysis to all four limbs and torso), per the Face Sheet. Resident 2's Brief Interview for Mental Status (BIMS, an assessment tool) score was 15, indicating intact cognition. Resident Council minutes from October 2025 indicated complaints about call light response in Old Business and New Business discussions. The facility response was that the call light policy would be reviewed with staff. Resident Council minutes from November 2025 indicated complaints about long waits for call light response. The facility response was that education would occur with Certified Nursing Assistants (CNAs) to remind them to communicate with each other. Resident Council minutes from December 2025 indicated that registry staff (nurses and CNAs who work for a staffing agency rather than the facility) were not good, and call light response took too long. The facility response was that management was working on hiring permanent staff to lessen the use of registry staff. Resident Council minutes from January 2026 indicated CNAs needed to communicate when they go on break so another CNA would respond to their call lights. The facility response was that a buddy system was being instituted, and the facility would do inservices and rounds to assess whether it helped with call light response times. Resident Council minutes from February 2026 indicated it was challenging to find an available CNA during some shifts to answer call lights. The facility response was to reeducate staff. 2. Resident 3 was admitted to the facility on [DATE] with diagnoses to include aftercare for joint replacement surgery and need for assistance with personal care, per the Face Sheet. A record review was conducted. Resident 3's BIMS score was 14, indicating intact cognition. An interview was conducted with Resident 3 on 2/17/26 at 9:25 A.M. Resident 3 stated she chose to leave the facility against medical advice (AMA, (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when a discharge is not approved by the physician) due to the problems she experienced there. Resident 3 stated, The worst thing was waiting for someone to answer the call light. Resident 3 stated in one instance, she waited over an hour, then when a staff member came to her room, they told her they would go get her CNA to assist her. Resident 3 stated later she found out the staff member was the CNA assigned to her. Resident 3 stated her room was near the nurses station and she could clearly hear staff seated for long periods of time just outside of her room, laughing and talking amongst themselves. 3. Resident 4 was admitted to the facility on [DATE] with diagnoses to include need for assistance with personal care, per the Face Sheet. A record review was conducted. Resident 4's BIMS score was 13, indicating intact cognition. A consumer complaint was received by CDPH on 2/17/26. The complaint outlined a family member's (FM 1) concerns while visiting Resident 4. FM 1 documented call lights often took up to 40 minutes for a staff member to respond. FM 1 indicated she had walked to the nurses station and observed three CNAs sitting at the desk, with call lights alarming. FM 1 documented when she requested assistance, staff often responded that the assigned staff person was on break, or busy attending to other residents, and no other staff was available to assist. An observation of call light response was conducted on 2/12/26 starting at 1:30 P.M.A call light was observed on. An employee (Em 1) walked past the room with the call light and did not stop to assist. Em 1 was stopped and asked what the process was for call light response. Em 1 stated she was from the Admissions office, and all staff was supposed to answer call lights. Em 1 stated she had kept another resident waiting for about an hour, so she passed the call light to attend to that resident's needs. Em 1 stated it was the expectation that all staff respond to call lights, and she had not done so. An interview was conducted with the Activities Director (AD) on 2/12/26 at 3 P.M. The AD stated she was responsible for taking notes during the Resident Council meetings, and for obtaining responses from department heads for any concerns expressed by the Council. The AD stated she was new to the role, but she had reviewed the Council's concerns for the previous months and determined call lights were an ongoing problem. The AD stated the additional training and monitoring of staff regarding call lights did not seem to have improved the process. The AD stated it was important to answer call lights in a timely manner to ensure residents were safe, and to treat them with dignity and respect. The AD stated, We have some work to do here. An observation of Resident 5 was conducted on 2/17/26 at 11:15 A.M. Resident 5 was seated in a wheelchair at the entrance to her room. Resident 5 asked if someone could get her help going to the bathroom. The call light was hit to get staff's attention. CNA 2 responded to the room, did not look at or address Resident 5, and proceeded to walk around Resident 5 to enter the room and turn off the call light. When asked, CNA 2 stated he was a CNA, but Resident 5 requested female CNAs only so he was unable to help her. CNA 2 stated he was unable to provide assistance with toileting so he would request a female CNA report to the room. CNA 2 stated he turned off the call light because he had come to the room, but he should have left the light on since he was unable to provide the care requested. The observation continued. Resident 5's personal caregiver (CG 1) arrived and greeted Resident 5 who was still seated in her wheelchair in the doorway of her room. CG 1 stated she came in to visit Resident 5 several times a week. CG 1 stated she worked for Resident 5 when she was home, but when she was in the nursing home she came to keep her company. CNA 3 then arrived, and did not greet or make eye contact with Resident 5. CNA 3 spoke to CG 1 and asked if it was safe to take Resident 5 to the bathroom. When asked, CNA 3 stated she addressed CG 1 since she was, Always here. CNA 3 stated she should have addressed her questions to Resident 5 in order to treat her with respect and dignity. CNA 3 stated she also should have spoken to her coworkers to find out how Resident 5 toileted rather than asking CG 1. An interview was conducted with Resident 6 on (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/17/26 at 11:40 A.M. Resident 6 stated his call light was always on, because when he needed something staff would come in and turn off the light, informing him they would return or they would go get the right person. Resident 6 stated it usually took about an hour for someone to come in and provide whatever he had requested. Resident 6 stated he had learned to turn the call light back on when staff turned it off. Resident 6 stated, .when the staff finally comes to my room, they have an attitude, like they're doing me a favor. An interview was conducted with Resident 7 on 2/17/26 at 11:50 A.M. Resident 7 stated it always took too long for staff to answer her call light. Resident 7 stated, Sometimes I think I'm the only one here and nobody can see me. An interview was conducted with Resident 8 on 2/17/26 at 3:45 P.M. Resident 8 stated it took a long time for staff to come and help her clean up. Resident 8 stated she heard other residents yelling, so she knew other people needed help and she tried to be patient while waiting for help. An interview was conducted with Resident 9 on 2/17/26 at 3:52 P.M. Resident 9 stated the staff was nice but it could be an hour before someone came in to help her An interview was conducted with the Director of Staff Development (DSD) on 2/17/26 at 4:30 P.M. The DSD stated she was responsible for monitoring and training of CNAs. The DSD stated she and the managers had spoken about how to monitor call lights to ensure residents were being attended to. The DSD stated the managers conducted rounds to ask residents how things were going, and any concerns were addressed by the managers. The DSD stated she worked with the CNAs to identify how they do their work to see if they were proficient, rather than observe call light response. An interview was conducted with the Director of Nursing (DON) on 2/17/26 at 5 P.M. The DON stated call lights response was an ongoing project. The DON stated the managers met daily to discuss resident concerns, and call lights were usually discussed. The DON stated, We still have an opportunity to do better. Per a facility policy, titled Resident Council Meeting and reviewed 2/2026, It is the policy of this facility to.Provide information to the residents on action taken on recommendations made at the Resident Council meetings.Resident Council is a chance for residents to provide input into.facility policies in general.The Council allows residents to discuss any special concerns they may be having.Residents are encouraged to discuss all aspects of nursing care received. Per a facility policy, titled Dignity and Privacy, reviewed 2/2026, It is the policy of this facility that all residents be treated with kindness, dignity and respect.Staff shall display respect for resident's rights, preferences.and shall communicate with residents in a courteous, calm and professional manner. Per a facility policy, undated and titled Call Light/Bell, .Answer the light within a reasonable time.Leave the resident comfortable.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications as ordered by the physician for one of three residents reviewed for medication administration (Resident 4) when:Resident 4 did not receive nine of the 14 medications within 24 hours of her admission; and,Resident 4 received a medication two times when it was scheduled five times over her admission to the facility. This failure had the potential to affect the health and well-being of Resident 4.Findings:Resident 4 was admitted to the facility on [DATE] with diagnoses to include diabetes (a long-lasting health condition that affects how the body turns food into energy), high blood pressure and heart failure, per the Face Sheet.A record review was conducted on 2/23/26.Resident 4's Brief Interview for Mental Status (BIMS, an assessment tool) score was 13, indicating intact cognition.According to the physician's orders, dated 11/5/26, Resident 4 had 14 scheduled medications to be administered at specific times of day.According to the Medication Administration Record (MAR), on 11/6/26 Resident 4 received five of the 14 medications prescribed. Three of the five medications were supplements (a product added to improve the diet, such as vitamins), as well as two over the counter medications, one for pain and one for allergies.According to the MAR, on 11/6/26 Resident 4 did not receive 9 medications. Those medications included two medications for diabetes, three medications for blood pressure, a medication for cholesterol, a blood thinner, a medication for depression and eye drops. For each medication not administered, the Licensed Nurse (LN) documented that the medication was not available, and the LN was waiting for the pharmacy to deliver the medication.The nurse who was responsible for documenting the medication was not available for an interview.2. Resident 4 had a physician's order , dated 11/5/25, for dulaglutide (a once-weekly injection which helped to control blood sugar), to be administered one time a day. No day of the week was indicated.According to LN notes, dated 11/6/25 and11/13/25, the facility was waiting for the pharmacy to deliver the medication. According to LN notes, dated 11/27/25 and 12/4/25, the medication was not administered, and no explanation was provided.According to the MAR, Resident 4 was admitted to the facility for five weeks, providing five opportunities for the facility to provide Trulicity as ordered. In the five weeks of Resident 4's admission, she received dulaglutide two times.On 2/17/26 at 3 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated all medications should be available for administration to residents within eight hours of admission. The DON stated she could not explain what had occurred during November as she was not at the facility, and another DON was covering for her during that time. The DON stated if a medication was not available, nurses should have informed the current DON or Assistant DON to identify a solution. The DON stated while the LNs had documented the medications were not available, no staff resolved the issue. According to the DON, .We did not administer the medications the way we should have.The covering DON was not available for interview.Per a facility policy, revised 6/2025 and titled Admission, .Order medications from the pharmacy. Medications are to be delivered within 8 hours of admission.Per a facility policy, reviewed 2/2026 and titled Medication Administration, It is the policy of this facility to accurately prepare and administer medications as ordered.