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	04/02/2026

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 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 observation, interview, and record review, the facility failed to ensure care plans for fall prevention were revised and updated with specific resident-centered interventions for two of five residents reviewed for falls (Residents 1 and 2). This failure had the potential to result in additional falls, and an increased risk for injuriesFindings: 1. A review of Resident 1's undated Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) and Parkinson's Disease (a movement disorder of the nervous system that worsens over time). A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool) dated 7/23/25, indicated a score of 0, or severely impaired cognition. A review of Resident 1's Nurse Practitioner/Physician's Assistant (NP/PA) progress note, dated 7/25/25, indicated Resident 1 had, evidence of severe cognitive impairment.indicating severe dementia. She is completely disoriented, unable to recall or repeat words, perform basic calculations, follow commands, or recognize objects. The NP/PA indicated Resident 1 did not speak, make eye contact or engage while being evaluated. A review of Resident 1's Physician's History and Physical Note, dated 8/17/25, indicated Resident 1 did not have the capacity to understand and make decisions. An observation of Resident 1 was conducted in her room on 3/10/26 at 10:15 A.M. Resident 1's name was outside of the room with a gold star next to her name. Resident 1 was seated in a wheelchair, in her room. Resident 1 did not respond to questions asked. Resident 1 was not wearing a colored wristband. A mattress with the edges built up was on the bed, and a fall mat was leaning against the wall. Resident 1's room was located approximately 10 feet from the nurse's station. A review of Resident 1's Nursing Progress Notes, Change in Condition Evaluations (COC, a form to evaluate a clinically significant change from the resident's normal levels of health) and care plan indicated the following incidents of fall and fall preventative measures initiated after each incident of a fall: Fall #1: The COC, dated 7/31/25, indicated the fall occurred on 7/31/25 at 2:18 A.M. The COC summarized that Resident 1 was found sitting on the floor in her room.A review of Resident 1's care plan, dated 7/31/25 indicated new fall preventative measures implemented were to ensure the bed was lowered to the floor, and monitor Resident 1 for any new problems as a result of the fall. Fall #2: The COC, dated 8/3/25, indicated Resident 1fell on 8/3/25 at approximately 1 P.M. in her room. The COC summarized that Resident 1 was found sitting on the floor near her bed.Resident 1's Fall risk assessment score, dated 8/3/25, re-evaluated her fall risk level from 16 to 13 (higher numbers indicate higher risk for falls). Resident 1's care plan, dated 8/3/25, indicated new fall preventative measures of moving Resident 1 closer to the nurses' station, and a physical therapy consult for strength and mobility. The care plan indicated unnamed facility staff would, .determine and address causative factors of the fall. Fall #3: The COC, dated 8/4/25, indicated Resident 1 fell on 8/4/25 at approximately 3:35 A.M. in the hallway outside of her room. Resident 1 was sent to the hospital for tests and returned to the facility.Resident 1's care plan, dated 8/4/25, indicated new fall preventative measures of adding floor mats next to the bed, and a consult from a pharmacist to evaluate Resident 1's medications. Fall #4: The COC, dated 8/11/25, indicated Resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 fell at approximately 7:30 A.M. in an unknown location.No new fall preventative measures were identified in Resident 1's 8/11/25 care plan. Fall #5: The COC, dated 9/18/25, indicated Resident 1 fell at approximately 6:40 A.M., in her room. Resident 1 was sent to the hospital for tests due to, Small knot noted to right side of head. Resident 1 later returned to the facility.Resident 1's care plan, dated 9/18/25, indicated new fall preventative measures identified were a physical therapy consult for strength and mobility, and moving Resident 1 closer to the nurse's station. Fall #6: The COC, dated 10/9/25, indicated Resident 1 fell at approximately 2:20 P.M. in the facility dining room.Resident 1's care plan, dated 10/9/25, indicated new fall preventative measures identified were increased monitoring of the resident during the evening shift, and offering toileting prior to bedtime. Fall #7: The COC, dated 10/17/25, indicated Resident 1 fell at approximately 7:37 A.M. in the hallway near the resident's room and the nurse's station.Resident 1's care plan, dated 10/17/25, indicated new fall preventative measures identified were to assist Resident 1 when walking, and when transferring from one place to another. Fall #8: The COC, dated 11/14/25, indicated Resident 1 fell at approximately 6:40 A.M., in her room.No new care plan fall preventative measures were identified. Fall #9: The COC, dated 11/18/25, indicated Resident 1 fell at approximately 3:50 A.M. in her room.Resident 1's care plan, dated 11/18/25, indicated new fall preventative measures of offering toileting assistance before bedtime, and increased visual checks during the evening shift. Fall #10: The COC, dated 12/12/25, indicated Resident 1 fell at approximately 4:57 P.M. in her room. X-rays were ordered by the physician.Resident 1's care plan, dated 12/12/25, indicated new fall preventative measures identified was to increase Restorative Nursing Assistant (RNA, a type of rehabilitative care to help restore independence) frequency, and to maintain needed items, such as water and the call light within reach. Fall #11: The COC, dated 1/2/26, indicated Resident 1 fell at approximately 7 P.M. outside of her room.Resident 1's care plan, dated 1/2/26, indicated new fall preventative measures of scheduled toileting and a physical therapy evaluation. Fall #12: The COC, dated 1/11/26, indicated Resident 1 fell at approximately 6:55 A.M. inside of her room.Resident 1's care plan, dated 1/11/26, indicated new fall preventative measures of obtaining a urine test for possible infection. Fall #13: The COC, dated 2/1/26, indicated Resident 1 at approximately 11 A.M. inside of her room. Per the COC, .Resident's bed noted elevated above the floor level. Resident 1 was sent to the hospital due to discoloration on the left side of her face.Resident 1's care plan, dated 2/1/26, indicated new fall preventative measures of a scoop mattress (a special mattress with raised edges around the perimeter to prevent the user from rolling off of the bed). A review of Resident 1's hospital imaging results, dated 2/1/26, indicated that Resident 1 had sustained a broken rib, a left zygomaticomaxillary complex fracture (the cheekbone) and an orbital fracture (one or more bones surrounding the eye, or the eye socket). An interview and concurrent review of Resident 1's medical record was conducted with the Director of Nursing (DON) on 3/10/26 at 2:45 P.M The DON stated she was not aware of how many falls Resident 1 had sustained. The DON stated the Interdisciplinary Team (IDT, a group of healthcare professionals) met following each fall to assess for patterns, such as the time of day the fall occurred, and to update the care plan. An interview was conducted with LN 1 on 3/10/26 at 3:03 P.M. Per LN 1, he was aware of Resident 1 falling several times. LN 1 stated he was familiar with Resident 1, and dementia was probably the reason Resident 1 tried to get out of bed or up from her wheelchair without assistance. LN 1 stated staff tried to keep eyes on Resident 1 to prevent injuries. Per LN 1, Resident 1's FM was very attentive, but staff were not always patient. LN 1 stated he had heard staff giving directions to Resident 1 even though she had dementia and would not understand the directions given. LN 1 stated, a one to one (1:1, a staff member assigned to monitor the resident at all times) may have worked to prevent more falls. Obviously with 11 falls, our staff did not prevent further falls. An interview was conducted with LN 2 on 3/10/26 at 3:15 P.M. LN 2 stated she had started her shift 2/1/26 at 3 P.M. and heard from another nurse Resident 1 had fallen and gone to the hospital. LN 2 stated she had called the hospital to get a report and to find out if Resident 1 was returning to the facility. LN 2 stated the hospital informed her Resident 1 had two (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facial fractures and would return to the facility. LN 2 stated she was aware Resident 1 had fallen from LN 3, who was the assigned nurse on 2/1/26. LN 2 stated Resident 1 had had previous falls, the most recent fall approximately two weeks earlier. LN 2 stated staff tried to keep Resident 1 from falling by keeping her engaged in activities. Per LN 2, We're trying everything for her, but it's not effective. An interview was conducted with Director of Staff Development (DSD, staff responsible for education and training of facility CNAs) on 3/10/26 at 4:07 P.M. Per the DSD, she was not aware how many falls Resident 1 had experienced. Per the DSD, Resident 1 had, .fallen quite a bit, maybe five to six times. The DSD stated Resident 1 needed something to do with her hands to keep her occupied. Per the DSD, the intervention to keep Resident 1 busy would not work during nighttime hours as Resident 1 needed to sleep. The DSD stated she was not aware of whether a 1:1 observation of Resident 1 had been attempted to keep her safe. The DSD stated staff should be familiar with Resident 1's diagnosis of dementia and how to provide care specific to the diagnosis . The DSD stated she recently started attending the IDT meetings regarding residents who had fallen. An observation of Resident 1 was conducted on 3/16/26 at 12:21 P.M. Resident 1 was seated in a wheelchair in the dining room, with the FM assisting her with the meal. An interview was conducted with CNA 2 on 3/16/26 at 12:21 P.M. CNA 2 stated he knew Resident 1 well. CNA 2 stated Resident 1 did not listen to staff, and .she does what she wants to.she falls often.she doesn't understand us. I'm not sure what her diagnosis is, or why she acts that way. Per CNA 2, Resident 1 usually fell at night. CNA 2 stated, When her [FM] is with her she doesn't seem to fall. If her [FM] would stay maybe she wouldn't fall. CNA 2 stated he received updates on the residents during the morning huddle, but he did not review the care plans for information. A telephone interview was conducted with CNA 1 on 3/17/26 at 11:15 A.M. CNA 1 stated he was assigned to provide care to Resident 1 on 2/1/26, the day of her fall with an injury. CNA 1 stated he often worked with Resident 1 and was familiar with her care. CNA 1 stated when he returned from break, he saw many staff in Resident 1's room and saw her sitting on the floor with her cheek appearing red. CNA 1 stated he noticed the bed was as high as it could go. CNA 1 stated he assisted getting Resident 1 back into bed, then prepared her to go to the hospital. CNA 1 stated it was difficult to work with Resident 1, even though he spoke the same language she did. CNA 1 stated, It's hard to get her to do things. She doesn't like to listen. CNA 1 stated he did not know what medical condition made Resident 1 act that way. CNA 1 stated he had received education on dementia in the past but did not know if Resident 1 had dementia. CNA 1 stated Resident 1 had fallen before but he did not know how many times, only that it was more than other residents, .maybe three falls. CNA 1 stated residents who were at risk for falls had a gold star by their name outside of the room, and staff knew to check on them more often. CNA 1 stated the facility should have implemented other things to prevent falls, like possibly having a CNA always sit with her. CNA 1 stated he was aware of the care plans but did not routinely review them. A telephone interview was conducted with LN 3 on 3/17/26 at 11:45 A.M. LN 3 stated she was assigned to Resident 1 on 2/1/26. LN 3 stated the FM for Resident 1 came to her and asked for help in the room. LN 3 stated she went to the room and saw Resident 1 sitting on the floor by her bed, hugging her legs. Per LN 3, Resident 1's bed was raised up to its highest level. LN 3 stated she saw a reddened area and swelling on Resident 1's face. LN 3 stated she assessed the resident, then called the physician. Per LN 3, Resident 1 was only aware of her own self, and was not oriented to the time, date, or her current location or situation. LN 3 stated she was not aware of Resident 1's diagnosis. Per LN 3, other staff told her Resident 1 was a fall risk, and she had assumed Resident 1 had fallen a few times, possibly two to three times. LN 3 stated nobody informed her of how many times Resident 1 had fallen. LN 3 stated she could look at care plans to obtain information about the residents, but she usually heard in report from the previous shift if a fall had occurred. LN 3 stated that was her primary way to receive information about the residents. 2. A review of Resident 2's undated Face Sheet indicated Resident 2 was readmitted to facility on 10/28/25 with diagnoses to include encephalopathy (a group of conditions that cause brain dysfunction) and history of falling. A review of Resident 2's BIMS score, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 10/29/25, indicated a score of 7, or severely impaired cognition. A review of Resident 2's Physician's History and Physical exam, dated 10/29/25, indicated Resident 2 had no memory of recent events, and had significant memory difficulty. The physician indicated Resident 2 had a past medical history of dementia and brain injury. An interview and observation of Resident 2 was conducted on 3/16/26. Outside of the room, Resident 2's name was posted, with a gold star next to it. Resident 2 was in bed, and the bed was low to the floor. Gray landing mats were next to the bed on the floor. Resident 2 was not wearing a yellow wristband. Resident 2 stated he was admitted for seizures. Resident 2 stated he fell at home about a week ago. Resident 2 stated he believed he was at a hospital due to the fall. A review of Resident 2's Nursing Progress Notes, Change in Condition Evaluations and care plans indicated the following incidents of fall and fall preventative measures initiated after each incident of a fall: Fall #1: The COC, dated 11/6/25, indicated an injury to Resident 2 had occurred at approximately 10:30 P.M. in Resident 2's room.A Nursing Progress Note, dated 11/6/25, indicated Resident 2 had been seen by his roommate crawling to the bathroom in their room.Resident 2's care plan for 11/6/25 did not indicate any new fall preventative measures implemented. Fall #2: The COC, dated 11/10/25, indicated the fall occurred in the morning. No specific time was documented. According to the COC, Resident 2 fell in his room, next to the bed.Resident 2's care plan, dated 11/10/25, indicated new fall preventative measures implemented were to ensure Resident 2's bed was in the lowest position. Fall #3: The COC, dated 11/23/25, indicated the fall occurred at approximately 6:09 A.M. in Resident 2's room. Resident 2 was found on the floor, seated near the bed.Resident 2 had dislodged a foley catheter (a device inserted into the bladder for urine collection) and had bleeding from the site.Resident 2's care plan, dated 11/23/25, indicated new fall preventative measures implemented were increased visual checks on the resident, and offering toileting assistance while awake. The care plan listed a pharmacist consult to review Resident 2's medications for potential contributors to falls. Fall #4: The COC, dated 11/25/25, indicated the fall occurred at night. No exact time was indicated. Resident 2 was found on his knees next to the bed.Resident 2's care plan, dated 11/25/25, did not identify any new fall preventative measures implemented. Fall #5: The COC, dated 12/19/25, indicated Resident 2 fell at approximately 7 A.M. and was found sitting on the floor next to the bed.Resident 2's care plan, dated 12/19/25, indicated no new fall preventative measures were implemented. Fall #6: The COC, dated 12/27/25, indicated Resident 2 fell in his room and was found on the floor next to his bed. The COC did not identify the exact time of the fall, only that it occurred at night.Resident 2's care plan, dated 12/27/25, did not identify any new fall preventative measures implemented. Fall #7: The COC, dated 1/7/26, indicated Resident 2 fell at night, no exact time was indicated. The COC indicated Resident 2 had a reddened area on his lower back from the fall.Resident 2's care plan, dated 1/7/26, indicated new fall preventative measures of scheduled toileting. Fall #8: The COC, dated 1/8/26, indicated a fall occurred in the morning. No exact time was indicated. Resident 2 was found sitting on the floor near his bed.Resident 2's care plan, dated 1/8/26, indicated a new fall preventative measure implemented was a psychiatric evaluation. Fall #9: The COC, dated 1/19/26, indicated Resident 2 was found on the floor in his room. The COC did not identify a specific time, and only specified morning.Resident 2's care plan, dated 1/19/26, indicated a new fall preventative measure of moving the resident to a room closer to the nurses station for higher visibility and monitoring. Fall #10: The COC, dated 1/25/26, indicated Resident 2 fell in the afternoon, although no specific time was identified. Resident 2 was found on the floor outside of the door to his room.A Nurses Progress Note dated 1/25/26 indicated Resident 2 had sustained a bruise on his hip, and a skin tear on his forearm.Resident 2's care plan, dated 1/25/26, indicated a new fall preventative measure of ordering lab tests to assess for infection. Fall #11: The COC, dated 2/1/26, indicated Resident 2 fell at approximately 3:15 P.M. Resident 2 was found sitting on the floor near his bed. Resident 2's care plan, dated 2/1/26, indicated a new fall preventative measure of a scoop mattress. Fall #12: The COC, dated 2/12/26, indicated Resident 2 had fallen in the afternoon, no exact time was indicated. Resident 2 was found sitting on the floor (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	next to his bed.Resident 2's care plan, dated 2/12/26, indicated a new fall preventative measure of positioning the bed against the wall. Fall #13: The COC, dated 2/19/26, indicated Resident 2 had fallen in the afternoon. No specific time was indicated. Resident 2 was found seated on the floor next to his bed.Resident 2's care plan, dated 2/19/26, indicated new fall preventative measure of getting Resident 2 up in a wheelchair during the day. An observation of Resident 2 and concurrent interview with CNA 4 was conducted on 3/18/26 at 5 P.M. Resident 2 was in bed, eating dinner. His bed was against the wall, and the mattress was curved upwards around the four sides. CNA 4 was seated next to Resident 2's bed. CNA 4 stated she usually sat outside the room to observe several residents who had a history of falling. CNA 4 stated she was aware Resident 2 had fallen before but did not know how many times or whether he had sustained any injuries. CNA 4 stated any residents who were at risk for falls had a gold star outside of their room by their name and wore a yellow wrist band. CNA 4 stated that it was important so that all staff could be aware that Resident 2 was at risk for falls, and they could monitor him and keep him safe. Resident 2 was asked if he had a wrist band on. He looked at his wrist, which did not have a wrist band, and replied, Nope. Nothing here. A concurrent interview and record review with the DON was conducted on 4/2/26 at 3:10 P.M. The DON acknowledged that despite adding care plan interventions for Residents 1 and 2, both residents had continued to have falls. The DON stated care plan interventions should be appropriate for the residents to ensure effectiveness. Per the DON, the purpose of the falls care plan was to implement actions that would prevent further falls and injuries. The DON stated each care plan should be updated to meet the individual needs of the residents. Per an undated facility document, titled Fall System, In the Event of a Fall.Individualized interventions initiated. A policy on updating care plans was requested but not provided by the facility.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement new, effective fall preventative measures after each fall incident for two of five residents reviewed for falls (Residents 1 and 2). These failures resulted in Resident 1 falling 13 times, sustaining two broken bones in her face and a broken rib.Findings:1. A review of Resident 1's undated Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included dementia (a loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life) and Parkinson's Disease (a movement disorder of the nervous system that worsens over time). A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool) dated 7/23/25, indicated a score of 0, or severely impaired cognition. A review of Resident 1's Nurse Practitioner/Physician's Assistant (NP/PA) progress note, dated 7/25/25, indicated Resident 1 had, evidence of severe cognitive impairment.indicating severe dementia. She is completely disoriented, unable to recall or repeat words, perform basic calculations, follow commands, or recognize objects. The NP/PA indicated Resident 1 did not speak, make eye contact or engage while being evaluated. A review of Resident 1's Physician's History and Physical Note, dated 8/17/25, indicated Resident 1 did not have the capacity to understand and make decisions. An observation of Resident 1 was conducted in her room on 3/10/26 at 10:15 A.M. Resident 1's name was outside of the room with a gold star (an indicator of fall risk) next to her name. Resident 1 was seated in a wheelchair, in her room. Resident 1 did not respond to questions asked. Resident 1 was not wearing a yellow wristband (an indicator of fall risk). A mattress with the edges built up was on the bed, and a fall mat was leaning against the wall. Resident 1's room was located approximately 10 feet from the nurse's station. A review of Resident 1's Nursing Progress Notes, Change in Condition Evaluations (COC, a form to evaluate a clinically significant change from the resident's normal levels of health) and care plan indicated the following incidents of fall and fall preventative measures initiated after each incident of a fall:Fall #1: The COC, dated 7/31/25, indicated the fall occurred on 7/31/25 at 2:18 A.M. The COC summarized that Resident 1 was found sitting on the floor in her room.A review of Resident 1's care plan, dated 7/31/25 indicated new fall preventative measures implemented were to ensure the bed was lowered to the floor, and monitor Resident 1 for any new problems as a result of the fall. Fall #2: The COC, dated 8/3/25, indicated Resident 1 had fallen on 8/3/25 at approximately 1 P.M. in her room. The COC summarized that Resident 1 was found sitting on the floor near her bed. Resident 1's care plan, dated 8/3/25, indicated new fall preventative measures of moving Resident 1 closer to the nurse's station, and a physical therapy consult for strength and mobility. The care plan indicated unnamed facility staff would, .determine and address causative factors of the fall. No documentation of causative factors were identified in the record review. Fall #3: The COC, dated 8/4/25, indicated Resident 1 fell on 8/4/25 at approximately 3:35 A.M. in the hallway outside of her room. Resident 1 was sent to the hospital for tests and returned to the facility. Resident 1's care plan, dated 8/4/25, indicated new fall preventative measures of adding floor mats next to the bed, and a pharmacist consult to evaluate Resident 1's medications. Fall #4: The COC, dated 8/11/25, indicated Resident 1 fell at approximately 7:30 A.M. in an unknown location. No new fall preventative measures were identified in Resident 1's 8/11/25 care plan. Fall #5: The COC, dated 9/18/25, indicated Resident 1 fell at approximately 6:40 A.M., in her room. Resident 1 was sent to the hospital for tests due to, Small knot noted to right side of head. Resident 1 later returned to the facility.Resident 1's care plan, dated 9/18/25, indicated new fall preventative measures identified were a physical therapy consult for strength and mobility, and to move Resident 1 closer to the nurses station. Fall #6: The COC, dated 10/9/25, indicated Resident 1 fell at approximately 2:20 P.M. in the facility dining room. Resident 1's care plan, dated 10/9/25, indicated new fall preventative measures identified were increased monitoring of the resident during (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the evening shift, and offering toileting prior to bedtime. Fall #7: The COC, dated 10/17/25, indicated Resident 1 fell at approximately 7:37 A.M. in the hallway near the resident's room and the nurse's station. Resident 1's care plan, dated 10/17/25, indicated new fall preventative measures identified were to assist Resident 1 when walking, and when transferring from one place to another. Fall #8: The COC, dated 11/14/25, indicated Resident 1 fell at approximately 6:40 A.M., in her room. No new care plan fall preventative measures were identified. Fall #9: The COC, dated 11/18/25, indicated Resident 1 fell at approximately 3:50 A.M. in her room. Resident 1's care plan, dated 11/18/25, indicated new fall preventative measures of offering toileting assistance before bedtime, and increased visually checking on the resident during the evening shift. Fall #10: The COC, dated 12/12/25, indicated Resident 1 fell at approximately 4:57 P.M. in her room. X-rays were ordered by the physician.Resident 1's care plan, dated 12/12/25, indicated new fall preventative measures identified were to increase Restorative Nursing Assistant (RNA, a type of rehabilitative care to help restore independence) frequency, and to maintain needed items, such as water and the call light within reach. Fall #11: The COC, dated 1/2/26, indicated Resident 1 fell at approximately 7 P.M. outside of her room. Resident 1's care plan, dated 1/2/26, indicated new fall preventative measures of scheduled toileting (a technique used to manage bowel and bladder issues by having the resident use the toilet at regular intervals) and a physical therapy evaluation. Fall #12: The COC, dated 1/11/26, indicated Resident 1 fell at approximately 6:55 A.M. inside of her room. Resident 1's care plan, dated 1/11/26, indicated new fall preventative measures of obtaining a urine test for possible infection. Fall #13: The COC, dated 2/1/26, indicated Resident 1 fell at approximately 11 A.M. inside of her room. According to the COC, the bed was raised to a high position. Resident 1 was sent to the hospital due to discoloration on the left side of her face. A review of Resident 1's hospital imaging results, dated 2/1/26, indicated that Resident 1 had sustained a broken rib, a left zygomaticomaxillary complex fracture (the cheekbone), and an orbital fracture (one or more bones surrounding the eye, or the eye socket). Resident 1's care plan, dated 2/1/26, indicated new fall preventative measures of a scoop mattress (a special mattress with raised edges around the perimeter to prevent the user from rolling off the bed). An interview and concurrent review of Resident 1's medical record was conducted with the Director of Nursing (DON) on 3/10/26 at 2:45 P.M. The DON stated all falls that occurred at the facility were tracked for patterns and discussed with leadership. The DON stated Resident 1's family member (FM) visited daily and monitored her due to her dementia and Parkinson's Disease. The DON stated if the FM was not present, staff placed Resident 1 at the nurse's station or in the activities area so they could monitor her for safety. According to the DON, the facility tried to do everything they could to prevent additional falls and keep Resident 1 safe. The DON stated she was not aware of how many falls Resident 1 had sustained. The DON provided an undated document titled Investigative Summary, which included details of Resident 1's fall that occurred on 2/1/26. The document indicated, Staff that were involved in the treatment and care of [Resident 1] were interviewed regarding their observations and interactions with the residents. Four staff members were listed. Licensed Nurses (LN) 1, 2, and 3, and Certified Nursing Assistant (CNA) 1. An interview was conducted with LN 1 on 3/10/26 at 3:03 P.M. Per LN 1, he was aware of Resident 1 falling several times. LN 1 stated he was familiar with Resident 1, and dementia was probably the reason Resident 1 tried to get out of bed or up from her wheelchair without assistance. LN 1 stated staff tried to keep eyes on Resident 1 to prevent injuries. Per LN 1, Resident 1's FM was very attentive, but staff were not always patient. LN 1 stated he had heard staff giving directions to Resident 1 even though she had dementia and would not understand the directions given. LN 1 stated, a one to one (1:1, a staff member assigned to monitor the resident at all times) may have worked to prevent more falls. Obviously with 11 falls, our staff did not prevent further falls. An interview was conducted with LN 2 on 3/10/26 at 3:15 P.M. LN 2 stated she had started her shift 2/1/26 at 3 P.M. and heard from another nurse Resident 1 had fallen and gone to the hospital. LN 2 stated she had called the hospital to get a report and to find out if Resident 1 was returning to the (continued on next page)

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	056182	A. Building B. Wing	04/02/2026

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility. LN 2 stated the hospital informed her Resident 1 had two facial fractures and would return to the facility. LN 2 stated she was informed Resident 1 had fallen from LN 3, who was the assigned nurse on 2/1/26. LN 2 stated Resident 1 had had previous falls, the most recent fall approximately two weeks earlier. LN 2 stated staff tried to keep Resident 1 from falling by keeping her engaged in activities. Per LN 2, We're trying everything for her, but it's not effective. An interview was conducted with Director of Staff Development (DSD, staff responsible for education and training of facility CNAs) on 3/10/26 at 4:07 P.M. Per the DSD, she was not aware how many falls Resident 1 had experienced. Per the DSD, Resident 1 had, .fallen quite a bit, maybe five to six times. The DSD stated Resident 1 needed something to do with her hands to keep her occupied. Per the DSD, the intervention to keep Resident 1 busy would not work during nighttime hours as Resident 1 needed to sleep. The DSD stated she was not aware of whether a 1:1 observation of Resident 1 had been attempted to keep her safe. The DSD stated staff should be familiar with Resident 1's diagnosis of dementia and how to provide care specific to the diagnosis. An observation of Resident 1 was conducted on 3/16/26 at 12:21 P.M. Resident 1 was seated in a wheelchair in the dining room, with the FM assisting her with the meal. An interview was conducted with CNA 2 on 3/16/26 at 12:21 P.M. CNA 2 stated he knew Resident 1 well. CNA 2 stated Resident 1 did not listen to staff, and .she does what she wants to.she falls often.she doesn't understand us. I'm not sure what her diagnosis is, or why she acts that way. Per CNA 2, Resident 1 usually fell at night. CNA 2 stated, When her [FM] is with her she doesn't seem to fall. If her [FM] would stay maybe she wouldn't fall. A telephone interview was conducted with CNA 1 on 3/17/26 at 11:15 A.M. CNA 1 stated he was assigned to provide care to Resident 1 on 2/1/26, the day of her fall with an injury. CNA 1 stated he often worked with Resident 1 and was familiar with her care. CNA 1 stated he had observed Resident 1 in bed, with her bed low to the floor at about 10:50 A.M., then went to break. CNA 1 stated when he returned from break, he saw many staff in Resident 1's room and saw her sitting on the floor with her cheek appearing red. CNA 1 stated he noticed the bed was positioned as high as it could go. CNA 1 stated he assisted getting Resident 1 back into bed, then prepared her to go to the hospital. CNA 1 stated it was difficult to work with Resident 1, even though he spoke the same language she did. CNA 1 stated, It's hard to get her to do things. She doesn't like to listen. CNA 1 stated he did not know what medical condition made Resident 1 act that way. CNA 1 stated he had received education on dementia in the past but did not know if Resident 1 had dementia. CNA 1 stated Resident 1 had fallen before but he did not know how many times, only that it was more than other residents, .maybe three falls. CNA 1 stated the facility should have implemented other things to prevent falls, like possibly having a CNA sit with her at all times. A telephone interview was conducted with LN 3 on 3/17/26 at 11:45 A.M. LN 3 stated she was assigned to Resident 1 on 2/1/26. LN 3 stated the FM for Resident 1 came to her and asked for help in the room. LN 3 stated she went to the room and saw Resident 1 sitting on the floor by her bed, hugging her legs. Per LN 3, Resident 1's bed was raised up to its highest level. LN 3 stated she saw a reddened area and swelling on Resident 1's face. LN 3 stated she assessed the resident, then called the physician. Per LN 3, Resident 1 was only aware of her own self, and was not oriented to the time, date, or her current location or situation. LN 3 stated she was not aware of Resident 1's diagnosis. Per LN 3, other staff told her Resident 1 was a fall risk, and she had assumed Resident 1 had fallen a few times, possibly two to three times. LN 3 stated nobody informed her of how many times Resident 1 had fallen. 2. A review of Resident 2's undated Face Sheet indicated Resident 2 was readmitted to facility on 10/28/25 with diagnoses to include encephalopathy (a group of conditions that cause brain dysfunction) and history of falling. A review of Resident 2's BIMS score, dated 10/29/25, indicated a score of 7, or severely impaired cognition. A review of Resident 2's Physician's History and Physical exam, dated 10/29/25, indicated Resident 2 had no memory of recent events, and had significant memory difficulty. The physician indicated Resident 2 had a past medical history of dementia and brain injury. An interview and observation of Resident 2 was conducted on 3/16/26. Outside of the room, Resident 2's name was posted, with a gold star next to it. Resident 2 was in bed, and the bed (continued on next page)

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	056182	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	was low to the floor. Gray landing mats were next to the bed on the floor. Resident 2 was not wearing a yellow wristband. Resident 2 stated he was admitted for seizures. Resident 2 stated he fell at home about a week ago. Resident 2 stated he believed he was at a hospital due to the fall. A review of Resident 2's Nursing Progress Notes, Change in Condition Evaluations and care plans indicated the following incidents of fall and fall preventative measures initiated after each incident of a fall: Fall #1: The COC, dated 11/6/25, indicated an injury to Resident 2 had occurred at approximately 10:30 P.M. in Resident 2's room.A Nursing Progress Note, dated 11/6/25, indicated Resident 2 had been seen by his roommate crawling to the bathroom in their room.Resident 2's care plan for 11/6/25 did not indicate any new fall preventative measures had been implemented. Fall #2: The COC, dated 11/10/25, indicated the fall occurred in the morning. No specific time was documented. According to the COC, Resident 2 fell in his room, next to the bed.Resident 2's care plan, dated 11/10/25, indicated new fall preventative measures implemented were to ensure Resident 2's bed was in the lowest position. Fall #3: The COC, dated 11/23/25, indicated the fall occurred at approximately 6:09 A.M. in Resident 2's room. Resident 2 was found on the floor, seated near the bed. Resident 2 had dislodged a foley catheter (a device inserted into the bladder for urine collection) and had bleeding from the site. Resident 2's care plan, dated 11/23/25, indicated new fall preventative measures implemented were increased visual checks on the resident, and offering toileting assistance while awake. The care plan listed a pharmacist consult to review Resident 2's medications for potential contributors to falls. Fall #4: The COC, dated 11/25/25, indicated the fall occurred at night. No exact time was indicated. Resident 2 was found on his knees next to the bed.Resident 2's care plan, dated 11/25/25, did not identify any new fall preventative measures implemented. Fall #5: The COC, dated 12/19/25, indicated Resident 2 fell at approximately 7 A.M. and was found sitting on the floor next to the bed.Resident 2's care plan, dated 12/19/25, indicated no new fall preventative measures were implemented. Fall #6: The COC, dated 12/27/25, indicated Resident 2 fell in his room and was found on the floor next to his bed. The COC did not identify the exact time of the fall, only that it occurred at night.Resident 2's care plan, dated 12/27/25, did not identify any new fall preventative measures implemented. Fall #7: The COC, dated 1/7/26, indicated Resident 2 fell at night, no exact time was indicated. The COC indicated Resident 2 had a reddened area on his lower back from the fall.Resident 2's care plan, dated 1/7/26, indicated new fall preventative measures of scheduled toileting. Fall #8: The COC, dated 1/8/26, indicated a fall occurred in the morning. No exact time was indicated. Resident 2 was found sitting on the floor near his bed.Resident 2's care plan, dated 1/8/26, indicated a new fall preventative measure implemented was a psychiatric evaluation. Fall #9: The COC, dated 1/19/26, indicated Resident 2 was found on the floor in his room. The COC did not identify a specific time, and only specified morning.Resident 2's care plan, dated 1/19/26, indicated a new fall preventative measure of moving the resident to a room closer to the nurse's station for higher visibility and monitoring. Fall #10: The COC, dated 1/25/26, indicated Resident 2 fell in the afternoon, although no specific time was identified. Resident 2 was found on the floor outside of the door to his room.A Nurses Progress Note, dated 1/25/26, indicated Resident 2 had sustained a bruise on his hip and a skin tear on his forearm.Resident 2's care plan, dated 1/25/26, indicated a new fall preventative measure of ordering lab tests to assess for infection. Fall #11: The COC, dated 2/1/26, indicated Resident 2 fell at approximately 3:15 P.M. Resident 2 was found sitting on the floor near his bed. Resident 2's care plan, dated 2/1/26, indicated a new fall preventative measure of a scoop mattress. Fall #12: The COC, dated 2/12/26, indicated Resident 2 had fallen in the afternoon, no exact time was indicated. Resident 2 was found sitting on the floor next to his bed.Resident 2's care plan, dated 2/12/26, indicated a new fall preventative measure of positioning the bed against the wall. Fall #13: The COC, dated 2/19/26, indicated Resident 2 had fallen in the afternoon. No specific time was indicated. Resident 2 was found seated on the floor next to his bed.Resident 2's care plan, dated 2/19/26, indicated new fall preventative measure of getting Resident 2 up in a wheelchair during the day. An observation of Resident 2 and concurrent interview with CNA 4 was conducted on 3/18/26 at (continued on next page)

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