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	04/22/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure resident rights were treated with respect and dignity for one of two resident 's (Resident 1) when the facility staff searched Resident 1's personal belongings without her permission.As a result, Resident 1 was observed anxious and stated she felt disrespected. On 4/20/26 at 9:15 A.M., an onsite investigation was conducted to investigate a Facility Reported Incident (FRI) reporting Resident 1 was involved in a MVA when her SO was driving the vehicle on 3/28/26.A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with aphasia (difficulty with speaking caused by brain damage) and right-sided weakness caused by a stroke.A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 3/19/26, indicated the resident's BIMS (Brief Interview for Mental Status) was 13 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On 4/20/26 at 10:17 A.M., an observation and interview was conducted with Resident 1. The resident was sitting in her wheelchair in the facility's courtyard. During the interview, Resident 1 saw a male Certified Nursing Assistant (CNA) 1 walk by, stopped him and pointed to visible nearby buildings around her. Resident 1 looked at CNA 1 and said ok, and waved her hand gesturing she did not need his help anymore and CNA 1 walked away. On 4/20/26 at 10:40 A.M., CNA 1 came back towards Resident 1 with a piece of paper and pen so Resident 1 could communicate in writing. Resident 1 refused to communicate with CNA 1 via paper and pen.On 4/20/26 at 10:50 A.M., an observation of Resident 2, the roommate of Resident 1, was conducted. Resident 2 was observed talking to Resident 1 in their room. Resident 2 stated a female and a male staff were searching Resident 1's personal belongings a few minutes ago. After hearing Resident 2, Resident 1 was shaking her head with her hand on her forehead and her face was grimaced. Resident 1 repeated no, and said why? Resident 1 was moving in her wheelchair anxiously in the room.On 4/20/26 at 11:02 A.M., an interview was conducted with the CNA 1. CNA 1 stated he was searching Resident 1's belongings looking for her communication board with the Social Services Director (SSD). CNA 1 stated he should have asked Resident 1 for her permission before going through her personal items.On 4/20/26 at 11:11 A.M., an interview was conducted with the SSD. The SSD stated Resident 1 had a communication device in her room and she and CNA 1 were looking for it in Resident 1's room. The SSD stated she should have gotten a permission from Resident 1 before searching through Resident 1's personal belongings. On 4/20/26 at 11:19 A.M., a follow-up interview was conducted with Resident 1. Resident 1 stated she felt disrespected but was feeling okay after CNA 1 and the SSD apologized to her.On 4/20/26 at 4:22 P.M., an interview with the Assistant Director of Nursing (ADON), the Administrator (ADM), and the SSD was conducted. The ADON, ADM, and SSD stated that staff should obtain a permission from a resident before searching through personal belongings.A review of the facility policy titled Resident Rights undated indicated, .The Resident has the right 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality.

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 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 care plan for one of three residents (Resident 1) to ensure the safety of Resident 1 was maintained while Out On Pass (OOP) due to a previous motor vehicle accident (MVA) which occurred while OOP. The lack of care plan development posed a potential risk for Resident 1 and the resident's significant other (SO) to have a repeat MVA situation to occur.On [DATE] at 9:15 A.M., an onsite investigation was conducted to investigate a Facility Reported Incident (FRI) reporting Resident 1 was involved in a MVA when her SO was driving the vehicle on [DATE].A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with aphasia (difficulty with speaking caused by brain damage) and right-sided weakness caused by a stroke.A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated [DATE], indicated the resident's BIMS (Brief Interview for Mental Status) was 13 out of 15, indicating the resident was cognitively intact (no memory, focus, or judgment issues).On [DATE] at 10:17 A.M., an observation and interview was conducted with Resident 1. The resident was sitting in her wheelchair in the facility's courtyard. Resident 1 stated her SO was driving at the time of the MVA. Resident 1 stated her SO had a history of seizure (a sudden surge of uncontrolled electrical activity in the brain that causes temporary changes in behavior, movement, or awareness) and was taking medications. Resident 1 was observed with her face grimaced and shaking her head while discussing the accident. Resident 1 stated the accident made her feel scared and her SO should not drive her anymore.A review of the emergency room record dated [DATE] indicated, .Patient was the passenger in the car.The driver from the car fled the scene and left the patient in the car. The record indicated Resident 1 sustained no injuries from the MVA and she was determined to be safe for discharge.A review of Resident 1's IDT dated [DATE] indicated the facility was unable to reach Resident 1 after the hours allowed to be OOP expired and received a call from the emergency room that the resident was in a MVA. Resident 1 returned to the facility on [DATE]. Upon return, the IDT was conducted with recommendations for a care conference to be arranged with Resident 1 and her SO. However, the facility was not able to reach the SO. There was no recommendation to develop and implement a care plan for Resident 1's OOP safety.On [DATE] at 1:05 P.M., an interview and record review was conducted with the Charge Nurse (CN). The CN reviewed and stated Resident 1 was on appropriate OOP visit with her SO, when they had a MVA. The CN reviewed Resident 1's care plan and stated the care plan did not address protection of the resident from the potential future MVA with her SO. The CN stated that she and other nurses discussed the facility should not allow Resident 1 to be in the vehicle driven by her SO anymore. The CN stated this should have been discussed among the facility's leadership and nursing staff and should have been addressed in the resident's care plan so that all nursing staff were aware.On [DATE] at 4:22 P.M., an interview was conducted with the Administrator (ADM), the Assistant Director of Nursing (ADON), and Social Services Director (SSD). The SSD stated she planned a care conference with Resident 1 and her SO but the attempts had been unsuccessful since the SO had not responded back to her calls. The ADM and ADON stated the SO should not drive Resident 1 for her safety and this should have been addressed as one of the interventions in Resident 1's care plan.