

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER San Diego Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 South Orange 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235</p> <p>Based on observation, interview and record review the facility failed to take appropriate action to protect one (Resident 5) of three residents reviewed for abuse, from his alleged perpetrator (person who inflicts harm).</p> <p>This failure had the potential for Resident 5 for repeat abuse from the perpetrator and placing other residents at risk for a potential abuse.</p> <p>Findings:</p> <p>On 3/19/25 at 9:04 A.M., an unannounced onsite visit at the facility was conducted related to a reported resident to resident altercation.</p> <p>Resident 5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a brain disorder that slowly destroys memory, thinking skills and eventually the ability to carry out simple tasks) and dementia (loss of memory, language, problem solving and other thinking abilities); (an impairment of brain function, such as memory loss and judgment) according to the facility's Admission Record.</p> <p>Resident 9 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit (problem with communication) and aphasia (language disorder affecting how to communicate) according to the facility's Admission Record.</p> <p>On 3/19/25 at 10:12 A.M. Resident 5 was observed sitting in the toilet at a shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] (Resident 9's room).</p> <p>A review of Resident 5's progress notes (PN) dated 3/13/25 at 5:44 P.M. was reviewed. The PN indicated Resident 5 was sitting on his bed in his room when Resident 9 wandered into his room. Resident 5 yelled at Resident 9 to leave and Resident 9 hit Resident 5 in the nose. Resident 5 sustained a nosebleed.</p> <p>During an interview on 3/19/25 at 10:15 A.M. with Licensed Nurse (LN) 3, LN 3 stated Resident 9 had episodes of aggression with attempts to hit staff and residents. LN 3 stated she heard that Resident 9 attempted to punch Resident 5 but did not know the details.</p> <p>(continued on next page)</p>

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: 555659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER San Diego Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 South Orange 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 3/19/25 at 10:23 A.M. with Certified Nurse Assistant (CNA) 2. CNA 2 stated Resident 5 was ambulatory and shared bathrooms with Resident 9. CNA 5 stated Resident 5 did not wander to other residents' rooms. CNA 5 stated she did not hear about Resident 5 being hit by Resident 9. CNA 5 stated Resident 9 was confused, wandered to other rooms and got agitated if other residents got in his way.</p> <p>During an observation and interview on 3/19/25 at 10:36 A.M. with Resident 5, Resident 5 stated he did not feel safe. Resident 5 stated someone hit him on the nose and still saw the other resident (Resident 9). Resident 5's nose was observed with yellow discoloration at the bridge of his nose.</p> <p>During an interview on 3/19/25 at 11:04 A.M. with the Assistant Director of Nursing (ADON), the ADON stated she was not aware that Resident 5 and Resident 9 shared bathrooms.</p> <p>An interview and concurrent record review was conducted on 3/19/25 at 12:09 P.M. with the ADON and the Director of Nursing (DON). The ADON reviewed the wandering assessment for Resident 9. The ADON stated the wandering assessment indicated a score of 12, indicating a wander risk. The ADON reviewed Resident 9's care plan regarding the altercation with Resident 5. The ADON stated the care plan did not indicate separating Resident 9 from Resident 5. The ADON then reviewed Resident 5's care plan regarding the altercation with Resident 9. The ADON stated the care plan for Resident 5 did not indicate separating Resident 5 from Resident 9. The DON stated Resident 5 and Resident 9 should be separated and should not have a shared bathroom to prevent further altercation. The DON further stated it was important to review the plan of care and update as necessary.</p> <p>A review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated September 2022 was conducted. The P&P indicated, .All reports of resident abuse .are reported .and thoroughly investigated by facility management. Findings of all investigations are documented .All allegations are thoroughly investigated .The individual conducting the investigation as a minimum .reviews all events leading up to the alleged incident .and documents the investigation completely and thoroughly .</p> <p>A review of the facility's policy and procedure (P&P) titled Resident-to-Resident Altercations, dated September 2022 was conducted. The P&P indicated, .If two residents are involved in an altercation, staff . make any necessary changes in the care plan approaches to any or all of the involved individuals .</p>		