STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555659	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Diego Post-Acute Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide a shower on scheduled shower days for one of three residents (Resident 1) reviewed for Activities of Daily Living (ADL).As a result, Resident 1 was not offered and provided a shower during his first week of admission to the facility. This failure had the potential to negatively affect the resident's well-being.Findings:A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of generalized weakness, major depressive disorder and cognitive communication deficit.A review of Resident 1's care plan, dated 7/1/25, indicated, ADL/Mobility: Resident.is at risk for ADL/mobility decline and requires assistance.will have no significant declines in ADL's or mobility.On 7/14/25 at 8:55 A.M., an interview was conducted with Resident 1. Resident 1 stated that the facility did not offer him a shower for a full week after admission.On 7/14/25 at 9:08 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated upon admission residents were assigned a shower twice a week. CNA 2 stated if a resident refused a shower it had to be documented on a shower sheet as well as in the electronic health record and the nurse would need to be notified. CNA 2 stated Resident 1 was scheduled to receive a shower on Wednesdays and Saturdays.A review of Resident 1's July 2025 shower sheets, indicated the resident first received a shower on 7/7/25, refused a shower on 7/9/25, and received a shower on 7/12/25. There was no documentation a shower had been offered or provided on Resident 1's scheduled shower days 7/2/25 and 7/5/25.A review of Resident 1's electronic health record for CNA documentation related to bathing indicated, No (not scheduled for this shift) was coded on 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, and 7/8/25.On 7/14/25 at 12:20 P.M., an interview and record review was conducted with the Charge Nurse (CN). The CN reviewed the unit's showers schedule and stated Resident 1's shower days were on Wednesday and Saturday. The CN reviewed Resident 1's clinical record and stated there was no documentation the resident received a shower on 7/2/25 and 7/5/25 and he should have received a shower. The CN stated that nursing staff kept track of resident showers using the shower sheets.On 7/14/25 at 1:42 P.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated there was no specific facility policy for resident showers. The ADON stated the facility referred to their Activities of Daily Living (ADL) policy.On 7/14/25 at 1:44 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1 should have been given a shower on his scheduled shower days.A review of the facility's policy titled Activities of Daily Living (ADLs), revised on March 2018, indicated, .2. Appropriate care and services will be provided for residents.a. Hygiene (bathing, dressing, grooming, and oral care);.

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
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	555659	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Diego Post-Acute Center	1201 South Orange Ave. El Cajon, CA 92020

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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 0686 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 one resident's (Resident 2) Low Air Loss mattress (LAL, a mattress that uses a continuous flow of air through tiny laser made air holes in the top of the mattress surface so that the user floats on a soft cushion of air that helps to prevent pressure ulcers) was functioning properly when a plastic inflatable overlay mattress was placed on top of the LAL mattress.As a result, this had the potential for Resident 2 to experience skin breakdown and develop pressure ulcers. Findings:A review of Resident 2's admission Record indicated the resident was re-admitted to the facility on [DATE] with a diagnosis of functional quadriplegia (paralysis of all four limbs), hereditary motor and sensory neuropathy (a condition that affects the nerves), pressure ulcer of sacral region stage 3 (a pressure injury that goes down into the fat and muscle tissue), pressure-induced deep tissue damage of left heel, and pressure-induced deep tissue damage of right heel.A review of Resident 2's care plan, dated 10/10/24, indicated Skin: Resident has skin impairment (left foot blister) and is at risk for delayed healing. Interventions/Tasks.Low air loss mattress.A review of Resident 2's orders, dated 1/31/25, indicated On low air loss mattress for skin management, Monitor LAL mattress for proper setting (according to residents weight /comfortability every shift).A review of Resident 2's vital summary, dated 6/21/25, indicated the resident weighed 214.5 pounds.On 7/14/25 at 8:58 A.M., an interview and observation was conducted with Resident 2 in his room. Resident 2 was lying on top of a tan colored plastic inflatable overlay mattress that extended the length and width of the LAL mattress and was approximatively three inches thick. The LAL mattress was underneath the plastic inflatable overlay mattress and had been set to firm for a weight of 350 pounds (lbs). Resident 2 stated that he bought the inflatable overlay mattress because his LAL mattress was uncomfortable.On 7/14/25 at 10:54 A.M., an interview was conducted with Licensed Nurse (LN) 11. LN 11 stated he was the nurse for Resident 2 and was familiar with his care needs. LN 11 stated Resident 2 required maximum assistance from staff for Activities of Daily Living (ADL, activities such as transferring, dressing, and bathing) and was at risk for skin breakdown. LN 11 stated he knew Resident 2 had a plastic inflatable overlay mattress over his LAL mattress but he did not know the purpose of a LAL mattress.On 7/14/25 at 11 A.M., an interview and observation was conducted with the Charge Nurse (CN). The CN stated Resident 2 had a LAL mattress to prevent pressure ulcers from developing. The CN went into Resident 2's room to observe the resident's bed and stated she was unaware that the plastic inflatable overlay mattress was on top of the LAL mattress. The CN stated she should have been made aware of Resident 2's plastic inflatable overlay mattress. The CN stated Resident 2's LAL mattress was set to firm for a resident weighing 350 lbs and should not have been set that high.On 7/14/25 at 11:29 A.M., an interview and observation was conducted with the Director of Nursing (DON) in Resident 2's room. The DON observed Resident 2's plastic inflatable overlay mattress on top of the LAL mattress. The DON stated there should not have been an overlay on top of Resident 2's LAL mattress because it could interfere with the functionality of the mattress. The DON stated Resident 2's LAL mattress setting should have been set to his weight and not to 350 lbs.On 7/14/25 at 1:07 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 2's LAL mattress should not have anything on top of it because it could affect the function of the mattress. The DSD stated an in-service had not been done related to LAL mattresses. The DSD stated nursing staff should know how to operate LAL mattresses and that they should not be covered with any other mattresses.On 7/14/25 at 1:44 P.M., an interview was conducted with the DON. The DON stated that nursing staff should have known the purpose of a LAL mattress and how to check for proper functioning. The DON stated it was her expectation for the nursing staff to round on the residents every two hours and they should have identified the plastic inflatable overlay mattress and removed it.A review of the facility document titled Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss User Manual, undated, indicated, Warning.adhere to the following instructions. Failure to do so could result in personal injury or equipment damage.Only use attachments and/or accessories that are recommended by the manufacturer.A review of the facility's policy titled Pressure Injury Risk Assessment, dated 2001, indicated, .2. Risk factors that increase a resident's susceptibility to develop or to not heal PIs [pressure injuries] include.b. Impaired/decreased mobility and decreased functional ability; c. the presence of previously healed PI;.A review of the facility's policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated 2001, indicated, 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for