

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 12/02/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a discharge care plan for one of three sampled residents (Resident 1).As a result, this deficient practice placed Resident 1 at risk for an unsafe or uncoordinated discharge, unmet care needs, and delays in services during any transition out of the facility. Findings:A review of Resident 1's admission Record indicated, Resident 1 was re-admitted to the facility on [DATE] with diagnoses which included history of Cerebrovascular Disease (conditions that affect blood flow to the brain).A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 9/5/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of two points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 12/2/25 at 12:30 P.M., an interview and record review was conducted with the Social Service Designee (SSD). The SSD stated they had planned on Resident 1 to discharge to a sister facility (same company of facility) that was out of state in Arizona before finding out Resident 1's family member contact information. The SSD stated she had reached out to Resident 1's primary care physician (PCP) on 11/7/25 who had Resident 1's family member (FM) current contact information, and spoke to Resident 1's FM who stated he wanted Resident 1 to move closer to him in El Centro, California and not Arizona. The SSD stated the interdisciplinary team (IDT: nurses, doctors, therapists, social workers, nutrition and other staff involved who work together to create one cohesive plan for a resident's care) had a care conference for Resident 1 on 11/6/25 but was unable to find a current and/or revised discharge care plan. The SSD stated it should have been developed after Resident 1's re-admission [DATE] to the facility.On 12/2/25 at 12:51 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations were, discharge planning and discharge care plans must be initiated and updated timely so all staff understand the resident's goals and needs starting from admission. The DON stated discharge care planning should be personalized to each resident and coordinated with the IDT and discussed with the resident and/or representative to ensure it reflected their goals and supports a safe discharge from the facility. The DON further stated that discharge care plans must be continuously updated based on the resident's level of care, condition changes, significant events, quarterly reviews and revised as needed. The DON acknowledged that timely discharge planning was essential to prevent delays, ensure resident safety, and support a coordinated transition out of the facility. A review of the facility's policy and procedure titled, Care Planning-Interdisciplinary Team dated March 2022, indicated .Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary (IDT) .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555659
		If continuation sheet Page 1 of 2

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 12/02/2025
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and revise a person-centered discharge care plan for one of three sampled residents (Resident 3) that reflected their discharge needs, preferences, and goals. As a result, this deficient practice placed Resident 3 at risk for an unsafe or uncoordinated discharge, unmet needs during transition, and delays in needed services. Findings: A review of Resident 3's admission Record indicated Resident 3 was re-admitted to the facility on [DATE] with diagnoses which included history of Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A record review of Resident 3's minimum data set (MDS - a federally mandated resident assessment tool) dated 11/12/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 3 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 12/2/25 at 11:45 A.M., a record review was conducted on Resident 3's clinical chart. Resident 3's discharge care plan initiated 8/12/25 was not revised as Resident 3's condition and planning needs changed. There was no documentation to Resident 3's discharge care plan showing:- Revised and/or updated discharge goals since baseline care plan was initiated on 8/12/25. - Revised and/or updated interventions for a safe transition since baseline care plan was initiated on 8/12/25.- No interdisciplinary team (IDT: healthcare professionals [i.e. physician, nurses, social services, nutrition and rehabilitation staff] and support staff who work together to create and coordinate a person's care plan) review was completed for discharge planning on scheduled care conference on 11/7/25. On 12/2/25 at 11:50 A.M., an interview and record review was conducted with the Social Service Designee (SSD). The SSD stated Resident 3's discharge care plan was not person-centered and should have been updated completion of the comprehensive care plan (21 days of re-admission) and continuously to keep current. The SSD stated she only spoke to Resident 3's family member on the phone on 11/7/25 without an IDT or Resident 3 present and stated, the discharge care plan was not revised and/or updated to reflect Resident 3's current discharge needs and goals. The SSD stated Resident 3's discharge care plan should have been reviewed by the IDT and updated on 11/7/25 but was not. The SSD stated it was important that a person-centered discharge care plan was reviewed and were necessary for all team members to understand Resident 3's current needs, goals and preferences to ensure a safe and appropriate discharge. The DON stated discharge care planning should be personalized to each resident and coordinated with the IDT and discussed with the resident and/or representative to ensure it reflected their goals and supports a safe discharge from the facility. The DON further stated discharge care plans must be continuously updated based on the resident's level of care, condition changes, significant events, quarterly reviews and revised as needed. The DON acknowledged that timely discharge planning was essential to prevent delays, ensure resident safety, and support a coordinated transition out of the facility. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered dated March 2022, indicated . The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission</p>		