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	01/23/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written notice of a room change to two of three residents (Resident 1 and 2).This deficient practice had the potential to cause psychosocial distress and limit the residents' and the responsible party's ability to participate in the decisions regarding having a room change.A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (progressive brain disorder that affects memory, thinking and behavior) and unspecified dementia (loss of cognitive functioning).A review of Resident 1's History and Physical dated 5/19/25 indicated the resident, .does NOT have the capacity to understand and make decisions.A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE].A review of the facility's Daily Census dated 1/8/26, indicated Resident 1 was in Room A. The Daily Census also indicated Resident 2 was in Room B.A review of Resident 1's Progress Note dated 1/8/26, indicated the resident was provided a room change to Room B. On 1/12/26 at 9:27 A.M., a concurrent interview and record review was conducted with the assistant director of nursing (ADON). The ADON stated Resident 1 was cognitively impaired and his responsible party (RP) was his decision maker. The ADON stated the facility had to notify Resident 1's RP prior to the room change. The ADON reviewed Resident's 1 clinical record and stated there was no documentation Resident 1's RP was notified of the resident's room change on 1/8/26. The ADON further stated residents should be notified about getting a roommate. The ADON reviewed Resident 2's clinical record and stated the resident was not provided a written notice that he would have a new roommate. The ADON stated it was the responsibility of the Social Worker to notify the RP and the potential roommate of a room change and to document that conversation.On 1/12/26 at 11:12 A.M., an interview was conducted with the Social Service Assistant (SSA). The SSA stated Resident 1's room change should have been documented on the room change form and as a progress note. The SSA stated Resident 2 also had to receive written notification of receiving a new roommate. The SSA stated this was not done for Resident 1 and Resident 2 and should have been done. The SSA stated it got missed.On 1/12/26 at 2:25 P.M., an interview was conducted with the administrator (ADM). The ADON was also present. The ADM stated written notice of room changes should have been provided to Resident 1's RP and to Resident 2. A review of the facility's policy titled Room Change/Roommate Assignment dated May 2017, indicated, . 2. Prior to changing a room or roommate assignment all parties involved. and their representatives. will be given a ____ hour/day advance notice of such change. 8. Documentation of a room change is recorded in the resident's medical record.

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of four residents (Resident 3, 4, 5, and 6) were free from physical abuse when:1. Resident 5's behavioral triggers (stimuli that may cause a specific action or response) were not identified, assessed, and care planned.2. Resident 6's wandering behavior into other residents' rooms was not identified, assessed, and care planned.As a result:1. Resident 5, when triggered, pushed Resident 4 down on 11/14/25, punched Resident 3 in the mouth on 12/25/25, and yelled at and grabbed Resident 6's arm on 12/30/25. Resident 3 sustained a laceration to the inner upper lip, experienced pain, and was distressed.2. Resident 6 entered Resident 5's room on 12/30/25 and put on his clothes. Resident 5 yelled and grabbed Resident 6 who then struck Resident 5 in the face causing him to fall to the floor.These failures to manage Resident 5 and Resident 6's behaviors put other residents on the secured unit (unit where residents need added supervision due to mental disorders and/or cognitive impairment) at risk for abuse. Cross reference F610, F742, and F744.On 1/8/26 at 8:30 A.M., an onsite visit was conducted to investigate two facility reported incidents of alleged abuse.A review of the facility's Report of Suspected Dependent Adult/Elder Abuse form (SOC 341, a form submitted to the State agency to report allegations of abuse) dated 12/25/25, indicated Resident 3 was seated in her wheelchair in the dining room when Resident 5 approached her and attempted to pull her wheelchair backwards. Resident 3 turned towards Resident 5 and instructed him to stop. Resident 5 then struck Resident 3 in the face for no apparent provocation. Resident 3 was noted with laceration to the upper inner lip. First aid and pain medication was administered to Resident 3. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse form dated 12/30/25, indicated, .[Resident 5] was ambulating down the hallway when he approached [Resident 6] and began yelling at him, and grabbed his arm. Before staff could intervene, [Resident 6] swung at [Resident 5] striking him in the face and causing [Resident 5] to fall to the ground.A review of the facility's Daily Census dated 1/8/26, indicated there were currently 60 residents on the secured unit.1. The First Reported Incident (occurring on 12/25/25):A review of Resident 3's admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses to include anxiety.A review of Resident 3's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 10/22/25, indicated the resident scored 15 out of 15 on the brief interview of mental status (which meant the resident was cognitively intact). A review of Resident 4's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include Alzheimer's dementia (a progressive brain disorder that affects memory, thinking, and behavior).A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include traumatic brain injury, post-traumatic stress disorder (PTSD, a mental health condition that develops after exposure to a traumatic event), bipolar disorder (a mood disorder that alternates between depression and mania), and Alzheimer's dementia.A review of Resident 5's Summary of Physician Discharge Instructions (hospital documentation) dated 8/4/25, indicated, .Safety Plan.How will you know when you are in crisis and that the safety plan should be used? What are your personal red flags . 2. I get angry or aggravated when people are [stealing] from me.A review of Resident 5's nursing note dated 11/14/25, indicated, .[Resident 4] was standing near the food cart when [Resident 5] .pushed him aside. This caused the other resident [Resident 4] to loss [sic] his balance and fall to the ground.A review of Resident 3's IDT (interdisciplinary team) note dated 12/26/25, indicated, . [Resident 3] was seated in her wheelchair in the dining room when another resident [Resident 5] approached her and attempted to pull her wheelchair backwards. [Resident 3] turned (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	towards the other resident [Resident 5] and instructed him to stop. The other resident [Resident 5] then struck this resident [Resident 3] in the face. This resident [Resident 3] was noted with laceration to the upper inner lip. First aid administered. Resident medicated for pain.A review of Resident 3's Alert Charting notes dated 12/26/25 and 12/27/25, indicated, Resident is on alert charting for being subject of aggression, neuro-check [an assessment] on progress, pain being treated with Tylenol as order [sic].On 1/8/26 at 9:41 A.M., an observation and interview was conducted with Resident 3 while inside her room. Resident 3 stated the incident with Resident 5 occurred on Christmas during lunchtime. Resident 3 stated Resident 5 got a hold of her wheelchair and would not let go. Resident 3 stated she told Resident 5 to let go of her wheelchair and he punched me in the mouth. Resident 3 pointed to one of her front teeth and stated being punched in the mouth had loosened one of her teeth. Resident 3 was asked if she experienced any pain from the incident and the resident stated, Oh, God yes. Resident 3 stated she got hurt and the pain lasted a long time. Resident 3 stated staff were not close enough to intervene until she got punched. Resident 3 stated staff told her Resident 5 was no longer in the facility and was gone. Resident 3 stated she would feel afraid if Resident 5 was on the unit and would not feel safe because of his violent nature. Resident 3 stated she was aware Resident 5 had hit other residents before.On 1/8/26 at 9:57 A.M., an observation was conducted in the hallway. Resident 5 approached and asked, Are you theft investigators? Here to investigate the thefts? Resident 5 was observed with staff providing 1:1 supervision (one staff assigned to provide continuous supervision).On 1/8/26 at 10:12 A.M., an interview was conducted with Resident 5 in front of the nurses' station. Resident 5 was asked about the altercations he was involved in with other residents. Resident 5 stated, Which one do you want to know about first? Resident 5 alleged Resident 3 had put her feet on the table to irritate him. Resident 5 stated he threw Resident 3's feet on the floor. Resident 5 was observed walking around the unit wearing white medical tape on his jacket with his name handwritten with black ink. L.V.N. [licensed vocational nurse], was also written underneath his name.On 1/8/26 at 10:30 A.M., an interview was conducted with Resident 1 while in the dining hall. Resident 1 was Resident 5's roommate. Resident 1 stated he was afraid of his roommate (Resident 5). Resident 1 stated, [Resident 5] said he'd kill me.On 1/8/26 at 12:43 P.M., an interview was conducted with certified nursing assistant (CNA) 1. CNA 1 stated she was working on 12/25/25 and had witnessed the incident between Resident 3 and Resident 5. CNA 1 stated Resident 3 was in front of the meal cart and Resident 5 was holding onto Resident 3's wheelchair handle. CNA 1 stated Resident 3 told Resident 5 to let go and he did not like to be told that. CNA 1 stated Resident 5 punched Resident 3 in the mouth with a closed fist. CNA 1 stated, It was a hard hit. CNA 1 stated she saw blood in Resident 3's mouth and the resident was screaming and saying, It hurts, it hurts. CNA 1 stated she was right next to the residents when the altercation happened, but things happened so fast and without warning. CNA 1 stated based on her abuse prevention training, this incident was physical abuse.CNA 1 further stated she was also present during an incident on 11/14/25 with Resident 5 and Resident 4. CNA 1 stated Resident 4 was touching the meal carts and that Resident 5 did not like that. CNA 1 stated Resident 5 pushed Resident 4 away [from the meal carts] so hard when he fell, I was afraid he'd die because he may have hit his head. CNA 1 stated Resident 5's behavior was impulsive and seemed to come out of nowhere. CNA 1 stated she was not aware of what triggered Resident 5's aggressive behavior.CNA 1 stated Resident 1 was Resident 5's roommate. CNA 1 stated it was believable when Resident 1 said Resident 5 threatened to kill him. CNA 1 stated she would take what Resident 1 said seriously. CNA 1 stated if she was Resident 5's roommate, I would absolutely not be comfortable because I've seen what [Resident 5's] capable of doing.On 1/8/26 at 3:30 P.M., an interview was conducted (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	with the assistant director of nursing (ADON). The ADON stated Resident 5 gets triggered by other residents. The ADON stated Resident 5 was specifically triggered when residents went in his room, opened his closet, and went into or were around the food carts during meals. The ADON stated Resident 5 thought he was a licensed nurse and wanted to control who touched the food carts.On 1/9/26 at 10:06 A.M., an interview was conducted with CNA 2. CNA 2 stated she provided 1:1 supervision to Resident 5 yesterday. CNA 2 stated Resident 5 got agitated by other residents. CNA 2 stated she was not aware of any behavioral triggers or of a PTSD diagnosis for Resident 5. CNA 2 stated all staff on the unit should be aware of any of Resident 5's behavioral triggers in order to prevent the resident from being triggered. CNA 2 stated Resident 5 thought about theft and seemed focused on people frequently stealing. CNA 2 stated based on her facility provided abuse prevention training, whether provoked or unprovoked, being punched in the mouth was physical abuse.On 1/9/26 at 10:20 A.M., an interview was conducted with CNA 3. CNA 3 stated she was familiar with Resident 5 and his behavior. CNA 3 stated Resident 5 would get upset and yell when other residents were yelling. CNA 3 stated Resident 5 was focused on his belongings and potential theft. CNA 3 stated Resident 5 was concerned about who entered his room because he thought the person was coming into his room to steal. CNA 3 stated Resident 5 did not like it when other residents were around the food carts because he thought they were going to steal the food. CNA 3 stated Resident 5 thought he was a nurse who worked at the facility. CNA 3 stated Resident 5 would help other residents by pushing their wheelchairs. CNA 3 stated she did not think it was a good idea for Resident 5 to wear medical tape identifying himself as a licensed vocational nurse. CNA 3 stated other confused residents on the unit could approach him thinking he was the nurse and Resident 5 may react aggressively toward them. CNA 3 stated Resident 5 believed he was a staff nurse which may empower him. CNA 3 stated she was aware Resident 5 had altercations with other residents, but she did not know who those residents were. CNA 3 stated it was important for all staff to know who the residents that were involved in the altercations with Resident 5 were. CNA 3 stated knowing who they were would help prevent further altercations from occurring. CNA 3 stated all staff on the unit should be aware of Resident 5's behavioral triggers to prevent his aggression. CNA 3 stated based on her facility provided abuse prevention training, when Resident 5 pushed and punched other residents, this was physical abuse.On 1/9/26 at 11:19 A.M., a joint interview and record review was conducted with licensed nurse (LN) 1. LN 1 stated she provided care to Resident 5 yesterday. LN 1 stated she did not know Resident 5 had behavioral triggers. LN 1 stated it was important for all staff on the unit to know what Resident 5's triggers were to avoid his aggressive behavior. LN 1 stated she was unaware of Resident 5's PTSD diagnosis and triggers. LN 1 stated residents with PTSD could become aggressive and hurt others when triggered. LN 1 reviewed Resident 5's care plans and stated Resident 5's behavioral triggers were not identified and care planned. LN 1 stated this should have been done. LN 1 stated she saw Resident 5 wearing medical tape on his jacket identifying himself as an L.V.N. LN 1 stated it was not safe for him to present himself as a staff nurse. LN 1 stated if other residents approached Resident 5 thinking he was the nurse, it may trigger his aggression and lead to an altercation. LN 1 stated it may also empower Resident 5 to have a perceived authority over other residents. LN 1 stated based on her facility provided training, pushing and punching other residents was physical abuse.On 1/9/26 at 2 P.M., a joint interview and record review was conducted with LN 2. LN 2 stated Resident 5 was triggered by other residents yelling and things had to be a certain way for him because he believed he built the building and was in charge. LN 2 stated, We play along with him to avoid his aggression or anger. LN 2 stated Resident 5 believed other people stole his things. LN 2 stated Resident 5 [was] usually the aggressor with other residents on the unit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	LN 2 reviewed Resident 5's clinical record and stated his care plans did not identify resident-specific triggers or interventions to prevent the resident from being triggered. LN 2 stated she was not aware Resident 5 identified himself as a staff nurse in writing on medical tape that was worn on his jacket. LN 2 stated this was unacceptable. LN 2 stated it may give him a feeling of authority over others and was not safe.On 1/9/26 at 3 P.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated she provided the abuse prevention training in the facility. The DSD stated residents with unmanaged behaviors could lead to altercations and abuse. The DSD stated behavioral and PTSD triggers had to be assessed with clear understanding of the reasons so further triggering could be avoided. The DSD stated all staff on the unit should be aware of Resident 5's behavioral triggers and these should have been put on the resident's care plan. The DSD stated the care plan should then have relevant interventions to prevent, address, and handle the behavior should it occur. The DSD stated not knowing Resident 5's triggers could lead to incidents of abuse. The DSD reviewed Resident 5's clinical record and written care plans and stated the resident's behavioral and PTSD care plans did not identify resident-specific triggers. The DSD stated all staff should be aware Resident 5 was preoccupied with thoughts of theft and that people were stealing from him. The DSD stated interventions should have included means to prevent situations from occurring when other residents went into his room or were around the meal carts. The DSD stated it was not appropriate for Resident 5 to have the designation as an L.V.N. on his jacket. The DSD stated it may empower Resident 5 to take action with other residents during perceived wrongs. The DSD further stated when Resident 5 punched Resident 3 in the mouth, this was physical abuse and caused harm to Resident 3. The DSD stated Resident 3 should not have been told Resident 5 was gone from the facility. The DSD stated Resident 3 should have been informed of a plan to keep her safe from Resident 5 to prevent the resident from experiencing fear or being traumatized. The DSD stated Resident 5's roommate (Resident 1) should have been interviewed to make sure he was safe around Resident 5. On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the ADON. The ADON stated when Resident 5 hit Resident 3 in the mouth that was considered physical abuse. The ADON reviewed Resident 3's clinical record and stated there was no documentation the resident had been seen by the physician or dentist after being punched in the mouth on 12/25/25. The ADON stated this should have been done soon after the incident to make sure Resident 3 sustained no injuries. The ADON stated residents who experienced abuse should be told of the plan to keep them safe from the perpetrator. The ADON stated there was no documentation in Resident 3's clinical record that she was informed of how she would be protected from Resident 5. The ADON stated Resident 3 was informed over the weekend that Resident 5 was on the unit, and she was offered a room change off the unit. The ADON stated Resident 3 accepted the room change and felt safer away from Resident 5.The ADON stated everyone on the unit should have been aware of Resident 5's behavioral triggers that caused him agitation and aggression which led to incidents of abuse. The ADON stated Resident 5 became aggressive when other residents were around the meal carts, and going into his room or closet. The ADON reviewed Resident 5's clinical record and written care plans and stated those specific behavioral triggers were not identified, assessed, and care planned. The ADON stated a lock was placed on Resident 5's closet after the incident occurred with Resident 6. The ADON acknowledged the need for a lock on Resident 5's closet should have been identified sooner. The ADON stated these behavioral triggers should have been care planned. The ADON stated Resident 5's behavior was not identified and care planned after Resident 5 pushed Resident 4 down for opening the meal cart on 11/14/25. The ADON stated corrective action after that incident should have identified Resident 5's triggers to prevent further incidents of abuse. The (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	ADON stated Resident 5 should not have been identifying himself as an L.V.N. on the unit as he could think he was in charge. The ADON stated this was unsafe. The ADON further stated all staff on the unit should be aware of which residents Resident 5 had altercations with to prevent further incidents of abuse from occurring.2. The Second Reported Incident (occurring on 12/30/25): A review of Resident 6's admission Record indicated the resident was admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses to include unspecified dementia (loss of cognitive functioning) and schizophrenia (a mental disorder characterized by paranoia and delusions). A review of Resident 6's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 12/12/25, indicated the resident scored 5 out of 15 on the brief interview of mental status (which meant the resident was cognitively impaired).A review of Resident 6's History and Physical Examination dated 12/12/25, indicated the resident, Does NOT have capacity to understand and make decisions. The document also indicated that Resident 6 was conserved (had a court-appointed decision maker).A review of Resident 6's SBAR Summary for Providers dated 12/1/25, indicated the resident was, .now going in another resident room slamming doors.Resident hard to redirect despite being approached calmly, explanation and encouragement [sic].A review of Resident 6's Nurse's Note dated 12/30/25, indicated, .[Resident 5] was ambulating down the hallway when he approached [Resident 6] and began yelling at him, and grabbed his arm. Before staff could intervene, [Resident 6] swung at [Resident 5] striking him in the face and causing [Resident 5] to fall to the ground.A review of Resident 5's Progress Notes dated 12/30/25, indicated the resident was sent out to the hospital for evaluation after the altercation with Resident 6. Resident 5 had a CT scan (computed tomography, a view of body's internal structures) of his head with negative results (no injuries).On 1/8/25 at 10:07 A.M., an observation and interview was conducted with Resident 6 while inside the resident's room. Resident 6 was observed seated in a chair and bent over hitting a supplemental protein shake container on the floor. An interview was attempted, but Resident 6 mumbled incoherently to himself. Resident 6's room was next door to Resident 5's room.On 1/8/26 at 10:12 A.M., an interview was conducted with Resident 5 in front of the nurses' station. Resident 5 stated he had an altercation because he saw Resident 6 wearing his shoes and he wanted them back. Resident 5 stated he went to Resident 6 and started to take them off him. Resident 5 stated Resident 6 then punched him and threw him across the hall where he hit his head on the door jamb. Resident 5 stated Resident 6 proceeded to kick him in the stomach. Resident 5's account of the incident with Resident 6 did not entirely make sense. On 1/8/26 at 12:12 P.M., an interview was conducted with the physical therapy assistant (PTA). The PTA stated on 12/30/25, she was walking a resident on the unit and heard yelling down the hall by Resident 5 and Resident 6's room. The PTA stated she saw Resident 6 take a swing at Resident 5 and she ran over to intervene. The PTA stated Resident 5 was on the floor and had been hit once. The PTA stated Resident 5 was conscious with no apparent injuries.On 1/8/26 at 12:43 P.M., an interview was conducted with CNA 1. CNA 1 stated Resident 6 was mentally gone. CNA 1 stated Resident 6 wandered into other residents' rooms. CNA 1 stated Resident 6 was easily startled and would react physically when grabbed by another person.On 1/8/26 at 3:30 P.M., an interview was conducted with the ADON. The ADON stated on 12/30/25, Resident 6 did go into Resident 5's room and into his closet. The ADON stated Resident 6 did put on Resident 5's clothing. The ADON stated Resident 5 would have been triggered by this incident.On 1/9/26 at 10:20 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 6 was, very confused and frequently wandered into other residents' rooms. CNA 3 stated she thought Resident 6 did this due to his confusion and he thought he was in his own room. CNA 3 stated on 12/30/25, Resident 6 had been inside of Resident 5's room, most of the day. CNA 3 stated she redirected Resident 6 away from Resident 5's room more than once but (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	he refused to be redirected. CNA 3 stated she informed LN 3 that Resident 6 was not responding to redirection. CNA 3 stated she was not sure what had been done about it. CNA 3 stated Resident 5 was not aware Resident 6 had been in his room most of the day. CNA 3 stated she was not present during the altercation but was aware Resident 5 had caught Resident 6 wearing his clothing. CNA 3 stated this would have triggered Resident 5's aggression. CNA 3 stated Resident 5 and Resident 6's rooms were right next door to each other and were too close together.On 1/9/26 at 11:19 A.M., an interview was conducted with LN 1. LN 1 stated Resident 6 was confused and wandered. LN 1 stated when Resident 6 was not redirectable on 12/30/25, the LN should have moved him to the nurses' station and called for help. LN 1 stated she thought Resident 5 and Resident 6's rooms should not have been right next to each other as Resident 6 was easily confused.On 1/9/26 at 3 P.M., a joint interview and record review was conducted with the DSD. The DSD reviewed Resident 6's clinical record and written care plans. The DSD stated Resident 6 had a wandering behavior and was known to enter other residents' rooms. The DSD stated wandering into other residents' rooms and rummaging or taking things could lead to altercations and incidents of abuse. The DSD stated Resident 6's wandering into other residents' rooms should have been addressed in the resident's care plan with resident-specific interventions to prevent it from happening. The DSD stated after the incident with Resident 6 and Resident 5 on 12/30/25, Resident 6's wandering into other residents' rooms still had not been identified and care planned. The DSD stated it should have been identified, assessed, and care planned.On 1/12/26 at 9:03 A.M., an interview was conducted with LN 3. LN 3 stated she was the LN assigned to Resident 5 and Resident 6 on 12/30/25. LN 3 stated she was not aware of Resident 6 having been inside Resident 5's room most of that day. LN 3 stated she was not aware of CNA 3 reporting that Resident 6 was not redirectable. LN 3 stated Resident 6 should have been brought to an activity or placed in another area to prevent re-entering Resident 5's room. LN 3 stated Resident 5 would be set off knowing or seeing Resident 6 in his room. LN 3 stated Resident 6's care plan should have personalized interventions to mitigate Resident 6's wandering into other residents' rooms.On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the ADON. The ADON stated Resident 6 wandered into other residents' rooms which could lead to altercations, especially with Resident 5 as this would cause him to become aggressive. The ADON stated when staff noticed Resident 6 was not redirectable out of Resident 5's room on 12/30/25, the resident should have been: Asked what he wanted, provided a room change away from Resident 5's room, and had visual reminders placed on his door to indicate which room was his. The ADON reviewed Resident 6's clinical record and written care plans and stated his wandering into other residents' rooms was not addressed. The ADON stated interventions should have been put in place to address and prevent Resident 6's unsafe wandering into other residents' rooms.On 1/12/26 at 2:25 P.M., an interview was conducted with the administrator (ADM). The ADON was also present. The ADM stated all staff on Resident 5's unit should have been aware of his behavioral triggers that led to altercations and abuse with other residents. The ADM acknowledged there was a pattern of Resident 5 being triggered by residents near the meal carts and going in his room which led to physical altercations. The ADM stated aggressive behaviors that caused abuse should have been care planned to prevent reoccurrence. The ADM stated it was physical abuse when Resident 5 punched Resident 3 in the mouth. The ADM further stated Resident 6's wandering into other residents' rooms should have been addressed and care planned as the behavior could lead to altercations.A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation Prevention Program revised April 2021, indicated, Residents have the right to be free from . physical abuse . The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support (continued on next page)

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	555659	A. Building B. Wing	01/23/2026

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	the following objectives: Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: other residents A review of the facility's policy titled Resident-to-Resident Altercations dated September 2022 indicated, . Behaviors that may provoke a reaction by residents or others include.physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving. rummaging through other's property and wandering into other's rooms/space. If two residents are involved in an altercation, staff.identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation. make any necessary changes in the care plan.document in the resident's clinical record all interventions and their effectiveness.A review of the facility's policy titled Behavioral Assessment, Intervention, and Monitoring revised February 2025, indicated, 1. Residents will have minimal complications associated with the management of altered or impaired behavior. 'Behavioral interventions' refers to individualized, nonpharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving.a resident's distress.As part of the comprehensive assessment, staff evaluate .c. the resident's typical or past responses to stress.and other triggers.The IDT thoroughly evaluates new or changing behavioral symptoms to identify underlying causes and address any modifiable factors. Interventions and Management.The IDT evaluates the behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develops a plan of care accordingly.Safety strategies are implemented immediately, if necessary, to protect the resident and others from harm. Interventions are individualized and part of the overall care environment.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate two facility reported incidents of physical abuse and take appropriate corrective action.As a result of this deficient practice, there was the potential for further resident-to-resident altercations and abuse to occur. Cross reference F600.The First Reported Incident (12/25/25):A review of Resident 3's admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses to include anxiety.A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include traumatic brain injury, post-traumatic stress disorder (PTSD, a mental health condition that develops after exposure to a traumatic event), bipolar disorder (a mood disorder that alternates between depression and mania), and Alzheimer's dementia.A review of the facility's Report of Suspected Dependent Adult/Elder Abuse form (SOC 341, a form submitted to the State agency to report allegations of abuse) dated 12/25/25, indicated Resident 3 was seated in her wheelchair in the dining room when Resident 5 approached her and attempted to pull her wheelchair backwards. Resident 3 turned towards Resident 5 and instructed him to stop. Resident 5 then struck Resident 3 in the face for no apparent provocation. Resident 3 was noted with laceration to the upper inner lip. First aid and pain medication was administered to Resident 3.A review of the facility's investigative summary for the altercation between Resident 5 and Resident 3, titled 5 Day and dated 12/30/25, indicated, On December 25, 2025, [Resident 3] was seated in her wheelchair in the dining room when [Resident 5] approached and attempted to pull her wheelchair backward. [Resident 3] turned toward [Resident 5] and instructed him to stop. [Resident 5] then struck [Resident 3] in the face without apparent provocation. Both residents were immediately separated and assessed for injuries. [Resident 3] was noted to have a laceration to the upper inner lip. First aid was administered. No other injuries were noted. No injuries were noted on [Resident 5]. The incident was promptly reported to the attending physician, [police department], [State Agency], the Responsible Party, and the Ombudsman under incident number [omitted]. Following the event, [Resident 3's] psychosocial well-being was closely monitored Social Services initiated 72-hour psychosocial monitoring. During the formal psychosocial well-being visit, [Resident 3] stated that she feels safe and supported within the facility. [Resident 3] was referred to both psychiatry and psychology for further evaluation. [Resident 5] was also identified as requiring additional psychiatric assessment, and appropriate referrals were made. [Resident 5] was transported to [hospital] for further evaluation. Social Services will continue to monitor both residents' emotional well-being and will remain available to support care coordination in collaboration with the interdisciplinary team. For any inquiries or additional information, please do not hesitate to contact me directly. [signed by the director of nursing].On 1/8/26 at 9:41 A.M., an observation and interview was conducted with Resident 3 while inside her room. Resident 3 stated the incident with Resident 5 occurred on Christmas during lunchtime. Resident 3 stated Resident 5 got a hold of her wheelchair and would not let go. Resident 3 stated she told Resident 5 to let go of her wheelchair and he punched me in the mouth. Resident 3 was asked if she experienced any pain from the incident and the resident stated, Oh, God yes. Resident 3 stated she got hurt and the pain lasted a long time. Resident 3 stated staff told her Resident 5 was no longer in the facility and was gone. Resident 3 stated she would feel afraid if Resident 5 was on the unit and would not feel safe because of his violent nature.On 1/8/26 at 3:30 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated Resident 5, gets triggered by other residents. The ADON stated Resident 5 was specifically triggered when residents went in his room, opened his closet, and went into or were around the food carts during meals. The ADON stated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5 thought he was a licensed nurse and wanted to control who touched the food carts. The ADON stated she was part of the interdisciplinary team (IDT) review of the 12/25/25 altercation between Resident 5 and Resident 3. The ADON stated an IDT meeting was conducted to discuss and investigate allegations of abuse.A review of Resident 5's IDT note dated 12/26/25 to discuss and investigate the resident-to resident altercation on 12/25/25, did not identify Resident 5's behavioral triggers as a contributing factor in the altercation or interventions to address them.On 1/9/26 at 3 P.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated she provided the abuse prevention training in the facility. The DSD stated residents with unmanaged behaviors could lead to altercations and abuse. The DSD stated behavioral and PTSD triggers had to be assessed with clear understanding of the reasons so further triggering could be avoided. The DSD stated all staff on the unit should be aware of Resident 5's behavioral triggers and these should have been put on the resident's care plan. The DSD stated the care plan should then have relevant interventions to prevent, address, and handle the behavior should it occur. The DSD stated not knowing Resident 5's triggers could lead to incidents of abuse. The DSD stated interventions should have included means to prevent situations from occurring when other residents went into Resident 5's room or were around the meal carts. The DSD stated Resident 3 should not have been told Resident 5 was gone from the facility. The DSD stated Resident 3 should have been informed of a plan to keep her safe from Resident 5 to prevent the resident from experiencing fear or being traumatized. On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the ADON. The ADON stated when Resident 5 hit Resident 3 in the mouth that was considered physical abuse. The ADON stated residents who experienced abuse should be told of the plan to keep them safe from the perpetrator at the conclusion of the facility's investigation. The ADON reviewed Resident 3's clinical record and stated there was no documentation the resident was informed of how she would be protected from Resident 5. The ADON stated Resident 3 was informed over the weekend that Resident 5 was on the unit, and she was offered a room change off the unit. The ADON stated Resident 3 accepted the room change and felt safer away from Resident 5.The ADON reviewed the prior incidents of physical altercations Resident 5 had been involved in. On 11/14/25, Resident 5 pushed another resident (Resident 4) away from the food carts causing the resident to fall to the floor. On 12/25/25, Resident 5 attempted to remove Resident 3 from in front of the meal carts, and when the resident complained, he punched Resident 3 in the mouth. On 12/30/25, Resident 5 got into an altercation with a resident (Resident 6) who had been wearing his clothing. The ADON stated Resident 5 became aggressive when other residents were around the meal carts, and going into his room or closet. The ADON stated everyone on the unit should have been aware of Resident 5's behavioral triggers that caused him agitation and aggression which led to incidents of abuse. The ADON reviewed Resident 5's clinical record and written care plans and stated those specific behavioral triggers were not identified, assessed, and care planned. The ADON stated a lock was placed on Resident 5's closet after the incident occurred with Resident 6. The ADON acknowledged the need for a lock on Resident 5's closet should have been identified sooner. The ADON stated these behavioral triggers should have been care planned. The ADON stated Resident 5's behavior was not identified and care planned after Resident 5 pushed Resident 4 down for opening the meal cart on 11/14/25. The ADON stated corrective action after that incident should have identified Resident 5's triggers to prevent further incidents of abuse. The ADON stated the facility's investigation into the altercation with Resident 3 and Resident 5 did not result in corrective action that would prevent further incidents of abuse. The ADON stated the facility's investigation into the incident did not identify Resident 5's behavioral triggers as a factor which led to altercations with others. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON reviewed the facility's investigative summary for the 12/25/25 altercation between Resident 5 and Resident 3, titled 5 Day dated 12/30/25, and stated it was not clear if the incident had been verified and what corrective action was taken.The Second Reported Incident (12/30/25):A review of Resident 6's admission Record indicated the resident was admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses to include unspecified dementia (loss of cognitive functioning) and schizophrenia (a mental disorder characterized by paranoia and delusions). A review of the facility's Report of Suspected Dependent Adult/Elder Abuse form dated 12/30/25, indicated, .[Resident 5] was ambulating down the hallway when he approached [Resident 6] and began yelling at him, and grabbed his arm. Before staff could intervene, [Resident 6] swung at [Resident 5] striking him in the face and causing [Resident 5] to fall to the ground.A review of the facility's investigative summary for the altercation between Resident 5 and Resident 6 on 12/30/25, titled 5 Day and dated 1/4/26, indicated, On December 30, 2025, the writer was notified of an incident involving [Resident 5] and [Resident 6]. [Resident 5] was observed ambulating in the hallway when he approached [Resident 6], began yelling, and grabbed [Resident 6's] arm. Prior to staff intervention, [Resident 6] reacted by swinging at [Resident 5], striking him in the face and causing [Resident 5] to fall to the floor. Staff immediately intervened, successfully separated both individuals, and completed assessments. No injuries were identified for either resident. The incident was promptly reported to the attending physician, [police department], [State Agency], the Responsible Party, and the Ombudsman under incident number [omitted]. Following the incident, [Resident 6's] psychosocial well-being was closely monitored. Social Services initiated a 72-hour psychosocial monitoring period. During a formal psychosocial well-being assessment, [Resident 6] reported feeling safe and supported within the facility. [Resident 6] was referred to Psychiatry and Psychology for further evaluation and support. Additionally, [Resident 5] was identified as requiring further psychiatric assessment, and appropriate referrals were initiated. Social Services will continue to monitor both residents' emotional well-being and will remain available to support care coordination in collaboration with the interdisciplinary team. For any inquiries or additional information, please do not hesitate to contact me directly. [signed by the director of nursing].A review of Resident 6's SBAR Summary for Providers dated 12/1/25, indicated the resident was, .now going in another resident room slamming doors.Resident hard to redirect despite being approached calmly, explanation and encouragement [sic].On 1/8/26 at 3:30 P.M., an interview was conducted with the ADON. The ADON stated on 12/30/25, Resident 6 did go into Resident 5's room and into his closet. The ADON stated Resident 6 did put on Resident 5's clothing. The ADON stated Resident 5 would have been triggered by this incident.On 1/9/26 at 10:20 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 6 was, very confused and frequently wandered into other residents' rooms. CNA 3 stated she thought Resident 6 did this due to his confusion and he thought he was in his own room. CNA 3 stated on 12/30/25, Resident 6 had been inside of Resident 5's room, most of the day. CNA 3 stated she redirected Resident 6 away from Resident 5's room more than once but he refused to be redirected. CNA 3 stated she informed LN 3 that Resident 6 was not responding to redirection. CNA 3 stated she was not sure what had been done about it. CNA 3 stated Resident 5 was not aware Resident 6 had been in his room most of the day. CNA 3 stated she was not present during the altercation but was aware Resident 5 had caught Resident 6 wearing his clothing. CNA 3 stated this would have triggered Resident 5's aggression.On 1/9/26 at 3 P.M., a joint interview and record review was conducted with the DSD. The DSD reviewed Resident 6's clinical record and written care plans. The DSD stated Resident 6 had a wandering behavior and was known to enter other residents' rooms. The DSD stated wandering into other residents' rooms and rummaging or taking things could lead to altercations (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and incidents of abuse. The DSD stated Resident 6's wandering into other residents' rooms should have been addressed in the resident's care plan with resident-specific interventions to prevent it from happening. The DSD stated after the incident with Resident 6 and Resident 5 on 12/30/25, Resident 6's wandering into other residents' rooms still had not been identified and care planned. The DSD stated it should have been identified, assessed, and care planned.A review of Resident 6's IDT note dated 12/31/25 to discuss and investigate the resident-to resident altercation between Resident 6 and Resident 5 on 12/30/25, did not identify Resident 6's wandering into other residents' rooms as a contributing factor in the altercation or interventions to address it.On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the ADON. The ADON stated Resident 6 wandered into other residents' rooms which could lead to altercations, especially with Resident 5 as this would cause him to become aggressive. The ADON stated the facility's investigation into the altercation with Resident 5 and Resident 6 did not result in corrective action that would prevent further incidents of abuse. The ADON stated the facility's investigation into the incident did not identify Resident 6's wandering into other residents' rooms as a factor which could lead to altercations with others. The ADON reviewed the facility's investigative summary for the altercation between Resident 5 and Resident 6, titled 5 Day dated 1/6/26, and stated it was not clear if the incident had been verified and what corrective action was taken.On 1/12/26 at 2:25 P.M., an interview was conducted with the administrator (ADM). The ADON was also present. The ADM stated all staff on Resident 5's unit should have been aware of his behavioral triggers that led to altercations and abuse with other residents. The ADM acknowledged there was a pattern of Resident 5 being triggered by residents near the meal carts and going in his room which led to physical altercations. The ADM stated aggressive behaviors that caused abuse should have been care planned to prevent reoccurrence. The ADM stated it was physical abuse when Resident 5 punched Resident 3 in the mouth. The ADM stated Resident 6's wandering into other residents' rooms should have been addressed and care planned as the behavior could lead to altercations. The ADM further stated he was the facility's abuse preventionist and the facility's investigations into the altercation on 12/25/25 with Resident 5 and Resident 3, and the altercation on 12/30/25 with Resident 5 and Resident 6, was not thorough enough. The ADM stated the facility should have identified Resident 5's behavioral triggers and Resident 6's wandering into other residents' rooms as contributing to altercations. The ADM acknowledged the facility's investigations into the incidents did not have corrective action. The ADM stated the facility's investigations, Didn't solve the problem, and We need to get better.A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised September 2022, indicated, .Investigating Allegations 1. All allegations are thoroughly investigated.Follow-Up Report.2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. 3. The follow-up investigation report will provide as much information as possible.4. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for the behavioral health care of one of three residents (Resident 5) with a diagnosed mental disorder and post-traumatic stress disorder (PTSD, a mental health condition that develops after exposure to a traumatic event) when:1. Resident 5's behavioral triggers were not assessed and care planned.2. Resident 5's PTSD was not assessed and care planned with resident-specific interventions.As a result of these deficient practices, Resident 5 was involved in physical altercations with other residents when triggered. There was also the potential for Resident 5 to be retraumatized when staff were not knowledgeable of the resident's PTSD diagnosis and behavioral triggers. Cross reference F600.A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include traumatic brain injury, post-traumatic stress disorder, bipolar disorder (a mood disorder that alternates between depression and mania), and Alzheimer's dementia.A review of Resident 5's Summary of Physician Discharge Instructions (hospital documentation) dated 8/4/25, indicated, .Safety Plan.How will you know when you are in crisis and that the safety plan should be used? What are your personal red flags . 2. I get angry or aggravated when people are [stealing] from me.A review of Resident 5's nursing note dated 11/14/25, indicated, .[Resident 4] was standing near the food cart when [Resident 5] .pushed him aside. This caused the other resident [Resident 4] to loss [sic] his balance and fall to the ground.A review of Resident 5's IDT (interdisciplinary team) note dated 12/26/25, indicated, .Writer was notified of an incident in the dinning [sic] room. Another resident [Resident 3] was seated in her wheelchair in the dinning [sic] room when this resident approached her and attempted to pull her wheelchair backwards. The other resident turned towards this resident and instructed him to stop. This resident then struck the other resident in the face without apparent provocation.A review of Resident 5's Nurse's Note dated 12/30/25, indicated, .Writer was notified that this resident was noted to be ambulating down the hallway when he approached another resident [Resident 6] and began yelling and grabbed his arm. Before staff could intervene, the other resident swung at this resident striking him in the face causing this resident to fall supine to the ground.On 1/8/26 at 9:57 A.M., an observation was conducted in the hallway. Resident 5 approached and asked, Are you theft investigators? Here to investigate the thefts? Resident 5 was observed with staff providing 1:1 supervision (one staff assigned to provide continuous supervision).On 1/8/26 at 10:12 A.M., an interview was conducted with Resident 5 in front of the nurses' station. Resident 5 was asked about the altercations he was involved in with other residents. Resident 5 stated, Which one do you want to know about first? Resident 5 alleged Resident 3 had put her feet on the table to irritate him. Resident 5 stated he threw Resident 3's feet on the floor. Resident 5 was observed walking around the unit wearing white medical tape on his jacket with his name handwritten with black ink. L.V.N. [licensed vocational nurse], was also written underneath his name.On 1/8/26 at 3:30 P.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated Resident 5 gets triggered by other residents. The ADON stated Resident 5 was specifically triggered when residents went in his room, opened his closet, and went into or were around the food carts during meals. The ADON stated Resident 5 thought he was a licensed nurse and wanted to control who touched the food carts. The ADON stated on 12/30/25, Resident 6 had been wearing Resident 5's clothing.On 1/9/26 at 10:06 A.M., an interview was conducted with CNA 2. CNA 2 stated she provided 1:1 supervision to Resident 5 yesterday. CNA 2 stated Resident 5 got agitated by other residents. CNA 2 (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was not aware of any behavioral triggers or of a PTSD diagnosis for Resident 5. CNA 2 stated all staff on the unit should be aware of any of Resident 5's behavioral triggers in order to prevent the resident from being triggered. CNA 2 stated Resident 5 thought about theft and seemed focused on people frequently stealing.On 1/9/26 at 10:20 A.M., an interview was conducted with CNA 3. CNA 3 stated she was familiar with Resident 5 and his behavior. CNA 3 stated Resident 5 would get upset and yell when other residents were yelling. CNA 3 stated Resident 5 was focused on his belongings and potential theft. CNA 3 stated Resident 5 was concerned about who entered his room because he thought the person was coming into his room to steal. CNA 3 stated Resident 5 did not like it when other residents were around the food carts because he thought they were going to steal the food. CNA 3 stated Resident 5 thought he was a nurse who worked at the facility. CNA 3 stated Resident 5 would help other residents by pushing their wheelchairs. CNA 3 stated she did not think it was a good idea for Resident 5 to wear medical tape identifying himself as a licensed vocational nurse. CNA 3 stated other confused residents on the unit could approach him thinking he was the nurse and Resident 5 may react aggressively toward them. CNA 3 stated Resident 5 believed he was a staff nurse which may empower him. CNA 3 stated all staff on the unit should be aware of Resident 5's behavioral triggers to prevent his aggression.A review of Resident 5's written care plan for Psychosocial-Emotional/Trauma related to PTSD dated 8/5/25, indicated, .Avoid Triggers Resident: Coast Guard Retired. Encourage to express emotions. Evaluate non-verbal cues to assess the degree and severity of pain for pain management. Help resident to identify triggers that prompt symptoms. Monitor and record complaints of pain (location, duration, quantity, quality, alleviating factors, aggravating factors) for pain management. Observe for signs and symptoms of distress such as crying, social isolation, withdrawal from normal demeanor, deviation from past spiritual beliefs, inability to control behavior or anger and stereotyped responses to any stressor. Vital signs as indicated.A review of Resident 5's written care plan for Psychosocial-Mood related to mood disorder dated 8/7/25, indicated, .Administer medications as ordered and monitor for side effects as indicated. Notify physician if observed. Assess coping strategies and respect resident's wishes to the extent possible. Assess preferences and choices with activities and encourage involvement. Assess the individual level of functioning and perception of the situation. Establish rapport using therapeutic communication. Observe for ineffective sleeping patterns. Observe for tearfulness, increased agitation, and decreased participation in care. Provide emotional support.A review of Resident 5's written care plan for Psychosocial-Behavior related to bipolar disorder and PTSD dated 8/7/25, indicated, .Activities assessment for diversional activities. Administer medication as ordered. Monitor for side effects and notify physician if observed. Anticipate needs and meet promptly. Document and record behavioral episodes. Encourage resident to verbalize feelings. Environmental evaluation to assess room for safety. Establish a rapport. Manage environmental factors to optimize comfort. Notify physician, responsible party/POA/legal guardian of episodes of aggression & LPN abusive behaviors. Observe and document changes in behavior, including frequency of occurrence and LPN potential triggers. Observe for clinical factors influencing behavioral indicators: (i.e., infection, pain, hypo/hyperglycemia, fever) and notify physician if observed. Observe resident's mood and response to medication. Observe whether the behavior endangers the resident and/or others. (Intervene if necessary: removing others from the surrounding area). Observe whether the behavior endangers the resident and/or others. (Intervene if necessary: removing others from the surrounding area). Obtain Psych Consult as indicated. Social Services visits as indicated.A review of Resident 5's written care plan for the altercation with Resident 4 dated 11/14/25, indicated, .Observe and document changes in behavior, including frequency of occurrence and potential triggers. (continued on next page)

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	555659	A. Building B. Wing	01/23/2026

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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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan did not identify Resident 5's known behavioral triggers.A review of Resident 5's written care plan for the altercation with Resident 3 dated 12/25/25, indicated, .Observe and document changes in behavior, including frequency of occurrence and potential triggers.Observe whether the behavior endangers the resident and/or others. (intervene if necessary: removing others from the surrounding area). The care plan did not identify Resident 5's known behavioral triggers.A review of Resident 5's written care plan for the altercation with Resident 6 dated 12/30/25, indicated, .Help resident identify triggers that prompt symptoms. The care plan did not identify Resident 5's known behavioral triggers.On 1/9/26 at 11:19 A.M., a joint interview and record review was conducted with licensed nurse (LN) 1. LN 1 stated she provided care to Resident 5 yesterday. LN 1 stated she did not know Resident 5 had behavioral triggers. LN 1 stated it was important for all staff on the unit to know what Resident 5's triggers were to avoid his aggressive behavior. LN 1 stated she was unaware of Resident 5's PTSD diagnosis and triggers. LN 1 stated residents with PTSD could become aggressive and hurt others when triggered. LN 1 reviewed Resident 5's care plans and stated Resident 5's behavioral triggers were not identified and care planned. LN 1 stated this should have been done. LN 1 stated she saw Resident 5 wearing medical tape on his jacket identifying himself as an L.V.N. LN 1 stated it was not safe for him to present himself as a staff nurse. LN 1 stated if other residents approached Resident 5 thinking he was the nurse, it may trigger his aggression and lead to an altercation. LN 1 stated it may also empower Resident 5 to have a perceived authority over other residents.On 1/9/26 at 2 P.M., a joint interview and record review was conducted with LN 2. LN 2 stated Resident 5 was triggered by other residents yelling and things had to be a certain way for him because he believed he built the building and was in charge. LN 2 stated, We play along with him to avoid his aggression or anger. LN 2 stated Resident 5 believed other people stole his things. LN 2 stated Resident 5 [was] usually the aggressor with other residents on the unit. LN 2 reviewed Resident 5's clinical record and stated his care plans did not identify resident-specific triggers or interventions to prevent the resident from being triggered. LN 2 stated she was not aware Resident 5 identified himself as a staff nurse in writing on medical tape that was worn on his jacket. LN 2 stated this was unacceptable. LN 2 stated it may give him a feeling of authority over others and was not safe.On 1/9/26 at 3 P.M., a joint interview and record review was conducted with the director of staff development (DSD). The DSD stated she provided the abuse prevention training in the facility. The DSD stated residents with unmanaged behaviors could lead to altercations and abuse. The DSD stated behavioral and PTSD triggers had to be assessed with clear understanding of the reasons so further triggering could be avoided. The DSD stated all staff on the unit should be aware of Resident 5's behavioral triggers and these should have been put on the resident's care plan. The DSD stated the care plan should then have relevant interventions to prevent, address, and handle the behavior should it occur. The DSD stated not knowing Resident 5's triggers could lead to incidents of abuse. The DSD reviewed Resident 5's clinical record and written care plans and stated the resident's behavioral and PTSD care plans did not identify resident-specific triggers. The DSD stated all staff should be aware Resident 5 was preoccupied with thoughts of theft and that people were stealing from him. The DSD stated interventions should have included means to prevent situations from occurring when other residents went into his room or were around the meal carts. The DSD stated it was not appropriate for Resident 5 to have the designation as an L.V.N. on his jacket. The DSD stated it may empower Resident 5 to take action with other residents during perceived wrongs. On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the ADON. The ADON stated everyone on the unit should have been aware of Resident 5's behavioral triggers that caused him agitation and aggression which led to incidents of (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse. The ADON stated Resident 5 became aggressive when other residents were around the meal carts, and going into his room or closet. The ADON reviewed Resident 5's clinical record and written care plans and stated those specific behavioral triggers were not identified, assessed, and care planned. The ADON stated a lock was placed on Resident 5's closet after the incident occurred with Resident 6. The ADON acknowledged the need for a lock on Resident 5's closet should have been identified sooner. The ADON stated these behavioral triggers should have been care planned. The ADON stated Resident 5's behavior was not identified and care planned after Resident 5 pushed Resident 4 down for opening the meal cart on 11/14/25. The ADON stated corrective action after that incident should have identified Resident 5's triggers to prevent further incidents of abuse. The ADON stated Resident 5 should not have been identifying himself as an L.V.N. on the unit as he could think he was in charge. The ADON stated this was unsafe. The ADON further stated the social services department conducted the assessments of residents with PTSD diagnosis to identify person-centered triggers. The ADON reviewed Resident 5's clinical record and stated there was no documentation the resident had been assessed for PTSD and his triggers. The ADON stated this should have been done. The ADON stated assessment had to be done first before a care plan with relevant interventions could be developed. The ADON reviewed a banner on Resident 5's written care plans, **PTSD: Please provide trauma-informed care and attempt to avoid triggers: Arguments/Confrontations, Loud Noises. The ADON stated she was not sure where or when that documentation occurred. The ADON stated she did not know how those triggers were identified without a PTSD assessment occurring. The ADON stated it was not personalized to Resident 5 and did not address his behavior.On 1/12/26 at 2:25 P.M., an interview was conducted with the administrator (ADM). The ADON was also present. The ADM stated all staff on Resident 5's unit should have been aware of his behavioral triggers that led to altercations and abuse with other residents. The ADM acknowledged there was a pattern of Resident 5 being triggered by residents near the meal carts and going in his room which led to physical altercations. The ADM stated aggressive behaviors that caused abuse should have been care planned to prevent reoccurrence.A review of the facility's policy titled Trauma Informed Care and Culturally Competent Care indicated, . To address the needs of trauma survivors by minimizing triggers and/or re-traumatization.Preparation.Nursing staff are trained on trauma screening and assessment tools. General Guidelines.3. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. 4. Triggers are highly individualized. Resident Screening 1. Perform universal screening of resident, which includes a brief, non-specialized identification of possible exposure to traumatic events.Resident Assessment 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers.Develop individualized care plans that address past trauma.Identify and decrease exposure to triggers that may re-traumatize the resident. Interventions are individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress.A review of the facility's policy titled Behavioral Assessment, Intervention, and Monitoring revised February 2025, indicated, 1. Residents will have minimal complications associated with the management of altered or impaired behavior. ‘Behavioral interventions' refers to individualized, nonpharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving.a resident's distress.As part of the comprehensive assessment, staff evaluate .c. the resident's typical or past responses to stress.and other triggers.The IDT thoroughly evaluates new or changing behavioral symptoms to identify underlying causes and address any modifiable factors. Interventions and (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management.The IDT evaluates the behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develops a plan of care accordingly.Safety strategies are implemented immediately, if necessary, to protect the resident and others from harm. Interventions are individualized and part of the overall care environment.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide personalized dementia care for one of two residents (Resident 6) when the resident's behavior of wandering into other residents' rooms was not identified, assessed, and care planned with individualized interventions.As a result, Resident 6 wandered into Resident 5's room, put on Resident 5's clothing which caused a physical altercation. This had the potential to negatively impact Resident 6's ability to achieve his highest level of functioning. Cross reference F600.A review of Resident 6's admission Record indicated the resident was admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses to include unspecified dementia (loss of cognitive functioning) and schizophrenia (a mental disorder characterized by paranoia and delusions). A review of Resident 6's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 12/12/25, indicated the resident scored 5 out of 15 on the brief interview of mental status (which meant the resident was cognitively impaired).A review of Resident 6's History and Physical Examination dated 12/12/25, indicated the resident, Does NOT have capacity to understand and make decisions. The document also indicated that Resident 6 was conserved (had a court-appointed decision maker).A review of Resident 6's SBAR Summary for Providers dated 12/1/25, indicated the resident was, .now going in another resident room slamming doors.Resident hard to redirect despite being approached calmly, explanation and encouragement [sic].A review of Resident 6's Nurse's Note dated 12/30/25, indicated, .[Resident 5] was ambulating down the hallway when he approached [Resident 6] and began yelling at him, and grabbed his arm. Before staff could intervene, [Resident 6] swung at [Resident 5] striking him in the face and causing [Resident 5] to fall to the ground.On 1/8/25 at 10:07 A.M., an observation and interview was conducted with Resident 6 while inside the resident's room. Resident 6 was observed seated in a chair and bent over hitting a supplemental protein shake container on the floor. An interview was attempted, but Resident 6 mumbled incoherently to himself. Resident 6's room was next door to Resident 5's room.On 1/8/26 at 12:43 P.M., an interview was conducted with CNA 1. CNA 1 stated Resident 6 was mentally gone. CNA 1 stated Resident 6 wandered into other residents' rooms. CNA 1 stated Resident 6 was easily startled and would react physically when grabbed by another person.On 1/8/26 at 3:30 P.M., an interview was conducted with the ADON. The ADON stated on 12/30/25, Resident 6 did go into Resident 5's room and into his closet. The ADON stated Resident 6 did put on Resident 5's clothing.On 1/9/26 at 10:20 A.M., an interview was conducted with CNA 3. CNA 3 stated Resident 6 was, very confused and frequently wandered into other residents' rooms. CNA 3 stated she thought Resident 6 did this due to his confusion and he thought he was in his own room. CNA 3 stated on 12/30/25, Resident 6 had been inside of Resident 5's room, most of the day. CNA 3 stated she redirected Resident 6 away from Resident 5's room more than once but he refused to be redirected. CNA 3 stated she informed LN 3 that Resident 6 was not responding to redirection. CNA 3 stated Resident 5 was not aware Resident 6 had been in his room most of the day. CNA 3 stated she was not present during the altercation but was aware Resident 5 had caught Resident 6 wearing his clothing. CNA 3 stated this would have triggered Resident 5's aggression. CNA 3 stated Resident 5 and Resident 6's rooms were right next door to each other and were too close together.A review of Resident 6's written care plan for Elopement dated 3/14/25 and Cognitive Impairment related to dementia dated 3/12/25, did not identify the resident's behavior of wandering into other residents' rooms and did not have individualized interventions to address it.On 1/9/26 at 3 P.M., a joint interview and record review was conducted with the DSD. The DSD reviewed Resident 6's clinical record and written care plans. The DSD stated Resident 6 had a wandering behavior and was known to enter other residents' (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms. The DSD stated wandering into other residents' rooms and rummaging or taking things could lead to altercations and incidents of abuse. The DSD stated Resident 6's wandering into other residents' rooms should have been addressed in the resident's care plan with resident-specific interventions to prevent it from happening. The DSD stated after the incident with Resident 6 and Resident 5 on 12/30/25, Resident 6's wandering into other residents' rooms still had not been identified and care planned. The DSD stated it should have been identified, assessed, and care planned.On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the ADON. The ADON stated Resident 6 wandered into other residents' rooms which could lead to altercations, especially with Resident 5 as this would cause him to become aggressive. The ADON stated when staff noticed Resident 6 was not redirectable out of Resident 5's room on 12/30/25, the resident should have been: Asked what he wanted, provided a room change away from Resident 5's room, and had visual reminders placed on his door to indicate which room was his. The ADON reviewed Resident 6's clinical record and written care plans and stated his wandering into other residents' rooms was not addressed. The ADON stated interventions should have been put in place to address and prevent Resident 6's unsafe wandering into other residents' rooms.On 1/12/26 at 2:25 P.M., an interview was conducted with the administrator (ADM). The ADON was also present. The ADM stated Resident 6's wandering into other residents' rooms should have been addressed and care planned as the behavior could lead to altercations.A review of the facility's policy titled Dementia-Clinical Protocol revised November 2018, indicated, .For individuals with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. The IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes and other relevant factors.A review of the facility's policy titled Resident-to-Resident Altercations dated September 2022 indicated, . Behaviors that may provoke a reaction by residents or others include.physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving. rummaging through other's property and wandering into other's rooms/space. If two residents are involved in an altercation, staff.identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation. make any necessary changes in the care plan.document in the resident's clinical record all interventions and their effectiveness.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of seven residents' (Resident 5) medical record was accurately and completely documented when:1. Resident 5's provider documentation indicated staff reported the resident was being aggressive and having mood swings, but these behaviors were not documented by staff.2. Resident 5's behavioral monitoring on the medication administration record (MAR) was inaccurate.As a result, Resident 5's medical record did not correctly represent the resident's actual behavioral condition.A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include traumatic brain injury, post-traumatic stress disorder, bipolar disorder (a mood disorder that alternates between depression and mania), and Alzheimer's dementia.A review of Resident 5's IDT (interdisciplinary team) note dated 12/26/25, indicated, .Writer was notified of an incident in the dinning [sic] room [on 12/25/25]. Another resident [Resident 3] was seated in her wheelchair in the dinning [sic] room when this resident approached her and attempted to pull her wheelchair backwards. The other resident turned towards this resident and instructed him to stop. This resident then struck the other resident in the face without apparent provocation.A review of Resident 5's Nurse's Note dated 12/30/25, indicated, .Writer was notified that this resident was noted to be ambulating down the hallway when he approached another resident [Resident 6] and began yelling and grabbed his arm. Before staff could intervene, the other resident swung at this resident striking him in the face causing this resident to fall supine to the ground.A review of Resident 5's MAR for December 2025, indicated the resident was monitored for the number of episodes of exhibited behavior: Agitation, irritability and hypervigilance. On 12/17/25, the resident's monitoring was blank. On 12/25/25 and 12/30/25, the resident's monitoring was documented as having zero episodes of the behavior.On 1/9/26 at 11:19 A.M., a joint interview and record review was conducted with licensed nurse (LN) 1. LN 1 reviewed Resident 5's December 2025 MAR and stated the episodes of behavioral monitoring should not have been blank on 12/17/25. LN 1 stated it should have been documented on the MAR if the resident was not in the facility. LN 1 stated Resident 5 had been involved in physical altercations on 12/25/25 and 12/30/25 and that was considered being irritable and/or agitated. LN 1 stated the MAR indicated Resident 5 had zero episodes of agitation and/or irritability on those days which was not accurate. LN 1 stated it was important for the behavior monitoring to be accurate as the data was used to determine the effectiveness of the medication used to address those behaviors.On 1/12/26 at 9:30 A.M., a joint interview and record review was conducted with the assistant director of nursing (ADON). The ADON reviewed Resident 5's December 2025 MAR for monitoring of the number of episodes of exhibited behavior: Agitation, irritability and hypervigilance. The ADON stated Resident 5 was involved in physical altercations on 12/25/25 and 12/30/25 and the MAR should not have zero episodes of behavior on those days. The ADON stated documentation should be accurate.The ADON reviewed Resident 5's Psychiatric Progress Note dated 12/9/25, which indicated, .Last assessed on 11/21/25. Staff report the patient has been anxious and aggressive at times. Still having mood swings and aggression as well. The ADON reviewed Resident 5's medical record and stated nurses had not been documenting that the resident was anxious, aggressive, or having mood swings. The ADON stated Resident 5's documentation should have been a clear picture of the resident's behavior and condition.On 1/12/26 at 2:25 P.M., an interview was conducted with the administrator (ADM). The ADON was also present. The ADM stated he expected nursing documentation to be accurate and complete.A review of the facility's policy titled Charting and Documentation revised July 2017, indicated, All services provided to the resident, progress (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.