

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/16/2026
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)		
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 one of one resident (Resident 1) was free from sexual abuse when: Maintenance Personnel (MP) kissed Resident 1's forehead without consent MP made contact with Resident 1's upper extremities without consent MP pulled Resident 1's pants without consent MP sat on Resident 1's bed without consent As a result, MP had continued access to Resident 1 These failures to identify and report allegations of abuse did not protect Resident 1 Cross reference F600 F607 F609 F610 Findings: On 5/11/2026 at 8 A.M. an unannounced onsite was conducted to investigate one facility reported incident of alleged abuse. On 5/19/2026 additional facility reported incident of alleged abuse for the same parties involved (MP to Resident 1). A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a report submitted to the State agency to report allegations of abuse) dated 4/29/26, indicated Resident 1 alleged MP inappropriately caressed her arm and sat on her bed in close proximity to her while she was seated in her wheelchair and reported type of abuse with check marked sexual. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse dated 5/13/26 indicated . Reopened investigation due to employee admission /inconsistent[sic] statements regarding kissing a resident. During CDPH interview, employee admitted to kissing [Resident 1] on the forehead. Facility reported type of abuse with check marked sexual. A review of the facility's Midnight Census Report dated 5/12/26 indicated there were currently 220 residents in the facility. A review of the facility's Midnight Census Report dated 6/15/26 indicated there were currently 228 residents in the facility. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include functional quadriplegia (a profound loss of mobility on all four limbs). A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 4/8/26 , indicated 15 out of a possible 15 on the brief interview of mental status (which meant the resident was cognitively intact). A review of Resident 1's MDS related to functional abilities dated 4/8/26 indicated Resident 1 was dependent to a helper to do all of the effort to complete an activity related to personal hygiene, putting on and off footwear and upper and lower body dressing. A review of Resident 1's physician History and Physical Examination (H&P) date 8/21/25, indicated Resident 1 had the capacity to understand and make decisions. A review of the physician order summary active orders as of 4/30/26 indicated Resident 1 may have power wheelchair to use for mobility due to diagnosis of quadriplegia. A review of Resident 1's IDT (interdisciplinary team, a group of healthcare providers to collaborate, plan, provide and evaluate patient care) note dated 4/30/26, indicated .[Resident 1] alleged that facility staff member inappropriately caressed her arm and sat in her bed in close proximity. A review of the facility Work Order Request indicated 4/21/26 at 5:35 P.M. MP provided service for problem related to wheelchair missing parts on which solution indicated it was done to Resident 1's room. A review of Certified Nursing Assistant (CNA for April 2026 indicated CNA 1 was scheduled on 4/24/26 and 4/25/26 night shift (3 to 11 P.M.) while CNA 2 was scheduled on 4/26/26 and 4/27/26. A review of the facility Maintenance Schedule for 2026 indicated that MP was scheduled to work from Tuesdays to Saturdays during the night shift. On 5/13/26 at 4:10 P.M. a (continued on next page)		

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	phone interview was conducted with MP with Assistant Director of Nursing (ADON) 2 present. MP stated he kissed Resident 1's forehead without asking Resident 1's permission. MP denied touching Resident 1's hands. MP denied pulling up Resident 1's pants. On 5/19/26 at 12:59 P.M., an interview with Director of Nursing (DON) 1 was conducted. DON 1 stated MP kissing Resident 1's forehead should not have happened. DON 1 stated this goes against code of conduct of an employee. On 6/16/26 at 8:50 A.M., an observation and interview was conducted with Resident 1 while inside her room. Resident 1 stated the incident with the MP started when Resident 1 needed assistance to fix her wheelchair. Resident 1 stated the MP came to her room and fixed it for about 45 minutes. Resident 1 stated she had conversations with the MP during this time. Resident 1 stated the MP, who was seated on Resident 1's bed stood up, went to face Resident 1, who was seated on her wheelchair, the MP suddenly grabbed both Resident 1's cheeks and kissed Resident 1's forehead. Resident 1 stated MP did not ask Resident 1's consent before kissing Resident 1's forehead. Resident 1 stated MP came about three times that day but could not recall whether MP kissed Resident 1's forehead on the first or second time MP was in Resident 1's room. Resident 1 stated at that time she did not react, because this was the first time it had happened to her. Resident 1 stated she felt grossed because Resident 1 felt MP's wet lips on Resident 1's forehead and MP's dirty hands grabbed both Resident 1's cheeks and kissed Resident 1 in the forehead. Resident 1 stated MP came up until Saturday. Resident 1 stated MP was not scheduled to work on Sundays. Resident 1 stated her family member was here on Wednesday and MP attempted to see Resident 1 about two times that day. Resident 1 stated the first day, MP was lightly petting Resident 1's hand up until Thursday, where MP was grabbing Resident 1's arm and MP was sitting at the edge of Resident 1's bed. Resident 1 stated that succeeding Thursday, MP kissed Resident 1's forehead again the same way where MP grabbed both Resident 1's cheeks and kissed Resident 1's forehead this time a little longer. Resident 1 stated MP did not asked Resident 1's consent before kissing Resident 1's forehead. Resident 1 stated at that point, she was not scared but she felt weird which meant that if this happened in the past, Resident 1 could walk before, Resident 1 stated she could defend herself. Resident 1 further stated, when MP did kiss her and touch her hands, she felt small. Resident 1 stated the succeeding Friday, she was sitting on her wheelchair wearing a shirt and baggy pants. Resident 1 stated her pants slid a few inches down. Resident 1 stated she felt MP look at me and look at my body like a pervert. Resident 1 stated MP pulled her pants up without asking her permission and MP stopped when she said no. Resident 1 stated that Friday, she asked CNA 1 to come to Resident 1's room when MP would come to Resident 1's room and pretend to do something. Resident 1 stated that same Friday, MP came to Resident 1's room and sat in Resident 1's bed. Resident 1 stated CNA 1 entered Resident 1's room and informed MP not to sit on Resident 1's bed. Resident 1 stated CNA 1 was made aware that MP kept coming to Resident 1's room, kissed Resident 1's forehead, pulled up Resident 1's pants. Resident 1 stated she did not report this incident and CNA 1 did not offer to report the incident but CNA 1 told Resident 1 she needed to speak up for herself. Resident 1 stated when her regular CNA (CNA2) returned to work, CNA was made aware that MP kissed Resident 1's forehead, pulled up Resident 1's pants, touching Resident 1's arm, MP spending time with Resident 1 and CNA 1 defended her. Resident 1 stated she felt uncomfortable about what happened because this was not good, she knew right from wrong and there should be boundaries. Resident 1 stated an employee should not have done these things to her. Resident 1 stated MP did not ask her consent. Resident 1 stated even if MP ask for her consent, Resident 1 would not allow MP to kiss her, touch, massage or rub her hand or pull her pants. On 6/16/2026 at 10: 30 A.M., an interview was conducted with Respiratory Therapist (RT) 1. RT 1 stated on 4/28/26 around 5 or 6 P.M., Resident 1 mentioned about a guy newly hired from maintenance where Resident 1 commented that MP was a weird vibe and creepy feel liked creepy weird. RT 1 stated on 4/29/2026, he was made aware of details MP did to Resident 1. RT 1 stated the newly hired MP kissed Resident 1's forehead, MP was massaging Resident 1's hands, MP was sitting on Resident 1's bed and MP pulled up Resident 1's pants. RT 1 stated on 4/28/2026 when Resident 1 commented (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	weird vibe and creepy feel like creepy weird, he should have asked and elaborate that time. RT 1 stated this incident between Resident 1 and MP was a sexual abuse MP kissed Resident 1's forehead, neglect because he did not paid attention to Resident 1 was telling him and a physical abuse because MP touched Resident 1. On 6/16/26 at 10:56 A.M., an interview was conducted with CNA 2. CNA 2 stated she returned on Sunday which was 4/26/26. CNA 2 stated she was made aware the following day when Resident 1 informed her. CNA 2 stated Resident 1 started telling her MP caressed Resident 1's arm, MP kissed Resident 1's forehead, MP pulled up Resident 1's pants. CNA 2 stated Resident 1 needed one person assistance for her activities of daily living (ADLs). CNA 2 stated she did not witness the incident but she failed to report the incident when she was made aware. CNA 2 stated she should have reported this incident immediately to protect Resident 1. On 6/16/26 at 11:19 A.M., an interview was conducted with CNA 1. CNA 1 stated while she was charting on the computer, Resident 1 called her. CNA 1 stated computer was facing Resident 1's room. CNA 1 stated Resident 1 asked her to come inside Resident 1's room when the new guy from maintenance (MP) come to Resident 1's room. CNA 1 stated she asked Resident 1 which guy and Resident 1 informed her it was new guy from maintenance. CNA 1 stated she used to see the new maintenance guy (MP) coming to Resident 1's room. CNA 1 stated she was not made aware of the details of the incident the first time because Resident 1 asked her to come to her room when the MP entered Resident 1's room. CNA 1 stated she was made aware of incident including MP sitting on Resident 1's bed which she witnessed and MP touching Resident 1's hand which she did not witness. CNA 1 stated she did not report the incident when she was made aware and she should have reported the incident immediately. On 6/16/26 at 12: 44 P.M., an interview was conducted with ADON 1, ADON 2 and DON 2. ADON 1 stated the facility did not protect Resident 1 when the employees were made aware and failed to report the incident immediately. According to the facility policy entitled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised date April 2012, indicated .Residents have the right to be free from abuse, neglect.freedom from.sexual.abuse.1.) Protect residents from abuse, neglect.from a facility staff.2.implement polices and protocols to prevent and identify.a. abuse.8.Identify and investigate all possible incidents of abuse.9.Investigate and report any allegations within timeframes required by federal requirements.10.Protect residents form any further harm.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when facility employees were made aware of allegations of abuse to one of one resident (Resident 1).As a result, facility failed to report in a timely manner and facility failed to protect Resident.Cross reference F600 F607 F609 F610Findings: According to the facility policy entitled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised date April 2012, indicated .Residents have the right to be free from abuse, neglect.freedom from.sexual.abuse.1.) Protect residents from abuse, neglect.from a facility staff.2.implement polices and protocols to prevent and identify.a. abuse.8.Identify and investigate all possible incidents of abuse.9.Investigate and report any allegations within timeframes required by federal requirements.10.Protect residents form any further harm.On 5/11/2026 at 8 A.M. an onsite was conducted to investigate one facility reported incident of alleged abuse. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a report submitted to the State agency to report allegations of abuse) dated 4/29/26, indicated Resident 1 alleged MP inappropriately caressed her arm and sat on her bed in close proximity to her while she was seated in her wheelchair and reported type of abuse with check marked sexual. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse dated 5/13/26 indicated .Reopened investigation due to employee admission /inconcistant[sic] statements regarding kissing a resident. During CDPH interview, employee admitted to kissing [Resident 1] on the forehead. Facility reported type of abuse with check marked sexual. A review of the facility's Midnight Census Report dated 5/12/26 indicated there were currently 220 residents in the facility. A review of the facility's Midnight Census Report dated 6/15/26 indicated there were currently 228 residents in the facility. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include functional quadriplegia (a profound loss of mobility on all four limbs). A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment tool) dated 4/8/26 , indicated 15 out of a possible 15 on the brief interview of mental status (which meant the resident was cognitively intact). A review of Resident 1's MDS related to functional abilities dated 4/8/26 indicated Resident 1 was dependent to a helper to do all of the effort to complete an activity related to personal hygiene, putting on and off footwear and upper and lower body dressing. A review of Resident 1's physician History and Physical Examination (H&P) date 8/21/25, indicated Resident 1 had the capacity to understand and make decisions. A review of the physician order summary active orders as of 4/30/26 indicated Resident 1 may have power wheelchair to use for mobility due to diagnosis of quadriplegia. A review of Resident 1's IDT (interdisciplinary team, a group of healthcare providers to collaborate, plan, provide and evaluate patient care) note dated 4/30/26, indicated .[Resident 1] alleged that facility staff member inappropriately caressed her arm and sat in her bed in close proximity. A review of the facility Work Order Request indicated 4/21/26 at 5:35 P.M. MP provided service for problem related to wheelchair missing parts on which the solution indicated it was done . A review of Certified Nursing Assistant (CNA for April 2026 indicated CNA 1 was scheduled on 4/24/26 and 4/25/26 night shift (3 to 11 P.M.) while CNA 2 was scheduled on 4/26/26 and 4/27/26. A review of the facility Maintenance Schedule for 2026 indicated that MP was scheduled to work from Tuesdays to Saturdays during the night shift. On 5/13/26 at 4:10 P.M. a phone interview was conducted with MP with Assistant Director of Nursing (ADON) 2 present. MP stated he kissed Resident 1's forehead without asking Resident 1's permission. MP denied touching Resident 1's hands. MP denied pulling up Resident 1's pants. On 5/19/26 at 12:59 P.M., an interview with Director of Nursing (DON) 1 was conducted. DON 1 stated MP kissing Resident 1's forehead should not have happened. DON 1 stated this goes against code of conduct of an employee. On 6/16/26 at 8:50 A.M., an observation and interview was conducted with Resident 1 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while inside her room. Resident 1 stated the incident with the MP started when Resident 1 needed assistance to fix her wheelchair. Resident 1 stated the MP came to her room and fixed it for about 45 minutes. Resident 1 stated she had conversations with the MP during this time. Resident 1 stated the MP, who was seated on Resident 1's bed stood up, went to face Resident 1, who was seated on her wheelchair, the MP suddenly grabbed both Resident 1's cheeks and kissed Resident 1's forehead. Resident 1 stated MP did not ask Resident 1's consent before kissing Resident 1's forehead. Resident 1 stated MP came about three times that day but could not recall whether MP kissed Resident 1's forehead on the first or second time MP was in Resident 1's room. Resident 1 stated at that time she did not react, because this was the first time it had happened to her. Resident 1 stated she felt grossed because Resident 1 felt MP's wet lips on Resident 1's forehead and MP's dirty hands grabbed both Resident 1's cheeks and kissed Resident 1 in the forehead. Resident 1 stated MP came up until Saturday. Resident 1 stated MP was not scheduled to work on Sundays. Resident 1 stated her family member was here on Wednesday and MP attempted to see Resident 1 about two times that day. Resident 1 stated the first day, MP was lightly petting Resident 1's hand up until Thursday, where MP was grabbing Resident 1's arm and MP was sitting at the edge of Resident 1's bed. Resident 1 stated that succeeding Thursday, MP kissed Resident 1's forehead again the same way where MP grabbed both Resident 1's cheeks and kissed Resident 1's forehead this time a little longer. Resident 1 stated MP did not asked Resident 1's consent before kissing Resident 1's forehead. Resident 1 stated at that point, she was not scared but she felt weird which meant that if this happened in the past, Resident 1 could walk before, Resident 1 stated she could defend herself. Resident 1 further stated, when MP did kiss her and touch her hands, she felt small. Resident 1 stated the succeeding Friday, she was sitting on her wheelchair wearing a shirt and baggy pants. Resident 1 stated her pants slid a few inches down. Resident 1 stated she felt MP look at me and look at my body like a pervert. Resident 1 stated MP pulled Resident 1's pants up without asking Resident 1's permission and MP stopped when she said no. Resident 1 stated that Friday, she asked CNA 1 to come to Resident 1's room when MP would come to Resident 1's room and pretend to do something. Resident 1 stated that same Friday, MP came to Resident 1's room and sat in Resident 1's bed. Resident 1 stated CNA 1 entered Resident 1's room and informed MP not to sit on Resident 1's bed. Resident 1 stated CNA 1 was made aware that MP kept coming to Resident 1's room, kissed Resident 1's forehead, and pulled up Resident 1's pants. Resident 1 stated she did not report this incident and CNA 1 did not offer to report the incident, but CNA 1 told Resident 1 she needed to speak up for herself. Resident 1 stated when her regular CNA (CNA2) returned to work, CNA was made aware that MP kissed Resident 1's forehead, pulled up Resident 1's pants, touching Resident 1's arm, MP spending time with Resident 1 and CNA 1 defended her. Resident 1 stated she felt uncomfortable about what happened because this was not good, she knew right from wrong and there should be boundaries. Resident 1 stated an employee should not have done these things to her. Resident 1 stated MP did not ask her consent. Resident 1 stated even if MP ask for her consent, Resident 1 would not allow MP to kiss her, touch, massage or rub her hand or pull her pants. On 6/16/2026 at 10: 30 A.M., an interview was conducted with Respiratory Therapist (RT) 1. RT 1 stated on 4/28/26 around 5 or 6 P.M., Resident 1 mentioned about a guy newly hired from maintenance where Resident 1 commented that MP was a weird vibe and creepy feel liked creepy weird. RT 1 stated on 4/29/2026, he was made aware of details MP did to Resident 1. RT 1 stated the newly hired MP kissed Resident 1's forehead, MP was massaging Resident 1's hands, MP was sitting on Resident 1's bed and MP pulled up Resident 1's pants. RT 1 stated on 4/28/2026 when Resident 1 commented weird vibe and creepy feel like creepy weird, he should have asked and elaborate that time. RT 1 stated this incident between Resident 1 and MP was a sexual abuse MP kissed Resident 1's forehead, neglect because he did not paid attention to Resident 1 was telling him and a physical abuse because MP touched Resident 1. On 6/16/26 at 10:56 A.M., an interview was conducted with CNA 2. CNA 2 stated she returned on Sunday which was 4/26/26. CNA 2 stated she was made aware the following day when Resident 1 informed her. CNA 2 (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 1 started telling me MP caressed Resident 1's arm, MP kissed Resident 1's forehead, MP pulled up Resident 1's pants. CNA 2 stated Resident 1 needed one person assistance for her activities of daily living (ADLs). CNA 2 stated she did not witness the incident but she failed to report the incident when she was made aware. CNA 2 stated she should have reported this incident immediately CNA 2 to protect Resident 1. On 6/16/26 at 11:19 A.M., an interview was conducted with CNA 1. CNA 1 stated while she was charting on the computer, Resident 1 called her. CNA 1 stated computer facing Resident 1's room. CNA 1 stated Resident 1 asked her to come inside Resident 1's room when the new guy from maintenance (MP) come to Resident 1's room. CNA 1 stated she asked Resident 1 which guy and Resident 1 informed her it was new guy from maintenance. CNA 1 stated she used to see the new maintenance guy (MP) coming to Resident 1's room. CNA 1 stated she was not made aware of the details of the incident the first time because Resident 1 asked her to come to her room when the MP entered Resident 1's room. CNA 1 stated she was made aware of incident including MP sitting on Resident 1's bed which she witnessed and MP touching Resident 1's hand which she did not witness. CNA 1 stated she did not report the incident when she was made aware and she should have reported the incident immediately. On 6/16/26 at 12: 44 P.M., an interview was conducted with ADON 1, ADON 2 and DON 2. ADON 1 stated the facility did not protect Resident 1 when the employees were made aware and failed to follow the facility policy to report the incident immediately.		

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when facility employees were made aware of allegations of abuse to one of one resident (Resident 1).As a result, facility failed to report in a timely manner and facility failed to protect Resident.Cross reference F600 F607 F609 F610Findings:On 5/11/2026 at 8 A.M. an onsite was conducted to investigate one facility reported incident of alleged abuse. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a report submitted to the State agency to report allegations of abuse) dated 4/29/26, indicated Resident 1 alleged MP inappropriately caressed her arm and sat on her bed in close proximity to her while she was seated in her wheelchair and reported type of abuse with check marked sexual. A review of Resident 1's IDT (interdisciplinary team, a group of healthcare providers to collaborate, plan, provide and evaluate patient care) note dated 4/30/26, indicated .[Resident 1] alleged that facility staff member inappropriately caressed her arm and sat in her bed in close proximity. A review of Certified Nursing Assistant (CNA for April 2026 indicated CNA 1 was scheduled on 4/24/26 and 4/25/26 night shift (3 to 11 P.M.) while CNA 2 was scheduled on 4/26/26 and 4/27/26. A review of the facility Maintenance Schedule for 2026 indicated that MP was scheduled to work from Tuesdays to Saturdays during the night shift. On 5/13/26 at 4:10 P.M. a phone interview was conducted with MP with Assistant Director of Nursing (ADON) 2 present. MP stated he kissed Resident 1's forehead without asking Resident 1's permission. MP denied touching Resident 1's hands. MP denied pulling up Resident 1's pants. On 5/19/26 at 12:59 P.M., an interview with Director of Nursing (DON) 1 was conducted. DON 1 stated MP kissing Resident 1's forehead should not have happened. DON 1 stated this goes against code of conduct of an employee. On 6/16/26 at 8:50 A.M., an observation and interview was conducted with Resident 1 while inside her room. Resident 1 stated the incident with the MP started when Resident 1 needed assistance to fix her wheelchair. Resident 1 stated the MP came to her room and fixed it for about 45 minutes. Resident 1 stated she had conversations with the MP during this time. Resident 1 stated the MP, who was seated on Resident 1's bed stood up, went to face Resident 1, who was seated on her wheelchair, the MP suddenly grabbed both Resident 1's cheeks and kissed Resident 1's forehead. Resident 1 stated MP did not ask Resident 1's consent before kissing Resident 1's forehead. Resident 1 stated MP came about three times that day but could not recall whether MP kissed Resident 1's forehead on the first or second time MP was in Resident 1's room. Resident 1 stated at that time she did not react, because this was the first time it had happened to her. Resident 1 stated she felt grossed because Resident 1 felt MP's wet lips on Resident 1's forehead and MP's dirty hands grabbed both Resident 1's cheeks and kissed Resident 1 in the forehead. Resident 1 stated MP came up until Saturday. Resident 1 stated MP was not scheduled to work on Sundays. Resident 1 stated her family member was here on Wednesday and MP attempted to see Resident 1 about two times that day. Resident 1 stated the first day, MP was lightly petting Resident 1's hand up until Thursday, where MP was grabbing Resident 1's arm and MP was sitting at the edge of Resident 1's bed. Resident 1 stated that succeeding Thursday, MP kissed Resident 1's forehead again the same way where MP grabbed both Resident 1's cheeks and kissed Resident 1's forehead this time a little longer. Resident 1 stated MP did not asked Resident 1's consent before kissing Resident 1's forehead. Resident 1 stated at that point, she was not scared but she felt weird which meant that if this happened in the past, Resident 1 could walk before, Resident 1 stated she could defend herself. Resident 1 further stated, when MP did kissed her and touch her hands, she felt small. Resident 1 stated the succeeding Friday, she was sitting on her wheelchair wearing a shirt and baggy pants. Resident 1 stated her pants slid a few inches down. Resident 1 stated she felt MP look at me and look at my body like a pervert. Resident 1 stated MP pulled Resident 1's pants up without asking Resident 1's permission and MP stopped when (continued on next page)		

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 06/16/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she said no. Resident 1 stated that Friday, she asked CNA 1 to come to Resident 1's room when MP would come to Resident 1's room and pretend to do something. Resident 1 stated that same Friday, MP came to Resident 1's room and sat in Resident 1's bed. Resident 1 stated CNA 1 entered Resident 1's room and informed MP not to sit on Resident 1's bed. Resident 1 stated CNA 1 was made aware that MP kept coming to Resident 1's room, kissed Resident 1's forehead, and pulled up Resident 1's pants. Resident 1 stated she did not report this incident and CNA 1 did not offer to report the incident, but CNA 1 told Resident 1 she needed to speak up for herself. Resident 1 stated when her regular CNA (CNA 2) returned to work, CNA 2 was made aware that MP kissed Resident 1's forehead, pulled up Resident 1's pants, touching Resident 1's arm, MP spending time with Resident 1 and CNA 1 defended her. Resident 1 stated she felt uncomfortable about what happened because this was not good, she knew right from wrong and there should be boundaries. Resident 1 stated an employee should not have done these things to her. Resident 1 stated MP did not ask her consent. Resident 1 stated even if MP ask for her consent, Resident 1 would not allow MP to kiss her, touch, massage or rub her hand or pull her pants. On 6/16/2026 at 10: 30 A.M., an interview was conducted with Respiratory Therapist (RT) 1. RT 1 stated on 4/28/26 around 5 or 6 P.M., Resident 1 mentioned about a guy newly hired from maintenance where Resident 1 commented that MP was a weird vibe and creepy feel liked creepy weird. RT 1 stated on 4/29/2026, he was made aware of details MP did to Resident 1. RT 1 stated the newly hired MP kissed Resident 1's forehead, MP was massaging Resident 1's hands, MP was sitting on Resident 1's bed and MP pulled up Resident 1's pants. RT 1 stated on 4/28/2026 when Resident 1 commented weird vibe and creepy feel like creepy weird, he should have asked and elaborate that time. RT 1 stated this incident between Resident 1 and MP was a sexual abuse MP kissed Resident 1's forehead, neglect because he did not paid attention to Resident 1 was telling him and a physical abuse because MP touched Resident 1. On 6/16/26 at 10:56 A.M., an interview was conducted with CNA 2. CNA 2 stated she returned on Sunday which was 4/26/26. CNA 2 stated she was made aware the following day when Resident 1 informed her. CNA 2 stated Resident 1 started telling me MP caressed Resident 1's arm, MP kissed Resident 1's forehead, MP pulled up Resident 1's pants. CNA 2 stated Resident 1 needed one person assistance for her activities of daily living (ADLs). CNA 2 stated she did not witness the incident but she failed to report the incident when she was made aware. CNA 2 stated she should have reported this incident immediately CNA 2 to protect Resident 1. On 6/16/26 at 11:19 A.M., an interview was conducted with CNA 1. CNA 1 stated while she was charting on the computer, Resident 1 called her. CNA 1 stated computer facing Resident 1's room. CNA 1 stated Resident 1 asked her to come inside Resident 1's room when the new guy from maintenance (MP) come to Resident 1's room. CNA 1 stated she asked Resident 1 which guy and Resident 1 informed her it was new guy from maintenance. CNA 1 stated she used to see the new maintenance guy (MP) coming to Resident 1's room. CNA 1 stated she was not made aware of the details of the incident the first time because Resident 1 asked her to come to her room when the MP entered Resident 1's room. CNA 1 stated she was made aware of incident including MP sitting on Resident 1's bed which she witnessed and MP touching Resident 1's hand which she did not witnessed. CNA 1 stated she did not report the incident when she was made aware and she should have reported the incident immediately. On 6/16/26 at 12: 44 P.M., an interview was conducted with ADON 1, ADON 2 and DON 2. ADON 1 stated the facility did not protect Resident 1 when the employees were made aware and failed to report the incident immediately. According to the facility policy entitled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised date April 2012, indicated .Residents have the right to be free from abuse, neglect.freedom from.sexual.abuse.1.) Protect residents from abuse, neglect.from a facility staff.2.implement polices and protocols to prevent and identify.a. abuse.8.Identify and investigate all possible incidents of abuse.9.Investigate and report any allegations within timeframes required by federal requirements.10.Protect residents form any further harm.		

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 06/16/2026
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview and record review, the facility failed to thoroughly investigate two facility reported incidents of sexual abuse. As a result of this deficient practice, there was the potential for continued employee access to residents in the building. Cross reference F600 F607 F609 F610 Findings: On 5/11/2026 at 8 A.M. an onsite was conducted to investigate one facility reported incident of alleged abuse. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341, a report submitted to the State agency to report allegations of abuse) dated 4/29/26, indicated Resident 1 alleged MP inappropriately caressed her arm and sat on her bed in close proximity to her while she was seated in her wheelchair and reported type of abuse with check marked sexual. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse dated 5/13/26 indicated .Reopened investigation due to employee admission /inconcistant[sic] statements regarding kissing a resident. During CDPH interview, employee admitted to kissing [Resident 1] on the forehead. Facility reported type of abuse with check marked sexual. A review of Certified Nurse Assistant (CNA) 1's written statement which has, no time and no job title of the employee who wrote the statement indicated .he is seattig[sic] on my bed.and touching my hand. According to the Assistance Director of Nursing (ADON) 1 this was written by CNA 1. A review of CNA 2's written statement which has no date , no time, name and job title of the employee who wrote the statement indicated .then all of a sudden he came to my room and sat on my bed really close.'then he caressed my arm and kissed my forehead and also helped pull my pants up.' According to the Assistance Director of Nursing (ADON) 1 this was written by CNA2 2. On 5/13/26 at 11:35 A.M. an interview and record review was conducted with Assistant Director of Nursing (ADON) 2. ADON 2 stated facility investigation did not include the following:The facility investigation did not include a timeline of the incident from the time the facility was made awareDid not include all the allegations in the SOC 341 that were indicated on the employees' written statements. In addition, employee-written statements did not included either name of the employee who wrote the statement, an official job title, date or time the written statement was completedResident interview record did not include details specific to the actual investigation in addition, there was no date and timeThe alleged employees date of birth did not match alleged employees background checkDuring this interview and record review, ADON 2 stated timeline in the facility investigation would show compliance of timely reporting and how facility protected the resident. ADON 2 stated facility investigations should have dates, times, name of employee who wrote the statements and official job title and have allegation details to make sure facility investigation was thorough and resident was safe. On 5/19/26 at 12: 43 P.M., an interview was conducted with ADON 1. ADON 1 stated it was important to indicate employee name and job tile, date and time to identify the employee and how much interaction between the employee and resident occurred. On 5/19/26 at 12:59 P.M., an interview was conducted with Director of Nursing (DON)1. DON 1 stated the employees should have immediately reported the incident. DON 1 stated the facility investigation was not thorough. DON 1 stated the facility should have caught the alleged employee date of birth did not matched alleged employee's background check. DON 1 stated resident interview record should have details including date, time specific to the investigation to show facility have done a thorough investigation. DON 1 stated all allegations should have been identified and investigated to show facility did a through investigations. According to the facility policy entitled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised date April 2012, indicated .Residents have the right to be free from abuse, neglect.freedom from.sexual.abuse.1.) Protect residents from abuse, neglect.from a facility staff.2.implement polices and protocols to prevent and identify.a.abuse.8.Identify and investigate all possible incidents of abuse.9.Investigate and report any allegations within timeframes required by federal requirements.10.Protect residents form any further harm.		