

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Victoria Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  654 S. Anza El Cajon, CA 92020	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</b></p> <p>Based on interview and record review, the facility failed to protect one resident (1) when Resident 1 reported being treated roughly by a staff member/licensed nurse (LN) 1. As a result, LN 1 was not immediately removed from providing care to the resident, per the facility ' s abuse policy and procedure. This failure had the potential to affect Resident 1 ' s feeling of safety and protection while at the facility.</p> <p>(Cross-reference F609)</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of non-traumatic intracranial hemorrhage (a brain attack that caused bleeding in the brain).</p> <p>A record review of Resident 1 ' s Minimum Data Set (MDS; assessment tool) dated 5/24/24, indicated a Brief Interview for Mental Status (BIM- developed by reviewing the resident's status during the prior seven day period) score of 15 out of 15 possible points, which indicated Resident 1 had no cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>An interview was conducted on 7/16/24 at 10:15 A.M., with the Social Services Director (SSD). The SSD stated that on 5/29/24, Resident 1 complained that LN 1 mishandled (treated roughly) him while providing care. The SSD stated she did not complete a five (5) DAY REPORT (a full investigation that includes sufficient information for up to five days to monitor and protect a resident from any suspected abuse or neglect) or report this (complaint) to the State Agency, because a grievance was completed. The SSD stated that Resident 1 and his daughter were okay with it. The SSD stated We couldn ' t verify [Resident 1 ' s] allegation because [Resident 1] had a mental disorder that caused him to hallucinate. The SSD stated that LN 1 was not suspended during the investigation. The SSD stated that a care plan was not developed or updated for this incident/complaint.</p> <p>A document review of Resident 1 ' s GRIEVANCE RESOLUTION FORM, dated 5/29/24 at 2:03 P.M. indicated .Resident expressed concerns regarding one of the male nurses. Resident stated that male nurse was not gentle enough when providing care .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555804
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 1 ' s Social Services progress notes dated 5/29/24 at 14:03 (2:03 PM) indicated SSD followed up with resident after his daughter [name] informed us that resident would like to transfer to another facility. SSD spoke with resident and his daughter who expressed concerns regarding one of his male nurses .he would feel safer if another nurse [sic] were assigned to him .</p> <p>There was no documented evidence that a thorough head- to -toe body check (assessment) was completed for Resident 1 on 5/29/24.</p> <p>On 7/16/24 at 10:30 A.M. The administrator (ADM) shared Resident 1 ' s complaint print dated 7/16/24 at 10:22 A.M., per Portal Cortex (facility messaging system used as a communication tool for resident and the facility) that indicated . I was bruised by a regular nurse by the name of [staff ' s name]. He grabbed me by the back of the neck and tried to throw me to the bed .</p> <p>An interview was conducted on 7/24/24 at 8:43 A.M., with LN 1. LN 1 stated that .the following work day after the incident I went to work and a bunch [sic] of staff started telling me don ' t go in there [referring to Resident 1 ' s room] saying he was complaining about you being rough with him saying I was too aggressive . LN 1 denied being rough or aggressive with Resident 1. LN 1 stated he was not suspended from that incident and that no body check was done for Resident 1 after Resident 1 ' s complaint allegation against him.</p> <p>An interview was conducted on 7/24/24 at 9:55 A.M., with Resident 1. Resident 1 stated that LN 1 physically grabbed me from the back of the neck and he forcefully put me back on the bed . Resident 1 stated that the facility ADM told him that he (Resident 1) would no longer see LN 1 and that LN 1 would no longer provide resident care for Resident 1. Resident 1 stated .so the next few days in [sic] the guy is my nurse (referring to LN 1) and his name was on the board for the next couple of days . Resident 1 stated I was very upset because he (LN1) did not get reprimanded (suspended) .</p> <p>An interview was conducted on 7/24/24 at 1:20 P.M., with the ADM The ADM stated that he thought that filing a grievance was enough to address Resident 1 ' s complaint of being mishandled by the staff member/LN 1. The ADM acknowledged that a grievance report of an alleged abuse such as mishandling of Resident 1 during resident care would not override (replace) their obligation as mandated reporters to their State survey agency, State law enforcement entities, and adult protective services. The ADM acknowledged that LN 1 should had been removed from the schedule and not assigned to care for Resident 1 when they had knowledge of Resident 1 ' s abuse (mishandling) allegation.</p> <p>A review of facility's Abuse policy titled Prevention of and Prohibition Against dated 2024, indicated .F. Investigation . 3. A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. G. Protection . 3. If an allegation of abuse, neglect, misappropriation of resident property, or exploitation involves an employee, the facility will: immediately remove the employee from the care of any resident. Suspend the employee during the pendency of the investigation.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</b></p> <p>Based on interview and record review, the facility failed to report an alleged abuse complaint to the State Agency (SA), protective services, and/or law enforcement entities per facility policy.</p> <p>As a result, a resident ' s (1) allegation of being mishandled was not completely investigated, which had the potential to affect Resident 1 ' s safety, comfort, and well-being.</p> <p>(Cross-reference F600)</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of non-traumatic intracranial hemorrhage (a brain attack that caused bleeding in the brain).</p> <p>A record review of Resident 1 ' s Minimum Data Set (MDS- assessment tool) dated 5/24/24, indicated a Brief Interview for Mental Status (BIM- developed by reviewing the resident's status during the prior seven day period) score of 15 out of 15 possible points which indicated Resident 1 had no cognitive (pertaining to memory, judgement, and reasoning ability) deficits.</p> <p>An interview was conducted on 7/16/24 at 10:15 A.M., with the Social Services Director (SSD). The SSD stated that on 5/29/24, Resident 1 complained that a licensed nurse (LN) 1 mishandled (to treat roughly) him during care. The SSD stated she did not complete a five (5) DAY REPORT (a full investigation that includes sufficient information for up to five days to monitor and protect a resident from any suspected abuse or neglect) or report this to the State Agency because a grievance was completed. The SSD stated that Resident 1 and his daughter were okay with it. The SSD stated .we couldn ' t verify [Resident 1 ' s] allegation because [Resident 1] had a mental disorder that caused him to hallucinate. The SSD stated that LN 1 was not suspended during the investigation.</p> <p>A document review of Resident 1 ' s GRIEVANCE RESOLUTION FORM dated 5/29/24 at 2:03 P.M. indicated .Resident expressed concerns regarding one of the male nurses. Resident stated that particular male nurse was not gentle enough when providing care .</p> <p>A record review of Resident 1 ' s Social Services progress notes on 5/29/24 at 14:03 (2:03 PM) indicated .he would feel safer if another nurse [sic] were assigned to him .</p> <p>There was no documentation that indicated Resident 1 ' s abuse allegation was reported to the SA, protective adult services or law enforcement.</p> <p>On 7/16/24 at 10:30 A.M. The administrator (ADM) referred to Resident 1 ' s complaint print dated 7/16/24 at 10:22 A.M., per Portal Cortex (facility messaging system used as a communication tool for resident and facility) that indicated . I was bruised by a regular nurse by the name of [staff ' s name]. He grabbed me by the back of the neck and tried to throw me to the bed .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 7/24/24 at 8:43 A.M., with LN 1. LN 1 stated that the following work day after the incident I went to work and a bunch [sic] of staff started telling me don ' t go in there [referring to Resident 1 ' s room] saying he was complaining about you being rough with him saying I was too aggressive . LN 1 denied being rough or aggressive while providing care to Resident 1. LN 1 further stated that he was not suspended for that complaint/allegation.</p> <p>An interview was conducted on 7/24/24 at 1:20 P.M., with the ADM. The ADM stated that he thought a grievance was enough to address Resident 1 ' s complaint of being mishandled by the staff member/LN 1. The ADM acknowledged that a grievance report of an alleged abuse such as mishandling of Resident 1 during resident care would not override (replace) their obligation as mandated reporters to their SA, protective services, and State law enforcement. The ADM did not provide a comment on what his expectations were, regarding if the incident with Resident 1 should had been reported.</p> <p>A review of facility's Abuse policy titled Prevention of and Prohibition Against dated 2024, indicated .H. Reporting/Response . 2. Allegations of abuse, neglect misappropriation of resident ' s property or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies .</p>		