

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Monterey Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1575 Skyline Drive Monterey, CA 93940	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision and monitoring to prevent accidents when one resident (Resident 1) left the facility without staff awareness and/or supervision and resulted in Resident 1 wandering along the road unprotected and was missing from the facility from 6:30 am to around 1:47 pm. This failure put Resident 1 at risk for medical complications and being struck by a motor vehicle. A review of Resident 1's medical records indicated an admission date of 4/25/25 with diagnoses including but not limited to other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus (a brain condition causing repeated seizures, which are temporary surges of abnormal electrical activity in the brain), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly), and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 7/15/25, indicated a brief interview for mental status [BIMS, a tool used to assess person's cognition level (knowing, learning, and understanding), a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] score of 6. A review of Resident 1's elopement evaluation questionnaire dated 08/06/25 indicated: Resident 1 is able to ambulate or self-propel wheelchair independently [Yes]. Does Resident have a history of elopement or an attempted elopement while at home [No]. Does Resident have a history of attempting to leave the facility without informing staff [Yes]. Has the Resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door [Yes]. Does the resident wander [Yes]. Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home, etc.) [No]. Has the Resident been recently admitted or readmitted (in past 30 days) and is not accepting the situation [Yes]. Does resident have a history of drug/alcohol abuse? [Yes]. Does the resident have a history of homelessness [Yes]. A review of Resident 1's Physician Orders indicated, monitor behaviors of exit seeking; every shift ordered on 8/6/25. Review of Resident 1's monitoring records indicated, There were monitoring records to/for: 1) Monitor behaviors for exit seeking every shift, started 8/6/25 until 8/24/25. 2) Visual checks every hour for Exit Seeking, started date 8/6/25-8/31/25. 3) Wander Guard/Wander Elopement Device due to poor safety awareness every shift check placement started 8/6/25 to 8/14/25, then this was changed to, 4) Wander Guard/Wander Elopement Device due to poor safety awareness, check placement and function every shift - from 8/14/25 evening shift to 8/31/25. Review of Resident 1's Care Plan indicated: The Resident is an elopement risk/wanderer AEB (as evidenced by) History of attempts to leave facility unattended and continuously wandering, actual elopement. Date initiated 8/6/2025. Revision 08/24/2025. Two (2) interventions were initiated on 8/6/25: Wander Sensor #8755 - Monitor function and placement q Shift (every shift) and Hourly visual checks. The other interventions in the care plan were only initiated on 8/24/25 after Resident 1's elopement incident on 8/12/25 which included: After Actual elopement 1:1 (a dedicated staff provides continuous, constant observation and care for a single patient) was initiated; Distract Resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; monitor for fatigue and weight loss. A review of Resident 1's progress notes dated 8/15/25 indicated, . Concern/Issue: IDT [interdisciplinary team] met to discuss resident's elopement event that happened on 8/12/25. At around 0745 nurse notified management that resident wasn't in his room and began to look throughout the facility. Resident was located at around 1347 by facility staff. Resident was evaluated by the local ER [emergency room] and returned to the facility at 1907. A review of general acute hospital records Emergency Physician Notes with date and time of service 8/12/2025 1442 indicated, ARRIVAL INFORMATION/CAVEATS: Patient presented to the Emergency Department by private vehicle. CHIEF CONCERN: Altered Mental Status (increased confusion since this morning. Patient eloped from [SNF name], patient was found by PG HS (Pacific Grove High School, which is about 3 miles away from the facility by car) and did not recall how he ended up there. HISTORY OF PRESENT ILLNESS: . resident of [SNF name], with a history of alcohol use disorder, . presents to Emergency Department with increased confusion. A staff member from [SNF name] is present at bedside and provides collateral history. She states she eloped from the facility around 6:30 AM today, and then staff found him wandering around Pacific Grove High School. They then brought him to the ED for evaluation for increased wandering and confusion over the past few days. Patient does not remember where he was or what he did today. During a concurrent interview and observation of Exit Doors on 8/22/25 at 2:27 p.m. with the Director of Nursing (DON) the DON stated all</p>		