

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Los Altos Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 809 Fremont Avenue Los Altos, CA 94024	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate supervision to prevent accidents was provided for one resident (Resident 1) out of one sampled Resident. This failure resulted in Resident 1's elopement, minor injuries, and subsequent hospital visit.FINDINGS: A review of Resident 1's medical record indicated an admission date of 9/16/25. Resident 1's diagnoses included but were not limited to unsteadiness on feet, other abnormalities of gait and mobility, and cognitive communication deficit.A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 1's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 8 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).A review of Resident 1's Progress Notes dated 11/4/25 at 10:39 am by Registered Nurse (RN) A indicated, Patient is at [hospital name].A review of a complaint filed with the Department on 11/4/25 12:04 p.m. regarding Resident 1 indicated, . English speaking pt (patient) who has been staying at [skilled nursing facility (SNF) name], length of stay unknown. Patient presented to [acute hospital name, hospital] ED (emergency department) and was BIB (brought in by) a good Samaritan near [hospital] due to patient reporting that he had a misstep, which lead to unwitnessed fall. He hit his head and had abrasion to left hand. Pt (patient) left [SNF name] and did not tell anyone because he, he had a feeling I was going to be killed. Currently, pt (patient) denies MH (mental health) symptoms [denied SI (suicidal Ideation)].per chart, pt (patient) has memory loss and his cognition is impaired .A review of After Visit Summary dated 11/4/25 from [hospital] indicated, Today's visit, Reason Visit: Fall; Diagnoses: Injury of head, initial encounter; Skin Abrasion. A Review of Resident 1's care plan indicated a care plan for Resident at risk for falls and/or injuries related to anemia, neutropenia, COPD, weakness, acute myeloblastic leukemia. Date Initiated 9/17/205 but interventions prior to 11/5/25 did not include monitoring for wandering and wanderguard (electronics security system used in senior living, hospitals and memory care facilities to prevent vulnerable residents, from wandering off and getting lost or into danger; by using wearable tags that trigger alarms or lock doors when they approach exit points) or a personalized care plan to include monitoring for safety for Resident 1 despite the diagnoses which included cognitive communication deficit.A review of Resident 1's clinical record indicated no elopement assessment and Elopement Care Plan prior to elopement incident on 11/4/25.A review of Resident 1's Progress Notes dated 11/4/25 at 4:31 pm by Licensed Vocational Nurse (LVN) B indicated, Resident arrived back to facility.able to make needs known verbally.Bruising and bandage noted to left hand/wrist area. Wanderguard [wearable tags and door sensors to alert staff and even lock doors if someone approaches an exit] placed.A review of Resident 1's Physician Order indicated, Monitor L [left] wrist Wanderguard placement and function q [every] shift, started 11/5/25 after the incident. During a concurrent observation and interview on</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
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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>11/5/25 at 1:47 p.m.at the front entrance of the facility with the Director of Nursing (DON), the DON verified there was no CCTV (video surveillance system) at the entrance/exit doors of the facility. The DON also verified there were three residents on the porch without any staff supervision.During an interview on 11/5/25 at 2:34 p.m. with the Receptionist, she confirmed the facility has no receptionist from 8:00 p.m. to 8:00 a.m. During an interview on 11/5/25 at 2:45 p.m. with RN A, RN A stated he was the nurse in charge for Resident 1 in the morning of 11/4/25. RN A stated, Resident 1 was not in the facility when his shift started. RN A also stated that by 8 a.m. on 11/4/25 the staff checked outside the facility and started looking for Resident 1. RN A stated he should have asked the outgoing nurse to check the residents with him during shift report (meaning do the rounds to check if all residents are accounted for during shift change). A review of facility's policy and procedure (P&P) entitled Elopements, the P&P indicated, 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to Administrator and nursing staff. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the departure in a courteous manner;.A review of facility's policy and procedure (P&P) entitled Safety and Supervision of Residents , the P&P indicated, Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities Individualized, Resident -Centered Approach to Safety: 1. Our individualized, resident -centered approach to safety addresses safety and accident hazards for individualized residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accidents hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.Systems Approach to Safety.2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment</p>		