STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Post-Acute	510 E. Washington Avenue 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on interview, and record review, the facility failed to provide resident ' s (Resident 1) safety when Resident 1 eloped (leave without notice) from a facility ' s entrance/exit without their knowledge. As a result, Resident 1 had a successful elopement (leaving the facility unsafely and unescorted) on 1/28/25, and was not found as of today, 1/30/25. The facility did not know Resident 1 ' s exit point and his whereabouts. Findings: On 1/29/25 at 9:57 A.M., an unannounced onsite to the facility was conducted related to a facility reported incident on resident safety. On 1/29/25, a review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (serious mental illness with disorganized thinking). On 1/29/25, a review of Resident 1 ' s minimum data set (MDS - a federally mandated resident assessment tool), dated 9/11/24, Resident 1 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 6/15, (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). On 1/29/25, a review of Resident 1 ' s history and physical examination completed by Resident 1 ' s attending physician, dated 10/15/24, indicated Resident 1 could make his needs known but could not make medical decision. On 1/29/25 at 10:46 A.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was ambulatory and was independent. CNA 1 stated Resident 1 resided in their station and his usual behavior was to go to another station to socialize. (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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(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	On 1/29/25 at 10:59 A.M., an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated Resident 1 could make his needs known but could not make a medical decision. LN 1 stated she had seen Resident 1 pushed other residents to the smoking patio and went to different stations to socialize with other residents. LN 1 stated Resident 1 was not in his room during meal tray pass and medication pass on 1/28/25. LN 1 stated Resident 1 had no wander guard (wearable bracelet that alerts the staff when the doors are opened) because he was low risk of elopement. LN 1 stated Resident had not exhibited an exit seeking behavior (a resident who leaves a safe area under the care of a facility). On 1/29/25 at 1:28 P.M., a telephone interview with LN 2 was conducted. LN 2 stated Resident 1 was assigned to her on 1/28/25. LN 2 stated Resident 1 had some cognitive deficiencies related to his diagnosis. LN 2 stated Resident 1 helped pushed other residents to the smoking patio. LN 2 stated Resident 1 was not always available in his room . LN 2 stated she did not see Resident 1 in his room from the beginning of her shift until the end of her shift on 1/28/25. On 1/29/25 at 2:04 P.M., a telephone interview with CNA 2 was conducted. CNA 2 stated Resident 1 was assigned under her care on 1/28/25. CNA 2 stated Resident 1 goes to his friends in another station. Per CNA 2, Resident 1 would stand in the nurses ' station to wait for his breakfast, but on 1/28/25 at around 7:30 in the morning, Resident 1 was not in the nurses ' station and was not in his bed. CNA 2 stated I did not think that was unusual for him. CNA 2 stated she informed LN 2 and LN 2 informed CNA 2 to check Resident 1 ' s vital signs when he gets back to his bed. CNA 2 stated on 1/28/25 at around 10 in the morning, Resident 1 was still not back in his bed, the staff went to check his whereabouts and a yellow code for missing person was initiated. CNA 2 stated Resident did not exhibit exit seeking behavior. CNA 2 stated she did not see Resident 1 on her shift on 1/28/25. On 1/29/25 at 2:49 P.M., a joint telephone interview with Unit Clerk (UC) and LN 3 was conducted. UC and LN 3 stated Resident 1 resided in one station, was last seen in another station on 1/28/25 at around 9:30 AM to 10 A.M. UC stated she saw Resident 1 while she was on the telephone. LN 3 stated she saw Resident 1 getting some coffee and she did not know where Resident 1 headed after preparing some coffee. LN 3 stated that was around 10ish. On 1/30/25, a review of Resident 1 ' s interdisciplinary (IDT, group of professionals who plan, coordinate and deliver personalized health care) notes was conducted. The information was as followed: - 12/29/22 - IDT notes. The IDT notes indicated Resident 1 was initially placed in the facility ' s secured unit (having doors that set off an alarm if opened without a code and secure windows to make sure residents do not end up anywhere dangerous) due to his history of leaving his previous facility. Per the IDT notes, since admission on 10/14/22, Resident 1 had remained in his room, and had not exhibited an interest in eloping or had an exit seeking behavior. Resident 1 was then placed in a non-secured unit and the plan was to monitor Resident 1. On 1/30/25, a review of Resident 1 ' s wandering and elopement assessment was conducted. - 10/14/22 - 60, at risk for elopement. - 1/17/23 - 60, at risk for elopement. - 3/3/23 - 60, at risk for elopement. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/11/23 - 60, at risk for elopement. - 7/5/23 - 10, not at risk for elopement. - 9/27/23 - 10, not at risk for elopement. - 12/18/23 - 10, not at risk for elopement. - 3/19/24 - low risk for wandering. - 6/19/24 - low risk for wandering. - 9/20/24 - low risk for wandering. - 12/20/24 - low risk for wandering. On 1/30/25 at 1:24 P.M., a conference call with CDPH facility supervisor and the Nursing Home Administrator (NHA) was conducted. The NHA stated the facility staff did not know where Resident 1 exited and was still not found as of 1/30/25. A review of the facility ' s policy titled, Routine Residents Checks, revised July 2013, indicated, Staff shall make routine resident checks to help maintain resident safety and well-being . Based on interview, and record review, the facility failed to provide resident's (Resident 1) safety when Resident 1 eloped (leave without notice) from a facility's entrance/exit without their knowledge. As a result, Resident 1 had a successful elopement (leaving the facility unsafely and unescorted) on 1/28/25, and was not found as of today, 1/30/25. The facility did not know Resident 1's exit point and his whereabouts. Findings: On 1/29/25 at 9:57 A.M., an unannounced onsite to the facility was conducted related to a facility reported incident on resident safety. On 1/29/25, a review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (serious mental illness with disorganized thinking). On 1/29/25, a review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool), dated 9/11/24, Resident 1 had a Brief Interview for Mental Status (BIMS, ability to recall) score of 6/15, (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25, a review of Resident 1's history and physical examination completed by Resident 1's attending physician, dated 10/15/24, indicated Resident 1 could make his needs known but could not make medical decision. On 1/29/25 at 10:46 A.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was ambulatory and was independent. CNA 1 stated Resident 1 resided in their station and his usual behavior was to go to another station to socialize. On 1/29/25 at 10:59 A.M., an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated Resident 1 could make his needs known but could not make a medical decision. LN 1 stated she had seen Resident 1 pushed other residents to the smoking patio and went to different stations to socialize with other residents. LN 1 stated Resident 1 was not in his room during meal tray pass and medication pass on 1/28/25. LN 1 stated Resident 1 had no wander guard (wearable bracelet that alerts the staff when the doors are opened) because he was low risk of elopement. LN 1 stated Resident had not exhibited an exit seeking behavior (a resident who leaves a safe area under the care of a facility). On 1/29/25 at 1:28 P.M., a telephone interview with LN 2 was conducted. LN 2 stated Resident 1 was assigned to her on 1/28/25. LN 2 stated Resident 1 had some cognitive deficiencies related to his diagnosis. LN 2 stated Resident 1 helped pushed other residents to the smoking patio. LN 2 stated Resident 1 was not always available in his room . LN 2 stated she did not see Resident 1 in his room from the beginning of her shift until the end of her shift on 1/28/25. On 1/29/25 at 2:04 P.M., a telephone interview with CNA 2 was conducted. CNA 2 stated Resident 1 was assigned under her care on 1/28/25. CNA 2 stated Resident 1 goes to his friends in another station. Per CNA 2, Resident 1 would stand in the nurses' station to wait for his breakfast, but on 1/28/25 at around 7:30 in the morning, Resident 1 was not in the nurses' station and was not in his bed. CNA 2 stated I did not think that was unusual for him. CNA 2 stated she informed LN 2 and LN 2 informed CNA 2 to check Resident 1's vital signs when he gets back to his bed. CNA 2 stated on 1/28/25 at around 10 in the morning, Resident 1 was still not back in his bed, the staff went to check his whereabouts and a yellow code for missing person was initiated. CNA 2 stated Resident did not exhibit exit seeking behavior. CNA 2 stated she did not see Resident 1 on her shift on 1/28/25. On 1/29/25 at 2:49 P.M., a joint telephone interview with Unit Clerk (UC) and LN 3 was conducted. UC and LN 3 stated Resident 1 resided in one station, was last seen in another station on 1/28/25 at around 9:30 AM to 10 A.M. UC stated she saw Resident 1 while she was on the telephone. LN 3 stated she saw Resident 1 getting some coffee and she did not know where Resident 1 headed after preparing some coffee. LN 3 stated that was around 10ish . On 1/30/25, a review of Resident 1's interdisciplinary (IDT, group of professionals who plan, coordinate and deliver personalized health care) notes was conducted. The information was as followed: - 12/29/22 - IDT notes. The IDT notes indicated Resident 1 was initially placed in the facility's secured unit (having doors that set off an alarm if opened without a code and secure windows to make sure residents do not end up anywhere dangerous) due to his history of leaving his previous facility. Per the IDT notes, since admission on 10/14/22, Resident 1 had remained in his room, and had not exhibited an interest in eloping or had an exit seeking behavior. Resident 1 was then placed in a non-secured unit and the plan was to monitor Resident 1. (continued on next page)

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