STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555106	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Lodge	5053 Peck Rd. El Monte, CA 91732

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** 48729 Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 1) who was at risk for elopement (when a resident leaves the facility without authorization) was monitored in the hallway and re-directed away from the exit door as indicated in the facility's policy and procedure (P&P) titled, Safety of Residents. Resident 1 eloped from the facility on 10/19/2024 without being noticed by staff and was not found until 10/21/2024. Resident 1 sustained a skin abrasion (scrape) above the left elbow. This deficient practice had the potential to result in serious bodily injury and physical decline to Resident 1 during the time Resident 1 was absent from the facility. Findings: During a review of Resident 1's Admission Record, (AR), the AR indicated Resident 1 was admitted on [DATE] with diagnoses that included dementia (loss of mental skills that affect daily life and cause problems with memory, thinking and planning) and major depressive disorder (mental health disorder that causes a persistent feeling of sadness and loss of interest in activities causing significant impairment in daily life). During a review of Resident 1's Care Plan (CP) titled, Elopement Risk, dated 5/5/2024, the CP indicated to, Redirect resident [Resident 1] if found standing in the [exit] door, and to, Monitor at frequent intervals. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, reason, plan) and required supervision or touching assistance (helper provides verbal cues and/ or touching/steadying as resident completes activity) for toileting and hygiene. During a review of Resident 1's Elopement Risk Evaluation (ERE) dated 9/20/2024, the ERE indicated Resident 1 was at risk for elopement/ wandering and included appropriate interventions to redirect Resident 1 if Resident 1 stayed near the exit door, frequent visual checks, and continuing to monitor Resident 1 for elopement. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Psychiatry Progress Note (PPN), date of service 10/18/2024, the PPN indicated Resident 1 was depressed, confused, and disorganized. The PPN indicated Resident 1 had unpredictable behavior and needed close monitoring and redirection. During an interview on 10/21/2024 at 12:15 PM with the Director of Nursing (DON), the DON stated facility staff were supposed to monitor the doors and hallways but during mealtimes there was no one monitoring in front of the exit door because staff were helping feed residents. During a concurrent interview on 10/21/2024 at 12:52 PM with the DON and a review of the facility's surveillance video dated 10/19/2024 at 4:42 PM. CNA 2 and the Dietary Aide (DA) entered the facility hallway from the exit door and walked away from the door. CNA 2 and the DA did not check if the exit door was closed or locked. Resident 1 was seen in the hallway standing next to the exit door and held the door open with one hand while CNA 2 and the DA walked away. Resident 1 looked through the empty hallways and passed through the door without staff noticing. The DON stated CNA 2 should have made sure the door was closed before walking away to prevent Resident 1 from eloping from the facility. During an interview on 10/21/2024 at 1:46 PM with Registered Nurse 1 (RN 1), RN 1 stated on 10/21/2024 [when Resident 1 was brought back to the facility], Resident 1 had a skin tear on the left arm above the elbow and had some discoloration on both upper arms but Resident 1 denied pain. During an interview on 10/21/2024 at 2 PM with Resident 1, Resident 1 stated while Resident 1 was outside of the facility, Resident 1 was sitting on a concrete porch, lost balance while trying to lay back, and Resident 1 scraped Resident 1's upper left arm. During a review of Resident 1's Skin Progress Report (SPR) dated 10/21/1024, the SPR indicated Resident 1 had a skin tear on the left antecubital (the space inside the crook of the elbow) area that measured 5 centimeters (cm - unit of measure) x 3 cm. During an interview on 10/21/2024 at 2:36 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated CNA 1 was inside Resident 1's room assisting a resident (unidentified) to eat during the time of Resident 1's elopement. CNA 1 stated Resident 1 ate dinner quickly and left Resident 1's room. CNA 1 stated Resident 1 went to the hallway after dinner and this behavior was usual for Resident 1. CNA 1 further stated [facility practice] before dinner, there were three CNAs (unidentified) that monitored the hallways but during dinner, many CNAs were inside resident rooms assisting them to eat. CNA 1 stated when staff passed [entered] through the exit doors, staff were supposed to physically check the doors were closed by [conducting] a push and pull motion. During an interview on 10/22/2024 at 1:56 PM with the Director of Nursing (DON), the DON stated the CNA (unidentified) that had been monitoring the exit door prior to dinner was inside a resident's room feeding the resident (unidentified) and was not monitoring the door or the hallway. The DON stated a staff member should always be posted in the hallway to monitor the hallway and the exit door. The DON stated the purpose of monitoring was to be able to prevent residents from leaving the facility, to determine if a resident needed help while in the hallway and prevent other adverse (harmful or abnormal) events from occurring. The DON stated if a resident left the facility unnoticed it was dangerous for the resident because the resident could get hit by a car, injured, or become dehydrated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/23/2024 at 10 AM with CNA 2, CNA 2 stated, on 10/19/2024, CNA 2 saw Resident 1 by the exit door but CNA 2 did not check if the exit door was closed after letting in a staff member. CNA 2 further stated it was normal to see Resident 1 standing in the general area by the exit door while waiting for a smoke break after dinner. CNA 2 stated the facility held an in-service (training) about two months ago that instructed the staff to make sure exit doors [remained] were closed, locked, and to redirect residents that were near the doors. CNA 2 stated it was CNA 2 's responsibility to check that the door was closed after letting in dietary staff. CNA 2 stated CNA 2 did not redirect Resident 1 or check if the door was closed/locked because CNA 2 did not think Resident 1 would elope. CNA 2 stated if a resident left the facility they could get physically hurt. During a review of the facility's P&P titled, Safety of Residents, dated 7/2021. The P&P indicated the facility is secure and strives to make an environment as free from accident hazards as possible. The P&P indicated, resident safety and supervision and assistance to prevent accidents/elopements were facility wide priorities. The P&P indicated, Implementing interventions to reduce accident risks and hazards shall include the following: f. Continuous supervision and redirection as needed.