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	06/30/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a specific and individualized care plan (CP) for one of two (Resident 1) sampled resident that addressed Resident 1's wandering, into other resident rooms, behavior.This deficient practice had the potential to result in unmet individualized needs for Resident 1 and the potential to affect Resident 1's physical and psychosocial well-being.Cross Reference F689Findings:During a review of Resident 1's Facesheet (FS, admission record), the FS indicated the facility admitted Resident 1 on 4/28/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), encephalopathy (broad term for any disease, damage, or malfunction of the brain).During a review of Resident 1's CP, initiated 5/1/2026, the CP indicated Resident 1 was at risk for purposeless wandering and potential for self-injury. The CP did not indicate Resident 1 wandered into other resident rooms or any interventions to prevent the behavior from occurring.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/2/2026, the MDS indicated Resident 1 had severe impairment in cognition (ability to think and make decisions), the MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene and toilet transfers.During a review of Resident 2's FS, the FS indicated Resident 2 was admitted to the facility 5/7/2026 with diagnoses that included dysphasia (a language disorder that impairs the ability to produce and understand spoken or written language) and hyperlipidemia (high amounts of fats in the blood).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired. The MDS indicated Resident 2 made self understood and was able to understand others.During an interview on 6/30/2026 at 9:35 AM with Resident 2, Resident 2 stated about two weeks ago [6/13/2026] Resident 1 entered Resident 2's room and opened Resident 2's drawers. Resident 2 stated Resident 2 told Resident 1 Resident 2's room was not Resident 1's room but Resident 1 came close to Resident 2 and touched Resident 2.During an interview on 6/30/2026 at 10:47 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 liked walking in the hallway and Resident 1 also entered (wander) into other resident rooms (usual behavior).During an interview on 6/30/2026 at 1:38 PM with CNA 2, CNA 2 stated CNA 2 had seen (no date recall) Resident 1 enter Room A one time, Resident 1 usually wandered into the room across Room A (unidentified resident's room).During an interview on 6/30/2026 at 2:30 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 walked around and entered (wandered) room to room every day. LVN 1 stated wandering room to room was Resident 1's [usual] behavior and no one cared about the behavior until Resident 1 was hit [by Resident 2].During a concurrent review and interview on 6/30/2026 at 3:28 PM with the Director of Nursing (DON), Resident 1's CP, initiated 5/1/2026, indicating Resident 1 was at risk for purposeless wandering and potential for self-injury. The DON stated Resident 1's CP did not address Resident 1's wandering behavior into other resident rooms. The DON stated the DON was not aware Resident 1 wandered into other resident rooms because Resident 1 usually attended activities during the daytime. The DON stated nurses (in general) who were aware of Resident 1's wandering (into resident rooms) behavior needed to inform the DON (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and needed to develop interventions that addressed behavior.During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated March 2023, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The P&P indicated, when possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.During a review of the facility's undated P&P titled Care of Wandering Residents the P&P indicated for residents who wandered, a plan of care shall address the wandering [behavior].

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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** Based on interview and record review, the facility failed to ensure adequate supervision for one of two sampled residents (Resident 1), who had a history of wandering (walking aimlessly with no specific direction) into other resident rooms.This deficient practice resulted in Resident 1 wandering into Resident 2's room on 6/13/2026 and Resident 1 getting close to Resident 2 leading to Resident 2 scratching Resident 1's left upper lip.Cross Reference F656Findings:During a review of Resident 1's Facesheet (FS, admission record), the FS indicated the facility admitted Resident 1 on 4/28/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), encephalopathy (broad term for any disease, damage, or malfunction of the brain).During a review of Resident 1's care plan (CP), initiated 5/1/2026, the CP indicated resident one was at risk for unavoidable decline related to dementia. The CP's interventions indicated to provide a safe environment to Resident 1.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/2/2026, the MDS indicated Resident 1 had severe impairment in cognition (ability to think and make decisions), the MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene and toilet transfers.During a review of Resident 1's COC/Interact Assessment Form (change of condition, an alteration in a resident's physical health that differs from the resident's previous baseline), dated 6/13/2026, the COC indicated Resident 1 was observed wandering in the hallway at 5 PM. The COC indicated at 6 PM, Resident 1 was still wandering into [resident] rooms. The COC indicated LVN 3 was called due to a resident-to-resident altercation [with Resident 2]. The COC indicated Resident 1 had a scratch near the cheek [left upper lip] with scant bleeding.During a review of Resident 1's Skin Reassessment, dated 6/13/2026, the reassessment indicated Resident 1 had skin scratches on the left upper lip.During a review of Resident 2's FS, the FS indicated Resident 2 was admitted to the facility 5/7/2026 with diagnoses that included dysphasia (a language disorder that impairs the ability to produce and understand spoken or written language) and hyperlipidemia (high amounts of fats in the blood).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired. The MDS indicated Resident 2 made self understood and was able to understand others.During a review of Resident 2's COC, dated 6/13/2026, the COC indicated Resident 2 was involved in a possible resident to resident altercation [with Resident 1].During an interview on 6/30/2026 at 9:35 AM, Resident 2 reacted by raising Resident 2's hand and accidentally scratched Resident 1 with his fingernails. Resident 2 showed his short fingernails and stated the CNA's had already cut the nails after what happened.During an interview on 6/30/2026 at 9:35 AM with Resident 2, Resident 2 stated about two weeks ago [6/13/2026] Resident 1 entered Resident 2's room and opened Resident 2's drawers. Resident 2 stated Resident 2 told Resident 1 Resident 2's room was not Resident 1's room but Resident 1 came close to Resident 2 and touched Resident 2. Resident 2 stated Resident 2 reacted by raising Resident 2's hand and accidentally scratched Resident 1 with Resident 2's fingernails.During an interview on 6/30/2026 at 10:47 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 liked walking in the hallway and Resident 1 also entered (wander) into other resident rooms (usual behavior). CNA 1 stated CNA 1 did not witness Resident 2 hit Resident 1 but saw Resident 1 walking in the hallway with a cut on Resident 1's cheek.During an interview on 6/30/2026 at 1:38 PM with CNA 2, CNA 2 stated CNA 2 had seen (no date recall) Resident 1 enter Room A one time, Resident 1 usually wandered into the room across Room A (unidentified resident's room).During an interview on 6/30/2026 at 2:30 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 walked around and entered (wandered) room to room every day. LVN 1 stated wandering room to room was Resident 1's [usual] behavior and no one [staff] cared about the behavior until Resident 1 was hit [by Resident 2]. LVN 1 stated wandering (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into other resident rooms could make other residents mad and could lead to Resident 1 getting hurt. LVN 1 stated we [facility staff] try our best to redirect Resident 1 but Resident 1 continued to wander into other resident rooms. LVN 1 stated Resident 1 might need [interventions such as] more direct supervision (no specific supervision plan for Resident 1) such as a one-to-one (one staff supervising one resident) supervision to protect Resident 1.During an interview on 6/30/2026 at 2:53 PM with LVN 2, LVN 2 stated LVN 2 had seen Resident 1 enter other resident rooms, room to room. LVN 2 stated other residents could get mad when Resident 1 entered their rooms.During a concurrent review of Resident 1's medical records and interview on 6/30/2026 at 3:28 PM with the Director of Nursing (DON), the DON stated there was no documented evidence indicating specific monitoring/supervision as an intervention for Resident 1 wandering into other resident rooms in Resident 1's record. The DON was not aware Resident 1 wandered into other resident rooms. The DON stated nurses (in general) who were aware of Resident 1's wandering (into resident rooms) behavior needed to inform the DON and the behavior needed to be addressed to protect Resident 1.During a review of the facility's undated Policy and Procedure (P&P) titled Care of Wandering Residents the P&P indicated for residents who wander, a plan of care shall address the wandering. The P&P indicated nursing and care duties included to continuously reorienting resident to room and belongings and to monitor the resident's location with visual checks as needed.During a review of the facility's undated P&P titled, Monitoring/Supervision Residents, the P&P indicated the P&P's purpose was to identify ways in which the facility monitored residents and resident care to ensure sufficient supervision at all times. The P&P indicated staff members would provide adequate supervision to all residents in accordance with their plans of care. The P&P indicated additionally to the every two-hour monitoring/supervision from the nursing department, the facility would provide supervision/monitoring from the following duties which included, one-to one monitoring if indicated: the facility may assign nursing or non-nursing personnel for this task as necessary. The P&P indicated designate specific personnel or rotate staff as necessary and ensure all monitoring findings and corrective actions are documented in the resident's record.