STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop a baseline care plan (detailed plan with information about a resident's treatment, goal, and interventions) for one of one sample resident related to a resident's (Resident 1) high risk of wandering/ elopement (when a resident leaves the facility without staff knowledge or supervision). As a result, the lack of a resident centered care plan with interventions had Resident 1 successfully eloped and unsafely wandered out of the facility on 11/5/25. Cross Reference: F 689Findings: On 11/5/25, the Department received a facility reported incident related to quality of care and resident safety. On 11/6/25, an unannounced onsite to the facility was conducted. On 11/6/25, a review of Resident 1's clinical record was conducted. Resident 1 was readmitted to the facility on [DATE], with diagnoses which included convulsions (uncontrollable muscle contraction), bipolar disorder (periods of extremely up, elated, irritable, or energized behavior [known as manic episodes] and very down, sad, indifferent, or hopeless periods [known as depressive episodes]), psychosis (a condition in which one is unable to distinguish between what is and is not real), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), per the facility's admission Record. Resident 1's History and Physical (H&P), dated 9/23/25, indicated Resident 1 was admitted to the facility for psychiatric care, and monitoring, did not have the capacity to make her own decisions and was under conservatorship (when a judge appoints another person to act or make decisions for the person who needs help). The H&P also indicated Resident 1 had a history of increased agitation and worsening auditory hallucinations which included voices to harm herself. Resident 1's wandering/elopement risk assessment dated [DATE] indicated Resident 1 had a history of wandering and was at high risk for wandering. Resident 1's care plan was reviewed. There was no care plan developed for Resident 1's high risk of wandering. On 11/6/25 at 2:12 P.M. , an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA 2 stated Resident 1 was alert, oriented and was ambulatory. CNA 2 stated Resident 1 was in a lock unit and would stroll in the patio when the patio was opened for smoking. CNA 2 stated for residents in the lock unit, the residents were closely monitored. CNA 2 stated the process was when a resident had an outpatient appointment, a staff member was assigned to escort the resident. CNA 2 stated, on 11/5/25, Resident 1 had an outpatient appointment, left at around 11:30 A.M. and was escorted by CNA 1. CNA 2 stated on 11/5/25 at around 1 P.M., CNA 1 called CNA 2 over the phone stating he lost Resident 1 while they were at Resident 1's outpatient appointment. On 11/6/25 at 2:47 P.M., an interview with CNA 3 was conducted. CNA 3 stated Resident 1 would walk around but could be redirected. CNA 3 stated the facility did not anticipate Resident 1 would elope because there was no indication that she would leave. CNA 3 further stated CNA 1 had been escorting residents out prior to the incident. CNA 3 stated, If we escort, that is our responsibility, we should not let our eyes away because we don't know what is in their minds. It is for their safety; it is our responsibility to make sure they are safe. CNA 1 was no longer employed at the facility and was not available for interview. On 11/6/25 at 3:03 P.M., a joint review of Resident 1's wandering assessment and an interview with Licensed Nurse (LN) 1 was conducted. LN 1 stated she was familiar with Resident 1 and had worked with the resident since her admission. LN 1 stated Resident 1 was alert and oriented with forgetfulness. LN 1 stated Resident 1's wandering assessment was high but there was no care plan developed related to Resident 1's high risk of wandering. On 11/6/25 at 3:43 P.M., a joint record review of Resident 1's care plan and an interview were conducted with the Director of Nursing (DON). The DON stated the expectation was for the LNs to develop a care plan to meet the expectation and to evaluate the intervention provided to the residents for their care and needs for resident's safety. A review of the facility's policy titled, Care Plans, Baseline, revised March 2022, indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555585	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores Post-Acute	2828 Meadowlark Drive San Diego, CA 92123

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure adequate supervision during an outpatient appointment for one of one sample resident (Resident 1) when: 1. A Certified Nursing Assistant (CNA) 1 did not set eyes on a resident (Resident 1) while escorting the resident on 11/5/25 to her outpatient appointment. Resident 1 was under conservatorship (when a judge appoints another person to act or make decisions for the person who needs help), who was placed in a lock unit (a locked, secure area designed specifically for residents with a risk of wandering) in the skilled nursing facility (SNF). Resident 1 wandered out of the SNF and was not found for more than 24 hours. 2. When Resident 1 was located on 11/6/25 at the general acute care hospital (GACH) emergency department (ED), Resident 1 was found more than 11 miles from the facility's location, intoxicated with alcohol, reported to have taken antipsychotic and antidepressant medications and found to have pneumonia (lung infection). 3. Resident 1 was assessed as having a high risk for wandering and Licensed Nurses (LNs) did not develop a care plan (detailed plan with information about a resident's treatment, goal, and interventions) for her wandering. As a result, the lack of a resident centered care plan with specific interventions had Resident 1 successfully eloped (when resident departs unsupervised and undetected) and unsafely wandered out of the SNF on 11/5/25. Resident 1 was not found as of onsite visit on 11/6/25. The facility did not specifically know Resident 1's whereabouts during the onsite visit. In addition, when Resident 1 was located, she was found to be intoxicated with alcohol. Cross Reference: F 655Findings: On 11/5/25, the Department received a facility reported incident related to quality of care and resident safety. On 11/6/25, an unannounced onsite to the facility was conducted. On 11/6/25, a review of Resident 1's clinical record was conducted.Resident 1 was readmitted to the facility on [DATE], with diagnoses which included convulsions (uncontrollable muscle contraction), bipolar disorder (periods of extremely up, elated, irritable, or energized behavior [known as manic episodes] and very down, sad, indifferent, or hopeless periods [known as depressive episodes]), psychosis (a condition in which one is unable to distinguish between what is and is not real), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), among other diagnoses per the facility's admission Record. A review of Resident 1's GACH 1 record was conducted. GACH 1 record prior to SNF admission, indicated Resident 1 had psychiatric evaluation and was admitted to GACH 1 on 9/10/25 due to extreme agitation and unable to keep shelter endangering others. A review of Resident 1's History and Physical (H&P), dated 9/23/25, was conducted. The H&P indicated Resident 1 was admitted to the SNF for psychiatric care, and monitoring, did not have the capacity to make her own decisions and was under conservatorship. The H&P also indicated Resident 1 had a history of increased agitation and worsening auditory hallucinations (hearing voices that was not there) which included voices to harm herself. A review of Resident 1's wandering/elopement risk assessment dated [DATE] was conducted. The form wandering/ elopement risk assessment indicated Resident 1 had a history of wandering and was at high risk for wandering. A review of Resident 1's care plan was conducted. There was no care plan developed for Resident 1's high risk of wandering. A review of Resident 1's SNF's interdisciplinary team (IDT, group of healthcare professionals and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a resident) was conducted. The IDT notes dated 11/6/25 indicated the timeline as follows:- On 11/5/25 at 11:30 A.M., Resident 1 and her CNA escort (CNA 1) were picked up by an ambulance.- On 11/5/25 at 11:32 A.M., CNA 1 and Resident 1 checked in at the outpatient clinic and sat down in the waiting area. CNA 1 briefly fell asleep while waiting, and woke up with the resident still beside him.- On 11/5/25 at 12:05 P.M., CNA 1 went to the bathroom. When CNA 1 returned from the bathroom, he noted that Resident 1 was not in sight, however, CNA 1 assumed Resident 1 was called in to her appointment. - About 10 -15 minutes later, CNA 1 heard clinic staff calling for Resident 1's name and this time CNA 1 realized Resident 1 left the clinic unnoticed. CNA 1 started to search around the building and notified the facility immediately.- On 11/5/25 at around 1:05 P.M., LN 1 received a call from CNA 1 stating Resident 1 left the clinic while CNA 1 was in the bathroom. CNA 1 searched around the area but did not find Resident 1.The IDT notes indicated Resident 1 was not found as of their IDT meeting on 11/6/25. When Resident 1 was located at the GACH on 11/6/25, Resident 1 was found more than 11 miles from the facility's location. The GACH record indicated Resident 1 was intoxicated with alcohol. A review of the GACH 2 record for Resident 1 was conducted on 11/13/25. Resident 1's GACH 2 ED physician notes on 11/6/25 at