

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER The Shores Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure two of two residents (Resident 1 and Resident 2) had preventative measures in place to prevent elopement when:An elevator that led to the facility basement was easily accessible to residents.Certified nursing assistant (CNA) 5 did not know what a Code [NAME] (emergency plan when a resident goes missing) was.The Exit Monitoring Logs were not consistently completed once a shift by maintenance staff.The Safety and Security Reminder In-service dated 6/30/26 had inaccurate information.Q (every)15-30-minute elopement monitoring logs for Resident 1 had missing documentation.Hall monitor times were not followed in the secured unit (a closed unit that housed residents with cognitive impairment who were at high risk for elopement)Assigned hall monitors on the secured unit attended to other resident needs during their hall monitoring time.IDT did not do a thorough investigation into elopement.As a result of these deficient practices, Resident 1 and Resident 2 eloped from the facility placing the residents at risk for serious harm. In addition, this deficient practice potentially placed the 80 residents on the secured unit at risk for elopement. Findings: 1. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include Schizoaffective Disorder (mental health condition), Difficulty in Walking, Morbid (Severe) Obesity Due to Excess Calories, Major Depressive Disorder (mental health condition), Psychotic Disorder (mental health condition) with Delusions Due to Known Physiological Condition, Bipolar Disorder (mental health condition), and Anxiety Disorder. A review of Resident 1's Nurses Notes dated 7/10/26 indicated Resident 1 was sent to the hospital and did not return to the facility. A review of Resident 1's Care Plan Report dated 4/14/25 indicated Resident 1 had episode/history of elopement. Resident with history of wandering out of the facility. A review of Resident 1's Wandering/Elopement Risk Scale dated 4/15/26 indicated a score of 11. The score 11 indicated High Risk for Wandering. A review of Resident 1's Alert Charting record dated 6/29/26 at 10:12 P.M., .Resident is observed having episodes of calling 911 saying he wants to leave. (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 - Some	A review of IDT (interdisciplinary team) Comprehensive Resident Support Notes dated 6/30/26 indicated, On June 30th [Resident 1] was found outside of the facility unattended and without having a out on pass order. Resident said that around 2000 [8 P.M.] he called the cops because he felt unsafe in the facility. Resident said origin: he was in the courtyard of station 2 when he heard voices telling him to leave. Resident said he attempted to climb the fence in station 2 but was unsuccessful at the attempt. Resident said after that he went to the back dining room and went down the elevator. Once the resident exit [sic] the building he went towards the [freeway]. On 7/15/26 at 8:40 A.M., an interview was conducted with the assistant director of nursing (ADON) 1. ADON 1 stated that on 6/30/26, Resident 1 became upset after speaking with his mother on the phone. ADON 1 stated that Resident 1 attempted to jump over the fence behind the dining room but was unsuccessful. ADON 1 stated that Resident 1 then reentered the facility, walked toward station three, took the elevator to the basement, exited through the basement door, and left the facility through the open parking lot gate. ADON 1 stated Resident 1 had schizophrenia and lacked the mental capacity to make safe decisions. ADON 1 stated Resident 1 wanted, revenge against the facility and would call 911 often. On 7/15/26 at 9 A.M., a joint observation and interview with ADON 1 was conducted. ADON 1 identified the elevator located behind station three and stated that this elevator was the only elevator in the facility. To the left of the elevator, a button panel with three horizontal buttons was observed. Each button contained a keyhole in the center. ADON 1 stated that the facility did not have a key for the elevator. ADON 1 used his fingers to press and turn the third button which activated the elevator. An observation of the basement was then conducted with ADON 1. ADON 1 stated that the basement was, not for residents. An exit door adjacent to the elevator was observed. ADON 1 stated that Resident 1 exited through that door and then left the facility through the parking lot gate during the elopement. On 7/15/26 at 9:17 A.M., an interview was conducted with CNA 5. CNA 5 stated that he was familiar with Resident 1. CNA 5 stated Resident 1 frequently sat in the hallways yelling, intentionally would vomit in the hallways, and preferred wearing soiled clothing. CNA 5 stated that Resident 1 required frequent staff monitoring. CNA 5 stated he was unsure if Resident 1 had a history of elopement. CNA 5 stated that he did not know what Code [NAME] was. On 7/15/26 at 10:21 A.M., a joint observation, interview, and record review was conducted with the Maintenance Supervisor (Main 1). The elevator behind station three was observed. Main 1 stated the elevator had previously required a key for access but no longer required one. Main 1 stated, anybody can get in the elevator and the elevator was not secured. The basement was then observed with Main 1. The kitchen, mechanical storage area, laundry area, and central supply area were identified to be part of the basement. Main 1 stated the mechanical storage area, parts of the laundry area, and the central supply area remained unlocked at all times. The mechanical storage area contained electrical panels, exposed wiring, and a, Beware High Voltage signage was hanging from the ceiling piping. The central supply area contained numerous boxes, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's Social Services Notes dated 6/30/26 stated, Resident came to Social Services office to say, 'did you hear what I did [referring to the elopement]. no one can stop me.' Resident also stated multiple times that he does not want to be in the facility and he would prefer to be homeless. A review of Resident 1's Primary Physician Progress Note dated 7/1/26 stated, .Patient is seen due to passive suicidal statement in context of feeling unsafe and wanting to leave the facility.He reports feeling unsafe in the facility and verbalizes desire to leave. He made a passive statement, 'I would kill myself first if I had to be here another day'. Continue close monitoring. On 7/15/26 at 2:14 P.M., a joint interview and record review was conducted with ADON 1. ADON 1 stated Resident 1 was at high risk for wandering and elopement. ADON 1 stated Resident 1 did not like being at the facility. ADON 1 further stated Resident 1 was alert, knew how to leave the facility, and would know how to remove a wander guard (safety and security device) if one were applied. ADON 1 stated after Resident 1 returned to the facility following the 6/30/26 elopement, Resident 1 was on Q 15-30-minute (documentation of whereabouts and activities every 15-30 minutes) until Resident 1's discharge on [DATE]. Resident 1's Q 15-30-minute Minutes Monitoring Logs were reviewed. ADON 1 stated Q 15-30-minute monitoring required staff to visually check on Resident 1 and document Resident 1's whereabouts, 24/7. A review of the monitoring logs revealed multiple undocumented rounds: On 6/30/26 11:30 P.M.-11:45 P.M. On 7/2/26 11:15 P.M. -11:45 P.M. On 7/3/26 11:30 P.M. On 7/4/26 12 MN (midnight) &ndash; 11:45 P.M. On 7/5/26 12 MN-6:30 A.M. and 11:30 P.M. On 7/6/26 1:30 A.M.- 2:30 P.M and 11:30 P.M. On 7/7/26 7 A.M.-2:30 P.M. On 7/8/26 9:30 A.M-2:30 P.M. On 7/9/26 7:15 A.M.- 12:30 P.M. and 11:30 P.M.- 11:45 P.M. ADON 1 acknowledged the Q 15-30-minute monitoring logs had missing documentation. ADON 1 stated it was his expectation that Q 15-30-minutes be completed and documented every 15- 30-minutes because Resident 1 remained at risk for another elopement. ADON 1 stated residents should not have access to the elevator due to the hazards in the basement and the basement exit door. ADON 1 further stated the elevator remained still easily accessible to residents. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of home prior to placement. A review of the facility's Report of Suspected Dependent Adult/Elder Abuse dated 7/6/26 indicated, .On 7/5/26 Resident [Resident 2] was noticed missing around 11:45 am. Code [NAME] activated. Resident found on [name of road omitted]. All appropriate parties were contacted. unknown how Resident was able to leave. investigation pending. On 7/15/26 at 9:04 A.M., an interview was conducted with the director of staff development (DSD). The DSD stated a certified nursing assistant (CNA) reported Resident 2 could not be found on 7/5/26 at 11:40 A.M. The DSD stated she did not know how Resident 2 left the facility. The DSD stated she believed Resident 2 followed the kitchen staff when they exited the secured unit after delivering the meal cart. The DSD stated the facility had assigned hall monitors in the secured unit that monitored the hallways and both exit doors. The DSD stated the unit did not have a hall monitor assigned at the time of Resident 2's elopement. The DSD stated sometimes the hall monitors walked around the unit. The DSD stated Resident 2 should not have been able to leave the facility unsupervised. The DSD stated all staff entering and exiting the secured unit should have ensured the exit doors were shut and locked behind them. The DSD stated staff found Resident 2 walking on the street near the facility. On 7/15/26 at 9:27 A.M., an interview was conducted with CNA 1 in the secured unit hallway. CNA 1 stated the CNAs had 30-minute shifts as the hall monitor with the responsibility to monitor the two exit doors and hallways to ensure residents did not leave the secured unit. CNA 1 stated there was a hall monitor to watch the exit door going out to station 2 and there was a second hall monitor that monitors the dining room and exit door that led out to station 3. CNA 1 stated there should be eyes on the exit doors 24 hours a day for the safety of the residents. CNA 1 stated if a resident got out of the secured unit, she would follow the resident and call for help. On 7/15/26 at 11:19 A.M., an interview was conducted with licensed nurse (LN) 1. LN 1 stated hall monitors sometimes left their post to assist with resident needs. LN 1 stated the assigned hall monitors should not leave their post. On 7/15/26 at 11:22 A.M., a joint observation and interview was conducted with CNA 2 in the secured unit hallway near station 2 exit door during her hall monitor scheduled time. CNA 2 stated she would leave her post if she needed to redirect a resident. CNA 2 stated all CNAs passed meal trays during meals so there was no hall monitor coverage during that time. CNA 2 was then observed leaving her hall monitor post to get a glass of water in a utility room for a resident. The station 2 exit door was not visible from the utility room. On 7/15/26 at 11:33 A.M., an observation and interview was conducted with the dietary aide (DA) 1 and DA 2 in the secured unit after delivering a meal cart. Both DA 1 and DA 2 stated it was very important to ensure the secured unit doors were completely closed after they entered and exited the unit to ensure residents did not follow them out. On 7/15/26 at 11:35 A.M., an observation was conducted in the secured unit. The secured unit CNAs and LNs passed out meal trays to the residents' rooms or the dining room. There was no hall monitor observed near the station 2 exit door at this time. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was unaware that a staff from the social services department was supposed to be assigned as the hall monitor routinely from 7:30-8:00 AM Monday through Friday. The SSD stated there should have been no gaps in the hall monitoring schedule for the secured unit. On 7/15/26 at 4:05 P.M., a joint interview and record review was conducted with medical records director (MRD) and medical record assistant (MRA). The MRD and the MRA reviewed the undated AM Monitoring Schedule with 9 CNA. The MRD stated CNAs covered the hall monitor role in the secured unit. MRD stated, We don't do that [hall monitor]. Maybe only when they ask us to do it. The MRA was in agreement with the MRD. The MRD and the MRA both stated neither one of them monitored the hall in the secured unit today between 11:30 A.M.- 12:00 P.M. as scheduled. Both the MRD and the MRA stated they never knew about the hall monitoring until today. On 7/15/26 at 4:38 P.M., a joint interview and record review was conducted with the ADM in the conference room. The administrator in training (AIT) was also present. The AM Monitoring Schedule with 9 CNA was reviewed with the ADM. The ADM stated it was very important to monitor the secured unit exit doors. The ADM stated the hall monitors were used in place of the wander guard. The ADM stated hall monitors should have been devoted to monitoring the halls and exit doors only. The ADM stated the hall monitors should not have had any other duties during their scheduled times. The ADM stated there should not have been any gaps in the hall monitoring schedule. The ADM stated, I can see the loophole [in the monitoring schedule]. The ADM further stated the facility's investigation into Resident 2's elopement should have been more thorough. A review of the facility's policy titled Wandering and Elopement revised March 2019 did not provide guidance related to supervision on the secured unit, monitoring exit alarms, securing the elevator, and Q 15-30 monitoring.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER The Shores Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 resident-specific care plan for one of four residents (Resident 3) when the interdisciplinary team (IDT) did not identify Resident 3's areas of incompatibility with potential roommates. As a result of this deficient practice, Resident 3 and Resident 4 (who were roommates) were verbally aggressive with each other which then led to a physical altercation. Findings: A review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include cognitive communication deficit and major depressive disorder. A review of Resident 4's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include schizoaffective (mental health condition) disorder, bipolar type and anxiety disorders. A review of Resident 4's Minimum Data Set Assessment (MDS - A comprehensive assessment tool) dated 6/23/26 indicated the resident had a Brief Interview of Mental Status score of 14 (a score of 13 to 15 meant the resident was cognitively intact). A review of the facility's undated Resident Abuse Investigation report indicated on 6/23/26, [Resident 3] was yelling. CNA responded and entered room. [Resident 4] also came in and requested [Resident 3] to be silent. [Resident 3] continued yelling. [Resident 4] came to her side of the bed and placed her hand on [Resident 3]'s arm, saying 'be quiet now'. staff members report. [Resident 4] was frustrated with [Resident 3] yelling to begin with and the situation escalated. A review of Resident 4's progress notes dated 6/17/26 indicated the resident was moved into Resident 3's room as a roommate. The progress note did not indicate if both residents had been assessed for roommate compatibility. According to the facility's undated Resident Abuse Investigation Report, Resident 4 was moved out of the room she shared with Resident 3 after the incident on 6/23/26. On 7/15/26 at 9 A.M., an interview was conducted with Resident 3. Resident 3 stated she did not remember what happened when asked about the altercation with her previous roommate (Resident 4). On 7/15/26 at 9:15 A.M., an interview was conducted with certified nursing assistant (CNA) 21. CNA 21 stated Resident 3 was picky and would want to do things on her own. CNA 21 stated Resident 3 would make noise by yanking the curtain when she did not like her roommates. CNA 21 stated this was a known behavior of Resident 3. CNA 21 stated Resident 3 would be quiet when she did not see her roommate (Resident 4). CNA 21 stated Resident 3 would tell Resident 4 to leave the room and get out when Resident 4 wanted to use the bathroom in their shared room. CNA 21 stated staff would escort Resident 4 to the bathroom because of Resident 3's behavior. CNA 21 stated Resident 3 was bedbound and never left the room. CNA 21 stated Resident 3 did not want roommates. CNA 21 stated staff would bring Resident 4 to the smoking area or to the staff area after she used the bathroom to keep Resident 4 away from Resident 3. CNA 21 stated Resident 4 would wait to go back inside their shared room when it was late and when Resident 3 was asleep to avoid an altercation. CNA 21 stated Resident 4 was loud when she talked. CNA 21 stated Resident 4 would say bad words which caused Resident 3 to become agitated. On 7/15/26 at 11:02 A.M., a telephone interview was conducted with CNA 22. CNA 22 stated she was a witness to the altercation between Resident 3 and Resident 4 on 6/23/26. CNA 22 stated Resident 3 was yelling inside the room before the altercation. CNA 22 stated Resident 4 went inside the room while Resident 3 was yelling. CNA 22 stated Resident 4 was agitated and opened her side of the curtain. CNA 22 stated Resident 4 went over to Resident 3, touched her right wrist and told Resident 3 to be quiet. CNA 22 stated Resident 4 got back to her wheelchair and left the room. On 7/15/26 at 11:25 A.M., an interview was conducted with licensed nurse (LN) 21. LN 21 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 3 yelled all the time and did not want any roommates. LN 21 stated Resident 3 always said bad words and would yank the curtain to make noise. LN 21 stated this was a known behavior for Resident 3. LN 21 stated Resident 3 was confused. LN 21 stated Resident 4 had verbal aggression. LN 21 stated Resident 4 and Resident 3 often yelled at each other. On 7/15/26 at 2:20 P.M., an interview and record review was conducted with LN 21. LN 21 stated there was no care plan regarding roommate compatibility with Resident 3. A review of Resident 3's IDT - Comprehensive Resident Support dated 6/24/26 indicated, .After discussions with both residents, it became clear that they were not suitable as roommates. The IDT did not identify what resident traits were incompatible with Resident 3.On 7/15/26 at 3:40 P.M., a concurrent interview was conducted with LN 21 and assistant director of nursing (ADON) 2. ADON 2 stated Resident 4 was not a good fit for Resident 3 as a roommate. ADON 2 stated residents who were alert and cognitively intact, had mental disorders, were ambulatory, and had aggression were not compatible as a roommate for Resident 3. ADON 2 stated the IDT meeting conducted to investigate Resident 3 and Resident 4's altercation on 6/23/26 should have identified the type of residents who were incompatible as a roommate for Resident 3. ADON 2 stated these identified incompatibility traits should have been care planned. ADON 2 stated care planning this roommate incompatibility would prevent further altercations with Resident 3. LN 21 stated she agreed with what ADON 2 had said.On 7/15/26 at 5:10 P.M., an interview was conducted with the administrator (ADM). The ADM stated a care plan should have been developed to prevent future altercations and to promote safety between Resident 3 and her roommates. The ADM stated the IDT should have identified Resident 3's compatibility and incompatibility with residents as roommates.A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised December 2016, indicated, .10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.13. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		