STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555630	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Heights Healthcare Center	4033 Sixth Avenue Ext San Diego, CA 92103

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)

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent a high risk elopement resident (1) from leaving the facility unnoticed. In addition, the facility failed to ensure transfer safety coordination was in place when the facility did not ensure the front entrance was secured and monitored in a manner that prevented the resident from leaving the facility unnoticed.As a result, Resident 1 eloped from the facility and required evaluation and observation in the emergency department (ED) after testing positive for methamphetamine (a highly addictive stimulant drug). The facility's failure to ensure safety coordination of transfer and monitoring resulted in Resident 1 not entering the facility and remained unattended in the community until located by emergency medical services. Resident 1 was admitted to the facility on [DATE] with diagnoses including vascular dementia (memory loss due to poor circulation to the brain) and psychoactive substance abuse (misuse of mind-altering drugs) per the facility admission record. A review of Resident 1's admission elopement assessment dated [DATE] indicated Resident 1 was categorized as a high risk for elopement. The assessment indicated that Resident 1 was ambulatory and had exit seeking behaviors with expressions of wanting to go home. A review of Resident 1's nursing note, dated 10/31/25 at 11:04 A.M., indicated at 10:30 A.M. the medication nurse reported Resident 1 was nowhere to be found, and the resident's roommate reported Resident 1 had verbalized she wanted to go to the welfare office. During an observation of the entrance to the facility on [DATE] at 1:20 P.M., the facility's wooden entry gate was open and the front door, equipped with a keypad lock, was unlocked and could be opened without entering a code. No alarm sounded when the door was opened.During an interview on 11/13/25 at 1:30 P.M. , Resident 1 stated she left the faciity on [DATE] without telling anyone because she did not like living there. Resident 1 stated she walked out through the front door, which she reported was always open and that she could get freely in and out of. Resident 1 stated she did not tell anyone she left, and no one tried to stop her from leaving. Resident 1 stated she left to go to the welfare office to ask about finding another place to live. During an observation and interview with the Maintenance Director (MD) on 11/13/25 at 1:50 P.M., the emergency exit doors closest to Resident 1's room were inspected. The left door of the emergency double doors was not fully shut in alignment with the right door. The MD stated the emergency exit door should have been fully closed for the safety of all clients to ensure the alarm was fully activated. The MD acknowledged if the door was not fully shut the facility could not ensure the alarm was functioning properly. The MD stated the main front entrance was not set up to alarm on opening and was kept unlocked during the day because the facility receptionist is stationed at the front desk to monitor who is entering and exiting. During an interview and record review on 11/13/25 at 2:30 P.M., receptionist (RCPT) 1 stated she worked Monday through Friday from 12:00 PM to 5:00 P.M. and was not working at the time Resident 1 eloped on 10/31/25. RCPT 1 stated receptionists are responsible for monitoring the front doors while stationed at the front desk. RCPT 1 stated residents at risk for elopement have their information and picture placed in the elopement binder kept at the front desk. The elopement binder was reviewed, and Resident 1 was listed in the binder as high risk for elopement. RCPT 1 stated if she saw a high-risk elopement resident listed in the binder attempting to leave, she would try to stop the resident and notify the director of nursing (DON) or charge nurse. During an interview on 11/13/25 at 2:47 P.M., licensed nurse (LN) 1 stated she last saw Resident 1 around 8:00 A.M. on 10/31/25. LN 1 stated she was not aware that Resident 1 was assessed as high risk for elopement.During an interview with certified nursing assistant (CNA) 1 on 11/13/25 at 3 P.M., CNA 1 stated he saw Resident 1 in the dining room around 8:30 A.M. on 10/31/25. CNA 1 was not aware Client 1 was classified as high risk for elopement. A review of Resident 1's nursing note dated 11/1/25 at 5:30 P.M., indicated the hospital [name] notified the facility that Resident 1 was in the emergency department following the resident's elopement of the facility on 10/31/25.A review of hospital ED provider notes dated 11/1/25-11/2/25, indicated, Resident 1 tested positive for methamphetamine intoxication. The notes indicated Resident 1 was a current resident at the facility and discharge and transportation would be arranged with the facility following overnight for observation in the ED. A review of Resident 1's nursing note dated 11/2/25 at 5:45 A.M., indicated that the hospital registered nurse notified licensed nurse (LN) 2 that Resident 1 would be returning to the facility by taxicab. LN 2's note indicated, .staff will be looking out for her transportation and will meet her in the parking lot and bring her inside.A review of nursing notes dated 11/2/25 at 6:45 A.M., indicated that during morning huddle, staff prepared for Resident 1's return. The note indicated an unnamed