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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555723	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Post-Acute	247 E. Bobier Drive Vista, CA 92084

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** 39111 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 1) had a written care plan for falls developed that was individualized with resident-specific interventions. In addition, Resident 1's plan of care to prevent falls was not communicated to all staff responsible for care, monitoring, and supervision of the resident. As a result, there was the potential Resident 1 would fall again and be placed at risk for fall-related injuries. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis to include dementia (a condition characterized by impaired judgement and memory), hallucinations (a false perception of objects or events involving your senses: sight, sound, smell touch, and taste), restlessness and agitation, muscle weakness, and history of falling. On 5/31/24, Resident 1's clinical record was reviewed. Resident 1's progress notes indicated the following: 3/11/24, Resident noted with auditory and visual hallucinations 3/12/24, .Resident is confused 3/18/24, .Found resident kneeling on the floor . Resident stated he wanted to get out of bed so he crawled on the floor. 3/20/24, Resident was found on the floor attempting to crawl. Resident stated he's been there for 2 days and was trying to get his shoes (doesn't have any shoes). Confusion is slightly increased 5/23/24, Resident 1 was sent out to the hospital. 5/26/24, Resident 1 was readmitted . (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: 555723	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Santa Fe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 247 E. Bobier Drive Vista, CA 92084	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/28/24, Fall IDT (interdisciplinary team) note. Resident had a fall from rolling out of bed on 5/27/24 at 11:30 A.M., and new interventions for: Routine CNA (certified nursing assistant) checks to anticipate needs, appropriate time in and out of bed, and environmental set up to promote safe interactions. A review of Resident 1's Minimum Data Set Assessment (MDS, a comprehensive assessment) dated 4/4/24, indicated the resident scored 06 on the brief interview for mental status (a score of 6 meant the resident had impaired cognition). The same MDS assessment indicated Resident 1 could not walk but was physically able to roll side to side in bed on his own. A review of Resident 1's written care plan titled Fall Care Plan dated 5/26/24 and revised 5/28/24, indicated the following interventions to prevent falls: -Call light is within reach and encourage the resident to use it for assistance -Conduct a root cause analysis for incidents of falls -Educate the resident and/or resident representative about safety reminders and what to do if a fall occurs -Encourage resident rest periods -Promote exercise -Therapy screening as needed The care plan did not include the resident's behavior of rolling/crawling out of bed. On 5/31/24 at 10:17 A.M., an observation and interview with Resident 1 was conducted while inside the resident's room. Resident 1 was in bed and covered with a blanket. Resident 1's bed was in a low position with landing mats (device used to cushion a fall) on both sides of the bed. Resident 1 opened his eyes when spoken to and stated that he was not as good as yesterday. When Resident 1 was asked to elaborate on that, he closed his eyes, turned his head, and did not respond. On 5/31/24 at 10:26 A.M., an interview was conducted with mental health worker (MHW) 1. MHW 1 stated she was a regular staff on Resident 1's unit and familiar with Resident 1. MHW 1 stated she provided supervision and monitoring to the residents on the unit. MHW 1 stated she was not sure what landing mats were used for or why Resident 1 had them placed at his bedside. On 5/31/24 at 10:33 A.M., an interview was conducted with CNA 1. CNA 1 stated she was familiar with Resident 1 and that the resident was confused and tried to get out of bed sometimes. CNA 1 stated she was not aware of Resident 1 having any fall incidents. CNA 1 was unsure if Resident 1 needed to use landing mats. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 12:57 P.M., an interview was conducted with CNA 2. CNA 2 stated he was assigned to provide care to Resident 1. CNA 2 stated he was not aware of Resident 1 having had any falls or incidents of rolling out of bed. CNA 2 stated he received a shift report (information essential to provide safe resident care) from the night shift CNA. CNA 2 stated he did not get any information about Resident 1's fall risk or behavior and of crawling out of bed. CNA 2 stated there was no shift report from the licensed nurses (LN). CNA 2 further stated it was his first time to provide care to Resident 1. On 5/31/24 at 1:08 P.M., an interview was conducted with LN 3. LN 3 stated Resident 1 had a behavior of crawling out of bed. Resident 1's fall care plan interventions were discussed with LN 3. LN 3 stated Resident 1 was too confused and was not able to recall and apply education about safety reminders or what to do for a fall. LN 3 stated Resident 1 was not capable of using the call light. LN 3 stated Resident 1's written fall care plan was not individualized to his specific needs and abilities and did not address his behavior of rolling or crawling out of bed which led to falls. LN 3 stated keeping the resident's bed low, use of fall mats, frequent CNA monitoring, and anticipation of the resident's needs would be resident-specific. LN 3 stated everyone on the unit should be aware of Resident 1's behavior of rolling out of bed and what interventions are being used to prevent this type of fall. On 5/31/24 at 1:25 P.M., a joint interview and record review was conducted with LN 4. LN 4 stated staff could talk to Resident 1 about the call light but, He can't actually use it. He can't press it. LN 4 reviewed Resident 1's clinical record and stated the resident had one active fall care plan dated 5/26/24 and revised 5/28/24. LN 4 reviewed the interventions and stated the written care plan was not individualized and should have been. On 5/31/24 at 2:14 P.M., an interview was conducted with the director of nursing (DON). The DON stated Resident 1's written fall care plan should have been individualized and resident-specific. The DON stated it was her expectation that all staff working on Resident 1's unit were knowledgeable of the resident's plan of care to prevent falls. On 5/31/24 at 3:25 P.M., a joint interview and record review was conducted with the DON. The administrator was also present. The DON reviewed Resident 1's clinical record and verified Resident 1 had one active fall care plan dated 5/26/24 and revised 5/28/24. The DON acknowledged the resident's written fall care plan had been revised again today. The DON acknowledged Resident 1 had three fall incidents since admission by rolling or crawling out of bed. The DON acknowledged the interventions that were added today should have been placed on the written care plan on 5/26/24 and/or 5/28/24 as the resident could have experienced further falls since then. The DON then stated the written care plan for falls should have included individualized interventions to address Resident 1's behavior of rolling/crawling out of bed. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised March 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident