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	02/06/2025

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28183 Based on interview and record review, the facility failed to conduct a comprehensive skin assessment on one resident (1) upon return from an Emergency Department (ED) visit after a change of condition As a result, ECG (electrocardiogram-a test that measures electrical activity of the heart; also known as EKG) stickers from a prior ED visit remained undetected on the resident's skin for a period of one week. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder (mental health disorder that affects cognitive abilities) and dysphagia (difficulty swallowing), per the resident's Admission Record. The clinical record was reviewed on 1/13/25. According to the Progress Notes, Resident 1 was sent to the ED on 12/24/24 for a change in condition. The resident returned back to the facility the same day. There was no skin assessment documented upon Resident 1's return. The next documented skin assessment was six days later, on 12/30/24, in the Skilled Nursing Weekly Summary. The skin assessment indicated the resident's skin was warm (normal) and dry. In addition, the assessment indicated there were no new skin conditions noted. On 12/31/24, according to the Progress Notes, Resident 1 was sent to the ED for a change of condition. The resident was admitted to the hospital and had not returned to the facility. The hospital clinical records were reviewed on 1/31/25. According to an ED Nursing Note, dated 12/31/24, Upon assessment - areas of hyperpigmentation with superficial skin evulsions present. Stickers from prior EKG's remained on patient .Patient was seen in this hospital in November and also recently 12/24. Suspected non removal of cardiac leads from prior visits. The ED physician documented in the ED Provider Note, dated 12/31/24, When nursing evaluated patient, they found EKG stickers still on the patient from when she was in the emergency department 7 days ago. (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
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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a hospital Wound Care Progress Note, dated 12/31/24, Patient noted with erythematic reaction to what appears to be ECG stickers, skin intact and epithelialized in 6 areas on mid chest and left chest. When interviewed on 1/13/25 at 1:12 P.M., Certified Nursing Assistant (CNA 1) stated that she assisted with giving Resident 1 a bedbath on 12/25/24. According to CNA 1, she saw just one ECG sticker on the resident. CNA 1 stated I only saw one. It was on the right upper chest. Nothing else on her body. CNA 1 further stated she thought the sticker was for some testing and that the nurses already knew about it, so she did not report it. On 1/13/25 at 2:15 P.M., Registered Nurse (RN 1) stated during an interview, I do a full body check upon admit and on shower days or if any changes. But I would check upon return from the ED anyways. Anything can happen in the ED. RN 2 stated during an interview on 1/13/25 at 2:25 P.M., that nurses do weekly checks, including skin assessment, for the weekly summary. In addition, nurses do a full body check on admission and if a resident has been out more than 24 hours. More than 24 hours is considered a readmission. RN 2 further stated, We don't do [skin assessments] daily or every shift, we have so many residents, that's our reality. It's long term. We also rely heavily on the CNAs to communicate anything during showers. The Director of Nursing (DON) stated during an interview on 1/13/25 at 2:35 P.M., You still have to do your head-toe assessment [upon return from the hospital], even if it's been less than 24 hours. That's the expectation. It's best nursing practice. You need to check because things could happen while resident is at the hospital. According to the facility's nursing policy, Prevention of Pressure Injuries, last revised April 2020, Conduct a comprehensive skin assessment upon (or soon after) admission .Inspect the skin on a daily basis when performing or assisting with personal cares or ADLs.