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	09/04/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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 0641 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 did not accurately assess and code the Minimum Data Set (MDS-Federally required assessment) for one of three residents (Resident 1) reviewed for pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). As a result, Resident 1's MDS was sent to the federal database with inaccurate information about Resident 1's health status.Cross-Reference F686Findings:A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] and discharged to the hospital on 8/13/25 with diagnoses which included a history of Paroxysmal Atrial Fibrillation (describes a fast, irregular heartbeat that only lasts a few hours or days).On 8/19/25 at 12:43 P.M., a review of Resident 2's records titled, admission initial skin assessment (AISA), dated 5/13/25 was conducted. The AISA indicated no pressure ulcers was identified on admission with .no history of skin conditions/issues. documented by a LN 2. On 8/19/25, a review of Resident 2's minimum data set (MDS-Federally required assessment), dated 5/20/25, indicated Resident 2 required substantial/maximal assistance (the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility to include rolling left to right, lying to sitting at the side of the bed and was dependent (helper does all the effort) with toileting hygiene. On 8/19/24, a review of document titled, Daily Skilled Charting dated 5/13/25 was documented as rash by a LN 2.On 8/19/24, a review of document titled, Braden Scale (a tool that healthcare providers use to figure out how likely someone is to get a pressure sore) dated 5/19/25 documented by LN 2, indicated a score of 15 as .at risk. for pressure ulcers.On 8/19/25, a review of document titled, Skin and Wound-Total Body assessment dated [DATE] documented by LN 1 indicated, .1 new wound. On 8/19/25, a review of the Minimum Data Set (MDS-Federally required assessment) dated 5/20/25 indicated, Resident 2 had a stage II pressure ulcer (Partial-thickness loss of skin, presenting as a shallow open sore or wound). On 8/19/25, a review of a change of condition titled, eINTERACT SBAR dated 5/27/25 at 7:20 AM, documented by LN 2 indicated .Pressure ulcer SACRAL [triangular-shaped bone located at the base of the spine that forms the posterior wall of the pelvis] REGION Stage 2.On 8/19/25, a review of document titled, Pressure Ulcer Care Plan initiated on 8/11/25, documented by LN 2 indicated .Has a Pressure Ulcer.unstageable ulcer [deep wound that can't be properly assessed because it's covered by a layer of dead, dead tissue, which obscures the extent of the damage beneath] to sacral coccyx [tail bone] with MASD [moisture associated skin damage] At Risk For Further Impairment.On 8/19/25, a review of the Physician's Order dated, 6/2/25 at 14:09 (2:09 PM), indicated .treatment sacral coccyx.(Stage II).SNF [Skilled Nursing Facility] wound care eval [evaluation] and tx [treatment].On 8/19/25, a review of the Physician's order note dated, 6/16/25 at 11:30 (AM), indicated, .treatment sacral coccyx.(Stage II). SNF wound care eval and tx. On 8/19/25, a review of a change of condition documentation titled, eINTERACT SBAR dated 7/7/25 7:20 A.M., indicated .snf wound care eval and tx stage II to Sacral coccyx. On 8/19/25, a review of a Physician's Order dated 8/11/25, indicated .sacral coccyx topically every day shift for (unstageable ulcer).On 8/19/25, a review of the Shower Day Inspection document dated 7/29/25, signed by a Certified Nursing Assistant (CNA) indicated .redness on bottom complain about pain.On 8/20/25 at 11:47 A.M. an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated he was one of the wound nurses for the facility. LN 1 stated Resident 2's initial admission assessment on 5/13/25 did not indicate Resident 2 had a pressure ulcer. LN 1 stated the progress note documented on 5/13/25 by LN 2 indicated that Resident 2 had a rash to the sacrum and did not indicate measurements. LN 1 stated he came in the next morning (5/14/25) to check Resident 2's sacrum and stated Resident 2 had a new wound which he did not stage with measurements of 5.3cm [centimeters] x5.6cm. LN 1 stated he was not with the wound Nurse Practitioner (NP) to confirm the pressure ulcer and was not a Registered Nurse (RN) to assess the wound and would only stage pressure ulcers with the wound NP. LN 1 stated on 7/7/25 the wound NP healed Resident 2's stage II pressure ulcer on the sacrum and reclassified the pressure ulcer as an MASD. LN 1 stated on 8/11/25 Resident 2's pressure ulcer re-opened and was assessed by the wound NP and staged as an unstageable pressure ulcer to the sacrum, with measurements of 3.3cm x1.9cm. LN 1 stated Resident 2's care plan was updated on 8/11/25 to reflect the unstageable pressure ulcer. LN 1 stated wound treatment on Resident 2's sacrum was missed on 8/8/25. LN 1 stated the wound NP usually came on Mondays to conduct wound rounds and see new admissions. LN 1 stated the first NP wound assessment for Resident 2 was completed on 7/7/25. LN 1 acknowledged it was important to

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 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 assess, stage, and provide timely wound care interventions for pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), for two of three residents (Resident 2 and Resident 3) reviewed when:1. Resident 2's initial admission assessment documented a rash on the sacrum (triangular-shaped bone located at the base of the spine that forms the posterior wall of the pelvis) and was staged later as a Stage II pressure ulcer (Partial-thickness loss of skin, presenting as a shallow open sore or wound) on the sacrum, (one month and three weeks) after admission on [DATE] by a Licensed Nurse and Nurse Practitioner (NP).2. Resident 3's initial admission assessment did not properly identify a stage III pressure ulcer (full-thickness loss of skin. Dead and black tissue may be visible) on the right (R) hip on admission and was later staged by a Nurse Practitioner (NP).As a result, Resident 2 and Resident 3's treatment and wound interventions were delayed for wound healing, increased pain, infection and preventable worsening of pressure injuries. Cross-Reference F641 Findings:1. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] and discharged to the hospital on 8/13/25 with diagnoses which included a history of Paroxysmal Atrial Fibrillation (describes a fast, irregular heartbeat that only lasts a few hours or days).On 8/19/25 at 12:43 P.M., a review of Resident 2's records was conducted that indicated: The document titled, admission initial skin assessment, dated 5/13/25, indicated no pressure ulcers was marked on admission with .no history of skin of skin conditions/issues. Resident 2's minimum data set (MDS-Federally required assessment), dated 5/20/25, indicated Resident 2 required substantial/maximal assistance (the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with bed mobility to include rolling left to right, lying to sitting at the side of the bed and was dependent (helper does all the effort) with toileting hygiene. A document titled, Daily Skilled Charting dated 8/13/25 was documented as Rash.A document titled, Braden Scale (a tool that healthcare providers use to figure out how likely someone is to get a pressure sore) dated 5/19/25, indicated a score of 15 as .at risk. for pressure ulcers.The Skin and Wound assessment dated [DATE] indicated, .1 new wound. The Minimum Data Set (MDS-Federally required assessment) dated 5/20/25, indicated, Resident 2 had a stage II pressure ulcer on admission [DATE]).A change of condition titled eINTERACT SBAR dated 5/27/25 at 7:20 AM, indicated .Pressure ulcer SACRAL [triangular-shaped bone located at the base of the spine that forms the posterior wall of the pelvis] REGION Stage 2.A review of document titled, Pressure Ulcer Care Plan initiated on 8/11/25, indicated .Has a Pressure Ulcer.unstageable ulcer to sacral coccyx [tail bone] with MASD [moisture associated skin damage] At Risk For Further Impairment.A Physician's Order dated, 6/2/25 at 14:09 (2:09 PM), indicated .treatment sacral coccyx.(Stage II).SNF [Skilled Nursing Facility] wound care eval [evaluation] and tx [treatment].A Physician's order note dated, 6/16/25 at 11:30 (AM), indicated, . treatment sacral coccyx.(Stage II). SNF wound care eval and tx. A change of condition documentation titled eINTERACT SBAR dated 7/7/25 7:20 A.M., indicated .snf wound care eval and tx stage II to Sacral coccyx. A Physician's Order dated 8/11/25, indicated .sacral coccyx topically every day shift for (unstageable ulcer).A Shower Day Inspection document dated 7/29/25, indicated .redness on bottom complain about pain.On 8/20/25 at 11:47 A.M. an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 stated he was one of the wound nurses for the facility. LN 1 stated Resident 2's initial admission assessment on 5/13/25 did not indicate Resident 2 had a pressure ulcer. LN 1 stated the progress note documented on 5/13/25 by LN 2 indicated that Resident 2 had a rash to the sacrum and did not indicate measurements. LN 1 stated he came in the next morning (5/14/25) to check Resident 2's sacrum and stated Resident 2 had a new wound which he did not stage with measurements of 5.3cm [centimeters] x 5.6cm. LN 1 stated he was not with the wound NP to confirm the pressure ulcer and was not a Registered Nurse (RN) to assess the wound and would only stage pressure ulcers with the wound NP. LN 1 stated on 7/7/25 treatment was provided to Resident 2's sacrum and it was healed. Resident 2's wound sacrum was reclassified as stage II pressure ulcer. LN 1 stated on 8/11/25 Resident 2's pressure ulcer re-opened and was assessed by the wound NP and classified as an unstageable pressure ulcer to the sacrum, with measurements of 3.3cm x1.9cm. LN 1 stated Resident 2's care plan was updated on 8/11/25 to reflect the unstageable pressure ulcer. LN 1 stated on 8/8/25 the treatment was not provided on Resident 2's sacrum according to the treatment administration record (TAR). LN 1 stated the wound NP usually came on Mondays to conduct wound rounds, see new

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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)

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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 and ensure timely reporting of an elopement to CDPH (California Department of Public Health) for one of three sampled residents (Resident 1) reviewed during a complaint investigation.This deficient practice placed Resident 1 at risk for serious injury, harm or death due to unsafe wandering, potential exposure to traffic-related injuries, falls, or becoming lost in the community. Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included a history of non-traumatic intracerebral hemorrhage (a type of stroke [brain attack] where bleeding occurs within the brain's tissue not caused by head injury).A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 8/8/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of three points out of 15 possible points which indicated Resident 1 had severe cognitive (pertaining to memory, judgement and reasoning ability) deficits. On 8/19/25 at 2:10 P.M., an interview was conducted with Resident 1, in Resident 1's room. Resident 1 stated he left the facility alone just recently but unable to remember the date and stated he walked up and down the street to go to the store but had no money. Resident 1 stated a male staff that he did not remember followed him and brought him back to the facility.On 8/20/25 at 4:17 P.M., an interview and record review was conducted with the Social Service Assistant (SSA). The SSA stated that the former Social Service Director (SSD) had told her that Resident 1 was trying to go to a restaurant to get something to eat. The SSA stated they did not report Resident 1's elopement incident to law enforcement, ombudsman and California Department of Public Health (CDPH) because Resident 1 did not disappear. The SSA stated the Mental Health Worker (MHW) had followed Resident 1 out of the facility then brought Resident 1 back to the facility.On 8/20/25 4:59 P.M., an interview was conducted with the MHW. The MHW stated he was on break at [Fast-Food Place Name] when he saw Resident 1 wandering the area alone. The MHW stated he did not see any staff members following Resident 1 and Resident 1 was unsupervised at the time of the incident. The MHW stated when he tried to catch up to Resident 1 he tried to grab Resident 1 but he had already crossed the street. The MHW stated Resident 1 could have gotten hit by ongoing traffic. The MHW stated once he caught up to Resident 1 on the other side of the street he had called the facility to notify them of the incident. On 8/22/25 at 11:53 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated Resident 1 was assigned to her the day of the elopement incident (8/3/25). CNA 2 stated she last saw Resident 1 at around 9AM in the facility patio eating breakfast. CNA 2 stated she went on break at 10AM and heard about the incident after her lunch break. CNA 2 stated she was informed that Resident 1 had eloped and that MHW brought Resident 1 back to the facility.On 8/26/25 10:26 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1 did not have an out of facility pass due to his cognitive capacity with brain trauma to be unsupervised and leave the facility. The DON stated Resident 1 was vulnerable to injuries during the elopement episode which could have impacted the welfare, safety, and well being of Resident 1. The DON stated her expectation was for the facility to report Resident's 1's elopement episode to the proper entities (law enforcement, ombudsman and CDPH) because this exposed Resident 1's safety to ongoing traffic accidents and injuries during the elopement episode.A review of the facility's policy and procedure titled, Unusual Occurrence Reporting (undated), indicated .As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors .Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.