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	09/24/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 82 residents on the behavioral health unit (BHU, an area of the building that housed residents with mental and psychosocial disorders [syndromes characterized by a clinically significant disturbance in an individual's cognition, emotion, regulation, or behavior]) were protected from physical abuse when:1) Resident 1 stopped taking her Zyprexa (an antipsychotic medication [medication that helps to reduce the symptoms of psychosis, such as hallucinations, delusions, and disorganized thinking]) on 8/25/25 and a written plan of care was not developed to monitor and prevent potential inappropriate and aggressive behaviors resulting from stopping Zyprexa.2) Resident 1 slapped Resident 2 in the face on 9/5/25 and a written plan of care was not developed timely to prevent further incidents of abuse.3) Resident 1 made threatening gestures and threw her lunch tray at her roommate (Resident 3) on 9/9/25 while unsupervised. 4) Resident 1 continued to have escalating physically aggressive and threatening behaviors on 9/7 and 9/9/25 and interventions to closely supervise the resident and prevent further behavioral escalations were not developed and implemented.As a result, Resident 2 and Resident 3 expressed fear of Resident 1 and stated they did not feel safe. Furthermore, these failures to provide adequate supervision to Resident 1 while she experienced escalating behaviors and demonstrated impulsive physical aggression posed an immediate jeopardy to the safety and well-being of the other 82 residents on the BHU. Findings:On 9/10/25 at 9:09 A.M., an onsite visit was conducted to investigate an allegation of physical abuse that occurred on 9/5/25 between Resident 1 and Resident 2. A review of the facility's Census dated 9/10/25, indicated there were 83 residents in the BHU.A review of Resident 1's admission Record dated 9/10/25, indicated the resident was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar type (a chronic mental health condition characterized by extreme mood swings between manic and depressive episodes). A review of Resident 2's admission Record dated 9/10/25, indicated the resident was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia (a subtype of schizophrenia characterized by persistent delusions and hallucinations, primarily of a persecutory or threatening nature). A review of Resident 3's admission Record dated 9/11/25, indicated the resident was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia and schizoaffective disorder, bipolar type. A review of Resident 1's physician orders indicated the resident was to receive:Zyprexa 20 mg (milligrams) by mouth at bedtime (order dated 2/21/25).Zyprexa 10 mg by mouth twice a day, give intramuscular (IM) injection if resident refused oral dose (order dated 8/28/25).Zyprexa 10 mg to be given IM every 24 hours if resident refuses oral dose (order dated 8/28/25).Zyprexa 10 mg to be given IM every 12 hours if resident refuses oral dose (order dated 9/2/25).A review of Resident 1's Medication Administration Record (MAR) for August and September 2025 for Zyprexa indicated:8/1 through 8/24/25 the resident took her Zyprexa as ordered. 8/25/25 the resident refused her Zyprexa.8/26/25 the resident refused her Zyprexa.8/27/25 the resident refused her Zyprexa.8/28/25 the resident refused her Zyprexa.8/29 through 9/11/25 the resident took some Zyprexa on and off but did not consistently take the full ordered dosage in a 24-hour period. A review of Resident 1's MAR for May, June, and July 2025 indicated the resident was monitored for behavioral manifestations. Resident 1 was monitored for abrupt change in mood (anger outbursts), constant refusal of care, and auditory hallucinations (voices telling to hurt herself). Resident 1 had zero incidents of behavioral manifestations in May, June, July, and August 1 through 27 2025. A review of Resident 1's August and September 2025 MAR indicated the following behavioral manifestations on:8/28/25 Four incidents of constant screaming/yelling profanities at others and two incidents of refusing care. 8/29/25 Four incidents of constant screaming/yelling profanities at others, three incidents of anger outbursts, and five incidents of refusing care. 8/30/25 Two incidents of screaming/yelling profanities and one incident of anger outbursts. 8/31/25 Three incidents of screaming/yelling profanities and two incidents of anger outbursts. 9/1/25 Two incidents of screaming/yelling profanities and two incidents of anger outbursts.9/2/25 One incident of screaming/yelling profanities and one incident of anger outbursts.9/3/25 Three incidents of screaming/yelling profanities and three incidents of anger outbursts.9/4/25 Five incidents of screaming/yelling profanities, six incidents of anger outbursts, and five incidents of refusing care. 9/5/25 Thirteen incidents of screaming/yelling profanities, twelve incidents of anger outbursts, seven incidents of refusing care, and

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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 0605 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 interview and record review, the facility failed to: 1. Have resident - specific and appropriate indications for behavior monitoring for two of three residents' (Resident 1 and Resident 3) antipsychotic medications (a medication used to control thoughts, mood, and behavior).2. Administer Resident 1's PRN (as needed) Intramuscular (IM) Zyprexa (antipsychotic medication) at the correct times as ordered nine times. As a result, the residents were at risk for receiving unnecessary antipsychotic medications. In addition, there was the potential for Resident 1 and Resident 3 to not have their right to refuse care be respected. Findings: A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar type (a chronic mental health condition characterized by extreme mood swings between manic depressive episodes). A review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia and schizoaffective disorder, bipolar type. 1. A review of Resident 1's physician order dated 10/7/24, indicated Behaviors/ Side Effects Monitoring Record for Zyprexa: Monitor Episodes of Schizoaffective as evidenced by constant refusal of care every shift. A review of Resident 3's physician order dated 5/3/25, indicated Behaviors/ Side Effects Monitoring Record for Haldol (antipsychotic medication): Monitor episodes of schizoaffective, manifested by refusal of care every shift.On 9/11/25 at 2:41 P.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 6. LN 6 reviewed Resident 1's physician order dated 10/7/24, indicated Behaviors/ Side Effects Monitoring Record for Zyprexa: Monitor Episodes of Schizoaffective as evidenced by constant refusal of care every shift. LN 6 stated behavior monitoring was used to determine the effectiveness of antipsychotic medications. LN 6 stated all residents had the right to refuse care. LN 6 stated antipsychotic medications should not be given to make residents comply with care as this would be a potential chemical restraint. LN 6 stated it was not appropriate to monitor the resident's refusal of care as an indication of Resident 1's antipsychotic effectiveness. LN 6 stated it would have been more appropriate to monitor Resident 1 for aggression and agitation related to the resident's psychosis (a mental health state where a person has a lost touch with reality, making it difficult to think, behave, or understand what is real). On 9/15/25 at 1:33 P.M., a concurrent interview and record review was conducted with the Mental Health Case Manager (MHCM). The MHCM reviewed Behaviors/ Side Effects Monitoring Record for Resident 1's Zyprexa. The MHCM stated that behavior monitoring was used to determine the effectiveness of antipsychotic medications and if the medication needed to be increased or decreased. The MHCM stated residents had the right to refuse care, we can't force anyone, and it should not be used to determine if antipsychotic medications were working. On 9/24/25 at 1:32 P.M., a concurrent interview and record review was conducted with the DON. The DON reviewed Resident 1's Behaviors/ Side Effects Monitoring Record for Zyprexa: Monitor Episodes of Schizoaffective as evidenced by constant refusal of care every shift and Resident 3's Behaviors/ Side Effects Monitoring Record for Haldol: Monitor episodes of schizoaffective, manifested by refusal of care every shift. The DON stated refusing care was a resident's right. The DON stated Resident 1 and Resident 3's behavior monitoring was too broad and should have been resident specific as to what care refusal was being monitored. A review of the facility's policy titled Psychotropic Medication Use revised July 2022, indicated, 3.d. adequate monitoring for efficacy.A review of the facility's policy titled Resident Rights revised December 2016, did not provide guidance on refusal of care. 2. A review of Resident 1's physician orders indicated:Zyprexa oral tablet 10 MG (milligrams) twice a day at 9A.M. and 6 P.M. for psychotic disorder and to give IM if the resident refuses (order dated 8/28/25). Zyprexa 10 MG IM every 24 hours PRN if the resident refused the oral Zyprexa dose (order dated 8/28/25). Zyprexa 10 MG IM every 12 hours PRN if the resident refused the oral Zyprexa dose (order dated 9/2/25).A review of Resident 1's Medication Administration Records (MAR) for August and September 2025 for Zyprexa indicated:8/29 the resident refused her oral Zyprexa at 9 A.M. and 6 P.M. and Zyprexa 10 MG IM was administered at 4:26 A.M. 9/1 the resident refused her oral Zyprexa at 9 A.M. but took her 6 P.M. dose. Zyprexa 10 MG IM was administered at 8 P.M. 9/2 the resident refused her oral Zyprexa at 9 A.M. and 6 P.M. and Zyprexa 10 MG IM was administered at 11:49 A.M. 9/4 the resident refused her oral Zyprexa at 9 A.M. and 6 P.M. and Zyprexa 10 MG IM was administered at 1:07 P.M. 9/5 the resident refused her oral Zyprexa at 9 A.M. and 6 P.M. and Zyprexa 10 MG IM was administered at 11:57 A.M. 9/6 the resident

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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 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. (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 0656 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 interview and record review, the facility failed to develop two residents' (Resident 1 and Resident 2) care plan in a timely manner after an incident of physical abuse on 9/5/25. As a result, Resident 1 and Resident 2 were at risk for potential delays of treatment and care.Findings: A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar type (a chronic mental health condition characterized by extreme mood swings between manic depressive episodes). A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia (a subtype of schizophrenia characterized by persistent delusions and hallucinations, primarily of a persecutory or threatening nature). A review of Resident 1's progress note dated 9/5/25 at 9:15 P.M., indicated that Resident 1 unprovokingly slapped Resident 2 in the face. Resident 1's Abuse Allegation Care Plan was reviewed on 9/10/25 and indicated that the care plan category of alleged abuse was started on 9/5/25 while the care plan goals and interventions were created on 9/10/25, five days after Resident 1 slapped Resident 2. Resident 2's Abuse Allegation Care Plan was reviewed on 9/10/25 and indicated that the care plan category of alleged abuse was started on 9/5/25 while the care plan goals were created on 9/10/25 and interventions were blank. On 9/11/25 at 9:55 A.M., a concurrent interview and record review was conducted with the Nursing Supervisor (NS). The NS reviewed Resident 1's Abuse Allegation Care Plan and stated that the care plan category alleged abuse was developed on 9/5/25 while the care plan goals and interventions were created on 9/10/25. The NS stated the interventions should have been developed and started on 9/5/25 when Resident 1 slapped Resident 2. The NS stated the care plan interventions were to be used to address the protection of other residents from Resident 1 after the incident. On 9/11/25 at 10:41 A.M., a concurrent interview and record review was conducted with Assistant Director of Nursing (ADON). The ADON reviewed Resident 1's Allegation Abuse Care Plan started on 9/5/25 and stated she started the resident's care plan with interventions the night of 9/5/25 while teleworking. The ADON stated the interventions in the care plan did not save in the electronic medical record (EMR). On 9/15/25 at 1:33 P.M., a concurrent interview and record review was conducted with the Mental Health Case Manager (MHCM). The MHCM reviewed Resident 1's Allegation of Abuse Care Plan created on 9/5/25 and interventions that were created on 9/10/25. The MHCM stated the care plan interventions were not developed timely and they should have been developed and implemented on the day of the incident (9/5/25). The MHCM stated 9/10/25 was too far out and would not prevent further occurrences of potential abuse. The MHCM reviewed Resident 2's Allegation of Abuse Care Plan created on 9/5/25 and interventions dated 9/10/25. The MHCM stated the care plan was developed late, and it should have been developed on the day of the incident (9/5/25). The MHCM stated the incident could cause Resident 2 to be triggered and act out. The MHCM stated this was developed late and maybe it's a [computer] glitch, too. On 9/17/25 at 8:15 A.M., a telephone interview was conducted with the Medical Record Director (MRD). The MRD stated any EMR glitches or problems with medical record must be reported to the Information Technology department to resolve the problems. The MRD stated she should have been made aware of any issues and glitches in their EMR that affected the residents' care plans. The MRD stated she was not aware of any recent issues with the EMR or glitches with resident care plans. On 9/24/25 at 1:32 P.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated after the incident on 9/5/25, there should have been Interdisciplinary Team (IDT) discussion and monitoring of Resident 1's behavior. The DON care plan should have been developed and implemented on the day of the incident. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised December 2016, indicated, .1. Person-centered care plan for each resident.10. targeted and meaningful to the resident.13. Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 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 interview and record review, the facility failed to provide the necessary behavioral health care and services to one of three residents (Resident 1) when: 1) Resident 1 stopped taking her Zyprexa (an antipsychotic medication [medication that helps to reduce the symptoms of psychosis, such as hallucinations, delusions, and disorganized thinking]) on 8/25/25 and a written plan of care was not developed to monitor and prevent potential inappropriate and aggressive behaviors resulting from stopping Zyprexa.2) Resident 1 continued to have escalating physically aggressive and threatening behaviors on 9/5, 9/7, and 9/9/25 and interventions to closely supervise the resident and prevent further behavioral escalations were not developed and implemented.As a result, Resident 1 was unable to maintain her highest practicable physical, mental, and psychosocial well-being. Cross reference F600. Findings: A review of Resident 1's admission Record dated 9/10/25, indicated the resident was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar type (a chronic mental health condition characterized by extreme mood swings between manic and depressive episodes). A review of Resident 1's physician orders indicated the resident was to receive:Zyprexa (antipsychotic medication used to control thoughts, mood, and behavior) 20 mg (milligrams) by mouth at bedtime (order dated 2/21/25).Zyprexa 10 mg by mouth twice a day, give intramuscular (IM) injection if resident refused oral dose (order dated 8/28/25). Zyprexa 10 mg to be given IM every 24 hours if resident refused oral dose (order dated 8/28/25).Zyprexa 10 mg to be given IM every 12 hours if resident refused oral dose (order dated 9/2/25).A review of Resident 1's Medication Administration Records (MAR) for August and September 2025 for Zyprexa indicated:8/1 through 8/24/25 the resident took her Zyprexa as ordered. 8/25/25 the resident refused her Zyprexa.8/26/25 the resident refused her Zyprexa.8/27/25 the resident refused her Zyprexa.8/28/25 the resident refused her Zyprexa.8/29 through 9/11/25 the resident took some Zyprexa on and off but did not consistently take the full ordered dosage in a 24-hour period. A review of Resident 1's MAR for May, June, and July 2025 indicated the resident was monitored for behavioral manifestations. Resident 1 was monitored for abrupt change in mood (anger outbursts), constant refusal of care, and auditory hallucinations (voices telling to hurt herself). Resident 1 had zero incidents of behavioral manifestations in May, June, July, and August 1 through 27 of 2025. A review of Resident 1's August and September 2025 MAR indicated the following behavioral manifestations on:8/28/25 Four incidents of constant screaming/yelling profanities at others and two incidents of refusing care. 8/29/25 Four incidents of constant screaming/yelling profanities at others, three incidents of anger outbursts, and five incidents of refusing care. 8/30/25 Two incidents of screaming/yelling profanities and one incident of anger outbursts. 8/31/25 Three incidents of screaming/yelling profanities and two incidents of anger outbursts. 9/1/25 Two incidents of screaming/yelling profanities and two incidents of anger outbursts.9/2/25 One incident of screaming/yelling profanities and one incident of anger outbursts. 9/3/25 Three incidents of screaming/yelling profanities and three incidents of anger outbursts.9/4/25 Five incidents of screaming/yelling profanities, six incidents of anger outbursts, and five incidents of refusing care. 9/5/25 Thirteen incidents of screaming/yelling profanities, twelve incidents of anger outbursts, seven incidents of refusing care, and seven incidents of auditory hallucinations.9/6/25 Two incidents of screaming/yelling profanities and four incidents of anger outbursts. 9/7/25 Nine incidents of screaming/yelling profanities and nine incidents of anger outbursts.9/8/25 Two incidents of screaming/yelling profanities and four incidents of anger outbursts.9/9/25 Three incidents of screaming/yelling profanities and two incidents of anger outbursts.9/10/25 Seven incidents of screaming/yelling profanities, seven incidents of anger outbursts, and six incidents of refusing care.9/11/25 Five incidents of screaming/yelling profanities, five incidents of anger outbursts, two incidents of refusing care, and three incidents of combative features striking at others. A review of Resident 1's clinical record indicated the resident did not have a written Plan of Care to address her refusal to take Zyprexa as ordered and interventions that were put in place to monitor and address potential behavioral manifestations resulting from not taking her Zyprexa. A review of Resident 1's Progress Notes indicated:On 8/25/25 at 8:14 A.M., Resident is refusing her medications. On 8/28/25 at 9:57 A.M., (Change of condition note) . [Resident 1] refusing all medications and exhibiting manic behavior, yelling at other residents. On 9/1/25 at 9:16 P.M., Resident noted with increased agitation, yelling and hitting staff, refused her psychotropic medication, Zyprexa, despite of explanation [sic] of risks and benefits. On 9/5/25 at

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Invega Sustenna (a long-acting antipsychotic medication that helps rebalance certain brain chemicals to reduce or control severe mental health symptoms) for Resident 1 for three months. As a result, there was the potential for Resident 1 to experience mental health symptoms. Findings: A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar type (a chronic mental health condition characterized by extreme mood swings between manic depressive episodes). A review of Resident 1's physician order dated 6/1/24, indicated Invega Sustenna Intramuscular Suspension Prefilled Syringe 234 MG (milligram)/1.5 ML (milliliter) give intramuscularly at bedtime to be given on the first of the month for schizoaffective disorder. A review of Resident 1's Medication Administration Record (MAR) for Invega from 5/1/25 through 7/31/25 indicated:5/1/25 was coded as 5 which meant Hold/See Progress Notes. 6/1/25 was coded as 11 which meant Med [medication] not available. 7/1/25 was also coded as 11.On 9/15/25 at 1:33 P.M., a concurrent interview and record review was conducted with the Mental Health Case Manager (MHCM). The MHCM reviewed Resident 1's Invega MAR and progress notes for 5/1/25. The Progress Note indicated, Invega IM injection not available, re-ordered from pharmacy and one time order in place to be administered once delivered. NP [Nurse Practitioner] made aware. The MHCM reviewed Resident 1's clinical record and stated the Invega was not administered in May. The MHCM stated the LN should have followed up with the provider for further direction and documented the discussion. The MHCM reviewed Resident 1's Invega MAR and progress notes for 6/1/25 and stated that Invega was not available to give at that time. The MHCM reviewed Resident 1's clinical record and stated the Invega was not administered in June and there was no documentation that the provider was notified. The MHCM stated the LN should have followed up with the provider for further direction and documented the discussion. The MHCM reviewed Resident 1's Invega MAR and progress notes for 7/1/25 and stated that Invega was not available to give at that time. The MHCM reviewed Resident 1's clinical record and stated the Invega was not administered in July and there was no documentation that the provider was notified. The MHCM stated the LN should have followed up with the provider for further direction and documented the discussion. The MHCM stated Resident 1 should have consistently received her Invega as it was ordered. On 9/24/25 at 1:32 P.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON reviewed Resident 1's Invega MAR for May to July 2025 and stated she expected the nurse to notify the DON if a medication was not available. The DON stated when the nurse notified the provider on 5/1/25 about Invega being unavailable, the nurse should have obtained further instructions from the provider. The DON stated Resident 1's Invega order should have been followed, and the medication should have been provided to the resident.A review of the facility's policy titled Administering Medications revised April 2019 indicated, .4. Medications are administered in accordance with prescriber orders. The policy did not provide guidance related to ordered medication unavailability.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	09/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three residents' (Resident 1 and Resident 3) clinical records were complete and accurate when: 1. Resident 1's provider progress reports and nursing notes related to the resident's medical condition were not available in the clinical record in a timely manner. 2a. Resident 1 had over 100 blank entries in her Medication Administration Record (MAR) from 5/1/25 through 9/15/25. 2b. Resident 3 had over 20 blank entries in her MAR from 8/1/25 through 9/15/25.3. Resident 1's MAR indicated the resident was at the hospital on 8/31/25 when she was not. 4. Resident 1's Psychiatric Nurse Practitioner's (NP) Psychiatric Assessment Progress Report dated 9/5/25 was inaccurate. As a result, it could not be determined what care and treatment was provided for Resident 1 and Resident 3. Findings:A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar type (a chronic mental health condition characterized by extreme mood swings between manic depressive episodes). A review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia and schizoaffective disorder, bipolar type. 1. A review of the provider order for Resident 1 indicated lithium (a medication used to manage acute manic, for the long-term maintenance treatment of bipolar disorder) was discontinued on 8/29/25. On 9/11/25 at 2:41 P. M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 6. LN 6 reviewed Resident 1's clinical record and stated Resident 1's refusal of her lithium started on 8/25/25 and the medication was discontinued on 8/29/25. LN 6 stated there was no documentation that indicated a rationale for the discontinuation of lithium. LN 6 stated there was no documentation of who discontinued the lithium. LN 6 stated if a nurse was discontinuing a medication, the nurse was expected to document a note of the provider communication. LN 6 reviewed Resident 1's progress note dated 8/28/25 at 9:57 A.M., which indicated that a nurse notified the primary provider of the resident's change in condition. The note indicated that the resident was refusing all her medications and was exhibiting manic behavior and yelling at other residents. The note indicated that the primary care provider recommended Resident 1 to be seen by the psychiatric NP. LN 6 stated there was no documentation that the resident was seen by the facility's psychiatric NP after Resident 1's change of condition until 9/6/25. LN 6 stated that when there was a change of condition, the resident should be seen by a psychiatric provider within 24 hours.On 9/15/25 at 1:33 P.M., a concurrent interview and record review was conducted with the Mental Health Case Manager (MHCM). The MHCM reviewed Resident 1's Psychiatric Assessment Progress Report dated 8/29/25, .Given her [Resident 1's] repeated refusal of the medication [lithium].the decision was made to discontinue lithium at this time. The MHCM stated this document was uploaded to Resident 1's medical record on the evening of 9/11/25. The MHCM acknowledged Resident 1's psychiatric documentation was not available in the resident's clinical records timely and stated that this was unacceptable. The MHCM stated psychiatric NP's documentation could take up to three weeks for the facility to receive them. The MHCM acknowledged that taking weeks for the facility to receive clinical documentation was unacceptable. The MHCM also stated the nurse who rounded with the psychiatric provider should have documented what took place while rounding. 2a. A review of Resident 1's MAR for Behaviors/ Side Effects Monitoring Record May first through September fifteenth 2025, indicated that the record had over 100 combined blank entries on the following days:5/3, 5/5,5/7,5/20, 5/23, 6/3,6/9,6/16,7/1,7/16,7/26,8/7,8/13,8/16,8/20,8/30, 9/1,9/8,9/9, and 9/11/25.On 9/11/25 at 2:41 P.M., a concurrent interview and record review was conducted with LN 6. LN 6 reviewed Resident 1's MAR for Behaviors/ Side Effects Monitoring Record May first through September fifteenth 2025 and stated there should not have been any blanks in resident's monitoring records. 2b. A review of Resident 3's MAR for Behaviors/ Side Effects Monitoring Record August first through September fifteenth 2025 indicated that the record had over 20 combined blank entries on the following days:8/13,8/16,8/21,8/30,9/1,9/11, and 9/15/25. On 9/17/25 at 8:15 A.M., a telephone interview was conducted with the Medical Record Director (MRD). The MRD stated the MAR should not have blanks. The MRD stated the MAR should not have blank entries because the facility would be unable to determine what care and treatment was provided to the residents. 3. A review of Resident 1's August 2025 MAR for Zyprexa (antipsychotic medication) was coded 6 which meant that the resident was hospitalized on 8/31/25. On 9/15/25 at 1:33 P.M., a concurrent interview and record