

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  02/02/2026
NAME OF PROVIDER OR SUPPLIER  Santa Fe Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide adequate supervision and monitoring for one resident (1) who was a known high risk for elopement (an unsupervised, undetected, and unauthorized departure from the facility). As a result, Resident 1 left the facility unnoticed and was gone for seven days. This failure had the potential harm for Resident 1 from environmental exposure from cold weather, physical injuries from accidents, and medical emergencies. Findings: Resident 1 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar type (mental health condition that is marked by a mix of schizophrenia (a severe mental disorder affecting a person's thoughts, feelings, and behavior, often leading to a disconnection with reality) symptoms, such as hallucinations (a false or distorted perception of sensory experiences- seeing, hearing, smelling, tasting, or feeling things that are not present), delusions (false belief that is not based in reality and remains unchanged despite clear contradictory evidence), and mood disorders and epilepsy (brain condition that causes recurring seizures), per the facility's 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, Resident 1 was fully ambulatory and had expressed desire to leave the facility. A review of LN (licensed nurse) 1 progress note, dated 12/28/25 at 10:50 A.M., indicated LN 1 was unable to locate Resident 1 in assigned room. LN1 conducted a search of the dining area and common spaces with negative results. LN 1 notified the assigned CNA (certified nursing assistant) 1 of the inability to locate Resident 1. CNA 1 reported to LN 1 that Resident 1 frequently ambulates independently throughout the facility and typically returns on his own. A review of the IDT (Interdisciplinary Team) meeting notes, dated 12/29/25 at 2 P.M., indicated Resident 1's prior elopement risk score was 18 based on the assessment dated [DATE]. An updated elopement risk assessment was completed on 12/28/25 and remained at 18. Per the facility's Skilled Nursing - admission Initial Eval, If Total Score was 10 or greater, Resident was considered an Elopement Risk. A review of LN 2 progress note, dated 12/29/25 at 3:06 P.M., indicated Resident 1 had a known history of leaving AWOL (absence without leave/notice) from other nursing facilities, board and cares, and Acute care hospitals as reported by Resident 1's Conservator. On 2/2/26 at 11:49 A.M., an interview was conducted with CNA 1. CNA 1 reported that Resident 1 was independent, walked on his own, and frequently moved between the dining room, patio, and his room throughout the day. CNA 1 stated he was assigned to Resident 1 on 12/28/25, from 6:30 A.M. through 2:30 P.M. CNA 1 stated Resident 1 was last seen in his room around 7 A.M., while taking his (Resident 1) vital signs (measuring temperature, pulse, respiratory rate). On 12/28/25 at 11 A.M., CNA 1 was informed by LN1 that Resident 1 could not be located. CNA 1 stated he went to the dining room/activity area but did not see Resident 1. CNA 1 stated he did not look further and went back to complete his assigned scheduled task (residents room sweep on Sundays). CNA 1 stated he finished his scheduled task at approximately</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1:30 P.M. CNA 1 stated at approximately 2:15 P.M., Resident 1 was not in his room during his rounds. CNA1 stated he was unaware that Resident 1 was an elopement risk. CNA 1 stated Code [NAME] (missing resident) was activated before he left the facility on [DATE]. On 2/2/26 at 12:15 P.M., an interview was conducted with CNA 2. CNA 2 stated she was familiar with Resident 1's care and worked on 12/28/25 but not assigned to Resident 1. CNA 2 stated Resident 1 would wander around the building throughout the day. Resident 1 would stay in the dining area and outside patio. CNA 2 stated from the patio a resident could go out to the street through the service/delivery gate. CNA 2 reported that the gate was open during the day. CNA 2 stated that she was not aware that Resident 1 was an elopement risk. CNA 2 stated residents at risk for elopement have their information and picture placed in the elopement binder kept at the nurses' station and front desk. On 2/2/26 at 1:30 P.M., an interview was conducted with the Director of Staff Development (DSD). On 1/4/26 at 3 P.M., a staff member found Resident 1 near the 7/11 store. DSD went to the store and spoke to Resident 1. The DSD stated Resident 1 appeared clean, alert, and responded appropriately. Resident 1 told the DSD that he wanted to go back to the facility but did not know how. Law enforcement was notified, and Resident 1 was transferred to an acute hospital before being readmitted to the facility on [DATE]. On 2/2/26 at 1:55 P.M., an interview was conducted with Resident 1. Resident 1 was re-admitted to a secured unit. Resident 1 was alert and verbally responsive. Resident 1 stated he remembered leaving the facility without telling anyone. Resident 1 stated he was at the patio area and went through the opened service/delivery gate to the street. Resident 1 stated he was found by the facility staff, brought to the hospital and came back to the facility. On 2/2/26 at 3:45 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1 was alert and oriented with a BIM (Brief Interview for Mental Status - cognitive assessment) score of 15. The DON acknowledged Resident 1 was assessed as high risk for elopement on the initial admission assessment, dated 6/5/24. The DON stated residents at high risk for elopement have their pictures and information placed in the elopement binder at the nurses' station and front desk. The DON stated Resident 1 was not listed as a high risk for elopement. The DON stated staff should have visually monitored residents at least every hour. On 2/2/26 at 4 P.M., a concurrent observation of the service/delivery gate and interview was conducted with the Administrator (ADM). The gate was opened. The ADM stated the gate was open during the day and closed at night. The ADM stated the gate should be locked after hours, but during the day time it was open for delivery. A review of the facility's policy and procedures titled, Wandering and elopement, dated 3/19, indicated. The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p>		