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	03/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate monitoring and supervision to a known high-risk resident (1) for elopement (an unsupervised, undetected, and unauthorized departure from the facility). As a result, Resident 1 left the facility unnoticed through the room window for the second time. This failure exposed Resident 1 to potential harm, including cold weather environmental exposure, physical injuries from accidents, and medical emergencies. Findings: Resident 1 was admitted to the facility on [DATE] in the secured unit, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bipolar disorder (a mental health condition that causes extreme mood swings), opioid dependence (uncontrollable need to use drugs such as prescription pain relievers, heroin, or fentanyl) ,and alcohol dependence (uncontrollable need to drink alcohol) , per the facility's admission record. A review of Resident 1's admission elopement risk score was 14, based on the assessment dated [DATE]. An updated elopement risk assessment was completed on 12/30/25, after his first elopement, and the score was 16. Per the facility's Skilled Nursing Risk Determination Evaluation, if the total score is 10 or greater, the resident was considered an elopement risk. A review of Resident 1's BIMS (Brief Interview for Mental Status- screening tool used to evaluate a patient's cognitive function) dated 3/6/26, indicated Resident 1 had a score of 15. A score of 15 indicated that Resident 1 demonstrated full cognitive function. A review of the IDT (Interdisciplinary Team - different types of staff work together to share expertise, knowledge, and skills to impact on patient care) meeting dated 3/16/26, indicated on 3/13/26 at approximately 11:55 P.M., Resident 1 was not in his room and the window was found open and screen was removed. A review of Resident 1' care plan was conducted.On 7/23/25, an initial wandering/elopement care plan was created, related to attempts to exit unit unattended, ETOH (alcohol abuse), and mental health illness. Interventions included: Resident educated on notification and supervision if needed to go outside of the unit, safe and hazard free environment, and structured activities provided. On 12/3/25, an actual elopement care plan for first elopement was created when Resident 1 exited through the window in his room. Interventions included discharged planning, 1:1sitter until evaluated by the psychiatrist nurse practitioner, every 30 minutes monitoring, moved to another room, social services to discuss elopement, and on going assessment and evaluation by the psychiatrist nurse practitioner. On 3/13/26, an actual elopement care plan for second elopement was created when Resident 1 exited through the window in his room. Interventions included alarms installed inside and outside windows, room door to remain open at all times, every 30 minutes check, social services to discuss elopement, and on going assessment and evaluation by the psychiatrist nurse practitioner. On 3/23/26 at 1:40 P.M., an interview was conducted with Resident 1. Resident 1 was in his room, lying on his bed. Resident 1 was alert and oriented. Resident 1 acknowledged that he left the facility through the window for the second time. Resident 1 stated he waited and left after the staff made their rounds. Resident 1 stated he left at around 11 P.M. Resident 1 stated I will not be able to leave the facility through the window next time since they put an alarm in the window. Resident 1 stated the police found him in the nearby [name of (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 03/23/2026
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the store] convenience store and brought him back to the facility. Resident 1 stated he was only out for a short time. Resident 1 stated he might have come back around midnight On 3/23/26 at 4:54 P.M., a telephone interview was conducted with LN1 (Licensed Nurse). LN 1 stated Resident 1 was alert and oriented. Resident 1 was ambulatory but at times would use a walker. LN 1 reported at midnight on 3/13/26, Resident 1 was not on his room and found the window was open. On 3/23/26 at 5:30 P.M., an interview was conducted with the DON (Director of Nursing) and BHD (Behavioral Health Director). Both the DON and BHD stated Resident 1 was alert and oriented. The DON stated every 30 minutes monitoring was discontinued after the team developed a plan. On 4/1/26 at 5:40 P.M., a telephone interview was conducted with LN 2. LN 2 stated, on 3/13/26 at 11 P.M., Resident 1 was in his room. Around 11:30 P.M., Resident 1 was not in his room and found the window was open. LN 2 stated she contacted law enforcement. The police found Resident 1 in the nearby [name of the store] convenience store. LN 2 stated Resident 1 came back around midnight. LN 2 stated when Resident 1 came back in his room, he put back the screen in the window and closed the window. On 4/1/26 at 6:46 P.M., a telephone interview was conducted with CNA 2 (certified nursing assistant). CNA 2 stated he worked on 3/13/26 and was assigned to Resident 1. CNA 2 stated that around 11- 11:20 P.M., he saw Resident 1 walking in the hallway near his room. CNA 2 stated he stationed himself in the hallway near Resident 1's room. CNA 2 stated LN 3 went to Resident 1's room around midnight and found Resident 1 was not in his bed and room. CNA 2 stated he entered the room and found the window open. CNA 2 stated Resident 1 came back around 1 A.M. and that CNA 2 stated he was stationed at Resident 1 for the rest of his shift. 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.