STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055407	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cupertino Healthcare & Wellness Center	22590 Voss Avenue Cupertino, CA 95014

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44583 Based on observation, interview and record review, the facility failed to implement their elopement care plan for one of three sampled residents (Resident 1). This failure had the potential to result in another incident of Resident 1's elopement to unsafe place. Findings: Review of Resident 1's face sheet (summary page of a patient's important information) dated 8/2/2024, indicated, Resident 1 was admitted to the facility with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and mental functions), dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning) with mood disturbance and history of falling. Review Resident 1's Elopement (to leave without notification or permission) Evaluation, dated 3/28/2024, indicated a score of 5 (Score value of 1 or higher indicates Risk of Elopement). Review of Resident 1's minimum data set (MDS, an assessment tool) quarterly assessment, dated 6/28/2024, indicated, Resident 1 had memory problems with short term and long-term memory. Further review indicated the following: Resident 1 had wandered in 1-3 days, used wheelchair for locomotion and she was just supervised with transfers. Review of Resident 1's Change in Condition Evaluation dated 6/18/2024, indicated, Resident 1 used a different wheelchair without the wanderguard (small device placed on the ankle or wrist of a resident, alarms to notify the staff if a resident tries to leave the facility) and was able to wheel herself outside the facility. Resident 1 was found at the corner of the facility's street and main street. Resident 1 did not sustain any injuries. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with licensed vocational nurse A (LVN A) on 7/31/2024 at 12:39 p.m., inside Resident 1's room, Resident 1 was seated on her wheelchair, eating her lunch. LVN A confirmed there was a wanderguard placed under Resident 1's wheelchair. LVN A confirmed Resident 1 had an elopement on June. LVN A stated, Resident 1 transferred herself to another resident's wheelchair without a wanderguard and was able to go out of the facility without triggering the alarm. LVN A further stated, their plan of care was to apply a purple ribbon in her wheelchair for staff to be aware that Resident 1 was on a right wheelchair. During this observation, there was no purple ribbon on Resident 1's wheelchair. LVN A was surprised not to find the purple ribbon on Resident 1's wheelchair. LVN A stated there should be purple ribbons on Resident 1's wheelchair handles as their plan of care to prevent another elopement. During a concurrent interview with director of nursing (DON) and record review on 7/31/2024 at 2:56 p.m., DON reviewed Resident 1's care plan about wandering and elopement dated 6/28/2024. DON confirmed the new intervention for Resident 1 elopement prevention was to have a ribbon on her wheelchair to determine that she was sitting on a right wheelchair. DON confirmed Resident 1 could transfer to another wheelchair without any physical assistance. DON stated nurses should follow Resident 1's care plan. During a follow up concurrent phone interview with DON and record review on 8/9/2024 at 2:48 p.m., DON stated she did not recall a 6/28/2024 intervention regarding Resident 1's elopement prevention. DON reviewed Resident 1's elopement care plan again and stated, staff should follow the plan of care for resident's safety. Review of Resident 1's care plan with problem, Resident tends to wander the facility, and switches into different wheelchairs. Resident needs wheelchair with wanderguard, dated 6/28/2024, indicated in one of the interventions, Resident's assigned wheelchair has two purple ribbons tied on the arm rest. During a review of the facility's policy titled, Wandering and Elopement, dated 2/10/2023, indicated, The Facility will identify residents at risk for elopement upon admission and when there is a change in condition to minimize the risk of elopement. Purpose: To enhance the safety of residents of the Facility.