STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055497	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Placerville Healthcare Center	1040 Marshall Way Placerville, CA 95667

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 - Some	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** 44971 Based on observation, interview, and record review, the facility failed to prevent an avoidable accident for one of 90 residents (Resident 1), when: 1. Resident 1 eloped from the facility, fell , sustained injuries, was found by police and transferred to a hospital, 2. Three out of four main entrance/exit doors had a non-functional or semi-functional wanderer monitoring system; and 3. Resident 1's wander guard physician order and elopement care plan were not followed. These failures decreased the facility's potential to maintain residents' safety. Findings: A review of an admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including traumatic subdural hemorrhage (bleeding between brain and skull) with loss of consciousness, cerebral infarction (disrupted blood flow to the brain), cognitive communication deficit, surgery on the nervous system, major depressive disorder, delirium (an altered state of consciousness characterized by episodes of confusion), alcohol dependence, muscle weakness, and abnormalities of gait and mobility. Admission record further indicated Resident 1's wife was the Responsible Party (RP). A review of Resident 1's Brief Interview for Mental Status (BIMS), dated 5/23/24, indicated BIMS score was six out of 15 indicating severe impairment in cognition and memory. A review of Resident 1's Elopement Risk Observation/Assessment, dated 5/20/24, indicated Resident 1's elopement risk score was 12 indicating he was at risk for elopement. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's Fall Care Plan, dated 5/21/24, indicated Resident 1 was at risk for falls related to altered mental status, visual and hearing impairment, unsteady gait, altered balance while standing and/or walking, decreased muscle coordination, antidepressants, history of orthostatic blood pressure (a sudden drop in blood pressure when standing up from sitting or lying down), history of falls, seizure (neurological disorder), Parkinson's disease (brain disorder that causes uncontrollable movements) and dehydration. A review of Resident 1's Order Summary Report, dated 5/29/24, indicated Resident 1 received 30 milligrams (mg; a unit of measure) of Duloxetine (antidepressant), 150 mg of lithium carbonate (mood stabilizer), 0.5 mg of lorazepam (treats anxiety and sleep problems), 15 mg of mirtazapine (antidepressant) and 100 mg of trazodone (antidepressant). 1. A review of Resident 1's 72-Hour Charting, dated 5/22/24 at 10:54 a.m., indicated Resident 1 had gross confusion and was wandering around trying to find his mom. The note further indicated Resident 1 was placed in activities to be monitored for elopement and safety. A review of Resident 1's 72-Hour Charting, dated 5/22/24 at 4:01 p.m., indicated Resident 1 was re-directed several times due to wandering into other residents' rooms and attempted elopement to go see his mom. A review of Resident 1's Social Service Note, dated 5/23/24, indicated Resident 1 was attempting to exit the back door of the building, noted to wander into other residents' rooms looking for unrealistic items or people, and attempted to elope from the building a couple times as well. The note further indicated Resident 1's BIMS score was six and was noted to be confused and forgetful. A review of Resident 1's Medication Administration Note, dated 5/26/24, indicated Resident 1 was confused at the end of night shift and refused to take his medication. A review of Resident 1's Nurse's Note, dated 5/26/24 at 3:41 p.m., indicated Resident 1 had increased confusion and was asking when his wife will come and when his car will be fixed. A review of Resident 1's Nurse's Note, dated 5/26/24 at 4:43 p.m., indicated Resident 1 was on alert charting for increased confusion and monitoring his location. The note further indicated Resident 1 walked the halls every now and then. A review of Resident 1's Nurse's Note, dated 5/26/24 at 6:40 p.m., indicated at approximately 6:45 p.m. Resident 1's wife was looking for her husband and he was not in his room. Staff searched for Resident 1 and did not find him. The note further indicated staff called the police when Resident 1's wife was made aware by another resident that her husband took a ride. A review of Resident 1's Nurse's Note, dated 5/26/24 at 8:29 p.m., indicated at approximately 8:15 p.m. the police officer returned to the facility and informed staff that Resident 1 was found, had a fall, and was transported to the emergency room . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a document titled, On-Line Health Facility Complaint, dated 5/27/24, indicated Resident 1 recently had a head surgery, was taken away from the facility without staff knowledge and then disappeared. Facility staff was unable to locate Resident 1 for nearly two hours. After an hour searching, police located Resident 1 at the bottom of a ravine with extensive injuries. The document further indicated the date and time of event was on 5/26/24 at 6:59 p.m. A review of Resident 1's Emergency Department (ED) Provider Note, dated 5/26/24, indicated Resident 1 presented to the ED with falls after being found down maybe about a mile from his potential care facility. Resident 1 was a missing person from his skilled nursing facility. Physical exam indicated Resident 1 had minor abrasion and contusion (bruise) to his right frontal area of head and multiple small skin tear lacerations (deep cuts) on bilateral forearms. ED note further indicated Resident 1 was a little bit confused and did not remember how he got out the facility and why he got into the place where he was found by the police. A review of Resident 1's Nurse's Note, dated 5/26/24 at 11:45 p.m., indicated Resident 1 returned from hospital around 11:45 p.m. via ambulance with several skin tears on his left forearm, right arm, and top of head. During an interview on 5/29/24 at 10:40 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 was confused and always wandered around looking for his wife. During an interview on 5/29/24 at 10:47 a.m. with Licensed Nurse 1 (LN 1), LN 1 stated Resident 1 was confused, wandered a lot looking for his mom, wanted to go to the East Bay, and wandered into other residents' rooms and the facility's back exit door in hall 2 because he could not find his room. During an interview on 5/29/24 at 11:37 a.m. with CNA 2, CNA 2 stated Resident 1 was super confused and wandered a lot into other residents' rooms. During a concurrent observation and interview on 5/29/24 at 10:26 a.m. in Resident 1's room, Resident 1 had two wander guards on bilateral ankles and skin tears on bilateral wrists, left forearm, and above right elbow. Resident 1 stated he left the facility walking through the facility's main entrance door, took a car ride with a man, and went to town. Resident 1 added the man dropped him off on the road and the road was brushy so he slipped, fell , and hurt his arms. Resident 1 further stated the fire department helped him and took him to the hospital, took care of his wounds, and returned him back to the facility. During an interview on 5/29/24 at 12:07 p.m. with Resident 1's wife, the wife stated she arrived to the facility on [DATE] around 6:15 p.m. and did not find her husband. Wife added staff had no idea where her husband went and were unable to see through the facility's cameras what time he left, how he left, and with whom. The wife added the police found her husband down a hill where he fell on a bike trail and took him to hospital because he hurt his head and arms. The wife further stated her husband was confused, unable to make clear decisions, unaware of the risks and benefits of leaving the facility, and confirmed she was the RP. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's Interdisciplinary IDT Note, dated 5/28/24, indicated Resident 1 left the facility against medical advice (AMA) by taking a ride from roommate's friend, was not discharged immediately, and 911 was called. Resident 1 was found and sent to ED after falling while out of facility. Resident 1 was examined by speech therapist using The St. Louis University Mental Status (SLUMS) exam and scored nine out of 30 (indicating cognitive impairment). IDT note further indicated Resident 1's wife was the RP. During an interview on 5/29/24 at 3:30 p.m. with the Director of Nursing (DON), DON stated Resident 1's wife notified the nurses her husband was missing, nurses called the police, and the police found him with sustained fall and injuries. DON added a friend of Resident 1's roommate took him outside the facility and dropped him in the neighborhood. DON further stated Resident 1 was not discharged AMA from the facility because the police found him, and even though he was confused, at risk for elopement, did not sign the AMA form, and staff did not call him or explain to him the AMA leave's risks and benefits, she would still consider it as an AMA leave and not elopement because he was deemed capable of making decisions as per physician order upon admission. During an interview on 5/29/24 at 3:55 p.m. with the Administrator (ADM), ADM stated Resident 1's elopement, fall, and sustained injuries were not an unusual occurrence. ADM further stated Resident 1's leave was AMA and not an elopement because he was deemed capable of making decisions as per physician order upon admission, even though he was confused, at risk for elopement, staff did not know what time he left the facility, and the facility's cameras did not catch through which door he left through and with whom. 2. During an observation on 5/29/24 at 10:26 a.m., Resident 1's room was located close to the facility's back exit door in hall 2. During a concurrent observation and interview on 5/29/24 at 11 a.m. with LN 1, Resident 1 walked through the facility's back exit and main entrance doors in hall 1. Both door alarms were activated with low sound when Resident 1 walked through. LN 1 confirmed the back exit door alarm's sound was low and the main entrance door alarm's sound was very low. LN 1 stated the door alarm sounds were barely heard and low, staff might not hear it, and Resident 1 might go outside the facility without being noticed especially during day where it could be very busy and crowded. During a concurrent observation and interview on 5/29/24 at 11:15 a.m. with Restorative Nurse Assistant 1 (RNA 1), Resident 1 walked through the facility's back exit and main entrance doors in hall 1. Both door alarms were activated with low sound when Resident 1 walked through. RNA 1 confirmed the back exit door alarm's sound was low and the main entrance door alarm's sound was very low. RNA 1 stated it was hard to hear the sounds of door alarms and Resident 1 could have walked outside the facility without being noticed by staff. During a concurrent observation and interview on 5/29/24 at 11:25 a.m. with the Maintenance Director (MD), MD tested the facility's door alarms using a testing wander guard: - The facility's back exit door alarm in hall 1 was activated with low sound. MD confirmed the door alarm was low and stated it was hard to hear it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The facility's main entrance door alarm in hall 1 was activated with very low sound. MD confirmed the door alarm was very low and stated he could barely hear the sound while standing at the door. MD further stated anybody could have walked outside the facility without being noticed because the sound of the alarm was very low. - The facility's back exit door alarm in hall 2 was not activated. MD stated the door alarm was not functional, was aware of that, and he applied a temporary back-up system to alert staff when a resident walks through the door. MD opened the door, and the back-up system was not activated. MD confirmed both the door alarm and back-up system were not activated and functional and stated, someone forgot to turn on the back-up system. - MD stated RNAs were supposed to check the functionality of the residents' wander guards and facility's door alarms and to notify MD about the low sound of alarms. MD further stated the low sound of door alarms in hall 1 and the non-functional and deactivated back exit door alarm systems in hall 2 were both a non-acceptable practice. During an interview on 5/29/24 at 3:30 p.m. with the DON, DON confirmed both door alarms in hall 1 had low sounds and the back exit door alarm in hall 2 was not working. DON stated the door alarms' sound was barely heard and residents who wander could have walked outside the facility without staff's notice. DON added Resident 1 had an injury after he left the facility and fell , and nurses were not aware of what happened to him. DON further stated staff should have checked the wander guards and doors and notified the MD if they were not working or could barely hear its sound. A review of the facility's policy and procedure (P&P) suggestions from Code Alert titled, Wanderer Monitoring System, dated 1999, indicated The Code Alert System should be checked at a minimum on a weekly basis for proper operation .Transmitter should be brought to the area .Attempt to open door. The alarm should sound .A documented log book should be kept of these testings. P&P further indicated .an in-house staff member .will be responsible for the routine weekly testing of each door system and will be responsible for communicating any changes with the system with other staff members .Each admission is to have a wandering assessment .If admission is found to be at risk, they are to be outfitted with a transmitter. 3. A review of Resident 1's Elopement Care Plan, dated 5/23/24, indicated Resident 1 was at risk for elopement/exiting seeking due to altered cognitive status, forgetfulness, episodes of delusions (a belief that is clearly false that indicates an abnormality in the affected person's content of thought), and diagnosis of subdural hemorrhage. Care plan further indicated staff will monitor Resident 1's whereabouts frequently, equip him with a device that alarms when he wanders, and check for proper functioning of device and alarms every shift. A review of Resident 1's Elopement Care Plan, dated 5/28/24, indicated staff will check door alarms promptly to ensure safety. A review of Resident 1's Order Summary Report, dated 5/29/24, indicated a wander guard was to be placed for Resident 1's safety since 5/21/24. The report further indicated on 5/28/24, staff started to check the battery function and placement of Resident 1's wander guard on his left ankle. A review of Resident 1's IDT Note, dated 5/28/24, indicated new orders for placing wander guard on Resident 1's left leg. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an untitled log, dated 5/24, indicated staff started to check Resident 1's wander guard on 5/28/24. During an interview on 5/29/24 at 10:40 a.m. with CNA 1, CNA 1 stated she worked with Resident 1 before he eloped from the facility and was unaware if he had a wander guard on his legs because she did not check them. During a concurrent observation and interview on 5/29/24 at 10:51 a.m. with LN 1, LN 1 confirmed Resident 1 had two wander guards on his bilateral ankles and stated she was not sure why he had two wander guards. LN 1 further stated she signed Resident 1's wander guard order without checking it, had no option but to sign the order, and she relied on the RNA to check the wander guard's functionality and battery status because it was not her responsibility. During a concurrent observation and interview on 5/29/24 at 11:11 a.m. with RNA 1, RNA 1 confirmed Resident 1 had two wander guards and stated she was not aware he had two wander guards on his ankles. RNA 1 further stated RNAs started checking Resident 1's wander guard on 5/28/24 and were not checking it before that date. During an interview on 5/29/24 at 3:30 p.m. with the DON, DON confirmed Resident 1 had an order for wander guard since 5/21/24, was at risk for elopement, and his elopement care plan indicated staff should have applied a wander guard and checked it for proper functioning every shift. DON stated she did not know if Resident 1 had a wander guard on the day he eloped and was unsure why he currently had two wander guards on his ankles. DON further stated the nurses should have discontinued Resident 1's order and care plan if he refused or had no wander guard; otherwise, the order and care plan should have been followed. A review of the facility's policy titled, Wandering and Elopements, dated 10/23, indicated The facility will identify residents who are at risk of unsafe wandering and provide interventions to decrease the risk and keep resident safe. If identified as at risk for wandering, elopement, will be provided to maintain the resident's safety .If a resident is missing, initiate the elopement/missing resident emergency procedure: Determine if the resident is out on an authorized leave or pass .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .report findings and conditions of the resident .