STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055649	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tulare Healthcare & Wellness Center, LP	680 East Merritt Avenue Tulare, CA 93274

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 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)

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 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 observation, interview, and record review, the facility failed to implement care plan intervention for one of three sampled residents (Resident 1) with a known history of elopement (the act of leaving facility unsupervised and without prior authorization) attempts. This failure resulted in Resident 1 leaving the facility unsupervised and without a wander guard (wearable bracelet that detects resident with cognitive impairments approaches or attempts to exit), putting Resident 1 at risk for serious injury.Findings:During a review of Resident 1's admission Record (AR), undated, the AR indicated Resident 1 was admitted on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Change of Condition (COC) note dated 7/2/25, at 2:09 p.m. the COC indicated, Resident eloped from facility . resident was last seen at 1 p.m. in hallway. resident was found by CNA (Certified Nursing Assistant) by Burger King. Resident 1's Elopement Evaluation dated 5/1/25. indicated Resident 1 has a history of elopement or attempted leaving the facility without informing staff. Resident 1's quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/16/25 indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 9 (8-12 moderate cognitive impairment).During a review of Resident 1's care plan, date initiated 2/2/24, the care plan indicated Resident 1 Risk for Wandering/Elopement Identified. Intervention included Monitor for placement and function of wander guard every shift.Wander guard to be placed on resident every shift.During a concurrent observation and interview on 7/3/25 at 12:13 p.m. with Resident 1, Resident 1 was standing at nurse station, drinking coffee, and talking on the phone. Resident 1 does not recall leaving the facility stating he goes outside to smoke.During an interview on 7/3/25 at 12:35 p.m. with Administrator, Administrator stated on 7/2/25, Resident 1 was seen at 1 p.m. in the facility hallway, and at 1:50 p.m. Resident 1 was seen outside of the facility walking on the street unsupervised. Administrator stated Resident 1 was alert with confusion.During an interview on 7/21/25 at 10:46 a.m. with Director of Nurses (DON), DON stated on 7/2/25, Certified Nursing Assistant (CNA 1) last saw Resident 1 in the facility at 1:50 p.m. Resident 1 was seen by CNA 2 walking unsupervised approximately 0.2 miles away from the facility.During an interview on 7/21/25 at 12:11 p.m. with CNA 1, CNA 1 stated on 7/2/25, she had seen Resident 1 in the hallway at 1 p.m. without a wander guard. CNA 1 stated Resident 1 was alert with confusion and has a history of trying to exit the facility unsupervised.During an interview on 7/24/25 at 3:08 p.m. with Licensed Vocational Nurse (LVN), LVN stated on 7/2/25, at 1:50 p.m. Resident 1 was found walking in the street away from the facility. LVN stated Resident 1 was not wearing a wander guard. LVN stated at approximately 12 p.m. on 7/2/25, she had noticed Resident 1 not wearing a wander guard. LVN stated she was not responsible in replacing missing wander guard and therefore did not put a new wander guard on Resident 1 when she noticed it was missing. LVN stated Resident 1's elopement could have been prevented if a wander guard was placed on him.During an interview on 7/25/25 at 9:52 a.m. with DON, DON stated it was facility protocol to immediately replace wander guard on resident when removed. DON stated Resident 1 was not wearing his ordered wander guard when found walking in the street away from the facility.During a review of the facility policy and procedures (P&P) titled, Resident Safety dated 4/21, the P&P indicated, I. During a comprehensive assessment period the Interdisciplinary [NAME] (IDT) members will assess the Resident's safety risk (e.g., smoking, self-administration, wandering, elopement, behaviors issues, etc.) as well as any other Resident specific safety risk. III. After a risk evaluation is completed, a Resident-centered care plan will be developed to mitigate safety risk factors. During a review of the facility P&P, titled, Comprehensive Person-Centered Care Planning, dated 2018, the P&P indicated, b. The Baseline Care Plan Summary (NP-04-Form B) will be developed and implemented, using the necessary combination of problem specific care plans.