STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056428	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Nursing & Rehabilitation Center	2299 North Indian Canyon Drive Palm Springs, CA 92262

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure for two of three residents, Residents 1 and 2, the plan of care was reviewed and updated after Residents 1 and 2 attempted to elope (when a patient leaves a healthcare facility without supervision or detection while they are unable to protect themselves) from the facility. This failure resulted in Resident 1 eloping from the facility on November 18, 2024, and had the potential to result in Resident 2 eloping from the facility. Findings: On November 5, 18, and 19, 2024, unannounced visits were conducted at the facility to investigate complaint allegations. On November 18, 2024, a review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of cognitive functioning, such as thinking, remembering, and reasoning, that interferes with daily life). A review of Resident 1's History and Physical dated May 6, 2024, indicated Resident 1 can make needs known but cannot make medical decisions. A review of Resident 1's Elopement Evaluation dated August 23, 2024, on PointClickCare (PCC - an electronic health record) indicated he was at risk for elopement. A review Resident 1 ' s care plan titled, The resident has a behavior problem attempted to leave the facility, dated August 19, 2024, indicated Resident 1 had an actual attempt to leave the facility on August 19, 2024, and he eloped on November 18, 2024. A review Resident 1 ' s care plan titled, Risk for Wandering / Elopement Identified with an initiated date of August 19, 2024, indicated Resident 1 had an episode of elopement on September 4, 2024, and three episodes of elopement on August 19, 2024. A review of Resident 1 ' s care plan titled Resident had an episode of non-compliance and attempted to leave the facility on October 27, 2024, and November 2, 2024. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 18, 2024, a review of Resident 2 ' s electronic health information on PointClickCare (PCC) indicated the following: -Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia and was identified at risk for elopement. -The Minimum Data Set (MDS - an assessment tool) dated August 17, 2024, indicated Resident 2 had moderate cognitive impairment. -The physician ' s order indicated Resident 2 had an order of .Wander Guard (sic) (bracelet worn by the resident that triggers alarms on doors to alert staff if a resident leaves a safe area) to left wrist for safety/elopement . on August 15, 2024. -The care plan titled Risk for Wandering /Elopement Identified dated August 13, 2024, and was revised on September 6, 2024, indicated Resident 2 left the faciity on [DATE], and Resident 2 attempted to elopement on September 6, 2024. On November 19, 2024, at 11:59 a.m., during an interview with Registered Nurse (RN) 1, RN 1 stated incidents of elopement were discussed during their stand-up meeting, and sometimes they do not document that. RN 1 further stated, it was usually the Social Service Director (SSD) who documents IDT ((interdisciplinary team - a group of healthcare professionals from different disciplines who work together to provide care for a resident) meetings. A record review of Resident 1 ' s care plan was conducted with RN 1. RN 1 stated the following: -Resident 1 eloped on September 4, 2024, and the IDT meeting was conducted on September 6, 2024. The IDT was trying to find placement for him. -Resident 1 eloped on September 19, 2024. There was no documented IDT meeting to address this elopement. -Resident 1 eloped on October 27, 2024, the IDT meeting was conducted on October 28, 2024, and there were no recommendations for new interventions. -Resident 1 eloped on November 2, 2024, and the IDT recommended for psychiatry and psychology evaluation, continue to monitor behavior, continue plan of care, and visual checks every 30 minutes. -The IDT had a behavioral IDT meeting with (name of psychiatrist) on October 5, 2024. The doctor did not have any recommendations for Resident 1. RN 1 stated there were no care plan revisions on the elopement care plan after the resident eloped on November 2, 15, and 18, 2024. RN 1 stated the care plan in place was ineffective because Resident 1 successfully eloped on November 18, 2024. There was no other documented evidence that the IDT met and discussed Resident 1 ' s multiple elopements and to evaluate if the interventions were effective. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 19, 2024, at 1:05 p.m., during a concurrent interview with the SSD and record review of Resident 2 ' s medical records, the SSD stated the facility conducted IDT meetings after every elopement to discuss the residents plan of care. The SSD stated Resident 2 eloped from the facility on August 23 and September 26, 2024. The SSD stated the IDT meetings after Resident 2 ' s elopements were not conducted. The SSD stated there were no documented updates on Resident 2 ' s care plan as well. The SSD stated Resident 2 was on a 1:1 (a medical intervention where a resident is constantly observed by a staff member) for a time, but it did now show on their documentation. The SSD stated the IDT was supposed to meet and review the interventions for elopements. On November 19, 2024, at 2:27 p.m., during a concurrent interview with the Director of Nursing (DON) and record review of Resident 2 ' s medical record, the DON stated the facility investigated elopements by interviewing staff, collecting information and discuss the situation during their clinical meetings. The DON stated the SSD, the Administrator (ADM), and herself were involved with the investigation and the care plan during their clinical meetings. A review of Resident 1 ' s record was conducted with the DON. The DON stated Resident eloped on August 19, September 4 and 19, October 27, November 2, 15, and 18, 2024. The DON stated there were no IDT meetings conducted for Resident 1 after he eloped on August 19, September 19, October 27, November 15, and 18, 2024. A review of Resident 2 ' s record was conducted with the DON. The DON stated there were no IDT meetings conducted and no updated interventions on the elopement care plan after Resident 2 eloped on August 23 and September 6, 2024. The DON further stated the facility relied on the SSD to conduct and document the IDT meetings. The DON stated the facility did not have an SSD from June to July 2024. The DON stated their current SSD was still on orientation when Resident 2 eloped. On November 25, 2024, at 11:25 a.m. during an interview with the DON, the DON stated IDT meetings should be conducted the following day after each elopement incident. The DON stated they also discussed the elopement incidents during their clinical meetings. The DON stated if an incident occurred on Friday, the IDT meeting was conducted on Monday. The DON stated the IDT meetings should be documented by the SSD or any IDT members in the resident ' s progress notes. In addition, the DON stated the MDS nurse was responsible for revising and updating the care plans when there are new interventions. A review of the facility ' s policy titled, Care Planning dated March 1, 2014 indicated .It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being .The care plan will be , periodically reviewed and revised by IDT at the following intervals .onset of new problems .change of condition .To address changes in behavior and care .other times as appropriated or necessary .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 48240 Based on observation, interview, and record review, the facility failed to ensure the facility's policy and procedures were followed, for two of three sampled residents, Residents 1 and 2, who were identified as at risk for elopement (when a resident leaves a healthcare facility without permission or when they are unable to make safe decisions on their own), when: 1. The facility did not provide supervision for Resident 1 who had multiple prior attempts to elope; and 2. The facility did not ensure there was a system in place to monitor placement and functionality of the WanderGuard (bracelet worn by the resident that triggers alarms on doors to alert staff if a resident leaves a safe area) when Resident 2 was observed not wearing a WanderGuard bracelet as ordered by the physician. On November 18, 2024, at 7:20 p.m., The Administrator (ADM) and Director of Nursing (DON) were verbally notified of an Immediate Jeopardy (IJ- situation in which the provider's noncompliance with one or more requirements of participation has caused or likely to cause serious injury, harm, impairment, or death to a resident), due to the facility ' s failure to implement a system for monitoring residents identified at risk for elopement. The facility failed to provide supervision to Resident 1, who was identified to be at risk for elopement and had multiple prior attempts to elope. This failure resulted in Resident 1 eloping from the facility on November 18, 2024, at approximately 2:00 a.m. , placing Resident 1 at risk for serious injury while out in the cold environment with no access to needed healthcare. The facility failed to monitor the placement and functionality of the WanderGuard for Resident 2, who was observed not wearing a WanderGuard bracelet as ordered by the physician. This failure resulted in the potential for Resident 2 to elope from the facility placing her at serious risk for injury and no access to needed healthcare. On November 19, 2024, at 3:30 p.m., the ADM presented an acceptable plan of action which included the following: On November 18, and 19, 2024: a. Resident 1 was located by law enforcement and taken to the hospital for evaluation. b. The DON/Designee reviewed and audited residents with multiple attempts to leave the facility. Resident 2 was identified and placed under one-on-one supervision for safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. The Maintenance Supervisor inspected all exit doors and the WanderGuard system to ensure the alarms were working. All alarms and systems were functioning properly. d. New orders to monitor WanderGuard placement and function were added to the medication administration records for the five residents who were at risk. All wander guards were in place as ordered. IDT ((interdisciplinary team - a group of healthcare professionals from different disciplines who work together to provide care for a resident), and care plans were updated based on elopement risk assessments. e. The Administrator and DON provided in-service training to facility staff on the facility's wandering and elopement, policies, focusing on interventions for residents attempting to leave the facility and monitoring the WanderGuard system. The Administrator initiated an in-service with facility staff regarding Adequate Supervision and providing the appropriate level of oversight for all residents based on their needs. f. The Administrator conducted an in-service to licensed nurses on using the transmitter tester for WanderGuard, including proper usage, storage, extra supplies, and battery changes. g. The elopement binder (book with information on the residents identified as an elopement risk) was updated, and residents are being monitored and supervised according to their care plans. h. Starting on 11/19/24, the licensed nurses will conduct room rounds every 2 hours during their assigned shifts to ensure all residents are accounted for and safe. i. DON/Designee checked that all resident identified as risk for elopement had orange arm bands. On November 19, 2024, at 7:43 p.m., the Immediate Jeopardy was removed in the presence of the ADM, DON, Regional Quality Management Consultant and ADM Consultant, upon onsite verification of implementation of the plan of action. Noncompliance for F689 remained at the lower scope and severity of D no actual harm with potential for more than minimal harm. Findings: On November 15, 18, and 19, 2024, unannounced visits were conducted at the facility to investigate complaint allegations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On November 18, 2024, at 12:00 p.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he received notice that Resident 1 eloped from the facility on November 18, 2024, during the night (11:00 p.m. to 7:00 a.m.) shift and had not returned yet. LVN 1 stated according to the information he received Resident 1 opened the front door of the facility at 2:00 a.m. A certified nursing assistant (CNA) tried to stop him, but he started running. LVN 1 stated the CNA tried to follow Resident 1 for 30 minutes outside the facility, but it got too dark, and the CNA returned to the facility. LVN 1 stated Resident 1 had an ankle monitor due to being on probation, and a WanderGuard as well. LVN 1 stated Resident 1 had a history of leaving the facility and staff had been able to bring him back to the facility. LVN 1 stated the facility placed an extra lock to the front door and there are alarms on all the doors of the facility. LVN 1 stated residents are assessed for risk for elopement upon admission, after each incident of elopement and quarterly. LVN 1 stated when a resident is identified as at risk for elopement, they get an order for WanderGuard from the physician, place the resident ' s information in the elopement binder, initiate a care plan and notify the staff as well. LVN 1 stated a resident at risk for eloping may also be placed on close monitoring like a 1:1 (a medical intervention where a resident is constantly observed by a staff member). LVN 1 stated a 1:1 is initiated after a resident tries to elope from the facility and if the resident is at high risk for elopement. LVN 1 stated the 1:1 ends depending on how the resident is doing. A concurrent review of Resident 1 ' s medical record was conducted with LVN 1. The record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of cognitive functioning, such as thinking, remembering, and reasoning, that interferes with daily life). A review of Resident 1 ' s Elopement assessment dated [DATE], indicated Resident 1 was identified as at risk for elopement. A review of Resident 1 ' s care plan indicated Resident 1 had multiple attempts to leave the facility on August 19 and 23, September 4 and 19, October 27, and November 2 and 15, 2024. LVN 1 stated Resident 1 should have been placed on a 1:1 and frequent visual checks. On November 18, 2024, at 2:10 p.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 was independent to most activities of daily living (ADL) and had a WanderGuard on. She stated on November 15, 2024, as they were passing out breakfast trays, she heard that Code Pink was announced and that meant that a resident eloped. CNA 1 stated she knew that it was Resident 1. CNA 1 stated LVN 3 followed Resident 1 up to the gasoline station and Resident 1 was brought back to the facility. CNA 1 stated Resident 1 was not placed on a 1:1. They just kept a closer eye on Resident 1, and all staff checked the doors. CNA 1 stated Resident 1 did not have any further attempts to elope during that shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On November 18, 2024, at 3:29 p.m., during an interview with LVN 2, LVN 2 stated residents identified as at risk for elopement were frequently checked visually, the facility has alarms installed on all exit doors and provides WanderGuard to these residents. LVN 2 stated she was the charge nurse for the night shift (11:00 p. m. to 7:00 a.m.) when Resident 1 eloped on November 18, 2024, at around 2:00 a.m. LVN 2 stated Resident 1 had frequently eloped from the facility, and they conducted visual checks on him every 30 minutes. LVN 2 stated Resident 1 was pacing throughout the hallways, she gave him Ativan (a medication that treats anxiety-a mental illness) and approximately 15 minutes after giving Resident 1 Ativan, a CNA saw Resident 1 leave through the emergency exit door. The CNA followed Resident 1 but was not able to bring him back to the facility. The CNA returned to the facility and took her car to continue searching for the resident but Resident 1 could not be located. LVN 2 stated Resident 1 was not on a 1:1 at the beginning of the shift, and he continued to pace around the facility. LVN 2 stated there were no other interventions initiated for Resident 1. LVN 2 stated when Resident 1 was pacing around the facility a 1:1 was indicated, and she would have placed Resident 1 on 1:1 if there was enough staff. A review of Resident 1 ' s medical record was conducted on November 18, 2024. Resident 1's History and Physical dated May 6, 2024, indicated Resident 1 can make needs known but cannot make medical decisions. A review of Resident 1's Elopement Evaluation dated August 23, 2024, on PointClickCare (PCC - an electronic health record) indicated he was at risk for elopement. A review of the care plan titled, The resident has a behavior problem attempted to leave the facility, initiated on July 9, 2024, and revised on November 18, 2024, indicated Resident 1 had an actual attempt to leave the facility on August 19, 2024, and he eloped on November 18, 2024. The care plan had interventions initiated on July 9, 2024, which included .Administer medications as ordered. Monitor/document for side effects and effectiveness .Anticipate and meet The (sic) resident ' s needs .Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately . The care plan also had interventions inititated on August 20, 2024, which included .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes .Provide a program of activities that is of interest and accommodates residents (sic) status . A review of the care plan titled, Risk for Wandering / Elopement Identified with an initiated date of August 19, 2024, indicated Resident 1 had an episode of elopement on September 4, 2024, and three episodes of elopement on August 19, 2024. The care plan had interventions initiated on September 4, 2024, which included, .Clearly identify Resident ' s room & bathroom .Engage Resident in purposeful activity .Identify if there is a certain time of day wandering / elopement attempts occur .Implement scheduled hydration, if not contraindicated .schedule time for regular walks / appropriate activity . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the care plan titled, Resident had an episode of non-compliance and attempted to leave the facility on 10/27/2024 .11/2/2024 . initiated on October 27, 2024 and revised on November 18, 2024, had interventions initiated on October 27, 2024, which included .Anticipate and meet needs .Apply wanderguard (sic) for increase safety, resident refused wanderguard (sic) .For monitoring of behavior per protocol .IDT with parole officer for safe discharge .Psychiatric evaluation . The care plan had interventions initiated on October 28, 2024, which included .Redirect resident as necessary . The care plan also had interventions initiated on November 2, 2024, which included .Lorazepam (Ativan) Tablet 0.5 mg Give 1 tablet by mouth every 8 hours as needed for restlessness for 14 Days and re-assess .Notify family per protocol .Notify MD (medical doctor) for recommendations . A review of Resident 1 ' s Physician Note titled Psychiatry dated October 29, 2024, indicated Resident 1 . presents significant risk to self due to impaired judgment and attempts to leave facility without safety awareness. Requires close supervision . A review of Resident 1's Behavior Note dated November 15, 2024, indicated .Resident 1 eloped this morning using emergency side door and staff were able to walk the resident back to the facility . A review of Resident 1 ' s Progress Notes indicated the following: a. On November 15, 2024, Resident 1 eloped from the facility in the morning using emergency side door. Resident 1 was brought back to the facility by staff. The ADM, Resident 1 ' s doctor and family were made aware. b. On November 18, 2024, at 2:13 a.m., staff heard a door alarm and ran to the doors. CNA 1 chased Resident 1 but was unable to redirect back to the facility. Staff drove around the perimeter of the facility but was unable to locate the resident. The ADM and Police Department were notified. Resident 1 ' s doctor and family were notified. There was no documented revision on Resident 1 ' s care plans or post elopement IDT meetings from November 15 to November 18, 2024, to address why Resident 1 continued to make elopement attempts or interventions implemented to reduce his risk for elopement. On November 19, 2024, at 11:59 a.m., during an interview with Registered Nurse (RN) 1, RN 1 stated residents who are at risk for elopement and exhibit exit seeking behaviors are provided with a WanderGuard and a 1:1. RN 1 further stated a 1:1 is also recommended for a patient who had eloped. RN 1 stated incidents of elopement were discussed during their stand-up meeting, and sometimes they do not document that. RN 1 further stated it was usually the Social Service Director who documents IDT meetings. A review of Resident 1 ' s care plan was conducted with RN 1. RN 1 stated there were no updates on Resident 1 ' s elopement care plans after November 2, 2024. RN 1 stated the care plans were ineffective because Resident 1 successfully eloped on November 18, 2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On November 19, 2024, at 2:27 p.m., during an interview with the DON, the DON stated Resident 1 had multiple attempts to elope, was always redirected back to the facility by staff, was provided with frequent visual checks, every 30-minute monitoring, had a psychiatry evaluation with (name of psychiatrist), and the family, doctors and parole officers were notified. The DON further stated the facility was not the proper place for Resident 1 and he needed a locked unit. The DON stated it was not appropriate for Resident 1 to stay at the facility. The DON stated every time Resident 1 eloped, they contacted the police; on August 19, 2024 after he attempted to elope, he was transferred to the hospital for evaluation and returned to the facility the same day, they contacted the crisis team interventions multiple times and sought a 5150 hold (a legal procedure that allows involuntary detention of an adult for up to 72 hours for psychiatric evaluation and treatment), but none were able to assist. A record review of the Social Services Progress Note dated November 5, 2024, indicated .Crisis team in this afternoon, no changes per team the resident is safe, and in safe environment . On November 19, 2024, at 6:30 p.m., during a concurrent interview and record review with the DON, Resident 1 ' s care plans and progress notes for the period of November 15 to 18, 2024 were reviewed. The DON stated there were no revisions on the care plans titled The resident has a behavior problem attempted to leave the facility, initiated on July 9, 2024, and revised on November 18, 2024, Risk for Wandering / Elopement Identified with an initiated date of August 19, 2024, and Resident had an episode of non-compliance and attempted to leave the facility on 10/27/2024 .11/2/2024 . initiated on October 27, 2024 and revised on November 18, 2024, and there was no IDT meeting conducted on November 15 to 18, 2024. On November 19, 2024, at 7:08 p.m., during an interview with the ADM, The ADM stated the expectation for staff and the IDT was to find other interventions to prevent Resident 1 from eloping from the facility, but it was challenging. The ADM stated the facility tried to manage Resident 1 the best they could. On November 20, 2024, at 11:30 a.m., during an interview with Resident 1 at the general acute hospital (GACH), Resident 1 stated he left the facility because his wife and cousins were waiting for him. A review of Resident 1 ' s GACH records titled, ED (Emergency Department) Note - Physician dated November 19, 2024, indicated Resident 1 was admitted to the GACH on November 18, 2024, at approximately 8:50 p.m., and was placed on a 5150 hold (a legal process for the involuntary detainment of an adult in a psychiatric hospital up to 72 hours). The police found Resident 1 wandering in a stranger ' s backyard covered in feces (poo) and was disoriented. On November 29, 2024, at 2:09 p.m., during a telephone interview with the DON, the DON stated prior to Resident 1 eloping on November 18th, he was being monitored for elopement every shift. The DON stated he was not placed on every 30-minute monitoring because his elopement attempts was considered as his behavior. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility ' s policy and procedure titled, ' Wandering and Elopement dated February 10, 2023 indicated .The resident ' s risk for elopement and preventative interventions will be documented in the resident ' s medical records and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly and upon change in condition .The IDT will develop a plan of care considering the individual risk factors of the resident .upon return the Licensed Nurse will implement immediate interventions to prevent further elopement of the resident and update the plan of care .The Interdisciplinary Team as part of the investigation will conduct a post elopement meeting to determine if alternative prevention measures can be put in place (activities, rehab, etc.) . A review of the facility ' s policy and procedure titled, Resident Safety dated April 15, 2021, indicated .During the comprehensive assessment period the interdisciplinary team (IDT) members will assess the Resident ' s safety risk (e.g.wandering, elopement .) as well as any other Resident specific safety risks . After a risk evaluation is completed, a Resident-centered care plan will be developed to mitigate safety risk factors . 2. On November 18, 2024, a review of Resident 2 ' s electronic health information on PointClickCare (PCC) indicated the following: -Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia and was identified at risk for elopement. -The Minimum Data Set (MDS - an assessment tool) dated August 17, 2024, indicated Resident 2 had moderate cognitive (ability to think and reason) impairment. -The physician ' s order indicated Resident 2 had an order for .Wander Guard to left wrist for safety/elopement . dated August 15, 2024. -The care plan titled Risk for Wandering /Elopement Identified dated August 13, 2024, and was revised on September 6, 2024, indicated Resident 2 left the faciity on [DATE], and Resident 2 attempted to elopement on September 6, 2024. On November 18, 2024, at 3:29 p.m., during an interview with LVN 2, LVN 2 stated she was not sure who monitors if the WanderGuards were functioning. On November 18, 2024, at 4:20 p.m., during an interview with LVN 3, LVN 3 stated Resident 2 had an order for a WanderGuard. On November 18, 2024, at 4:28 p.m., a concurrent interview and observation with Resident 2 was conducted with LVN 3. Resident 2 was in bed, alert, awake, and watching television. A suitcase was observed on top of a chair opposite her bed. Resident 2 stated she did not have any type of bracelet monitors on her. LVN 3 stated he did not know what happened to Resident 2 ' s WanderGuard. LVN 3 stated he did not know how to check if WanderGuards were working or how to connect it to the WanderGuard alarm system. LVN 3 stated that when a resident with a WanderGuard goes near the doors, the alarm will go off. On November 18, 2024, at 6:19 p.m., during a follow up observation of Resident 2 in her room, Resident 2 was not wearing a WanderGuard bracelet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056428	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Nursing & Rehabilitation Center	2299 North Indian Canyon Drive Palm Springs, CA 92262

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On November 18, 2024, at 6:20 p.m., CNA 2 was asked to check if Resident 1 was wearing a WanderGuard. CNA 2 stated Resident 2 did not have a WanderGuard, CNA 2 further stated Resident 2 should have a WanderGuard on because she packed her things and has said she wanted to leave the facility in the past. On November 19, 2024, at 2:27 p.m., during an interview with the Director of Nursing (DON), the DON stated Resident 2 should have the WanderGuard on because there was a physician ' s order. On November 25, 2024, at 11:29 a.m., during a telephone interview with the DON, the DON stated it was the licensed nurses ' responsibility to check for the placement and functionality of the WanderGuard. A review of the facility ' s policy and procedure titled .Signaling Device dated October 26, 2023, indicated .A Signaling device is an intervention that can be utilized as part of a Resident ' s plan of care when they have been identified as being at risk for elopement .The need for the use of a signaling device will be based on the Resident ' s Elopement Assessment . A Physician ' s order must be obtained for the use of signaling device . The placement will be verified every shift .Functionality of the signaling device should be verified daily .The licensed nurse will document the placement and functionality in the Resident ' s medical record .