STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056443	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George L Mee Memorial Hospital D/P Snf	300 Canal Street King City, CA 93930

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 - Immediate jeopardy to resident health or safety 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** Based on observation, interview, and record review, the facility failed to ensure the safety of two of three residents (Resident 45 and Resident 20) who were at risk for elopement (the unauthorized, unsupervised departure of a patient/resident from a healthcare facility when their condition puts them at risk for injury or death) when:1a. The facility failed to complete Resident 45's Elopement Evaluation Assessment (a formal assessment conducted by healthcare staff to determine the likelihood of a resident or patient leaving the premises without supervision or authorization) as ordered on [DATE].1b. The activity staff did not develop and implement Resident 45's care plan on his preference to have garden time independently who was at risk for elopement if left unsupervised.1c. The facility did not implement their Leave of Absence (LOA) policy and procedures (PnP) for Resident 45 when nurses did not complete and document Resident 45's mental, physical, and functional assessment prior to leaving and upon returning to the facility.1d. The facility staff failed to check Resident 45's whereabout when he was not seen in the skilled nursing unit on [DATE] for about four hours (from 1:36 p.m. - 5:20 p.m.).These failures resulted in Resident 45's elopement on [DATE] at 1:36 p.m., resulting to a motor vehicle accident on [DATE] at 5:20 p.m. outside the facility's premises, and eventually death on [DATE].2.The facility failed to complete Resident 20's Elopement Evaluation Assessment upon admission; he was allowed to have garden time, unassisted and did not implement the facility's LOA PnP when nurses did not complete and document Resident 20's mental, physical, and functional assessment prior to leaving and upon returning to the facility.These failures had the potential to contribute to Resident 20's elopement given with diagnosis of alcoholism, with moderately impaired cognition, and wheelchair bound.3. The facility failed to complete an Elopement Evaluation Assessment for 39 of 40 facility residents (Residents 12,13,15,16,19, 23, 26, 27, 28, 29, 32, 33, 35, 36, 37, 41, 1, 2, 3, 5, 6, 7, 9, 10, 11, 14, 17, 18, 20, 21, 22, 24, 25, 30, 31, 34, 38, 39, and 40) upon admission.The facility's failure to complete the Elopement Evaluation Assessments for 39 residents could result in not identifying resident's elopement risk level (whether high risk, or low risk) and not able to implement resident centered plan of care which had the potential to result in harm/injury/death to those residents identified as high risk of elopement.All the above failures required immediate correction to prevent similar occurrence of elopement which resulted on death of Resident 45.On [DATE] at 4:35 p.m., an immediate jeopardy (IJ, a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident) was identified and declared, in the presence of the skilled nursing facility's nurse manager (SNF NM), SNF assistant manager/minimum data set nurse (SNF AM/MDSN), director of quality (DOQ), assistant social worker (ASW), director of staff development (DSD), quality nurse coordinator (QNC), dietary manager (DM), director of nursing (DON) - virtually and administrator (ADM) - virtually related to the failures mentioned above.On [DATE] at 11:17 a.m., the IJ was lifted (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	documented Time in;[DATE] - indicated Resident 45 was signed out by a friend at 9:30 a.m., the destination indicated, out, there was no documented Time in, and no nurse initials;[DATE] - indicated Resident 45 signed himself out at 1:36 p.m., the destination indicated, out and there was no documented Time in;[DATE] - indicated Resident 45 signed himself out at 1:00 p.m., Time in indicated 5:35 p.m., the destination was out, and no nurse initials;[DATE] - indicated Resident 45 signed himself out at 2:54 p.m., no Time in documented, and the destination was out;[DATE] - indicated Resident 45 signed himself out to go to the Garden, at 12:33 p.m., and no documented Time in;[DATE] - indicated Resident 45 signed himself out to go to the Garden, at 12:43 p.m., and he was back at 5:25 p.m.;[DATE] - indicated Resident 45 signed himself out to go, outside, at 1:56 p.m., and he was back 5:21 p.m.;[DATE] - indicated Resident 45 signed himself out to go, outside, at 12:21 p.m., and he was back at 5:33 p.m.;[DATE] - indicated Resident 45 signed himself out to go to the garden, at 2:00 p.m., and there was no documented Time in;[DATE] - indicated Resident 45 signed himself out to go Downstairs, at 10:53 a.m., and there was no documented Time in;[DATE] - indicated Resident 45 was signed out by a friend to go to town, at 11:19 a.m. and with Time in at 5:50 p.m.;[DATE] - indicated Resident 45 signed himself out at 1:20 p.m., the documented destination was not legible, and there was no documented, Time in;[DATE] - indicated Resident 45 was signed out by a friend at 8:40 a.m., no documented destination, no Time in, and no nurse initials;[DATE] - indicated Resident 45 signed himself out to go to the Garden, at 12:30 p.m., and no documented Time in; and[DATE] - indicated, Time out, 1028; Time in LOA - 1740 (military time for 5:40 p.m.), Destination: Garden, signed by Resident 45.During an interview with SNF NM on [DATE] at 4:44 p.m., the SNF NM stated he did not get any report when Resident 45 came back intoxicated. The SNF NM stated the receptionist seated at the first-floor lobby, near the elevator (access to go to SNF - second floor) was just temporary. The SNF NM further stated they never checked who was leaving the SNF.During a concurrent interview and record review with SNF NM on [DATE] at 1:34 p.m., SNF NM reviewed Resident 45's [DATE] nurse's notes, the SNF NM confirmed nurses did not complete and document Resident 45's assessment prior to leaving and upon returning to the facility. The SNF NM stated nurses should assess Resident 45 first before he left and when he came back to the facility. He confirmed that when Resident 45 signed out to the garden, it was considered LOA and he had a choice to leave the facility premises while he was at the garden. The SNF NM stated it was his understanding that when Resident 45 signed himself out, it would release them (the facility) of their responsibilities to Resident 45. The SNF NM further stated that when Resident 45 went out of the facility's premises, he needed to have an RP to sign him out because Resident 45 had a history when he associated himself with some undesirable people. The SNF NM confirmed nurse's [DATE] progress notes did not indicate assessments were completed before Resident 45 left and when he came back to the facility on the following dates: [DATE] to [DATE], 12/6, 12/7, 12/9, 12/10, 12/11, 12/12, 12/13, [DATE] to [DATE].During a review of the facility's policy and procedure titled, Patient Leave of Absence, date revised 8/2022, indicated, Leave of Absence (LOA): Any absence from the facility. If the patient is not present for the midnight census count, he/she is placed on a bedhold.For all patients going on a Leave of Absence (LOA) the criteria below must be met:An order must be in the medical record, from the physician for LOA.The licensed nurse must do a complete mental, physical, and functional assessment immediately prior to (within 30 minutes) leaving and upon returning to the facility.Document assessment in the nursing progress notes in the EHR [Electronic Health Record].1d. During an interview with the social worker (SW) on [DATE] at 10:59 a.m., the SW stated Resident 45 was present in his care conference which was held on [DATE] after 1:00 p.m. The social worker could not recall the time when the care conference was completed on [DATE]. The SW further stated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	cavity (the space around the abdominal organs)]Traumatic intracerebral hemorrhage [a severe, often fatal, brain injury resulting from bleeding within the brain parenchyma due to trauma]Ribs, multiple fracturesPedestrian injured in motor vehicle collisionChance fracture of vertebraPedestrian injured in traffic accidentRespiratory failure [a critical condition where the lungs cannot properly oxygenate the blood causing severe shortness of breath, confusion, and bluish skin] (10)Liver Hematoma, grade II [collection of blood in or around the liver, often from trauma] (11)Alcoholic cirrhosisContributing ConditionsAlcohol intoxication Sternal fractureElevated troponin I levelRight humeral fractureChance fracture of vertebraAlcoholic cirrhosisLiver hematoma, grade IIFracture of lumbar spineAKI (acute kidney injury)(10)Thoracic spine fracture(11)Intraparenchymal hematoma of brain(12)Proximal humerus fracture(13)Ulnar shaft fracture(14)Fracture of humerus, proximal, right, closedSecondary DiagnosesAlcoholic cirrhosisAlcohol intoxication 2. During a review of Resident 20's face sheet, indicated Resident 20 was admitted to the facility on [DATE] and had a diagnoses of Alcoholism(persistent excessive consumption of alcohol resulting in impairment of health) , Diabetes mellitus (a chronic metabolic condition where the body has high blood sugar), Hemiplegia(paralysis of one side of the body) due to old stroke (medical condition in which poor blood flow to a part of the brain causes cell death), History of completed stroke , Hypercholesteremia (an excess of cholesterol in the bloodstream), Hypertension (a condition that affects the body's arteries), Wheelchair bound (people who is confined in a wheelchair).Review of Resident 20's quarterly Brief Interview for Mental Status (BIMS- a standardized cognitive screening tool used primarily in long-term care facilities to assess a resident's cognitive function) dated [DATE] indicated the score was 06 (a score of 0-7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).Review of Resident 20's clinical records indicated there was no Elopement Evaluation Assessment completed for Resident 20 upon admission on [DATE].During a concurrent interview and record review with the SNF NM on [DATE] at 11:30 a.m., the SNF NM reviewed Resident 20's clinical records on Elopement Risk Evaluation and he confirmed the Elopement Evaluation Assessment was not conducted upon Resident 20's admission. The SNF NM stated that the Elopement Evaluation Assessment is not done unless the resident was triggered, like when there were initial incidents of elopement and a change in condition that warranted an assessment. The SNF NM confirmed Resident 20 signed the LOA form every time he went out of the skilled nursing facility or went to the garden. The SNF NM also stated residents that are alert /oriented, mobile, even on wheelchair and decide to sign the LOA form can go out, and for those residents who have their responsible party they can go out with the RP for LOA.During an interview with Certified Nurse Assistant (CNA) E on [DATE] at 11:54 a.m., CNA E stated Resident 20 had a stroke, right-sided weakness, and used wheelchair for mobility, and he preferred going out to stores to purchase scratcher tickets (a form of instant -win lottery game) by himself. CNA E also stated Resident 20 signed the LOA form whenever he goes out of the facility by propelling his wheelchair with the use of his left arm and left leg. CNA E further stated staff did not take Resident 20's vital signs (measurable body functions used to detect or monitor medical problems, including heart rate, blood pressure, respiratory rate, and body temperature) every time he came back from LOA.Review of Resident 20's clinical record titled, Skilled Nursing Facility release of responsibility for leave of absence, dated:[DATE] - indicated Resident 20's signed himself out to go to the outside, at 5:50 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the outside, at 5:38 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the outside, at 12:55 p.m., and Resident 20 was back at 17:23 p.mXXX[DATE] - indicated Resident 20's signed himself out to go to the downstair, at 05:10 a.m., no documented time in, and no nurse initials[DATE] - (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056443	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George L Mee Memorial Hospital D/P Snf	300 Canal Street King City, CA 93930

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	indicated Resident 20's signed himself out to go to the outside, at 6:00 a.m., and Resident 20 was back at 16:53 (military time for 4:53 p.m.)[DATE] - indicated Resident 20's signed himself out to go to the bakery, at 6:00 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the outside, at 8:55 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the outside, at 8:20 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the outside, at 04:45 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the downstair, at 4:15 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the outside, at 6:25 a.m., and Resident 20 was back at 16:15 p.m., no documented relationship[DATE] - indicated Resident 20's signed himself out to go to the outside, at 8:23 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the downstair, at 4:25 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the store, at 5:45 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the downstair, at 5:45 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the outside(bakery), at 6:00 a.m., no documented time in, [DATE] - indicated Resident 20's signed himself out to go to the outside(bakery), at 5:45 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the downstair, at 5:00 a.m., no documented time in, and no nurse initial[DATE] - indicated Resident 20's signed himself out to go to the downstair, at 6:51 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the downstair, at 5:00a.m., and Resident 20 was back at 7:00 a.mXXX[DATE] - indicated Resident 20's signed himself out to go to the outside, at 6:00 a.m., no documented time in,[DATE] - indicated Resident 20's signed himself out to go to the street market, at 8:50 a.m., no documented time in, relationship, and no nurse initialXXX[DATE] - indicated Resident 20's signed himself out to go to the outside, at 5:00 a.m., no documented time in, and no nurse initialXXX[DATE] - indicated Resident 20's signed himself out to go to the