STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555034	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Mateo Medical Center D/P Snf	222 West 39th Avenue San Mateo, CA 94403

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to provide adequate supervision to Resident 1 to prevent his elopement. This failure did not ensure Resident 1 was residing in a safe and supervised environment.Findings:Review of Resident 1's medical records titled MDS (Minimum Data Set assessment: a standardized resident assessment tool), dated 3/12/26, indicated his BIMS (Brief interview for Mental Status: an assessment tool for evaluating memory and reasoning abilities) score was 8 out of 15. A BIMS score of 8 indicated Resident 1 was moderately impaired in his memory and reasoning abilities.Review of Resident 1's medical records titled Care Plan, initiated on 5/1/26, indicated .The resident is an elopement risk/wanderer.(related to) impaired safety awareness as .(manifested by) attempt to leave the facility at 06:50am on 05/01/2026.Review of Resident 1's medical records titled IDT Note (interdisciplinary team note: a healthcare team from various disciplines such as nursing, social services, rehab, dietary etc.), dated 5/13/26, indicated .Resident noted with wandering behaviors and exit-seeking attempts, placing resident at risk for elopement.(WanderGuard: a small wearable alarm device that activates an exit area alarm when a resident attempts to leave unsupervised) place on right wrist remains in place and functioning properly. Resident monitored routinely by staff with redirection and supervision provided as needed.Review of Resident 1's medical records titled eMAR (electronic Medication Administration Record), for the month of May 2026, indicated the 5/18/26 night shift charted Resident 1 .refused (his WanderGuard), offered multiple times. Resident verbally stated that, ?he is okay'. Risk and benefits explain to resident.During an interview on 5/21/26 at 12:41 PM, Certified Nursing Assistant (CNA)1 stated she did her morning rounds on May 19th around 10 AM and everything looked fine and Resident 1 was in his room. CNA 1 stated she went for her break around 11:30 AM and when she came back around 12 noon, Resident 1 was not in his room. CNA 1 stated that was when she alerted her nurse that Resident 1 was missing. CNA 1 stated Resident 1 was confused, was an elopement risk and had a WanderGuard. CNA 1 stated she believed Resident 1 had his WanderGuard on when she saw him in the morning of May 19.During an interview on 5/21/26 at 2:21 PM, License Vocational Nurse (LVN) 1 stated there was a recent physician order to apply a WanderGuard device due to Resident 1's increase risk in elopement. LVN 1 stated she had observed Resident 1 playing with his WanderGuard device and had to re-direct him not to play with his WanderGuard device. LVN 1 stated approximately two weeks ago a CNA had told her that Resident 1 tried to take off his WanderGuard. LVN 1 was asked if she received report from night shift that Resident 1 did not want to wear his WanderGuard? LVN 1 stated no, night shift did not report to her Resident 1 was refusing to wear his WanderGuard. LVN 1 was asked if she charted Resident 1's reported previous behavior in trying to remove his WanderGuard? LVN 1 stated no. LVN 1 was asked what more staff could have done to safeguard Resident 1. LVN 1 offered these additional interventions: Assess why Resident 1 did not want to wear his WanderGuard; Try switching the WanderGuard to a different area; More frequent checks on Resident;Timely charting of this behavior to alert other staff.During an interview on 05/21/26 at 1:45 PM, the Director of Nursing (DON) stated a staff found Resident 1's WanderGuard on his bed. The DON stated Resident 1 took off his WanderGuard and that was how he was able to get pass the alarm. The (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 - Few	DON was asked what else the facility could have done knowing these behaviors? The DON said more frequent checks.Review of the facility's policy titled Wandering and Elopement, effective date 2/20/23, 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.The Licensed Nurse, in collaboration with the Interdisciplinary Team (IDT), will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition according to the RAI (Resident Assessment Instrument) guidelines to determine their risk of elopement.