STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide appropriate supervision when they did not ensure one of three sampled residents (Resident 1) was wearing a wandering device (a wearable device, commonly referred to as a wander guard, with sensors that trigger alarms, used to prevent residents at risk of wandering from leaving a safe area unsupervised) according to Resident 1's physician orders (PO) and care plan (CP).This failure resulted in Resident 1 walking out of the facility unsupervised and without the facility's knowledge, which exposed the resident to cold temperatures, nightfall, and traffic, which could have resulted in serious injury, medical complications, and/or death. Findings:Resident 1 was admitted to the facility in September 2025 with multiple medical diagnoses which included dementia (a progressive state of decline in mental abilities), a history of falling, and a spinal fracture. 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 4 out of 15 which indicated Resident 1's cognitive function was severely impaired.During an interview on 11/24/25 at 11:30 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was a known wanderer who frequently walked up and down the hallways, exhibited exit-seeking behavior, and often needed re-direction. During an interview on 11/24/25 at 11:46 a.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 1 was confused and would frequently wander down the hallways and into other residents' rooms, requiring re-direction. LN 1 further stated Resident 1 was supposed to wear a wandering device on his left ankle; the wandering device would activate an alarm when Resident 1 neared the exit to signal staff. During an observation on 11/24/25 at 12:27 p.m. near the elevators, Resident 1 and their Responsible Party (RP) walked into the facility through the elevators. An alarm sounded upon the elevator doors opening.During an interview on 11/24/25 at 12:30 p.m. with RP, RP stated the facility notified him on 11/15/25 that Resident 1 had gone missing from the facility and they didn't know how he got out. RP stated the facility was aware Resident 1 had a history of wandering and elopement. RP further stated Resident 1 was very confused and like a little kid. RP, who stated he regularly visited Resident 1 twice weekly, had no recollection of Resident 1 wearing a wandering device prior to his elopement on 11/15/25.During a review of Resident 1's Wandering Risk Assessment (WRA), dated 9/29/25, the WRA indicated, Score of 3 or more = High risk for elopement .[Resident 1] Score: 8 .Has the resident [Resident 1] wandered before? Yes .Does the wandering place the resident [Resident 1] at significant risk of getting to a potentially dangerous place (stairs, outside the facility)? Yes.During a review of Resident 1's CP, dated 10/1/25, indicated, [Resident 1] is an elopement risk/wanderer r/t (related to) History of attempts to leave facility unattended, [Resident 1] wanders aimlessly at a risk for elopement assessment done with the score 8.0.Monitor [Resident 1] whereabouts.During a review of Resident 1's CP, dated 10/8/25, indicated, [Resident 1] have wander guard on left ankle r/t (related to) high risk of elopement and wandering .Ensure the [wander guard] device is functioning properly and securely attached to [Resident 1].During a review of Resident 1's PO, dated 10/8/25, indicated, Make sure Pt [Resident 1] have wander guard on left ankle # 9000-0138J exp 05/15/2026 every shift.During a review of Resident 1's Interdisciplinary Team (IDT) note, dated 11/17/25, the IDT indicated, ELOPEMENT November 15, 2025, at 5:45 PM .the resident [Resident 1] was missing .the PD (Police Department) .reported that the resident [Resident 1] had been located at . 7:00 PM .At 8:35 PM, the resident [Resident 1] was returned to the facility by law enforcement .[wander guard] was missing.During an interview on 11/24/25 at 1:22 p.m. with LN 2, LN 2 stated Resident 1 was a known wanderer and would attempt to walk out of the facility through the elevators. LN 2 further stated Resident 1 had an order to wear a wandering device and nurses were supposed to check off in the electronic Medication Administration Record (MAR) that Resident 1 wore it each shift.During a review of Resident 1's MAR, dated November 2025, the MAR indicated, Make sure Pt [Resident 1] have wander guard on left ankle .every shift . start date 10/08/2025. The MAR further indicated, n/N [no], on the following dates and shifts: 11/13/25 evening shift, 11/13/25 night shift, 11/14/25 day shift, 11/14/25 evening shift, 11/14/25 night shift, and 11/15/25 day shift. During a concurrent interview and record review on 11/24/25 at 2:22 p.m. with Director of Nursing (DON), Resident 1's MAR for November 2025 was reviewed. DON verified there was no documentation indicating Resident 1 was wearing a wandering device from 11/13/25 evening shift through the time of elopement on 11/15/25 and there should have been. DON acknowledged Resident 1 had PO, initiated on 10/8/25, to wear a wandering device, which should have been followed. DON stated it was the expectation for nurses to indicate yes or no in the MAR that Resident 1 was wearing his wandering device. If