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	02/10/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement measures to prevent an avoidable elopement for one of three sampled residents (Resident 1), when staff was unaware Resident 1 had left the facility unsupervised. This failure had the potential to negatively affect Resident 1's health and safety and could result to harm and injury. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with a primary diagnosis of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). A review of Resident 1's Wandering Risk Assessment, dated [DATE], indicated Resident was high risk for elopement. A review of Resident 1's physician orders and notice of admission form, both dated [DATE], indicated Resident 1 did not have the capacity to understand choices and make decisions. A review of Resident 1's Care Plan Report (CPR), initiated [DATE], indicated Resident 1 was non-compliant to facility's wander management system (WMS - a system to monitor wandering residents), and there were no nursing interventions on how staff were to monitor for safety and to decrease risk for elopement. The CPR indicated Resident 1 was a fall risk, and there was no schizoaffective disorder focus on how Resident 1's behaviors would be monitored. A review of Resident 1's progress notes, dated [DATE], indicated Resident 1 refused use of WMS, and staff documented as patient is on High Elopement risk.is currently restlessness and agitated. The staff did not document best practice monitored interventions on how Resident 1 would be kept safe from elopement. A review of Resident 1's progress note, dated [DATE] at 7:35 p.m., Licensed Nurse 1 (LN 1) documented Resident 1 was not found in the facility. There was no documentation LN 1 announced Code Pink to alert staff of Resident 1's elopement. A review of Resident 1's progress note, dated [DATE] at 10:05 p.m., LN 1 documented notified the Director of Nursing (DON) that Resident 1 had left the facility. The timeframe for administration notification was greater than two hours. A review of Resident 1's progress note, dated [DATE] at 3:17 a.m., indicated the DON faxed notification to police department that Resident 1 had eloped from facility. The timeframe for police notification was greater than 30 minutes. During an interview on [DATE] at 11 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the main entrance doors automatically locked at 5 p.m., the residents outside smoking, without a staff chaperone, would need to ring the doorbell which would notify staff for re-entrance. During a telephone interview on [DATE] at 12:25 p.m., with LN 1, LN 1 stated when she realized Resident 1 was missing from facility, she did not announce Code Pink. During a telephone interview, on [DATE] at 1 p.m., with CNA 2, CNA 2 stated, I can't tell when they [residents] leave the floor, if I'm busy on the other end of the hallway. [Resident 1] does not wear a [WMS], nothing. CNA 2 stated he did not hear Code Pink announced overhead. During an interview and record review, on [DATE] at 1:15 p.m. with the DON, the DON confirmed Resident 1 did not have capacity to make decisions, had high risk for elopement, that the care plan focus' did not address Resident 1's diagnosis for mental illness, and there were no interventions of how staff would monitor (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	Resident 1's safety when no [WMS] was worn. The DON stated her expectations were for staff to follow the elopement policy, and to notify me so I can follow appropriate actions. The DON stated these procedures were important for patient safety, especially if they don't have capacity. During an interview, on [DATE] at 3:30 p.m., with the Administrator (ADM), the ADM stated his expectations were for staff to communicate everything as soon as they know, staff should let management know if a resident needs a [WMS]. The ADM stated this was important for the well-being and safety of the resident. During a review of the facility's procedure titled, Elopement In-Service, undated, the procedure indicated, Elopement places residents at high risk for injury or harm and requires immediate action .Emergency Procedures: Missing Resident . Immediate Actions .Announce Code Pink .Notify Administration .If resident is not located after 30 minutes .notify police. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, revised 3/2019, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm.If identified as at risk for wandering, elopement,.the resident's care plan will include strategies and interventions to maintain the resident's safety.If a resident is missing, initiate the elopement/missing resident emergency procedure.