STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555757	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milpitas Care Center	120 Corning Avenue Milpitas, CA 95035

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** 44185 Based on interview and record review, the facility failed to provide supervision to prevent one of two residents (Resident 1) who were at risk for elopement from leaving the facility without staffs' knowledge and permission when Resident 1's wander guard (device used to keep track of residents), was not checked for functionality and staff did not provide Resident 1 with supervision or assistance. These failures compromised Resident 1's safety, as she was found outside of the facility. Findings: Review of Resident 1's admission record indicated, Resident 1 was readmitted to the facility on [DATE] with diagnoses including unspecified dementia (loss of memory), unspecified severity, with other behavioral disturbance, essential primary hypertension (occurs when the abnormally high blood pressure was not a result of a medical condition), mixed hyperlipidemia (high levels of fat particles in the blood), and history of falling. Review of Resident 1's interdisciplinary team (IDT, brings together knowledge from different health care disciplines to help residents with their needs) note dated 4/5/24, indicated, Resident 1 had episode of elopement on 3/31/24. Review of Resident 1's IDT note dated 4/10/24, Resident 1 had episode of elopement on 4/7/24 and was found in the street outside of the facility. Review of Resident 1's minimum data set (MDS, a standardized assessment tool that measures health status in nursing home residents), dated 1/26/24, indicated, Resident 1 needed supervision or assistance with walking and her activities of daily living (ADL, activities related to personal care). Review of Resident 1's post elopement care plan interventions, initiated on 4/1/24, indicated, to monitor wander guard placement every shift to left wrist and to monitor Resident 1's whereabouts frequently. During an interview with licensed vocational nurse A (LVN A) on 5/1/24 at 7:46 a.m., LVN A verified that the wander guard bracelet of Resident 1 was not checked that was the reason the staff did not notice Resident 1 went out of the facility. LVN A further verified that the whereabouts of Resident 1 was not regularly checked. (continued on next page)

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the certified nursing assistant B (CNA B) on 6/20/24 at 2:51 p.m., CNA B verified that she was not able to check if the wander guard bracelet of Resident 1 was working, when Resident 1 eloped on 4/7/24 because CNA B was changing another resident that time. CNA B further verified that she was not also able to check the whereabout of Resident 1 that time, because she was busy with another resident. Review of the facility's undated policy and procedure titled, Elopement, indicated, Staff shall investigate and report all cases of missing residents. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the charge nurse or director of nursing. Review of the facility's Elopement Summary of Content document dated, 4/8/24, indicated, Checking all wander guard doors and their back up alarms to make sure they are working . Know where the residents are at all times .