| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555866 | A. Building<br>B. Wing | 11/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sierra Vista Healthcare | 1715 South Cedar<br>Fresno, CA 93702 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on interview and record review, the facility failed to prevent the elopement (when a resident leaves the facility's premises or a safe area without authorization, or necessary supervision) of one of seven residents (Resident 7) when staff did not respond promptly to a security elopement alarm when Resident 7 eloped from the facility. This failure had the potential for Resident 7 to experience injury such as falling or struck by traffic, becoming disoriented and lost due to his unsupervised time away from the facility, and also the potential for six other residents who were identified as elopement risks (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) to elope. During a review of Resident 7's Progress Notes (PN), dated 11/1/25, at 8:23 p.m., the PN indicated he was admitted to the facility that evening with diagnoses that included acute encephalopathy (a rapid onset of altered brain function that can cause confusion and disorientation) and was noted to have episodes of. Severe impairment (affecting all areas of judgement). Walks frequently. During a review of Resident 7's Elopement Risk Assessment (ERA), dated 11/1/25, at 7:42 p.m., the ERA indicated he was independently mobile, had a history of recent elopements, exhibited purposeful exit-seeking and Aimless or goal-directed pacing or wandering, and was determined to be At Risk for Elopement. During a review of Resident 7's Morse Fall Risk Screen (MFRS), dated 11/1/25, at 8:06 p.m., the MFRS indicated he had fallen in the past, and Overestimates or forgets limits. The MFRS indicated Resident 7 was at High Risk for Falling. During a review of Resident 7's Order Summary Report (OSR), dated 11/1/25, the OSR indicated he had a physician's orders for a security bracelet (an electronic bracelet that activates a loud alarm at the facility's exit doors) secondary to . Aimless or goal-directed pacing or wandering, exited facility multiple times, multiple attempts to exit facility. The OSR indicated the security bracelet was to be placed on Resident 7's right ankle. During a review of Resident 7's Care Plan Report (CP), dated 11/1/25, the CP indicated he had a Focus of Risk for wandering related to . Aimless or goal-directed pacing or wandering, exited facility multiple times, multiple attempts to exit facility. At risk for elopement. Mobile ambulates around facility. Interventions included Apply wander-sensor monitoring device [security bracelet] as ordered [by physician]. Check [security bracelet] for proper functioning and placement per facility protocol. Check door alarm with Maintenance Supervisor. During a review of Resident 7's PN dated 11/1/25, at 11:41 p.m., the PN indicated Resident is [sic] wandered around the facility and anxious to get out of the facility, [Security bracelet] in place. Staff redirect resident attention to bring him back to his room. During a review of Resident 7's PN dated 11/2/25, at 2:55 p.m., the PN indicated that earlier that day, at 7:40 a.m., Resident 7 was seen by staff outside of his room. The PN indicated that at 7:50 a.m., while breakfast was being served, Resident 7 was not in his room and a search was begun inside and outside of the facility to find Resident 7. The PN indicated that at 8:10 a.m., Resident had not been located. The PN indicated that at 8:50 a.m., the facility received a call from Resident 7's family member, who stated he was at their home (located about one mile away); and his family returned him to the facility at 9:37 a.m. The PN indicated Resident 7 was then placed on one-to-one staff monitoring and an In-service given to all staff regarding respond to [security bracelet] alarm. During an interview on 11/4/25, at 10:35 a.m., with the Administrator, the Administrator stated Resident 7's family member lived about one mile away and Resident 7 knew exactly how to get there. The Administrator stated when Resident 7 returned to the facility, he still had his security bracelet on. The Administrator stated the only doors in the facility equipped with an alarm that detects the presence of the security bracelet are the front doors of the facility. During an interview on 11/4/25, at 10:40 a.m., with the Director of Nursing (DON), the DON stated Resident 7's security bracelet did work. It triggered the front door, the alarm went off, it was going off. The alarm at the front door was sounding. Nobody answered it immediately. Usually there is a receptionist at the front lobby [where the front doors are located], but she doesn't get in until 9 a.m., and this happened around breakfast, at 7:50 a.m. So, nobody responded to the alarm. We don't know how long it was sounding; we are still trying to determine how it got turned off. During a concurrent interview on 11/4/25, at 10:45 a.m., with the Administrator and DON, the Administrator and DON both stated the alarm at the front door was not responded to by staff timely when Resident 7 eloped from the facility on 11/2/25 at approximately 7:50 a.m. The Administrator stated the facility started in-services to educate the staff about the importance of responding to the front door alarm timely, beginning on 11/2/25. The Administrator stated the facility is fully staffed at 7:50 a.m., except for the receptionist who arrives on duty at 9 a.m. The Administrator stated there are also six other residents in the facility with security bracelets (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) |