STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555878	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Hills Healthcare & Wellness Centre, LLC	1340 E Madison Ave El Cajon, CA 92021

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview, and record review, the facility failed to develop and implement an individualized care plan for one of two residents (Resident 1) reviewed for elopement (leaving the facility without permission). This failure had the potential to put Resident 1 at risk for further elopements and injury. Findings: On 7/18/24, an unannounced visit was made to the facility following a facility reported incident of a resident's elopement from the secured unit. According to the facility's Admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses that include paranoid schizophrenia (a mental disorder that affects a person's ability to think, feel and behave clearly) and bipolar disorder (a mental condition that causes extreme mood swings). On 7/18/24 at 10:26 A.M., an observation was conducted in the secured unit. Resident 1's bedroom was observed with a sliding glass door leading to the outside patio. On 7/18/24 at 10:50 A.M., a concurrent observation and interview was conducted with Resident 1. Resident 1 was observed in the patio, sitting on a bench unattended. There was no other staff present in the patio. Resident 1 stated that on 7/15/24, he walked out the back door of the secured unit and climbed over a fence. Resident 1 stated he did not recall where he was trying to go or the reason he left the facility. On 7/18/24 at 10:56 A.M., an interview was conducted with certified nurse assistant (CNA) 1. CNA1 stated Resident 1 frequently ambulated throughout the secured unit. CNA1 stated Resident 1 liked to sit outside on the patio every day. CNA1 stated residents in the secured unit were allowed to go to the outside patio unattended by staff unless they are smoking or are on a 1:1 (continuous monitoring by staff) for behavior management. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 11:04 A.M., a joint interview and record review was conducted with Licensed Nurse (LN 1). LN1 reviewed Resident 1's physician's orders dated 7/15/24 which indicated Ok to apply wanderguard to resident to prevent unassisted ambulation off unit. Please check function every shift. LN1 stated the facility's wanderguard system was .not hooked up . and no alarm would be activated if the resident tried to leave the facility. LN1 reviewed Resident 1's physician's order dated 7/15/24 One on one staff monitoring for patient where abouts for 12 hours during the PM/NOC shift. LN1 stated Resident 1 was placed on a 1:1 monitoring between the hours of 7 P.M. and 7 A.M. LN1 stated the resident is on q hour checks between the hours of 7A.M. and 7 P.M. LN1 stated q hour checks are wellness checks. We're looking at him every hour to make sure he is still here . LN1 stated .he for sure can still leave, even during hour checks . On 7/18/24 at 12:32 P.M., a record review was conducted. An IDT note dated 7/17/24 at 12:50 P.M. indicated administration contacted company in assessing the height of the fence and raising the fence as needed. On 7/18/24 at 3:06 P.M., an interview was conducted with the Director of Nurses (DON). The DON stated that a wanderguard (a monitor which sounds an alarm when a resident exits through a facility door) was placed on the resident on 7/16/24, but it was removed .because we found out there was a system malfunction The DON stated that a wanderguard would not be effective if Resident 1 exited via the glass sliding door in his room. The DON acknowledged that Resident 1 would still have an opportunity to elope again by exiting the building and climbing over the fence. The DON acknowledged it was important to prevent the resident from eloping to prevent resident from injury. A review of the facility's policy and procedure revised July 2017 titled Wandering & Elopement was conducted. The policy indicated .The IDT will develop a plan of care considering the individual risk factors of the resident . and Upon return the Licensed Nurse will implement immediate interventions to prevent further elopement of the resident and update the plan of care