STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055402	A. BUILDING _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR EL CAMINO CARE CENTER	2540 CARMICHAEL WAY CARMICHAEL, CA 95608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00957235. The inspection was limited to the specific facility resported incident investigated and does not represent the findings of a full inspection of the facility. The Department substantiated facility reported incident #CA00957235, and a violation of regulations was written under tag #F689.	F 000	POC APPROVED 5/9/25 by HFES RV BIC 4/28/25	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure resident safety for one resident (Resident 1) out of a census of 158 when Resident 1's care plan was not implemented correctly and consistently, and facility did not know Resident 1's whereabouts. This failure resulted in Resident 1 missing and eloping from the facility and reduced the facility's potential in keeping Resident 1 safe from harm. Findings: Review of Resident 1's "Admission Record" (AR),	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/30/25

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.

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F 689	Continued From page 1 the AR indicated that Resident 1 was admitted in late February 2023 with diagnosis including schizoaffective disorder (a condition that can affect a person's perception of reality and mood) and other psychoactive substance abuse (a condition where someone struggles to control, and it impairs judgment and may lead to changes in brain structure). Review of "Nurse's Progress Note" dated 4/13/25 at 6:16 p.m., indicated, " ...Per charge hall nurse, resident was found missing from [facility] at approximately 4:00 PM hour. Charge hall nurse searched around and, in the facility, and not found. This writer drove down the street and found resident with bag within 30 mins ..." Review of Resident 1's "Care Plan" (CP), initiated on 4/13/25 the CP indicated, " ...Resident will remain safe in the facility and will have no elopement by next review ... Placed resident on Q 15-minute checks for her whereabouts for safety ..." Review of "Nurse's Progress Note" dated 4/14/25 at 10:17 p.m. indicated, " ... at about 20:30 [8:30 p.m.] Licensed Nurse (LN) noted that resident was not in a room ... resident was found about 20 minutes later at the bus stop smoking a cigarette ..." Review of facility document titled, "Q 15 Mins Check" dated 4/14/25, indicated Resident 1 was "in bed asleep" at 8 p.m., 8:15 p.m., 8:30 p.m., 8:45 p.m., 9:00 p.m. During a concurrent interview and record review, on 4/25/25 at 2:30 p.m. with Registered Nurse Case manager (CM), the CM reviewed the	F 689		

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F 689	Continued From page 2 Nurse's Progress Notes and Q15 mins Check documents both dated 4/14/25 and confirmed these two records were inconsistent and contradictory. Review of the facility policy (P&P), "Elopement" dated 3/22/22, the P&P, indicated, "the residents who exhibit wandering behavior/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wonder or elopement risk."	F 689		

The preparation and/or the execution of this plan of correction do not constitute admission of agreement by the provider of true facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of the Federal and State law require it.

This Plan of Correction constitutes the facility's credible allegation of compliance.

F689

Corrective action accomplished for identified resident (s) affected by the deficient practice.

- Resident 1 was located without injury and returned safely to a supervised area.
- Resident 1 care plan was immediately reviewed and revised to include enhanced elopement precautions.
- A 1:1 staff supervision protocol was initiated for Resident 1, with scheduled safety checks documented every 15 minutes.
- All staff involved were educated about failure to sufficiently follow care plan interventions.

How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken.

- A facility-wide audit was conducted of all residents identified as at-risk for elopement, using the facility's elopement risk assessment tool.
- Care plans for these residents were reviewed to ensure interventions are current, individualized, and being consistently implemented.
- Residents found to be at increased risk were reassessed, and additional safety precautions were implemented as needed and followed.

Immediate measures and systemic changes put in place to ensure that the deficient practice does not recur.

- On 4/28/25 Licensed Nurses and Direct Care Staff received retraining on elopement prevention policies, including;
    a. How to monitor residents at risk
    b. Documentation procedures for location checks
    c. Frequency of location checks
    d. Protocols for responding to missing residents
    e. Resident supervision and rounds documentation
- A system for tracking residents' whereabouts during the day, shifts changes, and high traffic times was implemented.

A description of the plans and persons responsible for monitoring ongoing performance and ensuring that the corrective actions are achieved and sustained.

- The DON or designee will perform weekly audits for 4 weeks, then monthly for 3 months, on;

    a. Implementation of care plan interventions for elopement-prone residents.
    b. Documentation on safety checks
    c. Functionality of wander preventions systems.
- The results of the audits will be reported to the Quality Assurance and Performance monthly for 3 months or until full compliance.

COMPLETION DATE 4/30/25