STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055871	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Skyline Care Center	348 Iris Drive Salinas, CA 93906

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 - Immediate jeopardy to resident health or safety 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 provide supervision for one of 14 residents (Resident 1) who was at risk for leaving the facility (elopement) when Resident 1 went out of the facility premises without the facility's knowledge on [DATE]. This failure resulted in Resident 1 leaving the facility unattended and Resident 1 being found by a bystander face down and unresponsive at a bus stop. The bystander called 911 (universal emergency number) and EMS (Emergency Medical Services, a system that provides emergency medical care) responded and resuscitated Resident 1. Resident 1 was transferred to an acute care hospital where Resident 1 expired on [DATE]. On [DATE], at 4:59 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified and declared, in the presence of the facility's Administrator (ADM), Director of Nursing (DON), Regional Clinical Resource Nurse (RCRN), and with the facility's Senior [NAME] Clinical Resource (SVCR) and [NAME] President of Operations (VPO), who were on the phone, due to the facility's failure to provide supervision for one of 14 residents (Resident 1) who left the facility's premises without the facility's knowledge on [DATE]. Resident 1 died in an acute care hospital the same day on [DATE]. On [DATE], at 8 a.m., an initial IJ removal plan (IJRP) with a completion date of [DATE] was submitted but was not accepted. On [DATE], a final revised IJRP was submitted with a completion date of [DATE]. The final revised IJRP was accepted. On [DATE] a visit was done to the facility to review the implementation of this revised IJRP. The IJ was lifted at 5 p.m. on [DATE]. The acceptable IJRP included the following corrective actions: 1) The ADM, DON and ADON (Assistant Director of Nursing) initiated in-service for the following staff: Licensed Nurses (LN), Certified Nursing Assistants (CNA), dietary, housekeeping and laundry, rehabilitation department, admissions, activities and maintenance on how to locate missing resident and what is considered elopement (occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so). 2) The facility's Interdisciplinary Team (IDT, a group of healthcare professionals from different fields that work together towards a common goal for a patient) completed a facility wide audit to evaluate 65 residents for the risk for elopement. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	3) 13 residents who are at risk for elopement were monitored by the LN for episodes of exit seeking behavior every shift and documented in the Medication Administration Record (MAR, a record of prescribed medications). 4) Licensed Vocational Nurse (LVN), Registered Nurse (RN), CNA and staff from other departments including but not limited to therapy, activities, admissions, payroll, dietary, housekeeping/laundry, maintenance, health information manager (HIM), social services and MDS departments who did not attend the in-service will be provided education at the beginning of their next scheduled shift by the DON, DSD or ADON. 5) The facility's ADON initiated an in-service to LVN and RN on the policy and procedures (P&P) titled Elopements Resident Behavior and Facility Practice including but not limited to how to locate a missing resident, completion of elopement assessment for new admission and resident who exhibits wandering behavior, residents who are considered an elopement risk and their interventions, how to initiate an elopement care plan, and if resident is deemed at risk for elopement notify Medical Doctor (MD) and if indicated obtain orders/consent for wander guard (a device worn by residents that would alert caregivers when a resident approached a monitored door) device and monitor resident for episodes of exit seeking behavior every shift. 6) The facility's ADM initiated an in-service to the Social Services, ADON, MDS nurse, Activities Director, Central Supply, Admissions Assistant/receptionist, Accounts payable, occupational therapist on steps to take when a resident is newly admitted or current resident exhibit newly wandering/exit seeking behaviors but not limited to elopement risk assessment, if deemed at risk for elopement notify MD and if indicated obtain orders/consent for wander guard device and monitor for episodes of exit seeking behavior every shift, initiate elopement care plan, and monitoring and managing residents at risk of elopement including but not limited to every 2 hour visual checks, in addition to wander guard placement if applicable. 7) The facility ADM and DON reviewed facility elopement P&P, related to a recent incident with Medical Director. 8) The facility's RCRN provided an education to the DON and ADM on what is considered elopement and the reporting requirements. 9) 13 residents who are a risk for elopement were monitored by the LN for episodes of exit seeking behavior every shift and documented in the MAR. 10) The facility's LN initiated the completion of the head count rounds at the beginning of the shift and document on the census sheet for the other residents who are not identified as at risk for elopement. 11) The facility's ADON, DON and RN supervisor initiated the validation of the completion of the daily head count monitoring by LN. Any needed corrections will be communicated to the assigned LN. 12) The facility's maintenance supervisor/designee checked the operation of door monitors and resident wandering system (Wander Guard System) was checked on [DATE] and [DATE] and found to be functional and will continue to check weekly. 13) A new measure was put in place when the Maintenance Director installed exit door alarms on 3 of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the 4 exit doors. When the doors are opened an alarm will sound which will allow staff to check if a resident is exiting the building unauthorized. 14) The facility's Social Services Director (SSD), Maintenance Director and DON initiated the in-service to the LN and CNA regarding the new alarm doors with an emphasis to respond when the exit door alarm to check the exit and that staff is to use only the main entrance to enter and exit the building. 15) The facility's IDT initiated the daily review of new admission and residents that show new wandering/elopement behavior to ensure the new behavior is addressed, care plan is updated and interventions such as monitor for exit seeking behaviors, increased visual checks, individualized activity plan, and wander guard are implemented. 16) The facility's HIM initiated the admission audits and change conditions audit when current residents exhibit new wandering or exit seeking behaviors including but not limited if applicable completion of elopement risk assessment, IDT note when resident is identified for elopement risk, orders for wander guard, consent for wander guard, care plan for risk of elopement and wander guard, monitor for episodes for exit seeking behaviors were put in place every shift, the elopement binder was updated with residents' picture and person identification information, and visual checks in place. Any missing items from this audit will be reported to DON/designee for further review and follow up. 17) The facility's HIM will present elopement related audits weekly for 4 weeks then monthly Quality Assurance Performance Improvement (QAPI) committee for review with Medical Director, evaluation trending and tracking every month for 3 months until compliance has been reached. 18) The corrective actions began on [DATE] and completed on [DATE]. As stated, this failure resulted in Resident 1 leaving the facility premises without facility's knowledge. Resident 1 was found face down and unresponsive at a bus stop and died in an acute care hospital that same day on [DATE]. Furthermore, this failure had the potential to likely put the other 13 residents who were at risk to leave the premises without staff supervision. Findings: Review of Resident 1's admission record indicated he was an elderly resident admitted to the facility on [DATE] with diagnoses including disorder of bone density and structure (occurs when bones become weak and brittle due to loss of bone mass), low back pain, bilateral primary osteoarthritis (breakdown of cartilage in the joints leading to pain, stiffness and reduced mobility) of hip, and generalized muscle weakness. Review of Resident 1's Minimum Data Set (MDS, an assessment tool) Section GG Functional Abilities, dated [DATE], indicated Resident 1 needed supervision or touching assistance to walk 150 feet once standing, and as well as to walk at least 150 feet in a corridor or similar space. Review of Resident 1's initial Elopement Evaluation, dated [DATE], did not indicate risk level for elopement. Review of Resident 1's Activity Care Plan, dated [DATE], indicated Resident 1 enjoyed independent activity such as walking around the facility or patio. The care plan further indicated interventions (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 3:28 p.m., the SSD stated on [DATE] Resident 1 left the facility and went to his old apartment and was gone for about an hour. The SSD stated she was made aware by a CNA that Resident 1 was not in the facility. The SSD stated she could not remember the time or who was the CNA at that time. During a concurrent interview and record review on [DATE], at 2:29 p.m., with the DON, she stated that the incident on [DATE] when Resident 1 left the facility and went to his old apartment was not considered an elopement because Resident 1 came back to the facility. The DON stated she did the elopement reevaluation and based on the evaluation Resident 1 was not at risk for elopement. The DON further stated that a care plan was not initiated for Resident 1, and it could have been the best practice to initiate a care plan for elopement when Resident 1 left the facility. When the DON was asked what was considered as an elopement, the DON stated elopement was when a resident leaves the facility without authorization. The DON further stated that when Resident 1 left the faciity on [DATE], it was not considered as an elopement because he had a purpose to go to his apartment and came back to the facility. During an interview on [DATE], at 3:07 p.m., with CNA C, she stated there was an episode when Resident 1 was in the hallway and asked where the bus stop and taxi was. CNA C stated Resident 1 verbalized he wants to go to the bus stop. CNA C stated another CNA, and a nurse heard the resident but could not remember who the CNA and the nurse were. CNA C could not remember the date when Resident 1 was asking where to find the bus stop and taxi. During an interview on [DATE], at 12:46 p.m., the DON stated the IDT (Interdisciplinary Team, a group of healthcare professionals from different fields that work together towards a common goal for a patient) decides if a resident was high risk of elopement or not. The DON stated the incident on [DATE] when Resident 1 left the facility and went to his old apartment was discussed by the IDT but determined Resident 1 was not a high risk for elopement. The DON acknowledged that the IDT discussion was not documented. Review of Resident 1's clinical record indicated there was no IDT note documented for the incident of [DATE] when Resident 1 went to his apartment to get a jacket. During a telephone interview on [DATE], at 1:01 p.m., with LVN E, the nurse assigned to Resident 1 on [DATE], LVN E stated that around 7:15 a.m. he saw Resident 1 in his room and the CNA informed LVN E around 9 a.m. that Resident 1 was not in the room. LVN E stated Resident 1 came back around 11 a.m. to the facility. LVN E stated Resident 1 mentioned he took the bus to go to his house to get his jacket. LVN E stated management team were informed because they had to search for Resident 1. LVN E stated he did not think he did an elopement evaluation after the incident. Review of Resident 1's Nurses Progress Note, dated [DATE], indicated Resident was seen in his room, at the start of the shift around 0720 [7:20 a.m.]. Resident was laying in bed, resting .Resident was seen by other staff during the morning rounds. Resident's walker noted in the from by reception, however, resident was not in the building. During an interview on [DATE], at 1:12 p.m., with LVN A, she stated on [DATE], around 7:20 a.m., Resident 1 was lying in bed. LVN A stated she saw Resident 1 an hour after when she gave the medications to Resident 1's roommate. LVN A stated around 8:30 a.m. is when she last saw Resident 1. LVN A stated she realized Resident 1 was not in the facility around lunch time between 12:00 noon to 12:30 p.m. when a CNA informed her that Resident 1 was not in the dining room. LVN A went to Resident 1's (continued on next page)

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