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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING _____ B. WING _____	C 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2065 FOREST AVENUE SAN JOSE, CA 95128

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey regarding an entity reported incident conducted from 11/5/13 through 11/8/13. For Entity Reported Incident CA00375841 regarding Quality of Care/Treatment, Federal deficiencies were identified (see F279 and F323). Also, a class B citation was issued (see F323). Investigation was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 23298, Health Facilities Evaluator Nurse and 26295, Health Facilities Evaluator Nurse.	F 000	**DISCLAIMER STATEMENT:** This Plan of Correction constitutes our written credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH NOV 27 2013 L & C DIVISION SAN JOSE	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	All Residents can potentially be affected by this deficient practice. Resident 1, 2 and 5 Care plans were reviewed and updated to remove the intervention of using a WanderGuard (system of alarms on exit doors activated when residents leave the area or cross over a doorway threshold) to prevent elopement by the IDT members MDS staff and the Unit Supervisors reviewed current residents that are at high risk for elopement with care plans on wandering and Elopement to ensure that the use of WanderGuard system is removed. No other issues were noted.	12-6-2013

LABORATORY DIRE[redacted]

Any deficiency stat[redacted] 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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LABORATORY DIRECT [redacted]

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 279	Continued From page 1 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the Wandering/Elopement care plans for three of five residents (1, 2, and 5) who were high risk for elopement. Three care plans indicated the intervention to use a WanderGuard (system of alarms on exit doors activated when residents leave the area or cross over a doorway threshold) to prevent elopement. The WanderGuard system in the facility was not functioning or available to be implemented. None of the three elopement risk care plans were revised with new interventions when the WanderGuard system was not available. Findings: During an interview on 11/5/13 at 1:30 p.m., the assistant director on nursing (ADON) stated the WanderGuard system broke years ago, but could not give a specific number of years. During an interview at 1:35 p.m., the receptionist (REC) stated the facility had been without a WanderGuard system for more than three years. During an interview at 2 p.m., licensed nurse B (LN B) stated the facility did not have a WanderGuard system. During an interview at 2:10 p.m., the maintenance supervisor (MTS) stated he was not even sure if there ever was a WanderGuard system in the	F 279	The Director of Nursing conducted in-service education on November 12, 2013 with the Licensed Nurses and the IDT members regarding care plan on wandering and elopement not to use the intervention of WanderGuard system until available. The IDT members will continue to review and update each resident's care plans quarterly per the MDS schedule with follow-up as indicated. Licensed Nurses and the IDT members will continue to review and update resident's care plans when there is a change in a resident's condition that pertains to wandering and elopement. IDT members will continue to review Physician orders daily during the Morning Stand-up meeting to ensure orders have been appropriately care planned with specific intervention and to follow-up as indicated. Findings and trends identified during the IDT members quarterly review of residents care plans will be reviewed by the QA&A Committee monthly with follow-up as indicated.	

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F 279	Continued From page 2 facility. During an interview at 10:30, the social service assistant (SSA) stated he worked in the facility for four years and had not seen a WanderGuard system. During a review of the clinical records for Residents 1, 2, and 5 on 11/6/13, all three residents were indicated at risk for elopement or wandering. All three had Wandering/Elopement care plans indicating the use of a WanderGuard as an intervention to prevent wandering or elopement. No revisions indicating the lack of a working WanderGuard system as a discontinued intervention to replace the discontinued intervention or new interventions documented on any of the three care plans. During an interview at 2:05 p.m., the administrator (ADM) stated he had been told there was a WanderGuard system in the past, but one was not available at present. There were no immediate plans to purchase or activate a WanderGuard system. A review on 11/6/13 of the facility's 11/15/2001 "Comprehensive Care Plan" policy indicated to highlight discontinued care plan interventions with a transparent yellow marker, then date and initial the discontinued item. Care plans are to be re-evaluated and modified as necessary to reflect changes in care, service and treatment quarterly and with significant change in status assessment.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	All Residents can potentially be affected by this deficient practice.	12-6-2013

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F 323	Continued From page 3 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility failed to adequately supervise and prevent one resident (1) from eloping (leaving the facility without permission or staff knowledge). After eloping, Resident 1 was found 2.7 miles from the facility, 25 hours after he was discovered missing. On 11/4/13, the night Resident 1 eloped, the exterior temperature dropped to a low of 40 degrees. Resident 1 was able to leave unobserved from one of six unlocked exit doors which had no alarm system in place. Only two of the exit doors were monitored on a continuing basis and staff was observed missing from this observation post. The chair alarm system, in use by Resident 1 to alert staff when he stood up from his wheelchair, failed to function at the time of his elopement. The facility had included the use of a WanderGuard (system of alarms on exit doors activated when residents leave the area or cross over a doorway threshold) for three residents' care plans to prevent elopement (1, 2, and 5). The WanderGuard system had not been functioning for more then three years and there were no immediate plans to replace the system. The care plans were not revised with new interventions to prevent elopement when the WanderGuard system was not available. Findings:	F 323	Resident no longer resides in the facility. Newly admitted or readmitted resident's charts will be brought to the Daily morning meeting to review for resident with risk for elopement. Based on the identified factors, Elopement risk assessment will be initiated. Resident picture will be taken and place on Elopement risk binder by the receptionist Desk as per facility protocol utilizing the Elopement risk identification form. Facility is currently in the process of obtaining a wander guard system from Stanley Corporation. When it is in place, the system will be put on residents based on risk and history of Elopement factors identified. Wander guard placement will be checked by Licensed nurses every shift. Facility exit doors will be checked by Maintenance staff member three times a day for proper functioning. Any issues reported with wander guard system will be brought to the facility daily morning meeting for immediate plan of action. Any incidents of Elopement will be reported to regulatory agencies/Department of health as per protocol and residents with incidents of Elopement will be discussed in weekly risk meeting for 4 weeks or as required. Plan of care will be developed accordingly and based on incident of elopement; plan of care will be revised to meet the resident needs. While the facility is in the process of obtaining a wander guard system, the Elopement Care Plan	

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F 323	Continued From page 4 Resident 1's clinical record reviewed on 11/5/13, indicated he was an insulin dependent diabetic, and also was to receive medications for high blood pressure and dementia. His 7/15/13 Minimum Data Set (MDS, an assessment tool) indicated he was confused at times and was only oriented to his name. He required one person assistance for transfer and had an unsteady gate. He used a wheelchair but was able to ambulate at times. He had previously eloped from the facility in April/2013. His Wandering/Elopement care plan for April 2013 had interventions to prevent his eloping in the future which included a WanderGuard bracelet and checking the alarm for functioning even though the facility had no WanderGuard system in place. Visual checks, encouragement to attend daily activities, and provide reassurance and redirection were also included interventions. On 11/5/13, a review of the facility's Brief Description of Incident form indicated the resident was last seen on 11/4/13 at 3:10 p.m. sitting in his wheelchair watching TV in his room. He was wearing a light blue shirt, light sweater, khaki pants, and shoes. At about 4 p.m., staff noted Resident 1's empty wheelchair next to the lobby elevator. During an interview on 11/5/13 at 1:30 p.m., the assistant director of nurses (ADON) stated a staff member noticed Resident 1's wheelchair by the lobby elevator. Resident 1 could walk, but usually used a wheelchair to wheel himself around the facility, so they initiated a search. She also stated the WanderGuard system, listed as an intervention on Resident 1's Wandering/Elopement care plan, was never	F 323	will include an intervention of having a sitter for a resident at risk for elopement from the hours of six in the morning when doors are open for employees until 8 at night when all doors are locked. Ambassador rounds will be conducted daily by the Department managers to make sure resident whereabouts and throughout the day from licensed nurses and certified nursing assistants to ensure resident safety. Any issues identified will be reported to the Director of Nursing and Administrator for immediate follow up. Staff was in-serviced on November 5, 2013 for policy and procedure for an Elopement, admission process, Risk identification, wander guard system and plan of care. Administrator and Director of nursing will be responsible to monitor the process. Any negative findings from morning meeting, daily morning rounds by the Ambassadors will be brought to the facility monthly QA&A meeting or until compliance is sustained.	

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F 323	Continued From page 5 implemented since the system was not functioning. During an interview on the same day at 1:40 p.m., the receptionist (REC) stated he saw the empty wheelchair on 11/4/13. He verified the facility had been without a WanderGuard system for more than three years. He stated the system the facility used is a high risk fall binder at the receptionist's desk. The receptionist could identify and stop residents before they left the facility. On 11/6/13 a review of the facility's 12/1/05 "Elopement" policy indicated "Elopement Risk form will be completed for all patients upon admission, readmission, quarterly, and with significant changes. Patients at risk for elopement will have a wander guard [sic] band placed if applicable for facility, along with a completed Elopement Identification Form with attached photo. These forms will be placed in the Elopement Binder and maintained at the reception desk." A review of the high risk fall binder at the receptionists' desk had 15 residents' pictures and information pages. In the binder, the REC stated only four of these 15 residents were current residents with elopement risks. The eleven other 11 resdients had been discharged. During an interview at 1:50 p.m., certified nursing assistant A (CNA A) stated Resident 1 was on whereabouts monitoring every hour. Not just the CNAs and licensed nurses monitored, but all staff members passing by the room checked the resident. During an interview on 11/5/13 at 2 p.m., licensed	F 323		

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F 323	Continued From page 6 nurse B (LN B) stated Resident 1 could walk but was not not very steady. She recalled Resident 1 eloped from the facility in 4/2013. She was aware there was no WanderGuard system in place, but Resident 1 did have a chair alarm. She stated nobody heard the chair alarm activate at the time of his elopement. On 11/6/13 at 11:20 a.m., during an observation with the maintenance supervisor (MTS) the following were observed: There were six exit doors kept unlocked during the day. There was a main door and an elevator near it. The elevator led to the basement which opened to two hallways. One hallway is short only about 10-15 feet and led to an unlocked door opening to the street. The other was a long hallway with an unlocked door opening to the parking garage. There were two doors at the back of the building (between Stations two and five) which led to a breezeway with an exit to the street/sidewalk. Only the main entrance and the nearby elevator were monitored and visible from the receptionist desk. During an observation on 11/5/13 at 4 p.m., the downstairs hallway was empty. All doors in the hallway were closed, except the activity department door. The door was marked as being alarmed. The door was tested and no alarm sounded. During an interview at 2:05 p.m., the MTS stated the doors were only locked from 8 p.m. until about 6:30 a.m. Only the main door and elevator were monitored during the day. During an interview on 11/6/13 at 10:30 a.m., the social service assistant (SSA) stated after the	F 323		

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F 323	Continued From page 7	F 323		

elopement incident on 11/4/13, none of the staff interviewed heard an alarm. He stated it was possible Resident 1 left through a downstairs door.

During an observation on 11/6/13 at 12:25 p.m., of the reception desk in the lobby, where two exits were visible and monitored, no staff member was present for two to three minutes.

During an interview on 11/6/13 at 2:05 p.m., the administrator (ADM) stated he was told the facility used to have a WanderGuard system. He stated he had looked into getting a system for the facility but only had a price quote at the present time. He also stated when the receptionist left for a few minutes and left the door and elevator unmonitored, this would be enough time for a resident to elope.

During an interview on 11/6/13 at 8 a.m., the social service director (SSD) stated Resident 1 gave conflicting stories about how he ended miles away from the facility. He was confused about where he had been or how he got there.

During an interview at 8:35 a.m., Resident 1 was disoriented to time and place and unable to answer simple addition math problems. He had no information about where he had been during the missing 25 hours, or how he got there.

During an observation at 8:45 a.m., Resident 1's unsteady gait was observed as he slowly pushed himself up out of wheelchair, winced, walked about five feet with a CNA in attendance, turned around while holding the wall, and walked a few steps back toward his wheelchair.

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F 323	Continued From page 8 During a telephone interview on 11/6/13 at 10:20 a.m., the medical director (MD) stated Resident 1's mental reasoning was getting worse. They were thinking of conservatorship (a representative who makes healthcare decisions for someone not capable of doing so). The MD stated he was aware Resident 1 had eloped once before in 4/2013 and it might be time to place him in a facility with some security. During a telephone interview on 11/8/13 at 8:45 a.m., the police detective stated Resident 1 was found by an emergency medical services crew approximately 2.7 miles from the facility and stated the location. An online review of the weather from the National Weather Service, for the time period Resident 1 eloped from the facility on 11/4/13 to 11/5/13, indicated the temperature dropped to a low of 40 degrees Fahrenheit.	F 323		