STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055750	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMBERWOOD GARDENS	**1601 PETERSEN AVENUE SAN JOSE, CA 95129**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to supervise and monitor one of three sampled residents (Resident 1) as indicated in the assessments and plan of care. This failure resulted in Resident 1 leaving the facility unattended and had the potential to result in physical harm. Findings: Review of Resident 1's clinical record indicated he had the [DIAGNOSES REDACTED]. Review of Resident 1's Wandering Risk Assessment, dated 9/11/2019, indicated he was at high risk for wandering (moving from place to place with or without a specified course or known direction). Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 5/28/2020, indicated he required supervision (oversight, encouragement or cueing) for walking in his room and in the corridor. The MDS also indicated Resident 1 required supervision with locomotion (moving between locations) on and off the unit. Review of Resident 1's situation, background, assessment, recommendation (SBAR, a communication tool), dated 5/29/2020, indicated between 6:30 p.m. and 6:45 p.m., the licensed nurse was not able to locate Resident 1 in the facility. The SBAR indicated that prior to this incident, the last time staff saw Resident 1 in the facility was between 5:30 p.m. and 5:35 p.m. According to the SBAR, a staff member located Resident 1 outside of the facility at 10:50 p.m. (close to four hours from the time staff noticed he was missing). During an interview with registered nurse A (RN A) on 7/16/2020 at 3:48 p.m., she stated that on 5/29/2020 between 6:30 p.m. and 6:45 p.m., she noticed Resident 1 was not in his room. She and other staff members looked inside and outside of the facility and still could not locate Resident 1. RN A stated the last time she saw Resident 1 prior to this incident was approximately at 5:00 p.m. During an interview with care support team member B (CSTM B) on 8/6/2020 at 3:35 p.m., translated by certified nursing assistant C (CNA C), CSTM B explained that she saw Resident 1 eating dinner in his room on the day he went missing. CSTM B estimated she saw Resident 1 eating dinner at approximately 5:00 p.m. CSTM B acknowledged she did not know where Resident 1 was from approximately 5:00 p.m. up until the time RN A noticed he was missing. During an interview with CNA D on 8/6/2020 at 3:40 p.m., he stated he took away Resident 1's dinner tray on the day he went missing. CNA D stated he took Resident 1's dinner tray between 4:30 p.m. and 5:00 p.m. and did not see the resident after that. CNA D acknowledged he did not know where Resident 1 was from the time he took the dinner tray up until the time RN A noticed he was missing. The facility's type-written investigation summary, dated 5/29/2020, was reviewed. The summary had a timeline of the events that took place on the day Resident 1 went missing. According to the timeline, facility staff saw Resident 1 sitting in the lobby at 5:30 p.m., then could not find him at 6:40 p.m. There was no documentation of Resident 1's whereabouts between 5:30 p.m. and 6:40 p.m. Review of Resident 1's care plan, revised 2/18/2020, indicated he exhibited wandering behavior, which placed him at risk for getting into dangerous places. The care plan indicated Resident 1 was at risk for elopement (wandering away from the facility unattended) due to his history of wandering out of the facility and/or history of wandering out of the home prior to placement in the facility. The care plan further indicated facility staff was to Check resident constantly and be aware of resident's whereabouts.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.