| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055855 | A. BUILDING _____ B. WING _____ | C 07/22/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARDEN POST ACUTE REHAB | 3400 ALTA ARDEN EXPRESSWAY SACRAMENTO, CA 95825 |

| (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<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00782470 and facility reported incident #CA00782418.<br><br>Representing the Department of Public Health: Health Facilities Evaluator Nurse, 42813<br><br>The inspection was limited to the specific complaint and facility reported incident investigated and does not represent the findings of a full inspection of the facility. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to provide monitoring and supervision to ensure the safety of one resident (Resident 1) in a sample of 4 residents identified at risk for elopement (an act or instance when a cognitively impaired person leaves a safe area or premises unsupervised) when:<br><br>1. Resident 1 eloped and facility did not know Resident 1 was missing until police called them on 4/23/22 at an unknown time. | F 689 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 8/16/22

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.

# Arden Post-Acute

# Plan of Correction (POC)

*This Plan of Correction is submitted as the facility's plan of correction for the abbreviated survey on 7/20/2022, #CA00782470 and #CA00782418*

*This Plan of Correction is prepared as part of the Quality Assurance process for the provider. This Plan of Correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such protected from discovery.*

*The Plan of Correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes and/or guidelines. As this transmission is required by law it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations.*

## F 689 : Free of Accident Hazards/Supervision/Devices

### *Finding*: Failed to provide monitoring and supervision to ensure the safety of Resident 1, when a cognitively impaired person leaves a safe area or premises unsupervised

**How corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:**

Resident 1 did not sustain injury and was added to the Facility's Elopement binder & wanderguard was initiated and in place.

No other residents were found to be affected by deficient practice. Since the incident, no other residents have been reported off the facility premises without faculty's knowledge.

**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**

- Facilty will perform an audit of all residents who are at risk of wandering or elopement by 8/19/22. All residents found to be at risk for wandering and elopement will be added to the elopement binder.

- All new admissions will be reviewed in IDT for wandering and elopement risk. Those identified will be added to the elopement binder and appropriate intervention such as but not limited to wanderguard.

**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**

- All new admissions will be assessed and screened for wandering and elopement risk. Those found to be at risk will have appropriate interventions put into place.
- DON or designee will audit elopement binder Q weekly x 30 days with IDT and monthly thereafter. All findings will be immediately corrected and reported to quarterly QA.
- Q shift wander guard checks will be put into place to ensure wander guard is functioning and placed on resident appropriately. All findings not consistent with policy will be corrected immediately.
- The maintenance department will do daily checks of all doors equipped with wanderguard system x 30 days then weekly thereafter. Any door identified to be malfunctioning will be fixed as soon as practicable and will be reported to daily QA (stand-up meeting) for further intervention if needed.
- All IDT members will be in serviced on facilities wandering and elopement policy and procedures by 8/19/22
- All nursing staff will be in serviced on facilities wandering and elopement policy and procedures and location of elopement binder by 8/19/22
- Any findings will be corrected immediately and reported to the Quarterly QA meeting

**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:**

- Weekly elopement binder review will be done by DON or designee during IDT under Risk Management to ensure the list is complete & updated; all interventions are effective and sustained. Systemic changes will be made as needed.

**Include dates when corrective action will be completed. The corrective completion dates must be acceptable to the State Agency.**

All in-services will be completed by 8/19/2022