STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. BUILDING _____ B. WING _____	C 08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OROVILLE HOSPITAL POST-ACUTE CENTER	**1000 EXECUTIVE PARKWAY OROVILLE, CA 95966**

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for two facility reported incidents. Facility Reported Incidents: 776586 and 780423 The survey was limited to the specific facility reported incidents investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 230838, Health Facilities Evaluator Nurse A deficiency was issued for facility reported incidents 776586 and 780423 at F689.	F 000		
F 689 SS=E	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 adequate supervision and prompt interventions for two of three sampled residents when Resident 1 and 2 eloped from the facility and were found outside alone and unsupervised.	F 689	"Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth on the Statement of Deficiencies. This Plan of Correction is	9/9/22

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

Electronically Signed | 09/09/2022

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F 689	Continued From page 1 These elopements due to lack of supervision had the potential for falls, fractures, and other accidents that could negatively affect residents' health and well being. Findings: A review of an undated policy titled, "Elopement/ Wandering," indicated the facility evaluates residents for wandering and/ exit seeking behavior, and implements appropriate interventions as indicated. The policy directed: On admission the Licensed Nurse (LN) completes the Nursing Admission Evaluation to determine if the resident is at risk for elopement. Should the data indicate further evaluation, the LN completes the Elopement / Exit Seeking Evaluation. Based on the results of the Elopement / Exit Seeking Evaluations a care plan is initiated and implemented with interventions to manage wandering and/or exit seeking behavior. The care plan addresses the resident's behavior, potential to exit seek and actual episodes of elopement. The care plan would also include measures to manage those behaviors. If the resident exhibits exit seeking behaviors the episodes would be documented in the resident's record which would include interventions used and their effectiveness. A review of an emergency plan "4.1 Missing Resident," indicated the procedure is to protect the safety of residents through early assessment of their risk for exit seeking behaviors. Once identified the facility would take steps to mitigate	F 689	prepared and/or executed solely because it is required by provisions of Health and Safety Code Section 1280 and 42 CFR 483 et seq." F689 CFR(s): 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Corrective Action/s: • It is the facilities policy to ensure all residents remain as free of accident hazards as possible and that each resident receives adequate supervision. On 3/12/22 an in-service was completed on emergency exit door alarms and wandering risk of residents. The education included how to respond when an alarm sounds and early identification if residents at risk for wondering. On 3/16/22 and Elopement Drill was conducted for all staff on all shifts to assist with education on the procedure regarding a missing resident. • Additional cameras have been placed at various exit doors to aid in visual supervision of any individual entering or exiting the building. Inservicing to Direct Care Staff has been initiated with a completion date of 9/30/2022. Resident(s) Affected: • All residents with wandering and elopement behaviors have the potential to be affected. How to Identify Other Residents:	

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F 689	Continued From page 2 the risk through an individualized care plan and good communication between staff, visitors and families regarding the supervision needed. 1. On 3/11/22 at 9 pm, the California Department of Public Health (CDPH) received notification that Resident 1 was found at the stop sign near the facility sitting on the curb. Security from a local acute care hospital found Resident 1 and contacted the facility. The facility was unaware Resident 1 had eloped. Resident 1 was admitted to the facility on 2/10/22 with diagnoses that included dementia (a progressive brain disorder that effects memory, mobility and often speech), difficulty walking, and muscle weakness. A review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 2/16/22 , assessed Resident 1 to be moderately cognitively impaired and required staff supervision for activities of daily living. A review of Resident 1's admission Wandering/Elopement Evaluation dated 2/10/22 at 7:37 pm, indicated he had cognitive impairment (intermittent confusion, hallucinations /delusions at all times and was independently mobile, had a diagnosis to include dementia, anxiety, and impaired judgement. The wandering score category listed on the evaluation assessed Resident 1 as a "low risk," and not a risk for elopement. The next Wandering/Elopement Evaluation was conducted on 2/12/22 at 11:48 am, indicating that Resident 1 packed his belongings to go home,	F 689	• To identify other residents, the Director of Nursing (DON) or designee will audit all current residents displaying wandering or exit seeking behaviors for completion of Wandering/Elopement Evaluation, appropriate implementation of interventions in plan of care, update of “Elopement Binder”, and alert documentation. Systemic Changes: • It is the facilities policy to ensure all residents remain as free of accident hazards as possible and that each resident receives adequate supervision. The facility evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process. The Wandering/Elopement Evaluation has been revised to indicate low risk, at risk, and high risk for wandering. This evaluation will be used to identify residents at risk for wandering and elopement on all new admissions or newly identified residents with exit seeking behaviors. • The Wandering/Elopement evaluation will be completed on all new admits or newly identified residents with exit seeking behaviors. If the resident is “at risk” or “high risk”, an elopement care plan will be initiated, the resident will be	

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F 689	Continued From page 3 continued to be cognitively impaired, having a diagnosis of dementia, stayed near exit doors, wandered aimlessly, and exhibited a pattern. The evaluation indicated that he was now a risk for elopement although the wandering score category listed him again as a "low risk." A review of an Interdisciplinary Note (IDT, a team of professionals that meet to discuss and plan the care of residents) dated 2/13/22 at 10:20 am, indicated a LN observed Resident 1 heading towards the main double doors from the West side of the facility setting off the door alarms around 7:30 am. A review of another Wandering/Elopement Evaluation dated 3/11/22 at 10:20 pm indicated Resident 1 eloped from the facility and was found by a stop sign by the parking lot. Again, the wandering risk score category still listed Resident 1 as "low risk." A review of an IDT note dated 3/12/22 at 12:31 am, indicated that a hospital security called and alerted the facility Resident 1 was outside sitting on a curb by a stop sign in a parking lot. A review of Resident 1's elopement risk /wandering care plan initiated on 2/12/22 indicated the goal was that Resident 1 would not leave the facility unattended. The care plan indicated that the facility would assess 1:1 (one on one supervision) candidacy on 3/12/22 and implement the 1:1 on 3/15/22, after Resident 1 had eloped and exhibited exit seeking behavior. During an interview with LN A on 5/25/22 at 9 am,	F 689	added to the “Elopement Binder” with date of initiation, and resident will be placed on alert charting to monitor for safety. Inservice to Licensed Nursing Staff has been initiated with a completion date of 9/30/2022. • Additional cameras have been placed at various exit doors to aid in visual supervision of any individual entering or exiting the building. Inservicing to Direct Care Staff has been initiated with a completion date of 9/30/2022. • Elopement Drills will be conducted Biannually for all staff on all shifts to assist with education on the procedure regarding a missing resident. Monitoring: • To monitor, new admission charts will be audited by the Director of Nursing (DON) or designee daily for the next 90 days, to ensure Wandering/Elopement Evaluation is complete and if the resident is determined to be an elopement risk a care plan has been initiated and the Elopement Binder is updated, then monthly thereafter.	

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she stated she was working when Resident 1 eloped from the facility and that they do not know how he got out. LN A stated no alarms were heard, they were not sure how he exited the facility.

On 6/15/22 at 1 pm, the Maintenance Supervisor (MS) was interviewed. MS stated Resident 1's room to where he was found outside on 3/11/22 was approximately 200 feet with a downward slope. He stated they never determined the route he took but he had to have exited through a closed fire door and an alarmed door. He stated staff have the code to the exit doors but cannot turn off the alarm. He stated staff can use the code to open the locked doors. MS stated the facility only has cameras for the front door and lobby.

During an interview with LN B on 6/15/22 at 2:30 pm, he stated he observed Resident 1 down the hill by the stop sign after the hospital security had notified them. LN B stated it was dark outside when they found him.

On 5/26/22 at 2:30 pm the Executive Director (ED) was interviewed. She stated no one saw Resident 1 leave the facility, and she knew staff needed to be educated.

2. On 4/12/22 at 7 am, CDPH received notification that Resident 2 was found outside of the facility on 4/11/22 at 4:30 pm.

Resident 2 was admitted to the facility on 3/21/22 with diagnoses that included dementia, kidney disease, difficulty walking, muscle weakness and a history of falling.

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F 689	Continued From page 5 A review of Resident 2's MDS dated 3/27/22 assessed Resident 2 as mentally impaired (unable to think or reason) and required one staff person assist for transfers and walking. A review of Resident 1's admission Wandering/Elopement Evaluation dated 3/21/22 indicated she was not an elopement risk. The next Wandering/Elopement Evaluation was conducted on 3/21/22 and the evaluation indicated Resident 2 was observed wandering, confused, and gathering her belongings stating she was looking for the living room. A review of another Wandering/Elopement Evaluation dated 4/11/22 was conducted after her elopement and indicated she continued to have behavior of exit seeking. All the above evaluations indicated Resident 2 wandering risk score and category was "low risk" despite her behaviors and her elopement on 4/11/22 . A review of an IDT note dated 4/12/22 at 8:03 am indicated Resident 2 was observed by a Certified Nursing Assistant (CNA) outside of the facility on 4/11/22. The note additionally indicated the one-on-one Hospitality Aid (HA) was assigned to a different resident during this time. Documentation indicated Resident 2 was reevaluated as a high risk due to the elopement. A review of Resident 2's elopement risk /wandering care plan initiated on 4/7/22 indicated the goal was that Resident 2 would not leave the	F 689		

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F 689	Continued From page 6	F 689		

facility unattended and was placed with a 1:1 on 4/12/22.

On 5/22/22 at 3:30 pm LN C was interviewed. She stated Resident 2 was back in the facility by the time she heard about the elopement. She stated prior to the elopement she was observed by staff packing her belongings and stating she wanted to go home.

During an interview with CNA D on 6/15/22 at 12:30 pm she stated she was the one who found Resident 2 outside. She stated she was caring for another resident and the blinds were open. CNA D stated she saw Resident 2 outside and immediately went and got her. CNA D stated prior to the elopement Resident 2 had moments when she kept saying she wanted to go home. She stated no alarms were heard and that someone had to have opened the door or turned off the alarm. She stated there was a HA on the hall and possibly the elopement happened when the HA went to the bathroom.

On 6/15/22 at 1 pm, the MS was interviewed. MS stated Resident 2's room was approximately 50 feet from where she was found outside of the facility.

During an interview with the Executive Director (ED) on 8/11/22 at 1:20 pm she stated the process of determining when a resident was assigned a 1:1 is determined by the IDT. She stated the decision was based on if staff can redirect them or if the behavior was habitual. ED would not state Resident 1 and 2 were not properly supervised. ED stated no one knew Resident 1 was out of the building and it was an

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F 689	Continued From page 7 "..anomality..." to her how Resident 2 got out. She acknowledged the facility only has the one camera in the lobby and they are now considering the placement of more cameras. She stated the facility was now wired for a network for the implementation of a wanderguard system (a bracelet device worn by the resident that alarms when the resident wanders past a protected zone).	F 689		