PRINTED: 04/28/2023 FORM APPROVED OMB NO. 0938-0391

| ND PLAN                  | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  |  | E SURVEY<br>IPLETED              |
|--------------------------|---|--|---------------------|--|--|----------------------------------|
|                          |   | 055887   | B. WING             |  |  | C<br>28/2023                     |
|                          | PROVIDER OR SUPPLIER BEND NURSING CEN   |  |                     | STREET ADDRESS, CITY, STATE, ZIE<br>2215 OAKMONT WAY<br>WEST SACRAMENTO, CA 95   | P CODE   | 2012023                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY  | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETIO<br>DATE        |
|                          | The following refl California Departra abbreviated surve reported incident in Representing the Health Facilities E.  The inspection was reported incident in represent the findifacility.  Free of Accident HCFR(s): 483.25(d)  §483.25(d) Accident Hacility must be §483.25(d)(1) The as free of accident supervision and a accidents. This REQUIREME by:  Based on observice of the front door and being aware of the This failure had the compromising the | ects the findings of the nent of Public Health during an y for the investigation of facility #CA00829822.  Department of Public Health: valuator Nurse (HFEN), 26987  Is limited to the specific facility nvestigated and does not ings of a full inspection of the dazards/Supervision/Devices (1)(2)  Ints. Insure that - In resident environment remains thazards as is possible; and in resident receives adequate esistance devices to prevent entire that and safety of 1 of 3 int 1), which could have been | F 00                | This document will serve a allegation of our intent to deficient practice identified Preparation and/or executi Plan of Correction do not dadmission or agreement, by provider, of the truth of the alleged or conclusions set Statement of Deficiencies. Correction is prepared and solely because it is require provisions of Health and S. Section 1280 and 42 C.F.F. How corrective action(s) we accomplished for those results have been affected by the practice.  -No other residents were for affected at this time. Upon of the alleged deficient prapurchased a new wanderg and installed for replacement malfunctioned system. All serviced on 3/8,3/9, and 3/4 the wanderguard system, and reporting, and appropring and appropring and appropring and preporting and appropring and system on one supervision until discharge on 3/10/2023. | correct the l. on of this constitute by the facts forth on the This Plan of Mor executed and by the afety Code R. 405.1907 will be sidents found to deficient cound to be identification actice, the facility guard system ent of the staff were infollogrent policy riate 1 unit discharge. | Received 5/31/23 APPRING 5/31/23 |

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RKMT11

Facility ID: CA030000027

If continuation sheet Page 1 of 8

PRINTED: 04/28/2023 FORM APPROVED OMB:NO. 0938-0391

| CENIER                   | (O LOD MEDIOVIVE   | OF MEDIOVAD OFFIVATOR  | g/   |  | <u> </u>                      |
|--------------------------|--|--|--|--|-------------------------------|
| STATEMENT<br>AND PLAN O  | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|                          |  | · .  |  | - The state of the | c                             |
|                          |  | 055887   | B. WING_   |  | 04/28/2023                    |
| NAME OF F                | PROVIDER OR SUPPLIER   | nomentinia k and the second se |  | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |
| THE REAL PROPERTY STATES | mam allimoteto ocali   | a Goas Bury  |  | 2215 OAKMONT WAY   | •                             |
| RIVER B                  | END NURSING CENT   | EK   |  | WEST SACRAMENTO, CA 95691  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | (TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | BE COMPLETI                   |
|                          | k samen ni vinancine kanzani kanisa kani |  | M. Land  |  |                               |
| F 689                    | Continued From pa  | age 1  | F 68   | How the facility will identify other res   | idente                        |
|                          |  | •  |  | having the potential to be affected b  |                               |
|                          | Findings:  | •  |  | the same deficient practice and wha  |                               |
|                          |  |  |  | corrective action will be taken.   | *                             |
|                          |  | ical record for Resident 1   |  |  |                               |
|                          |  | t 1 was admitted to the facility   | :<br>  | -No other residents were found to be   | e                             |
|                          |  | oses including, major<br>halopathy (a disease in which   |  | affected at this time. All residents ar  | 1                             |
| :                        |  | he brain is affected), stroke,   |  | potentially to be affected by this alle  | ged                           |
|                          |  | gnitive communication deficit  |  | deficient practice as failure to maint   | ain                           |
|                          |  | ing and language), serious   |  | supervision of residents at risk for   | :<br>                         |
|                          |  | chosis with delusions and  | ·<br>•   | elopement would affect patient care  | . All                         |
|                          |  | sorder characterized by a  | MCCOOL TO THE TOTAL THE TOTAL TO THE TOTAL TOTAL TO THE T | residents were assessed for elopen   |                               |
| ,                        | disconnection from   | reality), muscle weakness,   | 1  | and placement of wanderguard brace   | celet.                        |
|                          | and a lack of coord  | sination.  | 1  | IDT team to review the elopement   |                               |
|                          |  | er en  |  | assessment upon admission to the   |                               |
|                          |  | ysician Orders dated 8/11/22,  |  | and quarterly or as needed thereaft  | er.                           |
|                          |  | n system] to the right ankle at  | -  |  |                               |
|                          |  | nsed Nurse] to check   | -  | What measures will be put into place   |                               |
|                          | placement every s  | rm4.   | 1  | what systemic changes the facility v   |                               |
|                          | A review of a Care   | Plan for Resident 1 dated  |  | make to ensure that the deficient pr   | actice                        |
|                          |  | "Fall Risk score of 10 (score of   | :  | does not recur.  |                               |
|                          |  | a high risk for falls)."   |  | -It is the policy of the facility to ensu  | ira that                      |
|                          |  |  |  | the residents of the facility who are  |                               |
|                          |  | ysician's Orders dated 1/26/23   |  | risk for wandering will have wander  |                               |
|                          |  | r for the following medications  |  | bracelets. Residents will be evaluat   |                               |
|                          | for Resident 1:  |  |  | wandering risk at the time of admis  | 7                             |
|                          | :<br>: (A)   | and the manufication \ O E man   |  | quarterly or as needed thereafter. If  |                               |
|                          |  | anxiety medication) 0.5 mg of measurement) one tablet at   |  | will review MDS Coordinator/Design   |                               |
|                          |  | ssive behavior manifested by   |  | submission of the Elopement Asset  |                               |
|                          |  | order (mental illness with   | and the second   | Upon identification of the alleged   | -                             |
|                          |  | usional thought process).  | *  | deficiency, floor staff were inservice   |                               |
|                          | e sometiment in manifest and party on a  | marrant assauding branching.   |  | the importance of supervision and t  |                               |
|                          | Sertraline HCL (ar   | ntidepressant) 25 mg one tablet  | 2  | wanderguard system. The facility   | :                             |
|                          | by mouth daily for   | exit seeking behavior  |  | purchased and installed a new  | -                             |
|                          | manifested by ma   | or depression.   |  | wanderguard system.  | •                             |

A review of the Minimum Data Set

|                          |  |  | Address of the second s |  |  |  | MIN INC                           | . บฮง๐-บงฮู  |
|--------------------------|--|--|--|--|--|--|-----------------------------------|--|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUI<br>A. BUILC   |  | E CONSTRUCTION   |  | (X3) DAT<br>CON                   | E SURVEY<br>APLETED  |
|                          |  | 055887   | B. WING  |  | · · · · · · · · · · · · · · · · · · ·  |  |                                   | C<br>/28/2023  |
|                          | PROVIDER OR SUPPLIER  END NURSING CENT   | ER   | STREET ADDRESS, CITY, STATE, ZIP CODE 2215 OAKMONT WAY WEST SACRAMENTO, CA 95691   |  |  |  |                                   | Application of the Control of the Co |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG  |  | PROVIDER'S PLAN C<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE  | CTION SHOULD<br>O THE APPROPE  | BE                                | (X5)<br>COMPLETION<br>DATE   |
| F 689                    | (MDS-assessment serious mental illne interview for Menta (0-15, 0 is severe c 1 was ambulatory, assistance with bat dressing. Resident decision-making an party. Resident 1 hand the assessmen "Does the wanderin significant risk of gedangerous place? A Behavior or Other S getting "Worse" for | tool), dated 2/19/23, indicated ss, impaired vision, a Brief I Status (BIMS) score of 9, ognitive impairment). Resident required supervision and hing, cueing with eating and 1 was not capable of d family was their responsible ad wandering behaviors daily, at questionnaire indicated, g place the Resident at eting to a potentially answered, "Yes". A Change in Symptoms was assessed as Resident 1. | F  |  | The Maintenance Direct perform weekly checks of condition of the wanders. How the facility plans to performance to make sure sustained.  Maintenance Director/Deand findings to the DON Deficiency and intervent reviewed in the next two Administrator will bring 2 the meeting to discuss a understanding. | on the working uard system monitor its ure that solutions will resigned will resigned will resigned to be a QAPI meetions to be a QAPI meetions and PO | ng<br>n.<br>cons<br>report<br>or. |  |
|                          | medications available missed a total of for scheduled medication including, anxiety, obehaviors with hallus Resident 1's Medica (MAR) for March 20 missing four daily dof Clonazepam and   | ent, Resident 1 had no<br>ole for 36 hours. Resident 1<br>our doses of the regularly<br>ons for mental illness<br>depression, and aggressive<br>definitions. A review of<br>ation Administration Record<br>023 indicated, Resident 1 was<br>oses of medication. One dose<br>one dose of Sertraline on<br>se of Clonazepam and one<br>on 3/4/23.  |  |  | Date of compliance:3/17  | 7/2023   |                                   |  |
|                          | not be stopped abrumedication Sertralir problems as a side monitoring. Sertralir drowsiness, fainting  | ayo Clinic, Clonazepam should uptly to avoid withdrawal. The ne can cause bleeding effect and requires close ne has side effects of places of the cardiac problems. These of recommended to be   |  |  |  |  |                                   |  |
|                          | An interview with th   | e Maintenance Supervisor   |  |  |  |  |                                   | ,  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '   | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |   |
|---|--|---|---|---|---|
|   | 055887   |   |   |   | C<br>04/28/2023   |
| •   | PROVIDER OR SUPPLIER<br>END NURSING CEN  |   |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>2215 OAKMON'T WAY<br>WEST SACRAMENTO, CA 95691            | DE , .  |
| (X4) ID<br>PREFIX<br>TAG  | /FACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE COMPLÉTION   |
| F 689   | MS stated he was<br>or logging the fund<br>stated he did not k   | ed on 3/8/23 at 10:10 a.m. The<br>not checking the alarm system<br>ition of the system. The MS<br>now if it was working. The MS<br>alarm system had been  | F 68  | 39  |   |
|   | A record review ar conducted on 3/8/2 Director of Nursing eloped from the fa and was found in at 1:12 p.m. The Ecustody in another from a stranger. Tenforcement was the facility. The logacility they had R | nd concurrent interview 23, at 10:56 a.m. with the 3 (DON), indicated Resident 1 cility around 8 p.m. on 3/2/23, a jail in another town on 3/5/23 DON stated Resident 1 was in town after he had a car ride he DON confirmed local law alerted Resident 1 had eloped cal law enforcement notified the esident 1 in their custody. The vent to pick up Resident 1 from |   |   | A contract of the contract of |
|   | 3/8/23 at 11:12 a.i<br>unaware the door<br>in the facility. The<br>eloped from the fa<br>the facility on 3/5/<br>Resident 1 was al<br>was to have an al<br>times. The ADM of                                 | h the Administrator (ADM) on m. The ADM stated he was alarm system was not working ADM confirmed Resident 1 acility on 3/2/23, and returned to 23. The ADM further confirmed a high risk for wandering and arm system on his ankle at all confirmed no maintenance logs the working condition of the m.   |   |   |   |
| e per en den mangen des data dal distribute del data des        | Elopements, date<br>as at risk for wand<br>safety issues, the  | ity policy titled, Wandering and<br>d 8/3/21, indicated, "If identified<br>dering, elopement, or other<br>Resident's care plan will<br>and interventions to maintain  | Andrews and the second |   |   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '  |        | E CONSTRUCTION (X3) D/  | ATE SURVEÝ<br>OMPLETED   |
|---|--|--|--|--------|---|--|
|   |  | 055887   | B. WING  |        |   | С  |
| NAME OF   | PROVIDER OR SUPPLIER   |  | D. VIIIG   |        | TREET ADDRESS, CITY, STATE, ZIP CODE  | <del>1/28/2023</del>   |
| MAINE OF  | PROVIDEN ON GOLFLIER   | <i>,</i>   |  |        | 216 OAKMONT WAY   |  |
| RIVER B   | END NURSING CENT   | ER   |  |        | VEST SACRAMENTO, CA 95691   |  |
| (X4) ID   | SUMMARY STA  | TEMENT OF DEFICIENCIES   | · iD   | l      | PROVIDER'S PLAN OF CORRECTION   | (VE)   |
| PREFIX<br>TAG   | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREF<br>TAG  |        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |
| F 908<br>SS=D   | CFR(s): 483.90(d)(<br>§483.90(d)(2) Main<br>and patient care eq                                      | nt, Safe Operating Condition<br>2)<br>tain all mechanical, electrical,<br>juipment in safe operating   | F  | 908    | How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  |  |
|   | by: Based on observative review, the facility facility facility facility facility facility facility. | NT is not met as evidenced<br>tion, interview, and record<br>ailed to ensure the door alarm<br>king order, when Resident 1<br>ne front door and eloped the |  |        | -No other residents were found to be affected at this time. Upon identification of the alleged deficient practice, the facility purchased a new wanderguard system and installed for replacement of the malfunctioned system. All staff were in-    | The state of the s |
|   | for a census of 80.  This failure had the compromising the I   | being aware of the elopement potential of seriously health and safety of Resident been life-threatening to   |  |        | serviced on 3/8,3/9, and 3/10 regarding the wanderguard system, elopement polic and reporting, and appropriate management of Resident 1 unit discharge Resident 1 was put on one on one supervision until discharge from the facility on 3/10/2023. |  |
| ·   | with diagnoses incl<br>encephalopathy (a<br>functioning of the b<br>in left eye, cognitive           | mitted to the facility in 2021<br>uding, major depression,<br>disease in which the<br>rain is affected), stroke, blind<br>e communication deficit (able    |  |        | 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.  -No other residents were found to be affected at this time. All residents are          | A contraction contraction contraction contractions   |
|   | psychosis with delu  | ly), serious mental illness,<br>isions and hallucinations,<br>and a lack of coordination.  | Control of the contro |        | potentially to be affected by this alleged<br>deficient practice as failure to maintain<br>supervision of residents at risk for   |  |
| ,   | indicated, "[alarm   | sician Orders dated 8/11/22,<br>system] to the right ankle at<br>sed Nurse] to check<br>nift."   | Company of the control of the contro | ;<br>; | elopement would affect patient care. All residents were assessed for elopement risk and placement of wanderguard bracelet. IDT team to review the elopement assessment upon admission to  |  |
|   | 2/14/23, indicated,  | Plan for Resident 1 dated "Fall Risk score of 10 (score of a high risk for falls)"   | las ann com-adhronnoan voo an  |        | the facility and quarterly or as needed thereafter.   |  |

| 77 m 1 4 1 1 2 1 1 2 1 1 | 10 I OU MITOIOWIE   | CAMEDIONING PRIZITED  |                      | -  |  | A Parket of A parket  | 0000-0001  |
|--------------------------|---|---|----------------------|--|--|---|--|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/GLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |  | E CONSTRUCTION   |   | SURVEY<br>PLETED   |
|                          |   | 055887  | B. WING              | - Constitution of the Cons | # Market Control of the Control of t |   | )<br>28/2023   |
|                          | PROVIDER OR SUPPLIER  |   |                      | 22   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>215 OAKMONT WAY  |   | Harachan and Anna and |
| MAEK D                   | EMD MOKAHAG CEMI  |   |                      | W  | VEST SACRAMENTO, CA 95691  |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG   |  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE   |
| F 908                    | A review of the Min (MDS-assessment serious mental illne Interview for Mental (0-15, 0 is severe of 1 was ambulatory, assistance with bat dressing. Resident decision-making ar party. Resident 1 h and the assessment "Does the wanderin significant risk of g dangerous place? Behavior or Other getting "Worse" for documented evide indicating a revision elopement.  A review of the Me indicated an order Clonazepam (antial (milligram, a unit of bedtime for aggress schizoaffective dishallucinations, deluted in the second of the Me indicated an order Clonazepam (antial (milligram, a unit of bedtime for aggress schizoaffective dishallucinations, deluted in the second of the Me indicated an order Clonazepam (antial (milligram, a unit of bedtime for aggress schizoaffective dishallucinations, deluted in the second of the Me indicated an order Clonazepam (antial (milligram, a unit of bedtime for aggress schizoaffective dishallucinations, deluted in the second of the Me indicated an order Clonazepam (antial (milligram), a unit of bedtime for aggress schizoaffective dishallucinations, deluted in the second of the Me indicated an order Clonazepam (antial (milligram), a unit of bedtime for aggress schizoaffective dishallucinations, deluted in the second of the manufactions and the second of the second | imum Data Set tool) dated 2/19/23 indicated, tool) dated 2/19/23 indicated, tess, impaired vision, a Brief al Status (BIMS) score of 9, cognitive impairment). Resident required supervision and thing, cueing with eating and 1 was not capable of and family was their responsible ad wandering behaviors daily, and place the Resident at etting to a potentially Answered, "Yes". A Change in Symptoms was assessed as Resident 1. There was no note in Resident 1's Care Plans in to keep Resident 1 safe from dication Orders, dated 1/26/23, for the following medications: anxiety medication) 0.5 mg f measurement) one tablet at asive behavior manifested by order (mental illness with usional thought process). Attidepressant) 25 mg one tablet exit seeking behavior | F.                   |  | What measures will be put into place what systemic changes the facility wake to ensure that the deficient prodoes not recur.  It is the policy of the facility to ensure the residents of the facility who are risk for wandering will have wander bracelets. Residents will be evaluated wandering risk at the time of admission and quarterly or as needed thereafted team will review MDS Coordinator/Designee submission of the Elopent Assessment. Upon identification of alleged deficiency, floor staff were inserviced on the importance of supervision and the wanderguards. The facility purchased and installed wanderguard system. The Mainten Director/Designee will perform were checks on the working condition of wanderguard system.  How the facility plans to monitor its performance to make sure that solution are sustained.  Maintenance Director/Designee will and findings to the DON/Administrator be reviewed in the next two QAPI meand Administrator will bring 2567 and Fithe meeting to discuss and ensure understanding.  Date of compliance:3/17/2023   | vill actice  are that at high guard ed for sion er. IDT nent the  ystem. a new ance kly the  I report ator. etings. OC to |  |
|                          | According to the M  | layoClinic, Clonazepam should   |                      |  |  |   |  |

|                          | NOT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED  |  |   |                                       |   |    |                            |  |
|--------------------------|---|---|--|--|---|---------------------------------------|---|----|----------------------------|--|
| ٠                        |   | 055887  | B. WING  | -  |   | ·                                     |   |    | ີ<br>ກອ <i>າ</i> ຈຄວາ      |  |
|                          | NAME OF PROVIDER OR SUPPLIER RIVER BEND NURSING CENTER  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  2215 OAKMONT WAY  WEST SACRAMENTO, CA 95691   |   |                                       |   |    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG  |  | (EACH CO  | PRRECTIVE A                           | OF CORRECTION<br>ACTION SHOULD<br>TO THE APPROPE<br>ENCY) | BE | (X5)<br>COMPLETION<br>DATE |  |
| F 908                    | medication Sertral<br>problems as a sid<br>monitoring. Sertral<br>drowsiness, fainting<br>recommended to  | age 6 ruptly to avoid withdrawal. The line can cause bleeding e effect and requires close line has side effects of ag, cardlac problems. Not stop taking the medication   | The state of the s | 908  | regressed and the state of the | Accordance on the graph of the second | deng atau munimi digilih da samuna maga                   |    |                            |  |
| ·<br>·                   | medications while between 3/2/23 to   | I two daily doses of the<br>on elopement from the facility<br>3/5/23, which compromised the<br>and had the potential to be<br>Resident 1.   | ori menindis emili ki kilabilah kirilah dan dan karanca terpengan versi interden   | The state of the s |   |                                       |   | •  |                            |  |
|                          | (MS) was conduct<br>MS stated he was<br>or logging the fund<br>stated he did not le   | he Maintenance Supervisor<br>ed on 3/8/23 at 10:10 a.m. The<br>not checking the alarm system<br>ction of the system. The MS<br>know if it was working. The MS<br>alarm system had been<br>years.  | magninamenteration also the total of the terminates  |  |   |                                       |   |    |                            |  |
|                          | indicated Residen around 8 p.m. on in another town or interview with the 3/8/23 at 10:56 a.r was arrested in arride from a strangwere alerted the Facility and notified in their jail. The Do | nd concurrent interview, t 1 eloped from the facility 3/2/23, and was found in a jall a 3/5/23 at 1:12 p.m. In an Director of Nursing (DON) on m., the DON stated Resident 1 tother town after he had a car er. Stated the law enforcement tesident 1 had eloped the I the facility they had Resident 1 ON stated she went to pick the in the Detention Center on | · · · · · · · · · · · · · · · · · · ·  | escondinate de la constant   |   |                                       |   |    |                            |  |
|                          | at 11:12 a.m. The   | Administrator (ADM) on 3/8/23 ADM stated he was unaware   | The state of the s |  | :   | •                                     |   | •  |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  |  | CONSTRUCTION   | (X3) DAT<br>COM  | (X3) DATE SURVEY<br>COMPLETED |  |  |  |
|---|--|--|--|--|--|-------------------------------|--|--|--|
|   |  | 055887   | B. WING  |  |  |                               | C<br>28/2023                               |  |  |
|   | PROVIDER OR SUPPLIER<br>END NURSING CEN  | TER  | STREET ADDRESS, CITY, STATE, ZIP CODE  2216 OAKMONT WAY  WEST SACRAMENTO, CA 95691   |  |  |                               |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |  | IX   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE .                     | (X5)<br>COMPLETION<br>DATE                 |  |  |
| F 908   | facility on 3/2/23, a 3/5/23. The ADM f was at high risk for an alarm system of ADM further acknown or working and not maintenance of the of all residents.  A review of a facili Etopements, dated as at risk for wand safety issues, the   | age 7 ad Resident 1 eloped from the and returned to the facility on urther confirmed Resident 1 r wandering and was to have in his ankle at all times. The owledged the alarm system was a logs had been kept for the e system to ensure the safety by policy titled, Wandering and 18/3/21, indicated, "If identified lering, elopement, or other Resident's care plan will and interventions to maintain |  | 908  |  |                               |  |  |  |
| ·   | resident safety."  |  | and the second of the control of the | And the second s |  |                               | man de |  |  |
|   | The state of the s |  |  |  |  |                               |  |  |  |
|   |  |  | and the second s |  |  |                               |  |  |  |
|   |  | •  |  |  |  |                               |  |  |  |