STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00829822. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 26987 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	This document will serve as a credible allegation of our intent to correct the deficient practice identified. Preparation and/or execution of this Plan of Correction do not constitute admission or agreement, by the provider, of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
F 689 SS=D	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 to prevent an accident/hazard for Resident 1, when Resident 1 was able to open the front door and eloped the facility without staff being aware of the elopement for a census of 80. This failure had the potential of seriously compromising the health and safety of 1 of 3 residents (Resident 1), which could have been life-threatening to Resident 1.	F 689	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -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-serviced on 3/8,3/9, and 3/10 regarding the wanderguard system, elopement policy 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.	

Received 5/31/23
POC & EDC Revised & Approved 5/31/23
BIC 3/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 05/31/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 689	Continued From page 1 Findings: A review of the clinical record for Resident 1 indicated, Resident 1 was admitted to the facility in 2021 with diagnoses including, major depression, encephalopathy (a disease in which the functioning of the brain is affected), stroke, blind in left eye, cognitive communication deficit (difficulty with thinking and language), serious mental illness, psychosis with delusions and hallucinations (a disorder characterized by a disconnection from reality), muscle weakness, and a lack of coordination. A review of the Physician Orders dated 8/11/22, indicated, "...[alarm system] to the right ankle at all times. LN [Licensed Nurse] to check placement every shift. " A review of a Care Plan for Resident 1 dated 2/14/23, indicated, "Fall Risk score of 10 (score of 10 and above was a high risk for falls)." A review of the Physician's Orders dated 1/26/23 indicated, an order for the following medications for Resident 1: Clonazepam (antianxiety medication) 0.5 mg (milligram, a unit of measurement) one tablet at bedtime for aggressive behavior manifested by schizoaffective disorder (mental illness with hallucinations, delusional thought process). Sertraline HCL (antidepressant) 25 mg one tablet by mouth daily for exit seeking behavior manifested by major depression. A review of the Minimum Data Set	F 689	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 potentially to be affected by this alleged deficient practice as failure to maintain supervision of residents at risk for 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 the facility and quarterly or as needed thereafter. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. -It is the policy of the facility to ensure that the residents of the facility who are at high risk for wandering will have wanderguard bracelets. Residents will be evaluated for wandering risk at the time of admission and quarterly or as needed thereafter. IDT team will review MDS Coordinator/Designee submission of the Elopement Assessment. Upon identification of the alleged deficiency, floor staff were inserviced on the importance of supervision and the wanderguard system. The facility purchased and installed a new wanderguard system.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 689	Continued From page 2 (MDS-assessment tool), dated 2/19/23, indicated serious mental illness, impaired vision, a Brief Interview for Mental Status (BIMS) score of 9, (0-15, 0 is severe cognitive impairment). Resident 1 was ambulatory, required supervision and assistance with bathing, cueing with eating and dressing. Resident 1 was not capable of decision-making and family was their responsible party. Resident 1 had wandering behaviors daily, and the assessment questionnaire indicated, "Does the wandering place the Resident at significant risk of getting to a potentially dangerous place? Answered, "Yes". A Change in Behavior or Other Symptoms was assessed as getting "Worse" for Resident 1. During the elopement, Resident 1 had no medications available for 36 hours. Resident 1 missed a total of four doses of the regularly scheduled medications for mental illness including, anxiety, depression, and aggressive behaviors with hallucinations. A review of Resident 1's Medication Administration Record (MAR) for March 2023 indicated, Resident 1 was missing four daily doses of medication. One dose of Clonazepam and one dose of Sertraline on 3/3/23, and one dose of Clonazepam and one dose of Sertraline on 3/4/23. According to the Mayo Clinic, Clonazepam should not be stopped abruptly to avoid withdrawal. The medication Sertraline can cause bleeding problems as a side effect and requires close monitoring. Sertraline has side effects of drowsiness, fainting, cardiac problems. These medications were not recommended to be stopped abruptly. An interview with the Maintenance Supervisor	F 689	The Maintenance Director/Designee will perform weekly checks on the working condition of the wanderguard system. How the facility plans to monitor its performance to make sure that solutions are sustained. Maintenance Director/Designee will report and findings to the DON/Administrator. Deficiency and interventions to be reviewed in the next two QAPI meetings. Administrator will bring 2567 and POC to the meeting to discuss and ensure understanding. Date of compliance:3/17/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055687	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 689	Continued From page 3 (MS) was conducted on 3/8/23 at 10:10 a.m. The MS stated he was not checking the alarm system or logging the function of the system. The MS stated he did not know if it was working. The MS further stated the alarm system had been malfunctioning for years. A record review and concurrent interview conducted on 3/8/23, at 10:56 a.m. with the Director of Nursing (DON), indicated Resident 1 eloped from the facility around 8 p.m. on 3/2/23, and was found in a jail in another town on 3/5/23 at 1:12 p.m. The DON stated Resident 1 was in custody in another town after he had a car ride from a stranger. The DON confirmed local law enforcement was alerted Resident 1 had eloped the facility. The local law enforcement notified the facility they had Resident 1 in their custody. The DON stated she went to pick up Resident 1 from the Detention Center on 3/5/23. In an interview with the Administrator (ADM) on 3/8/23 at 11:12 a.m. The ADM stated he was unaware the door alarm system was not working in the facility. The ADM confirmed Resident 1 eloped from the facility on 3/2/23, and returned to the facility on 3/5/23. The ADM further confirmed Resident 1 was at a high risk for wandering and was to have an alarm system on his ankle at all times. The ADM confirmed no maintenance logs had been kept for the working condition of the door alarm system. A review of a facility policy titled, Wandering and Elopements, dated 8/3/21, indicated, "If identified as at risk for wandering, elopement, or other safety issues, the Resident's care plan will include strategies and interventions to maintain resident safety."	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the door alarm system was in working order, when Resident 1 was able to open the front door and eloped the facility without staff being aware of the elopement for a census of 80. This failure had the potential of seriously compromising the health and safety of Resident 1, which could have been life-threatening to Resident 1. Findings: Resident 1 was admitted to the facility in 2021 with diagnoses including, major depression, encephalopathy (a disease in which the functioning of the brain is affected), stroke, blind in left eye, cognitive communication deficit (able to say yes or no only), serious mental illness, psychosis with delusions and hallucinations, muscle weakness, and a lack of coordination. A review of the Physician Orders dated 8/11/22, indicated, "...[alarm system] to the right ankle at all times. LN [Licensed Nurse] to check placement every shift." A review of a Care Plan for Resident 1 dated 2/14/23, indicated, "Fall Risk score of 10 (score of 10 and above was a high risk for falls)."	F 908	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. -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-serviced on 3/8,3/9, and 3/10 regarding the wanderguard system, elopement policy 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. 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 potentially to be affected by this alleged deficient practice as failure to maintain supervision of residents at risk for 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 the facility and quarterly or as needed thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 908	Continued From page 5 A review of the Minimum Data Set (MDS-assessment tool) dated 2/19/23 indicated, serious mental illness, impaired vision, a Brief Interview for Mental Status (BIMS) score of 9, (0-15, 0 is severe cognitive impairment). Resident 1 was ambulatory, required supervision and assistance with bathing, cueing with eating and dressing. Resident 1 was not capable of decision-making and family was their responsible party. Resident 1 had wandering behaviors daily, and the assessment questionnaire indicated, "Does the wandering place the Resident at significant risk of getting to a potentially dangerous place? Answered, "Yes". A Change in Behavior or Other Symptoms was assessed as getting "Worse" for Resident 1. There was no documented evidence in Resident 1's Care Plans indicating a revision to keep Resident 1 safe from elopement. A review of the Medication Orders, dated 1/26/23, indicated an order for the following medications: Clonazepam (antianxiety medication) 0.5 mg (milligram, a unit of measurement) one tablet at bedtime for aggressive behavior manifested by schizoaffective disorder (mental illness with hallucinations, delusional thought process). Sertraline HCL (antidepressant) 25 mg one tablet by mouth daily for exit seeking behavior manifested by major depression. No medications were available to Resident 1 for 57 hours. Resident 1 missed 2 doses of his regularly scheduled medications for mental illness. According to the MayoClinic, Clonazepam should	F 908	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. -It is the policy of the facility to ensure that the residents of the facility who are at high risk for wandering will have wanderguard bracelets. Residents will be evaluated for wandering risk at the time of admission and quarterly or as needed thereafter. IDT team will review MDS Coordinator/ Designee submission of the Elopement Assessment. Upon identification of the alleged deficiency, floor staff were inserviced on the importance of supervision and the wanderguard system. The facility purchased and installed a new wanderguard system. The Maintenance Director/Designee will perform weekly checks on the working condition of the wanderguard system. How the facility plans to monitor its performance to make sure that solutions are sustained. Maintenance Director/Designee will report and findings to the DON/Administrator. Deficiency and interventions to be reviewed in the next two QAPI meetings. Administrator will bring 2567 and POC to the meeting to discuss and ensure understanding. Date of compliance:3/17/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 908	Continued From page 6 not be stopped abruptly to avoid withdrawal. The medication Sertraline can cause bleeding problems as a side effect and requires close monitoring. Sertraline has side effects of drowsiness, fainting, cardiac problems. Not recommended to stop taking the medication abruptly. Resident 1 missed two daily doses of the medications while on elopement from the facility between 3/2/23 to 3/5/23, which compromised the health and safety and had the potential to be life-threatening to Resident 1. An interview with the Maintenance Supervisor (MS) was conducted on 3/8/23 at 10:10 a.m. The MS stated he was not checking the alarm system or logging the function of the system. The MS stated he did not know if it was working. The MS further stated the alarm system had been malfunctioning for years. A record review and concurrent interview, indicated Resident 1 eloped from the facility around 8 p.m. on 3/2/23, and was found in a jail in another town on 3/5/23 at 1:12 p.m. In an interview with the Director of Nursing (DON) on 3/8/23 at 10:56 a.m., the DON stated Resident 1 was arrested in another town after he had a car ride from a stranger. Stated the law enforcement were alerted the Resident 1 had eloped the facility and notified the facility they had Resident 1 in their jail. The DON stated she went to pick the Resident 1 up from the Detention Center on 3/5/23. Interview with the Administrator (ADM) on 3/8/23 at 11:12 a.m. The ADM stated he was unaware the alarm system was not working in the facility.	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	C 04/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(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 908	Continued From page 7 The ADM confirmed Resident 1 eloped from the facility on 3/2/23, and returned to the facility on 3/5/23. The ADM further confirmed Resident 1 was at high risk for wandering and was to have an alarm system on his ankle at all times. The ADM further acknowledged the alarm system was not working and no logs had been kept for the maintenance of the system to ensure the safety of all residents. A review of a facility policy titled, Wandering and Elopements, dated 8/3/21, indicated, "If identified as at risk for wandering, elopement, or other safety issues, the Resident's care plan will include strategies and interventions to maintain resident safety."	F 908		