

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

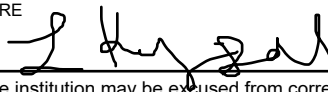
PRINTED: 07/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2023
NAME OF PROVIDER OR SUPPLIER STOCKTON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4545 SHELLEY COURT STOCKTON, CA 95207		
(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 #CA00847862. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 32525 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			
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 safety was maintained for 1 of 3 sampled residents (Resident 1) when she eloped and was brought back to the facility by a man at approximately 5:20 a.m. This failure placed Resident 1 at risk for injury when she wandered out of the facility unaccompanied at night. Findings:	F 689			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



7/30/2023

nha

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.

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F 689	<p>Continued From page 1</p> <p>According to Resident 1's 'Admission Record' the facility originally admitted her over 6 years ago with multiple diagnoses that included unspecified dementia (a condition manifested by loss of memory) and bipolar disorder (a mental condition characterized by episodes of mood swings). The most recent quarterly Minimum Data Assessment (MDS, a tool for assessment) indicated she scored 5 out of 15 in a Brief Interview for Mental Status (BIMS, a tool contained in the MDS) which indicated she had severe cognitive impairment.</p> <p>A review of Resident 1's 'Nurses Note' dated 6/28/23 indicated Licensed Nurse (LN 1) had given her something to eat and drink at around 4:45 a.m. after which, she "Walks with her walker back and forth in the hallway like she usually does... As per her elopement assessment on 6/7/23, she had a score of 8 and was considered of low risk... 0500 [5 a.m.] as per [name of the nurse's station] CNA [Certified Nursing Assistant 1], somebody knocking at the door. She then opened the door and saw the resident with a man ...saw her outside so I brought her back...0505 [5:05 a.m.], The writer met the resident at the nurse station scared and saying ...'I am scared.'"</p> <p>During an interview with CNA 1 on 7/11/23, at 6:52 p.m., CNA 1 stated, on the night Resident 1 eloped, she was assigned to the staff in another nursing station. CNA 1 stated she was providing incontinent care to a resident when she heard a loud bang at the main entrance, and she thought it was the kitchen staff reporting on day shift because they come in very early. CNA 1 stated the banging of the door continued and after she was done changing the resident, she went to check it out and a man showed up at the door</p>	F 689			

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F 689	<p>Continued From page 2</p> <p>with Resident 1 and reported he had found her at the corner. CNA 1 stated she did not ask the man which corner it was. CNA 1 stated Resident 1 was 'panicking and was scared' and she reported the incident to the nurse (LN 1) who was assigned to the resident. CNA 1 stated Resident 1 had behaviors of wandering from place to place inside the facility. CNA 1 stated they are assigned to many residents at night they can hardly have time to supervise wandering residents.</p> <p>An interview conducted with LN 1 on 7/11/23, at 9:51 p.m., she stated Resident 1 eloped on 6/28/23 after 4:45 a.m. and was brought back to the facility by a non-identified man between 5 a.m. to 5:20 a.m. LN 1 stated she may have eloped through a patio door because the main entrance door was locked. LN 1 stated the resident usually wandered inside the facility and the CNAs had indicated she was asking for her sister. LN 1 stated she was not aware the resident had exited the facility until a CNA (CNA 1) notified her of the incident. LN 1 stated the resident was scared when she assessed her, and she tried to calm her down. LN 1 stated the staff assumed the resident could not elope because she had not eloped in the past. LN 1 further stated residents with diagnoses of dementia have wandering behaviors and can wander anywhere and should be checked more frequently for safety.</p> <p>During an observation of the facility's exit doors on 7/10/23, at 12:10 p.m., accompanied by the Administrator, the alarm to some of the exit doors were noted to sound the alarm for residents wearing an alarmed device (wander guard) but not on being opened.</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>An interview conducted with the Administrator on 7/10/23, at 11:35 a.m., she stated Resident 1 had eloped for 20 minutes or less and was brought in by a community member. The Administrator reported Resident 1 did not have a wander guard because she was assessed as low risk of elopement and had not eloped in the past. The Administrator stated she was not aware of which door the resident exit through.</p> <p>A review of the facility's undated policy and procedure titled, "Wandering, Unsafe Resident" indicated, "The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement."</p>	F 689			

F689- Free of Accident Hazards/Supervision/Devices

CFR(s): 483.25(d)(1)(2)

Corrective Action: The Assistant Director of Nurses immediately added a wander guard to the resident to validate that this resident would be safe from eloping going forward. A new elopement assessment was also initiated and completed on 6/28/2023.

Identification of Others: The IDT met and discussed other residents who may be at risk of wandering to validate that all residents have appropriate interventions and care plans. Any concerns identified were corrected.

Systemic Changes: The Assistant Director of Nurses, Nurse consultant and Director of Staff Development began educating licensed nurses on risks of elopement, definition of elopement, policies for elopement, and new interventions for wandering residents at risk of elopement on 7/17/2023.

Monitoring: The IDT will meet 3 times per week times one month then monthly thereafter and as needed to identify any new concerns for wandering behaviors with appropriate interventions and care plans.

Any identified trends will be reported to the Quality Assurance, Performance Improvement committee monthly and as needed until a lessor frequency is deemed appropriate.

Correction Date: 7/17/2023