STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. BUILDING _____ B. WING _____	C 11/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLF CREEK CARE CENTER	107 CATHERINE LANE GRASS VALLEY, CA 95945

(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 Standard Survey for two entity reported incidents. Entity reported Incidents: 536251 and 560707 The inspection was limited to the specific entity reported incidents investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: 06879 HFEN and 37581 HFEN Two deficiencies were written for entity reported incident 536251 at F 323 and State Title 22 at B5030. No deficiencies were written for entity reported incident 560707.	F 000	1) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Every resident on a wander guard was at risk for this practice. The specific resident affected was transferred to a locked unit as is no longer at WCCC. 2) 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. Every resident with a wander guard was at risk for this practice. We reviewed all the care plans of residents with wander guards for appropriateness for wander guard placement and updated the elopement binder; all the care plans were reviewed and revised as needed. 3) What measures will be put in place or what systematic changes the facility will make in ensure that the deficient practice does not reoccur. The wander guard system was replaced with a higher/better frequency, which included a new	
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use and	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenneth Blankfield — TITLE: NHA — (X6) DATE: 1/2/18

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 323	Continued From page 1 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide adequate supervision to one of two sampled residents, Resident 1 on 5/19/17 when he had an unsafe wandering event out of the facility and was missing for two hours. This placed the resident at risk as he had walked alongside a busy highway and was found 2.3 miles from the facility. Findings: In an interview with the Director of Nurses (DON) on 11/27/17 at 1:00 pm, she stated that Resident 1 had been transferred on 9/11/17 to a facility that had a locked unit where Resident 1 could wander and be safe from elopement out of the building. During the record review on 11/27/17 it was noted that Resident 1, 76 years old, was admitted to the facility on 5/15/16 with diagnoses that included dementia, difficulty with walking, unsteadiness on feet, muscle weakness and Schizophrenia. Six months later, on 11/12/16, Resident 1 wandered from the facility and was found by the local police department three hours	F 323	receiver and all new wander guard bracelets. 4) How the facility plans to monitor its performance to make sure that solutions are sustained. LN's are checking wander guard devices every shift for proper placement and function. If one is missing, it is replaced immediately, and the DNS is informed. We also purchased all new wander guard devices and changed the frequency of our system to improve functionality. 5) Date the corrective action will be completed. Review of and updated care plans were completed by 11/29/17. New wander guard system was in place by 12/6/17.	

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F 323	Continued From page 2 later at a local Safeway store. The facility developed an "Elopement Care Plan" at that time that included using a wanderguard (a device that alarms when the resident wanders out of the building) and to "monitor resident's wherabouts frequently." The nursing progress notes showed Resident 1 attempted to elope from the facility on 4/21/17 when the "wanderguard set the front door alarm off when resident went outside. LN (Licensed Nurse) and CNAs (Certified Nursing Assistants) found the resident in the employee smoking area. Resident was brought back inside." In an interview with the Director of Nurses on 11/27/17 at 1:15 pm, she stated that the third elopement occurred on 5/19/17 around 12:45 pm. Staff drove around the area and found Resident 1 at 2:15 pm approximatedly 2.3 miles away from the facility. He was returned to the facility, assessed to have no injuries or other problems from his elopement. The facility assigned a staff member to monitor Resident 1 at all times after this incident. In an interview with CNA A on 6/1/17 at 1:57 pm she stated that she was assigned to care for Resident 1 on 5/19/17, the day he eloped from the facility. She said, "I was in the dining room (helping with the lunch service) when my hall partner (CNA B) told me that she had to redirect Resident 1 twice as he was wandering around the hallway. I went to check on him around 1:30 pm and he was missing. I went outside to look for him but did not find him so I told the nurse." In a telephone interview with CNA B on 11/28/17 at 1:30 pm, she confirmed that she worked on	F 323		

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F 323	Continued From page 3 5/19/17 and remembered the event. She stated, "most of the CNA's were in the dining room helping residents with their lunch meal. It was just myself and one other CNA who were monitoring the hallways and residents in their rooms. I went outside to the courtyard to pick up a resident's lunch tray and I heard the door alarm go off. I knew there was another CNA on the unit so I thought she would check on it. When I came in from the courtyard the alarm was still sounding so I went to the door and I did not see anyone so I thought it had been triggered by a resident who got too close to the door with their wanderguard and then they left the area. I never even thought to go outside to check to see if a resident actually got out of the building. It was my fault. I did not know that Resident 1 was the one who triggered the door alarm when he wandered out." On 11/28/17 at 9:45 am, the staffing assignments for Unit 1 (where Resident 1 resided) were reviewed with the DON. It showed that on 5/19/17 on the day shift (the day Resident 1 eloped) CNA A was assigned to care for 10 residents and CNA B was assigned to care for 9 residents. CNA B confirmed in the interview on 11/28/17 at 1:30 pm that during lunch times, it was difficult to watch residents with high elopement risk while doing lunch duties too. The facility policy titled, "Wandering, Unsafe Resident" was reviewed on 11/28/17 at 10:45 am and read, "staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior." Review of Resident 1's record showed that a	F 323		

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F 323	Continued From page 4 detailed plan was not done for Resident 1, as the care plan was general and read, "monitor resident's whereabouts frequently." This information was verified by the DON and administrator in an interview on 11/28/17 at 10:45 am.	F 323		