STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to maintain a safe environment for two of six sampled residents (Residents 1 and 2) with a Wander guard bracelet (system which triggers an alarm to alert staff when a resident at high risk for elopement [when a person leaves a safe area unattended and unsupervised] is close to an exit door) when Residents 1 and 2 did not have a Wander guard bracelet on and the Licensed Nurses (LN) failed to check the Wander guard for placement and functionality every shift according to the physician ' s order. This failure resulted in Resident 1 leaving the facility in his wheelchair, crossing a busy highway unattended and without staff knowledge on 4/28/24, which placed him at risk for serious injury and Resident 2 was at risk for elopement. (cross reference F921) Findings: During a review of Resident 1 ' s Nurses Notes, dated 4/28/24 at 7:14 a.m., the notes indicated, . 0635 [6:35 a.m.] Patient was seen wheeling himself down the street away from the facility. CN [charge nurse] informed and found patient down the street from the facility at 0645 [6:45 a.m.] . CN and another staff member were able to redirect the pt [patient] back to the facility at 0717 [7:17 a.m.] . During a review of Resident 1's Admission Record (AR-a document containing resident demographic information and medical diagnosis), undated, the AR indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included palliative care (specialized medical care for people with a serious illness), hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of body) following cerebral infarction (disrupted blood flow to the brain), chronic subdural hemorrhage (blood slowly leaking in the brain beneath the outermost layer), and cachexia (weakness and wasting of the body due to chronic illness). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental processes such as thinking, reasoning or remembering) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 06 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had a severe cognitive impairment. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s AR, undated, the AR indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnosis included Parkinsonism (progressive disorder that affects the nervous system [brain, spinal cord and nerves]), dementia (impaired ability to remember, think or make decisions), reduced mobility (move joints and muscles easily), and difficulty in walking. During a review of Resident 2 ' s MDS dated [DATE], indicated the BIMS assessment score was 05. The BIMS assessment indicated Resident 2 had a severe cognitive impairment. During a concurrent observation and interview on 5/15/24 at 12:22 p.m. with Resident 1, Resident 1 was lying in bed dressed. Resident 1 was alert with confusion but was able to answer questions. When asked about the elopement incident, Resident 1 stated he left the facility, and someone had brought him back. Resident 1 pulled up his pant leg showing a Wander guard bracelet on his right ankle and stated it was placed on his leg after the incident. During an interview 5/15/24 at 1:06 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was alert with confusion. CNA 1 stated Resident 1 had a Wander guard placed on his right leg after the elopement. CNA 1 stated she was unsure if Resident 1 had a Wander guard on prior to his elopement on 4/28/24. During a concurrent interview and record review on 5/15/24 at 1:15 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Order Summary Report, (OSR) dated 5/2024 was reviewed. The OSR indicated, . Monitor Placement and Function of SMART Wander-Guard to W/C [wheelchair] Qshift [every shift] . Order date 5/21/2023 . LVN 1 stated It [Resident 1 ' s Wander guard] was not on when he eloped according to report. LVN 1 stated she had placed a Wander guard bracelet on his right leg the day after the elopement. Resident 1 ' s Medication Administration Record, (MAR) dated 4/2024 and 5/2024 were reviewed, the MAR indicated, . Monitor Placement and Function of SMART Wander-Guard to W/C [wheelchair] Qshift every day and night shift . the MAR had a checkmark and initials every day and night shift in April and May. LVN 1 stated the checkmark and initials indicated the nurse had checked the Wander guard for placement and function. LVN 1 stated the residents Wander guards were supposed to be checked every shift. Resident 1 ' s elopement risk assessments were reviewed, the assessment dated [DATE] indicated Resident 1 was a low risk for elopement. LVN 1 stated Resident 1 had a Wander guard ordered and exit seeking behaviors, so she was not sure why the assessment indicated he was at low risk. Resident 1 ' s elopement risk assessment done on 4/28/24 after the incident indicated Resident 1 was at high risk for elopement. Resident 1 ' s elopement risk care plan dated 5/21/23 was reviewed, the care plan indicated, . [Resident 1 ' s name] is an Elopement risk/Wanderer R/T [related to] Disoriented to place, behaviors disturbance, Impaired safety awareness . Goal . Resident will have a reduced risk for elopement/wandering . Interventions . Check Placement and Function of SMART Wander-Guard on W/C Qshift . Monitor for behaviors of Wandering/Elopement Qshift . Re-Direct from wandering by offering pleasant diversions . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review, on 5/15/24 at 1:35 p.m. with LVN 1, Resident 2 ' s OSR, dated 5/2024 was reviewed, the OSR indicated, . WANDERGUARD-APPLY WANDERGUARD TO (RIGHT WRIST0 AND CHECK PLACEMENT &FUNCTIONING QS [every shift] AS A MONITORING DEVICE DUE TO EPISODES OF GOING OUT OF THE FACILITY UNASSISTED . Order Date . 8/9/2023 . Resident 2 ' s MAR dated 5/2024 was reviewed, the MAR was signed indicating the Wander guard had been checked for placement and function every shift. Resident 2 was observed lying in bed, dressed, with his eyes closed. LVN 1 asked Resident 2 to show his arms and legs, the Resident did not have a Wander guard on. LVN 1 stated she did not know how long Resident 2 had not been wearing a Wander guard. LVN 1 stated Resident 2 ' s physician ' s order to check for placement was not followed because the resident did not have a Wander guard on, and the MAR had been signed every shift to indicate it was checked. During a concurrent observation and interview on 5/15/24 at 3:21 p.m. with the Director of Maintenance (DOM), the Wander guard and exit door alarms were tested for function. The exit door next to room [ROOM NUMBER], which was on the same hallway as Resident 1 ' s room, was observed. The door was glass and lead to the parking area at the front of the building. The DOM stated the door does not have a Wander guard alarm on it. A red octagon (shape with eight sides) shaped box with the writing, stop alarm will sound hung at the top of the glass door. There was a keyhole towards the bottom of the alarm. The DOM stated a key was used to arm and disarm the alarm. The DOM stated the red alarm was an exit door alarm and would alert staff when opened. The DOM pushed the door open, and the alarm did not sound. The DOM stated the alarm should make a loud noise when the door was opened. The DOM opened the door again and there was no sound from the alarm. When asked if the exit alarm was functioning, the DOM stated, the alarm is not working if I open the door at this moment. The DOM opened the door a third time and the door alarm did not sound. The DOM pulled the front plate off the alarm and attempted to fix it, then removed it from the door and took it to the maintenance office. During a concurrent interview on 5/15/24 at 3:32 p.m. with the Administrator (ADM) and Director of Nursing (DON) at the exit door by room [ROOM NUMBER], the DON stated the exit door needed to have a functioning alarm on it for resident safety. Resident 1 ' s door could be observed from the exit door by room [ROOM NUMBER]. The DON stated she unsure which exit door Resident 1 used to elope. The ADM stated he did not know if the door alarm had been checked for function after Resident 1 ' s elopement. During a telephone interview on 5/16/24 at 6:31 a.m. with LVN 4, LVN 4 stated he arrived at work on 4/28/24 and received report from the previous shift. LVN 4 stated after report, he was notified Resident 1 was outside the facility. LVN 4 stated he was told by the staff to take his car because Resident 1 was far down the street. LVN 4 stated it took him a few minutes to find Resident 1 because he went across the highway in his wheelchair and was in a church parking lot. LVN 4 stated nobody heard a door alarm go off when Resident 1 eloped, so they did not know which door the resident left from. LVN 4 stated Wander guards were supposed to be checked for placement and function every shift. LVN 4 stated he thought there was a scanner to test the Wander guard somewhere in the facility, but he had never used it. LVN 4 stated Resident 1 did not have a Wander guard on when he found him, so he assumed the resident had cut it off. LVN 4 stated he never found Resident 1 ' s Wander guard in his room and was not sure where it was. During a telephone interview on 5/16/24 at 6:58 a.m. with CNA 5, CNA 5 stated when he arrived at work on 4/28/24 he was told to go down the street to the church and help LVN 4 bring Resident 1 back into the building. CNA 5 stated Resident 1 had crossed a busy highway to get to the church. CNA 5 stated he did not know how long Resident 1 had been out of the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1 ' s IDT (Interdisciplinary Team) note titled, IDT-Change of Condition/Incident, dated 4/29/24, the IDT note indicated, . INCIDENTS . Resident left facility unattended on 4/28/24 . INVESTIGATION . resident was noted wheeling himself down the street at approximately 0645 [6:45 a.m.]. Resident was directed back to the facility . During an interview on 6/5/24 at 11:58 a.m. with the DON, the DON stated her expectation was for the Licensed Nurses to check Wander guards for placement and function every shift. The DON stated there was a tester on every station to test the function of the Wander guard. The DON stated the staff was unable to figure out how Resident 1 eloped from the building. The DON stated Resident 1 did not have a Wander guard on when he eloped because he had removed if and the staff never found it. The DON stated the facility did not have a policy and procedure (P&P) for Wander guards or for testing the door alarms. During a review of the facility ' s policy and procedure (P&P) titled Elopements, dated 12/2007, the P&P indicated, . Staff shall investigate and report all cases of missing residents . Staff shall promptly report any resident who tries to leave the previses . If an employee observes a resident leaving the premises he/she should . Attempt to prevent the departure . Get help from other staff members in the immediate vicinity . When the resident returns to the facility . Examine the resident for injuries . Contact the Attending Physician . Notify the resident ' s legal representative . Complete and file an incident report . Document relevan information in the resident ' s medical record . During a review of the manufacturer ' s guidelines provided by the facility titled Anti-Wandering Door System, undated, the guidelines indicated, . We recommend that all caregivers receive periodic training in the operation of these systems and that the devices are tested daily . the system is not designed to replace good caregiving practices including, but not limited to . Direct patient supervision . Adequate training for staff personnel for fall prevention and elopement . This device is not a substitute for visual monitoring by a caregiver . To meet industry standards, door bars and wristbands should be tested at regular intervals to assure proper functionality. Daily testing recommended .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to provide a safe and functional environment when one of four exit door alarms tested did not function (to alert staff) properly. This failure had the potential for residents to leave the facility undetected by staff, which placed residents at risk for serious injury, accidents and/or death. (cross reference F689) Findings: During a concurrent interview and record review on 5/15/24 at 1:15 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Order Summary Report, (OSR) dated 5/2024 was reviewed. The OSR indicated, . Monitor Placement and Function of SMART Wander-Guard to W/C [wheelchair] Qshift [every shift] . Order date 5/21/2023 . LVN 1 stated Resident 1 had eloped (left the facility without staff knowledge or supervision) from the facility on 4/28/24. LVN 1 stated Resident 1 was known to have exit seeking (wandering and intentionally looking for a way out) behaviors but the Wander guard or exit door alarms should have alerted staff when Resident 1 had eloped. During a review of Resident 1's Admission Record (AR-a document containing resident demographic information and medical diagnosis), undated, the AR indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included palliative care (specialized medical care for people with a serious illness), hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of body) following cerebral infarction (disrupted blood flow to the brain), chronic subdural hemorrhage (blood slowly leaking in the brain beneath the outermost layer), and cachexia (weakness and wasting of the body due to chronic illness). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental processes such as thinking, reasoning or remembering) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 06 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had a severe cognitive impairment. During a review of Resident 1's Nurses Notes, dated 4/28/24 at 7:14 a.m., the notes indicated, . 0635 [6:35 a.m.] Patient was seen wheeling himself down the street away from the facility. CN [charge nurse] informed and found patient down the street from the facility at 0645 [6:45 a.m.] . CN and another staff member were able to redirect the pt [patient] back to the facility at 0717 [7:17 a.m.] . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/15/24 at 3:21 p.m. with the Director of Maintenance (DOM), the Wander guard (system which triggers an alarm to alert staff when a resident at high risk for elopement [when a person leaves a safe area unsupervised] is close to an exit door) and exit door alarms were tested for function. The DOM stated he had worked for the facility for approximately one month and checked all exit door alarms for function weekly. The DOM took a Wander guard monitor to the front door, the alarm sounded when the Wander guard monitor approached the door. The DOM walked to the exit door next to room [ROOM NUMBER] and stated the door did not have a Wander guard alarm on the door. The DOM stated the door had an exit door alarm which would alert staff when the door was opened. The DOM opened the door and the alarm sounded. The exit door next to room [ROOM NUMBER], which was on the same hallway as Resident 1's room, was observed. The door was glass and lead to the parking area at the front of the building. The DOM stated the door does not have a Wander guard alarm on it. A red octagon (shape with eight sides) shaped box with the writing, stop alarm will sound hung at the top of the glass door. There was a keyhole towards the bottom of the alarm. The DOM stated a key was used to arm and disarm the alarm. The DOM stated the red alarm was an exit door alarm and would alert staff when opened. The DOM pushed the door open, and the alarm did not sound. The DOM stated the alarm should make a loud noise when the door was opened. The DOM opened the door again and there was no sound from the alarm. When asked if the exit alarm was functioning, the DOM stated, the alarm is not working if I open the door at this moment. The DOM opened the door a third time and the door alarm did not sound. The DOM pulled the front plate off the alarm and attempted to fix it, then removed it from the door and took it to the maintenance office. During a concurrent interview on 5/15/24 at 3:32 p.m. with the Administrator (ADM) and Director of Nursing (DON) at the exit door by room [ROOM NUMBER], the DON stated the exit door needed to have a functioning alarm on it for resident safety. Resident 1's door could be observed from the exit door by room [ROOM NUMBER]. The DON stated she unsure which exit door Resident 1 used to elope. The ADM stated he did not know if the door alarm had been checked for function after Resident 1's elopement. During a concurrent observation and interview on 5/15/24 at 3:50 p.m. the DOM returned and placed the red door alarm onto the exit door next to room [ROOM NUMBER]. The DOM opened the door, and the alarm sounded a loud, high-pitched sound. The Medical Records Director (MRD) stepped out of her office next door and stated, I do not remember the last time I heard the alarm go off. During a concurrent observation and interview on 5/15/24 at 3:55 p.m. with the DOM, the DOM took a Wander guard and tested the exit door near room [ROOM NUMBER], as the DOM walked towards the end of the hallway the Wander guard alarm sounded. During a concurrent interview and record review on 5/15/24 at 4:00 p.m. with the DOM, the door alarm testing documentation was reviewed and indicated he had last tested the doors on 5/7/24. The DOM stated the previous DOM tested the doors monthly, but he checked them weekly. During an interview on 5/15/24 at 4:15 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she did not remember the last time she had heard the door alarm go off next to room [ROOM NUMBER]. CNA 4 stated she would normally hear the alarm throughout her shift because it was very sensitive and would go off whether the door was touched or not. CNA 4 stated she had not heard the alarm for a while and was not sure if it was working. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 4:20 p.m. with LVN 1, LVN 1 stated the exit door alarm next to room [ROOM NUMBER] was very sensitive and would sound even if the door was bumped. LVN 1 stated she did not remember the last time she had heard the door alarm. During an observation on 5/15/24 at 4:45 p.m. with LVN 1, LVN 1 opened the exit door next to room [ROOM NUMBER] to test the alarm and the alarm did trigger when the door was opened. During a concurrent observation and interview on 5/15/24 at 5:00 p.m. with the ADM and DON, the ADM stated the exit door alarm did not sound because it had not been activated with a key after the DOM fixed it. The DON stated a resident could have eloped from the door if the alarm was not working or if it was not activated properly. During a telephone interview on 5/16/24 at 6:31 a.m. with LVN 4, LVN 4 stated he was the nurse who had found Resident 1 after he eloped. LVN 4 stated on 4/28/24 he had arrived at work, received report from the previous charge nurse and was told Resident 1 had left the facility. LVN 4 stated he was told by a staff member Resident 1 was seen far down the street and he should take his car to find him. LVN 4 stated it took him a few minutes to find Resident 1 because he had gotten across the highway and was in a church parking lot. LVN 4 stated he did not know which door Resident 1 had used to leave the facility. LVN 4 stated the staff did not hear the exit door alarm go off. LVN 4 stated the red exit door alarm next to room [ROOM NUMBER] was sensitive and would frequently sound by itself. LVN 4 stated it had been a while since he had heard the alarm sound. During an interview on 6/5/24 at 11:58 a.m. with the DON, the DON stated she was unable to locate a policy and procedure regarding the use and testing of exit door alarms and Wander guard door alarms.