

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Elk Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9461 Batey Avenue Elk Grove, CA 95624	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident safety for one resident (Resident 1) out of a census of 130 when Resident 1 eloped the facility premises even with a Wanderguard monitor bracelet in place.</p> <p>This failure resulted in Resident 1 missing and eloping from the facility and has reduced the facility's potential in keeping Resident 1 safe from harm.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR), the AR indicated that Resident 1 was admitted [DATE] with diagnosis including Alzheimer's Disease (a disease characterized by progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated May 7, 2025, indicated Resident 1 had severe cognitive impairment.</p> <p>During a review of Nurses Progress Note dated 6/1/25 at 4:45 p.m., indicated, .at 1630 .patient not found . facility staff located patient sitting at the sidewalk .3 houses down from facility</p> <p>During an observation on 6/6/25 at 9:37 a.m. in his room, Resident 1 was wearing his Wanderguard bracelet on his right ankle.</p> <p>During a review of Resident 1's Care Plan, (CP) indicated, no documented evidence of a person-centered care plan related to the potential risk of elopement due to his Alzheimer's Disease and dementia prior to the incident.</p> <p>During a review of Resident 1's CP, initiated on 6/1/25, the CP's intervention indicated, Wander Alert Wanderguard (a type of security system used in facilities to prevent individuals with cognitive impairments from wandering off) placed to RT lower leg .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/5/25 at 12:10 p.m. with Director of Nursing (DON), the DON stated, .the purpose of the wander guard is to set off an alarm to warn the staff when the resident is near or has exited a door. The DON stated, the exit doors must have Wanderguard system sensors for it to work. The DON further stated, the North-north exit door does not have a Wanderguard system sensor. DON stated, The resident used the North - north exit door to wander off outside the facility property. The DON confirmed that Resident 1 was found sitting at a sidewalk 3 houses down from the facility. The DON stated and confirmed, Elopement care plan was not initiated before but after the incident.</p> <p>A review of the facility policy and procedure (P&P), Elopements dated 3/22/22, indicated, .the residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wonder or elopement risk.</p>		