

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 06/12/2025
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 provide adequate supervision for one resident (Resident 1) when resident left the facility unnoticed, for a census of 134.</p> <p>This failure resulted in Resident 1 not receiving nursing care and was exposed to unsafe environment for over 24 hours.</p> <p>Findings:</p> <p>A review of the clinical record indicated Resident 1 was admitted [DATE] with diagnoses including congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), type II diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).</p> <p>A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 4/22/25 indicated Resident 1 was cognitively intact.</p> <p>A review of Resident 1's Nurses Progress Note dated 6/3/25 at 3:30 p.m. indicated, Received [Resident 1] in bed around 0630 .gave her medications at 0830-0900. This time resident was in the room .[CNA 3] assisted resident to have a shower this morning @ around 0800. At 1130 went to check the residents BG [blood glucose] and found resident not in the room .Last time [CNA 3] saw her was around 0930- 1000 in her room . [CNA 4] from NW [northwest] noted resident in front of South Dining hallway ambulating using her FWW [front wheel walker] going towards the front station .At around 1215 [name of police department] was called and reported that we are unable to locate the resident .Attending MD [Medical Doctor] was notified .At .1632 [4:32 p.m.] the resident is still out.</p> <p>A review of Resident 1's Nurses Progress Note dated 6/4/25 at 5:30 p.m. indicated, At around 1730 PM [Resident 1] was returned back to the facility. It was reported that facility neighbor .saw her by corner of [name of 2 streets], given her water and a ride to the facility .resident agreed to go to the ER [emergency room] for further evaluation .</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>A review of Resident 1's History and Physical dated 6/8/25 indicated, .[Resident 1] left the facility without informing anybody (later stating she just wanted to go to the bank). Elopement was reported to PD. [Resident 1] said she spent the whole time out in the streets, sleeping in front of the library, because she could not figure out how to return to the facility. The following afternoon .good Samaritan found her and brought her to the facility. On arrival [Resident 1] was tachycardic [increased heart rate] .a little confused and was sent to the ER .was found to be dehydrated and received fluids .</p> <p>A concurrent observation and interview conducted on 6/12/25 at 9:32 a.m. inside Resident 1's room. Resident 1 was lying in bed with her eyes closed. Resident 1 opened her eyes when her name was called. Resident 1 stated she exited the front door at around 9 a.m. the day she left the facility. Resident further stated she left because she wanted to go to the bank and did not tell her nurse or CNA (Certified Nursing Assistant) she was going out. Resident 1 added she walked about a quarter mile then rode a bus going to the bank.</p> <p>In a subsequent observation and interview on 6/12/25 at 9:41 a.m., Resident 1 stated she had to go outside and she did not answer further questions. Resident 1 got up from bed, walked on the other side of her bed, took her walker and left her room. Observed CNA 1 follow Resident 1 all the way through the back patio.</p> <p>In an interview on 6/12/25 at 9:45 a.m., CNA 1 stated Resident 1 sometimes needs supervision from getting up from the bed because Resident 1 was a fall risk.</p> <p>In an interview on 6/12/25 at 10:05 a.m., CNA 2 stated on the day of the incident, Resident 1 came up to her in the nurse's station around 7 a.m. to 7:30 a.m. and asked for the facility's address and phone number. The CNA 2 further stated she wrote the information in a piece of paper and gave it to Resident 1. CNA 2 added, the front door of the facility had no alarm.</p> <p>In an interview on 6/12/25 at 10:11 a.m., CNA 3 stated he was assigned to Resident 1 on 6/3/25. The CNA 3 stated he gave a shower to Resident 1 around 7:30 a.m. and served resident her breakfast between 8 a.m. to 8:30 a.m. The CNA 3 further stated he picked up Resident 1's breakfast tray at 9 a.m. and she ate 100%. CNA 3 checked Resident 1 at 10 a.m. and resident was not in her room.</p> <p>In a telephone interview on 6/12/25 at 2:21 p.m., CNA 4 stated prior to the incident, she saw Resident 1 walking using her walker towards the south part of the facility. Resident 1 had jogging pants and she was holding her bag. CNA 4 further stated she asked Resident 1 where she was going and Resident 1 answered, I'm going out. CNA 4 stated she did not follow Resident 1 while walking towards the front door of the facility. CNA 4 added she did not report this information to Resident 1's nurse or CNA because she assumed they knew the resident was leaving.</p> <p>In a telephone interview on 6/13/25 at 10:24 a.m., the Assistant Director of Nursing (ADON) confirmed Resident 1 left the facility without telling anyone, and was gone for over 24 hours. The ADON further confirmed Resident 1 did not receive her medications for over 24 hours. The ADON stated the facility had to protect their residents for safety reasons.</p> <p>A review of the facility's policy & procedure (P & P) revised 2/21/25 and titled, Elopements indicated, .occurs when a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so.</p> <p>(continued on next page)</p>		

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