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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055338	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sage Post Acute	1832 B Street Hayward, CA 94541

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. 36593 Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) with impaired mental status received adequate supervision to prevent accident hazards when Resident 1 left the facility and was found and brought to the police station by a concerned citizen. This failure resulted in Resident 1's elopement (elopement is when a patient or resident who is incapable of adequately protecting themselves, departs the health care facility unsupervised and undetected) and had the potential for Resident 1 to be dehydrated, injured, or struck by a motor vehicle. Findings: During a review of Resident 1's Annual Minimum Data Set (MDS - Resident assessment and care guide tool), dated 4/20/24, the MDS indicated Resident 1's Basic Interview of Mental status (BIMS, a scoring system used to determine the resident's cognitive status regarding attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) score was 04 and indicated poorly impaired mental status. The MDS indicated Resident 1 was unable to recall the correct year, month and day of the week. The MDS indicated Resident 1 used a manual wheelchair for mobility. The MDS indicated Resident 1 responded only to simple and direct communication. The MDS further indicated Resident 1 had diagnosis of Non-Alzheimer's Dementia (a group of diseases characterized by progressive deficits in behavior, executive function or language). During a review of Resident 1's progress notes, dated 5/30/24, the progress notes indicated on 5/29/24 at 8:10 p.m., Resident 1 eloped from the facility and the police were notified. The progress notes indicated the police dispatcher mentioned Resident 1 was brought to the police station by a concerned citizen. The progress notes further indicated Resident 1's Family Member (FM1) brought Resident 1 back to the facility. During a concurrent observation and interview, on 6/13/24, at 11:20 a.m., with the Administrator (Admin), Resident 1's room observed with two sliding doors that exited directly into the car parking lot. An exit alarm was observed located on top of the exit sliding doors. The Admin stated the sliding door exit alarm next to Resident 1's bed was found to be loosely connected and not working when Resident 1 eloped from the facility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Sage Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1832 B Street Hayward, CA 94541	

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(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	During a concurrent observation and interview, on 6/13/24, at 11:30 a.m., Resident 1 was observed sitting in a wheelchair in the activity room, verbally responsive with incomprehensible sounds. During a concurrent interview and record review, on 6/13/24 at 12:35 p.m., with Admin, Admin stated Resident 1 attempted to open her room's sliding door in the past. Admin could not provide documentation that addressed Resident 1's attempts to open sliding door that exited into the car parking area, offered room change, and revised care plan prior to the elopement. During an interview on 6/13/24 at 1:39 p.m., with Maintenance Staff (MS), MS stated usually he checked facility's exit door alarms monthly for proper functioning. MS said he did not keep records of scheduled checks or maintenance. MS stated the string to the exit door alarm next to Resident 1's bed was disconnected and loosely screwed. MS stated he reattached the alarm string with a washer to have it in place. MS stated removing the exit door alarm string deactivated the alarm. During an interview on 6/13/24 at 2:45 p.m., Licensed Vocational Nurse (LVN 1), LVN 1 stated she was on duty as charge nurse when Resident 1 eloped. LVN 1 stated she was aware Resident 1 was confused and wandered with risk for elopement. LVN 1 stated one staff member told her Resident 1 was missing. LVN 1 said she went to Resident 1's room, the sliding door was opened, and the alarm to the sliding door was not working. LVN 1 said the exit alarm did not make a sound, the alarm string cord was disconnected and pulled out. LVN 1 said Resident 1's wheelchair was next to her bed and Resident 1 was not in her room. LVN 1 said she called the police right away informed police Resident 1 was missing. Police informed LVN 1 that Resident 1 was found and brought to the police station by a good citizen. During an interview on 6/14/24 at 11:30 a.m., FM 1 stated she was at the facility to visit Resident 1 on 5/29/24 at about 8:00 p.m. when staff could not find Resident 1. FM 1 said staff told her Resident 1 was missing. FM 1 stated she called the Police and was informed that Resident 1 was found about nine blocks away from the facility and was brought to the police station by a good citizen. FM 1 stated she drove to the police station and brought Resident back to the facility. FM 1 stated staff told her Resident 1 was last seen after dinner around 5:30 p.m. FM 1 stated she told the charge nurse about her concern regarding the opened sliding doors in Resident 1''s room several days before Resident 1 left the facility. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised December 2007, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.