STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055807	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shasta View Estates	445 Park Street Weed, CA 96094

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 43755 Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 1), sampled for unsafe wandering (a random, aimless or repetitive search for an exit that is non-goal-directed), and elopement (a resident leaves the premises or a safe area without the facility's knowledge and supervision) was assessed and monitored for unsafe wandering and elopement. Resident 1 eloped twice from the facility and had no wander/elopement risk assessments or care planning done, and the facility had no dedicated alarm system in place for residents who wandered or were at risk to elope. This resulted in Resident 1 eloping from the facility and was found by the police in a ditch near a highway with a scratched face, bruised chin and pain in her right leg. An Immediate Jeopardy (IJ) situation was identified on 7/2/24 at 4:18 pm, in the presence of the Administrator (Admin) and Director of Nursing (DON), due to not having an elopement system in place that ensured the health, safety and welfare of those residents who were at risk for wandering and elopement. An immediate corrective action plan (IJ removal plan) was requested from the Admin and DON. An IJ removal plan was provided by the DON and accepted on 7/3/24 at 1:04 pm. The IJ removal plan included wandering/elopement risk assessments for all residents who resided in the facility, the development of wander/elopement care plans, and the installation of a Wanderguard alarm system (an alarm system where the resident wears a bracelet that triggers an alarm system on the exit doors when they get too close). The IJ removal plan was verified by the surveyor while on site to be fully implemented. The IJ was removed on 7/5/24 at 1:01 pm. Findings: A review of the facility's policy titled, Wandering and Elopements revised March 2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 1. If identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's policy titled, Safety and Supervision of Residents revised July 2017, 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. Individualized, Resident-Centered Approach to Safety . 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: d. Ensuring that interventions are implemented. Resident Risks and Environmental Hazards: 1. Due to their complexity and scope, certain resent risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include e. Unsafe Wandering. A review of Resident 1's Admission Record, undated, indicated Resident 1 was initially admitted on [DATE] and then readmitted on [DATE], after a short hospital stay. Resident 1's diagnoses included dementia (loss of memory and ability to make sound decisions), anxiety disorder, osteoporosis (a decrease in bone mass which causes an increase in risk for bone fractures), diabetes (high sugar in the blood), insomnia (difficulty sleeping), restlessness and agitation. A review Resident 1's Admission Minimum Data Set (MDS, a clinical assessment), dated 6/13/23, indicated Resident 1's cognition (thinking and decision making), was severely impaired and identified that she wandered. No care plan was developed for wandering on admission. A review of Resident 1's, Elopement Risk Documentation Tool (which was kept in an elopement book at the nurse's desk) dated 7/5/23, was reviewed and indicated a single intervention to redirect resident when she was wandering. Types of supervision included, checks by staff, door alarm is on, and usually sits in common area. A review of the facility's daily, Quality Assurance/Interdisciplinary meeting dated 7/6/23, indicated Resident 1 walked out the front door on 7/5/23 and became combative when redirected. Follow up was to do elopement monitoring. No care plan was developed following that elopement. A review of Resident 1's, Wander/Elopement care plan dated 11/7/23 (4 months after first attempted elopement), indicated she was at risk for elopement related to Alzheimer's disease and dementia as evidenced by multiple attempts to leave the facility. Interventions included to assess Resident 1 for elopement/wander risk upon admission and as needed as appropriate. Document elopement attempts. Staff to monitor front door when front door alarms. A review of Resident 1's annual MDS assessment dated [DATE], indicated that wandering behavior for Resident 1 occurred daily. She was independent for getting around in her wheelchair and she could walk 150 feet with supervision. A review of Resident 1's progress notes dated 5/8/24 at 11:14 pm, indicated that Licensed Vocational Nurse (LVN) A documented, Resident was sitting in her wheelchair in the hallway around 9:00 pm - 9:10 pm . CNA [Certified Nursing Assistant] staff approached me around 9:15 pm and stated that she [Resident 1] was unable to be found. I searched with staff around the entire facility, and she was not found by staff .police department called at 9:25 pm stating they found resident on Highway 97 and stated she had a fall with a scratch on her face and they were sending her to the ER [emergency room] for further work up. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 1's Hospital emergency room Visit on 5/8/24 at 11:10 pm, the Physician (MD) documented, [Resident 1] is an [AGE] year-old female with history of dementia reportedly wandered off from [facility name] brought in by ambulance after getting a ride to [Highway] 97 and getting out of the car and falling into a ditch. She has some bruising in her chin which is the only thing she says hurts on initial assessment but on secondary assessment she reports her right leg hurts a little bit as well. A review of Resident 1's Wander/Elopement care plan updated on 5/9/24, indicated new interventions to include; every 15 minute visual checks until no elopement attempts occurred after 5 days, Resident 1 to have one-to-one monitoring by staff (a staff with Resident 1 at all times), on PM (evening) shift when she is the most active to maintain safety and ensure someone is with her if she wishes to go outside and Admin/DON to obtain tracking/safety monitoring device to ensure/maintain resident's safety. A review of Resident 1's progress notes dated 6/11/24 at 11:09 pm, LVN B documented, 8:00 pm-This LVN was unable to locate resident to administer HS [evening] meds. I found resident [Resident 1] sitting on bench [outside] in front of facility. She asked if I could start her car for her so she could go home. A review of Resident 1's Wander/Elopement care plan last edited on 6/14/24, had no mention of her 6/11/24 elopement episode and no new interventions were developed. One-to-one staffing was still mentioned as an intervention and tracking /safety device was still an intervention to maintain Resident 1's safety. On 7/1/24 at 12:45 pm, the front door and Resident 1 were observed. When the front door was opened an alarm would chirp and the sound would stop when the door was closed. Resident 1 was sitting in the hallway near the nurse's desk. During an interview on 7/1/24 at 12:58 pm, the DON indicated they had a sensor on the front door and sliding glass back door that would alarm every time those doors were opened, but it would automatically turn off when the doors closed. The DON continued to say there was no additional system or alarm to indicate when a resident was leaving the facility as opposed to staff and visitors. DON stated that all other exit doors had a loud alarm when opened and had to be turned off with a key. During an interview on 7/1/24 at 2:11 pm, the DON stated there was no formal unsafe wandering or risk for elopement assessments done for the residents upon admission or at any time frame thereafter for reevaluating a residents risk for wandering or elopement. The DON stated that, it's just talked about it at a stand-up meeting, (IDT meeting, a daily meeting where the Interdisciplinary Team, a group of facility managers, discuss the care and services that the facility provides to their residents). The DON indicated there were 4 other residents that the facility's IDT had informally identified that had a risk to wander/elope. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and record review on 7/1/24 at 2:20 pm, Resident 1's care plan was reviewed with the DON. The DON indicated that on the PM shift starting on 5/9/24, a CNA would sit with Resident 1 until she was in bed for the night. She stated they did this for a few weeks then stopped. The DON confirmed that one staff member was to provide dedicated supervision to Resident 1 at all times and this was still an intervention on Resident 1's care plan, but indicated they did not have the staffing to continue this, so they were not doing it anymore. They just kept an eye on her. The DON confirmed that Resident 1's care planned interventions were to have a tracking/monitoring device but that they had not done this. The DON stated, the door alarms will let us know if someone was going out and that they all kept an eye on [Resident 1]. During an observation and interview on 7/1/24 at 3:21 pm, the front doors were observed with a Housekeeping/Maintenance (HSK) staff. Resident 1 was sitting at her usual spot near the nurse's station. HSK indicated the front doors have a chirping/alarm sound when it was opened and the alarm would stop when the door closed. He stated the sound was very low because it needed new batteries. HSK confirmed that the chirp/alarm would alarm every time the door opened whether it was a resident, staff or visitor. He confirmed that if staff were down the hallways, and a resident went outside, they may not hear the alarm sound. He said that the alarm goes on and off all day long and there was nothing different to indicate that the door was opened by a resident. During an observation and interview on 7/1/24 from 3:30 pm to 3:38 pm, 5 other exit doors were observed with the HSK. HSK indicated 4 other exit doors had emergency alarms that would alarm whenever opened and the alarm would not turn off unless a staff used a key at the door. The dining room sliding glass door led to an outside patio and grassy area surrounded by a fence and unlocked gate. This door did not alarm when opened. HSK indicated the chirp alarm was turned off. During an observation on 7/1/24 at 3:51 pm, this surveyor opened the front door and initiated the chirp/alarm. No staff came to see what initiated the alarm. When the door closed the alarm turned off. No one was at the nurse's station which was in view of the front door. During an interview on 7/1/24 at 3:53 pm, LVN C indicated she was the Resident Care Manager (RCM) and she sat at the nurse's desk most of the day and watched the front door to make sure residents did not elope. She confirmed that she was not at the desk a few minutes ago and did not know the front door was opened. She confirmed that there was no other system to alert staff when a resident went outside unsupervised. She indicated that she was away from the desk for about 30 minutes every day for a stand-up meeting and at that time she would not be watching the front door and it was possible for a resident to elope. During an interview on 7/1/24 at 4:10 pm, Registered Nurse (RN) D indicated that Resident 1 was confused and impulsive. RN confirmed that Resident 1 was supposed to have one-to-one supervision (one staff member dedicated to only Resident 1's supervision), on the PM shift, but she did not because there was not enough staff to do this. RN D stated they checked on Resident 1 every 15 minutes but was unable to provide documentation that this was done. RN D continued to say that no one was in charge of monitoring who went in or out of the front door. RN D confirmed that it was possible that a resident could get out of the facility without their knowledge. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/1/24 at 4:46 pm, CNA E stated she was taking care of Resident 1 on 5/8/24, the night she eloped and ended up in the ER. CNA E indicated that the Maintenance Supervisor (MS) was going in and out of the front doors that evening so the front door chirp/alarm was constantly alarming. Resident 1 was sitting by the nurse's station like she always did. CNA E indicated Resident 1 was out of her sight for 15 min while she helped another resident, and when CNA E returned to help Resident 1 to bed Resident 1 was gone. CNA E indicated that the nurse at the desk did not notice Resident 1 go out the front door. During an interview on 7/1/24 at 4:55 pm, CNA F indicated she was working the night Resident 1 left the faciity on [DATE]. CNA confirmed that she did not hear the front door alarm because she was down the hall in resident rooms helping them to bed. She indicated that the front door alarm did not differentiate between a resident, staff member or the pharmacy delivering medications. CNA F indicated that when she does hear the alarm she does not go and investigate it. During an observation on 7/2/24 at 9:30 am, this surveyor entered the facility through the front door which alarmed when opened but stopped when closed. No staff came to identify who opened the door and there was no staff at the nurse's desk. During an interview on 7/2/24 at 9:46 am, MS stated that the front door alarmed so much that some staff may get, immune to it. During an interview with LVN G and a record review on 7/2/24 at 11:00 pm, Resident 1's progress notes and Wandering/Elopement care plans were reviewed. LVN G indicated that Resident 1 was to be a one-to-one on the PM shift because that was when she tried to leave the facility. LVN G confirmed that the one-to-one was not being done because of a staffing shortage but it should be. LVN G confirmed that the facility had not developed new interventions following each elopement for Resident 1 to protect her from eloping again and stated, we should because she could elope again. During an interview on 7/2/24 at 12:32 pm, the DON confirmed they were not doing assessments upon admission to identify a resident's risk for unsafe wandering and elopement. The DON was not aware of an assessment form that she could use for that. The DON confirmed that there was no care plan developed for Resident 1 on admission for being at risk for unsafe wandering and elopement, and there should have been. The DON confirmed that Resident 1 had eloped on 6/11/24. The DON indicated that she had not been informed of that elopement. The DON confirmed that there was no documentation that the facility was checking on Resident 1 every 15 minutes.