STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056090	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Rehabilitation & Behavioral Health	850 Sonoma Ave Santa Rosa, CA 95404

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 - 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** 43238 Based on interview and record review, the facility failed to ensure supervision for one of three sampled residents (Resident 1) when Resident 1 eloped (the act of leaving a facility unsupervised and without prior authorization) fell and sustained injuries. This failure resulted in Resident 1 sustaining a fracture (broken bone) of the left distal phalanx (a small bone on the tip of the thumb located under the nail) and abrasions (a partial loss of skin, usually due to scraping) to his face and both knees. Findings: A review of Resident 1's admission record indicated he was admitted on [DATE] with diagnoses including cerebral infarction (stroke- loss of blood flow to the brain). A review of Resident 1's clinical record included the following documents: A Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 2/14/24, indicated Resident 1 had severe memory impairment and had impairment in both arms and legs requiring assistance with walking. A Fall Risk Assessment, dated 2/7/24, indicated Resident 1 was at moderate risk for falls. A Fall Risk Care Plan, initiated 2/7/24, indicated Resident 1 was at high risk for falls related to neuromuscular/functional problems such as recent stroke. An Elopement Risk Assessment, dated 2/7/24, indicated Resident 1 was at low risk for wandering. A Wandering Risk Assessment (WRA), dated 2/7/24, indicated Resident 1 was at low risk for wandering. An Elopement Care Plan, initiated 2/15/24, indicated Resident 1 was an elopement risk related to his wandering around, trying to go outside or attempting to leave the facility. A Physician's Order, dated 2/15/24, indicated a brand name wandering device (WMD -a sensory device placed on residents that alarms if near a monitored exit) was to be placed on Resident 1. (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 - Actual harm Residents Affected - Few	A nursing progress note, dated 2/15/24 at 1:06 p.m., indicated Resident 1 was confused, wandering, wanted to go home and was attempting to elope the facility by himself. The note further indicated a WMD alarm had been placed on Resident 1's wheelchair. A nursing progress note, dated 2/22/24 at 9:07 p.m., indicated Resident 1 had been trying to leave the facility through the back door of his room throughout the evening. The note further indicated Resident 1 had stated he wanted to go home and he needed constant monitoring for elopement. A nursing progress note, dated 2/23/24, indicated around 12 a.m. staff were unable to locate Resident 1, searched the facility and found his empty wheelchair in the lobby. The note indicated a Certified Nursing Assistant (CNA) found Resident 1 lying on the sidewalk outside the facility. A SBAR note (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition in the resident), dated 2/23/24 at 3:07 a.m., indicated Resident 1 had eloped and fell on the sidewalk. The note further indicated Resident 1 had abrasions to his face, both knees were bleeding and 911 was called. An X-ray report from the hospital, dated 2/23/24, indicated Resident 1 had an recent fracture at the left thumb. A nursing progress note, dated 2/23/24 at 8:06 a.m., indicated Resident 1 had returned to the facility. During an interview, on 1/7/25 at 1:30 p.m., the Social Services Director (SSD) stated she remembered Resident 1 and he kept trying to leave the facility. The SSD stated he was a high risk for elopement if a WMD was ordered for him. During an interview, on 1/7/25 at 2:01 p.m., the Director of Nursing (DON) agreed Resident 1's WRA on 2/15/24 was inaccurate and he should have had a higher risk score since both an elopement care plan was initiated and a WMD had been ordered that same day. The DON stated WMDs were typically placed on the resident's wrist or ankle and not placed on a resident's wheelchair. The DON stated, but the reason should have been documented in the elopement care plan and confirmed it was not. The DON agreed Resident 1 was not adequately supervised and the facility was responsible for ensuring resident safety. The DON confirmed there was a breakdown in the system which resulted in Resident 1 eloping the facility on 2/23/24 without staff knowledge. During a review of a facility policy titled, Use of WMD undated, indicated WMDs were used for those residents at risk for leaving the facility unassisted. This facility believes that good technology saves lives to maintain a safe and secure environment to all residents. During a review of a facility policy titled, Safety and Supervision of Residents, dated 7/17, stipulated, 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.