STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Healthcare & Wellness Centre, LP	2490 Court Street Redding, CA 96001

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to identify specific risk factors (root cause, the reason why), reevaluate interventions (written instructions that described care provided), monitor interventions for effectiveness, and follow their policies and procedures (P&P) for one out of three sampled residents (Resident 1) that were identified as an elopement (leave without supervision) risk. This failure resulted in Resident 1 ' s second elopement on 9/7/24 and placed Resident 1 at an increased risk for continued elopement and injury. Findings: A review of the facility ' s P&P titled, Wandering and Elopement, revised 7/1/17, indicated, the Interdisciplinary Team (IDT, a group of medical professionals that discussed resident concerns and required care needs) would review, re-evaluate, and develop a care plan (a plan that included interventions and care the resident required) that included individual risk factors for residents that were identified as elopement risks. The P&P indicated, Licensed Nurses (LN) would document how the elopement occurred, the facility would make necessary reports to state agencies, and the residents Physician and responsible party (RP, person who made decisions for a resident) would be notified. The P&P indicated; the LN would assess the resident when the resident returned to the facility. Review of the facility ' s P&P titled Elopement Risk Reduction Approaches, revised 11/1/12, indicated, staff would Promote identification of residents who are at risk for elopement. A review of Resident 1 ' s undated Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses of memory deficient following cerebral infarction (memory loss following a stroke), muscle weakness, and unsteadiness on feet. Resident 1 was not his own RP. A review of Resident 1 ' s admission Minimum Data Set (MDS, an assessment) dated 2/10/24, indicated, Resident 1 had a BIMS (a memory assessment, where a score of 15 out of 15 meant intact memory) score of 3 out of 15, indicating severe cognitive decline. The MDS indicated, Resident 1 was not at risk for elopement and did not wander. The MDS indicated, Resident 1 required the use of a walker and assistance of staff to safely walk 50 feet. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Progress Notes (PN) dated 7/30/24, indicated, Resident 1 eloped from the facility and was missing for approximately one hour on 7/30/24. The PN indicated, Resident 1 was offered a wander guard transmitter (wander guard, a sensor device that was worn on the ankle or wrist that triggered an alarm when the exit door was opened), refused to wear the wander guard, and was provided one-on-one supervision (a staff member always kept eyes on resident). A review of Resident 1 ' s care plan titled, Risk for Elopement/Wandering Risk dated 7/30/24, indicated, on 7/30/24, interventions in place for Resident 1 ' s wandering included: identifying wandering/elopement triggers, specific times of the day Resident 1 attempted to elope, what de-escalation behaviors worked, and that facility staff would schedule time for regular walks/appropriate activity. During a concurrent interview and record review on 9/11/24 at 3:15 p.m., with LN B, Resident 1 ' s Medication Administration Record (MAR, a document that described what medications were provided and what monitors were in place for a resident) dated 9/1/24 through 9/30/24 was reviewed. LN B stated, the MAR indicated, Resident 1 had a wander guard located on the right ankle that required LN B to monitor every two hours for placement. LN B stated, LN B was Resident 1 ' s nurse for the day and was unaware that Resident 1 had been identified as being at risk for elopement. LN B stated, LN B was not aware that Resident 1 had eloped on 7/30/24. LN B stated, resident information was provided in a verbal report from LN to LN during shift change, LN B should have been made aware that Resident 1 had eloped in the past, and no LN had shared that information during report. LN B stated, LN B could utilize the residents care plan and progress notes to obtain resident information and stated, LN B did not have enough time to review resident medical records. LN B was asked how often Resident 1 ' s wander guard was tested for functionality. LN B stated unawareness of who performed or how often the wander guard functionality test was required to be performed. LN B reviewed all the active orders in Resident 1 ' s record, dated 7/30/24 through 9/11/24. LN B stated, there was no order in place for LN to check the wander guard for functionality or to perform weekly skin assessments to ensure the wander guard did not cause skin breakdown. During a concurrent interview and record review on 9/11/24 at 3:33 p.m., with Registered Nurse (RN), Resident 1 ' s active orders dated 7/30/24 through 9/11/24 were reviewed. RN confirmed there was no order in place that instructed the LN to monitor Resident 1 ' s wander guard for functionality. RN stated, there was a box (transmitter tester) located on each medication cart that was used to test the wander guard ' s functionality and the LN who oversaw Resident 1 ' s care was responsible to check the wander guard ' s functionality daily. RN stated, the LN was responsible to perform a weekly skin assessment. RN confirmed, there was no order to perform weekly skin assessments at the wander guard ' s location site. RN stated, each nurse station had a binder that contained documentation for each resident that was at risk for wandering or elopement. During a concurrent observation, interview, and record review, on 9/11/24 at 3:40 p.m., the Unit 2 Nurse Station was observed to have several binders along the length of the Nurse Station. While looking for the binder that contained documentation for elopement risk residents, the facility ' s interim (temporary) Assistant Director of Nurses (IADON) arrived. IADON assisted with locating the binder. IADON found a binder with the words Wing 2 Elopement written on the side. IADON stated, the binder was not easily visible and confirmed, all residents that were at risk for elopement were in the binder, including Resident 1. While reviewing the binder, LN B approached and stated, LN B had no awareness that there was an elopement binder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s quarterly MDS dated [DATE], indicated, Resident 1 had scored 9 out of 15 on the BIMS assessment, indicating moderate cognitive decline. The MDS indicated, Resident 1 was identified as a risk for wandering. The MDS indicated, Resident 1 required the use of a walker or a cane to walk and was able to safely walk 150 feet independently. During an observation on 9/11/24 at 3:50 p.m., Resident 1 was observed walking out of his room and into the hallway. Resident 1 utilized a cane, had an unsteady gait (abnormal, uncoordinated, or unsteady), and was walking fast. IADON utilized the transmitter tester to test Resident 1 ' s wander guard for functionality. LN B was observed talking to the IADON and LN B stated, unawareness that the transmitter tester was in the medication cart and had not used the transmitter tester to test any wander guards since being employed at the facility. During a concurrent interview and record review on 9/11/24 at 4:23 p.m., with IADON, the facility ' s manufacture recommendations titled, Wander Management Transmitters, dated 11/1/18, was reviewed. IADON acknowledged, the manufacture recommendations indicated, residents who wore a wander guard required weekly testing to assure alarm transmitter functionality and the facility staff would document testing results. IADON confirmed, facility staff was not documenting or monitoring Resident 1 ' s wander guard for functionality and stated they should have. The wander guard P&P was requested from the IADON, but not provided. During an interview on 9/12/24 at 1:40 p.m., Resident 1 ' s RP stated, Resident 1 had called RP on 9/7/24, and told RP that Resident 1 had walked to the park across the street by himself because Resident 1 needed some fresh air. RP stated, the facility did not call RP and notify of Resident 1 ' s elopement on 9/7/24. During an interview on 9/13/24 at 10:05 a.m., Resident 1 confirmed, on 9/7/24, Resident 1 walked across the street and went to the park without alerting facility staff. Resident 1 stated, I leave this place once a week and facility staff did not know about it. Resident 1 stated, he liked to walk outside, go to the park, and get fresh air. During a concurrent interview and record review on 9/13/24 at 10:15 a.m., with MDS nurse, Resident 1 ' s progress notes, dated 7/30/24 through 8/1/24 was reviewed. MDS nurse stated, the progress note dated 7/30/24 indicated, Resident 1 eloped from the facility and had been missing for approximately one hour. MDS nurse stated, when a resident eloped, an IDT meeting was held and the team reviewed what happened, what triggered the elopement, and the care plan would be developed or revised. MDS confirmed, there was no IDT post elopement documentation and stated there should have been. MDS nurse reviewed Resident 1 ' s care plan titled, Risk for Wandering/Elopement Identified, dated 7/30/24. MDS nurse stated, the care plan was revised on 8/12/24 with the focus of Resident 1 having a wander guard in place. MDS nurse was not able to find documentation that indicated when Resident 1 was taken off one-on-one supervision or when Resident 1 agreed to wear the wander guard. MDS nurse stated, the care plan should have been updated when Resident 1 ' s wander guard was placed. MDS stated, the reason for Resident 1 ' s elopement and elopement attempts were that Resident 1 did not want to be here. MDS stated, not having awareness that Resident 1 had eloped on 9/7/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 9/13/24 at 11:14 a.m., Resident 1 ' s medical records were reviewed. IADON stated, IADON stopped by the facility on 9/7/24, to retrieve an item left behind, and it was IADON ' s day off. IADON stated, overhearing a staff member state Resident 1 had got out and housekeeping (HSK) was bringing Resident 1 back into the facility. IADON stated, telling LN A (Resident 1 ' s primary nurse for the day), the elopement did not need to be reported, due to Resident 1 being observed while attempting to elope. IADON stated being told multiple versions of what had happened, and was not sure if Resident 1 had eloped or attempted to elope. IADON reviewed PN dated 9/7/24 through 9/13/24 and stated, there was no documentation present that indicated Resident 1 had eloped or attempted to elope. IADON reviewed the care plan titled, Risk for Elopement/Wandering Risk dated 7/30/24. IADON confirmed, the care plan indicated interventions in place for Resident 1 ' s wandering included: identifying wandering/elopement triggers, specific times of the day Resident 1 attempted to elope, what de-escalation behaviors worked, and that facility staff would schedule time for regular walks/appropriate activity. IADON confirmed, there was no documentation in Resident 1 ' s PN or MAR dated 7/30/24 through 9/13/24, that supported staff was monitoring which interventions were working and there was no documentation or schedule that indicated staff had scheduled walks for Resident 1. IADON confirmed, the care plan had not been updated, and there was no documentation that indicated Resident 1 ' s individual risks or root cause for elopement. IADON reviewed Resident 1 ' s PN dated 8/1/24 and stated the PN indicated Resident 1 had a wander guard in place. IADON reviewed Resident 1 ' s MAR dated 7/1/24 through 7/31/24, and stated, the MAR indicated, on 7/31/24, staff were to monitor Resident 1 ' s wander guard, located on the right ankle, every two hours. IADON confirmed, there was no documentation present that indicated the date LN had placed the wander guard on Resident 1 and stated, documentation was lacking. During a concurrent record review and interview on 9/13/24 at 1:58 p.m., HSK stated, on 9/7/24, HSK had walked outside to take a break with a coworker. HSK stated, the coworker noticed a resident across the street at the park. HSK confirmed, Resident 1 was across the street, in the park near the garbage cans, alone at approximately 10:15 a.m HSK stated, he had last seen resident 1 leaving the resident smoking area around 9:15 am. HSK stated, when assisting Resident 1 back into the facility, the wander guard alarm triggered, the alarm was heard by staff, and a lot of staff arrived. HSK stated, that was the first time HSK had heard the alarm during that day. HSK stated, upon returning Resident 1 to the facility, LN A was observed talking to Resident 1 outside the facility. HSK stated, alerting LN C of what had happened. IADON was present during HSK ' s interview and stated, after hearing HKS statements during the interview, it was clear that Resident 1 had eloped the facility on 9/7/24. IADON reviewed the P&P titled, Wandering and Elopement, revised 7/1/17, and confirmed the P&P indicated, after a resident eloped the facility, the IDT would review the elopement, re-evaluate interventons, and revise the care plan. IADON confirmed, the P&P indicated, LN would document how the elopement occurred, the facility would make necessary reports to state agencies, and the residents Physician and RP would be notified. IADON confirmed, the P&P indicated; the LN would assess the resident when the resident returned to the facility. IADON stated, none of what the P&P described had occurred for Resident 1 ' s elopement on 9/7/24 and confirmed, the P&P had not been followed. During an interview on 9/13/24 at 2:14 p.m., LN C confirmed, HSK had notified LN C of Resident 1 ' s elopement on 9/7/24. LN C stated, LN A was Resident 1 ' s primary nurse on 9/7/24, and was not able to recall if LN A had been notified that HSK found Resident 1 across the street at the park. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 9/13/24 at 2:27 p.m., Maintenance Director (MD) was observed testing the door alarm, located next to the resident dining area. The door alarm rang at the door and the nurse ' s station. MD and IADON were observed walking out the door and to a large metal gate that had a hook with a chain that was utilized to keep the gate closed. The hook was easily removed. MD and IADON walked off the facility grounds and stopped at the curb next to a street. HSK appeared and pointed to an enclosed dumpster that was located across the street, in the park, and stated that was where HSK had found Resident 1 on 9/7/24. MD and IADON stated, the enclosed dumpster was approximately 125 to 150 feet away. IADON and MD confirmed, for Resident 1 to get to the enclosed dumpster, Resident 1 was required to step down off the curb into a busy road that was uneven, cross the street and walk up the area where cars pulled into the parking lot of the park, cross the uneven parking lot, step up onto a curb and walk through the grass. During an interview on 9/13/24 at 2:44 p.m., Resident 1 stated, the door alarm did not go off when Resident 1 eloped on 9/7/24. Resident 1 stated, having knowledge of how to get out without triggering the facility ' s door alarms.