STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555098	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhaven Healthcare Center	455 Florin Road Sacramento, CA 95831

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. 48860 Based on observation, interview and record review, the facility failed to provide adequate monitoring and supervision for one of three sampled residents (Resident 1), when Resident 1 eloped from the facility. This failure had the potential to cause harm to Resident 1. Findings: Resident 1 was admitted Summer of 2023 with diagnoses which included Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and age-related cataracts (a cloudy area in the lens of your eye). During a review of Resident 1's Face Sheet (a document that gives a patient's information at a quick glance), the Face Sheet indicated Resident 1's family member was the Responsible Party (person who is responsible for the patient; can make decisions on their behalf). During a review of Resident 1's Change in Condition (CIC), dated 8/30/24 at 8 a.m., the CIC indicated, .She had an episode of elopement this AM [morning]. She was found next door in the courtyard of the [apartment complex]. During a review of Resident 1's Progress Note: Nurse Progress Notes (PN), dated 8/30/24, at 12:57 p.m., the PN indicated, I was told about 0645 that someone had saw [sic] her outside off the property in her w/c [wheelchair] going down the street . The assigned CNA [certified nursing assistant] and another staff member looked outside, drove around in the car, and returned without finding her . I called 911 for the missing resident . She was found to be in the courtyard of the [apartment complex] next door . She was returned and, in the building, around 0718. During a review of Resident 1's PN, dated 8/30/24 at 2:15 p.m., the PN indicated, It was assumed she went out the front door, because the alram [sic] had went off and the maintenance worker [staff name] said he had to reset it . her wander guard [a bracelet that sounds an alarm when the resident tries to go out the door] was on and rechecked . RP [family member name] is aware of behaviors. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 review of Resident 1's Wandering Risk Assessment (evaluates a person's condition and likelihood of wandering), dated 8/30/24 at 1:50 p.m., it indicated .Score: 7 . Score of 3 or more = High risk of for elopement (IDT to review document risk and interventions). During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 8/13/24, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. During an interview on 9/5/24 at 11:51 a.m., with CNA 1, CNA 1 confirmed the patient was on elopement protocol, wearing a wander guard, and was found at the nearby apartment complex. CNA 1 stated it's just the patient was really fast, and we missed her. CNA added there was no staff at the front when Resident 1 went out the door of the main lobby and alarm was not heard in Station A. During an interview on 9/5/24 at 12:08 p.m., with CNA 2, CNA 2 stated, She went out the front door and the alarm went off, but nobody knew the alarm went off because they said they couldn't hear it, but maintenance had told us that it was reset by somebody. She added it was a former employee who lives in the apartment that called and notified the facility about Resident 1's location. During an interview on 9/5/24, at 12:59 a.m., with Licensed Nurse (LN) 2, LN 2 stated there were no staff members in the front office when she reset the alarm at 6:45 a.m. She mentioned that she did not know when the alarm had started. LN 1 added that she looked outside the door and did not see any residents. She then initiated a Code Pink (facility alert for elopement). During an interview on 9/5/24 at 1:30 p.m., with the Director of Nursing (DON), DON stated that Resident 1 had been diagnosed with Alzheimer's disease and had a history of wandering incidents. The DON mentioned that the alarm was loud and that Station B, which has the most staff, should have heard and responded to it. She noted, There's a gentleman who used to work here for many years and lives in those apartments back there; he's the one who found her. The DON added that the staff did not meet her expectations for monitoring residents at risk for elopement. During a review of the video surveillance recording with the Director of Nursing (DON) on 9/5/24, at 1:40 p.m. , the footage revealed that Resident 1, in a wheelchair, exited the facility at 6:34 a.m., followed by several staff members at 6:55 a.m. During a review of the facility's policy and procedure (P&P) titled, Emergency Procedure, dated August 2018, the P&P indicated, Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. During a review of the facility' s policy and procedure (P&P) titled, Wandering and Elopements, dated July 2024, the P&P 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 the residents.