

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/11/2024
NAME OF PROVIDER OR SUPPLIER  Professional Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE  81 Professional Center Parkway San Rafael, CA 94903	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38088</p> <p>Based on observation, interviews and record review, the facility did not ensure the safety of 1 out of 5 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5), when Resident 4 eloped from the facility and was found .4 miles away by the Police Department.</p> <p>This failure had the potential for all residents at risk of elopement, to be at risk of falls, injury and possible death.</p> <p>Findings:</p> <p>During an observation on 6/11/24, at 8:25 a.m., the front of the facility located at 81 Professional Center Parkway sat on the side of a hill, with a steep inclined driveway up to the front entrance. The facility was located on a street with moderate traffic in the middle of a hill that contained high-density housing, offices and a convenience store. The street began on a frontage road at the base of a steep incline up to where the facility was located.</p> <p>During an observation 6/11/24, at 10:29 a.m. the hallway corridor that ended at the north side of facility, led to the outside courtyard. The metal door that led outside was not locked or alarmed and allowed unsupervised passage for residents and staff from inside to the outside facility courtyard area. To the right of the door, resident rooms had sliding glass doors that appeared closed. A gazebo / shaded area was towards the east side of the courtyard. Behind the gazebo, there was a painted wooden shed with a door and behind the shed was a wooden painted gate (See Photo) that separated the right / east side of the courtyard from a walkway that led along the facility ' s east side out to the front of the facility and to the street (Professional Center Drive). To the left of the unsupervised door, observations indicated a steep walkway with a small chain suspended at waist level (See photo). The walkway went down a steep incline past the first floor of the facility and ended in the parking level of the front of the facility and opened to Professional Center Parkway.</p> <p>During an observation 6/11/24 at 10:30 a.m., Resident 4 sat in the outside courtyard, under the gazebo, playing guitar. The Maintenance Director was conducting repairs on a resident's room screen door at the corner of facility facing the courtyard. Resident 4 was dressed in pants and a shirt and wore a baseball cap. Resident 4 wore walking shoes and socks and had a monitoring device on his right ankle.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and observation, on 6/11/24, at 11:20 a.m., with the Maintenance Director, he stated he checked the doors with alarms every morning. He stated the only doors without an alarm on them was the door leading from the facility out to the back courtyard and the resident rooms with patio doors that led out to the back courtyard. He stated he did not know if Resident 4 had a security device on the day he eloped. He stated he did not check the security devices on the residents and stated he did not know how the nurses checked for functionality. He stated he did not know what the manufacturer ' s instructions for use was for the security alarms and devices that alerted when a resident attempted to exit the facility. The Maintenance Director stated he conducted safety rounds once a month with other administrators and team members, that included a walk around the facility to identify what physical features might be an accident or safety hazard for residents. The Maintenance Director stated he did not recall if the outside courtyard had been identified as a resident risk. He stated, from the back outside courtyard, the residents and staff had access to the front of the facility through a gate on the east side of the courtyard (See Photo). He stated the gate was used by kitchen staff to get dietary items out of a shed (See Photo). He stated the other way was a walkway down the side of the facility but it was steep and he put a chain there to keep residents from walking out that way (See Photo). The Maintenance Director walked outside, through a door at the end of the hall by the kitchen, on the east side of the facility. The door was alarmed when he opened it. It opened onto a walkway on the east side of the facility that led to the front of the facility on the right side, and to the left side, the walkway led to the courtyard at the back of the facility on the north side against a steep hill (See photo of gate leading to outside courtyard). He stated kitchen staff used the gate all the time to get to the shed (See Photo). He stated it had a latch and they were supposed to close it. The gate was opened by the use of a simple metal latch, and the Maintenance Director opened and walked through the gate. The gate was not alarmed and did not have an auto-closure mechanism with a spring. The gate was as tall as the Maintenance Director ' s shoulders (See Photo). When he closed the gate, he stated there was the shed the kitchen staff stored stuff in (See Photo). He stated the staff used the gate to get dietary stuff out of the shed and take it back to the kitchen. The Maintenance Director reached over the top of the gate and unlocked the metal latch to open the gate and exit through the gate to leave the courtyard and go back to the walkway that led to the driveway at the front of the facility. He stated a resident as tall as Resident 4 would be able to reach over and unlatch it himself and walk away from the facility. The Maintenance Director stated he was out in the courtyard this morning to repair some patio doors. He stated he did not remember if Resident 4 had any visitors in the smoking gazebo while he was working in the courtyard. The Maintenance Director stated residents walked out to the courtyard through the one door that did not have an alarm security system, all the time. He stated they walked in and out whenever they wanted. He stated, if a resident did walk out to the front of the facility they had the potential to fall.</p> <p>During an interview and record review, on 6/11/24 at 10:20 a.m., Licensed Nurse B stated she did not know where Resident 4 was. She stated he was always walking around. She stated she was assigned to him. She stated she was unaware of any safety concerns for Resident 4. She stated he had a personal security alarm device, and did not check it. She stated the battery was good until 2025. During a review of a binder titled, Elopement Binder, she stated if a resident was an elopement risk the resident information and photographs were in the binder. Review of the binder indicated Resident 1, Resident 2, Resident 3, Resident 4 and Resident 5, were listed as facility resident elopement risks. She stated, if someone thought a resident was missing, they were supposed to call a Code Green. Review of the Elopement Binder indicated it was supposed to be Code Yellow.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/24, at 10:24 a.m., Licensed Nurse A stated Resident 4 was a very easy resident and did not have safety issues. She stated she did not know where Resident 4 was, and he usually walked around independently and liked to go outside to the courtyard and sit. She stated he went out there by himself. She stated no one was assigned to watch him like a 1:1 resident. She stated everyone knew he went out there. She stated she thought Resident 4 eloped out of the building through his bedroom patio, and that is why they moved him to another room that had a patio door that opened to the inner courtyard that did not have an exit to the courtyard.</p> <p>During an interview on 6/11/24, at 10:31 a.m., Resident 4 stated he remembered he took a walk a few days ago because he needed to go to the bank. He stated, I just had to go because I have some issues. He stated he walked out his room ' s patio door into the courtyard and walked out the gate. He stated the gate was open. The interview concluded after 20 minutes, at 10:51 a.m.</p> <p>During an interview on 6/11/24, at 11 a.m., the Social Services Director stated Resident 4 could ambulate without issue, had lowered cognition, participated in activities, but mostly liked to walk around the building and play his guitar. She stated she interviewed him after he eloped, and he stated, I just wanted to go out for a walk. She stated she did not think he had a security device alarm at that time. She stated he just walked away from the facility, maybe through his patio door at the time. She stated he walked into the courtyard and then outside the facility. She stated, after the elopement he was moved to room that had access to a secure inner courtyard without access to the outside of the facility. She stated she did not know if the other residents at risk for elopement were roomed on the interior secure courtyard.</p> <p>During an interview on 6/11/24, at 12:10 p.m., the Director of Nursing stated Resident 4 had been out on the patio this morning. She stated maintenance had watched him while he was out there. She stated all the department heads conducted safety rounds in the facility and outside the facility, everyday. She stated it had not been done for last two weeks. She stated the nursing staff were supposed to check the functionality of the resident ' s security alarm they wear, every shift, by using the testing device from the manufacturer.</p> <p>During an interview and record review on 6/11/24, at 1:30 p.m., with the Director of Nursing, she stated the facility did not conduct a Root Cause Analysis for Resident 4's elopement. He stated the post-event review documentation did not indicate a trigger for review of the environment. She stated Resident 4 ' s elopement was not caused by a security alarm bracelet. She stated Resident 4 was not wearing a security device at the time. She stated all the nurses knew how to check the devices for functionality. She state they should check the devices every shift, by using the manufacturer ' s testing device.</p> <p>During an interview on 6/11/24, at 1:32, p.m. Licensed Nurse C stated she did not know if any of her assigned residents were elopement risks. She stated she did not know of an Elopement Binder that had residents at risk of elopement listed in it at the nursing station. She stated she did not know how to check if a resident ' s personal security alarm device was working. She stated she did not know what the facility P&amp;P was for resident security alarm device testing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/24, at 1:35 p.m., with the Licensed Nurse B, she stated she checked the resident security alarm device by walking them past an alarm door, and if it alarmed, she knew it was working. She stated she did not know how the nurses on the midnight-to-morning shift checked the residents devices. She stated she did know about a manufacturer ' s testing device that could be used to test a resident ' s device.</p> <p>During an interview on 6/11/24, at 1:40 p.m., Licensed Nurse A stated resident security alarm devices were checked by using a special device that should have been in the medicine cart, every shift. She attempted to locate one in the medication carts and was unable to find a device. She stated she would walk a resident by a door with a, alarm and if the door alarmed she knew the device was working. She stated she did not know how the night nurses would check if a resident's device was working.</p> <p>During a phone interview and record review on 6/12/24, at 3:45 p.m., the Administrator stated, when Resident 4 eloped on 5/27/24, at dinnertime, the staff followed facility P&amp;P. She stated they called the police, who found the resident and returned him to the facility. She stated there was no police report yet. She stated when the resident returned he was on a 1:1 observation for 72 hours, the staff checked the functionality of all the alarmed security doors, and moved him to a room without access to an outside courtyard. She stated Resident 4 was ambulatory and had never eloped since she had been at the facility, since January. She stated the facility suspected he eloped through the patio door in his bedroom that led out to the courtyard. She stated a post-event huddle was conducted and all those in attendance discussed any areas that could have been improved to prevent elopement. She stated there was no facility P&amp;P for resident safety. She stated environmental safety rounds were conducted daily, assigned to all managers and then discussed at the stand-up meetings. She there were no cameras or video of the outside of the facility. She stated the conclusion of the stand-up meeting was the gate used by kitchen staff on the side of the building was where he probably exited the courtyard. She stated Resident 4 may have seen staff, who used the gate to come in and leave the courtyard, and gotten out of the facility through that gate. She stated she did not know if Resident 4 went out the other side of the courtyard with the chain because it was more dangerous and unleveled.</p> <p>A review of a facility document titled, Post event review V-2, dated 5/30/24, indicated, No in the section: 1. Was environment and assistive equipment checked for potential issues that could have contributed to event? She stated it should have been marked, Yes. She stated the environment was checked. She stated all the patio doors were closed and locked from the inside, the gate was checked, and it was closed. She stated, due to emergency egress issues, the facility could not lock the gate or outside access. She stated the gate did not close automatically, and they were in process of putting an automatic spring door closure on the gate. A copy of the receipt of purchase of the spring closure device was requested and not received by the end of the survey. She stated the gate was not secured by a closure device 12 days after Resident 4 eloped, and the facility suspected he exited through that gate. She stated the chain at the other exit was a huge trip hazard. She stated there was no timeline in place to address the two elopement / safety risks identified in the outside courtyard. She stated residents were allowed to be outside, unattended, in the patio courtyard area and monitoring them for safety was a collective team effort. She stated nurses were supposed to check residents' personal security alarm devices by walking them past a door with an alarm. She stated they did not do it on night shift. She stated there was no manufacturer ' s testing device, because they got lost and were expensive. She stated, We know the risk of elopement if that residents would wander off the premises, and hurt themselves.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility Policy and Procedure (P&amp;P) titled, Safety and Supervision of Residents, Revised July 2023, 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 .When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible .Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.</p> <p>Review of a facility care plan for Resident 4, dated 9/30/21, revision on 5/28/24, indicated, At risk for elopement/wandering r/t (Related to): -cognitive loss - impaired decision making - DX(Diagnosis) history of CVA (Cerebral vascular accident)(Stroke) - wanders outside of facility property - wanders into other resident ' s rooms.</p>