STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555245	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Post-Acute	2586 Buthmann Ave Tracy, CA 95376

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** Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a safe environment was provided to prevent an elopement (a resident leaves the facility or a secured area without staff permission or knowledge, putting them at severe risk of injury, getting lost, or death from exposure, traffic, or missed medical care) from occurring for one of two sampled residents (Resident 1) when, Resident 1, with severe cognitive impairment (a condition that affects a person's ability to think clearly, remember information, and make safe decisions) and known wandering risk, eloped from the facility during the night on 12/16/25 through an unlocked and unalarmed door located in the facilities laundry room.This failure resulted in Resident 1 leaving the facility without immediate staff knowledge of Resident 1's departure, Resident 1 remained missing for several hours during the night/early morning hours, Resident 1 entered a private residence approximately 0.4 miles from the facility, and Resident 1 was subsequently brought to the hospital (due to the cold weather conditions, age, and health conditions). Resident 1 was diagnosed at the hospital with an acute (new, sudden, and occurring over a short period of time) cardiac injury (damage to the heart).Findings:A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses including encephalopathy (a condition where the brain is not functioning normally), delirium (reduced awareness of surroundings, impaired ability to focus, disorganized thinking, and hallucination (seeing things that are not there)), abnormalities of gait and mobility (when a person's walk is different from what would be considered normal), need for assistance with personal care, and dementia (a condition that slowly affects memory, thinking, and the ability to make decisions), among other diagnoses.A review of Resident 1's care plan for wandering and elopement, initiated on 2/20/25, the document indicated, Focus.Risk for wandering or elopement related to With [sic] exit seeking behavior, Focus on wanting to go home, Able to propel self around the facility, Dementia, Wanders aimlessly.Goal.Will have no episodes of elopement.Will maintain resident's safety.Will minimize episodes or [sic] wandering or elopement and possible injuries.Interventions/Tasks.Call the attention of the resident and redirect when seen going towards the exit door Date Initiated: 02/20/2025.Frequent check of resident's whereabouts Date Initiated: 02/20/2025.Assess for need of wander/elopement alarm Date Initiated: 02/20/2025.Apply wander guard [electronic monitoring device that alert staff if a resident tries to leave the building through an exit door] as ordered Date Initiated: 02/20/2025.A review of an Order Listing Report, dated 12/16/25, the document indicated, .Resident Name.[Resident 1].Wander guard placement secondary to: exit seeking behavior.[Order status] Active.[Revision Date] 09/25/2025.A review of Resident 1's Nurses Weekly Progress Notes., dated 12/12/25, the document indicated, .Cognitive Function.Confused [was selected].Able to make needs known? .No [was selected].ADL. ACTIVITIES OF DAILY LIVING.MOBILITY.Walk 10 feet.Supervision or touching assistance [was selected].Walk 50 feet with 2 turns.Supervision or touching assistance [was selected].Walk 150 feet.Not (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 - Minimal harm or potential for actual harm Residents Affected - Few	attempted due to medical condition or safety concerns [was selected].A review of Resident 1's Progress Notes, dated 12/16/25, indicated that Licensed Nurse (LN) 3 documented, .Resident was last seen by night shift CNA [Certified Nursing Assistant].walking up and down the hallway.at approximately 0235 [2:35 AM] Resident's roommate came out inquiring about [Resident 1].resident was not in the building. [LN 3] searched outside premises with no luck.DON [Director of Nursing] was notified around 0353 [3:53 AM].Administrator [ADM] was also informed around 0400 [4 AM].Administrator and DON came to building to try to locate patient. At approximately 0500 [5 AM] Administrator contacted [name of local police department]. Police department came and searched the building.A review of Resident 1's IDT [Interdisciplinary Team, a group of healthcare staff working together to plan and coordinate resident's care] Notes, dated 12/16/25, the record indicated, .[Resident 1].alert and awake, ambulatory [able to walk].at the time of exiting the facility, resident wander guard did not alarm d/t [due to] resident exited through a door that did not have an alarm and is out of the patient care area.resident was found by Police.and was transferred to [name of local hospital].During an interview with the ADM on 1/7/26 at 1:04 PM, the ADM stated that Resident 1 exited through the laundry door, which did not have an alarm and was left unlocked on 12/16/25.During an interview and record review with the Maintenance Director , Administrator-in-Training, and the ADM on 1/7/26 at 1:42 PM, the ADM stated that at the time of the interview, all exit doors were alarmed. However, the ADM stated that prior to the elopement, there was one door located in the laundry area that was not alarmed, and that Resident 1 eloped through that door. The ADM stated that the laundry area has two doors, with a second door located beyond the first door in the hallway. The ADM further stated that the laundry door through which Resident 1 exited did not have an alarm at the time of elopement and that although the second door is usually kept locked, it was not locked on the day of the elopement because staff forgot to lock it. The ADM added that on the day of the elopement (12/16/25), the facility's exit safety systems included a Wander Guard system and door alarm system, and that all other exit alarms were operational that night. The ADM further stated that after the incident, the facility added a door alarm to the laundry door, tested all wandering and door alarm systems, and reassessed residents for elopement risk. During a concurrent interview and record review with the Director of Nursing (DON) and the Administrator (ADM), on 1/7/26, at 2:58 PM, the DON stated Resident 1's BIMS (Brief Interview for Mental Status, an assessment tool) score, dated 11/12/25, was one (1), indicating severe impairment in thinking and memory. The ADM stated that per facility policy, residents were assessed for elopement risk upon admission and monitored for exit-seeking behaviors throughout their stay, and that prior to the elopement, Resident 1 did not exhibit exit-seeking behaviors. The DON stated that the facility provided adequate supervision but acknowledged that communication among staff could have been better. The ADM further stated that, during the facility's investigation, between 1:50 AM and 2:30 AM, Resident 1 was redirected and left in the activities room because she did not want to remain in bed. The ADM stated that after assisting another resident, the CNA returned and observed that Resident 1 was no longer in the activities room or in her bedroom, at which time staff initiated a search of the building. The ADM identified the laundry room exit being left unlocked as a contributing factor to Resident 1's elopement.During a concurrent observation and interview with the ADM on 1/7/26 at 3:41 PM, in the facility laundry room, the ADM showed the laundry area, checked the doors, and demonstrated that the newly installed red alarm on the laundry door was functioning. The ADM stated that the first laundry door is routinely unlocked because it is used by staff to sort laundry. The ADM stated that the second laundry door was required to be locked from the inside when staff leave the area and that the alarm was added to that door as an additional safeguard. It was observed upon entering (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the second door of the laundry area that there was a third door to the left, which was easily opened and appeared to lead to the street.During a phone interview with LN 3 on 1/7/26, at 4:25 PM, LN 3 confirmed that she was the nurse assigned to Resident 1 on the night of 12/16/25, when Resident 1 eloped, and stated she was responsible for 30 residents during that shift. LN 3 stated that at approximately 1:50 AM, she accompanied an x-ray technician (a healthcare professional who operates imaging equipment that takes pictures of the inside of the body) to assist with other residents and left Resident 1 under the supervision of the assigned CNA. LN 3 stated she remained with the x-ray technician until approximately 2:30 AM, then took her scheduled lunch break, assuming Resident 1 remained under the CNA's supervision. LN 3 stated she became aware Resident 1 was missing when the resident's roommate approached staff asking about her whereabouts. LN 3 stated she believed Resident 1 remained in the building because no door alarm had sounded. LN 3 identified a communication barrier with the assigned CNA, stating the CNA did not speak English fluently and required a translator. LN 3 stated she specifically instructed the CNA to keep an eye on Resident 1, as the resident did not want to go to bed yet, and that it was okay to keep her in the activities room since she was not bothering anyone. LN 3 stated she believed that while she was assisting the x-ray technician, the CNA attempted to place Resident 1 in bed despite the resident refusing, and that the resident likely got up and wandered off independently. LN 3 acknowledged Resident 1 had dementia, was frequently confused, and was a known wandering risk, stating the resident often stayed near the nursing station and required redirection and staff supervision. LN 3 stated that prior to the incident, staff interventions included keeping the resident near the nursing station and use of a wander guard. LN 3 confirmed the facility had exit alarms in place except for the laundry room exit and later learned Resident 1 had exited the facility through the unalarmed laundry room door.A review of the Police Department record titled, Missing Persons - 1 Report, dated 12/17/25, indicated, .On 12/16/2025 at approximately 0529 hours [5:29 AM], I responded to a missing person call at [name of facility].I contacted the nurse that had last seen [Resident 1].[LN 3] said that [Resident 1] typically walked around the nursing home but always returned to her room.[LN 3] said that the last time she saw [Resident 1] was at approximately 0219 hours [2:19 AM]. [LN 3] remembered the time specifically because she had looked at her watch to remember the time and take her lunch at 0230 hours [2:30 AM].It should be noted that while I spoke to the staff members at the facility, multiple.officers were searching in the neighboring area for [Resident 1]. A description of [Resident 1] was put out over the radio: yellow gown, yellow socks, she was not wearing any shoes.A drone was also dispatched to further assist. At approximately 0618 hours [6:18 AM].dispatch advised they had located a subject possibly matching the description of [Resident 1].a subject in what appeared to be a light-colored gown at the intersection of Grante Line Rd. and [NAME] Dr. [an online direction's map showed the intersection was 0.7 to 0.8 miles away from the facility, dependent on the route walked].At approximately 0719 hours [7:19 AM].[name of caller from the community] called [name of police department] advising that there was a female in her house with a yellow gown. [Name of caller] provided the address to her home to be [address redacted; an online directions map showed the address was 0.4 miles away from facility].officers arrived shortly afterwards and positively identified [Resident 1].[name of caller] said that when she walked into her living room, she saw [Resident 1] wearing a yellow gown and sitting on the couch and called 911 as she did not recognize who the female was.Due to the extreme cold weather, [Resident 1's] age and health conditions, [name of ambulance company] was requested to respond to the scene to examine [Resident 1]. Ultimately, [name of ambulance company] transported [Resident 1] to [name of local hospital] for further evaluation.A review of Resident 1's hospital record titled Discharge Summary, dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/18/25, at 8:33 AM, the record indicated, .FINAL DIAGNOSES: Acute altered mental status.NSTEMI [Non- ST Elevation Myocardial Infarction, a type of heart attack].REASON FOR admission: .[Resident 1] was found by police.brought into ED [Emergency Department]. has severe dementia.found to have elevated serum troponin [a blood test. Levels above the normal range suggest heart muscle injury].admitted to the hospital for further evaluation.HOSPITAL COURSE: [Resident 1] was admitted with acute NSTEMI, evidenced by elevated troponin [indicates injury to the heart muscle, often resulting from acute myocardial infarction (heart attack) but also caused by various non-cardiac conditions], and was started with heparin [a medicine that helps stop blood clots, especially during heart problems].she experienced a brief episode of SVT [Supraventricular Tachycardia, an episode where the heart beats very fast] on telemetry [a way of monitoring your heart while you are in the hospital to watch the pattern of your heartbeats and find any heart problems you may have with your heartbeat].A review of Resident 1's hospital record titled COMPREHENSIVE CONSULT NOTE, dated 12/16/25, at 4:39 PM, signed by the Cardiologist (heart doctor), the record indicated, .Reason for consultation.troponin elevation.ASSESSMENT & PLAN: Acute NSTEMI, Severe dementia.A review of the facility's policy titled, Wandering, Unsafe Resident revised on 8/14 indicated .The staff will identify residents who are at risk for harm because unsafe wandering (including elopement).The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included.A missing resident is considered a facility-wide emergency.If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the attending Physician, law enforcement officials.A review of the facility's policy titled, Elopement Prevention and Management revised on 9/2025 indicated .Residents who exhibit wandering behavior and/or at risk for elopement will receive adequate supervision to prevent accidents.Assess risk of elopement and/or unsafe wandering upon admission and throughout stay.Implement a plan of care to increase staff awareness, modify resident behavior, and minimize elopement hazards and risks. When use of an electronic monitoring system or door alarm device is deemed appropriate, maintain and utilize system.Monitor responses to interventions.evaluate effectiveness.and make changes as needed.Any staff member suspecting a Resident is missing should promptly utilize established internal communication procedures.if resident is not located.Administrator or Designee should notify police department.A review of the facility's policy titled, Safety and supervision of Residents Revised on 7/17 indicated .Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.resident supervision is a core component of the systems approach to safety, with the type of frequency of supervision determined by the individual resident's assessed needs and identified hazards in the environment.