STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555430	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountains, The	1260 Williams Way Yuba City, CA 95991

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** 51923 Based on interview and record review, the facility failed to provide an environment free from accidents and hazards by not developing and implementing a plan of care to prevent wandering/Elopement (leaving a healthcare facility without permission or notice) for one of four sampled residents (Resident 4) when: 1. Resident 4 exited the facility unsupervised and was found on the sidewalk near the roadway outside the facility premises. The facility ' s failure to develop a plan of care to prevent leaving the facility unsupervised which resulted in Resident 4 to leave the facility and put him at risk for harm and injury. Findings: A record review of facility policy titled Resident Care - Wandering/Elopement, revised 06/25/20 indicated under policy compliance under prevention that all residents shall be assessed by the interdisciplinary team regarding the risk of wandering on admission, quarterly, and when behavior changes. If the resident is at risk of wandering from the facility an alert device shall be considered, if it is determined that an alert device is needed nursing personnel shall attach the device to the resident. If the resident is in imminent danger of leaving the staff shall provide one to one staffing if available. The care plan will be updated to include interventions to prevent wandering included but not limited to an alert bracelet, assignment to a room away from exits that are commonly utilized if a room is available at that time, sign on the residence room, and engagement and group activities. A record review of hospital Clinical Note dated 01/01/25 at 04:05 am, Registered Nursed document that Resident 4 was agitated, trying to crawl out of bed, yelling, and required a sitter at the bedside. A record review of an admission record, indicated that Resident 4 was admitted on [DATE] with diagnoses that included but not limited to a psychotic disorder (a mental disorder that causes abnormal thinking and perceptions) with delusions and adjustment order with anxiety. (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: 555430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER: Fountains, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 1260 Williams Way Yuba City, CA 95991	

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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	A record review of Elopement Evaluation dated 01/02/25 at 8:36pm, indicated Resident 4 to be non-ambulatory (unable to walk) and unable to perform independent wheelchair locomotion (to move from one place to another). Additionally, that Resident 4 had no history of wandering or displayed any behaviors that would indicate an attempt to leave, with an elopement risk score of 0 (no risk). A record review of Admission Observation dated 01/02/25 at 8:47pm indicated Resident 4 had a mood disorder, hallucinations, and used a cane as a mobility device. A record review of a Minimum Data Set (resident assessment) dated 01/09/25, Section GG Functional Abilities, indicated that Resident 4 was able, with supervision or touching assistance, to walk 10 feet A record review of Resident 4 Progress Notes dated 01/12/25 at 04:07am indicated that two Certified Nurse Assistants (CNA ' s) went to get the Resident 4 who had left the building and was opening the gate. The CNAs were trying to prevent the resident from entering the street/traffic, local law enforcement was called for help as the resident was fighting to get away, police officers arrived and assisted returning Resident 4 to the facility. A record review of Resident 4 Progress Notes dated 1/12/25 at 12 am indicated that Resident 4 was found in the parking lot and the and the family was notified. The family stated that he gets hallucinations and starts walking and takes off when he gets them. the family was informed that the plan was to put a wander guard device (a wearable device that triggers an alarm when approaching a restricted area or doorway) on Resident 4. Family stated, I thought they put one on his ankle earlier when he did this. A record review titled General Order dated 1/12/25 at 12:57 am, indicated Resident 4 was to have an Ankle Wander Guard related to elopement. A record review of Resident 4 ' s care plans dated 01/12/2025 indicated a new care plan was initiated post elopement for wandering/elopement risk related to strong desire to go home, Cognitive Loss, Parkinson ' s Disease due to history of attempts to leave facility unattended., Wandering into other residents ' rooms, and impaired safety awareness. A record review of admission 48-hour Baseline Person-Centered Care Planning dated1/02/25 at 8:40 pm, indicated that Resident 4 ' s family was present at the time of the care plan meeting. An interview with Registered Nurse (RN B) on 03/03/25 at 12:15 pm, RN B stated Resident 4 had requested to go home with family and was observed following them to the door when the family would leave. RN B explained she was aware that Resident 4 was an elopement risk 4 days after his admit, due to observing him hanging around the front door of the facility and overheard statements he made to his family about wanting to go home. RN B confirmed the behavior and statements made by Resident 4 would make him an elopement risk and should have been reassessed for it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on 03/03/25 at 1225, DON stated that Resident 4 had a recent room transfer which placed him in a room one door from the exit door. DON explained that on the evening of January 11th at about 6pm Resident 4 attempted to leave the facility by following family to the door after a visit. [NAME] stated at about 11pm Resident 4 again attempted to leave the facility, this time through the exit door near his room. DON agreed that he should have had a Wander Guard device on after the first attempt. DON confirmed no care conference was done during the admission and usually the goal was to have it done within the first 5 days of admission where families usually participate in plan of care. An interview with Licensed Nurse (LN C) on 03/03/25 at 3:50 pm, Resident 4 was confused and ran out of the building, the CNAs were able to stop him, but he was kicking and hitting them. LN C stated that behaviors such as a resident moving around the building or looking for a way out, would prompt a reassessment of the risk for elopement. An interview with Certified Nurse Assistant (CNA A) on 03/05/24 at 2:41 pm, Resident 4 ran from bed out of the facility. CNA A and another CNA were able to stop the resident at the sidewalk, outside of the gate to the facility. They feared the resident would be hit by a car and called law enforcement for assistance. An interview with a family member (FM) of Resident 4 on 03/06/25 at 1135 am, Resident 4 had tried to leave the building earlier in the evening, prior to the elopement. FM discussed that prior to this incident staff would keep an extra eye on him to keep him from leaving the facility. Fm stated that Resident 4 ' s past psychosis and elopement behavior were discussed during his admit, and that it is why he was there.