

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER Capital Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6821 24th Street Sacramento, CA 95822	

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 - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17069</p> <p>Based on interview, record review and policy review, the facility failed to provide supervision and monitoring for one of three sampled residents (Resident 1) when Resident 1, after several attempts, eloped from the facility.</p> <p>This failure had the potential to result in serious injury or death for Resident 1.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) affecting right dominant side, intracranial injury (brain injury) without loss of consciousness, mild cognitive impairment, right knee pain, and cognitive communication deficit.</p> <p>Resident 1's Admission MDS (Minimum Data Set-an assessment tool), dated 6/4/13 documented Resident 1 as having unclear speech, usually able to understand others, usually able to make self-understood and his Brief Interview for Mental Status (BIMS) summary score as an 8 (moderate impairment). The MDS described Resident 1 as having no delirium or behavioral symptoms. The MDS also described Resident 1 as needing limited assistance with bed mobility, transfers, locomotion on and off unit, dressing, and toilet use.</p> <p>During a review of Resident 1's Elopement Risk-V2, dated 5/3/23 indicated Resident 1's Elopement Risk Category: At Risk for Elopement.</p> <p>During a review of Resident 1's Order Summary Report, for July 2023, a physician's order, dated 5/31/23, indicated, MD (Medical Doctor) determines that resident does NOT have the mental capacity to make healthcare decisions as per history & physical or transfer orders or preferred intensity of care.</p> <p>During a review of Resident 1's Nurses Progress Note (PN), dated 7/25/23 at 5:54 a.m., the PN indicated, Resident awake most of the shift, being intrusive in peers rooms, asking staff 'Where can I buy meth,' writer explained that asking that is inappropriate, resident continued, resident also left out of facility @0545 (5:45 a. m.), he propelled himself out to the back parking lot of the facility and had to be redirected by staff.</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 - Few</p>	<p>During a review of Resident 1's PN, dated 7/25/23 at 5:55 a.m., the PN indicated, At approximately 0550 (5:50 a.m.) the custodian alerted the nurse for station 4 that he (Resident 1) was escaping the building. When supervisor found out the news, she witnessed the custodian and the nurse coming back from the neighborhood just beyond the field to the side of the building. Resident safely escorted back into the facility.</p> <p>During a review of Resident 1's PN, dated 7/25/23 at 8:05 a.m., the PN indicated, At the beginning of AM shift writer was notified by one of the staff that she saw the res (resident) outside the facility heading to the streets. Found res outside right by the church, asked res why he was wandering outside res verbalized, 'I'm looking for Meth.' Res was refusing to go back to the facility, risk and benefits explained then res verbalized I dont (sic) give a shit. After couple of minutes of talking to the res, he finally turned around and returned back to the facility. Res is calm at the moment. Will cont (continue) to monitor.</p> <p>During a review of Resident 1's PN, dated 7/25/23 at 10:07 p.m., the PN indicated, Res left facility around 5pm, Staff was unsuccessful with locating Res. Res had attempted to leave facility several times earlier in the day. Res did not return to facility after 4 hrs. Due to Res physical condition a police report was made to the Sacramento Police Dept. with incident #23-2097816 and Res was noted to have left AMA (Against Medical Advice) @2145 (9:45 p.m.).</p> <p>During an interview, on 3/26/24 at 9:06 a.m. with the Director of Nursing (DON), the DON confirmed Resident 1 did not have capacity per physician's order, dated 5/31/23, and Resident 1's responsible party (RP) was his brother. The DON also confirmed there was no documentation Resident 1 had a scheduled appointment or went out on a leave of absence (LOA) on 7/25/23. The DON confirmed according to Resident 1's elopement risk assessment that Resident 1 was as risk for elopement. The DON stated there was no documentation Resident 1's RP, physician, or the Department were notified of his elopement. The DON did not know where Resident 1 went or what happened to him after eloping from the facility on 7/25/23.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Elopement and Missing Resident Policy, revised October 2009, indicated, It is standard policy to monitor and evaluate residents at risk for wandering and elopement. The Interdisciplinary Team (IDT) is responsible for identifying residents at risk for elopement, implementing preventative measures to reduce risk, and provide a process for action if an incident of elopement occurs. Elopement Definition: Elopement occurs when a resident leaves the premises or a safe area without authorization or staff notification and/or any necessary supervision to do so If wandering or exit seeking behavior is identified for any resident who previously has not exhibited this behavior, a change of condition IDT Walking Rounds should be completed .If the resident is not located on the grounds of the facility, the Executive Director/designee takes over primary responsibility for managing the response plan. The Executive Director/designee should follow all internal communication guidelines outlined in the Incident Management Standard .Notify the Responsible party and query possible destinations that the resident may have attempted to travel. Notify the Primary care physician .The Executive Director/or designee is responsible for notification to State Agencies if applicable.</p>		