

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2024
NAME OF PROVIDER OR SUPPLIER  Gramercy Court		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Gramercy Drive Sacramento, CA 95825	

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>47563</p> <p>Based on 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 (departed health facility unsupervised and undetected) during a group outdoor walking activity.</p> <p>This failure had the potential to increase Resident 1's risks for experiencing harm while away from the facility unsupervised.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated Resident 1 was admitted to facility in late 2023 under conservatorship (when a judge appoints another person, a conservator, to manage the affairs and care for another adult), with diagnoses that included bipolar type schizoaffective disorder (illness that can cause hallucinations, delusions, and dramatic moods swings), diabetes (a chronic condition that affects the way the body processes blood sugar), and need for assistance with personal care.</p> <p>A review of Resident 1's Minimum Data Set (MDS: an assessment tool), dated 6/7/24, indicated resident could walk independently and did not use an elopement alarm (device that would alert staff if the wearer attempted to leave via alarmed exit).</p> <p>A review of Resident 1's Special Care Center Facility care plan, initiated 12/6/23 and revised 3/5/24, indicated .at risk for elopement r/t [related to] involuntary placement: history of behaviors, include .elopement .Goal .will not leave facility unattended .</p> <p>An interview via phone on 8/14/24 at 1:45 p.m., Resident 1's Conservator (R1C) stated facility staff notified him on 8/12/24 that Resident 1 had gone missing from the facility and could not be found. R1C added, Resident 1 does have a history of elopement attempts while he was at another facility.</p> <p>During a concurrent interview and record review on 8/14/24 at 2:04 p.m. with the Walking Activity Staff 1 (WAS 1), the STP [special treatment program] group sign in sheet, dated 8/12/24 at 10 a.m. was reviewed. The WAS 1 confirmed the sign in sheet showed 19 residents, including Resident 1, had participated in the walking activity. The WAS 1 stated at the beginning of the walking activity staff have residents write their name on the sign in sheet and have the residents sign when they return after the walking activity.</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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NAME OF PROVIDER OR SUPPLIER  Gramercy Court		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Gramercy Drive Sacramento, CA 95825	
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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>The WAS 1 stated there were four staff members total supervising the walking activity around the outside of the facility. The WAS 1 confirmed staff discovered Resident 1 was missing upon returning from the walking activity and WAS 1 had not seen Resident 1 leave the walking group.</p> <p>During a concurrent interview and record review on 8/14/24 at 2:27 p.m. with the WAS 2, the STP group sign in sheet, dated 8/12/24 at 10 a.m., was reviewed. The WAS 2 stated on 8/12/24 there was a total of four staff supervising the group walking activity around the outside of the facility. The WAS 2 confirmed knowing Resident 1 was participating in the group walking activity because Resident 1's name was on the sign in sheet, but the WAS 2 added, had not seen Resident 1 during the walking activity at all. The WAS 2 expressed concern that Resident 1 may not be able to get enough food to eat or be able to take care of himself when away from the facility.</p> <p>An interview via phone on 8/15/24 at 9:19 a.m., the WAS 3 confirmed being on the group walking activity on 8/12/24 with three other staff members, had seen Resident 1 during the walking activity, had not seen Resident 1 leave the walking group, and discovered Resident 1 had not returned to the facility with the group around 10:43 a.m. The WAS 3 added to prevent further resident elopements, staff should be expected to do a head count during activities outside the facility, not just at the beginning and ending.</p> <p>An interview via phone on 8/15/24 at 10:14 a.m., the WAS 4 confirmed being on the large group walking activity on 8/12/24 with three other staff members, had seen Resident 1 during the walking activity, had not seen Resident 1 leave the walking group, and was surprised when learning Resident 1 had not returned with the group. The WAS 4 indicated smaller groups would help prevent further resident elopements.</p> <p>An interview via phone on 8/15/24 at 10:38 a.m., The STP Unit Manager (SUM) confirmed during the group walking activity on 8/12/24 none of the staff noticed when Resident 1 left the group. The SUM added she expected that staff taking residents out for walks will supervise the residents and notice if/when a resident leaves the group.</p> <p>A review of Resident 1's behavioral health note, dated 8/12/24, written by the SUM indicated, ELOPEMENT . At 0945 staff and residents exited the unit for morning walking group . [Resident 1] was the last resident to join the group . Staff last observed him toward the middle of the peer group, at approximately 1005 but did not witness his elopement. Resident was last seen near the front of the facility building . around 1045, staff found that [Resident 1] was unaccounted for .</p> <p>A review of facility documents titled, Group Supervision guidance, effective date 7/2024, indicated, .During Group: Groups should have ample staff to facilitate in addition to supervise .groups outside .staff should be actively involved in supervising .To keep attendance .write down name of all attendings using the .Group Sign in sheet .once the group has completed, each attendee should sign their name .on the . Group Sign in Sheet .</p> <p>A review of facility policy and procedure (P&amp;P) titled, Elopement, effective date 5/2022, indicated, .Policy to maintain a safe and secure environment for all residents. Elopement .is a serious risk .risk to the resident ' s health and safety and places the resident at risk of heat or cold exposure, dehydration [when body does not have enough water] and/or other medical complications .</p>		