

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER Riverwood Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5320 Carrington Circle Stockton, CA 95210	

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 - 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** 50925</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 1 and Resident 3) who were at risk for elopement (the act of leaving a facility unsupervised and without prior authorization), had implemented elopement prevention measures in place when:</p> <ol style="list-style-type: none"> 1. Resident 1 had exit seeking behaviors on [DATE] but orders for a wander guard device (an alarm that alerts the facility when a wandering resident tries to leave the facility unattended) and monitoring for wandering behavior were not initiated according to Resident 1's care plan , and an elopement risk assessment was not completed; and, 2. Resident 1 ' s wander guard was not working when the elopement happened on [DATE]; and, 3. Resident 1 ' s charting for monitoring wander guard placement (where the device is on the body) was not consistently documented for the months of [DATE] and [DATE]; and, 4. Resident 3 ' s wander guard was found to be expired while being worn. <p>These failures led to Resident 1 ' s elopement which resulted in a head injury, a hospital visit, and stitches, and the potential for Resident 3 to leave the facility unsupervised which could result in physical harm.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 1 ' s ADMISSION RECORD, indicated that Resident 1 was admitted to the facility with diagnoses which included dementia (a progressive state of decline in mental abilities), generalized muscle weakness, and history of falling. <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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with Licensed Nurse (LN) 2 on [DATE], at 9:50 a.m., Resident 1's exit seeking care plan was reviewed. LN 2 confirmed that Resident 1 had a care plan for exit seeking behavior due to wandering aimlessly that was initiated on [DATE]. LN 2 stated that if a resident had wandering behavior the resident 's doctor should be notified and an order for wander guard would be obtained. LN 2 stated when an order was in place for wander guard it would pop up (in the resident 's medical record) for each nurse to check if the wander guard was in place on the resident and was active. LN 2 confirmed that Resident 1 did not have an order for wander guard placement when the wandering behavior started on [DATE].</p> <p>During a concurrent interview and record review with LN 3, on [DATE], at 10:28 a.m., Resident 1's exit seeking care plan and the facility's high risk for elopement binder kept at the receptionist's desk were reviewed. LN 3 stated Resident 1 was sitting on her wheelchair telling staff that she wanted to go home and was trying to look for exits on [DATE]. LN 3 confirmed that the care plan initiated on [DATE] for the exit seeking behavior included frequent monitoring and placement of a wander guard device under the interventions. LN 3 confirmed that there should have been an order obtained for the wander guard when the change in behavior happened on [DATE]. LN 3 stated it would have been important to have an order for the wander guard and monitoring in place when the behavior started on [DATE]. LN 3 stated that if a resident had an order in place for wander guard the nurse would check for placement of the device on the resident and the expiration date every shift. LN 3 stated that Resident 1 was especially at risk of elopement due to her dementia. LN 3 stated at the time of Resident 1's elopement there was not a receptionist sitting at the front desk like there usually was. The facility's high risk for elopement binder kept at the receptionist's desk was reviewed with LN 3. The binder revealed a facesheet (personal information about the resident) and photo for Resident 1. LN 3 stated the binder was to notify reception staff about residents who were at risk of eloping.</p> <p>A review of Resident 1 's exit seeking care plan, initiated on [DATE], indicated .Focus .[Resident 1] exit seeking behavior r/t [related to] [Resident 1] wanders aimlessly .Goal .[Resident 1] will not leave facility unattended through the review date .Interventions .Monitor location every .1 hr [hour] Document wandering behavior and attempted diversional interventions in behavior log .WANDER ALERT [wander guard] .</p> <p>A review of Resident 1 's medical record indicated an elopement risk assessment was completed on [DATE]. There was no elopement risk assessment completed on [DATE] when Resident 1 's exit seeking behavior started.</p> <p>During a concurrent interview and record review with the Director of Nursing (DON), on [DATE], at 3:32 p.m., Resident 1's medical record was reviewed. The DON stated it was her expectation that if a resident was determined to have wandering behavior, then an elopement risk assessment should have been initiated and orders should have been obtained for wander guard placement and behavior monitoring (for exit seeking). The DON confirmed that there was no elopement risk assessment, and no orders for both the wander guard placement and behavior monitoring when Resident 1 's wandering behavior started on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident 1 ' s doctor (MD), on [DATE], at 3:44 p.m., the MD stated that he recalls the change of condition initiated in [DATE] due to Resident 1 verbalizing wanting to go home but did not clearly remember if the facility ' s staff requested an order for the wander guard at the time. The MD stated that it was his expectation for the facility to initiate interventions including obtaining the order for the wander guard and elopement behavior monitoring if exit seeking behaviors were present.</p> <p>2. During a concurrent observation and interview with Resident 1, on [DATE], at 9:13 a.m., Resident 1 stated that she was heading out to the parking lot in her wheelchair (on [DATE]) and the wheel hit the curb, and she fell out of the wheelchair and hit her forehead. Resident 1 motioned to the right side of her forehead. Resident 1 stated she was feeling alright now but was still a little sore. Resident 1 was observed with a healed scar on the right side of the forehead.</p> <p>A review of Resident 1 ' s physician order, dated [DATE], indicated, .Wander guard placement secondary to: (Elopement/exit seeking behavior). Monitor for placement every shift .</p> <p>During an interview with CNA 2, on [DATE], at 9:15 a.m., CNA 2 stated that the current wander guard was placed on Resident 1 on [DATE], but previously Resident 1 had a wander guard that was not working. CNA 2 stated that he worked on the day of the elopement ([DATE]) and everyone was busy that morning. CNA 2 stated that Resident 1 fell in the parking lot and was sent out to the hospital on the same day. CNA 2 stated that the nurses were the ones who document in the resident ' s chart for the presence of the wander guard and the CNA also checks if the wander guard was on. CNA 2 stated that it was important to ensure that the wander guard was functional because of the risk of elopement that can cause accidents or harm to residents.</p> <p>During an interview with LN 4 on [DATE], at 2:27 p.m., LN 4 stated that she was the nurse assigned to Resident 1 when the elopement happened on [DATE]. LN 4 stated that Resident 1 verbalized a lot about needing to leave the facility and would like to sit by the nurse ' s station. LN 4 stated that Resident 1 had a wander guard on before the elopement incident. LN 4 stated that she was passing medications at the end of the hallway when the elopement happened at about 9:20 AM, when the housekeeping staff came running to LN 4 yelling and stating that Resident 1 was bleeding. LN 4 stated that Resident 1 was seen by housekeeping staff who was driving through the facility ' s parking lot when Resident 1 fell off the wheelchair. LN 4 stated that Resident 1 was already sitting on her bottom when she arrived and saw that Resident 1 had a deep gash to her right forehead with lots of bleeding. LN 4 stated that she cut off Resident 1 ' s wander guard before the paramedics came and transported Resident 1 to the hospital. LN 4 stated that Resident 1 received stitches at the hospital and came back the same day around 5 p.m. LN 4 stated that she immediately called the DON and had read the expiration date on the wander guard, which was expired, dated [DATE]. LN 4 stated that she tested the wander guard by the door and the alarm did not go off. LN 4 stated that Resident 1 did not have an order in place for the wander guard before the elopement but Resident 1 had the wander guard in place. LN 4 stated that the wander guard was for resident ' s safety. LN 4 stated it was important for the wander guard to be in place, functioning, and not expired to avoid any accidents. LN 4 stated Resident 1 had been seen by staff ,d+[DATE] minutes prior to the incident and if there was an order in place for wander guard and an order for monitoring, then staff would have been checking the wander guard's functionality and the incident may have been prevented.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s discharge document titled Discharge Instructions Document, dated [DATE], indicated .You were seen today for a fall and a laceration of the forehead .I put 8 stitches in your forehead for the cut .</p> <p>During an interview with the DON, on [DATE], at 3:32 p.m., the DON stated that Resident 1 had a wander guard on at the time of the elopement and that the nurse told her that the wander guard did not go off. The DON stated that the Maintenance person mainly checked the wander guard devices, but the nurses also checked for the functionality as well. The DON confirmed that Resident 1 had a care plan in place that was started on [DATE] that included the wander guard as an intervention. The DON stated that the risk of the wander guard not working was resident elopement. The DON stated that the resident's safety was important and that the staff are expected to follow interventions to prevent elopement. The DON confirmed that the LN should have obtained orders for wander guard, behavior monitoring, and completed an elopement screening when Resident 1's behavior of wanting to the leave the facility was determined on [DATE]. The DON stated that this incident could have been prevented if orders were in place to ensure staff were monitoring Resident 1's wander guard placement and exit seeking behaviors.</p> <p>During an interview on [DATE], at 1:21 p.m., the Administrator (ADM) stated that he could not determine where the November and [DATE] logs were which showed the wander guard devices functionality were being checked by the maintenance department.</p> <p>During an interview with Resident 1 ' s doctor (MD) on [DATE], at 3:44 p.m., the MD stated that he was notified of the elopement but was not aware that the wander guard was not working on [DATE]. The MD stated that if the wander guard was checked and if it was working, an alarm would go off and the facility staff would have acted on it promptly. The MD stated that the facility should have monitored Resident 1 due to the wandering behavior and made sure that the wander guard was in place and functional. The MD further stated that the facility should look after resident ' s safety and should be proactive to prevent accidents.</p> <p>3. During an interview with LN 1, on [DATE], at 9:23 a.m., LN 1 stated that the nurse was responsible for checking the wander guard placement and expiration date of the device every shift.</p> <p>During a concurrent interview and record review with LN 2 on [DATE], at 9:50 a.m., LN 2 stated that the nurses were charting for wander guard placement in the electronic medical record under a section for devices. LN 2 stated that if there was an order in place, it would pop up for each nurse to check if the wander guard was in place and active.</p> <p>A review of Resident 1 ' s monthly report to monitor for wander guard placement every shift with a start date of [DATE], indicated the following dates without any documentation: [DATE] evening and night shift, [DATE] day shift, [DATE], [DATE] and [DATE] day and evening shifts, [DATE], [DATE] day shift, and [DATE] day and night shifts, [DATE] and [DATE] day and evening shifts, [DATE] day, evening and night shifts, and [DATE] day shift. The monthly report for the month of [DATE], indicated the following dates without any documentation: [DATE] and [DATE] day and evening shift, [DATE] day shift, [DATE] day and night shift, [DATE] and [DATE] day shift, [DATE] day and evening shift, [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] day shifts.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with the DON, on [DATE], at 3:32 p.m., Resident 1 ' s monthly report to monitor for wander guard placement for [DATE] and [DATE] was reviewed. The DON confirmed that there were several days on both months that did not have documentation. The DON stated that her expectation was for staff to have monitored and charted according to the order to make sure that all orders were being followed and completely documented.</p> <p>4. A review of the facility ' s list provided for residents with a wander guard titled .Order Listing Report . indicated Resident 3 ' s order, .Wander guard placement secondary to: risk for elopement every shift .</p> <p>During a concurrent observation and interview with the Maintenance Assistant (MA) and LN 4, on [DATE], at 2:17 p.m., Resident 3 was observed with a wander guard device on the right ankle. The MA and LN 4 confirmed the expiration date on Resident 3 ' s wander guard was [DATE] and that the date indicated that it was expired. LN 4 stated that when a wander guard was determined expired the process was to notify the Maintenance person and the DON.</p> <p>During an interview with LN 4 on [DATE], at 2:27 p.m., LN 4 stated that when she reported Resident 3 ' s expired wander guard to the DON, she was told that the wander guard was still good 1.5 years after the expiration date.</p> <p>During an interview with the DON, on [DATE], at 3:32 p.m., the DON stated that the risk of the wander guard not working was resident elopement.</p> <p>A review of the facility document titled Wander Management Transmitters User Guide, dated ,d+[DATE], indicated .Each transmitter is stamped with a warranty expiration date. This date indicates the date that RF Technologies ' warranty on that transmitter expires. If the warranty period has expired, discard the transmitter immediately .WARNING: Using a transmitter beyond the printed expiration date can result in system failure and/or elopement .Visual Inspection .1. Verify that the warranty expiration date that is stamped on the transmitter is not expired .Weekly Testing .</p>