

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555658	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER River Walk Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 West Morton Avenue Porterville, CA 93257	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34401</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision for one of two sampled residents (Resident 1) with a diagnosis of dementia (a progressive state of decline in mental abilities), is a high risk for elopement and had a history of elopement. This failure resulted in Resident 1 eloping from the facility without staff being aware and potential for harm.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), undated, the AR indicated Resident 1 was admitted on [DATE].</p> <p>During a review of Resident 1's Progress Note (PN), dated 11/2/24, at 5:46 p.m. the PN indicated, Another resident [Resident 2] stated that resident [Resident 1] walked out the front door and turned right, and left the facility. Staff member ended up finding resident walking on the sidewalk and brought him back to the facility via car.</p> <p>Resident 1's Elopement Evaluation dated 5/1/24, 7/19/24, and 10/11/24 indicated Resident 1 was a high risk for elopement. Resident 1's quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/13/24 indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 (8-12 moderate cognitive impairment).</p> <p>During an interview on 11/8/24 at 11:39 a.m. with Director of Nurses (DON), DON stated Resident 1 had a history of elopement. DON stated Resident 1 had eloped on 10/11/24 and 11/2/24 without staff being aware.</p> <p>During a concurrent observation and interview on 11/8/24 at 11:57 a.m. Resident 1 was in the dining room sitting at a table. Resident 1 stated he did not have any family and did not know where he was at.</p> <p>During an interview on 11/8/24 at 12:12 p.m. with Licensed Vocational Nurse (LVN), LVN stated on 11/2/24 at 4:45 p.m. he was passing medications when Certified Nursing Assistant (CNA) was going up and down the hall looking for Resident 1. LVN stated Resident 1 was found at approximately 5:30 p.m. approximately one mile away from the facility.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/18/24 at 12:20 p.m. with CNA, CNA stated on 11/2/24 at 4:15 p.m. she was looking for Resident 1 to take to the dining room for dinner. CNA stated she looked for Resident 1 everywhere in the facility but was unable to find Resident 1. CNA 1 stated Resident 1 was found at 5:05 p.m. walking on the side of the road approximately one mile away from the facility.</p> <p>During an interview on 11/8/24 at 12:31 p.m. with Resident 2, Resident 2 stated he had seen Resident 1 pushing the door open and walking out of the facility.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents dated 7/17, the P&P indicated, Systems Approach to Safety. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of the resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.</p>		