

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555769	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER University Retirement Community at Davis		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 Shasta Drive Davis, CA 95616	

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>43247</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe environment with adequate supervision for one of three sampled residents (Resident 1), when Resident 1 eloped (left facility unsupervised and without prior authorization) from facility, fell , and then was moved after the fall before being assessed by a licensed nurse (LN).</p> <p>This failure resulted in Resident 1 experiencing a left orbital fracture (fracture of the bones of the eye socket) and contusion (bruise) of right lower leg and had the potential for further injury.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility, initially, in April 2019 with multiple diagnoses including dementia (progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D).</p> <p>A review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), Cognitive Patterns, dated 8/31/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 out of 15 which indicated Resident 1 had severe cognitive impairment. A review of Resident 1's MDS, Functional Abilities and Goals, dated 8/31/24, indicated Resident 1 required moderate assistance for bed mobility and supervision or contact guard assistance [hands on assistance to maintain balance] for transfers and walking.</p> <p>A review of Resident 1's order dated 5/25/24, indicated May have wander guard [wander management system using sensors to alert caregivers of elopement] attached to wheelchair to alert staff for attempt of exiting door unassisted .</p> <p>A review of Resident 1's Order Summary Report indicated order dated 10/19/24, Monitor left facial (eye) hematoma for s/sx [signs or symptoms] of worsening .</p> <p>A review of Resident 1's Order Summary Report indicated order dated 10/19/24, Staff to rounds and do visual checks on Resident every 30 minutes .</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Order Summary Report indicated order dated 10/19/24, Behavior Monitoring: Attempts to exit facility without assistance. Record the # [number] of times behavior exhibited during shift .</p> <p>A review of Resident 1's Order Summary Report indicated order dated 10/21/24, Resident may have Wanderguard at all times. Check placement and functionality. Monitor and records [sic] of refusal to wear the wanderguard .</p> <p>A review of Resident 1's Wandering Risk Assessment, dated 7/11/24, indicated Resident 1 was a high risk for wandering.</p> <p>A review of Resident 1's SBAR [situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition in the resident] Communication Form, dated 8/31/24, indicated .change in condition: Elopement attempts .Reoriented .</p> <p>A review of Resident 1's SBAR Communication Form, dated 9/4/24, indicated .Falls .CNA [Certified Nursing Assistant] was passing by resident's room, heard loud noise coming from resident's room. CNA found resident lying on the floor by her dresser .c/o [complained of] L[left] side rib cage pain .</p> <p>A review of Resident 1's SBAR Communication Form, dated 10/18/24, indicated .Falls .CNA reported to this RN [Registered Nurse] resident was found outside down on the ground. Resident was last seen at approx [approximately] 0230 [2:30 a.m.] in her bed. She sat in her wheelchair at RN station .CNA cleaned her and placed her back into her bed .</p> <p>A review of Resident 1's Progress Notes, dated 10/18/24 at 8:17 a.m., indicated .Resident was sent out to [name of acute hospital] after an unwitnessed fall with left eye hematoma found down outside of facility. Resident was last seen approx 0230 [2:30 a.m.] during safety rounds. Unknown how long resident was outside of facility or how she exited .</p> <p>A review of Resident 1's Progress Notes, dated 10/18/24 at 6:31 p.m., indicated .Resident readmitted . following a fall, presenting with an orbital floor fracture on the left, subacute fractures of the left lateral ribs (6-8) .</p> <p>A review of Resident 1's Care Plan, initiated 8/16/23, revised 9/9/24, At risk for elopement as she is independent with ambulation. Refused to wear wanderguard and thinks she is a prisoner .Uses wheelchair at times. Resident can ambulate with FWW [Front Wheeled Walker] with supervision .impulsively ambulate without walker .has a hx [history] of wandering in the hallways .Goal .Resident will not have a serious injury from episodes of elopement until next review date .Target Date: 11/30/2024 .Interventions .Redirect as needed .Staff will offer assistance and redirect .back for safety . Date Initiated : 07/11/2024 .Redirect resident if she is trying to walk out of the unit .Date Initiated: 08/18/2023 . has a wanderguard on the bottom part of w/c [wheelchair]. Agreed to used necklace wanderguard but often takes it off. She also has a wanderguard on the FWW. Monitor episodes of removing .Date Initiated: 10/20/2024 .</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 Emergency Department After Visit Summary, dated 10/18/24, indicated .Reason for Visit Fall Diagnoses .Closed fracture of left orbital floor .Contusion of right lower leg .Unwitnessed fall . CT [computed tomography scan- a type of imaging study] Maxillofacial [relating to the jaws and face] . Impression .There is a fracture involving the left inferior orbital wall, with notable involvement of the infraorbital foramen [small opening in the upper jawbone] .The fracture lines extend along the superior wall of the maxillary sinus [cavities in bones in the cheeks] .</p> <p>During an interview on 10/25/24 at 10:22 a.m. with the Director of Nursing (DON), the DON stated Resident 1 walked out of the building on 10/18/24 at approximately 5:00 a.m. without her walker and CNA found her outside. Resident 1 was found sitting on the ground with bruise to left eye. Resident 1 walked back to the nurse's station with the CNA. The DON stated Resident 1 did not have wanderguard on at the time of the elopement and fall. The wanderguard was on Resident 1's wheelchair. The DON stated the wanderguard was initially ordered on 4/5/23 for the wheelchair then tried wanderguard to the ankle on 5/13/23, but Resident 1 would not tolerate it. The DON stated have tried in the past to have Resident 1 use a wanderguard on her person, including ankle and wrist, but Resident 1 was able to remove it. Resident 1 was sent to the emergency department on 10/18/24 and had left orbital fracture and possible rib fractures. The DON acknowledged that Resident 1 had fallen in the past including on 9/4/24 and frequently wandered in the building.</p> <p>During a concurrent observation and interview on 10/25/24 at 10:49 a.m. with Resident 1, observed Resident 1 in bed with blankets covering her chest up to her neck. Observed large purple discoloration over outer left eye. Observed wanderguard sensors on wheelchair and walker at bedside. Resident 1 stated she did not remember fall and did not want to talk.</p> <p>During a telephone interview on 10/25/24 at 11:19 a.m. with CNA 1, CNA 1 stated CNA 2 saw Resident 1 outside through the window when she was assisting a resident in another room. CNA 2 notified CNA 1 that Resident 1 was outside. CNA 1 stated she panicked and attempted to locate the LN to notify her but was not able to find her. CNA 2 went outside to get Resident 1. CNA 2 brought Resident 1 back into the building prior to the LN assessing Resident 1. CNA 1 stated Resident 1 was cold, bruised, and had blood on her face. CNA 1 stated they were short staffed that night. Usually have 3 CNAs with 12 residents each, but that night only had 2 CNAs with 18 residents each. CNA 1 stated normally do rounds on residents every two hours but since short staffed it was difficult to get to everybody. CNA 1 stated the CNAs were busy doing rounds and did not know when Resident 1 left the building. CNA 1 stated she last saw Resident 1 in bed, sleeping, around 3:00 a.m. CNA 1 stated Resident 1 was not stable on her feet and should use the wheelchair or walker, but would get up on her own without using the call light. CNA 1 stated Resident 1 takes her wanderguard off.</p> <p>During an interview on 10/25/24 at 11:38 a.m. with the DON, the DON stated CNA should not have gotten resident up before nurse assessed. Trained to not pick up resident. Did not wait for the nurse. The DON stated the CNA may have panicked and decided on her own to pick up resident. The DON acknowledged that the LN did not go outside to assess Resident 1. The DON stated, The nurse just started at the facility. The DON acknowledged that usually there are 3 CNAs working the night shift, but that night between 2:00 a. m. and after 5:00 a.m. there were only 2 CNAs working.</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 telephone interview on 10/25/24 at 12:27 p.m. with CNA 2, CNA 2 stated she was with a resident in another room and saw through the window Resident 1 outside sitting on the ground. CNA 2 stated she notified CNA 1 who looked for the nurse. CNA 2 went outside to Resident 1. CNA 2 stated she helped Resident 1 to stand up and walked her back into the building. CNA 2 stated she brought Resident 1 to the nurse's station and asked a housekeeper to watch her while she went to get a wheelchair. CNA 2 and a CNA who arrived for day shift assisted Resident 1 to bed. The LN came to Resident 1's room after she was in bed. CNA 2 stated the day shift nurse came, assessed the resident, and called an ambulance. When asked about policy for CNAs getting residents up after falls, CNA 2 stated, Not supposed to get them up until nurse has assessed. Couldn't find her [nurse]. It was really cold that day. She did not have shoes on. Got her up and back into the building. CNA 2 stated Resident 1 takes off the wanderguard. CNA 2 stated Resident 1 gets up on her own, is really quick, and does not use her call light.</p> <p>During an interview on 10/25/24 at 1:15 p.m. with LN 1, LN 1 stated if resident falls, should assess for injuries before moving resident. LN 1 stated if a CNA finds a resident who has fallen, the CNA must notify the nurse before moving resident.</p> <p>During a telephone interview on 10/25/24 at 1:59 p.m. with LN 2, LN 2 stated on 10/18/24 at approximately 5:20 a.m. she was notified by two CNAs that Resident 1 was found outside and one of the CNAs had walked Resident 1 back into the building. LN 2 stated the CNA was concerned that Resident 1 was outside in the cold. LN 2 observed Resident 1 in the wheelchair at the nurse's station. LN 2 stated, CNAs should contact nurse before moving resident. CNAs should have contacted me first, absolutely. LN 2 stated 'Resident 1's left eye was swollen and bruised and when she asked Resident 1 if she had any pain, Resident 1 pointed to her left eye. LN 2 stated Resident 1 had wanderguard earlier in the night, but not at the time she left the building. When LN 2 was asked how staff know wanderguard was working, LN 2 stated, I don't know. Just make sure it is in place. Never assessed for wanderguard prior to this incident. Now document wanderguard in place and behaviors. LN 2 stated Resident 1 gets up independently. LN 2 stated only had 2 CNAs on that night and that may have contributed to the elopement incident because they had limited frequency to check on residents.</p> <p>During a concurrent interview and policy review on 10/25/24 at 3:22 p.m. with the DON, the DON acknowledged that the facility policy titled Fall Reduction and Management Program-SNF [skilled nursing facility] indicated resident will not be moved until directed by the LN. The DON stated, Have told CNAs not to move residents until nurse assessed. Could have back injury. The DON acknowledged that only 2 CNAs were working at the time of the incident instead of the usual 3 CNAs. The DON stated Resident 1 slipped by the staff that night. When asked if having 3 CNAs that night would have prevented Resident 1's elopement and fall, the DON stated, If extra eyes, maybe would not have occurred. Staff is so busy all the time. The DON stated Resident 1's wanderguard is now being checked since the incident but was not being checked prior to this incident. The DON stated there was no wanderguard charting prior to the new order on 10/21/24 and was not being monitored prior.</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 telephone interview on 10/25/24 at 5:14 p.m. with LN 3, LN 3 stated she arrived at facility after Resident 1's elopement and fall at approximately 6:00 a.m. LN 3 stated Resident 1 was in bed, and she assisted LN 2 who was new to the facility. LN 3 stated she assessed Resident 1 and observed Resident 1's left eye was bruised. LN 3 stated she saw Resident 1's wanderguard necklace on the dresser when she arrived in the room and was told Resident 1 had removed the wanderguard and was not wearing it when she left the building. LN 3 stated if a resident has fallen the CNA needs to contact the nurse before the resident is moved. LN 3 stated, CNAs are not supposed to move residents before the nurse assesses the resident.</p> <p>A review of the facility's Policy and Procedure (P&P) titled Elopement and Hazardous Wandering, revised 6/22, indicated .Hazardous or unsafe wandering .by a resident who may be oblivious to his or her physical or safety needs and the wandering places the resident at significant risk of getting to a dangerous place (e.g. wandering outside .) or encountering a dangerous situation .Elopement is a situation in which a resident with impaired cognition an/or demonstrated lack of safety awareness or judgment successfully leaves the organization or a secured area, .undetected or unsupervised by staff .It is the policy of the Company to be responsible for maintaining a system that provides protection for those residents who are at risk for elopement The facility will put measures in place to minimize the risk of elopement Individualized interventions may include .Accounting for residents at risk for elopement every 30 minutes .Use of resident safety alarms .In the event of a resident elopement from the facility: .If the individual is found, nurse to assess for any injuries and necessary treatment .</p> <p>A review of the facility's P&P titled Safe Environment/Accident Prevention, revised 11/16, indicated .All reasonable precautions will be taken by the facility to protect a resident from possible injury from dangerous conditions, falling, wandering .Monitoring of all accidents and incidents will be completed with follow up recommendations to prevent further occurrence by the Director of Nursing or designee .</p> <p>A review of the facility's P&P titled Fall Reduction and Management Program- SNF, revised 10/23, indicated . It is the policy of the Facility that every effort be made to reduce and/or prevent falls from occurring and/or minimize serious injury if fall should happen .The Licensed Nurse will: .Evaluate each resident's need for supervision, the resident environment, and assistive devices to avoid a fall .Considerations of special needs may include .Residents with cognitive impairment .Residents with recurrent falls .unsafe behaviors . Response to a fall .When a fall occurs, the fall will be immediately reported to the Licensed Nurse .The resident who fell will not be left alone, if possible, and will not be moved unless directed to do so by the Licensed Nurse .Licensed Nurse will complete a full body check to assess for injury and proceed accordingly to treat and/or protect, and keep the resident safe .</p> <p>A review of the facility's P&P titled Wandering Resident Management : Wanderguard, revised 3/15, indicated .Facilities will provide devices to assist in monitoring the whereabouts of wandering residents and prevention of elopement from the facility .If it is determined he/she is at risk for unsafe wandering/elopement, a Wanderguard Bracelet will be placed on the resident .If the resident will not keep the bracelet on wrist/ankle, place it either on the resident's walker, wheelchair or personal clothing .Staff will monitor the Wanderguard for proper placement and function every shift and will be documented on the MAR [Medication Administration Record] or TAR [Treatment Administration Record] .At each change of shift, the whereabouts of all residents shall be determined. During rounds, CNA will verify the location of each of their residents .</p>		