

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
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NAME OF PROVIDER OR SUPPLIER ARBOR POST ACUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 SPRINGFIELD DRIVE CHICO, CA 95928
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the investigation of one complaint and one facility reported incident.</p> <p>Complaint Number: 949210 Facility Reported Incident Number: 948662</p> <p>The inspection was limited to the specific complaint and facility reported incident investigated and does not represent the findings of a full inspection of the facility.</p> <p>One deficiency was issued for complaint 949210 at F578. One deficiency was issued for facility reported incident 948662 at F689.</p>	F 000		
F 578 SS=D	<p>Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse</p>	F 578	<p>F 578 Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir</p> <p>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The resident's rights were followed on 2/10/25 when the diet order was updated by the physician to align with the resident's wishes.</p> <p>The Gastrointestinal Tube was removed on 3/11/25 during an outpatient appointment.</p>	

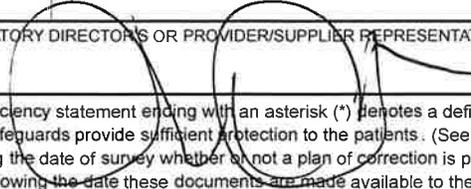
CA DEPT OF PUBLIC HEALTH
CHCQ Field Operations North Division- Chico

Received Date: 3/20/25

Compliance Date: 3/18/25

Approved Date: 3/20/25

Approved By: Gyovonne Mulcahy

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/19/25
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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.

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility violated a request for refusal of treatment for one of two residents sampled for resident rights (Resident 1) when, Resident 1 requested no artificial means of nutrition, including feeding tubes (Gastrointestinal Tube(G-tube)), a flexible tube that is placed through the abdominal wall and into the stomach for feeding liquid nutrition), because he wanted to eat and drink regular food and liquids, and the facility continued to feed Resident 1 by G-tube for 24 days after he had signed a Physician Order for Life Sustaining Treatment (POLST, a document of resident wishes).	F 578	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Any resident who updates their POLST (Physician Orders for Life-Sustaining Treatment) to include no artificial means of nutrition following the surgical implementation of a Gastrointestinal Tube may be affected by this practice. No other residents were affected by this practice. On 3/13/25, Medical Records completed a facility-wide audit of resident POLSTs, identifying and correcting any issues. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not reoccur: On 3/17/25, the Medical Records Director initiated in-service training for nursing staff on the proper POLST process, including order updates. Medical Records will conduct daily audits, Monday through Friday, of the POLST Binder at each station to ensure the timely completion of any updated POLST orders. How the facility plans to monitor its performance to make sure that the solutions are sustained: Audit results will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting. If 95% compliance is achieved after 90 days, the issue will be resolved within QAPI.		

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F 578	<p>Continued From page 2</p> <p>This failure caused Resident 1 distress, frustration and pain and negatively impacted his quality of life.</p> <p>Findings:</p> <p>A review of the facility ' s admission agreement titled, "California Standard Admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities" revised 5/11, the agreement indicated " ...you have the right, to the extent permitted by law, to refuse any treatment and the right to be informed of potential medical consequences should you refuse treatment."</p> <p>A review of the facility ' s, "POLST" form indicated, "First follow these orders then contact Physician ...A copy of the signed POLST form is a legally valid physician order."</p> <p>A review of Resident 1 ' s Admission Record indicated Resident 1 was originally admitted on 3/12/18 with diagnoses that included diabetes, obesity, heart failure, and major depression. On 1/18/25 Resident 1 was re-admitted to the facility after a short hospital stay with new diagnoses that included placement of a G-tube due to dysphagia (difficulty swallowing certain foods or liquids which causes coughing and choking), and aspiration (when food or fluids are accidentally inhaled into the lungs, instead of the stomach). Resident 1 made his own health care decisions.</p> <p>A review of Resident 1 ' s Admission Minimum Data Set (a data driven clinical assessment), dated 1/21/25, section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS, evaluation of cognition, thinking, memory recall and decision making that scores from 00 to 15),</p>	F 578	<p>Include dates when corrective action will be completed:</p> <p>Corrective action for deficient practice will be completed by March 18th, 2025.</p>	
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F 578	<p>Continued From page 3</p> <p>reflected that Resident 1's BIMS score was a 15.</p> <p>A review of Resident 1 ' s POLST dated 1/31/25, indicated Resident 1 ' s wishes were, "Do not attempt Resuscitation [DNR, allow natural death], and, "No artificial means of nutrition, including feeding tubes." Resident 1 and the Medical Director both signed the form on 1/31/25.</p> <p>A review of Resident ' 1 ' s Physician's Orders for February 2025, indicated an Enteral (the administration of nutrition through a G-Tube) feeding order was started 1/18/25 and discontinued on 2/24/25, twenty-four days after Resident 1 made his wishes clear.</p> <p>A review of Resident 1 ' s nursing Progress Notes were reviewed and reflected the following:</p> <p>On 2/2/25 at 4:15 pm, a nurse documented, "Resident on alert charting r/t [related to] monitoring for noncompliance with NPO [nothing by mouth] diet. Fluids and meals given via [by way of] G-Tube as scheduled"</p> <p>On 2/3/25 at 4:07 pm, a nurse documented, "Resident on alert charting r/t monitoring for noncompliance with NPO diet. Fluids and meals given via (by the way of) G-Tube as scheduled"</p> <p>On 2/4/25 at 10:48 pm, a nurse documented, "At approx. 10:20 [pm] CNA [Certified Nursing Assistant] approached nurse and said residents G-Tube was no longer intact, the nurse went in room to find resident holding g-tube. When asked what happened he states, "it was an accident it got caught on my blankets." EMS [Emergency Medical System, an ambulance] called."</p> <p>On 2/5/25 at 9:45 am, a nurse documented, "Resident return from acute on 2/5/25 with new</p>	F 578		

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F 578	<p>Continued From page 4</p> <p>G-tube in place."</p> <p>On 2/6/25 at 10:45 pm, a nurse documented, "Weekly Summary notes ...Resident is NPO and receives 2500 mL [milliliters] daily via g-tube, also some flushes too as tolerated. Resident has been non-compliant at times with new diet by consuming oral snacks and beverages."</p> <p>On 2/7/25 at 10:45 am, a nurse documented, "Attempted to speak with resident regarding TF [tube feeding] and weight refusal. Resident continues to be upset about feeding tube. Writer offered sympathetic listening. He then stated, ' I am either going to commit suicide or take this thing out [the G-tube]' He went on to state he is mad how big the tube out of his stomach is and stated, ' I want this F* thing out ' ."</p> <p>During an observation and interview with Resident 1 on 3/11/25 at 11:30 am, Resident 1 was observed in bed with no shirt on and a sheet covering the lower half of his body, a G-tube was visible coming from his stomach. Resident 1 stated, "They said I was aspirating. I had pneumonia and I failed the swallowing test. I want to get it [the G-tube] out ...I want to eat regular food." Resident 1 indicated the G-tube caused him pain and discomfort.</p> <p>During a concurrent interview with Director of Nursing (DON) and record review on 3/11/25 at 4:31 pm, Resident 1 ' s POLST and physician orders were reviewed. DON confirmed that Resident 1 indicated he did not want feeding through a tube on his POLST and the Medical Director signed it on 1/31/25. The DON confirmed Resident 1 had received feedings through his G-tube after he had signed his POLST, requesting not to have this treatment. The DON confirmed the facility should have followed</p>	F 578			

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F 578	Continued From page 5 Resident 1 ' s wishes beginning on 1/31/25, but instead continued to feed Resident 1 against his will, for another 24 days. Resident 1 ' s nursing progress notes were reviewed and the DON who confirmed that nursing documentation reflected Resident 1 was distraught over being fed by a G-tube.	F 578			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the safety and security of seven of seven residents (Residents 1, 2, 3, 4, 5, 6 and 7) sampled as those who had been identified as high risk for wandering and/or elopement (when a resident unsafely leaves the facility undetected) when: 1. The Touchpad Exit Controller (TEC, a system located on exit doors that alarms when resident wearing a Wanderguard (a wrist or ankle bracelet that alarms), passes through any of those exits), alarm system did not alarm and Resident 1 eloped from the facility without staffs knowledge, and Resident 1 was found across the street from the facility by a person who was driving by, with his wheelchair stuck in a sidewalk crack. 2. The monitoring check-off log of the TEC	F 689	F689 Accidents and Hazards How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The resident identified experienced no adverse effects and does not recall the incident. The resident was moved to a new room on 2/26/25, further from an exit door with no new incident noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Any resident who has been identified as an elopement risk had the potential to be affected. No other residents were affected. 1. On 2/25/25, the nurse on duty addressed the loose wire on the identified door. Maintenance conducted an assessment on 2/26/25 and secured the wiring further. Additionally, on 2/26/25, Maintenance installed a Velcro stop sign on the identified door as a deterrent. A fire alarm box was added to this door on 3/13/25 as an additional safety measure.		

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F 689	<p>Continued From page 6</p> <p>system and exit door alarms had not identified which doors were being tested, had not included all of the facility exit doors, and had days where there was no documentation that reflected that the doors had been checked.</p> <p>3. The TEC system on Station 3 ' s exit door was not functioning and had not alarmed when tested by the surveyor.</p> <p>4. The physician ' s orders for Residents 2, 3, 4, 5, 6, and 7, indicated the resident's wanderguards would be checked once daily which was not in accordance with the facility's policy that indicated the checks would be done every shift (three times a day).</p> <p>5. Registered Nurse (RN) A and Licensed Vocational Nurse (LVN) B were not checking the functionality (whether they would alarm or not if they went through the TEC system) of the wanderguards as ordered.</p> <p>The facility's lack of oversight of ensuring their TEC and Wanderguard systems were fully functional, resulted in Resident 1 eloping from the facility and endangered the safety and welfare of six other residents who were known to wander.</p> <p>Findings:</p> <p>A review of the facility ' s policy titled, "Safety and Supervision of Residents" revised July 2017, indicated, "Our facility strives to make the environment as free from accident hazards as possible. Residents ' safety and supervision and assistance to prevent accidents are facility-wide priorities." "These risk factors and environmental hazards include the following:" "e. unsafe wandering."</p> <p>1. A review of Resident 1 ' s admission record</p>	F 689	<p>2.Maintenance log/audit was updated on 3/13/25 to include all doors and the device that is being checked on each door.</p> <p>3.Tec system on station 3 door is working but showing a slight delay when alarming. Tec systems have been contacted to address the need for increased sensitivity. Additionally, this door includes a locked alarm box that alarms, the wanderguard sensor was an additional backup alarm.</p> <p>4.Wanderguard Process Guide was edited to match the physician orders.</p> <p>5.On 3/12/25, nurses identified as not knowing how to check the wander guard functionality were in serviced by the nurse manager.</p> <p>What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not reoccur:</p> <p>On 3/17/25, the Administrator provided in-service training to the Director of Maintenance during the routine inspection of doors equipped with WanderGuard sensors. The inspection will now also include checks for loose wiring and sensor is secure.</p> <p>On 3/17/25, the Nurse Manager initiated in-service training for licensed nurses on the proper method to check the functionality of the WanderGuard system for their residents.</p>		

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F 689	<p>Continued From page 7</p> <p>indicated that Resident 1 was admitted on 12/14/24 with diagnoses that included, dementia (a group of symptoms that affecting memory, thinking and social abilities), depression, history of falling, muscle weakness, heart failure and a stroke (the brain goes without blood and causes damage to that certain area affected). Resident 1 was unable to make his own health care decisions.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS, a data driven clinical assessment) dated 2/10/25, section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS, evaluation of cognition, thinking, memory recall and decision making with a score from 00 to15) score of 7, severely impaired cognition. Section E indicated Resident 1 had wandering behaviors one to three times a week.</p> <p>A review of Resident 1 ' s Physician's Order, revised 2/11/25, reflected an order for, "Wandergard (wanderguard) to right ankle due to elopement risk."</p> <p>A review of Resident 1 ' s nurses Progress Notes written by LVN D, dated 2/25/25 at 8:29 pm, indicated at approximately 6:10 pm, "A member of the community came into the facility and informed this nurse that there was a man in a w/c (wheelchair) stuck on the sidewalk. This nurse walked outside with the community member where she proceeded to point out where the man was, stating he was across the street and stuck by the fence. This nurse walked out to the sidewalk and saw a man in a w/c across the street facing a fence and seemingly stuck. This nurse went across the street and spoke with the man, asked his name, he identified himself, this nurse recognized him as a resident of this</p>	F 689	<p>Maintenance will complete a daily audit (Monday through Friday) of the exit doors alarm systems including WanderGuard system and/or Red Fire Box, this audit will include a review for potential loose wires, Wanderguard sensor and functionality and Redi Fire Box sensor and functionality.</p> <p>Medical Records will check weekly that the Wanderguard orders match the policy. The Director of Nursing (or designee) will audit two nurses weekly to ensure they can correctly verbalize the process for checking a resident's WanderGuard functionality.</p> <p>How the facility plans to monitor its performance to make sure that the solutions are sustained:</p> <p>Results of audit will be brought to Quality Assurance Performance Improvement (QAPI) monthly. If 95% compliance is met after 90 days QAPI will be resolved.</p> <p>Include dates when corrective action will be completed:</p> <p>Corrective action for deficient practice will be completed by March 18th, 2025.</p>		

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F 689	<p>Continued From page 8 facility."</p> <p>A report by the facility to the California Department of Public Health on 2/26/25 at 3:01 pm, indicated Resident 1 had a wanderguard placed on his left ankle that failed to alarm when he went out of one of the facility exit doors. The facility indicated that their wanderguard system (TEC) was assessed by the facility and found to have an unconnected wire and was not working.</p> <p>During an interview on 3/12/25 at 11:30 am, LVN C indicated Resident 1 ' s room was next to the North door on Station 1 and the TEC system which was mounted next to the door on the wall, "Was missing a screw, was loose and unplugged behind the cover the day [Resident 1] got out." LVN C indicated that after she plugged in the TEC and replaced the screws the alarm was working again.</p> <p>During an interview with the Administrator (Admin) on 3/13/25 at 11:30 am, the Admin confirmed the TEC system on the North door on Station 1 was not working when Resident 1 eloped on 2/25/25.</p> <p>2. During an observation and interview with the Maintenance Director (MD) on 3/12/25 at 11:49 am, the exit doors of the facility were observed. There were nine exit doors identified to exit the building. Station 1 ' s North exit door, Station 1 ' s East exit door, Station 2 ' s East exit door, Station 2 ' s South exit door, Station 3 ' s exit door, Station 4 ' s exit door, the Dining Room exit door, the Lobby exit door, and the Laundry Hall exit door. The MD indicated the door alarms and locks are checked every morning on all nine doors. The MD indicated that on the morning of</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>2/25/25, the nine exit doors were check for the sound of the alarm, but it was not noticed if the TEC cover was loose, were missing screws or unplugged. The MD indicated they just checked to see if the alarms were working.</p> <p>During a concurrent interview with the Admin and record review on 3/13/25 at 11:30 am, a facility ' s door monitoring check-off log titled, "Logbook document ... for Doors, Locks, Gates and Alarms: Test operation of doors and locks" for dates 2/16/25 thru 2/26/25 were reviewed. The check-off log had no documentation that any of the alarms had been checked on Sunday February 16th, Saturday February 22nd, and Sunday February 23, 2025. The check-off log only listed seven of the nine exit doors in the facility. The Admin confirmed there were nine exit doors, but the log only identified seven and had not included one door on Station 1 and one door on Station 2. The Admin confirmed that all nine doors should be checked daily to ensure all alarms and locks were functioning for the safety of the residents.</p> <p>3. During a concurrent observation and interview with the MD on 3/12/25 at 11:49 am, the TEC system for the exit door on Station 3 was tested. This surveyor held onto a wanderguard (the device that the resident wears which signals the TEC to alarm), with her right hand and walked out Station 3 ' s door and the TEC alarm did not go off. MD was previously unaware that alarm was not working.</p> <p>4. During a review of the facility policy titled, "WanderGaurd Process Guide" Revised March 2019, the policy indicated, "7. Monitor placement and functioning of the device per order. Order</p>	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/13/2025
NAME OF PROVIDER OR SUPPLIER ARBOR POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 SPRINGFIELD DRIVE CHICO, CA 95928		
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F 689	<p>Continued From page 10</p> <p>should include:" b. Every shift monitoring of WanderGaurd device functioning."</p> <p>During a concurrent interview with the Admin and record review on 3/13/25 at 11:30 am, physician's orders for Residents 1, 2, 3, 4, 5, 6, and 7 who the facility had identified as wanderers with the potential to elope, were reviewed. Residents 2, 3, 4, 5, 6, and 7 had an order to "check functionality (of the wanderguard) ... every day shift." The Admin confirmed the facility had not followed their policy by checking the functionality of the wanderguards every day instead of every shift.</p> <p>5. A review of the facility's,"Wander Management Transmitters user guide" dated 2018, the guide instructions reviewed testing and care of the transmitter (wanderguard), which included: "Visual Inspection 1. Verify that the warranty expirations date that is stamped on the transmitter is not expired. 2. Visually inspect the transmitter for damage or loose parts." "Operation 1. Place the transmitter tester directly on the transmitter (wanderguard). 2. Press and hold the button on the left side of the transmitter tester. 3 The device beeps once when you initially press the button. 3. While holding the button in, the indicator light flashes and a tone sounds once per second. 5. Wait for at least 3 flashes of the indicator light and 3 tones from the transmitter tester to verify that the transmitter is functioning correctly."</p> <p>During an interview on 3/12/25 at 12:28 pm, Registered Nurse (RN) A indicated that she would look at the residents wanderguards daily to make sure they were physically on the residents, but she did not check functionality with a tester. RN A indicated, "About every four days or so" she</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>would place a resident next to an exit door to see if it would alarm and that was how she checked it.</p> <p>During an interview on 3/12/25 at 12:38 pm, LVN B indicated he checked that the residents were wearing their wanderguards every day, but did not check to see if they worked. LVN B indicated he had not used a transmitter tester to test the wanderguards.</p> <p>During an interview on 3/12/25 at 12:45 pm, Director of Nursing (DON) indicated that there was a tool available to staff to check the functionality of the wanderguards and the staff should be using that.</p>	F 689			