POC received - 11/4/25
POC approved - 11/4/25
BIC - 11/3/25 per DB, HFES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030001004	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN RIVER CENTER	3900 GARFIELD AVENUE , CARMICHAEL, California, 95608

(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
C0000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of one (1) facility reported incident #2633261 and one (1) complaint #2641384. The inspection was limited to the specific facility reported incident and complaint investigated and does not represent the findings of a full inspection of the facility. The facility was found not in compliance with the State requirements and regulations for Skilled Nursing Facilities for facility reported incident #2633261.	C0000		11/04/2025
C0835	Nursing Service--General CFR(s): T22 DIV5 CH3 ART3-72311(a)(2) (a) Nursing service shall include, but not be limited to, the following: (2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent one of three sampled residents (Resident 1) from elopement (to leave an area of safety unsupervised and undetected) outside the facility. This failure had the potential to result in serious injury or death for Resident 1. Findings: A review of Resident 1's "Admission Record" indicated; Resident 1 was admitted to the facility in 2025 with a diagnoses that included, Dementia (a group of symptoms affecting memory, thinking, and social abilities) and Traumatic Brain Injury.	C0835	The preparation and/or the execution of this plan of correction do not constitute admission of agreement by the provider of true facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of the Federal and State law require it. This Plan of Correction constitutes the facility's credible allegation of compliance. C0835 Corrective action accomplished for identified resident (s) affected by the deficient practice: Resident 1 was found and brought back into the facility without incident or injury. Resident placed on 1 on 1 supervision until the wanderguard system for the front door was adjusted with an additional reader on 10/3/2025. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken: On 10/2/2025, an audit of all residents that triggered	11/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	11/7/2025

California State Department of Health

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C0835	Continued from page 1 A review of Resident 1's, "Minimum Data Set" (MDS – an assessment tool to guide care) Cognitive (having full understanding) Patterns, dated 7/22/25, indicated Resident 1 had a Brief Interview for Mental Status (a tool to assess a person's full understanding) score of six which indicated Resident 1 did not have full understanding. A review of Resident 1's, "Elopement Evaluation" dated 10/1/25, indicated Resident 1 had a score of five which indicated, Resident 1 was at risk for elopement. A review of Resident 1's "Care Plan" dated 7/22/25 indicated, "Resident is at risk for elopement related to: Alcohol/Drug-seeking behavior and a history of elopement at the hospital…" During an interview with the Licensed Nurse (LN) on 10/17/2025 at 2:07 p.m., LN stated, they were informed by a staff member that Resident 1 was missing and had last been seen at approximately 6:00 p.m. Resident 1 was located approximately one hour later at 7:00 p.m. A review of Resident 1's "Progress Notes" dated 9/30/25, indicated Resident 1 was found missing from the facility on 9/29/25 at approximately 6:00 p.m., the facility located Resident 1 at approximately 7:00p.m., on 9/29/25. During an interview with the Administrator (ADM) on 10/20/2025 at 11:32 a.m., the ADM stated Resident 1 is confused and at high risk for elopement. The ADM further stated, "Resident 1 should have been watched more closely." Lastly the ADM stated, "The expectation is for no residents to elope." A review of the facility policy titled, "Elopements" dated 2/21/25 indicated, "The resident who exhibits wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk."	C0835	Continued from page 1 as at risk for elopement was completed by the Medical Records Director to ensure that they all have appropriate interventions in place. Updates made as identified. Immediate measures and systemic changes put in place to ensure that the deficient practice does not recur: On 10/1/2025 and 10/2/2025, the Director of Staff Development in-serviced CNAs and Licensed Nurses on the elopement policy and procedure and wanderguard devices. A description of the plans and persons responsible for monitoring ongoing performance, and ensuring that the corrective actions are achieved and sustained: The Medical Records Director or designee will conduct an audit for residents triggering as elopement risks weekly to confirm interventions are in place. The results of the audits will be reported to the QAPI Committee meeting monthly for 3 months and then re-evaluated thereafter. Completion Date: 11/4/2025	