STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055304	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DYCORA TRANSITIONAL HEALTH - QUAIL LAKE	**1221 ROSEMARIE LANE STOCKTON, CA 95207**

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)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record, and facility policy review, the facility failed to ensure one of three sampled residents (Resident 1) received adequate monitoring and supervision when Resident 1 left the facility unsupervised and without staffs' knowledge. This failure placed Resident 1's health and safety at risk. Findings: Review of Resident 1's admission record revealed, Resident 1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, an assessment tool) dated 11/21/18, revealed a score of 12 indicating mild cognitive impairment. Review of Resident 1's care plan initiated 9/11/18, indicated, .At risk for elopement (a dependent resident leaving a facility without observation or knowledge of departure and under circumstances that place the resident's health, safety, or welfare at risk) related to: attempts to leave Living Center . Review of Resident 1's physician's order dated 1/31/19, indicated, .May have wander guard . Wanderguard is an electronic door monitoring device that sends alert notification to facility staff for residents who are at risk for elopement. On 2/8/19, the Department received a report from the facility that Resident 1 had left the building on 2/7/19 unsupervised and without staffs' knowledge. The report revealed, Resident 1's case worker found her on a sidewalk at a busy cross street at approximately 11 a.m. The report further indicated, .Wander guard tested . Wander guard not working . Further review of Resident 1's progress notes dated 2/6/19, revealed, at approximately 6:30 p.m., the facility staff found Resident 1 outside the facility walking around unsupervised and without staffs' knowledge. Resident 1 had previously left the building prior to the reported incident of 2/7/19. The progress notes also indicated, .wander guard was on her R (right) wrist .Wander guard replaced to avoid elopement . There was no documented evidence the replaced wanderguard was checked for proper functioning. In an interview with the certified nurse assistant (CNA) 1 on 2/22/19, at 11:35 a.m., she stated she did not know who and how often wanderguards were checked. In an interview with the licensed nurse (LN) 1 on 2/22/19, at 12:25 p.m., she stated she was not sure how often wanderguards were checked. She added, nurses did not check wanderguards. There was no documentation in the treatment record that wanderguards were checked for proper functioning. In an interview with the director of nursing (DON) 1 on 2/22/19, at 12:50 p.m., she stated it was the responsibility of the restorative nurse assistant to check wanderguards weekly on Tuesdays. She added, the wanderguard was not checked for proper functioning because it was not scheduled to be checked. In a concurrent interview and clinical record review with LN 2 on 3/3/20, at 2:52 p.m., Resident 1's care plan created 2/11/19, indicated, .Found resident in the parking lot . LN 2 confirmed Resident 1 had another episode of elopement on 2/11/19 after the incident of 2/7/19. In a concurrent observation and interview with LN 3 on 3/3/20, at 4:12 p.m., when asked to check the wanderguard for Resident 2 by going through the front door of the building, the wanderguard did not work. LN 3 stated, It did not work. In a subsequent observation and interview with LN 4, when asked to check the wanderguard for Resident 3 by going through the front door of the building, the wanderguard did not work. LN 4 stated, It did not work . In an interview with DON 2 and the administrator (ADM) on 3/3/20, at 4:30 p.m., DON 2 stated, .We will change the wanderguard . The ADM stated, the wanderguards and alarm system should have worked. In a phone interview with the maintenance supervisor (MS) on 3/4/20, at 8:46 a.m., he stated he used a wanderguard device to check all exit doors every Monday. He added, he did not know why the front door did not work. He continued, It should had worked. When asked how he would ensure the wanderguards for each resident and all the alarm doors were working on other days, he stated maybe it should be done everyday. Review of the facility policy titled, Elopement Guideline updated October 2015, indicated in pertinent parts, .Elopement occurs when a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so .Prevention .Staff will: Observe that each resident's bracelet alarm/device is still in place each shift .The charge nurse or designee shall test resident personal alarms/devices .Documentation should include .Bracelet alarm/device is in place and functioning (per TAR (treatment administration record) or other form of documentation) .The following elements are in place .to demonstrate satisfactory compliance .Door alarms are checked and documented .Alarm bracelet function is checked daily and documented .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.