STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to ensure the quarterly Minimum Data Set Assessment (MDS-a resident assessment tool used to identify resident cognitive and physical function) accurately reflected the residents healthcare and functional status for one of nine sampled residents (Resident 2) when Resident 2 ' s plan of care addressed an unsteady gait (manner of walking) and declining health status on 11/2/24 and Minimum Data Set Coordinator (MDSC) 2 assessed his ambulation (ability to walk) status as independent in the MDS Assessment Section GG-Functional Abilities on 11/23/24. This failure resulted in an inaccurate assessment of Resident 2 ' s functional status as not needing supervision to ambulate, and the resident was left on an outside patio unsupervised and fell on [DATE] sustaining a laceration above his left eye. (Cross reference F689) Findings: During an observation on 1/6/25 at 11:33 a.m. in the activities room, Resident 2 in a sat chair. Resident 2 had a sutured (threads closing a wound) laceration (cut in the skin) above the left eyebrow with yellowish discoloration around the left eye. Resident 2 was confused and unable to verbalize what happened to his eye. During a review of Resident 2 ' s Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included dementia (loss of cognitive functioning-thinking, remembering, and reasoning), epilepsy (nerve cell activity in the brain is disturbed causing seizures [burst of sudden electrical activity]), muscle weakness, and difficulty in walking. During a review of Residents 2 ' s Minimum Data Set assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 06 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 had severely impaired cognition. During an interview on 1/6/25 at 11:35 a.m., in the memory care unit hallway with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 2 ' s health had been declining since early November 2024. CNA 2 stated Resident 2 required supervision to ambulate safely. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/7/25 at 4:48 p.m. with Licensed Vocational Nurse (LVN) 7, LVN 7 stated she was on duty 1/2/25 when Resident 2 fell . LVN 7 stated Resident 2 had an unwitnessed fall on the patio outside and was found face down on his stomach. LVN 7 stated when Resident 2 was assessed, he had a bleeding laceration above his left eyebrow and was sent to the hospital by ambulance. LVN 7 stated Resident 2 ' s fall may have been prevented if he had staff supervision at the time of the fall. During an interview on 1/8/25 at 11:41 a.m. with CNA 8, CNA 8 stated she was assigned to Resident 2 at the time of his fall on 1/2/25. CNA 8 stated Resident 2 would frequently walk to the patio by himself. CNA 8 stated Resident 2 ' s health and activities of daily living (ADL-skills to care for oneself such as eating, bathing and mobility) abilities had declined since the beginning of November. CNA 8 stated, he needs more assistance with everything. CNA 8 stated during lunch on 1/2/25 Resident 2 was outside on the patio, she told him to come in for lunch and left the resident unsupervised on the patio. CNA 8 stated she did not walk Resident 2 back inside because he would normally come back into the facility by himself. CNA 8 stated Resident 2 fell before he reached the door. CNA 8 stated Resident 2 had episodes of leaning forward with a shuffling gait when he walked, so he required supervision to ambulate safely. CNA 8 stated, he must have had one of those episodes [on the patio] and fell . CNA 8 stated she left Resident 2 on the patio because she could not leave the dining room unattended and thought he would come back into the building on his own. CNA 8 stated Resident 2 did not have the mental capacity to call for help which increased the need for supervision. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/8/25 at 2:42 p.m. with Registered Nurse (RN) 1, Resident 2 ' s CIC dated 12/13/24 was reviewed. RN 1 stated Resident 2 was found on the ground in his room by a therapist on 12/13/24. RN 1 stated Resident 2 ' s health had declined since early November 2024, and he required supervision for safety. RN 1 stated Resident 2 had episodes of leaning forward with a shuffling gait which increased his fall risk and need for supervision. Resident 2 ' s care plan dated 11/2/24 was reviewed, the care plan indicated, . Resident c/o lower back pain, headache and unsteady gait . RN 1 stated the care plan indicated Resident 2 ' s gait had been unsteady gait since 11/2/24. Resident 2 ' s Post-Fall Review, (PFR) dated 1/2/25 was reviewed. The PFR indicated, . Date and Time of Fall . 1/2/25 13:20 [1:20 p.m.] . Discovered on the floor (Unwitnessed) . Went outside to give the resident his medication. CNA called for him to come in to eat his lunch. Resident was taking long time to come in so I went to go check outside. Found resident lying face down on the floor with a laceration to his eyebrow . describe location where resident was found . outside on dementia patio . Was resident using assistive device for ambulation or transfer . no . IDT [Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident] Review and Summary of Root Cause . 1/2/2025 IDT met to review regarding resident ' s fall obtaining a laceration on his R [right] eyebrow and was send to hospital per physician ' s order . Resident has a poor safety due to poor cognition, adverse effects of medication . IDT recommendations . Continue on PT & OT . PT with recommendations to use a wheelchair for resident ' s mobility . Put resident bed in low position . RN 1 stated Resident 2 should have been supervised when ambulating and all residents from the memory care unit should be supervised while on the patio. Resident 2 ' s fall care plan dated 11/2/24 was reviewed. RN 1 stated she was unable to find a fall risk assessment performed after Resident 2 ' s fall on 12/13/24 and 1/2/25. RN 1 stated the facility did not perform fall risk assessments before and after falls. Resident 2's MDS Assessment, Section GG, dated 11/23/24 (before Resident 2's fall on 12/13/24), was reviewed. The MDS Section GG indicated, .I. walk 10 feet . code 06 [independent] . J. Walk 50 feet with two turns . code 06 [independent] . E. Walk 150 feet . code 06 [independent] . RN 1 stated the MDS was incorrect because Resident 2 was unsafe to ambulate independently since early November. During a concurrent interview and record review on 1/8/25 at 3:39 p.m. with Minimum Data Set Coordinator (MDSC) 1, Resident 2 ' s MDS Assessments were reviewed. MDSC 1 stated Resident 2 had a change in condition MDS on 12/31/24 because his health and function had declined significantly. MDSC 1 stated his decline was in cognition, bowel and bladder and ambulation. MDSC 1 stated Resident 2 ' s quarterly MDS had been completed on 11/23/24. The MDS Section GG was reviewed, MDSC 1 stated the MDS indicated he was independent with ambulation. Resident 2 ' s care plan for pain and unsteady gait dated 11/2/24 was reviewed. MDSC 1 stated the care plan indicated Resident 2 had poor balance and she would have expected the 11/23/24 MDS to be coded as needing supervision with ambulation. MDSC 1 stated Resident 2 ' s care plan indicated was unsteady when walking and he would have required supervision for safety. During a concurrent interview and record review on 1/8/25 at 3:50 p.m. with MDSC 2 and MDSC 1, Resident 2 ' s MDS dated [DATE] and unsteady gait care plan dated 11/2/24 were reviewed. MDSC 2 stated she was unsure why she coded Resident 2 as independent with ambulation on 11/23/24 after the care plan indicated his gait was unsteady. MDSC 2 stated, I will have to go back to check the MDS and see what the CNAs documented [for ambulation]. MDSC 2 stated when she completed an MDS, she used the CNAs documentation to assess the level of assistance the residents required and sometimes she would check the residents herself. MDSC 2 stated, I can ' t remember, I think I did [observe the resident]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/9/25 at 11:05 a.m. with LVN 8, Resident 2 ' s care plan for unsteady gait dated 11/2/24 was reviewed. LVN 8 stated Resident 2 had an unsteady gait on 11/2/24 which would have indicated he needed supervision to safely ambulate. Resident 2 ' s MDS dated [DATE] was reviewed, LVN 8 stated Resident 2 ' s ambulation was coded as independent which would not be accurate because his gait was unsteady. During a concurrent interview and record review on 1/9/25 at 2:30 p.m. with the Director of Nursing (DON), Resident 2 ' s unsteady gait care plan dated 11/2/24 was reviewed. The DON stated the care plan indicated Resident 2 ' s health and function was declining, and he was not safe to ambulate without assistance. The DON reviewed Resident 2 ' s quarterly MDS Section GG dated 11/23/24 and stated the ambulation was not accurately coded. The DON stated the MDSCs did utilize CNA documentation for their MDS assessments, but his expectation was for them to also interview the staff and do visual assessments of the residents when completing the MDS. The DON stated Resident 2 was not safe on the patio without supervision and his fall on 1/2/25 could have been prevented if the CNA walked him back into the building for lunch. During a review of the facility ' s policy and procedure (P&P) titled Resident Assessments, dated 3/2022, the P&P indicated, . A comprehensive assessment of every resident ' s needs is made at intervals designated by OBRA and PPS requirements . The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate residents assessments and reviews . A comprehensive assessment includes . completion of the Minimum Data Set . development of the comprehensive care plan . All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy . During a review of a reference located at https://nursinghomehelp.org/wp-content/uploads/2024/01/MDS-AND-CARE-PLANS-RAI.pdf titled MDS Accuracy and Comprehensive Care Plans, undated, the reference indicated, . Accuracy of Assessments . The assessment must accurately reflect the resident ' s status . Facilities are responsible for ensuraing that all participants in the assessment process have the requisite knowledge to complete an accurate assessment . The assessment must represent an accurate picture of the resident ' s status . Accuracy of Assessments: Why . Proper care planning . MDS accuracy: How . Interview the resident . Interview to the family . Interview to the staff . Review the medical record . Observe resident ' s conditions care aspects . Based on observation, interview, and record review, the facility failed to ensure the quarterly Minimum Data Set Assessment (MDS-a resident assessment tool used to identify resident cognitive and physical function) accurately reflected the residents healthcare and functional status for one of nine sampled residents (Resident 2) when Resident 2's plan of care addressed an unsteady gait (manner of walking) and declining health status on 11/2/24 and Minimum Data Set Coordinator (MDSC) 2 assessed his ambulation (ability to walk) status as independent in the MDS Assessment Section GG-Functional Abilities on 11/23/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to prevent falls for two of four sampled residents (Residents 2 and 8) when: 1. Nursing staff were aware of Resident 2 ' s decline in functional status, poor safety awareness and need to be supervised while ambulating and did not develop and implement effective care plan interventions to prevent falls. This failure resulted in Resident 2 ' s fall on 1/2/25 sustaining a laceration (cut in the skin caused by an injury) above the left eyebrow requiring transportation to the emergency department (ED) for sutures (a row of stitches holding together edges of a wound). 2. Nursing staff were aware of Resident 8 ' s severe cognitive impairment, poor safety awareness and failed to develop and implement effective person-specific care plan interventions to prevent falls. This failure resulted in Resident 8 suffering avoidable falls on the following dates: 10/13/24, 12/20/24, 12/29/24, 1/1/25 and 1/8/25 and placed the resident at risk for injury. Findings: 1. During an observation on 1/6/25 at 11:33 a.m. in the activities room, Resident 2 sat in a chair. Resident 2 had a sutured laceration above the left eyebrow with yellowish discoloration around the left eye. Resident 2 was confused and unable to verbalize what happened to his eye. During a review of Resident 2 ' s Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included dementia, epilepsy (nerve cell activity in the brain is disturbed causing seizures [burst of sudden electrical activity]), muscle weakness, and difficulty in walking. During a review of Residents 2 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 06 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 was severely impaired. During a telephone interview on 1/7/25 at 4:48 p.m. with LVN 7, LVN 7 stated she worked on 1/2/25 when Resident 2 fell . LVN 7 stated Resident 2 did not have any supervision when he was on the patio and fell . LVN 7 stated supervision may have prevented his fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Acute Care Hospital (ACH) document titled, Clinical Notes, dated 1/2/25, the note indicated (. patient is a 67 y.o. [year old] male . presents to the ED [emergency department] after fall. Per skilled nursing facility, patient had an unwitnessed ground level fall outside . Left eyebrow laceration was repaired . follow up for wound check and suture removal . During an interview on 1/8/25 at 11:41 a.m. with CNA 8, CNA 8 stated she was assigned to Resident 2 at the time of his fall on 1/2/25. CNA 8 stated Resident 2 would frequently walk to the patio by himself. CNA 8 stated Resident 2 ' s health and activities of daily living (ADL-skills to care for oneself such as eating, bathing and mobility) abilities had declined since the beginning of November. CNA 8 stated, he needs more assistance with everything. CNA 8 stated during lunch on 1/2/25 Resident 2 was outside on the patio, she told him to come in for lunch and left the resident unsupervised on the patio. CNA 8 stated Resident 2 fell before he reached the door. CNA 8 stated Resident 2 had episodes of leaning forward with a shuffling gait when he walked, so he required supervision to ambulate safely. During a review of Resident 2 ' s fall risk care plans dated 2/3/21, the care plan indicated, . resident at risk for falls r/t [related to] Deconditioning, Gait/balance problems, Unaware of safety needs. Dx [diagnosis] of Dementia, Epilepsy . Date Initiated: 2/3/2021 . Anticipate and meet The resident ' s needs and increase monitoring [revised 1/6/25] . Be sure The resident ' s call light is within reach and encourage (The resident to use it [revised 2/3/21] . Ensure that The resident iswearing [sic] appropriate footwear [2/3/21] . IDT recommendations . Continue on PT & OT . Psychologist evaluation and treatment . Put resident bed in low position . PT/OT evaluate and treat as ordered [1/6/25] . The resident needs a safe environment . [3/13/21] . During a concurrent interview and record review on 1/8/25 at 2:42 p.m. with RN 1, Resident 2 ' s pain and unsteady gait care plan dated 11/2/24 was reviewed. The care plan indicated, . Resident c/o [complained of] lower back pain, headache and unsteady gait . date initiated: 11/2/24 . Interventions . Encouraged resident bed rest as tolerated . Refer Resident to PT services . Provide PRN [as needed] pain medications as ordered . RN 1 stated Resident 2 ' s health and function had declined since early November, and he required assistance to ambulate safely. RN 1 stated Resident 2 ' s care plan interventions did not address the amount of supervision he required for safe ambulation. RN 1 stated Resident 1 was not on bedrest, and she was unsure why it was entered as an intervention. RN 1 stated Resident 1 had dementia and would not tolerate bed rest. RN 1 stated Resident 2 ' s gait was not addressed, and the care plan should have included specific interventions to indicate the level of assistance and supervision he needed. RN 1 stated Resident 2 had a shuffling gait and would lean forward while ambulating and it was not addressed in the care plans. RN 1 stated care plans were important to direct the care a resident needed. RN 1 stated Resident 2 fell on [DATE] in his room. Resident 2 ' s fall care plan dated 12/13/24 was reviewed, the care plan indicated, . Patient is on monitoring for s/p [status post] fall . Interventions . assess vital signs . Ensure resident is wearing non skid socks . educate resident to wear nonslip shoes . monitor . encourage resident to use call light . perform head to toe assessment . RN 1 stated Resident 2 had dementia and the interventions to encourage or educate would not be effective because the resident had a severe cognitive impairment and could not retain information. RN 1 stated the interventions put into place on 12/13/24 were not effective because Resident 2 fell again on 1/2/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/9/25 at 11:05 a.m. with LVN 8, Resident 2 ' s care plan dated 11/2/24 was reviewed. LVN 8 stated the care plan was not accurate because Resident 2 was never on bed rest. LVN 8 reviewed Resident 2 ' s fall risk care plan dated 2/3/21 and stated the care plan did not specify the level of supervision Resident 2 required for safety while ambulating. LVN 8 stated the interventions should have been updated and the ones no longer appropriate for the resident should have been discontinued or resolved to reflect the resident ' s current fall risk prevention needs. During a concurrent interview and record review on 1/9/25 at 2:30 p.m. with the Director of Nursing (DON), Resident 2 ' s pain and unsteady gait care plan dated 11/2/24 was reviewed. The DON stated Resident 2 ' s care plans needed to indicate the amount of supervision he required because he was not safe to ambulate unsupervised. The DON stated Resident 2 had multiple fall risk care plans with interventions several to remind and educate which were inappropriate because Resident 2 had dementia and would not retain the information. The DON stated Resident 2 ' s care plans needed to be updated and personalized because they were not effective in preventing his fall on 1/2/25. 2. During an observation on 1/8/25 at 3:23 p.m., in Resident 8 ' s room, Resident 8 was dressed, lying in bed. Her bed was in the low position with no fall mats at the bedside. During a review of Resident 8 ' s AR, undated, the AR indicated, Resident 8 was admitted to the facility on [DATE] with diagnosis including encephalopathy (disturbance of brain function), cerebral infarction (blood flow to brain is disrupted), dementia, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), muscle weakness, abnormalities of gait (manner of walking) and mobility and repeated falls. During a review of Residents 8 ' s MDS assessment dated [DATE], indicated Resident 8 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 8 ' s cognition was severely impaired. LVN 8 stated Resident 8 ' s falls happened while she was in bed. LVN 8 reviewed Resident 8 ' s care plan dated 3/23/24, the care plan indicated, . resident is (high) risk for unavoidable falls with injury r/t [related to] limited mobility, Deconditioning and has history of falls, poor safety awareness d/t [due to] DX [diagnosis] Dementia, hx [history of] multiple falls, non-compliance, impulsive behaviors . Interventions . Toileting scheduled . Keep in visual areas . IDT Recommends . Keep Resident in visual areas when not in bed . Continue with therapy . Be sure The resident ' s call light is within reach and encourage to use it for assistance . Increase monitoring of resident . Increase supervision specially [especially] when up in wheelchair and put resident at the nurse ' s station where other staff can supervise resident . LVN 8 stated Resident 8 ' s falls happened while she was in bed and the interventions of keeping the resident in visual areas, increased monitoring when up in wheelchair did not address the cause of her falls which happened while she was in bed unsupervised. LVN 8 stated Resident 8 ' s care plan interventions needed to be person-centered and to include supervision when she was in bed to prevent her falls. LVN 8 stated the care plans did not include the frequency of monitoring and the interventions were not effective in preventing her repeated falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 1:45 p.m. with the DON, the DON stated Resident 8 was a high fall risk and the facility could not prevent her falls. Resident 8 ' s fall care plan dated 3/23/24 was reviewed. The DON stated the IDT updated the care plan after each fall. The DON stated some interventions were not appropriate for Resident 8 due to her cognitive impairment. The DON stated the intervention of increased monitoring indicated she needed more supervision but not include the frequency of supervision needed. The DON reviewed the list of Resident 8 ' s five falls between 10/13/24 and 1/8/25. The DON stated the falls occurred when she was in bed unsupervised, and she would need one on one supervision while in bed to prevent falls. The DON stated the care plan was not person-centered because it did not address Resident 8 ' s falls were in her room while she was in bed unsupervised. The DON stated care plans needed to be personalized for each resident because it painted a picture of the resident, identified their needs and the goals must be measurable. During a review of the facility ' s policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . comprehensive, person-centered care plan that include measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident . interdisciplinary team (IDT- [involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources for the best interest of the resident]) . develops and implements a comprehensive, person-centered care plan for each resident . includes measurable objectives and timeframes . describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being . When possible, interventions address the underlying source(s) of the problem area(s), not just the symptoms or triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change . The interdisciplinary team reviews and updates the care plan . when there has been a significant change in the resident ' s condition . at least quarterly . During a review of the facility ' s policy and procedure titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, . Based on previous evaluations and current data the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors . Resident conditions that may contribute to the risk of falls . other cognitive impairment . lower extremity weakness . medication side effects . functional impairments . Medical factors that contribute to the risk of falls . neurological disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce their specific risk factor(s) of falls for each resident . During a review of the facility ' s P&P titled Safety and Supervision of Residents, dated 7/2017, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible . Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents . care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to prevent falls for two of four sampled residents (Residents 2 and 8) when:

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on interview and record review the facility failed to ensure services provided met professional stands of practice for six of nine sampled residents (Residents 1, 2, 3, 6, 7 and 8) when: 1. Nursing staff were aware that four of four sampled residents (Residents 2, 3, 7 and 8) with severe cognitive impairment, poor safety awareness and a history of falls did not perform fall risk assessments (medical evaluation that determines likelihood of falling by examining factors such a medical history, physical abilities, balance, gait, and medications) after falls and quarterly. This failure resulted in Resident 2 ' s falls on 12/13/24 and 1/2/25 sustaining a laceration above the left eyebrow, Resident 3 ' s fall on 12/18/24, Resident 7 ' s falls on 10/22/24, 10/25/24, 11/13/24, 11/19/24 and 12/23/24 and Resident 8 ' s falls on 10/13/24, 12/20/24, 12/29/24, 1/1/25 and 1/8/25 and had the potential for severe injuries. (cross reference F689) 2. Licensed Nurses did not follow the manufacturer guidelines to check two of two sampled resident ' s (Residents 1 and 6) Wander guard (an elopement [leave without supervision] detection device) for function. This failure resulted in Resident 1 ' s elopement from the facility on 12/15/24 when his elopement detection device malfunctioned and placed Resident 6 at risk for elopement. (cross reference F689) Findings: 1. During an interview on 1/6/25 at 2:02 p.m. with LVN 3 and LVN 9, Resident 2 ' s electronic medical record (EMR) was reviewed. LVN 3 stated Resident 2 had fallen on 12/13/24 and 1/2/25. LVN 3 stated Resident 3 had fallen on 12/18/24. LVN 3 stated she was unable to locate a fall risk assessment before and after Resident 2 and Resident 3 ' s falls. LVN 9 stated the facility did not perform a formal fall risk assessment when a resident falls and located a Post Fall Review for Residents 2 and 3. LVN 9 stated the Post Fall Review was a summary of the fall but did not assess a resident ' s risk factors for falling or provide a fall risk score. During a concurrent interview and record review on 1/9/25 at 11:05 a.m. with LVN 8, Resident 7 and 8 ' s progress notes and assessments were reviewed, LVN 8 stated Resident 7 had fallen on 10/22/24, 10/25/24, 11/13/24, 11/19/24 and 12/23/24. LVN 8 reviewed Resident 8 ' s progress notes and stated Resident 8 had fallen on 10/13/24, 12/20/24, 12/29/24, 1/1/25 and 1/8/25. LVN 8 stated the facility did not utilize fall risk assessments to determine the severity of a resident ' s fall risk. LVN 8 stated fall risk assessments were important to determine the level of a resident ' s fall risk, what factors contribute to the fall risk and to help determine what interventions would be effective. During a review of Resident 2 ' s Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included dementia (progressive state of decline in mental abilities), epilepsy (nerve cell activity in the brain is disturbed causing seizures [burst of sudden electrical activity]), muscle weakness, and difficulty in walking. (continued on next page)

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Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Residents 2 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 06 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 ' s cognition was severely impaired. During a review of Resident 3 ' s AR, undated, the AR indicated, Resident 3 was admitted to the facility on [DATE] with diagnosis including congestive heart failure (a heart disorder which causes the heart to not pump blood efficiently), fracture (broken bone) left femur (bone in the upper thigh), presence of right artificial hip joint (type of prosthesis [synthetic body part]), presence of left artificial hip joint, muscle weakness, neuralgia (sharp, shocking pain that follows path of the nerve), abnormalities of gait (walking pattern) and mobility (ability to move from one place to another), need for assistance with personal care. During a review of Residents 3 ' s Minimum Data Set assessment dated [DATE], indicated Resident 3 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 3 ' s cognition was severely impaired. During a review of Resident 7 ' s AR, undated, the AR indicated, Resident 7 was admitted to the facility on [DATE] with diagnosis including cerebral infarction (blood flow to the brain is disrupted), atrial fibrillation (heart condition that causes an irregular heartbeat), dementia, and psychosis (severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Residents 7 ' s Minimum Data Set assessment dated [DATE], indicated Resident 7 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 7 ' s cognition was severely impaired. During a review of Resident 8 ' s AR, undated, the AR indicated, Resident 8 was admitted to the facility on [DATE] with diagnosis including encephalopathy (disturbance of brain function), cerebral infarction, dementia, psychosis, muscle weakness, abnormalities of gait and mobility and repeated falls. During a review of Residents 8 ' s MDS assessment dated [DATE], indicated Resident 8 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 8 ' s cognition was severely impaired. During a concurrent interview and record review on 1/9/25 at 1:45 p.m. with the Director of Nursing (DON) the DON reviewed Resident 8 ' s progress notes and assessments. The DON stated Resident 8 had several falls and was a high fall risk. The DON was unable to locate any fall risk assessments for Resident 8. During a concurrent interview and record review on 1/9/25 at 2:30 p.m. with the DON, the DON reviewed Resident 2, Resident 3, and Resident 7 ' s progress notes and assessments. The DON was unable to locate the residents ' fall risk assessments and stated the facility did not utilize fall risk assessments on the residents. The DON stated fall risk assessments were important because they provided a score to assess what factors placed a resident at low, medium, or high risk for falls and interventions could be put into place. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled Fall Risk Assessment, dated 3/2018, . nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information . Upon admission, the nursing staff and the physician will review a resident ' s record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time . review for medications or medication combinations that could relate to falls or fall risk . staff will look for evidence of a possible link between the onset of falling . Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls . staff . will evaluate functional and psychological factors that may increase falls risk, including ambulation, mobility, gait, balance . activities of daily living (ADL) capabilities . cognition Staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable . https://my.clevelandclinic. org/health/articles/23330-fall-risk-assessment titled Fall Risk Assessment, dated 6/23/22, the article indicated, .Commonly used in older adults, a fall risk assessment checks your risk of falling . A fall risk assessment is important because knowing which factors increase your chances of falling helps you . Minimize your risk of falling or hurting yourself . Reduce your unique risks . All adults [AGE] years and older should have an initial fall risk screening . Many different conditions can increase your risk of falling, such as . Advanced age . Balance problems . Difficulty in walking . Easily distracted . Medications that make you dizzy, sleepy or unsteady . Prior falls . Healthcare providers often use these fall risk assessment tool to test your balance, strength, and pattern of walking . 2. During a concurrent observation and interview on 1/6/25 at 10:13 a.m. in Resident 1 ' s room, Resident 1 was dressed, lying in bed. Resident 1 was confused and unable to remember leaving the facility on 12/15/24. Resident 1 stated, it sounds like something I would do. Resident 1 had a wander guard alarm bracelet on his right ankle. During a review of Resident 1 ' s AR, undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including cerebral aneurysm (bulge in a weakened artery wall), dementia, mood disorder (mental health condition), muscle weakness, abnormalities of gait and mobility and need for assistance with personal care. During a review of Residents 1 ' s MDS assessment dated [DATE], indicated Resident 1 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 1 ' s cognition was severely impaired. During a concurrent interview and record review on 1/6/25 at 3:19 p.m. with LVN 2, Resident 1 ' s Post-Event Review, dated 12/15/24, indicated, . Date and Time of Event . 12/15/2024 19:00 [7:00 p.m.] . describe event . Elopement . IDT Summary Review and Recommendations . Resident was successfully eloped 12/15/24 . Based on interview and investigation IDT determined that there is a malfunctioning of the resident ' s wander guard and after incident resident was assessed by LN . a new functioning wander guard was replaced immediately . Resident is at risk for elopement . LVN 2 stated Resident 1 would wander and exit seek when he had episodes of agitation. LVN 2 stated Resident 1 ' s wander guard should be checked for placement and function every shift. LVN 2 stated the facility tested Resident 1 ' s wander guards by taking him to a wander guard alarmed door and check if the alarm sounded when the resident was near it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 1/6/25 at 3:39 p.m. with the DON and Assistant Director of Nursing (ADON), the DON stated the root cause of Resident 1 ' s elopement was his wander guard was not working, he left the building and got lost. The ADON stated the wander guards needed to have placement and function checked every shift. The DON stated if the wander guard was on the resident without checking the function it would be useless. During an interview on 1/6/25 at 3:49 p.m. with LVN 4, LVN 4 stated to check wander guards for function the staff would take the resident to an alarmed door and see if the wander guard bracelet triggered the alarm. During a telephone interview on 1/7/25 at 4:13 p.m. with LVN 6, LVN 6 stated she was on duty when Resident 1 eloped on 12/15/24. LVN 6 stated shortly after she had returned from lunch at 6:45 p.m., they received a call there was a resident outside. LVN 6 stated the staff went outside the facility on A street and the police were bringing Resident 1 back to the facility in a wheelchair. LVN 6 stated Resident 1 had a wander guard on when he eloped and when he was brought back into the building, the wander guard door alarm did not go off and they realized his wander guard bracelet was not working. LVN 6 stated she had not checked Resident ' s 1 wander guard for function before he eloped. During an interview on 1/8/25 at 4:21 p.m. with the DON, the DON stated his expectation was for the residents ' wander guards to be checked for placement and function every shift. The DON stated the facility nurses checked the wander guards by taking the resident wearing the wander guard to an alarmed door and check if the wander guard detection alarm goes off. The wander guard manufacturer instructions provided with each wander guard was reviewed. The instructions indicated, .Resident Wristband Transmitter . Testing . It is very important to test your Resident Wristband Transmitters on a regular basis. It is the facility ' s responsibility to implement a regular testing procedure . Take Door System Tester . pass tester within proximity of resident wearing Resident Wristband Transmitter . The DON stated the facility did not have a wand to test the wander guards. During a telephone interview on 1/9/25, at 9:14 p.m., with the Wander Guard Vendor (WGV), The WGV stated according to manufacturer ' s guidelines, the correct way to test the wander guard was to take a handheld testing device to the resident. The WGV stated once the wrist band is properly activated it was good for six months. During a review of the document supplied by the WGV, the document indicated, . Cordless and wireless systems and devices are intended as an adjunct to good care giving practices and are not a substitute for proper staffing and patient management practices. We recommend that all caregivers receive periodic training in the operation of these systems and that the devices are tested daily . the system is not designed to replace good caregiving practices including, but not limited to . Direct patient supervision . Adequate training for staff . Testing the system before each use . Failure to comply with the warning may result in injury or death . This device is not a substitute for visual monitoring by a caregiver . During a concurrent interview and record review on 1/9/25 at 1:45 p.m. with the DON, the document provided by the WGV was reviewed. The DON stated the instructions indicated there should be a portable device to take to the resident to test the wander guard and the facility was not following the manufacturer ' s guidelines by taking the resident to the door. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled Wandering and Elopements, dated 3/2019, the P&P indicated, . facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . If identified as at risk for wandering, elopement . resident ' s care plan will include strategies and interventions to maintain resident ' s safety . if a resident is missing initiate the elopement/missing resident emergency procedure . When the resident returns to the facility . examine the resident for injuries . document relevant information in the resident ' s medical record .

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(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 - 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** 42123 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance to prevent falls for two of five sampled residents (Residents 2 and 8) and to prevent elopement for one of two sampled residents (Resident 1) when: 1. Nursing staff were aware of Resident 2 ' s decline in functional status, poor safety awareness and need to be supervised while ambulating and failed to assign staff to supervise Resident 2. On 1/2/25 Resident 2 was left unsupervised, and he ambulated unassisted to the outdoor patio where he was found on the ground after an unwitnessed fall. This failure resulted in Resident 2 ' s fall on 1/2/25 sustaining a laceration (cut in the skin caused by an injury) above the left eyebrow requiring transportation to the emergency department (ED) for sutures (a row of stitches holding together edges of a wound) and placed him at risk for emotional distress due to his altered cognitive status (person ' s ability to process and understand information) from dementia (loss of cognitive functioning-thinking, remembering and reasoning). 2. Nursing staff were aware of Resident 8 ' s severe cognitive impairment, poor safety awareness and failed to implement effective supervision to prevent a history of falls. These failures resulted in Resident 8 suffering avoidable falls on the following dates: 10/13/24, 12/20/24, 12/29/24, 1/1/25, and 1/8/25 and placed the resident at risk of injury. 3. Facility staff were aware of Resident 1 ' s exit seeking behavior and high risk of elopement and failed to implement effective measures and assistive devices to prevent elopement. On 12/15/24 the elopement detection device failed to function and alarm and Resident 1 eloped undetected and unsupervised. This failure resulted in Resident 1 leaving the facility after dark into the surrounding neighborhood until a neighbor called the police who found the resident alone and confused placing Resident 1 at risk for injuries from cold exposure, being hit by a car or physical attack. Findings: 1. During an observation on 1/6/25 at 11:33 a.m. in the activities room, Resident 2 sat in a chair. Resident 2 had a sutured laceration above the left eyebrow with yellowish discoloration around the left eye. Resident 2 was confused and unable to verbalize what happened to his eye. During a review of Resident 2 ' s Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included dementia, epilepsy (nerve cell activity in the brain is disturbed causing seizures [burst of sudden electrical activity]), muscle weakness, and difficulty in walking. (continued on next page)

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(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 - Actual harm Residents Affected - Few	During a review of Residents 2 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 06 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 ' s cognition was severely impaired. During a review of the Acute Care Hospital (ACH) document titled, Clinical Notes, dated 1/2/25, the note indicated (. patient is a 67 y.o. [year old] male . presents to the ED [emergency department] after fall. Per skilled nursing facility, patient had an unwitnessed ground level fall outside . Left eyebrow laceration was repaired . follow up for wound check and suture removal . During an interview on 1/6/25 at 11:35 a.m. in the memory care unit hallway with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 2 ' s health had been declining since early November 2024. CNA 2 stated Resident 2 required supervision to ambulate (walk) safely. During a telephone interview on 1/7/25 at 4:48 p.m. with Licensed Vocational Nurse (LVN) 7, LVN 7 stated she was on duty 1/2/25 when Resident 2 fell . LVN 7 stated Resident 2 had an unwitnessed fall on the patio outside and was found face down on his stomach. LVN 7 stated when Resident 2 was assessed, he had a bleeding laceration above his left eyebrow and was sent to the hospital by ambulance. LVN 7 stated Resident 2 ' s fall may have been prevented if he had been supervised by staff at the time of the fall. During a concurrent observation and interview on 1/8/25 at 10:45 a.m. with CNA 6 in the memory care unit activities room, Resident 2 had a laceration above his left eyebrow with yellowish discoloration around the eye. Resident 2 would suddenly stand up on his own and CNA 6 would redirect him to sit down. CNA 6 stated he required close monitoring because he was unsafe to ambulate alone. CNA 6 stated Resident 2 ' s functional and health had been declining since early November and he required supervision because his ability to ambulate fluctuated throughout the day. CNA 6 stated she was on duty when Resident 2 fell on [DATE]. CNA 6 stated at lunchtime on 1/2/25 she saw two nurses walk out to the patio and Resident 2 was found on the ground with a bleeding cut above his left eyebrow. CNA 6 stated the memory care residents did not require constant supervision on the outside patio because the staff would check on them every 10-15 minutes. CNA 6 stated the staff was busy passing out lunch trays and had not noticed Resident 2 was not in the dining room at his usual time. The memory care outdoor patio was observed, the exit door was heavy to open and there was a slight incline at the building entrance. CNA 6 showed where Resident 2 was found on the ground near the entrance door to the facility and stated she was not sure why he fell . During an interview on 1/8/25 at 11:11 a.m. with CNA 7, CNA 7 stated at the beginning of December the CNAs noticed the resident started to walk bent forward with a shuffling gait (walking pattern where someone drags their feet). CNA 7 stated Resident 2 needed supervision to ambulate safely because his gait made him unsteady and the staff was concerned, he would fall forward while ambulating. CNA 7 stated while she passed lunch trays on 1/2/25 she heard a nurse say Resident 2 fell outside. CNA 7 stated Resident 2 was found on the ground with blood above his left eyebrow. CNA 7 stated the residents were allowed to be on the outside patio without direct supervision because the staff would check on them frequently. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/8/25 at 11:41 a.m. with CNA 8, CNA 8 stated she was assigned to Resident 2 at the time of his fall on 1/2/25. CNA 8 stated Resident 2 would frequently walk to the patio by himself. CNA 8 stated Resident 2 ' s health and activities of daily living (ADL-skills to care for oneself such as eating, bathing and mobility) abilities had declined since the beginning of November. CNA 8 stated, he needs more assistance with everything. CNA 8 stated during lunch on 1/2/25 Resident 2 was outside on the patio, she told him to come in for lunch and left the resident unsupervised on the patio. CNA 8 stated she did not walk Resident 2 back inside because he would normally come back into the facility by himself. CNA 8 stated Resident 2 fell before he reached the door. CNA 8 stated Resident 2 had episodes of leaning forward with a shuffling gait when he walked, so he required supervision to ambulate safely. CNA 8 stated, he must have had one of those episodes [on the patio] and fell . CNA 8 stated she left Resident 2 on the patio because she could not leave the dining room unattended and thought he would come back into the building on his own. CNA 8 stated Resident 2 did not have the mental capacity to call for help which increased the need for supervision. During a concurrent interview and record review on 1/8/25 at 2:42 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 2 ' s health had declined since early November 2024, and he required supervision for safety. RN 1 stated Resident 2 had episodes of leaning forward with a shuffling gait which increased his fall risk and need for supervision. Resident 2 ' s care plan dated 11/2/24 was reviewed, the care plan indicated, . Resident c/o lower back pain, headache and unsteady gait . RN 1 stated the care plan indicated Resident 2 ' s gait had been unsteady gait since 11/2/24. Resident 2 ' s Post-Fall Review, (PFR) dated 1/2/25 was reviewed. The PFR indicated, . Date and Time of Fall . 1/2/25 13:20 [1:20 p.m.] . Discovered on the floor (Unwitnessed) . Went outside to give the resident his medication. CNA called for him to come in to eat his lunch. Resident was taking long time to come in so I went to go check outside. Found resident lying face down on the floor with a laceration to his eyebrow . describe location where resident was found . outside on dementia patio . Was resident using assistive device for ambulation or transfer . no . IDT [Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident] Review and Summary of Root Cause . 1/2/2025 IDT met to review regarding resident ' s fall obtaining a laceration on his R [right] eyebrow and was send to hospital per physician ' s order . Resident has a poor safety due to poor cognition, adverse effects of medication . IDT recommendations . Continue on PT & OT . PT with recommendations to use a wheelchair for resident ' s mobility . Put resident bed in low position . RN 1 stated Resident 2 should have been supervised when ambulating and all residents from the memory care unit should be supervised while on the patio. Resident 2 ' s fall care plan dated 11/2/24 was reviewed. RN 1 stated she was unable to find a fall risk assessment performed after Resident 2 ' s fall on 12/13/24 and 1/2/25. RN 1 stated the facility did not perform fall risk assessments before and after falls. During a concurrent interview and record review on 1/8/25 with Minimum Data Set Coordinator (MDSC) 1, Resident 2 ' s MDS was reviewed. MDSC 1 stated Resident 2 had a change in condition MDS on 12/31/24 because his health and function had declined significantly. MDSC 1 stated his decline was in cognition, bowel and bladder and ambulation. MDSC 1 stated Resident 2 ' s quarterly MDS had been completed on 11/23/24. The MDS Section GG was reviewed, MDSC 1 stated the MDS indicated he was independent with ambulation. Resident 2 ' s care plan for pain and unsteady gait dated 11/2/24 was reviewed. MDSC 1 stated the care plan indicated Resident 2 had poor balance and she would have expected the 11/23/24 MDS to be coded as needing supervision with ambulation. MDSC 1 stated Resident 2 ' s care plan indicated was unsteady when walking and he would have required supervision for safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 1/9/25 at 11:05 a.m. with LVN 8, Resident 2 ' s electronic medical record (EMR) was reviewed. LVN 8 was unable to locate Resident 2 ' s fall risk assessment and stated the facility did not utilize fall risk assessments. LVN 8 stated fall risk assessments were important to determine how high of a fall risk a resident was so appropriate interventions could be put in place. LVN 8 stated memory care residents would frequently go to the patio unsupervised. LVN 8 stated Resident 2 was at high risk for falls because of his medications, impaired cognition and decline in functional abilities and was not safe on the patio unsupervised. During a concurrent interview and record review on 1/9/25 at 2:30 p.m. with the Director of Nursing (DON), Resident 2 ' s care plan dated 11/2/24 was reviewed. The DON stated the care plan indicated Resident 2 ' s health and function was declining, and he was not safe to ambulate without assistance. The DON stated Resident 2 had dementia and did not have the capacity to understand to call for help. The DON stated Resident 2 was not safe on the patio without supervision and his fall on 1/2/25 could have been prevented if the CNA walked him back into the building for lunch. During a review of Resident 2 ' s Physical Therapy Treatment Encounter Note(s), dated 12/31/24, the note indicated, . Pt [patient] appeared seated on bench . Provided pt gait training with FWW [front wheeled walker] . without AD [assistive device], [NAME] [maximum assistance] . Pt demonstrates unsafe navigation of AD, Pt appeared falling over multiple times, requiring [NAME] for balance recovery . During a review of the facility ' s policy and procedure titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, . Based on previous evaluations and current data the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors . Resident conditions that may contribute to the risk of falls . other cognitive impairment . lower extremity weakness . medication side effects . functional impairments . Medical factors that contribute to the risk of falls . neurological disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce their specific risk factor(s) of falls for each resident . During a review of the facility ' s P&P titled Safety and Supervision of Residents, dated 7/2017, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible . Safety risks and environmental hazards are identified on an ongoing basis . When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) . Employees shall be trained on potential accident hazards and demonstrate competency . and try to prevent avoidable accidents . Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents . care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . 2. During an observation on 1/8/25 at 3:23 p.m., in Resident 8 ' s room, Resident 8 was dressed, lying in bed. Her bed was in the low position with no fall mats at the bedside. During a review of Resident 8 ' s AR, undated, the AR indicated, Resident 8 was admitted to the facility on [DATE] with diagnosis including encephalopathy (disturbance of brain function), cerebral infarction (blood flow to brain is disrupted), dementia, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), muscle weakness, abnormalities of gait (manner of walking) and mobility and repeated falls. (continued on next page)

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Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Residents 8 ' s MDS assessment dated [DATE], indicated Resident 8 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 8 ' s cognition was severely impaired. During an interview on 1/8/25 at 3:53 p.m. with CNA 10, CNA 10 stated she was assigned to Resident 8. CNA 10 stated Resident 8 was a high fall risk because she had dementia and would stand without assistance. CNA 10 stated interventions such as redirecting the resident or reminding to use the call light were not successful because the resident was confused and was unable to remember instructions. During a concurrent interview and record review on 1/8/25 at 3:50 p.m. with MDSC 1 and MDSC 2, Resident 8 ' s MDS was reviewed. MDSC 2 reviewed Resident 8 ' s MDS section GG and stated Resident 8 was wheelchair bound. MDSC 2 stated Resident 8 required maximum assistance from the CNAs for care and mobility due to safety awareness, wheelchair bound and low cognition. During a concurrent interview and record review on 1/9/25 at 11:05 a.m. with LVN 8, Resident 8 ' s EMR was reviewed. LVN 8 was unable to locate Resident 8 ' s fall risk assessment or a fall risk score. LVN 8 stated Resident 8 had severely impaired cognition and interventions such as reminding to use call light or call for help were not effective because she was unable to remember. Resident 8 ' s falls since 10/6/24 were reviewed and were as follows: 10/13/24- found on floor next to bed. 12/20/24- found on floor next to bed. 12/29/24-found on floor next to bed. 1/1/25- found on floor next to bed. 1/8/25- found on floor next to bed. LVN 8 stated Resident 8 ' s falls happened while she was in bed. LVN 8 reviewed Resident 8 ' s care plan dated 3/23/24, the care plan indicated, . resident is (high) risk for unavoidable falls with injury r/t [related to] limited mobility, Deconditioning [decline in physical function as a result of physical inactivity] and has history of falls, poor safety awareness d/t [due to] DX [diagnosis] Dementia, hx [history of] multiple falls, non-compliance, impulsive behaviors . Interventions . Toileting scheduled . Keep in visual areas . IDT Recommends . Keep Resident in visual areas when not in bed . Continue with therapy . Be sure The resident ' s call light is within reach and encourage to use it for assistance . Increase monitoring of resident . Increase supervision specially [especially] when up in wheelchair and put resident at the nurse ' s station where other staff can supervise resident . LVN 8 stated Resident 8 ' s falls happened while she was in bed and the interventions of keeping the resident in visual areas, increased monitoring when up in wheelchair would not address the cause of her falls which happened while she was in bed unsupervised. LVN 8 stated Resident 8 needed supervision when in bed to prevent her falls. During an observation on 1/9/25 at 12:54 p.m. in Resident 8 ' s room, Resident 8 was lying in bed, dressed, the head of bed was elevated to a 45-degree angle and her lunch on the bedside table in front of her. There were no staff members present in the room. Resident 8 had both feet hanging off the edge of the bed and her body was lined up at the edge of the bed almost hanging off. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/9/25 at 1:45 p.m. with the DON, the DON stated Resident 8 was a high fall risk and the facility could not prevent her falls. Resident 8 ' s fall care plan dated 3/23/24 was reviewed. The DON stated the IDT updated the care plan after each fall. The DON stated some interventions were not appropriate for Resident 8 due to her cognitive impairment. The DON stated the intervention of increased monitoring indicated she needed more supervision. The DON stated the staff would put her in a visible area if there was no one with her. The DON reviewed the list of Resident 8 ' s five falls between 10/13/24 and 1/8/25. The DON stated the falls occurred when she was in bed unsupervised, and she would need one on one supervision while in bed to prevent falls. During a review of a professional reference located at https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod3sess2.html titled Module 3: Falls Prevention and Management, dated 10/2014, the reference indicated, . An important job for licensed nurses is to assess residents ' risk of falling. This is best done using a protocol or instrument that asks the licensed nurse to look at or test several features about the residents . Implement an individualized care plan . nursing should add an individualized approach for falls to the resident ' s care plan . An individualized care plan for falls is not a one-time solution. Licensed nurses and other staff must revisit the plan to make sure it is effective in preventing additional falls and injuries from falls . 3. During a review of Resident 1 ' s Health Status Note, dated 12/15/24, the note indicated, . At 1900 [7:00 p.m.], received a phone call to facility phone that one of facility ' s resident is outside around south A street . at 1910 [7:10 p.m.], Police Officers brought resident back to facility in wheelchair . Per officer ' s statement, A house owner called the [NAME] police department around 1844 [6:44 p.m.] that he was at their house outside, confused . Resident ' s Wander guard [system that alarms (sound notifying staff) when a resident with a Wander guard bracelet (signaling detection device) attempts to exit a door with a Wander guard alarm] checked, noted to be not working properly . During a concurrent observation and interview on 1/6/25 at 10:13 a.m. in Resident 1 ' s room, Resident 1 was dressed, lying in bed. Resident 1 was confused and unable to remember leaving the facility on 12/15/24. Resident 1 stated, it sounds like something I would do. Resident 1 had a wander guard alarm bracelet on his right ankle. During an interview on 1/6/25 at 10:17 a.m. with CNA 1, CNA 1 stated Resident 1 was sometimes verbally aggressive and difficult to redirect. CNA 1 stated Resident 1 had behaviors of wandering around the facility. CNA 1 stated after Resident 1 ' s elopement on 12/15/24, a wander guard bracelet was also placed on his wheelchair. During a review of Resident 1 ' s AR, undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including cerebral aneurysm (bulge in a weakened artery wall), dementia, mood disorder (mental health condition), muscle weakness, abnormalities of gait and mobility and need for assistance with personal care. During a review of Residents 1 ' s MDS assessment dated [DATE], indicated Resident 1 ' s BIMS scored 03 of 15. The BIMS assessment indicated Resident 1 ' s cognition was severely impaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 1/6/25 at 3:19 p.m. with LVN 2, Resident 1 ' s Post-Event Review, dated 12/15/24, indicated, . Date and Time of Event . 12/15/2024 19:00 [7:00 p.m.] . describe event . Elopement . IDT Summary Review and Recommendations . Resident was successfully eloped 12/15/24 . Based on interview and investigation IDT determined that there is a malfunctioning of the resident ' s wander guard and after incident resident was assessed by LN . a new functioning wander guard was replaced immediately . Resident is at risk for elopement . LVN 2 stated Resident 1 would wander and exit seek when he had episodes of agitation. LVN 2 stated Resident 1 ' s wander guard should be checked for placement and function every shift. LVN 2 stated the facility tested Resident 1 ' s wander guards by taking him to a wander guard alarmed door and check if the alarm sounded when the resident was near it. During a concurrent interview on 1/6/25 at 3:39 p.m. with the DON and Assistant Director of Nursing (ADON), the DON stated the root cause of Resident 1 ' s elopement was his wander guard was not working, he left the building and got lost. The ADON stated the wander guards needed to have placement and function checked every shift. The DON stated if the wander guard was on the resident without checking the function it would be useless. During a telephone interview on 1/7/25 at 4:13 p.m. with LVN 6, LVN 6 stated she was on duty when Resident 1 eloped on 12/15/24. LVN 6 stated shortly after she had returned from lunch at 6:45 p.m., they received a call there was a resident outside. LVN 6 stated the staff went outside the facility on A street and the police were bringing Resident 1 back to the facility in a wheelchair. LVN 6 stated she had last seen Resident 1 about an hour before the police brought him back. LVN 6 stated Resident 1 had a wander guard on when he eloped and when he was brought back into the building, the wander guard door alarm did not go off and they realized his wander guard bracelet was not working. LVN 6 stated she had not checked Resident ' s 1 wander guard for function before he eloped. During a concurrent observation and interview on 1/8/25 at 2:01 p.m. with the Director of Maintenance (DOM), the DOM stated the facility had three doors armed with a wander guard system. The DOM stated the wander guard was a system to prevent elopements. The DOM stated he checked the doors alarmed with wander guard alarms for function every Friday. The DOM stated the A street door alarm was working the Friday before Resident 1 eloped. During an interview on 1/8/25 at 4:21 p.m. with the DON, the DON stated his expectation was for the residents ' wander guards to be checked for placement and function every shift. The DON stated the facility nurses checked the wander guards by taking the resident wearing the wander guard to an alarmed door and check if the wander guard detection alarm goes off. The wander guard manufacturer instructions provided with each wander guard was reviewed. The instructions indicated, .Resident Wristband Transmitter . Testing . It is very important to test your Resident Wristband Transmitters on a regular basis. It is the facility ' s responsibility to implement a regular testing procedure . Take Door System Tester . pass tester within proximity of resident wearing Resident Wristband Transmitter . The DON stated the facility did not have a wand to test the wander guards, so they took the residents to an alarmed door. During a telephone interview on 1/9/25, at 9:14 p.m., with the Wander Guard Vendor (WGV), The WGV stated according to manufacturer ' s guidelines, the correct way to test the wander guard was to take a handheld testing device to the resident. The WGV stated once the wrist band is properly activated it was good for six months. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the document supplied by the WGV, the document indicated, . Cordless and wireless systems and devices are intended as an adjunct to good care giving practices and are not a substitute for proper staffing and patient management practices. We recommend that all caregivers receive periodic training in the operation of these systems and that the devices are tested daily . the system is not designed to replace good caregiving practices including, but not limited to . Direct patient supervision . Adequate training for staff . Testing the system before each use . Failure to comply with the warning may result in injury or death . This device is not a substitute for visual monitoring by a caregiver . During a concurrent interview and record review on 1/9/25 at 1:45 p.m. with the DON, the document provided by the WGV was reviewed. The DON stated the instructions indicated there should be a portable device to take to the resident to test the wander guard and the facility was not following the manufacturer ' s guidelines by taking the resident to the door. During a review of the facility ' s P&P titled Wandering and Elopements, dated 3/2019, the P&P indicated, . facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . If identified as at risk for wandering, elopement . resident ' s care plan will include strategies and interventions to maintain resident ' s safety . if a resident is missing initiate the elopement/missing resident emergency procedure . When the resident returns to the facility . examine the resident for injuries . document relevant information in the resident ' s medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review the facility failed to maintain an effective infection control program when: 1. One of 11 sampled Certified Nursing Assistants (CNA 1) assisted Resident 1, who was on contact precautions for symptoms of norovirus (a highly contagious virus [infectious agent] that causes nausea, vomiting and diarrhea), from the bathroom to his bed and failed to wear personal protective equipment (PPE-includes protective gowns, gloves, face shields or goggles and face masks to protect the wearer from injury or the spread of infection or illness) according to the facility ' s policy and procedure (P&P) for norovirus prevention and control. This failure had the potential for CNA 1 to spread norovirus to other residents and staff. 2. Eleven of 22 (rooms 1, 2, 6, 16, 21, 24, 35, 38, 42, 47 and 48) with isolation precautions did not have biohazard receptacles in the room for staff and visitors to dispose of contaminated PPE prior to exiting the room. This failure had the potential for employees and visitors to exit resident rooms wearing contaminated PPE and spread germs (microorganisms which cause disease) to residents and staff. Findings: 1. During an observation on 1/6/25 at 10:03 a.m. with the Director of Nursing (DON), CNA 1 was observed in Resident 1 ' s room, holding the resident ' s left arm while assisting him from the bathroom to his bed. CNA 1 wore a mask and did not have a gown or gloves on. There was a sign by Resident 1 ' s door which indicated Contact Precautions with instructions to wear a gown and gloves when physically caring for the resident. During a concurrent observation and interview on 1/6/25 at 10:05 a.m. with CNA 1, CNA 1 had a bedside table and chair at the foot of Resident 1 ' s bed. CNA 1 stated she was assigned to provide one-on-one supervision of Resident 1. CNA 1 stated she held onto Resident 1 ' s arm when he walked from the bathroom to his bed because he required physical help to steady while walking. CNA 1 stated Resident 1 was on contact precautions for a potential norovirus infection and had symptoms of nausea and diarrhea. CNA 1 stated she should have donned (put on) a gown and gloves before touching the resident. CNA 1 stated PPE was required to prevent her from infecting herself or spreading germs to other residents. During an interview on 1/6/25 at 10:46 a.m. with the DON, the DON stated there were positive norovirus cases in the facility and symptomatic residents were placed on contact precautions to prevent an outbreak. The DON stated CNA 1 did not have the correct PPE on when walking Resident 1 from the bathroom to his bed. The DON stated CNA 1 should have worn a gown and gloves to protect herself from norovirus and potentially spreading it to others. The DON stated his expectation was for staff to don the correct PPE to prevent cross contamination and cause an outbreak in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/6/25 at 1:50 p.m. with CNA 3, CNA 3 stated Resident 1 was on contact precautions because he had nausea and diarrhea which were symptoms of Norovirus. CNA 3 stated a gown and gloves were required when in contact with Resident 1 or his surroundings. CNA 3 stated the correct PPE was important to prevent an outbreak because they could spread the germs to other residents and to prevent taking the virus home spreading it to their families. During an interview on 1/6/25 at 4:14 p.m. with the Infection Preventionist (IP), the IP stated the facility had an outbreak of norovirus. The IP stated they had two positive cases and multiple other residents were symptomatic. The IP stated any residents with symptoms of norovirus were immediately put on contact isolation whether their tests were positive or negative until 48 hours after the symptoms subside. The IP stated her expectation was for the staff to wear the correct PPE in resident rooms to prevent the spread of illness. The IP stated CNA 1 should have donned a gown and gloves prior to going into Resident 1 ' s room. During a review of the facility ' s policy and procedure (P&P) titled Norovirus Prevention and Control, dated 10/2011, the P&P indicated, . This facility will implement strict infection control measures to prevent the transmission of norovirus infection . Avoid exposure to vomitus or diarrhea. Place residents on contact precautions . when symptoms are consistent with norovirus gastroenteritis . During outbreaks, residents with norovirus gastroenteritis [inflammation of the stomach and intestines resulting from bacterial (microscopic organism) or viral infection] will be placed on contact precautions for a minimum of 48 hours after the resolution of symptoms . During a review of the facility ' s P&P titled Isolation-Categories of Transmission-Based Precautions, dated 9/2022, the P&P indicated, . Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection . Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected . Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces . Staff and visitors wear gloves when entering the room . Staff avoid touching potentially contaminated environmental surfaces or items in the resident ' s room after gloves are removed . Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room . During a review of professional reference found at https://www.cdc.gov/infection-control/media/pdfs/Guideline-Norovirus-H.pdftitled Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, dated 2/15/2017, the reference indicated, . During outbreaks, place patients with norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients . If norovirus infection is suspected, adherence to PPE use according to Contact and Standard Precautions is recommended for individuals entering the patient care area . During a review of a professional reference located at https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.htmltitled Transmission-Based Precautions, dated 4/3/2024, the reference indicated, . Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission . Use Personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient ' s environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on 1/6/25 at 3:53 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 exited room [ROOM NUMBER] and stopped outside the doorway, in front of the medication cart wearing a mask, gown and gloves. LVN 5 looked down the hallway and doffed the gown and gloves while standing in front of the medication cart and stood holding the balled-up gown and gloves. LVN 5 stated there was no biohazard trash receptacle in the room and she had nowhere to throw out the used PPE. LVN 5 stated it was important to doff the PPE while still in the resident ' s room to prevent the spread of infection. The room was marked with a Contact Precaution sign. During a concurrent observation and interview on 1/6/25 at 3:55 p.m. with CNA 5, a yellow bag marked biohazard on it was lying in the hallway in front of room [ROOM NUMBER]. CNA 5 was in room [ROOM NUMBER] assisting Resident 4 while wearing a mask, gown, and gloves. CNA 5 walked to the doorway and doffed her contaminated gown and gloves into the yellow bag while it was on the ground in the hallway. CNA 5 stated the room did not have a biohazard trash receptacle to doff her PPE. CNA 5 stated Resident 4 had symptoms of norovirus and required contact precautions. During a concurrent observation and interview on 1/6/25 at 4:14 p.m. with the IP, the rooms with isolation precaution signs hanging on the door were observed for biohazard receptacles. The following rooms required PPE for droplet or contact precautions and did not have biohazard receptacles: Rooms 1, 2, 6, 16, 21, 24, 35, 38, 42, 47 and 48. The IP stated the isolation rooms housed residents with Norovirus or influenza symptoms which required PPE. The IP stated PPE should always be removed inside the room to prevent exposure of germs to other people and prevent a potential outbreak. The IP stated the yellow bag should not have been on the ground in the hallway because the outside of the bag could have been contaminated and spread germs into the hallway. During an interview on 1/6/25 at 4:20 p.m. with the DON, the DON stated all isolation rooms needed a proper biohazard receptacle because contaminated PPE needed to be removed and disposed of prior to leaving the room. The DON stated the yellow biohazard bag on the ground was contaminated and should not have been in the hallway. The DON stated the PPE needed to be disposed correctly to prevent cross contamination. During a review of the facility ' s P&P titled Isolation-Categories of Transmission-Based Precautions, dated 9/2022, the P&P indicated, . Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection . Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected . Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces . Staff and visitors wear gloves when entering the room . Staff avoid touching potentially contaminated environmental surfaces or items in the resident ' s room after gloves are removed . Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room . Masks are worn when entering the room . Gloves, gown and goggles are worn if there is risk of spraying respiratory secretions . During a review of the facility ' s P&P titled Influenza Outbreak, dated 10/2019, the P&P indicated, . facility follows current guidelines and recommendations for managing influenza outbreak in the facility . Contact and droplet precautions are implemented during care of residents with suspected or confirmed cases of influenza . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility ' s policy and procedure (P&P) titled Norovirus Prevention and Control, dated 10/2011, the P&P indicated, . This facility will implement strict infection control measures to prevent the transmission of norovirus infection . Avoid exposure to vomitus or diarrhea. Place residents on contact precautions . when symptoms are consistent with norovirus gastroenteritis . During outbreaks, residents with norovirus gastroenteritis will be placed on contact precautions for a minimum of 48 hours after the resolution of symptoms . https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.htmltitled Transmission-Based Precautions, dated 4/3/24, the reference indicated, . Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent transmission . Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient ' s environment . Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens . During a review of a professional reference located at https://www.cdc. gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, dated 9/2024, the reference indicated, . Designated containers for used disposable or reusable PPE should be placed in a location that is convenient to the site of removal to facilitate disposal and containment of contaminated materials .