STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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** 27137 Based on interview and record review, the facility failed to ensure one of two residents (Resident 1) had a correctly completed Minimum Data Set Assessment (MDS, a comprehensive, standardized assessment tool) when a review indicated six (6) incorrect entries. These six (6) errors indicated a pattern of incorrect assessment results, resulting in Resident 1's MDS that was not reflective of her status at the time of the assessment, and had the potential for Resident 1 to have unmet care needs that did not address her status, needs, strengths, and areas of decline. Findings: During a review of Resident 1's Minimum Data Set (MDS), dated [DATE], the MDS indicated at Question A2300 as having an Assessment Reference Date of [DATE], which indicated a look back period of 7 days (unless another time period is indicated). For Resident 1's MDS assessment, the 7-day time period was [DATE] through [DATE]. The MDS contained six (6) errors at the following questions: Question C1310C Question E900 Question I2300 Question J1800 Question K0310 Question P200E (Question C1310C) During a review of Resident 1's MDS, dated [DATE], the MDS indicated at Question C1310C, Disorganized Thinking - Was the resident's thinking disorganized or incoherent. unclear or illogical ideas. The answer indicated Behavior not present. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Admission Record (AR), dated [DATE], the AR indicated Resident 1 was admitted to the facility with diagnoses that included psychosis (refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not); and Strange and Inexplicable behavior. During a review of Resident 1's Progress Notes (PN), dated [DATE], at 2:14 PM, the PN indicated Resident 1 was outside in the parking area with a Certified Nursing Assistant (CNA), when gate began to open, and resident stood up and ran out of the gate. CNA stopped resident while calling for help. Multiple staff members came out. Resident stated I want to be free. Resident refused to come back into facility. Staff member is sitting outside with her. During a concurrent interview and record review on [DATE], at 1:30 PM, with the Director of Social Services (SSD), Resident 1's PN dated [DATE], and MDS dated [DATE] were reviewed. The SSD stated she was the staff member that had answered Question C1310C on Resident 1's MDS. The SSD stated, That was episode of disorganized thinking. It was answered incorrectly. When I completed that MDS, I wasn't thinking of that situation [on [DATE]]. I don't always look at the nurses' notes [PN from the 7-day assessment reference period]. During a concurrent interview and record review on [DATE], at 4 PM, with the Director of Nursing (DON), Resident 1's PN dated [DATE], and MDS dated [DATE] were reviewed. The DON stated Resident 1 certainly had cognitive impairment [confusion or memory losses]. (Question E900) During a review of Resident 1's MDS, dated [DATE], the MDS indicated at Question E900 - Wandering - Presence & Frequency - Does the resident wander? The answer indicated, Behavior not exhibited. During a review of the Centers for Medicaid and Medicare Services' Long Term Care Facility Assessment Instrument 3.0 User's Manual, Version 1.18.11 (RAI Manual, provides guidance and instruction on how to accurately complete a MDS), dated [DATE], the RAI Manual indicated Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to their physical or safety needs. The resident may have a purpose such as searching to find something, but they persist without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes they must find their parent, who staff know is deceased). During a concurrent interview and record review on [DATE], at 1:39 PM, with the MDS Coordinator (MDS-C), Resident 1's PN dated [DATE], the MDS dated [DATE], and the RAI Manual guidance on Question E900 were reviewed. The MDS-C stated she was not employed at the facility during [DATE], and she did not complete Resident 1's MDS from that date. The MDS-C stated Question E900 should have been marked 'yes', indicating wandering behavior was present for Resident 1. (Question I2300) (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 review of Resident 1's MDS, dated [DATE], the MDS indicated at Question I2300 Urinary Tract Infection (UTI) in the last 30 days[?]. The answer indicated Resident 1 had not had a UTI in the last 30 days. The RAI Manual indicated regarding MDS Question I2300 Urinary tract infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days. Code only if both of the following are met in the last 30 days: It was determined that the resident had a UTI using evidence-based criteria such as McGeer. in the last 30 days, AND A physician documented UTI diagnosis. in the last 30 days. During a review of McGeer's Criteria, Table 5, at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/ , dated ,d+[DATE], the McGeer's Criteria indicated, a UTI is defined as a having symptoms such as painful urination (dysuria) and having greater than 100,000 bacteria in the urine. During a review of Resident 1's PN dated [DATE], at 6:37 AM, and 6:15 PM, the PN indicated she was being monitored for complaints of painful urination. The PN dated [DATE], at 8:42 PM, indicated Resident 1's physician ordered her to start antibiotics for a UTI. The PN dated [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], indicated nursing staff was monitoring performing additional assessments for Resident 1's UTI. During a concurrent interview and record review on [DATE], at 4 PM, with the Director of Nursing (DON), Resident 1's Culture and Sensitivity Report (C&S), dated [DATE], were reviewed. The DON stated Resident 1's C&S indicated she had greater than 100,000 bacteria in her urine. The PN dated [DATE] was reviewed with the DON and she confirmed Resident 1 had complained of painful urination, and her physician had prescribed her medication for a UTI. During a concurrent interview and record review on [DATE], at 1:39 PM, with the MDS-C, Resident 1's PN dated [DATE] through [DATE], the MDS dated [DATE], and the RAI Manual guidance on Question I2300 were reviewed. The MDS-C stated Question I2300 confirmed Question I2300 was answered as 'no UTI in last 30 days.' (Question J1800) During a review of Resident 1's MDS, dated [DATE], the MDS indicated at Question J1800 Has the resident had any falls since admission/entry or reentry or the prior assessment. whichever is more recent? The answer indicated No. The RAI Manual indicated regarding J1800, An intercepted fall is considered a fall. During a concurrent interview and record review on [DATE], at 1:39 PM, with the MDS-C, Resident 1's PN dated [DATE], at 2:14 PM, the MDS dated [DATE], and the RAI Manual guidance on Question J1800 were reviewed. The PN indicated, . resident started to lose balance and was guided to the ground. The MDS-C stated Question J1800 should have been answered as yes. During an interview with the DON on [DATE], at 4 PM, the DON stated that a fall is defined any change in plane. (Question K0310) (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 review of Resident 1's MDS, dated [DATE], the MDS indicated at Question K0310 Weight Gain - [Has the resident experienced a] Gain of 5% or more in the last month or gain of 10% or more in the last 6 months. The question was answered as No. During a concurrent interview and record review on [DATE], at 1:39 PM, with the MDS-C, Resident 1's PN dated [DATE], at 12:22 PM, the MDS dated [DATE], and the RAI Manual guidance on Question K0310 were reviewed. The PN indicated, Change in Condition and that Resident 1 had gained 12.2 pounds, which resulted in an overall gain of 8.7% of her body weight. Resident 1's weights were reviewed with the MDS-C. The MDS-C stated Resident 1 weighed 153.2 pounds on [DATE]; 148 pounds on [DATE]; and 142 pounds on [DATE]. The MDS-C stated K0310 should have been answered as 'yes'. (Question P200E) During a review of Resident 1's MDS, dated [DATE], the MDS indicated at Question P200E, Alarms - An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected - E - Wander/elopement alarm. The answer indicated such an alarm was not used for Resident 1. During a review of Resident 1's Care Plan (CP), dated [DATE], the CP indicated, resident has wander guard [an electronic monitoring bracelet that the resident wears that activates an alarm when in the vicinity of a sensor, usually placed at facility exits] in place on her right ankle - Date Initiated: [DATE]. During a concurrent interview and record review on [DATE], at 1:39 PM, with the MDS-C, Resident 1's PN dated [DATE] through [DATE], the MDS dated [DATE] were reviewed. The PN dated [DATE], at 1:25 PM, indicated, alarm is on and working properly. The PN dated [DATE], at 10:01 AM, indicated, alarm is on and working properly. The PN dated [DATE], at 2:16 PM, indicated, alarm is on and working properly. The PN dated [DATE], at 1:18 PM, indicated, alarm is on and working properly. The MDS-C stated Resident 1's MDS Question P200E should have been answered yes for the wander guard that she wears.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled residents (Resident 1) when Resident 1 had a new onset of confusion, hallucinations (seeing and/or hearing things that are not real) and was yelling. This failure resulted for Resident 1's new onset of altered level of consciousness needs such as monitoring and safety to go unmet. Findings: During a review of Resident 1's Admission Record, dated 4/17/24, at 4:08 PM, the Admission Record indicated Resident 1 was a [AGE] year-old female admitted to the facility on [DATE]. During a review of Resident 1's Minimum Data Set (MDS, a standardized, comprehensive assessment tool), dated 3/26/24, the MDS indicated at Section C500, Brief Interview for Mental Status, a score of eight out of 15, which indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. During a review of Resident 1's clinical record, Progress Notes, dated 3/19/24, at 10:52 PM, the Progress Notes indicated Resident 1 was yelling and talking about a fire and had slight confusion. During a review of Resident 1's Progress Notes, dated 3/21/24, at 1:50 PM, the Progress Notes indicated a care conference meeting was held with Resident 1's Family Member (FM 1). The Progress Notes indicated Discussed recent behaviors such as audio and visual hallucinations. During a review of Resident 1's Progress Notes, dated 3/22/24, at 00:08 AM, the Progress Notes indicated Resident noted to have yelling behaviors throughout night. During an interview with the Social Services Director (SSD), on 4/17/24, at 11:40 AM, the SSD stated Resident 1 had episodes of confusion. During an interview with Certified Nursing Assistant (CNA) 1, on 4/17/24, at 1:08 PM, CNA 1 stated Resident 1 was sometimes confused. During an interview with Resident 1's Family Member (FM) 1, who is also her Responsible Party, on 4/17/24, at 1:54 PM, FM 1 stated, We noticed some confusion most every day. My father and sister visit almost every day, for 2-3 hours at a time. The confusion was new. She was not confused before admission there. After admission to facility, she was disoriented, delusional, confused. That confusion was not there earlier, before admission. The confusion started after she was placed there. During a concurrent interview and record review on 4/17/24, at 3:30 PM, with Licensed Vocational Nurse (LVN) 1, Resident 1's Progress Notes, various dates, was reviewed. LVN 1 stated Resident 1's Progress Notes indicated periods of confusion. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/24, at 3:40 PM, with the Clinical Resource Registered Nurse (CRRN) 3:40 PM, Resident 1's Care Plan (CP), was reviewed. The CRRN stated that there was no CP addressing Resident 1's altered level of consciousness and a CP should have been done to ensure resident safety. During a review of the facility's policy and procedure titled Admission of a Resident, dated 2/22, the document indicated, in part, Policy: The admission process is intended to obtain all the information possible about the resident, for the development of comprehensive plans of care, and to assist the resident in becoming comfortable in the facility. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. Information gathered will be placed into the resident's medical record via the facility's means of recordkeeping (i.e., paper, electronic).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137 Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for one of three sampled residents (Resident 1) when Resident 1 was assessed with a new onset of confusion and hallucination (seeing and/or hearing things that are not real) and a physician's order for urine culture and sensitivity test (lab test to check for bacteria and germs in the urine) was not done to determine if an infection was present and the cause of the confusion. This failure resulted for Resident 1's urinary tract infection (UTI-a condition in which bacteria invades and grow in the urinary tract) to go untreated which led to Resident 1's new onset of confusion and hallucination. Findings: During a review of Resident 1's Admission Record (AR), dated 4/17/24, at 4:08 PM, the AR indicated Resident 1 was a [AGE] year-old female admitted to the facility on [DATE]. During a review of Resident 1's Progress Notes (PN), dated 3/19/24, at 10:52 PM, the PN indicated Resident 1 was yelling, talking about a fire, and had slight confusion. The nursing staff notified physician and ordered a UA and a culture and sensitivity test if indicated. During a review of Resident 1's Order Summary Report (OSR), dated 4/17/24, the OSR indicated on 3/19/24 the physician ordered for a urinalysis and culture and sensitivity test if indicated and may collect the urine sample from the urinary catheter bag (a drainage bag that collects urine that is connected by a tube inserted into the urinary bladder). During a review of Resident 1's Laboratory Report (LR), dated 3/20/24, at 9:01 PM, the LR indicated a urinalysis test was performed for Resident 1. Resident 1's urinalysis indicated several abnormal results, including: 1. Positive [NAME] Blood Cells (An increased number of white blood cells in the urine may indicate an infection or inflammation in the urinary tract. [NAME] blood cells are the body's natural infection fighters) 2. High levels (4+) of Leukocyte Esterase (High levels of leukocytes in the urine typically indicate an infection in the urinary system. Leukocytes are a type of white blood cells) 3. Positive Nitrates (Nitrites in urine are a common sign of a UTI. UTIs are caused by different types of bacteria) 4. Positive Protein (A large amount of protein in urine may indicate a problem with the kidneys (organs that filter extra water and wastes out of blood to make urine) 5. Positive Red Blood Cells (Indicated there is blood in the urine and may indicate a UTI) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Many Bacteria (Often associated with a UTI, especially if the resident is having symptoms of a UTI, including confusion) The Laboratory Report indicated TEXT WAIT CS [culture and sensitivity] and was signed by Physician 1 on 3/21/24, at 1:03 PM. During a review of Resident 1's PN, dated 3/21/24, at 6:51 AM, the PN indicated MD [Medical Doctor] digitally signed Labs Report with no new orders at this time. waiting CS report. During a review of Resident 1's PN, dated 3/21/24, at 1:50 PM, the PN indicated a care conference meeting was held with Resident 1's Family Member (FM 1). The PN indicated Discussed recent behaviors such as audio and visual hallucinations. Informed [FM 1] that UA was obtained, results received, C&S pending with [no new orders] now from MD. During a review of Resident 1's PN, dated 3/22/24, at 00:08 AM, the PN indicated UA ordered and reviewed by MD. C/S [culture sensitivity] result pending. Resident noted to have yelling behaviors throughout night. During a review of Resident 1's PN, dated 3/22/24, at 11:03 AM, the PN indicated UA collected and reviewed by MD awaiting C+S [culture and sensitivity] results. Resident was yelling out briefly. During a review of Resident 1's PN, dated 3/23/24, at 9:29 PM, the PN indicated UA ordered and reviewed by MD. C&S result pending. During a review of Resident 1's PN, dated 3/25/24, at 8:20 AM, the PN indicated Results for UA are pending. There were no further entries in Resident 1's Progress Notes regarding her UA or C/S results. During a review of Resident 1's Minimum Data Set (MDS - a standardized, comprehensive assessment tool), dated 3/26/24, the MDS indicated at Section C500, Brief Interview for Mental Status, a score of eight out of 15, which indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. During an interview with the Infection Preventionist Nurse (IPN) on 4/17/24, at 11:20 AM, the IPN stated Resident 1 had hallucination and did not make sense when she speaks. The IPN stated Resident 1 would say a man was in her room, when there was no one. During an interview with the Social Services Director (SSD), on 4/17/24, at 11:40 AM, the SSD stated Resident 1 had episodes of confusion. During an interview with Certified Nursing Assistant (CNA) 1, on 4/17/24, at 1:08 PM, CNA 1 stated Resident 1 had episodes of confusion. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1's Family Member (FM) 1 and Responsible Party, on 4/17/24, at 1:54 PM, FM 1 stated, We noticed some confusion most every day. My father and sister visit almost every day, for 2-3 hours at a time. The confusion was new. She was not confused before admission there. After admission to facility, she was disoriented, delusional, confused. That confusion was not there earlier, before admission. The confusion started after she was placed there [Skilled Nursing Facility]. During a concurrent interview and record review on 4/17/24, at 3:30 PM, with Licensed Vocational Nurse (LVN), Resident 1's LR, dated 3/20/24 and clinical record was reviewed. LVN 1 stated Resident 1 was having confusion and confusion was of the common sign for elderly with urinary tract infection. LVN 1 stated Resident 1's UA result was abnormal, and a CS was indicated to determine if Resident 1 had a urinary tract infection and the treatment needed. LVN 1 was unable to find the CS result. LVN 1 stated a CS was not done and should have been done to determine the cause of the confusion. During a concurrent interview and record review on 4/17/24, at 3:40 PM, with the Clinical Resource Registered Nurse (CRRN) 3:40 PM, Resident 1's clinical record was reviewed. The CCRN was unable to find Resident 1 CS result. The CCRN stated altered level of consciousness, such as confusion, was a common sign of UTI in elderly. The CCRN stated, There should have been follow-up on the UA, determine what happened with the culture and sensitivity report. Someone should have asked where it [CS] is? During an interview with the IPN, on 4/17/24, at 4:15 PM, the IPN stated Resident 1 had a urinary catheter and she just learned from the facility contracted laboratory for residents with a urinary catheter there should be a separate physician order for the CS. The IPN stated the CS was never done because there was no separate physician's order. The IPN stated she and the facility license nurses was not aware of the facility contracted lab services policy and procedures for UA and CS. The IPN stated Resident 1 had a new onset of confusion and the physician ordered a UA, the UA result had abnormal values indicative of a UTI and a CS should have been done. During a review of the professional reference from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9827929/#:~:text=Symptoms%20of%20UTI%20are%20atypical, the%20absence%20of%20a%20fever titled, Urinary Tract Infection Induced Delirium [ ] in Elderly Patients: A Systematic Review dated 12/2022. The Professional indicated, Urinary tract infection (UTI) is common in older adults, mainly due to several age-related risk factors. Symptoms of UTI are atypical in the elderly population, like hypotension, tachycardia, urinary incontinence, poor appetite, drowsiness, frequent falls, and delirium. UTI manifests more commonly and specifically for this age group as delirium or confusion in the absence of a fever . Urinary tract infection (UTI) is a common infection in the elderly, mainly due to age-related risk factors like malnutrition, inadequately controlled diabetes mellitus [a condition that results in too much sugar in blood], poor bladder control leading to urinary retention or incontinence, constipation, long-term hospitalization s . and altered mental state. UTIs are responsible for around 25% of all geriatric hospitalization s attributing to almost 6.2% of deaths due to infectious diseases and repeated emergency department . UTI manifests more atypically for this age group as delirium, confusion, dizziness, drowsiness, falls, urinary incontinence, or poor appetite in the absence of fever making the diagnosis of UTI a difficult task as patients are unable to report their urinary symptoms clearly . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the professional reference from https://www.healthline.com/health/uti-in-elderly titled, Urinary Tract Infections (UTIs) in Older Adults Older adults may not always show the classic signs of a UTI. They may experience other symptoms, including confusion and lethargy. The classic symptoms of a urinary tract infection (UTI) are burning pain and frequent urination . When bacteria enter the urethra (opening that carries urine to the bladder [an organ that stores urine]) and your immune system doesn't fight them off, they may spread to the bladder and kidneys. The result is a UTI . What causes a urinary tract infection? The main cause of UTIs, at any age, is usually bacteria. Escherichia coli [a type of bacteria] is the primary cause, but other organisms can also cause a UTI. In older adults who catheters or live in a nursing home or other full-time care facility . Diagnosing a urinary tract infection in older adults . uncommon symptoms such as confusion make UTIs challenging to diagnose in many older adults. If your doctor suspects a UTI, a urinalysis will likely be ordered along with other tests to determine the true cause of the symptoms. Your doctor may perform a urine culture to determine the type of bacteria causing the infection and the best antibiotic to treat it . Treating a urinary tract infection in older adults . More severe infections may require a broad-spectrum antibiotic [medication used to kill harmful or disease-causing bacteria] .You should start antibiotics as soon as possible and take them for the entire duration of treatment as prescribed by your doctor. Stopping treatment early, even if symptoms resolve, increases the risks of recurrence and antibiotic resistance .

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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 - 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. 27137 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had a history of psychological problems and previous attempts to leave the facility on 4/11/24, received the necessary supervision from staff during another attempt to leave the facility on 5/12/24. This failure resulted in Resident 1 being unattended while in the parking area of the facility, who then quickly left the facility without supervision and was found 20 minutes later wandering on a nearby street. This failure had the potential for injury to Resident 1. Findings: During a review of Resident 1's Admission Record (AR), dated 5/29/24, the AR indicated Resident 1 was admitted to the facility with diagnoses that included psychosis (refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not), and Strange and Inexplicable Behavior. During a review of Resident 1's Care Plan (CP), dated 3/18/24, the CP indicated Resident 1 had attempted elopement. The CP dated 3/25/24 indicated Resident 1 is an elopement risk/wanderer as evidenced by History of attempts to leave facility unattended and impaired safety awareness. The CP dated 4/11/24 indicated Resident 1 had eloped [from] from the facility. The CP dated 5/12/24 indicated elopement. The CP dated 5/12/24 indicated Staff educated to keep resident in line of sight while attempting to get help. Use call phone to call the facility/staff to assist rather than 'going to get help.' During a review of Resident 1's Progress Notes (PN), dated 5/12/24, at 9:10 AM, the PN indicated, Approximately around 0830, [Certified Nursing Assistant, or CNA] came to let writer know that the resident is not in the facility, wheelchair was outside near main gate, Writer look inside and then drove car to look outside, writer found her approximately around 0850am in church, writer tried to convince resident to come back to facility, Resident refused, writer called [Director of Nursing] and administrator, made them aware, called Police and explain them, writer and other 2 staff member were following resident in street while talking to police and giving direction to them. resident was walking down the street, and it was unsafe for resident crossing the road, writer was stopping the cars. after discussion with Police, Resident convinced and ready to come back to facility and ask for ride, one of the staff members gave ride and resident came back to facility around 9am. The PN was written by Registered Nurse (RN) 1. (continued on next page)

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	055454	A. Building B. Wing	05/29/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's PN, dated 5/12/24, at 11:18 AM, the PN indicated, Around 0825 Writer was doing med pass and heard the door alarm. writer ran to door to check, Resident was outside, writer went outside to convinced her to come back, she refused, rude, aggressive to writer, writer came back to facility to get assistance, then another CNA came to let writer know that the resident was nowhere to be found. CNA went outside and seen her [wheel]chair outside next to the gate. This is not the first-time resident has attempted to leave the facility. Resident has been educated and redirected of why leaving the facility can be not safe. Writer notified RN supervisor, DON, and [Medical Doctor] via telephone. RN supervisor went looking for the resident and found her approximately around 0850am. RN supervisor informed writer that the resident was walking down the street and how unsafe it was for her crossing the road. Resident came back to the facility around 9am. The PN was written by Licensed Vocational Nurse (LVN) 1. During an interview on 5/29/24, at 12:44 PM, with Activities Director (AD), the AD stated she noted an empty wheelchair in the facility's parking area while she was driving into work on 5/12/24, at about 9 AM. The AD stated there are two gates, one for cars, one for pedestrians. The AD stated that as the car gate slid open, she noticed empty wheelchair by pedestrian gate. The AD stated no other staff were present in the area at this time. The AD stated she then called a facility nurse from her cell phone while still in her car. The AD stated she looked at the empty wheelchair and recognized it as belonging to Resident 1. The AD stated she then saw some Certified Nursing Assistants (CNAs) coming out of the facility to look for her. The AD stated I drove around the neighborhood in my car looking for her, and others were out looking too. The AD stated we found Resident 1 about 100-150 yards away from the facility, walking into the road area, the sidewalk-road area, in a zig-zag way. The AD stated the police arrived and brought Resident 1 back to the facility. The AD stated Resident 1 had said she was walking to Fresno (about 11 miles away), and wanted to visit her husband, but her chart says she has no family. During a concurrent interview and observation on 5/29/24, at 12:50 PM, with Resident 1, in the facility dining room, Resident 1 stated, Yes, I went for a walk a while ago. I feel safe out there because I had a nurse with me. Resident 1 was noted to be seated in a wheelchair and wearing a wander guard, an electronic monitoring bracelet, on her right ankle. During an interview on 5/29/24, at 1 PM, with LVN 1, LVN 1 stated she recalled that on the morning of 5/12/24, at about 8:30 AM, Resident 1] coming to my medication cart asking for her medications. LVN 1 stated I gave them to her, then Resident 1 wheeled herself down the hall towards the front door. LVN 1 stated I heard the wander guard alarm go off and could tell it was the front door alarm. LVN 1 stated, that after about 1-2 minutes, I went outside to check on Resident 1. LVN 1 stated Resident 1 can be aggressive and stated, I didn't want to get hit, I avoid getting hit. I don't want to get her mad. LVN 1 stated Resident 1 didn't want to come back in. LVN 1 stated, I came back in. That was my mistake. My plan was to come inside and get more staff to convince her to come inside. LVN 1 stated that once back inside, LVN 1 told a CNA and RN charge nurse what happened. LVN 1 stated, We looked for her through the windows, I saw the empty wheelchair. This was about 10 minutes later. Then [the AD] called me. This was maybe 5-10 minutes after she first left the building. [The AD] called me about 9-ish. I was in panic mode. We could not find her through the window. LVN 1 stated she had updated RN 1 on these events. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24, at 1:47 PM, with the AD, the AD stated, [Resident 1] is wobbly, but she can get out of wheelchair and run. The AD stated, I was told to not leave her alone, she has to be watched at all times when outside because of her elopement risk, ever since her elopement in April. She has threatened to hit me before, yelling, being profane. She's never actually hit anyone as far as I know. She's not physically violent. During an interview on 5/29/24, at 2 PM, with the Director of Nursing (DON), the DON stated, [Resident 1] is quick. She had 2 previous elopements [prior to the one on 5/12/24]. She can get out of her wheelchair. The nurse was with her, then stepped inside to get help - but we can't take our eyes off of her. She's a quick one. She's whizzed past me before. During an interview on 5/30/24 at 9:45 AM with RN 1, RN 1 stated she recalled that on the morning of 5/12/24, Certified Nursing Assistant (CNA) 1, informed her that there was an empty wheelchair outside the facility. RN 1 stated, I went outside, I didn't find resident. RN 1 stated that LVN 1 had heard the wander guard alarm, LVN 1 went outside, then she came inside and told us Resident 1 was out there. RN 1 stated, I used my car look for her, I was the one who found her. I tried to convince her to come back, but she was not listening. I called cops for help. Two CNAs were with me, we were following her all the way. The cops finally able to convince her to return. RN 1 stated the nurse that came back inside the facility to get help was LVN 1. RN 1 stated CNA 1 assisted her with finding Resident 1. During an interview on 5/30/24, at 10:20 AM, with CNA 1, CNA 1 stated, I went with the other nurses to go and find [Resident 1. RN 1] found her first. I saw [Resident 1]. She had behavior problems, she was trying to swing and fight back. She didn't want to come with us at all. She was just walking everywhere, walking in middle of street. She has behaviors, thinking problems. We had to stop cars to make sure she wasn't in the way of cars, they moved around her. Like 3 or 4 cars passed by while she was in the street. During a review of the facility Policy and Procedure (P&P) titled, Elopements and Wandering Residents, dated 4/16/21, the P&P indicated, in part, Policy: The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization. and/or any necessary supervision to do so. Alarms are not a replacement for necessary supervision. Adequate supervision will be provided to help prevent accidents or elopements.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137 Based on interview and record review, the facility failed to ensure one of 48 sampled residents (Resident 1) received Trauma Informed Care Evaluation (a process that acknowledge the need to understand patients ' life experiences to deliver effective care and treatment) performed when the Social Services Director (SSD) did not complete a Trauma Informed Care Evaluation for Resident 1. This failure had the potential for the facility ' s inability to identify triggers which could result in Resident 1 ' s re-traumatization (the reactivation of trauma symptoms by way of thoughts, memories, or feelings related to past experienced). Findings: During a review of Resident 1 ' s Admission Record, dated 4/17/24, at 4:08 PM, the Admission Record indicated Resident 1 was a [AGE] year-old female admitted to the facility on [DATE]. During a review of Resident 1 ' s Progress Notes, dated 3/21/24, at 1:50 PM, the Progress Notes indicated a care conference meeting was held with Resident 1 ' s Family Member (FM 1). During an interview on 4/17/24, at 1:54 PM, with Resident 1 ' s Family Member (FM) 1, FM 1 stated she attended a care plan meeting regarding Resident 1 ' s care. FM 1 stated, I was not asked if she had a history of trauma or mental illness. During a concurrent interview and record review on 4/17/24, at 11:40 AM with the SSD, Resident 1 ' s clinical record was reviewed. The SSD stated Resident 1 did not have a Trauma Informed Care Evaluation. The SSD stated she was responsible to complete the Trauma Informed Care Evaluation for each resident within 48 hours after admission in the facility. The SSD stated she should have completed the Trauma Informed Care Evaluation for Resident 1 to ensure appropriate intervention was implemented if needed. The SSD stated she started working at the facility on 3/7/24 and had been playing catch-up since I ' ve got here. I ' m not caught up now. During a review of the facility document titled Social Services Director - Job Description dated 3/7/24, the document indicated All facilities must provide medically related social services to residents. The Social Services Director is responsible for overseeing the development, implementation, supervision, and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintain their highest practicable well-being. This included identifying the need for medically related social services and ensuring that these services are provided in accordance with State and Federal regulations. The Social Services Director - Job Description was signed by SSD on 3/7/24. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure titled Admission of a Resident, dated 2/22, the document indicated, in part, Policy: The admission process is intended to obtain all the information possible about the resident, for the development of comprehensive plans of care, and to assist the resident in becoming comfortable in the facility. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. Information gathered will be placed into the resident ' s medical record via the facility ' s means of recordkeeping (i.e., paper, electronic). The social service designee should determine any needs for the use of outside resources, such as psychosocial services .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137 Based on interview and record review, the facility failed to ensure one of 48 sampled residents (Resident 1) had a Social Services Evaluation completed. This failure had the potential for unmet care needs for Resident 1, who was recently admitted to the facility, including care for mood and behaviors, adjustment to the new environment, mental health history, support systems, and behavioral interventions. Findings: During a review of Resident 1 ' s Admission Record, dated 4/17/24, at 4:08 PM, the Admission Record indicated Resident 1 was a [AGE] year-old female admitted to the facility on [DATE]. During a concurrent interview and record review on 4/24/24, at 10 AM with the Social Services Director (SSD), Resident 1 ' s clinical record was reviewed. The SSD stated Resident 1 did not have a Social Services Evaluation. The SSD stated Resident 1 was admitted on [DATE] and the Social Services Evaluation should have been done. The SSD stated she was responsible to complete Resident 1 ' s Social Services Evaluation. The SSD stated she started working at the facility on 3/7/24 and did not know which assessments to do. The SSD stated she did not get any training until about three weeks in the job. During a review of the facility document titled Social Services Evaluation, undated, the Social Services Evaluation indicated questions for residents and/or family members which included Work History, Interests/Hobbies, Ability to see and hear, Communication status, Cognition status, Mood & Behaviors, Social/Mental Health History, Adjustment to Environment, Other mood & behavior concerns, Behavioral Interventions, Support Systems, and Resident Strengths. During a review of the facility document titled Social Services Director - Job Description dated 3/7/24, the document indicated All facilities must provide medically related social services to residents. The Social Services Director is responsible for overseeing the development, implementation, supervision, and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintain their highest practicable well-being. This included identifying the need for medically related social services and ensuring that these services are provided in accordance with State and Federal regulations. The Social Services Director - Job Description was signed by SSD on 3/7/24. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure titled Admission of a Resident, dated 2/22, the document indicated, in part, Policy: The admission process is intended to obtain all the information possible about the resident, for the development of comprehensive plans of care, and to assist the resident in becoming comfortable in the facility. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. Information gathered will be placed into the resident ' s medical record via the facility ' s means of recordkeeping (i.e., paper, electronic). The social service designee should determine any needs for the use of outside resources, such as psychosocial services, equipment, clothing, money, etc., and make attempts to arrange for the goods or services as soon as possible.