

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Main West Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 812 West Main Street Turlock, CA 95380	

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)
<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</p> <p>Based on interview, record review, and observation, the facility failed to ensure sufficient preparation and orientation for a safe and orderly discharge from the facility for one of one sampled resident (Resident 1) when the facility planned to discharge Resident 1, a [AGE] year-old female with medical and physical needs, to a homeless shelter.</p> <p>This failure resulted in emotional stress, increased anxiety, an increase in antipsychotic medication (used to treat mental health disorders), and near daily episodes of mood swings as evidenced by angry outbursts from Resident 1 and potential for an unsafe discharge.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (AR), dated 8/6/24, the AR indicated Resident 1 was a [AGE] year-old female admitted to the facility six years ago. Resident 1 ' s diagnoses included Multiple Sclerosis (MS, a chronic neurological disorder), Type 2 Diabetes Mellitus (chronic condition regarding the inability to control blood sugar), Chronic Obstructive Pulmonary Disease (COPD, a condition caused by damage to the airways), Hypertension (high blood pressure, when the force of the blood pushing against the walls of the blood vessels is too high), Generalized Anxiety Disorder (persistent feeling of anxiety or dread), Bipolar Disorder (mental illness that causes unusual shifts in a person ' s mood, energy, activity levels, and concentration), Major Depressive Disorder (mood disorder, causing severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working), Glaucoma (eye disease that gradually deteriorates vision), Hyperlipidemia (too much cholesterol, a waxy, fat-like substance, in the blood), Hypothyroidism (thyroid gland does not produce enough hormones which are used to regulate several body functions), Muscle Weakness, Edema (an accumulation of excess fluid in the body), Pain, Abnormalities of gait and mobility (difficulties with walking and getting from place to place), and Suicidal Ideations (thoughts of ending one ' s life).</p> <p>(continued on next page)</p>

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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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Order Summary Report (OSR), dated 8/6/24, the OSR indicated Resident 1 had physician ' s orders that included: quetiapine twice a day (antipsychotic medication used to regulate chemicals in the brain), clonazepam four times a day (an anti-anxiety medication), oxygen to be administered via nasal canula (through a tube inserted into Resident 1 ' s nose), ipratropium-albuterol four times a day, inhaled from a nebulizer (a machine that requires electricity and turns the liquid medication into a fine mist), insulin aspart, (a hormone that helps regulate blood glucose levels, injected by a needle and syringe into the fatty tissue of the body), insulin glargine every night at bedtime - (a long-acting insulin), lisinopril (medication used to lower blood pressure), tramadol (a pain reliver for moderate to moderately severe pain), baclofen (a muscle relaxer), gabapentin (used to relieve pain by changing the way pain is perceived in the brain), furosemide (used to make the body get rid of extra fluid through the kidneys and increases urination), levothyroxine (a thyroid gland hormone replacement).</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 6/26/24, at 2:55 PM, the PN indicated the facility had [R]eceived email from . residents insurance, stating they will no longer cover her stay beyond July 31st [2024]. SSD [Social Services Director] notified resident and asked her what her income was, resident stated I have a headache and I can not talk about this right now.</p> <p>During a review of a follow-up email from Resident 1 ' s insurance provider, dated 7/3/24, at 2:44 PM, and addressed to the facility ' s SSD, the email indicated Resident 1 . does not have needs that require this level of care [care required by a Skilled Nursing Facility] . the member is appropriate to discharge to a lower level of care.</p> <p>During a review of Resident 1 ' s PN dated 7/15/24, at 2:40 PM, the PN indicated, SSD found a place for [Resident 1 to] rent. SSD presented information to resident. SSD reminded her d/c [discharge] is coming up at the end of this month.</p> <p>During a review of Resident 1 ' s PN dated 7/16/24, at 10:11 AM, the PN indicated, the SSD had located a room and board facility for the resident. The PN indicated, SSD will present information to the resident.</p> <p>During a review of Resident 1 ' s PN dated 8/2/24, at 2:55 PM, the PN indicated a Licensed Vocational Nurse (LVN) . monitored [Resident 1 ' s oxygen saturation without the use of oxygen. [Oxygen saturation] steadily declined and after around 20 minutes [Resident 1 ' s oxygen saturation] dropped to 87[%].</p> <p>During a review of Resident 1 ' s PN dated 8/5/24, at 12:54 PM, the PN indicated, SSD and DON [Director of Nursing] went to speak with resident to confirm discharge plans for 8/6/24. SSD and DON reminded resident that resident does have safe discharge tomorrow, SSD secured a bed for resident at [name of a shelter]. Resident stated, I am not leaving tomorrow. SSD spoke with [Resident 1 ' s insurance provider agent] to notify that resident has a safe discharge location and is refusing to discharge tomorrow.</p> <p>During a review of Resident 1 ' s Notice of Transfer/Discharge (NTD), dated 8/5/24, the NTD indicated Resident 1 was given a 30-day notice that she was to be discharged from the facility to [name of shelter], a homeless shelter located at [address of shelter], on 9/4/24. The NTD indicated Resident 1 refused to sign the document.</p> <p>(continued on next page)</p>

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the website for above named shelter in the discharge, at https://turlockgospelmission.org, the website indicated the facility Helps the Homeless and Hurting, and Services Provided - A Warm Bed, Clothing & Hygiene, Cooling and Warming Shelter, Meal Services, Case Management, Community Service and Diversion Services Opportunities, A safe environment during the day .a positive alternative to the parks.</p> <p>During a review of Resident 1 ' s PN dated 8/5/24, at 4:33 PM, the PN indicated, SSD, joined by DON, issued resident 30 day notice for discharge [due to] Residents health has improved sufficiently that the resident no longer needs the services provide by this facility. Resident has until 9/4/24 to cooperate with SSD for discharge. Resident refused to sign notice. SSD and DON signed notice at witnesses.</p> <p>During a concurrent observation and interview on 8/6/24, at 10:50 AM, with Resident 1, in her room at the facility, Resident 1 was a female who appeared her age, lying in her bed, a wheelchair was bedside. Resident 1 was receiving supplemental oxygen delivered to her nose through a tube connected to an oxygen concentrator. Noted on her bed was a nebulizer machine for her prescribed breathing treatments. Resident 1 had many possessions near her bed. Resident 1 stated she was very upset about the 30-day discharge to a homeless shelter. Resident 1 stated she has never been homeless before. Resident 1 stated the nursing staff give her breathing treatments four times a day and perform blood glucose checks four times day. Resident 1 stated the facility planned to switch her insulins to oral medication for her diabetes, and stated, How is that going to work? Resident 1 stated she could transfer herself from her bed to her wheelchair, to the toilet and back again, but that was all, can could not walk outside of her room. Resident 1 stated, I have MS. Throughout the interview, Resident 1 appeared anxious, wringing her hands, spoke with pressured and halting speech, moving head from side-to-side, often placing her hands up in the air in a gesture of frustration, and at times seemed near tears.</p> <p>During an interview on 8/6/24, at 11:10 AM, with the SSD, the SSD stated Resident 1 was issued a 30-day notice yesterday, she has until 9/4/24. She would be financially responsible for costs after 8/31/24. [Resident 1 ' s health insurance] denied her because they reviewed her MDS [a comprehensive, standardized assessment tool], showed member is overall high functioning, independent with ADLs [activities of daily living], continent [able to use the toilet], no wound, [assessment screening] negative for serious mental illness. No behaviors or wandering. [name of shelter] is a homeless shelter. [Resident 1] told ombudsman that she used to be homeless, so that is where her current discharge location is. The SSD stated she was aware Resident 1 has been a resident of this facility continuously for the last six years and was admitted to the facility in August 2018. The SSD stated, The Ombudsman told me she had been homeless before admission here, but [Resident 1] doesn ' t really talk to me much anymore. Home health would follow her at homeless shelter, 3 or 4 times a week. I recommended to [Resident 1] she consider switching to oral diabetic agents. But no physician has ordered this. If she were to be discharged , nursing staff would teach her how to do her own [blood glucose monitoring], self-administer her meds. She would be discharged to homeless shelter with a portable oxygen concentrator. All the medications would be sent with her. She would self-medicate with that. I don ' t know if she self-medicates now.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 8/6/24, at 10:20 AM, with the DON, the DON stated she was aware Resident 1 was prescribed many different medications, including continuous oxygen, blood glucose monitoring with insulin injections four times a day. The DON stated, I think she can do it herself at the homeless shelter. We can train her to [administer all her medications]. I understand she has been her for six years.</p> <p>During an interview on 8/6/24, at 1:30 PM, with Resident 1, Resident 1 stated she feels like she has been in a cognitive decline. I ' m not as sharp as I used to be.</p> <p>During an interview on 8/6/24, at 1:45 PM, with Resident 1 ' s Family Member (FM 1), FM 1 stated Resident 1 was never homeless. FM 1 stated she talks to Resident 1 frequently and Resident 1 is very stressed out over this. She is overwhelmed.</p> <p>During an observation and interview on 8/6/24, at 2:05 PM, in Resident 1 ' s room, with Resident 1, the DON, and the SSD, Resident 1 was noted to be anxious and upset, tearful, appearing short of breath. The SSD and DON were discussing with Resident 1 an updated discharge plan that did not include a homeless shelter. When asked if they thought Resident 1 was anxious and distraught during the conversation, the DON and SSD nodded their heads and stated, Yes.</p> <p>During a review of Resident 1 ' s Medication Administration Record (MAR) for June 2024, the MAR indicated Resident 1 had a physician ' s order for quetiapine, dated 1/24/23, in the amount of 75 mg to be given every evening at bedtime. The MAR indicated on 6/29/24, the facility nursing staff began to monitor Resident 1 every shift for mood swings as evidence by angry outbursts. The MAR indicated Resident 1 received 120 blood glucose checks during the month and required insulin 119 times.</p> <p>During a review of Resident 1 ' s MAR for July 2024, the MAR indicated on 7/24/24, Resident 1 had a physician ' s order to increase her quetiapine dose to include an additional 25 mg to be given every morning. The MAR indicated that on 7/30/24, the 25 mg morning dose of quetiapine was doubled to 50 mg to be given every morning, for a total of quetiapine 50 mg every morning, and quetiapine 75 mg to be given every evening. The MAR indicated Resident 1 was documented to have begun having mood swings as evidence by angry outbursts on 7/24/24, and continued on 7/25/24, 7/26/24, 7/27/24, 7/28/24, 7/30/24, and 7/30/24 (some days having multiple episodes). The MAR indicated Resident 1 received 124 blood glucose checks during the month and required insulin 124 times.</p> <p>During a review of Resident 1 ' s PN dated 7/30/24, at 10:21 AM, the PN indicated Resident 1 was seen by a Nurse Practitioner on 7/29/24. The PN indicated the facility ' s Interdisciplinary Team (usually comprised of facility staff representing nursing, social services, dietary, and activity departments) recommended increasing Resident 1 ' s [morning] dose of quetiapine to 50 mg, and resident had [history] of bipolar and experiences sudden mood swings.</p> <p>During a review of Resident 1 ' s MAR dated through 8/23/24, the MAR indicated Resident 1 was documented to have mood swings as evidence by angry outbursts on 8/1/24, 8/2/24, 8/3/24, 8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/12/24, 8/14/24, 8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/19/24, 8/22/24 (some days having multiple episodes). The MAR indicated Resident 1 received 86 blood glucose checks from 8/1/24 to 8/23/24 and required insulin 84 times.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized, comprehensive assessment tool), dated 6/11/24, the MDS indicated at Question C500 - Brief Interview for Mental Status, a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG0170 FF - Tub/Shower transfer: The ability to get in and out of a tub/shower, a score of 1, which indicated Resident 1 required a Helper who does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required to complete the activity.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 J - Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns, a score of 6, which indicated Resident 1 was Independent - Resident completes the activity by themselves with no assistance from a helper.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 K - Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space, a score of 6, which indicated Resident 1 was Independent - Resident completes the activity by themselves with no assistance from a helper.</p> <p>During a concurrent interview and record review on 8/13/24, at 10:23 AM, with the DON, Resident 1 ' s MDS dated [DATE] was reviewed. The DON stated she knew Resident 1 could walk in her room, but I don ' t know about 50 or 150 feet. I don ' t know why it was coded that way.</p> <p>During an interview on 8/15/24, at 9:45 AM, with Resident 1, Resident 1 stated, I ' ve not walked up and down the hallway in years. I can walk a little bit from the wheelchair to the bathroom, and I need oxygen to do that. I ' ve never walked up and down the hallway ever since I ' ve been here. I need help showering and getting dressed. I can ' t do my hair or nothing. I can get from my bed to my wheelchair myself.</p> <p>During an interview on 8/23/24, at 9:06 AM, with the Medical Records Director (MRD), the MRD stated she has known Resident 1 for many years. The MRD stated, I ' ve not seen her walk outside her room, not in hallway, no. No, honestly, I have not.</p> <p>During an interview on 8/23/24, at 9:25 AM, with the DON, the DON stated, I ' ve not seen her walk 50 feet with two turns, or 150 feet, only in her room.</p> <p>During an interview on 8/23/24, at 9:40 AM, with Registered Nurse (RN) 1, RN 1 stated she has worked at the facility for six years and was familiar with Resident 1. RN 1 stated, I ' ve never seen her walk in hallway, only in wheelchair. I ' ve only seen her walk in her room. She ' s been like that for the whole 6 years she ' s been here.</p> <p>During an interview on 8/23/24, at 9:45 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated she has worked at the facility or 3 years and was familiar with Resident 1. CNA 1 stated, Resident 1 only walks in her room, not in the hallway. Maybe 10-20 feet in room. Always been like that, for the 3 years I ' ve been here. Sometimes she bathes herself, but usually we help her. One person needs to be with her at all times, she may fall or slip. One person with her at all times while she bathes, for safety. Once in the shower room, she can mostly bathe herself, but she does need help with her hair.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/23/24, at 9:50 AM, with CNA/Restorative Nursing Assistant (CNA/RNA), the CNA/RNA stated she has worked at the facility for about seven years and was familiar with Resident 1. CNA/RNA stated, I ' ve only seen [Resident 1] walk in her room. From bed to closet to bathroom. Never in hallway. She ' s never walked in hallway since I ' ve been here.</p> <p>During an interview on 8/29/24, at 12:37 PM, with the [NAME] County Ombudsman, the Ombudsman stated she recalled talking with Resident 1 and the facility about ever having a history of homelessness. The Ombudsman stated Resident 1 ' s information conflicted and was unsure if Resident 1 was ever homeless or not.</p> <p>During a concurrent interview and record review on 8/29/24, at 1:03 PM, with the DON, Resident 1 ' s MARs dated 6/24, 7/24, and 8/24, were reviewed. The DON verified the documentation as accurate.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</p> <p>Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 1) had an accurate Minimum Data Set Assessment (MDS, a set of comprehensive, standardized assessments), when her MDS assessment dated [DATE] was not accurate.</p> <p>This failure had to potential to affect the care and facility placement of Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (AR), dated 8/6/24, the AR indicated Resident 1 was a [AGE] year-old female admitted to the facility six years ago.</p> <p>During a review of an email from Resident 1 ' s insurance provider, dated 7/3/24, at 2:44 PM, and addressed to the facility ' s Social Services Director, the email indicated Resident 1 . does not have needs that require this level of care [care required by a Skilled Nursing Facility] . the member is appropriate to discharge to a lower level of care.</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 8/5/24, at 4:33 PM, the PN indicated, SSD, joined by DON [Director of Nursing], issued resident 30 day notice for discharge [due to] Residents health has improved sufficiently that the resident no longer needs the services provide by this facility.</p> <p>During an interview on 8/6/24, at 11:10 AM, with the SSD, the SSD stated Resident 1 was issued a 30-day notice yesterday, she has until 9/4/24. [Resident 1 ' s health insurance] denied her because they reviewed her MDS which showed [Resident 1] is overall high functioning, independent with ADLs [Activities of Daily Living]. The SSD stated she was aware Resident 1 was admitted to the facility in August 2018 and has been a resident of this facility continuously for the last six years.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 Mobility - J - Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns, a score of 9, which indicated Not applicable - Not attempted and the resident did not perform his activity prior to the current illness, exacerbation [worsening] or injury[.]</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 Mobility - K - Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space, a score of 9, which indicated Not applicable - Not attempted and the resident did not perform his activity prior to the current illness, exacerbation [worsening] or injury[.]</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 Mobility - J - Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns, a score of 6, which indicated Resident 1 was Independent - Resident completes the activity by themselves with no assistance from a helper.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 Mobility - K - Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space, a score of 9, which indicated Not applicable - Not attempted and the resident did not perform his activity prior to the current illness, exacerbation [worsening] or injury[.]</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 Mobility - J - Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns, a score of 6, which indicated Resident 1 was Independent - Resident completes the activity by themselves with no assistance from a helper.</p> <p>During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated at Question GG 0170 Mobility - K - Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space, a score of 6, which indicated Resident 1 was Independent - Resident completes the activity by themselves with no assistance from a helper.</p> <p>The MDS dated from 12/19/23 to 6/11/24 indicated an significant improvement in Resident 1 ' s ability to walk 50 feet with two turns, and to 150 feet.</p> <p>During a concurrent interview and record review on 8/13/24, at 10:23 AM, with the DON, Resident 1 ' s MDS dated [DATE] was reviewed. The DON stated she knew Resident 1 could walk in her room, but I don ' t know about 50 or 150 feet. I don ' t know why it was coded that way.</p> <p>During a concurrent interview and record review on 8/13/24, at 4:45 PM, with the MDS Consultant (MDS-C), Resident 1 ' s MDS dated [DATE], 3/18/24, and 6/11/24 were reviewed. The MDS-S confirmed the entries at Question GG 0170 Mobility - K and J. The MDS-C stated that after six years in the facility, a sudden improvement should have been verified by facility staff.</p> <p>During an interview on 8/15/24, at 9:45 AM, with Resident 1, Resident 1 stated, I ' ve not walked up and down the hallway in years. I can walk a little bit from the wheelchair to the bathroom, and I need oxygen to do that. I ' ve never walked up and down the hallway ever since I ' ve been here. I can get from my bed to my wheelchair myself.</p> <p>During an interview on 8/23/24, at 9:06 AM, with the Medical Records Director (MRD), the MRD stated she has known Resident 1 for many years. The MRD stated, I ' ve not seen her walk outside her room, not in hallway, no. 150 feet? How far is 150 feet? [Stated to the MRD that 150 feet was half a football field]. No, honestly, I have not.</p> <p>During an interview on 8/23/24, at 9:25 AM, with the DON, the DON stated, I ' ve not seen [Resident 1] walk 50 feet with two turns, or 150 feet, only in her room.</p> <p>During an interview on 8/23/24, at 9:40 AM, with Registered Nurse (RN) 1, RN 1 stated she has worked at the facility for six years and was familiar with Resident 1. RN 1 stated, I ' ve never seen her walk in hallway, only in wheelchair. I ' ve only seen her walk in her room. She ' s been like that for the whole 6 years she ' s been here.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/23/24, at 9:45 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated she has worked at the facility or 3 years and was familiar with Resident 1. CNA 1 stated, Resident 1 only walks in her room, not in the hallway. Maybe 10-20 feet in room. Always been like that, for the 3 years I ' ve been here.</p> <p>During an interview on 8/23/24, at 9:50 AM, with CNA/Restorative Nursing Assistant (CNA/RNA), the CNA/RNA stated she has worked at the facility for about seven years and was familiar with Resident 1. CNA/RNA stated, I ' ve only seen [Resident 1] walk in her room. From bed to closet to bathroom. Never in hallway. She ' s never walked in hallway since I ' ve been here.</p> <p>During a concurrent interview and record review on 8/23/24, at 11:30 AM, with the DON, Resident 1 ' s MDS dated [DATE], Question GG 0170 Mobility - K and J was reviewed. The DON stated, It can be an error. I will check with the data and if it is not accurate, we will do a correction.</p>		