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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055573	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsburg Center	1101 Stroud Ave Kingsburg, CA 93631

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 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. 41187 Based on interview and record review, the facility failed to create a care plan for elopement (to run away secretively) risk for one of three sampled residents (Resident 1) when Resident 1 attempted to leave against medical advice (AMA) from an appointment at the dialysis center on 8/23/23 and was assessed to be a risk for elopement. This failure resulted in Resident 1 successfully leaving AMA from the dialysis center on 9/6/23. FINDINGS: During an interview on 9/13/23 at 8:35 a.m. with Social Service Director (SSD), SSD stated she was aware Resident 1 had eloped from previous Skilled Nursing Facilities (SNF) but she had never eloped from current SNF. SSD stated she did not know if Resident 1 had a care plan for Elopement. During a concurrent interview and record review on 9/13/23 at 8:48 am with Licensed Vocational Nurse (LVN) 1, Patient 1's care plans, nurses notes dated 8/23/23, and elopement evaluations dated 8/10/23 and 8/23/24 were reviewed. LVN 1 stated Resident 1 often talked about how she wanted to get out of this place . LVN 1 read the nurses note from 8/23/23 by LVN 2 which indicated the facility had been made aware of Resident 1 attempting to elope from the dialysis center on 8/23/23. LVN 1 validated Resident 1 had an elopement evaluation completed on 8/10/23 that indicated Resident 1 was not a risk for elopement as she was not able to ambulate or self-propel in wheelchair independently, and an elopement evaluation completed on 8/23/23 which indicated Resident 1 could self-propel in wheelchair independently, had a history of actual elopement or attempted elopement, had a history of wandering that placed the patient at significant risk of getting to a potentially dangerous place outside the facility, and was at risk for elopement. LVN 1 stated there should have been a care plan made for Resident 1 on elopement risk as soon as she was identified as being at risk. During an interview with Resident 2 on 9/13/23 at 8:50 am, Resident 2 stated she had been Resident 1's roommate. Resident 2 stated Resident 1 was always talking about going home and had said she had a check coming, and a lot of food stamps waiting for her. Resident 2 stated Resident 1 was always saying she was leaving in a couple days. During a concurrent interview and record review with SSD on 9/13/23 at 8:57 am, Resident 1's records were reviewed. SSD confirmed Resident 1 did not have a care plan initiated for wandering or elopement and there had been no communication to the transportation company regarding Resident 1 being a wandering risk. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsburg Center	1101 Stroud Ave Kingsburg, CA 93631

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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 with Minimum Data Set Coordinator (MDSC) on 9/13/23 at 9:12 am, Resident 1's Minimum Data Set (MDS) section C (Brief Interview for Mental Status/ BIMS) and section E (Behavior) dated 8/17/23 were reviewed. MDSC stated Resident 1 had not displayed any indication of wandering for her. MDSC validated Resident 1 had been assessed with a BIMS score of 15 (0-7 suggests sever cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests that cognition is intact), and section E indicated the resident had shown no behaviors of wandering. During a concurrent interview and record review with SSD on 9/13/23 at 10:08 am, the facility Wander Risk Binder was reviewed. SSD stated all residents who were at risk for wandering were identified in the binder along with their care plan. SSD validated Resident 1 was not in the binder. During a concurrent interview and record review on 9/13/23 at 10:30 am with Director of Staff Development (DSD), the facilities Policy and Procedure (P&P) titled, Elopement of Resident , dated 7/12/23 was reviewed. DSD stated the expectation was for a wandering assessment to be completed for any resident that had any history of wandering or displayed wandering behavior. DSD stated the nurse doing the assessment was to report to DSD, Director of Nursing (DON), and SSD when a resident had been identified as a wandering risk so they could follow through with an order for a wander guard and care plan the risk for elopement. DSD stated the expectation was for nurse who assessed the resident as a risk for elopement would make the care plan for wandering. DSD validated there was no care plan for wandering or risk for elopement developed for Resident 1 and there were no interventions listed under any of Resident 1's care plans that addressed Resident 1's risk for elopement. During an interview on 9/13/23 at 3:20 pm with LVN 2, LVN 2 stated she was not sure of the facility's protocol on elopement of a resident and had not seen the P&P Elopement of Resident . LVN 2 validated that she documented in Resident 1's nurse's notes that Resident 1 had attempted to elope from the dialysis center, updated Resident 1's elopement evaluation, and notified the Director of Nursing (DON). LVN 2 stated the DON had told her to notify Resident 1's doctor. LVN 2 stated when she notified the doctor, he wrote and order for a Wander Guard (a wearable device used to help healthcare facilities keep track of residents at risk for wandering through the doors of the facility) for Resident 1. LVN 2 stated the Wander Guard would only alert staff if the resident went through a facility door and would not work outside the SNF. LVN 2 stated she was not aware she was supposed to update the care plan when an elopement happened outside the facility. LVN 2 stated she had not followed the P&P because she had not added Resident 1 to the Wander Risk Binder, and she had not created a care plan. During a concurrent interview and record review with DON on 9/13/23, Resident 1's electronic records and the P&P Elopement of Resident was reviewed. DON stated no care plan for elopement or wandering had been made for Resident 1 and no IDT meeting was held after Resident 1's attempted elopement from the dialysis center on 8/23/23. DON stated, per the P&P, should have been put in the elopement binder. DON stated the IDT was responsible for making sure the P&Ps are followed. DON confirmed that there was no communication with the dialysis center for monitoring of Resident 1. (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 review of the facilities P&P titled Elopement of Resident dated 7/12/23, indicated, II. Policy . Residents will be evaluated for elopement risk upon admission . and with a change in condition .Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury .III. Procedure 1. Assessment/Evaluation .1.2 For Residents identified as at risk, an interdisciplinary elopement prevention person-centered care plan will be developed .1.2.2 Complete the Elopement Risk Identification for all residents at risk of elopement and place in a binder that is easily accessible to staff .