

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 01/24/2025
NAME OF PROVIDER OR SUPPLIER Kingsburg Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 three sampled residents (Resident 1) had an elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision) assessment done quarterly (every three months) as per their written policy and procedure, and failed to initiate elopement risk interventions for Resident 1 when she was assessed to have a significant increase in her elopement risk factors.</p> <p>These failures had the potential to result in Resident 1's elopement from the facility when she was found outside the facility briefly in a confused state early in the winter morning, potentially causing significant risks to Resident 1's health and safety, placing Resident 1 at risk of cold exposure, fear, dehydration and/or other medical complications, or being struck by a motor vehicle.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR) , dated 1/27/25, the AR indicated she was admitted to the facility during May 2024. Resident 1 had diagnoses that included dementia (a progressive mental disorder affecting mood, memory, and judgement).</p> <p>During a review of the facility document titled Incident: Elopement (IE) , dated 1/27/25, the IE indicated staff saw Resident 1 safely in bed at 4:40 a.m., and On the morning of 1/23/25 at approximately 4:50 am [Resident 1] was found outside of the facility on the front sidewalk. Staff completed a head-to-toe assessment and found no injury to [Resident 1]. The resident elopement assessment and care plan was updated and an order to place a [security bracelet] was obtained.</p> <p>During a review of Resident 1's Progress Notes (PN) , dated 1/23/25, at 5:05 a.m., the PN indicated, At approximately [4:50 a.m.] kitchen staff informed [Licensed Vocational Nurse, or LVN 1] that resident [1] was found outside in the facility parking lot. Staff stated that resident was with a gentleman that was calling 911. Police not involved once staff proceeded to inform gentleman that resident belonged inside facility. Resident [1] was brought into facility and insisted to try to go outside. Resident was observed during shift trying to go into different rooms and seeking exits. Informed [Resident 1's physician] and gave order to place [security bracelet].</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 0689</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 Sheet (MDS, a comprehensive, standardized assessment tool) , dated 11/7/24, the MDS indicated at Question C0500 a score of 8 out of a possible 15, which indicated Resident 1's cognition (having sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the resident's environment) was moderately impaired.</p> <p>During a review of Resident 1's Order Summary Report (OSR) , dated 1/23/25, the OSR indicated Resident 1 had a physician's order for [Security Bracelet]/Wander Elopement Device due to poor safety awareness[.]</p> <p>During a review of Resident 1's Elopement Evaluation (EE) , dated 5/30/24, the EE indicated Resident 1 was able to ambulate or self-propel wheelchair independently and had expressed a desire to leave [the facility]: e. g., go home, talked about going on a trip, attempted to pack belongings[.] and Resident [1] desire to leave[.]</p> <p>During a review of Resident 1's EE , dated 7/29/24, the EE indicated Resident 1 continued to be able to ambulate or self-propel wheelchair independently and had again expressed a desire to leave [the facility]: e.g. , go home, talked about going on a trip, attempted to pack belongings[.] The EE dated 7/29/24 also indicated Resident 1 had additional risk factors identified, including has a history of actual elopement or attempted elopement[.] has a history of wandering that places the [resident] at significant risk of getting to a potentially dangerous place, e.g., stairs, outside facility[.] has a history of wandering that significantly intrudes on the privacy and/or activity of others[.] [was] unable to locate significant landmarks without assistance, e.g., bathroom, dining room, patient room[.] exhibits attempts to maintain daily routines and leisure interests not consistent with their new environment routines that may result in exit-seeking behavior[.]</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Elopement of Resident , dated 7/12/23, the P&P indicated, Residents will be evaluated for elopement risk upon admission, re-admission, quarterly [every three months] and with a change of condition as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. For residents identified at risk, an interdisciplinary elopement prevention person-centered care plan will be developed.</p> <p>During an interview on 1/24/25, at 1:50 p.m., with the Director of Nursing (DON), the DON stated, [Resident 1] had not ever attempted to elope from the facility before. She didn't have a [security bracelet on, but we have a [security bracelet] on [Resident 1] now. The DON stated Resident 1 was alert to person only [but did not normally know where she was or what the time and date was] and has forgetfulness.</p> <p>During an observation on 1/24/25, at 1:55 p.m., Resident 1 was observed sitting in a wheelchair near the nursing station, with a security bracelet on her left ankle.</p> <p>During an interview on 1/24/25, at 2 p.m., with the Administrator, the Administrator stated the facility just started using a security bracelet with Resident 1.</p> <p>During an interview on 1/24/25, at 2:30 p.m., with the Administrator, the Administrator stated it was determined Resident 1 did not have a security bracelet on when she eloped from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/30/25, at 10:22 a.m., with LVN 1, LVN 1 stated she was Resident 1's nurse during the night shift ending on the morning of 1/23/25. LVN 1 stated she was giving medications to Resident 1's roommate at about 4:40 a.m. and noted Resident 1 to be asleep in her bed at that time. LVN 1 stated prior to that, Resident 1 was confused, and had been up all night that night, up in her wheelchair, at the nurses' station, talking to me about her husband and taxes. She was trying to go into other resident rooms, we had to redirect her from going into other's rooms. But I've never seen her try to elope before. LVN 1 stated at approximately 4:50 a.m., a kitchen staff person told her Resident 1 was outside the facility and brought her back inside. LVN 1 stated Resident 1 was wearing a shirt and pajama pants. LVN 1 stated, She was in bed just a few minutes [prior to this. Resident 1] can self-transfer [from bed to wheelchair], she is pretty quick in her wheelchair. LVN 1 stated when Resident 1 was returned to the facility, she was confused. Every time I asked her where she was going, she had a different answer.</p> <p>During a concurrent interview and record review, on 2/4/25, at 11:55 a.m., with the Minimum Data Set Nurse (MDS-N), Resident 1's clinical record was reviewed. The MDS-N stated that Elopement Assessments (EE) are normally done prior to the completion of an MDS, which are conducted no less frequently than quarterly. The MDS-N stated she did not see a quarterly EE performed for Resident 1 for the Quarterly MDS completed on 11/7/24, as required by the facility's P&P titled Elopement of Resident . The MDS-N stated, I do not see one.</p> <p>During a concurrent interview and record review, on 2/4/25, at 12:57 p.m., with the DON, Resident 1's clinical record was reviewed. The DON stated Resident 1's Care Plan regarding her Risk for Elopement was created on 1/23/25. The DON stated she herself initiated this Care Plan and the interventions. The Care Plan Interventions included, Utilize and monitor security bracelet per protocol. The DON stated this Care Plan dated 1/23/25 was the first Care Plan in Resident 1's clinical record regarding her elopement risks.</p> <p>The DON stated Resident 1's EE dated 7/29/24 indicated a significant increase in elopement risk factors over the EE dated 5/30/24. The DON stated she did not consider Resident 1's 7/29/24 EE to be inaccurate but could not find any corroborating evidence elsewhere in the clinical record. The DON stated there should have been another EE done in November 2024, to coincide with the MDS dated [DATE], and could not find one. The DON stated an Elopement Risk Care Plan and corresponding interventions to reduce the risk of Resident 1's elopement risks should have been further evaluated in July 2024, in response to the EE dated 7/29/24.</p> <p>During a review of the facility's Policy and Procedure, dated 12/12/24, titled Tab Alarms, Bed Alarms, [Security Bracelet] System (P&P) , the P&P indicated, [Security Bracelet] would be used for residents at risk for elopement. The [Security] bracelet will be applied to the resident's wrist or ankle and not removed until replacement is needed.</p> <p>During a review of the National Weather Service website (NWS) Climatological Data for the facility's area, dated 1/23/25, the NWS indicated the area had an overnight low temperature of 36 degrees Fahrenheit.</p>		