STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055662	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Society San Joaquin County	930 West Main Street Ripon, CA 95366

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to revise a comprehensive elopement (leaving a designated area, often a place of supervision or care, without permission) risk care plan (a guide that healthcare workers used to ensure Resident 1 received tailored care to his/her individual needs and goals) for one of two residents at risk for elopement (Resident 1), when Resident 1 was seen by facility staff sitting outside of the building unattended.This failure placed Resident 1 at risk for elopement and injury. Findings:During a review of Resident 1's clinical record titled, admission RECORD, (a document that contained the resident's demographic information) indicated Resident 1 was admitted to the facility with a diagnoses that included Dementia (a condition which caused a decline in memory, reasoning, and other thinking skills), tremors (shaking), dizziness, and hypertension (high blood pressure - the force of blood pushing against the artery walls).A review of Resident 1's clinical record titled, BRIEF INTERVIEW FOR MENTAL STATUS, (BIMS - a screening tool used to measure short term memory and orientation) dated 5/6/25, indicated Resident 1 had a BIMS score of 99 (99 is scored when the resident was unable to complete the interview).During a concurrent interview and record review on 7/17/25 at 3:03 p.m. with the Assistant Director of Nursing (ADON), Resident 1's clinical record titled, Progress Notes, dated 5/27/25, was reviewed. The progress note indicated Resident 1 was found outside of the facility building by the therapy office. The ADON stated Resident 1 was not supposed to be in the therapy rooms unattended and could have potentially wandered further away from the facility.During an interview with LN 2 on 7/17/25, at 2:42 p.m., LN 2 stated when Resident 1 eloped he was at risk of injury, such as being hit by a car, and/or getting lost. During a concurrent interview and record review on 7/17/25 at 4:05 p.m. with the Administrator (ADM), Resident 1's care plan titled, I AM AN ELOPEMENT RISK, revised on 8/20/24, was reviewed. The care plan indicated a goal was to maintain safety through the review date. The ADM stated the care plan was not revised after Resident 1 eloped and it was her expectation that care plans should have been revised after any assessment or change of condition. The ADM further stated the care plan should have accurately reflected interventions in place that maintained Resident 1's safety, and that the effectiveness of the interventions was monitored.A review of the facility's policy and procedure titled, Care Plan Policy and Procedure, dated 11/28/16, indicated, .New or additional problems, goals and approach will be added to the care plan by the appropriate discipline as they arise.Care planned long term problems will be evaluated for appropriateness.Each care plan will be reviewed quarterly at the interdisciplinary team (IDT) meeting and at the time of a change in condition.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055662	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, interview, and record review, the facility failed to ensure adequate supervision for one of two sampled residents (Resident 1), at risk for elopement (leaving a designated area, often a place of supervision or care, without permission), when Resident 1 was found outside of the physical therapy office back door on 5/27/25 at approximately 5:00 p.m.This failure placed Resident 1 at risk of serious injury and harm.Findings:During a review of Resident 1's clinical record titled, admission RECORD, (a document that contained the resident's demographic information) indicated Resident 1 was admitted to the facility with a diagnoses that included Dementia (a condition which caused a decline in memory, reasoning, and other thinking skills), tremor (shaking), dizziness, and hypertension (high blood pressure- the force of blood pushing against the artery walls).A review of Resident 1's clinical record titled, Progress Notes, dated 5/27/25 at 10:37 p.m., written by the Licensed Nurse (LN) 1, indicated at approximately 5:00 p.m., Resident 1 was found outside by the physical therapy door by an activities team member.A review of Resident 1's clinical record titled, BRIEF INTERVIEW FOR MENTAL STATUS, (BIMS - a screening tool used to measure short term memory and orientation) dated 5/6/25, indicated Resident 1 had a BIMS score of 99 (99 was scored when the resident was unable to complete the interview).A review of Resident 1's care plan (a document that contained the resident's individualized problems, goals, and interventions) titled, I AM AN ELOPEMENT RISK, dated 8/20/24, indicated Resident 1's goal was to maintain safety through review date. During an interview with LN 2 on 7/17/25, at 2:42 p.m., LN 2 stated when Resident 1 eloped he was at risk of injury, such as being hit by a car, and/or getting lost.During an interview with the Assistant Director of Nursing (ADON) on 7/17/25, at 3:03 p.m., the ADON stated the physical therapy office back door did not have an alarm to alert staff when Resident 1 was found outside. The ADON further stated Resident 1 was not supposed to be in those rooms unattended and that therapy staff were responsible for the therapy room doors to be locked when not in use.During an interview with the Administrator (ADM) on 7/17/25, at 4:05 p.m. , the ADM stated someone from the physical therapy department left the room unlocked, and it was her expectation that the physical therapy room was locked when not in use. The ADM further stated Resident 1 was a safety risk if left unattended because he could wander further away, get lost, or injured.A review of the facility's policy and procedure (P&P) titled, Resident Rights Policy and Procedure, dated November 28, 2016, was reviewed. The P&P indicated, .The resident has a right to a safe, clean, and comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety.