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	04/15/2026

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure two of three residents (Resident 5 and Resident 8) were provided with a safe environment when:1. Resident 5 eloped (a resident leaving the premises or a secure area without authorization, supervision, or the knowledge of the staff) from the facility2. The C Hall exit door did not have an alarm activated during the day3. Resident 5 and Resident 8's [Brand Name] elopement bracelets (bracelet that can be placed on a resident and sets off a door alarm when the resident tries to exit through the door) were not checked at least daily for placement and function and not all exit doors at the facility were alarmed. These failures resulted in Resident 5 leaving the facility unsupervised and had the potential for Resident 8 to leave the facility unsupervised, with the potential for both Resident 5 and Resident 8 to experience getting lost and sustaining injuries, which had the potential to negatively affect their health, well-being, and psychosocial well-being.Findings:1. A review of Resident 5's clinical document titled, admission RECORD, date printed 4/15/26, indicated Resident 5 was admitted to the facility with diagnoses which included difficulty walking, mild cognitive impairment (a condition where individuals experience noticeable memory or thinking problems greater than typical for their age), and bilateral macular degeneration (an eye disease that can cause partial blindness).A review of Resident 5's clinical document titled, MDS Section E - Behavior . Section E0900 [Minimum Data Set Section E0900 - is a standardized assessment item that documents the presence and frequency of a nursing home resident wandering within the last 7 days], dated 10/21/25, indicated, . Wandering - Presence & [and] Frequency . Behavior of this type occurred 4- [to] 6 days .A review of Resident 5's clinical document titled, MDS Section E - Behavior . Section E0900, dated 1/7/26, indicated, . Wandering - Presence & Frequency . Behavior of this type occurred 4-6 days .A review of Resident 5's clinical document titled, MDS Section E - Behavior . Section E0900, dated 4/7/26, indicated, .Wandering - Presence & Frequency . Behavior of this type occurred 4-6 days .A review of Resident 5's clinical document titled, Care Plan Report [a written document that outlines a person's health needs, goals for treatment, and the specific actions healthcare providers will take to support them], dated 4/21/26, indicated, . Problem . I [Resident 5] am an elopement risk r/t [related to] frequent exit seeking with verbalizations of wanting to leave facility unattended, and impaired safety awareness . Date initiated 10/08/2025 . Goal . I will have reduced risk of leaving the facility unattended through the review date . Date Initiated 10/08/2025 . Interventions . Assess for fall risk . Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . WANDER ALERT . I have [Brand Name elopement] bracelet on right ankle .During an interview on 4/30/26 at 11:23 AM with the Director of Nursing (DON), the DON stated the facility did not only have elopement assessments for the residents. The DON explained residents at risk for elopement have the information in their care plans.During an interview on 4/30/26 at 8:34 AM, with the Dietary Aide/Cook (DA/Cook), the DA/Cook stated when she saw Resident 5, Resident 5 was in Independent Living Facility (a lifestyle that allows individuals to live on their own terms, maintaining personal autonomy and self-determination) not the Skilled Nursing Facility (SNF - a licensed, 24-hour medical (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility that provides short-term rehabilitation or intensive nursing care for patients transitioning from the hospital to home). The DA/Cook explained Resident 5 was in the dining room of Independent Living Facility when she was approached by Resident 5. The DA/Cook Further explained Resident 5 requested help opening the front door because her daughter was going to pick her up, and the DA/Cook stated she opened the front door of the Independent Living Facility for Resident 5 and Resident 5 went outside.During an interview on 4/30/26 at 8:40 AM, with the DON, the DON stated neither her nor the nursing staff knew how long Resident 5 was in the Independent Living Facility before she approached the DA/Cook.During an interview on 4/30/26 at 8:43 AM with the DA/Cook, the DA/Cook stated she was told Resident 5 had been in line for Sunday church, went out of the line, and wandered to the Independent Living Facility. The DA/Cook explained from the SNF, Resident 5 would have had to exit C Hall and gone up the ramp into the Independent Living Facility.A record review of an e-mail sent on 4/30/26 at 10:33 AM, by the facility ADM to the Department, indicated Resident 5 went with residents from the SNF church services back to the Independent Living Facility around 10:45 AM on 3/15/26. The ADM's e-mail further explained residents started lining up for church services at 10 AM, which indicated Resident 5 could have been missing from 15 minutes to 1 hour.2. A review of the facility provided facility map indicated the C Hall exit had an alarm equipped.During an interview on 4/30/26 at 8:19 AM with the Administrator (ADM), the ADM stated all doors in the facility were equipped with alarms and the alarms were activated when opened. The ADM explained the alarm on the C Hall door was only turned on at night and off during the day, and all other alarms were on 24 hours a day, 7 days a week. The ADM further explained the entrance to the facility was the only door that had the [Brand Name] elopement alarm (the entrance door alarms only activated when a resident who was wearing the [Namee Brand] elopement bracelet passed through the doors).During an interview on 4/30/26 at 8:25 AM with the Director of Nursing (DON), the DON stated that her expectation for facility staff, if they witnessed a resident attempting to elope, was to immediately intervene, redirect the resident, and keep the resident safe by not allowing them to leave the facility. The DON explained that the risk to the residents was that they could elope, and the facility would not know if they were safe. Furthermore, the DON explained that the main concern was a loss of safety for the residents and not having anyone present to ensure their safety, placing the residents at risk of injury.3a. A review of Resident 5's clinical document titled, admission RECORD, date printed 4/15/26, indicated Resident 5 was admitted to the facility with diagnoses which included difficulty walking, mild cognitive impairment and bilateral macular degeneration.A review of Resident 5's clinical document titled, Progress Notes, dated 3/19/26, indicated, . On 3/15/26 approximately at 1100 [11 AM] resident [Resident 5] was found outside the facility in the parking lot by the maintenance office. Resident was spotted by the activity staff through the East dining room window . Per activity staff, resident was noted in the parking lot wheeling herself. Upon noticing the resident, activity staff rushed immediately outside and brought the resident back inside and notified the charge nurse. When asked about the incident, shestated [sic] to the nurse that she wheeled herself through the double doors leading into the breezeway between SNF [skilled nursing facility] and the [independent living facility] and asked dietary staff to help her make her way into the [independent living facility] because her daughter was waiting for her. Resident stated that the dietary staff pushed her through the second set of double doors into the [independent living facility] .During an interview on 4/15/26 at 10:37 AM with the Activities Aide (AA) 1, AA 1 stated he saw Resident 5 in the back parking lot on 3/15/26 at approximately 11 AM and went to get her. AA 1 explained once Resident 5 was back in the facility he informed his charge nurse of the incident.During a concurrent observation and interview on 4/15/26 at 11:29 AM with Resident 5, Resident 5 stated she left the facility one time (3/15/26). Resident 5 explained she was too scared to leave the facility by herself anymore and preferred if staff were with her. Resident 5's [Brand Name] elopement bracelet was noted to be on her right ankle.A review of Resident 5's clinical documents titled, Medication Administration Record [MAR - a document that contains the resident's ordered and administered (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications], dated 3/1/26 through 3/31/26, and Treatment Administration Record [TAR] - a document that contains the resident's ordered and administered treatments], dated 3/1/26 through 3/31/26, did not indicate daily checks for placement and functioning of Resident 5's [Brand Name] elopement bracelet.3b. A review of Resident 8's clinical document titled, admission RECORD, date printed 4//17/26, indicated Resident 8 was admitted to the facility with diagnoses which included dementia (a decline in brain function that interferes with daily life, usually caused by progressive, irreversible brain damage) and osteoporosis (a common bone disease making bones thin, brittle, and highly prone to fractures).A review of Resident 8's clinical document titled, MDS Section E - Behavior . Section E0900, dated 12/27/21, indicated, .Wandering - Presence & Frequency . Behavior of this type occurred 1-3 days .A review of Resident 8's clinical document titled, MDS Section E - Behavior . Section E0900, dated 12/9/25, indicated, .Wandering - Presence & Frequency . Behavior of this type occurred 1-3 days .A review of Resident 8's clinical document titled, MDS Section E - Behavior . Section E0900, dated 3/10/26, indicated, .Wandering - Presence & Frequency . Behavior of this type occurred 1-3 days .A review of Resident 8's clinical document titled, Care Plan Report, dated 4/14/26, indicated, . Problem . I AM AN ELOPEMENT RISK R/T [related to] MY WANDERING BEHAVIOR . I HAVE A WONDER ALARM ON MY W/C [wheelchair] . Date Initiated: 04/27/2023 . Goal . I will not leave facility unattended . Interventions . Assess for fall risk . Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation . Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate . [Brand Name elopement bracelet] .A review of Resident 8's clinical documents titled, Medication Administration Record [MAR], dated 3/1/26 through 3/31/26, and Treatment Administration Record [TAR], dated 3/1/26 through 3/31/26, did not indicate daily checks for placement and functioning of Resident 8's [Brand Name] elopement bracelet.During an interview on 4/17/26 at 12:07 PM with Licensed Nurse (LN) 5, LN 5 stated she had not documented the placement or function of the [[NAME] Name] elopement bracelets in the past.During an interview on 4/17/26 at 12:20 PM with LN 6, LN 6 stated visual checks and daily documentation were supposed to be done on residents with [Brand Name] elopement bracelet devices.During a joint interview on 4/28/26 at 2:25 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), the DON confirmed Resident 5 existed the facility with the assistance of kitchen staff. The ADON stated the exit door Resident 5 left the facility through only had the alarms activated at night, not during the day, so when Resident 5 was assisted by kitchen staff, the alarm was not activated. The DON confirmed there was no daily documentation in place for placement and functioning of Resident 5 and Resident 8's [Brand Name] elopement bracelets. The ADON stated the importance of having daily checks for placement and functioning of the [Brand Name] elopement bracelets were to prevent elopement and ensure resident safety. The ADON explained not having daily checks in place for placement and functioning of the [Brand Name] elopement bracelets placed Resident 5 and Resident 8 at risk of going outside unsupervised where an injury could occur.A review of the facility policy titled, [Brand Name Elopement Device] Policy, dated 3/13, indicated, POLICY: To alert staff of a potential elopement and provide a safe environment for residents . PURPOSE: . Any resident who has demonstrated a behavior of wandering without desire to elope purposefully may use a [brand name elopement device] . The [brand name elopement device] alarm is placed on wheel chair or walker and the alarm will sound if resident is within five feet of the front door, allowing staff to re-direct resident .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review the facility failed to ensure one of three sampled residents' (Resident 1) drug regimen (a structured, prescribed plan for taking medication) was appropriately followed when Resident 1's prescribed narcotic pain medication (a strong, addictive, a regulated pain medication) that was prescribed for moderate to severe pain every six hours, was given without assessing Resident 1's pain level (the numerical pain scale 0 through 10; 0 indicates no pain,1 through 3 indicates mild pain; 4 through 6 indicates moderate pain; 7 through 10 indicates severe pain).This failure had the potential to result in Resident 1 being over-medicated and placed Resident 1 at risk for falls, negatively affecting Resident 1's health and well-being. Findings:A review of Resident 1's clinical document titled, admission RECORD, date printed 4/15/26, indicated Resident 1 was admitted to the facility with diagnoses which included dementia (a decline in brain function that interferes with daily life, usually caused by progressive, irreversible brain damage) and osteoporosis (a common bone disease making bones thin, brittle, and highly prone to fractures).A review of Resident 1's clinical document titled, Medication Administration Record [MAR-a document that contains the resident's orders and administered medications], dated 3/1/26 through 3/31/26, indicated, .HYDROcodone-Acetaminophen Oral Tablet 5-325 MG [milligrams - a unit of measurement] . Give 1 tablet by mouth every 6 hours for mod [moderate pain]- [to] severe pain . Start Date . 3/16/26 . D/C [discontinue] Date 3/23/26 . The above medication was administered every 6 hours for the duration of the order without documenting Resident 1's pain level.-3/16/26 at 6 PM-3/17/26 at 12 AM, 6 AM, 12 PM, 6 PM-3/18/26 at 12 AM, 6 AM, 12 PM, 6 PM-3/19/26 at 12 AM, 6 AM, 12 PM, 6 PM-3/20/26 at 12 AM, 6 AM, 12 PM, 6 PM-3/21/26 at 12 AM, 6 AM, 12 PM, 6 PM-3/22/26 at 12 AM, 6 AM, 12 PM, 6 PM-3/23/26 at 12 AM, 6 AM, 12 PM, 6 PMA review of Resident 1's MAR, dated 3/1/26 through 3/31/26, indicated, Pain Assessment every shift-rate on scale of 0- [through] 10, document location & [and] character of pain every 8 hours for pain screening . Start Date . 3/20/23 . D/C date 4/10/26 . From 3/16/26 to 3/24/26 there was one instance where Resident 1 had documented pain greater than 0, it was on 3/19/26 at 6 AM with a pain score of 3 (mild pain).During an interview on 4/29/26 at 1:34 PM with the Director of Nursing (DON), the DON stated a pain level of 0 through 3 indicated mild pain, 4 through 6 indicated moderate pain, and 7 through 10 indicated severe pain.During a concurrent interview and record review on 4/15/26 at 11:39 AM, with Licensed Nurse (LN) 1, Resident 1's MAR, dated 3/1/26 through 3/31/26 was reviewed. LN 1 confirmed Resident 1's pain level was not documented on the MAR and there was not a place to document on the MAR the resident's pain level score. LN 1 explained that Resident 1's pain level should have been assessed and documented prior to administering pain medication.During a concurrent interview and record review on 4/15/26 at 1:17 PM with the Assistant Director of Nursing (ADON), Resident 1's MAR, dated 3/1/26 through 3/31/26 was reviewed. The ADON stated before administering HYDROcodone medication, Resident 1's pain level should have been assessed. The ADON explained Resident 1 had a routine order for HYDROcodone and a pain assessment was needed prior to medication administration. The ADON further explained the indications for administration for the HYDROcodone was for moderate to severe pain and there should have been an assessment of Resident 1's pain level, and there was not. The ADON explained there was a risk of over medicating Resident 1 and an increased risk for falls.During a concurrent interview and record review on 4/15/26 at 3:34 PM, with the Director of Nursing (DON), Resident 1's MAR, dated 3/1/26 through 3/31/26 was reviewed. The DON stated Resident 1's pain level should have been assessed prior to administering the HYDROcodone. The DON explained the importance of knowing the pain level was to ensure pain medication was not administered if the resident was not experiencing pain.A review of the facility policy titled, Pain Management/Assessment Policy, dated 12/9/16, indicated, . Pain will be assessed Q [every] shift and any time that vital signs are taken . A review of the facility policy titled, MEDICATION ADMINISTRATION, dated 3/15, indicated, . Medications and treatment shall be administered as (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed . Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to maintain complete and accurate records for one of two sampled residents (Resident 1) when Resident 1's document titled, Weekly Summary, (a weekly review of the resident's condition) for the week ending in 3/25/226, did not reflect Residents 1's current health status.This failure resulted in an inaccurate representation of Resident 1's current health status and had the potential to negatively impact Resident 1's health regarding wounds and pain management. Findings:A review of Resident 1's clinical document titled, admission RECORD, date printed 4/15/26, indicated Resident 1 was admitted to the facility with diagnoses which included dementia (a decline in brain function that interferes with daily life, usually caused by progressive, irreversible brain damage) and osteoporosis (a common bone disease making bones thin, brittle, and highly prone to fractures).A review of Resident 1's clinical document titled, Weekly Summary, dated 3/25/26, indicated, A. Skin Assessment . No wounds currently . Site . buttock . Type . MASD [Moisture-Associated Skin Damage, inflammation and erosion (a condition where the skin becomes red, swollen, and warm, followed by the breaking down or scraping away of its top layer of skin)] . Current treatment & [and] summary of effectiveness . [no response in box provided] . C. Pain Management . No Pain . Number of episodes of PRN [as needed] used in last 7 days [referring to pain medication] . none . Indicate type: (Pain Type-chronic, sharp, dull, etc.) (Medication Used) [no response in box provided] . A review of Resident 1's clinical document titled, Progress Notes, dated 3/21/26 indicated, . resident noted to have a MASD related fissure [a linear, superficial skin break or split that occurs within areas of MASD] to upper gluteal cleft [upper portion where buttocks separate]. the [sic] fissure measures 5x [by] 2cm [centimeters (cm, a unit of measurement)]. no s/sx [signs or symptoms] of infection noted. resident is incontinent [involuntary leakage of urine and stool] of bowel and bladder which increases the risk for skin damage. [Physician] made aware, and order received for Triad [topical medication to protect the skin] every shift .A review of Resident 1's clinical document titled, Progress Notes, dated 3/22/26, indicated, .Call out to MD [Medical Director] to change [HYDROcodone-Acetaminophen [Oral Tablet 5/325 MG prescribed narcotic (a strong, addictive, semisynthetic opioid pain medication used to treat moderate-to-severe pain)] pain medication tablet to liquid due to inadequate pain control. Resident noted to vocalized mild to moderate pain when touched or moved. Resident is refusing meds or having a difficult time taking crushed meds .A review of Resident 1's clinical document titled, Progress Notes, dated 3/23/26, indicated, . MD . called back with new orders for Morphine sulfate [a strong, addictive, opioid pain medication used to treat moderate-to-severe pain] oral solution .A review of Resident 1's clinical document titled, Medication Administration Record [MAR, a document that contains the resident's ordered and administrated medications], dated 3/1/26 through 3/31/26, indicated, . HYDROcodone-Acetaminophen Oral Tablet 5/325 MG . give every 6 hours . Start Date . 3/16/26 . Resident 1 received the medication every six hours from 3/16/26 at 6 PM through 3/23/26 at 6 PM for pain control for a total of 23 doses.A review of Resident 1's clinical document titled, Medication Administration Record, dated 3/1/26 through 3/31/26, indicated, Morphine Sulfate . every 4 hours as needed for Generalize pain and discomfort . Start date . 3/23/26 . Resident 1 received a dose of Morphine Sulfate on 3/24/26 at 10 AM and another dose on 3/25/25 at 9:45 AM.During a concurrent interview and record review with Licensed Nurse (LN) 1 on 4/15/26 at 11:39 AM, Resident 1's clinical document titled, Weekly Summary, for the week ending in 3/25/26 was reviewed. LN 1 confirmed she had not documented any wounds for Resident 1 in Resident 1's Weekly Summary, for the week ending 3/25/26, and she should have. LN 1 further confirmed she had not documented the new pain medication orders for hydrocodone and morphine or the new order for Triad cream in the Weekly Summary, and she should have. LN 1 further confirmed she should have documented when Resident 1 was experiencing pain. LN 1 explained the purpose of the Weekly Summary was to note any changes (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that occurred in the week prior, indicate new treatments and medications and document any changes in Resident 1's physical and mental condition. LN 1 further explained the risk to Resident 1 when the treatment and health changes were not documented in the Weekly Summary was the resident's health could have gotten worse due to poor communication and action between healthcare providers.During a concurrent interview and record review on 4/15/26 at 1:17 PM with the Assistant Director of Nursing (ADON), Resident 1's Weekly Summary, for the week ending in 3/25/26 was reviewed. The ADON stated the expectation was for the nursing staff to document skin issues and document new treatments and medications in the Weekly Summary. The ADON confirmed Resident 1'sWeekly Summary, dated 3/25/26 did not reflect these changes. The ADON stated the risk to Resident 1 was the MASD with a fissure could have gotten worse.During a concurrent interview and record review on 4/15/26 at 3:34 PM with the Director of Nursing (DON), Resident 1's clinical document titled, Weekly Summary, dated 3/25/26 was reviewed. The DON stated the LNs should have completed Resident 1's Weekly Summary after they retrieved the resident's vital signs (heart rate and respiration rate per minute, blood pressure, oxygen saturation percentage, and pain level) taken by the certified nursing assistants, reviewed the physician's orders, and documented any new orders in the Weekly Summary. The DON explained the LNs should have assessed Resident 1's skin to ensure there were not any new wounds. The DON confirmed Resident 1's Weekly Summary, dated 3/25/26 should have reflected Resident 1's new pain medication orders, new wounds and the size of the wound.A review of the facility policy titled, SKIN ASSESMENT AND TREATMENT, dated 11/14, indicated, .The licensed nurse is expected to be aware of any skin problem . on any of her residents. The licensed nurse is expected to observe, report and document any changed [sic] in these areas to the physician .A review of the facility policy titled, Pain Management/Assessment Policy, dated 12/9/16, indicated, . A review of the pain and medication used for the pain is done weekly on the weekly summary .