STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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 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** 47254 Based on interview and record review, the facility failed to provide adequate supervision and an accident-free environment for one of two sampled residents (Resident 1), when Resident 1 eloped (a resident who departs from a facility unsupervised and undetected) on 3/10/25 from the facility through the front entrance door and was found on 3/14/25 when resident returned back to her apartment. This failure resulted in Resident 1 eloping from the facility on 3/10/25, which placed Resident 1 at risk for harm, injury and/or death. Findings: During a review of Resident 1's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis history that includes but not limited to epilepsy (A disorder in which nerve cell activity in the brain is disturbed, causing seizures), cerebral ischemia (a condition in which there is insufficient blood flow to the brain), atelectasis (partial or complete collapse of the lung.), urinary tract infection (an infection in any part of the urinary system), syncope and collapse (a loss of consciousness), and unspecified convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders such as epilepsy). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 11 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating moderate cognitive impairment. During a review of Resident 1's Admission Initial Eval -Elopement Risk, dated 3/7/2025, the Elopement Risk, indicated, .a score of 6 was obtained and Risk Determination indicates if total score is 10 or greater, resident is considered an Elopement 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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25, at 3:15 p.m., with the Administrator (ADM), the ADM stated on 3/10/25 he was notified that resident eloped from the facility at approximately 4:30. from the facility. A Code GREEN (Elopement Code notifying staff of a missing resident) was called by the floor nurse and staff conducted a search of the premises and surrounding areas. Resident 1 was not located. On 3/11/25 the local police department was notified and assisted with search of surrounding area, as well as Resident 1's last known residence. During a review of Resident 1's Progress Note, dated 3/11/25 at 3:38, Resident 1's IDT Review - (Interdisciplinary Team-group of health professionals that address the care of a resident) indicated .Resident was noted to be in her room at [4:10 pm] on 3/10/25 speaking to . visitors in her room at bedside. Resident was no longer observed by facility staff in her room around [4:40 pm]. Charge nurse notified and charge nurse initiated a Code GREEN. A sweep of the facility grounds was completed inside and outside premises by staff/managers. [Inter disciplinary team] visitors .in which they stated resident did not leave with them. Emergency contact, Medical Doctor, . Police Department and Adult Protective Services were notified . During an interview on 3/11/25 at 3:42 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had just been admitted . CNA 1 stated on 3/10/25, the day of the elopement, she was assigned to Resident 1 and had observed Resident 1 speaking with two gentlemen while in her room at approximately 4 p.m. before CNA 1. CNA 1 stated she returned from her break at approximately 4:20 p.m. at that time she noticed Resident 1 was no longer in her room visiting with her visitors. CNA 1 stated she notified her charge nurse and charge nurse initiated a Code GREEN for the eloped resident. During an interview on 3/11/25 at 4 p.m., with Resident 2, Resident 2 stated on the day of the elopement, Resident 1 was visiting with two gentleman who had brought her some personal items. Resident 2 stated Resident 1 got up with the visitors and stated she was leaving and that was the last time she saw Resident 1 in their room. Resident 2 stated CNA 1 came looking for Resident 1 and she let her know Resident 1 said she was leaving. During an interview on 3/11/25 at 4:18 p.m., with Visitor 1, Visitor 1 stated they came to visit Resident 1 on 3/10/25 to bring her some personal items. Visitor 1 stated when it was time to leave Resident 1 assumed she would be leaving with the visitors, and he let her know she was not allowed to go with them and would need to check with the facility. During an interview on 3/11/25 at 4:32 p.m., with Police Officer (FPO), FPO stated they were advised that Resident 1 was missing on 3/10/25 at approximately 4:45-. FPO stated personnel went to facility to canvass the surrounding areas but were unable to locate the resident. FPO stated Resident 1 remains missing at this time and Missing Persons unit has been notified. FPO stated they also went to last known location of residence but Resident 1 was not there. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/11/25 at 4:41 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated she was assigned to Resident 1 on 3/10/25 when Resident 1 eloped from facility. LVN 1 stated on the day of the incident, Resident 1 was seen visiting two gentlemen. Resident 1 was currently taking antibiotics for her recent urinary tract infection and was alert and oriented to person, place and time at the time during her shift. LVN 1 stated at approximately 4:30 p.m., CNA 1 notified her that Resident 1 was no longer was in her room. LVN 1 stated she followed CNA 1 back to Resident 1 room and a Code GREEN was called for the eloped resident. LVN 1 stated the inside and outside the facility was searched, the Police Department, Resident 1's MD and emergency contact was notified. LVN 1 stated an elopement is when a resident leaves the facility without permission or notification. LVN 1 stated she would consider Resident 1 potentially at risk of being injured or possibly killed. LVN 1 stated Resident 1 was not a high risk for elopement based on her recent elopement risk assessment. During an interview on 3/11/25 at 4:52 p.m., with the Director of Nurses (DON), the DON stated an elopement is when someone is off the premises unattended, and she would consider Resident 1 as an eloped resident. The DON stated Resident 1's safety and well-being were at risk. The DON stated Resident 1 was also at risk for, injury or potential death. During an interview on 3/11/25 at 5:14 p.m., with the ADM, the ADM stated Resident 1 is considered an eloped resident because she left the facility premises unsupervised without the knowledge of staff. The ADM stated facility policy indicates staff to call Code GREEN as soon as knowledge of an eloped resident is known and to begin a search of inside and outside of the facility along with proper notification of emergency contacts, MD, local law enforcement and leadership. During an interview on 3/17/25 at 10 a.m., with the Administrator in Training (AIT), the AIT stated Resident 1 was at her home address. AIT stated Resident 1's history of substance abuse did not place a resident at higher risk for elopement. During a review of the acute care hopitals Case Management Discharge Summary/Orders Report, dated 3/6/25, the Case Management Discharge Summary/Orders Report indicated, Resident 1 had a history of substance abuse and was counseled to quit using with patient voicing understanding. During an interview on 3/20/25 at 9 a.m., with the Admission Nurse (AN), the AN stated Elopement risk assessment was conducted upon admission 3/6/25 with designated elopement questions being generated by facility systems. AN stated he reviews medical history when doing elopement risk assessment but he was not aware of Resident 1's history of substance abuse as indicated in the Case Management Discharge Summary/Orders Report. AN stated prior drug abuse would not have changed the outcome or score of Resident 1's elopement risk. AN stated Resident 1 indicated she was homeless and that information did not have affect the elopement risk score. During a review of the facility policy and procedure (P&P) titled, Wandering and Elopements dated March 2019, the policy and procedure indicated, If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.If a resident is missing, initiate the elopement/missing resident emergency procedure: Determine if the resident is out on an authorized leave or pass; if the resident was not authorized to leave, initiate a search of the building(s) and premises; and if the resident is not located, notify the administrator and the director of nursing services, the residents legal representative, the attending physician, law enforcement officials and (as necessary) volunteer agencies .