

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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** Based on observation, interviews, and record review, the facility failed to ensure a safe environment and adequate supervision for one of three sampled residents (Resident 1) when Resident 1 exited the facility unsupervised through the main entrance door, where the door alarm failed to sound an audible alert and staff did not conduct the required fifteen-minute checks. This failure resulted in Resident 1 who was cognitively impaired and has insulin dependent diabetes (IDDM-a chronic condition where the pancreas makes little or no insulin, the hormone which allows sugar to enter cells to produce energy) eloping from the facility and roaming city streets for approximately three hours and eight minutes (between the hours of 3:55 p.m. and 7:03 p.m.) with ambient outdoor temperatures of 98 to 100 Fahrenheit (F-a temperature scale) placing Resident 1 at immediate risk for getting hit by a car and severe medical complications, including dehydration (a condition that occurs when your body loses more fluids that it takes in), heat exhaustion (the body's response to excessive fluid and salt loss from prolonged sweating in high temperatures), and acute blood sugar emergencies (low blood sugar). Findings: During a review of Resident 1's admission Record (AR) (document containing resident demographic information and medical diagnosis), dated 7/17/16, the AR indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included but are not limited to .Type 2 Diabetes Mellitus without Complications (chronic condition that affects the way the body processes blood sugar), Hypertensive Heart Disease (problems with your heart that can develop if you have high blood pressure) without Heart Failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), Cognitive Communication Deficit (problems with communication that happen because of trouble with thinking skills), Asthma (a chronic lung disease caused by inflammation and muscle tightening around the airways making it hard to breathe), Adjustment Disorder (an emotional or behavioral reaction to a stressful event or change in a person's life) with Mixed Anxiety and Depressed Mood (patients who suffer from both anxiety and depressive symptoms of limited and equal intensity accompanied by at least some unconscious processes). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/14/26, the MDS, indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 1 had moderate cognitive impairment.During an observation on 6/17/26 at 9:55 a.m., no alarm was triggered upon entry into the facility's main entrance (south) door. During a phone interview on 6/17/26 at 12:51 p.m. with the Good Samaritan (GS- a person who stops to help a stranger in distress without expecting a reward), the GS stated on 6/14/26 around 6-6:06 p.m. she was driving on [NAME] Ave. toward [NAME] Ave. and saw Resident 1 had fallen on the right sidewalk. The GS stated she pulled over to help Resident 1 who did not speak English, so she called a friend to help translate. The GS stated Resident 1 was sweating and had stumbled so was concerned as it was really hot outside and may have affected the resident. The GS stated Resident 1 had to hold (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: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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	onto her when she walked to her air-conditioned car as her legs gave out. The GS stated Resident 1 did not know where she was going. The GS found Resident 1's phone in her backpack and called her daughter who provided the facility's details and asked the GS to return the resident to the facility. The GS stated the facility was a 49-minute walk from her current location. The GS stated she returned Resident 1 to the facility at 7:08 p.m. During an interview on 6/17/26 at 1:28 pm with the Licensed Vocational Nurse (LVN) 1, the LVN 1 stated residents' elopement risk was assessed upon admission. LVN 1 stated if the resident was determined to be at risk for elopement or displayed exit seeking behaviors the charge nurse would notify the MD and staff would be alerted to perform frequent rounds on the resident to ensure resident's safety. The LVN 1 stated residents without exit seeking behaviors were rounded on every two hours, however, residents at risk of elopement may be checked on by staff every 15, 20 or 30 minutes depending on the resident. LVN 1 stated the facility doors were not locked so they would place alarms on the doors which may sound like a rooster or chime when someone enters or exits the door. LVN 1 stated the Certified Nurse's Aide (CNA) and licensed nurses (LN) were usually responsible for monitoring residents every 15 minutes (Q15'). LVN 1 stated when the CNA went on a break, they would hand off Q15' checks to the LN. LVN 1 stated if the LN got busy, they would delegate Q15' check to another CNA on the floor. The LVN 1 stated Resident 1 ambulated independently without a walker and would carry her backpack. LVN 1 stated Resident 1 was forgetful and a known wanderer since admission, but she was initially easily redirectable, however, the longer she stayed at the facility her wandering got worse. LVN 1 stated on 6/11/26 Resident 1 was sent to the hospital for evaluation after she had a change in behavior after she clawed at staff with her nails, increased wandering and not being easily redirected. LVN 1 stated upon return from the hospital Resident 1 was placed on visual checks Q15' without having to document the resident's location on a log. LVN 1 stated she was burdened because Resident 1 required so much oversight. During a concurrent observation and interview on 6/17/26 at 1:52 p.m. with LVN 1, staff and visitors walked through the entrance door and no alarm was heard. LVN 1 stated the alarm was not plugged into the wall socket outside of the Administrative Office door. The west door exited towards the parking lot and a rooster alert sounded when the door was opened. The north door exited towards a secure patio and a chime alert sounded when the door was opened. The east door exited towards a secured patio and did not chime when the door was opened. During an interview on 6/17/26 at 2:12 p.m. with CNA 1, CNA 1 stated a resident who wandered, checked the doors, was not content with staying still and was always on the move could be at risk for elopement. CNA 1 stated when a resident was identified at high risk for elopement, the CNAs would check on them more frequently, monitor if they walked outside or redirect the behavior such as taking them to activities. CNA 1 stated when a resident was placed on Q15's checks, the CNAs would check on the resident every 15 minutes and document the resident's location on a log and initial the entry. CNA 1 stated all nursing staff were responsible for monitoring residents on Q15' checks and could document on the Q15' log. CNA 1 stated the licensed nurses were responsible to ensure Q15' monitoring was occurring. CNA 1 stated the purpose of the log was to show where the resident went to identify behavior patterns and to ensure the resident's safety and well-being. CNA 1 stated if Q15' was not maintained, the residents could elope and be at risk of getting hit by a car. CNA 1 stated the facility had door alarms that triggered when someone opened the door. CNA 1 stated all exit doors should have an alarm. CNA 1 stated the front entrance door should have an alarm plugged into the wall socket. CNA 1 stated maintenance ensures the door alarms are in place and function. CNA 1 stated Resident 1 was nice, active and walked up and down the hall, would check here and there. CNA 1 stated prior to the elopement incident, Resident 1 was frequently monitored but was not on Q15's checks. CNA 1 stated Resident 1 was placed on Q15's checks with logging her location on the log after the elopement incident. During a concurrent observation and interview on 6/17/26 at 2:32 p.m. with the Administrator (ADM), the entrance door was observed without an alarm plugged into the wall socket outside of the AD office. The ADM stated there should be an alarm in the wall socket when the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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	facility had a resident who was at risk of elopement. The ADM stated if the facility did not have a high risk for elopement residents in the building, the facility would not maintain the front door alarm. The ADM stated all facility exit doors were equipped with a Wander Guard sensor system however the system was no longer functioning the company no longer sold the bracelets or ankle monitors. The ADM stated the facility adopted a new system by installing door sensors on each exit door that were paired to an alarm device that was plugged into a nearby wall socket. The ADM stated when the door opened, the alarm would produce a siren, rooster or chime sound. The ADM stated the exit alarms were in place one day after Resident 1 admitted and was identified at risk for elopement. The ADM stated he ensured the alarms were in place at all exit doors. During a concurrent record review and interview on 6/17/26 at 2:47 p.m. with LVN 2, Resident 1's Care Plan (CP) dated 5/11/26, 5/15/26 and 6/15/26 were reviewed. The CP dated 5/11/26 indicated Elopement Care Plan monitor location throughout the shift. Document wandering behavior and attempt diversional interventions as needed. The CP dated 5/15/26 indicated Mood Care Plan. Resident visual checks every 15 minutes. The CP dated 6/15/26 indicated Risk of injury related to impaired safety awareness, cognitive impairment and unauthorized facility exit (elopement) with subsequent unwitnessed fall while off premises. Interventions-escalate elopement interventions: engineering egress control at the front entrances (door alarm); reassess monitoring level beyond 15-minute checks, consider relocation within staff line of sight. LVN 2 stated all residents were assessed for the risk of elopement upon admission and if the residents displayed behaviors concerning elopement during their stay. LVN 2 stated if residents were identified at risk of elopement and appeared restless, the staff would offer the resident food, water or assistance to the restroom. LVN 2 stated if the resident declined food, water or assistance to the restroom, they may call the resident's family to try and redirect the resident's behavior. LVN 2 stated all staff visually check where Resident 1 was located throughout the shift but did not have to document the resident's location unless she tried to go outside. LVN 2 stated that when visual checks every 15 minutes were initiated on 5/15/26, the staff would check to see where the resident was but did not have to document the resident's location as was not on 1:1 supervision (one staff member assigned to monitor one resident). LVN 2 stated she worked and was assigned to Resident 1 on 6/14/26 the shift she eloped. LVN 2 stated Resident 1 was known to be at risk of elopement. LVN 2 stated Resident 1 ambulated independently and wanted to go home. LVN 2 stated the facility was a compact building and staff did not leave Resident 1 alone. LVN 2 stated when the door alarms ringed everyone would look to see who came into the door. LVN 2 stated if there was no alarm, therapy, admissions, the desk nurse and the ADM would monitor the door. LVN 2 stated on 6/14/26 at approximately 3:50 p.m. LVN 2 was sitting at the nursing station and made eye contact with Resident 1 who stood by the family room entrance that was next to the entrance door. LVN 2 stated she then performed finger stick blood sugar (FSBS-a test to measure the level of glucose (sugar) in your blood) checks for her assigned residents in preparation for dinner. LVN 2 stated she completed FSBS checks for her residents within 15 minutes and approximately 4:10 p.m. looked for Resident 1 to check her blood sugar but could not find her in her room, the restroom or the Dining Hall. LVN 2 asked Resident 1's CNA but the CNA had not seen the resident. LVN 2 asked the charge nurse at the nursing station to call a code 10 (used to alert staff a resident is missing and to trigger an all staff search for the resident). LVN 2 stated one nurse checked the surveillance cameras, while other staff searched each room, closet, and locked offices. LVN 2 stated the surveillance camera indicated Resident 1 went into the family room and waited for a little bit then eloped out the front door. LVN 2 stated Resident 1 was returned to the facility around 7:05 pm and was informed the resident had a fall. LVN 2 stated Resident 1 was assessed, vital signs were stable, FSBS was fine, the resident was not in any pain. LVN 2 stated Resident 1 was fed, showered, and Q15's checks with documentation log were initiated. During an interview on 6/17/26 at 4:03 pm with the admission Coordinator (AC), the AC stated he monitored the front entrance doors to ensure an exit seeking resident did not leave the building. The AC stated the team was responsible for monitoring the door, but for the most part, therapy and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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	admissions were responsible to monitor who goes in or out of the building. The AC stated he started employment on 6/1/26 and the front door alarms were not in place. The AC stated the alarms were in place about a week after he started working as the alarm would go off constantly and was annoying. The AC stated that if the entrance doors were not monitored when there was a resident at risk for elopement in the building, the resident would have an increased safety risk for successfully eloping. The AC stated would receive communication via group chat to alert staff of a high risk for elopement residents. The AC stated it was important for all staff to be aware of elopement risk residents to increase the number of eyes monitoring the residents and to ensure resident safety and well-being. The AC stated the risk of not monitoring the risk of elopement residents would increase their ability to elope. The AC stated he was not working on 6/14/26, the day Resident 1 eloped as he does not work on the weekend. The AC stated he was not aware of who would be responsible for monitoring the doors when Admissions or therapy staff were not working. During an interview on 6/17/26 at 4:30 p.m. with the Physical Therapy Assistant (PTA), the PTA stated everyone was responsible for monitoring who goes in and out of the front door. The PTA stated a door alarm would trigger when anyone went in or out of the entrance door. The PTA stated therapy staff paid more attention to the entrance door as the therapy room was next to the front door and the therapy staff were familiar with all residents. The PTA stated if a resident was observed walking out of the entrance door, the staff would follow the resident and redirect them to return to the facility. The PTA stated most therapy staff worked only on weekdays, however, a Certified Occupational Therapy Assistant (COTA) therapy staff member was routinely scheduled on weekends and worked on 6/14/26, the day Resident 1 eloped. The PTA stated Resident 1 was a very confused lady and would always try to go outside once she passed the nursing station. During an interview on 6/18/26 at 10:18 a.m. with Housekeeping (HSKP), HSKP stated she does not receive a report of residents who are at risk of elopement. The HSKP stated if she were aware of an at risk for elopement resident, she would monitor the exit doors, so the resident does not leave the building. The HSKP stated the entrance door had an alarm, the back door did not have an alarm because the area was gated and secured but did not pay much attention to either door because she was assigned to the [NAME] Hall and paid attention to the west door alarm when triggered. During an interview on 6/18/26 at 10:32 a.m. with the Certified Dietary Manager (CDM), the CDM stated when the facility identified an at risk for elopement resident it would be communicated to all staff during the morning huddle when the team reviews pertinent information for kitchen staff. The CDM stated all staff were responsible for monitoring residents at risk for elopement. The CDM stated when a door was opened, it triggered an alarm with an annoying sound so all staff would go who went out the door. The CDM stated door alarms were in place for the entrance door, north and west doors but the east door did not have an alarm as it exited to a secure area. The CDM stated door alarms were put in place when the facility had an identified at risk of elopement resident. The CDM stated that when an elopement resident walked toward the door, the staff would shadow the resident but did not hover over the resident to avoid annoying the resident. The CDM stated if the resident stepped outside, the staff would follow the resident and redirect the resident inside. The CDM stated she was not present when Resident 1 eloped on 6/14/26. The CDM stated surveillance cameras were installed in the hallways pointing toward each exit door and the ADM and Maintenance (MAIN) had access to surveillance footage. During an interview on 6/18/26 at 10:45 a.m. with the Activity Director (AD), the AD stated the DON would communicate when there was an at risk for elopement resident during huddle or morning meetings. The AD stated she was not sure who was responsible for monitoring at risk for elopement residents. The AD stated the facility doors had alarms that required bracelets but were not sure if they were being used. The AD stated staff monitored the exit doors and the facility recently implemented a doorbell system a week ago that did not require bracelets. The AD stated staff with an office near an exit door would monitor the doors as well as the CNAs. During an interview on 6/18/26 at 10:51 a.m. with the maintenance (MAIN), the MAIN stated he started working at the facility two and a half years ago and the pre-existing Wander Guard system (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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	that required a bracelet was not functioning. The MAIN stated the facility had an Elopement Binder at the nursing station that had a Face sheet of any residents at risk for eloping. The MAIN stated the desk nurse, DON or ADM would communicate to him when there was an at risk for elopement resident and he would plug an alarm into the wall socket programed for each exit door that would remain in place all day and all night until the resident was discharged or determined no longer at risk for eloping. The MAIN stated the door alarms were placed at each door even if it led to a secure area. The MAIN stated exit doors which did not lead to a secure area would trigger an obnoxious sound. The MAIN stated if the facility did not have any at risk for elopement residents, he would remove the door alarms. The MAIN stated the purpose of the door alarms was to notify those closest to the door that the door was opened so they monitor what was going on. The MAIN stated if the doors did not have an alarm, at risk for elopement residents could leave the facility. The MAIN stated he was notified of Resident 1's elopement risk on the day of admit, 5/11/26 and the door alarms were installed to all exit doors that day. The MAIN stated the door alarms should remain in place 24 hours a day seven days a week, until the resident was discharged . The MAIN stated the facility had 16 security cameras installed to monitor each hallway, front door exit to the parking lot, west door exit to the parking lot, back gate, north exit to the lawn area, the north covered patio and east exit laundry area. The MAIN stated the camera surveillance system captures those who enter and exit the building and parking lots. The MAIN stated he, Information Technology (IT), ADM, and DON had access to video footage. The MAIN stated he was not aware how long the footage was stored. During an interview on 6/18/26 at 11:39 am with the Certified Occupational Therapy Assistant (COTA), the COTA stated the facility had an Elopement Binder at the nursing station and the therapy supervisor would communicate with the staff when there was an at risk for elopement resident in the building. The COTA stated all staff would monitor the residents to make sure the residents do not attempt to go out of the facility. The COTA stated the therapy room was close to the entrance door and therapy staff would monitor who entered and exited the door, but they were not assigned to monitor the door as they were busy with treatments. The COTA stated therapy staff were aware of at-risk residents and would try to redirect the residents when they tried to go out or would alert the nurse for interventions. The COTA stated he worked on 6/14/26, the day Resident 1 eloped. The COTA stated he was the only therapy staff who worked that Sunday. The COTA stated the AC was not in the office that day so the charge nurse at the nursing station would be responsible for monitoring the facility entrance. The COTA stated the nurses monitored the doors and would manage whether the alarm was in place. The COTA stated he did not hear the entrance door alarm on 6/14/26. The COTA stated he did not witness Resident 1 elopement on 6/14/26 as he was performing bedside treatment when a CNA entered the room and asked him if he had seen Resident 1. During a concurrent record review and interview on 6/18/26 at 12:09 p.m. with Social Services (SS), the Wandering and Elopements Policy and Procedure (P&P), dated 3/2019 was reviewed. The P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The SS stated residents who wandered around would have a formal elopement risk assessment. The SS stated if a resident was determined at risk for elopement their Facesheet would be placed in the Elopement Binder at the nursing station so the staff could review which residents were at risk for elopement and required additional monitoring. The SS stated some residents would be placed on Q15' checks and the staff would keep an eye on the resident as a collective team. The SS stated she was not aware of who was responsible for ensuring Q15' monitoring was implemented. The SS stated the Q15' monitoring should be documented on the progress notes. The SS stated the staff ensure the door alarms were in place and the alarms should be in place 24 hours seven days a week whenever an at risk for elopement resident was identified. The SS stated everyone should monitor the doors for who goes in or out. The SS stated on weekends the doors were monitored by the charge nurse (aka. Desk nurse) and therapy staff if they were onsite. The SS stated it was important for the facility to prevent residents from eloping as they could be harmed, would not have access to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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	medication they needed and could fall and hurt themselves. The SS stated she was not working on 6/14/26. The SS stated the facility failed to monitor the door to prevent Resident 1 from walking out. During a phone interview on 6/18/26 at 1:39 p.m. with LVN 3, LVN 3 stated residents were assessed for elopement risk upon admission and throughout their stay at the facility. LVN 3 stated if a resident started to pack their belongings, walk towards the door, or say they wanted to go home their elopement risk would be assessed. LVN 3 stated the facility implemented elopement prevention interventions such as placing alarms on the doors which trigger a sound when the door was opened, all staff monitored the doors to see who goes in or out of building and staff would communicate using walkie talkies to communicate with other staff what the at risk residents were doing or if they needed someone else to watch an at risk resident. LVN 3 stated it was important to monitor the doors when there was an at risk for elopement residents to maintain the residents' safety. LVN 3 stated if a resident eloped, it would not be safe if the weather was hot as even health people may get dehydrated. LVN 3 stated some residents would be placed on Q15' monitoring but could not recall if Resident 1 was on Q15' monitoring prior to her elopement. LVN 3 stated after Resident 1 eloped, he printed Resident 1's Face sheet and placed it in the elopement binder to ensure all staff were ware of her elopement risk. LVN 3 stated he was not aware Resident 1 was at risk for elopement. LVN 3 stated he worked on 6/14/26, returned from lunch break at 3:54 p.m., and went to the nursing station. LVN 3 stated around 4:10-4:15 p.m. he was alerted by LVN 2 that Resident 1 was missing. LVN 3 stated LVN 2 went to check Resident 1's FSBS and could not find her. LVN 3 stated he announced to search the building and check every room. LVN 3 stated all staff searched inside of every room, closets and outside, and they realized that Resident 1 was not in the building. LVN 3 stated he sent two CNAs to look around outside, and they returned but did not find Resident 1. LVN 3 stated he notified the DON, physician (MD) and resident representative (RP) of Resident 1's elopement and the DON notified the ADM. LVN 3 stated he notified law enforcement and provided a description of Resident 1 and potential places the resident may have visited. LVN 3 stated law enforcement dispatched an officer to look for Resident 1 and provided him a case # and call back number for communication updates. LVN 3 stated around 7 p.m. someone returned Resident 1 to the facility, and he contacted the RP, law enforcement, MD, DON, supervisor and ADM to notify of Resident 1's return. LVN 3 stated he completed a head-to-toe assessment of Resident 1, checked her vital signs and FSBS, changed the resident's clothes that were wet with sweat as it was hot outside, fed her and gave her fluids. LVN3 stated the MD ordered Resident 1 to be sent to the hospital for an evaluation and treatment, however Resident 1 and her son refused. LVN 3 stated the MD was notified of Resident 1's and son's refusal for hospital evaluation, the MD ordered 72-hour monitoring of the resident for delayed injury, Q15' checks to include documentation of the resident's location on a log. LVN 3 stated everyone should have been monitoring Resident 1 and the doors for elopement. LVN 3 stated he was assigned as the desk nurse and could monitor three doors from the nursing station but was responsible for answering phone calls, and assisting whoever went to the nursing station for help. LVN 3 stated he could not recall hearing the entrance door alarm on 6/14/26 at 3:54 p.m. when he entered after his lunch break. LVN 3 stated he was unsure if the door alarm was triggered at the start of his shift at 10:30 a.m. LVN 3 stated he did not know Resident 1 was an elopement risk and was not concerned the alarm was not working as Resident 1 had not tried to elope before. LVN 3 stated Resident 1's elopement was the first incident that he was aware of. LVN 3 stated when monitoring at risk for elopement residents, the CNA was primarily responsible, then the licensed nurses secondary, followed by all staff. LVN 3 stated the facility had lapses in Resident 1's supervision, including himself. During a concurrent record review and interview on 6/18/26 at 2:09 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Skilled Nursing-admission Initial Eval - V11 Elopement Risk Score (Elopement), dated 5/11/26, Resident 1's Elopement Care Plan (CP) dated 5/11/26, Resident 1's Cognitive CP dated 5/15/26 and Resident 1's Mood CP dated 5/15/26 were reviewed. The Elopement indicated Resident 1 was considered at risk of elopement. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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	Elopement CP indicated resident was at risk for wandering and/or elopement related to cognitive impairment with suspected dementia, history of wandering, impaired judgement and decreased safety awareness with positions ALS, NALL, and SS to identify pattern of wandering and intervene as appropriate, the positions CNA, NALL and SS were to monitor Resident 1's location throughout the shift and positions ALS and NALL were to document wandering behavior and attempted diversional interventions as needed. The Cognitive CP indicated Resident 1 had moderately impaired cognition and positions SS, SSD, NALL, and CNA were to allow the resident time to adjust to surrounding and people, provide redirection as needed. The Mood CP indicated Resident 1 was at risk for altered mood and behavior as exhibited by episodes of wanting to leave facility and Nursing Services were to redirect resident to other activity and resident visual check every 15 minutes. The ADON stated all residents were assessed for their elopement risk upon admission. The ADON stated if the resident was at risk for elopement, the facility would initiate an elopement care plan, alert the CNA and LN to monitor the residents, place the resident's Face sheet in the Elopement Binder at the nursing station and monitor door alarms. The ADON stated once a high risk for elopement resident was identified, the facility would notify maintenance to install door alarms at each exit door that would be in place 24 hours a day, 7 days a week. The ADON stated all staff ensured the door alarms were in place and functioning properly. The ADON stated if a door alarm was missing or broken, the staff would report it to maintenance for replacement. The ADON stated the doors were monitored by all staff and the therapy and business office staff knew how to keep an eye on the entrance door as their offices were near that door. The ADON stated on weekends the entrance doors were monitored by all staff and staff would use radios to communicate where high risk for elopement residents was located. ADON stated all staff take the same amount of responsibility for monitoring high risk for elopement residents. The ADON stated Resident 1 was identified as high risk for elopement at the time of admission. ADON stated the CP interventions auto populated the positions indicating which staff were responsible to implement the chosen intervention. The ADON stated CNA was for the Certified Nursing Assistants, SS was for Social Services, and was unsure which staff were assigned for NALL. ADON stated the CNAs, [NAME] and SSs would be responsible for monitoring the resident's location and documenting wandering behaviors and attempted diversional interventions throughout the shift in a progress note. The ADON stated Resident 1's BIMS was 12 indicating she was moderately cognitively impaired. ADON stated as of 5/15/26, the CNA and LN were responsible for checking the resident's location and documenting their findings every 15 minutes. The ADON stated that even if all elopement prevention interventions were in place, there would be a risk of Resident 1 eloping, especially on the weekend when LNs and CNAs were busy performing patient care tasks. The ADON stated if the staff did not implement elopement prevention interventions, the resident could elope and would be at a higher risk of injury due to her low cognitive function and medical conditions would not be supervised. During an interview on 6/18/26 at 2:45 p.m. with CNA 2, CNA 2 stated that when a resident was identified as an elopement risk, their Face sheet would be placed in the Elopement Binder at the nurse's station. CNA 2 stated Resident 1's Face sheet was not in the binder prior to her elopement. CNA 2 stated if a resident's Face sheet was in the binder, the CNAs, LN, everyone in the building should keep an eye on the resident including therapy, housekeeping, maintenance, activities staff. CNA 2 stated if a resident was on Q15', staff would need to locate the resident and document their location every 15 minutes on a log. CNA 2 stated the CNA would be responsible for monitoring the resident Q15' and if the CNA had to assist another resident when the Q15' was due, the CNA would need to hand off the task to the LN or another CNA. CNA 2 stated the Q15' checks were to ensure the residents were safe and in the building. CNA 2 stated if Q15's checks were not performed in a timely manner the resident would be at risk of eloping and not being safe. CNA 2 stated the entrance door alarm would make a noise whenever someone went out. CNA 2 stated the door alarm was in place all the time. CNA 2 stated staff who were near the doors and staff at the nursing station were responsible for monitoring the doors, especially when the CNAs were busy with patient care. CNA 2 stated[TRUNCATED		