STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555186	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Square Post Acute Care	1032 N. Lincoln Street Stockton, CA 95203

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. Based on interview, and record review, the facility failed to ensure an environment free of accidents or hazards for one of two sampled residents (Resident 1) when Resident 1 exited the facility through an unlocked door on 3/22/25 and was missing from the facility for one and one-half hours before staff became aware. This failure resulted in Resident 1 falling out of her wheelchair sustaining injuries that included bruises (contusion, ecchymosis; skin discoloration from damaged, leaking blood vessels under the skin) and a facial laceration (cut) that required sutures (stitches). This failure had the potential to result in Resident 1 sustaining life-threatening injuries. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2022 with diagnoses which included diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic kidney disease (progressive damage and loss of function in the kidneys), and spinal stenosis (spinal stenosis happens when the space inside the backbone is too small, this can put pressure on the spinal cord and nerves that travel through the spine). A review of Resident 1's Minimum Data Set, (MDS, a comprehensive care assessment tool) dated 3/24/25, indicated, .Brief Interview for Mental Status Score: 06 [BIMS, a tool to assess cognition. The total possible BIMS score ranges from 00 to 15. 13 - 15: cognitively intact; 08 - 12: moderately impaired; 00 - 07: severe impairment] . A review of Resident 1's Elopement [a resident who is incapable of adequately protecting himself or herself departs the healthcare facility unsupervised and undetected]/Wandering [a resident who roams around and becomes lost or confused about their location] Risk Assessment, dated 12/24/24, indicated, .Instructions . select most appropriate answer .the number next to your selection is the score .add all scores at the end of your assessment to determine if resident is at risk for elopement. A score of 9 or higher indicates a risk for elopement .Mental Status .1. Intermittent Confusion .Usual emotional behavior .0. Complacent .Ambulation . 3. Ambulatory with assistance (including ability to self propel in w/c [wheelchair]) .Mobility .3. Slightly Impaired .Medications .0. No significant change .Elopement risk .0. Has not attempted to leave the facility and does not wander .Total score: 7 .Is the resident at risk for elopement? No .Summarize findings, conclusions and recommendations: No risk for elopement . (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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(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	A review of Resident 1's Elopement/Wandering Risk Assessment, dated 3/21/25, indicated, .Instructions . select most appropriate answer .the number next to your selection is the score .add all scores at the end of your assessment to determine if resident is at risk for elopement. A score of 9 or higher indicates a risk for elopement .Mental Status .1. Intermittent Confusion .Usual emotional behavior .0. Complacent .Ambulation . 3. Ambulatory with assistance (including ability to self propel in w/c) .Mobility .3. Slightly Impaired . Medications .0. No significant change .Elopement risk .0. Has not attempted to leave the facility and does not wander .Total score: 7 .Is the resident at risk for elopement? No .Summarize findings, conclusions and recommendations: No risk for elopement . A review of Resident 1's Elopement/Wandering Risk Assessment, dated 3/22/25, indicated, .Instructions . select most appropriate answer .the number next to your selection is the score .add all scores at the end of your assessment to determine if resident is at risk for elopement. A score of 9 or higher indicates a risk for elopement .Mental Status .1. Intermittent Confusion .Usual emotional behavior .0. Complacent .Ambulation . 3. Ambulatory with assistance (including ability to self propel in w/c) .Mobility .3. Slightly Impaired . Medications .0. No significant change .Elopement risk .3. Has attempted to leave the building 1-2 times within a week unattended .Total score: 10 .Is the resident at risk for elopement? Yes .Select all interventions initiated .a. Wander guard [A Wander Guard system consists of a bracelet that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alarms] .c. Identification bracelet .d. Recreational activities .f. Photo on wander list .g. Staff aware of resident's wander risk .Summarize findings, conclusions, and recommendations: RESIDENT HAD ONE EPISODE OF ELOPEMENT .Effective Date 03/22/2025 23:00 [11 PM] . A review of Resident 1's Interdisciplinary Team Meeting, (IDT, a group of healthcare professionals with various levels of expertise who work together toward the goals of their residents) dated 3/24/25, indicated, . IDT - Incident Review .Resident elopement incident .date and time of incident: 03/22/2025 17:15 [5:15 PM] . Description of incident: Around 1715, Resident was not in the room for dinner. CNA [Certified Nursing Assistant] alerted her LN [Licensed Nurse]; LN and other staffs [sic] went around to check in rooms, (bedrooms, bathrooms, dining rooms, outdoor patio) and around the perimeters of the facility. LN informed the administration (at 1726 [5:26 PM]) .Some staff drove around the facility area looking for the resident; LN called hospitals EDs [emergency departments] to check for the resident .ED at 1730 [5:30 PM] stated resident is there in their ED. She was identified with her ID [Identification] band. 2 facility staff went to ED to identify and confirmed. Per ED .resident was brought in by a good Samaritan [bystander] .Resident .treated . for a Left lateral eye laceration [cut on the side of the left eye] .being sutured .son was informed .Dr. [doctor] was also informed .Contributing factors .k. Cognitive impairment .n. History of Fall(s) .Cognitive impairment comments: BIMS - 06 .Resident is alert and oriented X2 [to person (self) and place] with periods of forgetfulness and confusion . (continued on next page)

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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	A review of Resident 1's [HOSPITAL NAME] EMERGENCY RECORD, dated 3/22/25, indicated, .3/22/25 1623 [4:23 PM] initial vital signs [recorded temperature, heart rate and blood pressure readings] .Pt [patient] BIBA [brought in by ambulance] bystander after sustaining a fall outside of the hospital .hitting the front of her face .laceration to the left side of the face. Bleeding controlled .Spanish-speaking only .pain left side of face, on a scale of 0-10 [numeric pain scale with 0 being no pain and 10 being highest level of pain] .rates pain as 5 .also complained of loss of consciousness .PHYSICAL EXAM .Head exam included findings of, Battle's sign [bruising on bone behind the ear that can appear after a head injury] present, Raccoon Eyes (bruising around the eyes that can appear after a head injury) present, Contusion to face, Abrasion to face, Laceration to face .DIAGNOSIS .FINAL: PRIMARY: Acute facial injury, [bone or soft tissue damage to the face caused by fall] ADDITIONAL: Acute head injury [any sort of injury to your brain, skull, or scalp], Cervical spine sprain [injury to muscles or ligaments in the back of the neck; whiplash], Left facial laceration [cut to the left side of the face] .sutures to wound .discharged .in a wheelchair, transported via non-urgent ambulance, accompanied by emergency medical services personnel . During an interview on 5/23/25, at 2:15 p.m., with the Director of Nursing (DON), the DON stated the footage from the facility cameras was reviewed on 3/25/25. The DON further stated that during the facility camera footage review, Resident 1 was seen on camera footage exiting the facility through the rear Dining Room door. The DON stated that the rear Dining Room door led to a courtyard where the Maintenance and facility portables were. The DON further stated the courtyard had a gate that led to the facility's rear parking lot. The DON stated Resident 1 left the facility around 3:25 p.m. to 3:30 p.m. in her wheelchair per the camera footage timestamp on 3/22/25. The DON further stated that during the facility cameras footage review Resident 1 was then seen crossing the street in her wheelchair headed toward the acute care facility across the street. The DON stated that after Resident 1 crossed the street toward the acute care facility in her wheelchair, she was out of the facility camera view. The DON further stated that based on the facility camera footage timestamp, Resident 1 was out of the facility for one and one-half hours before facility staff discovered that she was missing. The DON stated that Resident 1 had not attempted to leave the facility since being admitted to the facility in 2022. The DON further stated that Resident 1 was Spanish-speaking, but some of the facility staff spoke Spanish. The DON stated that there was no alarm on the rear Dining Room door on the day of the incident, but an alarm was installed after the incident. (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 5/23/25, at 2:39 p.m., with LN 1, LN 1 stated she was familiar with Resident 1 and was on duty on the day of the incident on 3/22/25. LN 1 further stated the CNA told her at 5 p.m. that day that Resident 1 was not in her room. LN 1 stated that she and the CNA looked for Resident 1 while alerting the rest of the staff on duty that day that Resident 1 was missing. LN 1 further stated they checked the facility and the patio areas, but did not find Resident 1. LN 1 stated that she drove around the neighborhood in a two to three block radius (measure of distance) looking for Resident 1, but did not find her. LN 1 further stated that Resident 1's family was called to see if they had picked her up, but the family had not picked her up. LN 1 explained that the family was notified that Resident 1 was missing. LN 1 stated the Administrator (ADM) and the DON were also notified. LN 1 further stated that they called 911. LN 1 explained that another LN called the local acute care hospitals and discovered Resident 1 was in the ED at a local acute care hospital located across the street from the facility. LN 1 stated that she and another LN went to the ED and verified that Resident 1 was there. LN 1 further that Resident 1's family, the ADM, the DON and Resident 1's physician were notified. LN 1 stated that the ED staff told her that Resident 1 fell out of her wheelchair in front of the hospital and a bystander brought her to the ED. LN 1 further stated that the CNAs checked the residents in the facility at shift change and every two hours for incontinent (loss of bladder or bowel control) care. LN 1 stated Resident 1 was usually in her wheelchair in the Dining Room and would let staff know when she needed toileting. LN 1 further stated Resident 1 was Spanish-speaking, and facility staff spoke Spanish. LN 1 stated that she had no idea how long Resident 1 was away from the facility. LN 1 further started Resident 1 had an alarm in her wheelchair that alarmed when she stood up. LN 1 stated that Resident 1 did not have a Wander Guard device before the incident. LN 1 further stated that Resident 1 was given a Wander Guard bracelet after the incident. LN 1 stated that extra alarms were added to the doors after the incident. During an interview on 5/23/25, at 2:47 p.m., with the CNA, the CNA stated that the facility CNAs made rounds every two hours for incontinent care. The CNA further stated that prior to the incident Resident 1 had a wheelchair alarm but no Wander Guard. The CNA explained that the wheelchair alarm sounded whenever Resident 1 stood up. The CNA stated that Resident 1 had a bed alarm that sounded when she got out of bed. The CNA further stated that she checked Resident 1 whenever the chair alarm went off, because Resident 1 did not like the alarm sound. The CNA stated that Resident 1 was scheduled for a shower on the day of the incident, so she went to her room to prepare her for her shower at the beginning of her shift, but Resident 1 refused her shower. The CNA further stated she went back a bit later, but Resident 1 refused her shower again. The CNA stated that at 4 p.m. she was in the breakroom and she heard a chair alarm sounding. The CNA further stated that her coworker said that she saw Resident 1 at 4 p.m. when the chair alarm sounded but she was okay. The CNA stated that at dinnertime during the tray pass is when she found out that Resident 1 was not in her room. The CNA further stated she reported to LN 1 that Resident 1 was not in her room, and she and LN 1 began looking for her. The CNA stated that Resident 1 was brought back to the facility that evening. During an interview with Resident 1 in her room on 5/23/25, at 3 p.m., Resident 1 responded to questions in Spanish. Resident 1 stated in Spanish that she was fine. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/25, at 3:05 p.m., with the Maintenance Supervisor (MS), the facility Wander Guard testing logs were reviewed. The MS stated that he checked the Wander Guard system once a week and documented the results in a computer log. The MS further stated that he took the tester device and walked to all of the facility exit doors to set off the Wander Guard alarm to test it weekly. The MS stated the rear Dining Room door now had a Wander Guard alarm. The MS further stated that he logged the test results as a pass or fail. The Main stated that if he was late in checking the Wander Guard system or if he did not check it when scheduled, the electronic log would turn red. During an interview on 5/23/25, at 4 p.m., with the DON, the DON stated that Resident 1 was not deemed a high risk for elopement prior to the incident. The DON further stated that there could have been a safety risk if Resident 1 was deemed a high risk for elopement at the time of the incident. The DON stated that the rear Dining Room door could be considered a hazard because there was no alarm on the door on the day of the incident, and Resident 1 was not aware of the hazard. During a phone interview on 5/27/25, at 1 p.m., with Resident 1's primary physician (MD), the MD stated that he vaguely remembered Resident 1's elopement incident. The MD further stated Resident 1 did not have any long-lasting effects due to her injuries from the fall. The MD stated that he was not aware of how Resident 1 got out of the facility. The MD further stated that he was not aware that there was no lock or alarm on the rear Dining Room door leading outside of the facility on the day of the incident. During a phone interview on 5/27/25, at 2:50 p.m., with Resident 1's Family Member (FM), the FM stated the facility called on the day of the incident asking if any family had come to the facility to take Resident 1 out on pass (out of the facility with family). The FM further stated she told facility staff that they had not taken Resident 1 out on pass. The FM explained that the facility staff notified her that Resident 1 was missing and that they had called 911 and were looking for her and would call them back. The FM stated that about 30 minutes to one hour later, the facility called back to say that Resident 1 was in the acute care hospital ED across the street from the facility. The FM further stated that the facility staff told them that someone had found Resident 1 and took her to the ED. The FM stated that she and her father went to the ED and stayed with Resident 1 until she was returned to the facility. The FM further stated that the facility informed them a few days later that they would put a Wander Guard bracelet on Resident 1 to alert staff if she attempted to leave again. The FM stated that the family signed consent for the Wander Guard. The FM stated that sometimes Resident 1 was disoriented (confusion about who she was, where she was, and what time of day it was), she believed due to her medications, and wanted to leave the facility. The FM further stated that she and her father informed the facility that they could call when Resident 1 became disoriented, and they would come to visit her as they lived ten minutes from the facility. (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 5/27/25, at 3:25 p.m., with the Clinical Consultant (CC), the CC stated that on the day of the incident the rear Dining Room door leading to the outside was unlocked. The CC further stated that the Wander Guard alarm and an alarm chime that made a doorbell sound when the door was opened were added to the rear Dining Room door leading to the outside after the incident. The CC stated that she did not think that Resident 1 was at risk because she was assessed for elopement and her elopement risk was low. The CC further stated that Resident 1 was at risk because of her confusion. The CC stated that the unlocked door in the rear of the Dining Room was not a hazard to Resident 1 as she never tried to exit the door before. The CC stated that the gate leading to the rear parking lot was locked from the outside, so a resident had to push it open from the inside to enter the rear parking lot. During a phone interview on 5/27/25, at 3:40 p.m., with the ADM, the ADM stated the rear Dining Room door was not locked during business hours as it was an exit door. The ADM further stated the rear Dining Room door was an egress (a means of going out), and that both the rear Dining Room door and the gate in the patio outside of the rear Dining Room were the exit route for residents and staff in case of a fire at the facility. The ADM stated that there were no issues with needing a lock on the rear Dining Room door. The ADM further stated that based on the elopement assessment, Resident 1 was not an elopement risk, and the facility was not a locked facility. The ADM stated that he did not believe the elopement and injury to Resident 1 during the incident was preventable - the ADM stated that it was an accident. The ADM further stated that based on an egress the unlocked rear Dining Room door was not a hazard. The ADM stated that Resident 1 was in the Dining Room every day participating in activities and was not an elopement risk. During a concurrent interview and record review of a posted facility document on 5/27/25, at 3:57 p.m., in the hallway next to the Physical Therapy department with LN 2, LN 2 stated that in the event of a fire at the facility, the black dotted lines on the posted facility document indicated the exit routes for staff and residents to take. LN 2 further stated that staff and residents in the Dining Room would exit the Dining Room through the front entrance, go down the hallway past the ADM's office, and exit the building through the exit door near the facility Laundry Room as indicated by the black dotted lines and arrows on the posted facility document. LN 2 stated that the rear door in the Dining Room that led to the patio was not a fire exit as indicated on the posted facility document. A review of a facility policy titled, Accidents and Incidents . dated July 2017, indicated, .7. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities . Based on interview and record review, the facility failed to ensure an environment free of accidents or hazards for one of two sampled residents (Resident 1) when Resident 1 exited the facility through an unlocked door on 3/22/25 and was missing from the facility for one and one-half hours before staff became aware. This failure resulted in Resident 1 falling out of her wheelchair sustaining injuries that included bruises (contusion, ecchymosis; skin discoloration from damaged, leaking blood vessels under the skin) and a facial laceration (cut) that required sutures (stitches). This failure had the potential to result in Resident 1 sustaining life-threatening injuries. Findings: (continued on next page)

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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	A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2022 with diagnoses which included diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic kidney disease (progressive damage and loss of function in the kidneys), and spinal stenosis (spinal stenosis happens when the space inside the backbone is too small, this can put pressure on the spinal cord and nerves that travel through the spine). A review of Resident 1's Minimum Data Set, (MDS, a comprehensive care assessment tool) dated 3/24/25, indicated, .Brief Interview for Mental Status Score: 06 [BIMS, a tool to assess cognition. The total possible BIMS score ranges from 00 to 15. 13 - 15: cognitively intact; 08 - 12: moderately impaired; 00 - 07: severe impairment] . A review of Resident 1's Elopement [a resident who is incapable of adequately protecting himself or herself departs the healthcare facility unsupervised and undetected]/Wandering [a resident who roams around and becomes lost or confused about their location] Risk Assessment, dated 12/24/24, indicated, .Instructions . select most appropriate answer .the number next to your selection is the score .add all scores at the end of your assessment to determine if resident is at risk for elopement. A score of 9 or higher indicates a risk for elopement .Mental Status .1. Intermittent Confusion .Usual emotional behavior .0. Complacent .Ambulation . 3. Ambulatory with assistance (including ability to self propel in w/c [wheelchair]) .Mobility .3. Slightly Impaired .Medications .0. No significant change .Elopement risk .0. Has not attempted to leave the facility and does not wander .Total score: 7 .Is the resident at risk for elopement? No .Summarize findings, conclusions and recommendations: No risk for elopement . A review of Resident 1's Elopement/Wandering Risk Assessment, dated 3/21/25, indicated, .Instructions . select most appropriate answer .the number next to your selection is the score .add all scores at the end of your assessment to determine if resident is at risk for elopement. A score of 9 or higher indicates a risk for elopement .Mental Status .1. Intermittent Confusion .Usual emotional behavior .0. Complacent .Ambulation . 3. Ambulatory with assistance (including ability to self propel in w/c) .Mobility .3. Slightly Impaired . Medications .0. No significant change .Elopement risk .0. Has not attempted to leave the facility and does not wander .Total score: 7 .Is the resident at risk for elopement? No .Summarize findings, conclusions and recommendations: No risk for elopement . A review of Resident 1's Elopement/Wandering Risk Assessment, dated 3/22/25, indicated, .Instructions . select most appropriate answer .the number next to your selection is the score .add all scores at the end of your assessment to determine if resident is at risk for elopement. A score of 9 or higher indicates a risk for elopement .Mental Status .1. Intermittent Confusion .Usual emotional behavior .0. Complacent .Ambulation . 3. Ambulatory with assistance (including ability to self propel in w/c) .Mobility .3. Slightly Impaired . Medications .0. No significant change .Elopement risk .3. Has attempted to leave the building 1-2 times within a week unattended .Total score: 10 .Is the resident at risk for elopement? Yes .Select all interventions initiated .a. Wander guard [A Wander Guard system consists of a bracelet that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alarms] .c. Identification bracelet .d. Recreational activities .f. Photo on wander list .g. Staff aware of resident's wander risk .Summarize findings, conclusions, and recommendations: RESIDENT HAD ONE EPISODE OF ELOPEMENT .Effective Date 03/22/2025 23:00 [11 PM] . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Interdisciplinary Team Meeting, (IDT, a group of healthcare professionals with various levels of expertise who work together toward the goals of their residents) dated 3/24/25, indicated, . IDT - Incident Review .Resident elopement incident .date and time of incident: 03/22/2025 17:15 [5:15 PM] . Description of incident: Around 1715, Resident was not in the room for dinner. CNA [Certified Nursing Assistant] alerted her LN [Licensed Nurse]; LN and other staffs [sic] went around to check in rooms, (bedrooms, bathrooms, dining rooms, outdoor patio) and around the perimeters of the facility. LN informed the administration (at 1726 [5:26 PM]) .Some staff drove around the facility area looking for the resident; LN called hospitals EDs [emergency departments] to check for the resident .ED at 1730 [5:30 PM] stated resident is there in their ED. She was identified with her ID [Identification] band. 2 facility staff went to ED to identify and confirmed. Per ED .resident was brought in by a good Samaritan [bystander] .Resident .treated . for a Left lateral eye laceration [cut on the side of the left eye] .being sutured .son was informed .Dr. [doctor] was also informed .Contributing factors .k. Cognitive impairment .n. History of Fall(s) .Cognitive impairment comments: BIMS - 06 .Resident is alert and oriented X2 [to person (self) and place] with periods of forgetfulness and confusion . A review of Resident 1's [HOSPITAL NAME] EMERGENCY RECORD, dated 3/22/25, indicated, .3/22/25 1623 [4:23 PM] initial vital signs [recorded temperature, heart rate and blood pressure readings] .Pt [patient] BIBA [brought in by ambulance] bystander after sustaining a fall outside of the hospital .hitting the front of her face .laceration to the left side of the face. Bleeding controlled .Spanish-speaking only .pain left side of face, on a scale of 0-10 [numeric pain scale with 0 being no pain and 10 being highest level of pain] .rates pain as 5 .also complained of loss of consciousness .PHYSICAL EXAM .Head exam included findings of, Battle's sign [bruising on bone behind the ear that can appear after a head injury] present, Raccoon Eyes (bruising around the eyes that can appear after a head injury) present, Contusion to face, Abrasion to face, Laceration to face .DIAGNOSIS .FINAL: PRIMARY: Acute facial injury, [bone or soft tissue damage to the face caused by fall] ADDITIONAL: Acute head injury [any sort of injury to your brain, skull, or scalp], Cervical spine sprain [injury to muscles or ligaments in the back of the neck; whiplash], Left facial laceration [cut to the left side of the face] .sutures to wound .discharged .in a wheelchair, transported via non-urgent ambulance, accompanied by emergency medical services personnel . During an interview on 5/23/25, at 2:15 p.m., with the Director of Nursing (DON), the DON stated the footage from the facility cameras was reviewed on 3/25/25. The DON further stated that during the facility camera footage review, Resident 1 was seen on camera footage exiting the facility through the rear Dining Room door. The DON stated that the rear Dining Room door led to a courtyard where the Maintenance and facility portables were. The DON further stated the courtyard had a gate that led to the facility's rear parking lot. The DON stated Resident 1 left the facility around 3:25 p.m. to 3:30 p.m. in her wheelchair per the camera footage timestamp on 3/22/25. The DON further stated that during the facility cameras footage review Resident 1 was then seen crossing the street in her wheelchair headed toward the acute care facility across the street. The DON stated that after Resident 1 crossed the street toward the acute care facility in her wheelchair, she was out of the facility camera view. The DON further stated that based on the facility camera footage timestamp, Resident 1 was out of the facility for one and one-half hours before facility staff discovered that she was missing. The DON stated that Resident 1 had not attempted to leave the facility since being admitted to the facility in 2022. The DON further stated that Resident 1 was Spanish-speaking, but some of the facility staff spoke Spanish. The DON stated that there was no alarm on the rear Dining Room door on the day of the incident, but an alarm was installed after the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555186	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Square Post Acute Care	1032 N. Lincoln Street Stockton, CA 95203

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	During an interview on 5/23/25, at 2:39 p.m., with LN 1, LN 1 stated she was familiar with Resident 1 and was on duty on the day of the incident on 3/22/25. LN 1 further stated the CNA told her at 5 p.m. that day that Resident 1 was not in her room. LN 1 stated that she and the CNA looked for Resident 1 while alerting the rest of the staff on duty that day that Resident 1 was missing. LN 1 further stated they checked the facility and the patio areas, but did not find Resident 1. LN 1 stated that she drove around the neighborhood in a two to three block radius (measure of distance) looking for Resident 1, but did not find her. LN 1 further stated that Resident 1's family was called to see if they had picked her up, but the family had not picked her up. LN 1 explained that the family was notified that Resident 1 was missing. LN 1 stated the Administrator (ADM) and the DON were also notified. LN 1 further stated that they called 911. LN 1 explained that another LN called the local acute care hospitals and discovered Resident 1 was in the ED at a local acute care hospital located across the street from the facility. LN 1 stated that she and another LN went to the ED and verified that Resident 1 was there. LN 1 further that Resident 1's family, the ADM, the DON and Resident 1's physician were notified. LN 1 stated that the ED staff told her that Resident 1 fell out of her wheelchair in front of the hospital and a bystander brought her to the ED. LN 1 further stated that the CNAs checked the residents in the facility at shift change and every two hours for incontinent (loss of bladder or bowel control) care. LN 1 stated Resident 1 was usually in her wheelchair in the Dining Room and would let staff know when she needed toileting. LN 1 further stated Resident 1 was Spanish-speaking, and facility staff spoke Spanish. LN 1 stated that she had no idea how long Resident 1 was away from the facility. LN 1 further started Resident 1 had an alarm in her wheelchair that alarmed when she stood up. LN 1 stated that Resident 1 did not have a Wander Guard device before the incident. LN 1 further stated that Resident 1 was given a Wander Guard bracelet after the incident. LN 1 stated that extra alarms were added to the doors after the incident. During an interview on 5/23/25, at 2:47 p.m., with the CNA, the CNA stated that the facility CNAs made rounds every two hours for incontinent care. The CNA further stated that prior to the incident Resident 1 had a wheelchair alarm but no Wander Guard. The CNA explained that the wheelchair alarm sounded whenever Resident 1 stood up. The CNA stated that Resident 1 had a bed alarm that sounded when she got out of bed. The CNA further stated that she checked Resident 1 whenever the chair alarm went off, because Resident 1 did not like the alarm sound. The CNA stated that Resident 1 was scheduled for a shower on the day of the incident, so she went to her room to prepare her for her shower at the beginning of her shift, but Resident 1 refused her shower. The CNA further stated she went back a bit later, but Resident 1 refused her shower again. The CNA stated that at 4 p.m. she was in the breakroom and she heard a chair alarm sounding. The CNA further stated that her coworker said that she saw Resident 1 at 4 p.m. when the chair alarm sounded but she was okay. The CNA stated that at dinnertime during the tray pass is when she found out that Resident 1 was not in her room. The CNA further stated she reported to LN 1 that Resident 1 was not in her room, and she and LN 1 began looking for her. The CNA stated that Resident 1 was brought back to the facility that evening. During an interview with Resident 1 in her room on 5/23/25, at 3 p.m., Resident 1 responded to questions in Spanish. Resident 1 stated in Spanish that she was fine. During a concurrent interview and record review on 5/23/25, at 3:05 p.m., with the Maintenance Supervisor (M[TRUNCATED]