STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555244	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anberry Nursing and Rehabilitation Center	1685 Shaffer Rd Atwater, CA 95301

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 Note: The nursing home is disputing this citation.	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** 48713 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent accidents for one of three sampled residents (Resident 1), when on 10/23/24, Resident 1 eloped (leaves a facility without supervision or permission and may be a danger to themselves or others) from his bedroom through the sliding door that should have been securely locked in place. This failure resulted in Resident 1 allegedly removing the sliding door lock, opening the sliding door and eloped from the facility, resulting in Resident 1 ' s emergency room visit on 10/24/24. Findings: During a review of Resident 1's Interdisciplinary Team (IDT- team that consists of various staff that are involved with resident ' s care) Note, dated 10/24/24, the note indicated, . Resident eloped on 10/23/2024. Discussed and reviewed with IDT. After reviewing with staff, resident removed door lock and eloped through sliding glass door sometime after hourly check. Staff reported resident was last seen during hourly checks at 0700 (7:00 a.m.). At 0720 (7:20 a.m.) resident unable to be located for breakfast and medication pass . During an interview on 10/25/24 at 2:00 p.m. with the director of nursing (DON), the DON stated on 10/23/24, Resident 1 had eloped from the facility. The DON stated it was concluded that Resident 1 had removed the secured lock on Resident 1 ' s room sliding door and left the facility. During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis for Schizoaffective disorder (mental disorder that includes seeing or hearing and holding false beliefs), depression (mental disorder that causes sad mood or loss of interest in activities), need for assistance with personal care . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 9/13/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a review of Resident 1's, Elopement Care plan (CP), dated 9/17/24, the CP indicated, . Special treatment Program facility . at risk for elopement related to involuntary placement, refusal to take medication, danger to self/community, self-well-being history of substance abuse, past history of elopement . will not leave facility unattended .admit to a locked/secured (egress) facility . During an interview on 10/25/24 at 2:48 p.m. with the mental health worker (MHW), the MHW stated he had been notified of the incident in which Resident 1 had eloped from the facility and exited through the sliding door. The MHW stated the sliding doors in resident ' s rooms were always kept locked and all doors were secured with a window screw. During an interview on 10/25/24 at 2:58 p.m. with licensed vocational nurse (LVN) 1, the LVN 1 stated she was aware of the incident that occurred on 10/23/24, when Resident 1 eloped from the facility and exited through the sliding door in Resident 1 ' s room. LVN 1 stated the facility expectation was for all sliding doors in resident ' s rooms to have been locked and secured at all times. During a concurrent observation and interview on 10/25/24 at 3:06 p.m. in Resident 1's room with the maintenance assistant (MA), the MA stated he was aware of the incident that occurred on 10/23/24, when Resident 1 eloped from the facility and exited through the sliding door in Resident 1's room. The MA stated Resident 1 had removed the lock stopper that was in place to secure the resident ' s sliding door from opening. The MA stated the sliding doors should have been locked at all times as the sliding doors were not used. The MA stated the sliding door locks were tightened with pliers, but if continued disruption occurred, the locks could have loosened allowing the sliding door to open. The MA stated the sliding doors were checked during monthly inspections. The MA stated checking the sliding doors was not documented on the maintenance checklist and was just something they did. During an interview on 10/25/24 at 3:18 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she was aware of the incident that occurred on 10/23/24, when Resident 1 eloped from the facility and exited through the sliding door in Resident 1's room. CNA 1 stated the sliding door locks were put in place to keep the sliding doors locked and closed. CNA 1 stated it was easy to open the sliding doors because the sliding door locks were simple to remove. CNA 1 stated since (after the incident) the sliding doors were secured with wood, the doors could no longer open and were effectively locked. During a telephone interview on 10/30/24 at 11:59 a.m. with the administrator (ADM) and the Maintenance Director (MD), the ADM stated the sliding doors were not used and could have been considered a wall as the sliding doors had no purpose. The ADM stated the sliding doors should have been locked at all times. The ADM stated Resident 1 figured out how to open the door and remove the lock. The MD stated the sliding doors should have been locked and secured at all times and were checked monthly and randomly to ensure they were secured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1's acute care hospital document titled, Emergency Department Notes, dated 10/24/24, the document indicated, . History of bipolar (mental illness that causes mood swings) disorder and suicide risk brought in by police department for anxiety and medical clearance for placement. Per law enforcement, patient is conserved and recently ran away from the facility he is staying in . Patient comes in with complaints of increased anxiety. Upon evaluation patient is here for medical clearance and admits to methamphetamine [is a synthetic (man-made) stimulant(a substance that raises levels of physiological or nervous activity in the body)] use . Amphetamine (is a stimulant drug) use on 10/24/2024 . During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, dated 12/09, the P&P indicated, . Maintenance service shall be provided to all areas of the building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . Maintaining the building in good repair and free from hazards . During a review of the facility ' s policy and procedure (P&P) titled, Behavioral Health Elopement, dated 5/1/2024, the P&P indicated, . To establish a clear and effective process for preventing elopement, managing elopement incidents, and ensuring resident safety in a Special Treatment Program . To maintain a safer and secure environment for all residents. Elopement or unauthorized departure from the facility is a serious risk and requires immediate attention. This policy outlines the procedures for preventing, identifying, and responding to elopement incidents in our mental health facility . During a review of the facility ' s P&P titled, Safety and Supervision of Resident ' s, dated 7/2017, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Resident supervision is a core component of the systems approach to safety .

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation interview and record review the facility failed to provide a safe environment for one of three sampled residents (Resident 1), when on 10/23/24, Resident 1 eloped (leaves a facility without supervision or permission and may be a danger to themselves or others) from his bedroom through the sliding door that should have been securely locked in place. This failure resulted in Resident 1 allegedly removing the sliding door lock, opening the sliding door and eloped from the facility, resulting in Resident 1's emergency room visit on 10/24/24. Findings: During a review of Resident 1's Interdisciplinary Team (IDT- team that consists of various staff that are involved with resident's care) Note, dated 10/24/24, the note indicated, . Resident eloped on 10/23/2024. Discussed and reviewed with IDT. After reviewing with staff, resident removed door lock and eloped through sliding glass door sometime after hourly check. Staff reported resident was last seen during hourly checks at 0700 (7:00 a.m.). At 0720 (7:20 a.m.) resident unable to be located for breakfast and medication pass . During an interview on 10/25/24 at 2:00 p.m. with the director of nursing (DON), the DON stated on 10/23/24, Resident 1 had eloped from the facility. The DON stated it was concluded that Resident 1 had removed the secured lock on Resident 1's room sliding door and left the facility. During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis for Schizoaffective disorder (mental disorder that includes seeing or hearing and holding false beliefs), depression (mental disorder that causes sad mood or loss of interest in activities), need for assistance with personal care . 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 9/13/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a review of Resident 1 ' s, Elopement Care plan (CP), dated 9/17/24, the CP indicated, . Special treatment Program facility . at risk for elopement related to involuntary placement, refusal to take medication, danger to self/community, self-well-being history of substance abuse, past history of elopement . will not leave facility unattended .admit to a locked/secured (egress) facility . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 2:48 p.m. with the mental health worker (MHW), the MHW stated he had been notified of the incident in which Resident 1 had eloped from the facility and exited through the sliding door. The MHW stated the sliding doors in resident' s rooms were always kept locked and all doors were secured with a window screw. During an interview on 10/25/24 at 2:58 p.m. with licensed vocational nurse (LVN) 1, the LVN 1 stated she was aware of the incident that occurred on 10/23/24, when Resident 1 eloped from the facility and exited through the sliding door in Resident 1's room. LVN 1 stated the facility expectation was for all sliding doors in resident ' s rooms to have been locked and secured at all times. During a concurrent observation and interview on 10/25/24 at 3:06 p.m. in Resident 1's room with the maintenance assistant (MA), the MA stated he was aware of the incident that occurred on 10/23/24, when Resident 1 eloped from the facility and exited through the sliding door in Resident 1 ' s room. The MA stated Resident 1 had removed the lock stopper that was in place to secure the resident ' s sliding door from opening. The MA stated the sliding doors should have been locked at all times as the sliding doors were not used. The MA stated the sliding door locks were tightened with pliers, but if continued disruption occurred, the locks could have loosened allowing the sliding door to open. The MA stated the sliding doors were checked during monthly inspections. The MA stated checking the sliding doors was not documented on the maintenance checklist and was just something they did. During an interview on 10/25/24 at 3:18 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she was aware of the incident that occurred on 10/23/24, when Resident 1 eloped from the facility and exited through the sliding door in Resident 1 ' s room. CNA 1 stated the sliding door locks were put in place to keep the sliding doors locked and closed. CNA 1 stated it was easy to open the sliding doors because the sliding door locks were simple to remove. CNA 1 stated since (after the incident) the sliding doors were secured with wood, the doors could no longer open and were effectively locked. During a telephone interview on 10/30/24 at 11:59 a.m. with the administrator (ADM) and the Maintenance Director (MD), the ADM stated the sliding doors were not used and could have been considered a wall as the sliding doors had no purpose. The ADM stated the sliding doors should have been locked at all times. The ADM stated Resident 1 figured out how to open the door and remove the lock. The MD stated the sliding doors should have been locked and secured at all times and were checked monthly and randomly to ensure they were secured. During a review of Resident 1 ' s acute care hospital document titled, Emergency Department Notes, dated 10/24/24, the document indicated, . History of bipolar (mental illness that causes mood swings) disorder and suicide risk brought in by police department for anxiety and medical clearance for placement. Per law enforcement, patient is conserved and recently ran away from the facility he is staying in . Patient comes in with complaints of increased anxiety. Upon evaluation patient is here for medical clearance and admits to methamphetamine [is a synthetic (man-made) stimulant(a substance that raises levels of physiological or nervous activity in the body)] use . Amphetamine (is a stimulant drug) use on 10/24/2024 . (continued on next page)

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