STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Park Nursing & Rehabilitation Center	2257 Fair Oaks Blvd. Sacramento, CA 95825

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. 43247 Based on observation, interview and record review, the facility failed to identify that one of three sampled residents (Resident 1) left facility without staff awareness or physician order for Leave of Absence (LOA), when Resident 1 left facility with unidentified person and was not known to have left facility until he returned to the facility on his own. This failure resulted in Resident 1 going to an unsafe environment with risk for harm and injury. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in June 2024 with multiple diagnoses including acute osteomyelitis (infection in a bone) of left ankle and foot, pressure injury to right hip, and generalized muscle weakness. A review of Resident 1's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 6/20/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 14 out of 15 which indicated Resident 1 was cognitively intact. A review of Resident 1's MDS, Functional Abilities and Goals, dated 6/20/24, indicated Resident 1 was dependent for bed mobility and was not able to attempt transfers or standing. A review of Resident 1's Physical Therapy Treatment Encounter Note, dated 8/1/24, indicated Resident 1 was moderate assist for bed mobility and did not attempt transfers. A review of Resident 1's Leave of Absence sign out sheet from his chart at nursing station, did not indicate anyone had signed Resident 1 out of facility on 7/25/24. A review of Resident 1's Care Plan, initiated 6/13/24, indicated .Resident is at risk for falls . (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	A review of Resident 1's Progress Notes, dated 7/25/24, indicated .This writer was informed by the friend/visitor that the pt [patient] is not in the room. As per the Assigned CNA [Certified Nursing Assistant] this writer was informed that a friend had picked him up. This pt had no approved LOA. Upon further investigation, this writer called [Family Member 1- FM 1] . to inquire re [regarding]: LOA. As per [FM 1], he's not aware of the LOA and will reach out to the friend. The friend brought the pt back to the facility .The pt and visitor was educated not to take the pt home without approved LOA. The assigned CNA was also educated by this writer to further check with the charge nurse prior to the pt leaving. A review of Resident 1's Progress Note, dated 7/29/24 at 1:47 p.m., indicated .This writer received a call and was informed by [FM 2] . regarding pt's recent visit to his home without an approved LOA. Per [FM 2] upon pt's friend [Name of friend]'s routine evening visit the pt was not in his room and questioned the charge nurse. The charge nurse further investigated and called [FM 1] who also was not aware of the pt's whereabouts. The pt's friend [Name of friend] went by the pt's home and brought the pt back to the facility. This writer assured the [FM 2]] that pt was not discharged and will further investigate. A review of Resident 1's Progress Note, dated 7/29/24 at 3:28 p.m., indicated .Upon further investigation, the charge nurse sch [scheduled] to work on Thursday PM [evening] shift was informed that the pt's [sic] had called someone to pick him up and had decided to leave the building without anyone's knowledge. This writer spoke with the pt along with the DON [Director of Nursing], per the pt, he was missing his son and had taken the [rideshare service] home to visit his son. This writer educated the pt that d/t [due to] safety reasons, the pt has to inform the charge nurse and to get an approved LOA from the MD [Medical Doctor] prior to leaving the building. The charge nurse was also educated to monitor the pt's whereabouts at all times A review of Resident 1's Progress Note, dated 8/13/24, indicated .This writer received a call from [FM 2] .re: . f/u [follow up] on the pt left the facility unattended. This writer informed [FM 2] that per the pt, he was missing his son therefore he had called [rideshare service] and left the facility without informing anyone. The pt and the staff were educated to follow the facility protocol for LOA . During a joint telephone interview on 8/21/24 at 10:37 a.m. with Resident 1's FM 1 and FM 3, FM 3 stated Resident 1's friend came to facility to visit and Resident 1 was not there. FM 3 stated the facility staff told him Resident 1 was discharged by mistake. FM 3 stated Resident 1's friend went to his home and found Resident 1 there and persuaded him to return to the facility. FM 1 stated the facility told him that I was the one who picked him up. FM 1 stated he did not pick up Resident 1 that day. FM 1 stated, later, the facility staff told him Resident 1 had arranged for an [rideshare service] ride to leave the facility and then said that a friend picked him up. FM 1 stated he had not had any discussions regarding Resident 1's discharge prior to this incident. FM 1 stated Resident 1 is unable to care for himself at home. FM 1 stated Resident was discharged mistakenly. (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 joint interview on 8/22/24 at 11:59 a.m. with the Assistant Administrator (AADM) and the Director of Nursing (DON), the DON stated on 7/25/24 Resident 1 called a friend to pick him up and transport him home. The DON stated, It was a mistake. Resident 1 was moving rooms and may have been under the impression he was discharged . The DON stated a different friend came to visit Resident 1 on 7/25/24 and asked nurse where Resident 1 was. Resident 1 could not be located in the facility. The nurse asked the assigned CNA where Resident 1 was and the CNA reported a friend had picked up Resident 1. The DON stated the nurse called the son and Resident 1 was not with family. The DON stated a friend brought Resident 1 back to the facility. The DON stated that for residents to have LOA, they must have a physician order. When asked what may have happened if Resident 1 was left alone in his home, the DON stated, Unable to say what adverse outcome would be if friend had not been there. During an interview on 8/22/24 at 12:41 p.m. with the Case Manager (CM), the CM stated Resident 1's friend had come to visit and Resident 1 was nowhere to be found. Resident 1's friend questioned the charge nurse and was told Resident 1 had left for home. The CM stated she spoke with Resident 1 who told her he was missing his son and had called a [rideshare service] and went home, but planned to return to the facility. The CM stated she followed up with the charge nurse and educated her on LOA process. The CM stated Resident 1 is wheelchair bound and requires 1 to 2 person assist or mechanical lift for transfers. The CM stated there had not been any discharge planning for Resident 1 up to now. The insurance program is looking for placement for Resident 1. During an interview on 8/22/24 at 1:01 p.m. with Licensed Nurse (LN) 1, LN 1 stated Resident 1 had changed rooms the day of the incident. LN 1 stated a friend came to visit Resident 1 and asked where Resident 1 was. LN 1 stated she checked with Resident 1's assigned CNA. The CNA reported to her that Resident 1 told him his son had come to pick him up. Resident 1 had left the facility. LN 1 stated she looked for an LOA order but there was not an order. Resident 1's son called and reported he had not picked up Resident 1. LN 1 stated the CNA had transferred Resident 1 to a wheelchair. The CNA reported to LN 1 that he thought that the friend was his son and he was going with him. Resident 1 returned to the facility and reported to LN 1 that he was missing his son and booked a ride. LN 1 stated must have a physician's order for a LOA and a copy of identification of the person taking the resident out of facility. LN 1 stated the CNA was a new hire and may not have known what the LOA policy was. LN 1 stated that when she educated the CNA of the LOA policy, he reported to her that he did not know the policy and that Resident 1 stated that it was his son. LN 1 stated, Could have had bad consequences. Anything could have happened. During an interview on 8/22/24 at 2:08 p.m. with Resident 1, Resident 1 stated he does not know anything about incident when he left the facility. Did not provide any information about returning to his home or who had picked him up. During an interview on 8/22/24 at 2:20 p.m. with LN 2, LN 2 stated Resident 1 requires assist with transfers to wheelchair. LN 2 stated for a LOA a physician order is needed. Will need to obtain identification of person taking resident out and sign in and out at nursing station. During an interview on 8/22/24 at 2:24 p.m. with CNA 1, CNA 1 stated Resident 1 needs assistance with eating, changing, turning, and transfers to the wheelchair with two person assist. CNA 1 stated if someone came to take a resident out of the facility, she would check with the nurse. (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 8/22/24 at 2:29 p.m. with CNA 2, CNA 2 stated a tall young male came in and Resident 1 told him that was his son. CNA 2 stated Resident 1 told him he wanted to go out with him. CNA stated he transferred Resident 1 to a wheelchair, went to get the nurse and when he returned Resident 1 was not in his room. CNA 2 stated he thought Resident 1 was still in the facility, but later he came back to facility with the same man. CNA 2 stated he saw Resident 1 back in his room and transferred him back to bed. CNA 2 stated if resident wants to leave the facility, he should tell the nurse first and have them sign everything at front desk. CNA 2 stated he was not aware of LOA sign out sheet in residents' charts. During a telephone interview on 8/29/24 at 2:26 p.m. with Resident 1's friend (FR), the FR stated he went to visit Resident 1 and he was not in his room. The FR stated he notified the nurse at the facility and the nurse looked for him but could not find him. The FR stated that staff told him Resident 1 had been discharged . The FR stated, He can't do anything for himself, how could he be discharged . Then staff told him the resident in bed next to Resident 1 had been discharged . The FR stated the staff told him a younger male had come in and Resident 1 had left with him. The FR stated he went to Resident 1's home and the younger male was attempting to transfer Resident 1 out of the car. The FR stated the younger male was a friend of Resident 1's but did not know his name. The FR stated he persuaded Resident 1 to return to the facility and the younger male transported him back. The FR stated, Don't understand how this could have happened. Shouldn't have happened. A review of the facility's Policy and Procedure (P&P) titled Resident Leave of Absence, revised 8/2006, .All residents requesting a personal leave of absence must have an MD order .Each resident leaving the premises (excluding transfers/discharges/appointments) must obtain an MD order for approved leave of absence (LOA) .Written and/or oral instructions on when and how to administer the medications will be provided to the resident or to the person signing the resident out .Restrictions noted on the resident's chart concerning who may not sign the resident out must be honored unless otherwise prohibited by the facility policy or state/federal law governing such releases . A review of the facility's P&P titled Transfer or Discharge, Facility-Initiated, dated 10/22, indicated . Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, documentation as specified .A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility .A member of the interdisciplinary team will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place .