STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555918	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fowler Care Center	8448 East Adams Avenue Fowler, CA 93625

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 - Some	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** 27137 Based on observation, interview, and record review, the facility failed to provide adequate supervision for one of one sampled resident (Resident 1) who was a high risk for elopement when Resident 1 eloped from the facility on 6/16/24. This Failure placed Resident 1's safety at risk when Resident 1 was found walking on the side of the road 1/2 a mile away from the facility. Findings: During a review of Resident 1's Admission Record (AR- a document containing resident profile information) dated 6/27/24, the AR indicated Resident 1 was a [AGE] year-old male admitted to the facility with diagnoses included traumatic brain injury (TBI, serious injury to the brain that affects problems with how a person thinks, understands, moves, communicates, and acts), and mild cognitive impairment (impaired ability to remember, think, or make decisions). During a review of Resident 1's Care Plan (CP), dated 6/26/24, the CP indicated Resident 1 is an elopement risk/wanderer related to impaired safety awareness, Resident wanders aimlessly. The resident's safety will be maintained. The resident will not leave facility unattended. The CP dated 3/5/24 indicated Resident 1 has impaired cognitive function or impaired thought processes related to head injury (TBI). During a review of Resident 1's Minimum Data Set (MDS, a comprehensive, standardized assessment), dated 5/15/24, the MDS indicated at Question C500 Brief Interview for Mental Status, a score of 8 out of a possible 15, which indicated moderately impaired cognition. During a review of Resident 1's Progress Notes (PN), dated 6/17/24, the PN indicated, on 6/16/24, Resident 1 was noted walking down the street. CNA [Certified Nursing Assistant] staff brought resident back to the facility. Upon arrival at 11:44 a.m., Resident was unable to state how or when he left facility. Resident last seen approx [approximately]. 10:30 a.m. by staff member during smoke break. (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 - Some	During an interview with the Administrator, on 6/27/24, at 12 p.m., the Administrator stated Resident 1 was not on one-to-one monitoring at the time of his elopement on 6/16/24. The Administrator stated Resident 1 had been on one-to-one monitoring due to past elopement, but the monitoring was discontinued due to no elopement attempts. The Administrator stated she had seen Resident 1 with paper clips and twigs from the tree unsuccessfully trying to pick the gate lock. The DON stated Resident 1 sits near the gate and tried to take every opportunity to leave the facility through the gate when staff enters and leaves the facility, and we constantly redirect him. During an interview on 6/27/24, at 2:55 p.m., with CNA 1, CNA 1 stated she was the one who found Resident 1 walking on the side of the road on 6/16/24 at around 11:30 a.m. CNA 1 stated it was her day off from work and was driving doing some errands and saw a person walking on the opposite side of the road. CNA 1 stated she slowed down and noticed it was Resident 1. CNA 1 stated she pulled over and did a U-turn to be on the same side of the road with Resident 1. CNA 1 stated she got out of the car and talked to Resident 1. CNA 1 stated Resident 1 recognized her. CNA 1 stated Resident 1 was wearing a t-shirt, sweatpants, hat, and shoes. CNA 1 stated Resident 1 was sweaty and did not have water. CNA 1 stated she told Resident 1 to get inside the car and she will take him home. CNA 1 stated she called and notified the facility she found Resident 1 walking on the side of the road. CNA 1 stated the facility did not know Resident 1 eloped. CNA 1 stated she brought Resident 1 back to the facility. During a concurrent observation and interview on 6/27/24, at 3:15 p.m., with the Maintenance Supervisor (MS), the facility's front gate was observed. The MS stated this was the only area where staff, residents and visitors enter and leave the facility. The entire facility is surrounded by an 8-foot-tall metal fence. The gate was observed opening and closing several times at varying degrees, the gate closed promptly and securely each time. The gate and fence were made of robust steel, the gate closed forcefully with a loud 'clang' each time. The MS stated he checked the gate weekly and had made no repairs since the gate was operating normally. The MS stated he sees no evidence the gate lock had been tampered, has never found debris in the keyhole, no scratches other than the normal wear, no debris on ground at gate, and no evidence the lock had been picked. The MS stated there were no footholds or other methods to climb over the gate or fence. Three staff observed leaving the facility, gate lock opened with a key, and the gate promptly closed shut at each exit. During an interview on 7/1/24, at 11:05 a.m., with the Activity Director (AD), the AD stated she recalled seeing Resident 1 on the day of his elopement on 6/16/24, between 10:20 a.m. and 10:30 a.m. The AD stated she was taking her morning break and saw Resident 1 sitting in a chair by the front gate. The AD stated during this time, a Dietary Aide (DA 1) had opened the gate to take some garbage out, and she assisted DA 1 with the gate, and ensured the gate was closed. The AD stated, I honestly don't know how he [Resident 1] got out. The AD stated when her break was over, the gate was closed, and Resident 1 was still sitting by the gate with no staff present. The AD stated she knew a second Dietary Aide reported to work and entered the facility a few minutes later, after she and DA 1 had returned inside the facility. During an interview on 7/1/24, at 11:12 a.m., with DA 1, she stated she was working in the kitchen on 6/16/24 and had to take out the trash. DA 1 stated the AD had assisted her with the gate and recalled seeing Resident 1 sitting by the gate. DA 1 stated, I always make sure the gate is shut, I'm really paranoid about that. I always pull on it to make sure it is shut, but it always shuts on its own. Even if you wanted to leave it open a little bit, it closes on its own. I know that a few minutes later, a little before 11 a.m., [DA 2] came into work through that gate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/24, at 4:25 p.m., with DA 2, DA 2 stated he reported to work and entered the gate on 6/16/24 at 10:58 a.m. DA 2 stated he used his key to open the gate and heard the gate closed. DA 2 stated he did not see Resident 1 anywhere near the gate. During a review of the facility Policy and Procedure (P&P) titled, Elopements and Wandering Residents, dated 10/24, the P&P indicated, in part, Policy: This facility ensures that residents who exhibit wandering behavior and/or are risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization. and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: The facility is equipped with door locks/alarms to help avoid elopements. Adequate supervision will be provided to help prevent accidents or elopements.