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	09/26/2024

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 - 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** 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 9/2/24. This Failure placed Resident 1's safety at risk when Resident 1 was found on the side of the road half a mile away from the facility by a passing motorist. Findings: During an observation on 9/18/24, at 8:20 a.m., the facility building was surrounded with an 8-foot-tall metal fence. The fence extended entirely around the building and staff & visitors entered and exited the facility through a single locked gate which opened with a key. During a concurrent observation and interview on 9/18/24, at 8:40 a.m., with Sitter 1, in Resident 1's room, Sitter 1 was sitting at Resident 1's bedside. Sitter 1 stated she was assigned to provide one-on-one monitoring and supervision for Resident 1. Sitter 1 stated Resident 1 recently eloped. During a review Resident 1's Progress Notes (PN) dated 9/2/24, the PN indicated, Resident was last seen at 0945 headed towards room. At 1015 call was received asking if we had a resident under the name of [Resident 1] at our building . Resident was noted to be missing. Near the back gate, resident wheelchair was found with a barrel on top. Person [passing motorist] on the phone stated he was at [name of street]. At 1020 staff [facility staff] went to pick up resident. Person [passing motorist] who picked up resident stated resident was noted to be waving cars down on [name of cross streets] .Resident was brought back to facility by staff . Minor scratches were noted to knees . (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	During a review of Resident 1's Admission Record (AR- a document that contains patient's medical and demographic information) dated 9/18/24, the AR indicated Resident 1 was a [AGE] year old male admitted to the facility on [DATE] with diagnoses which included traumatic brain injury (TBI- caused by a forceful bump, blow, or jolt to the head, or from an object entering the brain, can cause temporary or short-term problems with brain function, including problems with how a person thinks, understands, moves, communicates, and acts, possibly leading to severe and permanent disability, and even death), psychosis (refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality, a person ' s thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not), history of falling, difficulty walking, alcohol dependence (a chronic disease in which a person craves drinks that contains alcohol) and seizure (a sudden uncontrolled burst of electrical brain activity in the brain). During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 9 of 15 (a score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired, and 0-7 indicates severe impairment). The BIMS assessment indicated Resident 1 was moderately impaired. During an interview on 9/18/24 at 8:55 a.m. with the Maintenance Supervisor (MS), the MS stated Resident 1 eloped from the rear corner of the facility. The MS stated Resident 1 placed a barrel on top of the wheelchair and climb over the 8-foot fence and slid down to the other side of the fence. The MS stated the barrel should have not been left near the fence. During a concurrent interview and record review on 9/18/24 at 9 a.m. with the Administrator the facility document titled Event 5-Day Follow Up (5-Day), dated 9/6/24 was reviewed., The 5-Day indicated, On 9/2/2024 at 10:15 A.M. Staff member received a call to facility asking if we had a resident under the name of [Resident 1] at our building. Head count was done by staff. Resident was noted to be missing. [Resident 1] was last seen at 0945 [a.m.] headed toward room. Near the back gate, resident wheelchair was found with a barrel on top. Person on phone stated he was at [an address about 2.3 miles from facility] at the corner market. At 1020 [a.m.] staff sent to pick up resident. Person who picked up resident stated resident was noted to be waving cars down [at an address about 1/2 mile from facility]. He then picked him up and drove [Resident 1] to [local police department], however it was closed and drove to corner market. Resident was brought back to facility by staff member, Resident was able to walk and get into car with no issues noted. Full body check was done. Minor scratches were noted to knees. Resident denies falling or hitting head during event Near the back gate, resident wheelchair was found with a barrel on top. All gates securely locked. Resident stated he was attempting to go home. The Administrator stated the facility was known in the community and acute care hospitals as a secured and locked facility, and we admitted a lot of elopement risk residents from other facilities. The Administrator stated Resident 1 showed the area where he eloped and used the barrel to climb over the fence. The Administrator stated the barrel should have not been stored near the fence. (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 9/18/24 at 9:30 a.m. with License Vocational Nurse (LVN) 1, LVN 1 stated she was the nurse on duty when Resident 1 eloped. LVN 1 stated on 9/2/24 she received a call asking if we have resident named [Resident 1]. LVN 1 stated she went outside and at the back corner of the facility saw a barrel stacked on top of Resident 1's wheelchair. LVN 1 stated Resident 1 used the barrel to climb over the fence and eloped from the facility. LVN 1 stated Resident 1 was picked up by a passing motorist half a mile from the facility and was taken to the police station. LVN 1 stated the police station was closed because of the holiday and the motorist drove to a store and called the facility. During an interview on 9/18/24, at 10:55 a.m., with the Administrator, the Administrator stated the facility had four doors which lead to the outside of the building. The main door and one other door does not have a door alarm, and the other two doors had a door alarm. The Administrator stated the outside area of the building was surrounded with eight-foot-tall fence and was used by residents to get fresh air. The Administrator stated, I don't know exactly how many residents go outside, a good chunk of them do . The Administrator stated the facility staff does not provide resident supervision once outside the building within the fenced area. 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.