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	11/13/2024

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. 47298 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent elopement for one of three sampled residents (Resident 1) who was a high risk for elopement (when a resident, who is incapable of adequately protecting themselves, departs the facility unsupervised and undetected) when Resident 1 eloped from the facility on 11/6/24. This failure placed Resident 1 ' s safety at risk when Resident 1 was found on the side of the road a mile and a half away from the facility by staff. Findings: During record review of Resident 1 ' s Admission Record (AR- a document that provides resident contact details, a brief medical history), the AR indicated, Resident 1 had diagnoses which included .TRAUMATIC BRAIN INJURY (alteration in brain function caused by an external force such as a blow, bump or jolt to the head) .ALCOHOL DEPENDENCE .SEIZURES (a sudden uncontrolled burst of electrical activity in the brain) . HISTORY OF FALLING .ANXIETY DISORDER (mental health condition that causes excessive and persistent feelings of worry and uneasiness) .MAJOR DEPRESSIVE DISORDER (a mood disorder that causes a persistent feeling of sadness and loss of interest) .PSYCHOSIS (a collection of symptoms that affect the mind where an individual loses touch with reality) .DIFFICULTY IN WALKING . During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 8/8/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- an evaluation of attention, orientation and memory recall) indicated a score of 9 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had moderate cognitive impairment. During an observation on 11/13/24 at 9:20 a.m. outside on facility premises, there was a metal fence surrounding the facility premises that was 8 feet tall. A locked gate was located by the parking lot for visitors and employees to enter and exit the enclosed premises. The locked gate was opened with a key by a staff member. (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 an interview on 11/13/24 at 9:29 a.m. with Director of Nursing (DON), the DON stated, a hospitality aide (HA) was assigned every shift to do outdoor perimeter checks around the facility premises every 15 minutes. The DON stated, HA had started the shift on 11/6/24 and at 6:41 a.m. had found a meal cart placed next to the fence behind a shed. The DON stated, the HA used a walkie-talkie (a small portable radio used for receiving and sending a message) to alert staff inside the facility to perform a head count in order to identify any potentially missing residents. The DON stated, Resident 1 was identified to be missing. The DON stated, a staff member was driving to work, spotted Resident 1 on the side of the road and called the facility to alert staff of his location. The DON stated, Resident 1 was brought back to the facility by Director of Staff Development (DSD) and Licensed Vocational Nurse (LVN) 2. The DON stated, she believed Resident 1 had used the kitchen cart to climb over the facility ' s fence. The DON stated, Resident 1 had eloped before by putting a barrel on his wheelchair and climbing over the facility ' s fence. The DON stated, the perimeter checks every 15 minutes was implemented after Resident 1 ' s first elopement. The DON stated, the HA assigned to monitor the perimeter during Resident 1 ' s elopement was inside. The DON stated, the HA should should have been outside the facility building to monitor the facility perimeter. During an interview on 11/13/24 at 9:50 a.m. with HA 1, HA 1 stated, on 11/6/24 at 6:41 a.m. she was assigned to monitor the facility outside perimeter, grabbed a walkie talkie and began the first perimeter check of her shift. HA 1 stated, she saw a kitchen meal cart with a temporary orange fence wrapped around the cart. HA 1 stated, the perimeter checks should have been performed every 15 minutes. HA 1 stated, the prior HA should have been outside looking for suspicious items or equipment residents could use to elope and climb over the fence or cause harm. HA 1 stated, the prior HA should have been outside at all times except on a restroom break or lunch break. HA 1 stated, it was important to perform the perimeter checks accurately and to provide resident supervision to ensure the safety of residents, especially residents who are high elopement risk. During a concurrent observation and interview on 11/13/24 at 10:00 a.m. with Resident 1 in the dining room, Resident 1 was observed talking and interacting with staff. Resident 1 stated, he left the facility premises over a fence to walk home. During an interview on 11/13/24 at 10:17 a.m. with LVN 1, LVN 1 stated, Resident 1 was an elopement risk. LVN 1 stated, Resident 1 was at danger of falling, getting hit by a car or receiving skin injuries when he eloped due to the lack of supervision he received. (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 11/13/24 at 10:30 a.m. with DSD, DSD stated, Resident 1 was a high elopement risk. DSD stated, staff were educated to remove all barrels and other objects outdoors as well as lock gates for resident safety. DSD stated, the HA was told to do perimeter checks, ensure gates were locked and identify suspicious activity amongst residents. DSD stated, HAs' were instructed to remain outdoors at all times except for bathroom breaks or lunch breaks. DSD stated, HA's were told to use the walkie talkie to notify staff inside of any irregularities identified outside or if another staff member was needed to relieve them of their duties for a break. DSD stated, it was important to provide adequate supervision to residents and perform perimeter checks accurately to prevent residents from eloping. DSD stated, on 11/6/24 at around 6:41 a.m. HA 1 saw a kitchen meal cart next to the fence and notified staff to perform a count of all residents and a code green (indicating a missing resident) was initiated to search for Resident 1 at 6:50 a.m. DSD stated, staff searched the facility premises and the surrounding streets for Resident 1. DSD stated, Resident 1 was found on the corner of a street one and a half miles away from the facility at 7:02 a.m. DSD stated, Resident 1 was brought back to the facility at 7:15 a.m. and assessed for injuries. DSD stated, Resident 1 had eloped prior to this incident. During an interview on 11/13/24 at 11:52 a.m. with the DON, the DON stated, HA 2 assigned to monitor the facility perimeter was indoors at the time of Resident 1 ' s elopement. The DON stated, the training and expectation for HA 2 was to stay outside, do shift report (communication between staff when responsibility and accountability is transferred) outside, do perimeter checks every 15 minutes, ensure gates are closed and locked, observe for suspicious activity and notify staff indoors of any abnormal findings. The DON stated, the facility should have ensured resident ' s environment was free from accident hazards and each resident received adequate supervision to prevent elopement and accidents. The DON stated, there was a failure with staff to provide resident supervision because HA 2 did not perform the perimeter checks every 15 minutes. DON stated, the failure to provide adequate supervision impacted Resident 1 ' s safety and Resident 1 could have been injured during his elopement. During a telephone interview on 11/13/24 at 5:09 p.m. with LVN 2, LVN 2 stated, Resident 1 was identified missing by staff when a perimeter check revealed a kitchen meal cart found outside next to the fence. LVN 2 stated, an employee found Resident 1 walking on the side of the road about a mile and a half away. LVN 2 stated, DSD and LVN 2 drove to find Resident 1. LVN 2 stated, she last saw Resident 1 during medication pass about an hour before the elopement. LVN 2 stated, Resident 1 was taken back to the facility after initially resisting. LVN 2 stated, the perimeter checks was implemented due to multiple past resident elopements. LVN 2 stated, the residents are under the care of the facility and adequate supervision should have been provided. LVN 2 stated, Resident 1 could have been hit by a truck and seriously injured when he eloped. During a review of Resident 1 ' s IDT [Interdisciplinary Care Team]- Interdisciplinary Post Event Note (IPEN), dated 9/3/24, the IPEN indicated, .IDT met to review elopement occurred on 9/2/24 where Resident was last seen on 0945 [9:45 a.m.] headed towards room by on duty staff. At 1015 [10:15 a.m.] .on duty nurse received a call 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. Near the back gate, resident wheelchair was found with a barrel on top .at 1020 staff went to pick up resident. Person who picked up resident stated resident was noted to be waving cars down .Full body check was done. Minor scratches were noted to knees upon assessment .he was able to describe to the IDT that he went in the back of the facility and used w/c [wheelchair] to climb over the wood fence and went on top of the barrel and then went over the fence .He stated, ' I was just going home as my home is nearby ' . (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 review of Resident 1 ' s Change in Condition Evaluation (CIC), dated 11/6/24, the CIC indicated, . Elopement .This started on .11/06/2024 .Resident noted missing from facility. Found walking at intersection of [cross streets] . Resident returned to facility at 0715 [7:15 a.m.] .Resident agitated and verbally aggressive with staff. Resident says sister told him to walk to his house . During a review of Resident 1 ' s IPEN, dated 11/6/24, the IPEN indicated, .The Interdisciplinary Team (IDT) met with the resident following an elopement attempt earlier this morning. The resident, who is ambulatory without assistance .stated his intention to ' go home ' .resident responded that he intended to walk as his sister told him to walk home .Staff observed a rack positioned against the fence, which the resident confirmed he used to climb over .Date and Time of Event .11/06/2024 06:45 [6:45 a.m.] . During a review of Perimeter Rounds: Check List (PRCL), dated 11/6/24, the PRCL indicated, Ensure no barrels are present .Ensure gates are closed at all times .Ensure no equipment are present for resident ' s safety . During a review of the facility ' s policy and procedure (P&P) titled, Elopements and Wandering Residents, dated 11/24, the P&P indicated, .This facility ensures that residents who exhibit wandering behavior and/or are at 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 necessary supervision to do so .The facility is equipped with door locks/alarms to help avoid elopements . Alarms are not a replacement for necessary supervision .Adequate supervision will be provided to help prevent accidents or elopements .