STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055189	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1260 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00955814, #CA00955920, and facility reported incident #CA00955703. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	POC Received: 5/8/25 POC Approved: 5/9/25 BIC: 5/5/25 Per Mary Kihagi	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.	F 626		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature] A. Calimas, NHA Administrator 5/8/2025

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.

GREENFIELD
CARE CENTER OF FAIRFIELD, LLC
1260 Travis Blvd Fairfield, CA 94533
Tel: 707 425 0669, Fax: 707 438 0272

GREENFIELD CARE CENTER OF FAIRFIELD
PLAN OF CORRECTION: Abbreviated Survey: CA00955814 & CA00955920
Facility Reported Incident: CA00955703

SUBMITTED: May 8, 2025

"Preparation and/or execution of this plan of Correction, does not constitute admission or Agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR ET seq."

This Plan of Correction constitutes the facility's credible allegation of compliance

F 626 Permitting Residents to Return to Facility

The facility has a written policy on permitting resident to return to the facility after they are hospitalize or place on therapeutic leave.

A.

Resident #1 is no longer in the facility.

1 The facility Nurse Consultant provided 1:1 in-service to the Director of Nursing; (DON), regarding facility's Policy and Procedures on "Admission Screening" including but not limited to criteria for admission of residents where in the facility is able to provide the needed care and services of the resident such as; medical, physical and psychosocial needs. The Bed-Hold Policy was also discussed with emphasis on the following:

Residents are not discharged unless:

a. the discharge or transfer is necessary for the resident's welfare, and the facility cannot meet the resident's needs;
b. the resident's health has improved sufficiently so that the resident is no longer needs the services of the facility;
c. the resident's clinical or behavioral status endangers the safety of individuals in the facility;
d. the resident's clinical or behavioral status endangers the health of individuals in the facility; and/or

e. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility which applies if:
   - the resident does not submit the necessary paperwork for third party payment or
   - the third party, including Medicare of Medicaid, denies the claim and the resident refuses to pay for his or her stay; or
   - The facility ceases to operate

It should also be considered that following a hospitalization, residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred.

B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:

No other resident affected similar to this deficient practice. All residents transferred to the emergency room/acute hospital were readmitted back to the facility.

C. Measures to Prevent Recurrence:

The following in-services were provided:

1. Policy and Procedure on Admission Screening by Administrator to Interdisciplinary Team (IDT) on 4/14/25 and Admission/Readmission on 4/29/25.
2. Policy and Procedure on Re-admission within 48 hours by Administrator to IDT on 5/5/25.
3. Policy and Procedure on Resident Discharge to Acute, Bed hold by DSD to Licensed Nurses (LNs) on 5/7/25.
4. Bed-hold Policy by Administrator to IDT on 5/7/25.

D. Monitoring

1. The Director of Nursing (DON) or Designee will review admission referral to ensure that the facility will only accept residents that we can provide needed care and services. The Administrator will also be notified of the residents who are transferred to the acute hospital to also help in the decision of readmitting resident following the facility Policy and Procedure for Bed-hold and return from acute hospital.

2. The Business Office Manager (BOM) or Designee will monitor by reviewing daily census, will check residents who were transferred to the acute hospital to ensure Bed-hold policy is followed; (Medical automatic bed-hold x 7 days and other insurance to ask resident or family member if they want to want to hold the bed, BOM will discuss financial responsibility with the resident or the resident's representative. This will be documented in the resident's medical record and financial file.

3. Medical Records or Designee monitor by auditing resident's chart of the residents who are transferred to the acute hospital to ensure bed-hold orders are obtained. This will be recorded on the Notice of Proposed Transfer/Discharge (Unplanned) Log. Any problems will be brought to the attention of the Administrator.

Quality Assurance:

The Administrator and the Quality Assurance Performance Improvement; (QAPI), team members will discuss system effectiveness of the plan of correction for this deficient practice related to F 626 Permitting Residents to Return to Facility including but not limited to admitting residents that the facility can provide care/services and Bed-hold Policy. If the system is effective, the team will continue to monitor and discuss in the monthly QAPI meeting to ensure compliance. If system is ineffective the team will discuss a different plan.

E. Date of Completion & Compliance

5/11/2025.

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F 626	Continued From page 1 §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to permit one of three sampled residents (Resident 1) to return to facility after the facility sent the resident to Emergency Room (ER). This failure resulted in denial of Resident 1's rights to return to the facility, which resulted in the resident's continuation of unnecessary hospital stay while waiting for placement. Findings: A review of the facility's ' Policy and Procedure on Admission Screening,' dated 7/2012, stipulated, "The main criteria for admission are the facility is equipped and be able to provide the needed care and services of the resident. " The policy indicated further, "The Director of Nursing ...will assess the resident's concerns based on the information provided ...for resident admission ...If the assessment result revealed that the facility has the capacity to provide the needed care and services ...based on medical background, other concerns such as physical and psychosocial needs ...administrator or	F 626		

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F 626	Continued From page 2 designee will give the "Go " signal for admission. " A review of the general acute care hospital (GACH) notification sent to the Department on 4/8/25, indicated the facility refused to accept Resident 1 back to facility. During a telephone interview on 4/11/25, at 4:15 p.m., the case manager (CM) from the GACH stated the facility transferred Resident 1 to ER on 4/4/25 without medical necessity and refused to readmit the resident back. The CS stated, "We reached out to them several times and they still declined to take the resident back ...She [Resident 1] was literally dumped here with no reason ...It was unfair for [age] years old sitting in ER for over 60 hours waiting for the placement. " A review of the Admission Record indicated the facility admitted Resident 1 on 4/3/25 with multiple diagnoses, which included stroke, depression, and muscle weakness. A review of the facility's ' Admission Assessment' for Resident 1 dated 4/3/25, at 1:55 p.m., described the resident as "friendly ...disoriented to... time, place, and person ...mood ...wanders mentally ...slow comprehension. " Per Admission Assessment Resident 1 required staff's assistance with personal care, eating, transfer and ambulation. A review of social services (SS) progress notes dated 4/4/25, at 5:52 p.m., indicated that the facility was notified by "male bystander " that Resident 1 was found in another facility across the street. SS documented that Resident 1 was	F 626		

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F 626	Continued From page 3 brought back to the facility. During an interview on 4/11/25, at 10 a.m., the facility's Administrator (ADM) confirmed that Resident 1 left the facility around 8 a.m., on 4/4/25 without staff's knowledge and crossed the street. The ADM explained that the resident was immediately placed on one-on-one supervision and a few hours later, the resident was sent to acute hospital for evaluation. The ADM stated, "We refused to readmit her ...she was not safe here ...There is something acute going with her. " The ADM confirmed that the facility had several conversations with GACH staff and continuously refused to readmit Resident 1 back to facility. The ADM stated, "When she [Resident 1] started getting agitated and anxious we sent her to acute. [Resident 1] did not hurt anyone, but we determined that she was not safe here. " The ADM did not provide any answer when asked if the resident was danger to herself or endangered other residents. During an interview on 4/11/25, commencing at 10:20 a.m., the Director of Nursing (DON) was asked to explain the facility's criteria for admission of new residents. The DON explained, "We did not go to the hospital to physically assess if resident was appropriate for us ...I reviewed her referral documents with the information I had at that time along with admission coordinator (AC) and determined that [Resident 1] was appropriate to be here and the resident was accepted. The DON stated that a day after admission Resident 1 left the facility without staff's knowledge (eloped) and that after she was brought back, the facility determined that the resident was not safe and sent her to	F 626		

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F 626	Continued From page 4 ER. During a continued interview with DON on 4/11/25, at 10:20 a.m., the DON stated the facility will not readmit Resident 1 because it was "not safe here, very busy street. " The DON continued, "She was focused on leaving all the time and we thought she needs more attention ...Very unstable gait and unstable on her feet ...somebody had to be with her all the time ...She would sit down [in wheelchair] and then would get up ...Talked non-stop about wanting to get new slippers. " The DON stated that Resident 1 was "dangerous because she could have been hit by a car when she crossed the street " and added that she explained to the ER staff that facility did not "have any amenities to keep [Resident 1] safe here with such a busy street and intersection [referring to the busy road near the facility]. " The DON explained that Resident 1 became more confused on the second day after admission and there might have been changes in the resident's condition. The DON stated Resident 1 had not been seen by her physician when she was admitted and neither physician nor Nurse Practitioner (NP) assessed and evaluated Resident 1 after she was found wandering in the parking lot of another facility. The DON agreed that the resident was elderly and could have been confused seeing unfamiliar faces and a new place. The DON stated the facility placed Resident 1 on one-to-one supervision, but the resident insisted on leaving the facility. The DON stated, "When we tried to redirect her and bring her back, she was getting agitated ...Talked non-stop about wanting to get new slippers. " The DON denied that the resident endangered other residents. The DON	F 626		

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F 626	Continued From page 5	F 626		

stated she was not aware if the facility attempted any other interventions beside one-on-one supervision before sending the resident to ER.

During an interview with social services (SS) on 4/11/25, at 11:55 a.m., the SS stated when the staff brought Resident 1 from another facility, the resident had no physical behaviors and was not agitated or aggressive. The SS explained that Resident 1 was wearing non-skid socks and was talking about buying new slippers. The SS stated she stayed with the resident for some time and the resident "was very confused ...but not agitated ...not combative ... and repeatedly talked about new slippers. " The SS stated the resident was not dangerous and did not present any behaviors of endangering other residents.

During an interview on 4/11/25, at 12:10 p.m., Certified Nursing Assistant (CNA 1) stated after Resident 1 was brought back to facility, the resident "looked confused, talked about random things ...was not aggressive, not yelling and not screaming, and had no physical behaviors. "

During an interview on 4/11/25, at 12:25 p.m., Licensed Nurse 1 (LN 1) stated that the resident "explained that she left because she had things to do and needed to see her son " when she was brought back. LN 1 stated Resident 1 took her morning medications and was cooperative during assessment. LN 1 added, "No physical behaviors or agitation, she was not screaming or yelling ... very confused and talked that she needed new slippers. " LN 1 stated the resident "was constantly attempting to get up from her wheelchair, but otherwise she was fine ... She did not present a danger to herself, to her roommate

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F 626	Continued From page 6	F 626		

or staff. " LN 1 stated when she called NP to report that Resident 1 had elopement incident earlier in the morning, the NP ordered a wander guard (an electronic safety device used to alert staff for potential elopement) and one-on-one supervision. LN 1 stated the NP requested to send Resident 1 to ER.

During the telephone interview with NP on 4/11/25, at 12:40 p.m., the NP stated, "I did not see the resident ...received a call informing about elopement ...I was informed by staff that she was hard to redirect and determined she was not appropriate for the facility. The DON told me that the resident was pushing staff away and I ordered one-on-one supervision ...Not sure if she had physical behaviors, except that she pushed staff who prevented her from getting out of wheelchair and walk away ... and I gave a verbal order to send her [out]. " The NP acknowledged that Resident 1 did not endanger other residents. When the NP was asked if the resident was danger to herself, the NP stated, "I did not speak with resident, but from what I was told, she did not belong here. "

A review of the undated ' Transfer and Discharge from the Facility Policy,' indicated, "It is the policy of this facility that each resident has the right to remain in the facility ...unless a transfer or discharge from the facility is ...necessary for the resident's welfare and the resident's needs cannot be met in the facility ...The safety of individuals in the facility is endangered due to clinical or behavioral status of the resident. " The policy further indicated that the facility would communicate appropriate resident's information to the receiving institution. The policy indicated,

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F 626	Continued From page 7 "When a resident discharge is due to the resident's welfare and the facility cannot meet the resident's needs, documentation by the resident's physician must include: 1. The specific resident need the facility could not meet; 2. The facility's efforts to meet those needs ...physician documentation regarding the necessary transfer and discharge. " During a follow up interview with DON on 4/11/25, at 12:55 p.m., the DON stated that the basis for Resident 1's transfer to the hospital and refusal to readmit back to facility was because the facility could not meet resident's safety needs. The DON was unable to find any clinical records indicating that the resident was agitated, was not redirectable, and presented danger to self or other residents. The DON was not able to provide any documented evidence that the facility identified likely cause for Resident 1's increased confusion and validated that the resident was not evaluated by physician. The DON stated there was no physician documentation regarding the necessary transfer or discharge as indicated in the Transfer and Discharge policy. The DON agreed that beside wanting to leave and buy new slippers Resident 1 had no other behaviors and clarified, "When she goes across the busy street and intersection, it is dangerous for her. " The DON acknowledged that having wander guard and adequate supervision might have prevented Resident 1's elopement and subsequent transfer to ER. During a follow up interview with ADM on 4/11/25, at 1:15 p.m., the ADM stated, "Once we accept the resident, we have responsibility to keep the resident safe. "	F 626		

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision, accurate assessment, and interventions for one of 3 sampled residents (Resident 1) to prevent the resident leaving the facility, when Resident 1 left the facility without staff's knowledge (eloped), crossed a busy street, and was found wandering on the parking lot of another facility. This failure resulted in exposing Resident 1 to health hazards and fatal accidents. Findings: A review of the Admission Record indicated the facility admitted Resident 1 on 4/3/25 after a brief hospitalization. Resident 1's multiple diagnoses included depression, muscle weakness and difficulty in walking. A review of Resident 1's hospital records dated 3/24/25 indicated the resident was brought to the hospital with confusion, weakness, and frequent falls at home. A review of the hospital document titled,	F 689		

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F 689	Continued From page 9	F 689		

"Inter-Facility Transfer Report " dated 4/3/25 indicated that Resident 1 was diagnosed with acute encephalopathy (impaired/altered mental status) caused by stroke (brain injury). The document indicated the resident was confused, had generalized weakness, and was at high risk for falls.

A review of the facility's ' Admission Assessment' for Resident 1 dated 4/3/25, at 1:55 p.m., described the resident as "friendly ...disoriented to... time, place, and person ...mood ...wanders mentally ...slow comprehension. " Per Admission Assessment Resident 1 required staff's assistance with personal care, eating, transfer and ambulation.

A review of the ' Elopement Assessment' dated 4/3/25, indicated the resident scored 4, which indicated low risk for elopement.

A review of nursing progress notes dated 4/4/25, at 8:31 a.m., indicated that at 7:40 a.m., Resident 1 was observed with her walker standing by her room door. The Licensed Nurse (LN 1) documented that the resident informed LN 1 "that she's just got things to do, trying to find her slippers. "

A review of social services (SS) progress notes dated 4/4/25, at 5:52 p.m., and written as "LATE ENTRY " indicated that the facility was notified by "male bystander " that Resident 1 was found in another facility across the street. SS documented that Resident 1 was brought back to the facility.

During an interview on 4/11/25, at 10 a.m., the

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F 689	Continued From page 10 facility's Administrator (ADM) confirmed that Resident 1 left the facility around 8 a.m., on 4/4/25 without staff's knowledge and crossed the street. The ADM stated, "The street is very busy and dangerous ...two (2) lines each, " and acknowledged that the resident could have gotten hurt or killed. During an interview on 4/11/25, at 11:55 a.m., SS stated she was at the nursing station when a concerned citizen entered the building and informed staff that he found Resident 1 wandering in parking lot across the street. The concerned citizen informed the staff that he thought the resident lived at another facility and took her there. The SS stated when the SS and Certified Nursing Assistant (CNA 1) went to another facility, Resident 1 was wearing socks. SS stated the resident was confused and insisted that she needed to buy new slippers. During an interview on 4/11/25, at 12:55 p.m., the Director of Nursing (DON) stated that Resident 1 had no wander guard (an electronic safety device used to alert staff for potential elopement) because she scored low on elopement assessment. Upon reviewing the elopement assessment completed on 4/3/25, the DON validated the elopement assessment was inaccurate. The DON stated if the elopement assessment was accurate, the resident would score as high risk for elopement and would have a wander guard placed which would alert the staff when she left the facility. The DON stated the resident was confused, continuously wandered around the building and into other residents' rooms at night, and required lots of redirection and staff supervision. The DON	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD CARE CENTER OF FAIRFIELD	1260 TRAVIS BLVD FAIRFIELD, CA 94533

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 acknowledged that it was unsafe situation that Resident 1 crossed the busy street during busy morning commute and agreed that the resident could have been injured or killed. A review of the facility's ' Elopement Risk Precautions and Procedures,' with the revision date of 6/24 indicated, "It is the policy of the facility to identify residents who are wanderers or who are a threat to leave the facility unattended without the knowledge of the facility staff ...Purpose: To ensure resident's safety ...Procedure: Obtain information during pre-admission or admission ...regarding ...potential for elopement ...Staff is responsible for knowing or recognizing the resident who has exit seeking behavior to intervene as needed.	F 689		

GREENFIELD
CARE CENTER OF FAIRFIELD, LLC

1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: P & P on Admission screening including criteria for admissions and bedhold Policy

Date Started: 4/15/20 Time (From): 1:30 pm Time (To): 1:45 pm Length: ______

Presented by: [signature] RN - (QA nurse consultant)
Signature / Title

Program: Orientation ☑ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
Arnulfo B Vidad	[signature]	RN DON

GREENFIELD
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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: P + P on Admission Screening

Date Started: 5/5/23 Time (From): 9:30 am Time (To): 10:00 am Length: 30 min

Presented by: Theresa Cardinas Administrator
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
SUSAN PANGILINAN	[signature]	SSD
Venerando Demayo	[signature]	DSS
MELVIN RIMANDO	[signature]	DSD
Jazmique Williams	[signature]	MARKETING
[illegible]	[signature]	[illegible] Admission
Arnulfo B Vidad	[signature]	RN DON
JOHNWIN Cin	[signature]	mar/[illegible]
Annabelle S. Mangnu	[signature]	Med Rec
Olive Ordonia	[signature]	BOM
Fernando Camarillo Jr.	[signature]	Maint. Super.

POLICY AND PROCEDURE ON ADMISSION SCREENING

POLICY

To ensures that all residents whose needs and services could be met and provided are the only ones to be admitted in the facility. It does not discriminate admission based on age, race, color, sex, and religion.

PROCEDURE

The main criteria for admission are the facility is equipped and be able to provide the needed care and services of the resident. In order to meet his goal, the following procedure will be complied with:

1. All inquiry will be received by the Administrator or her designee.
2. The Director of Nursing and the Assistant Director of Nursing will assess the resident's concerns based on the information provided by the inquiring facility for resident admission. If the assessment result revealed that the facility has the capability to provide the needed care and services to the prospective resident, the information will be provided to the business office personnel.
3. Business Office Manager will verify payor coverage of the prospective resident. Finding of this verification will be forwarded to the Administrator.
4. Administrator will make the final decision based on the medical background, other concerns such as physical and psychosocial needs as well as financial capability of meeting his or her obligation for payment of the care.
5. Administrator or designee will give the "Go" signal for admission form the facility or inquiring provider referring the resident for admission.
6. The Director of Nursing or designee will ensure that resident has an attending physician who will admit the resident in the facility.
7. All medications and other ancillary orders will be verified by the licensed nurse admitting the resident from the attending physician.

Tittle

LESSON PLAN

PROGRAM: Admission Screening	**LOCATION: Greenfield Care Center of Fairfield**
CLASS TITILE: Admission Screening	**LENGTH OF TIME:**
INSTRUCTOR: Melvin Rimando RN/DON	**AUDIENCE: Staff Member**

PERFORMAMANCE STANDARD / OBJECTIVE	COURSE CONTENT	TEACHING METHODS	EVALUATION
Participant will be able to: • Verbalize understanding of the Admission Screening Process and Policy	**POLICY AND PROCEDURE ON ADMISSION SCREENING** POLICY To ensures that all residents whose needs and services could be met and provided are the only ones to be admitted in the facility. It does not discriminate admission based on age, race, color, sex, and religion. PROCEDURE The main criteria for admission are the facility is equipped and be able to provide the needed care and services of the resident. In order to meet his goal, the following procedure will be complied with: 1. All inquiry will be received by the Administrator or her designee. 2. The Director of Nursing and the Assistant Director of Nursing will assess the resident's concerns based on the information provided by the inquiring facility for resident admission. If the assessment result revealed that the facility has the capability to provide the needed care and services to the prospective resident, the information will be provided to the business office	Lecture and Discussion	Question and Answer

	personnel. 3. Business Office Manager will verify payor coverage of the prospective resident. Finding of this verification will be forwarded to the Administrator. 4. Administrator will make the final decision based on the medical background, other concerns such as physical and psychosocial needs as well as financial capability of meeting his or her obligation for payment of the care. 5. Administrator or designee will give the "Go" signal for admission form the facility or inquiring provider referring the resident for admission. 6. The Director of Nursing or designee will ensure that resident has an attending physician who will admit the resident in the facility. 7. All medications and other ancillary orders will be verified by the licensed nurse admitting the resident from the attending physician.		

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: REQUEST TRANSFER/DISCHARGE TO ACUTE FACILITY (7 DAY BED HOLD FOR MEDICAL, PVT/NON-MEDICAL WILL NEED TO PAY PRIVATELY 09/02/26

Date Started: 5-7-25 Time (From): 2:00 PM Time (To): _____ Length: _____

Presented by: MELVIN RIMANDO RN/DSD
Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
Nisha Tripathi		RN
ZARINA MARTINEZ		RN
Armando B Vidad		RN DON
RENEE MALLAKI		RN
LANY MAGTOTO		RN
VILMA CABAN		LVN
Daisy Shadid		RN
Elizabeth Romo		LVN
Victoria Palma		RN
Azeezah Jackson		RN

Discharge/Hospital

POLICY:

It is the policy of this facility that before residents are discharged from the facility, per physicians order, a review of the resident's medical records and inter-facility transfer will be completed.

PURPOSE:

To make a smooth transfer from one facility to another, by providing continuous medical and/or nursing services.

PROCEDURES: (Discharge to Hospital)

1. Nurse will attain a physicians order to discharge resident to the acute hospital due to change of condition. In the event of an emergency departure due to a critical/drastic change of condition, 911 will be contacted prior to MD notification. The physician will be informed as soon as possible of a transfer due to critical change of condition.
2. Facility may contact the acute hospital before transfer if applicable/feasible.
3. Nurse will complete an inter-facility, transfer form and attach copies of the following documents from the resident medical record:
    a. Face Sheet
    b. Advance Directive information/POLST
    c. Current Physicians Order, H & P, Med Sheet, copies of lab and/or x-rays, and other pertinent records as required
4. These records may not be sent with the resident who was transferred via 911.
5. A copy of the inter-facility transfer form needs to be retained in the medical record.
6. Nurse will coordinate ambulance or other transport arrangements.
7. Send only crucial person items (hearing aids, dentures, glasses) with resident but such should be reflected in the transfer paper. All other personal items should be inventoried, packed, and placed in a secure location.
8. Nurse will inform Dietary Department, Business Office and Housekeeping Department of discharge.
9. Resident's room/bed will be disinfected and be cleaned ready for resident to come back or new resident's admission.
10. Noticed of proposed transfer will be sent to ombudsman as soon as practical.

Documentation:

1. Nursing is to write a discharge nursing note, including:

a. Date and time of transfer
b. Physician notification
c. Condition of resident including but not limited to skin, vital signs, LOC, ADL support
d. Date and time of notification of family/responsible party
e. Method of transport and by whom
f. Disposition of personal belongings, medication 7 days bed hold if applicable

LESSON PLAN

PROGRAM: Resident Transfer/Discharge to Acute Hospital (Bedhold policy)	LOCATION:
CLASS TITILE: Transfers ,Discharge to Acute Facility/Bedhold policy	LENGTH OF TIME: 50min
INSTRUCTOR: Melvin Rimando, RN/DSD	AUDIENCE: Licensed Nurses

PERFORMANCE STANDARE/OBJECTIVE	COURSE CONTENT	TEACHING METHODS	EVALUATION
Participant will be able to: Understand the process of discharging the resident to acute hospital	Discharge/Hospital POLICY: It is the policy of this facility that before residents are discharged from the facility, per physicians order, a review of the resident's medical records and inter-facility transfer will be completed. PURPOSE: To make a smooth transfer from one facility to another, by providing continuous medical and/or	Lecture/ Discussion	• Question and Answer

	nursing services. PROCEDURES: (Discharge to Hospital) 1. Nurse will attain a physicians order to discharge resident to the acute hospital due to change of condition. In the event of an emergency departure due to a critical/drastic change of condition, 911 will be contacted prior to MD notification. The physician will be informed as soon as possible of a transfer due to critical change of condition. 2. Facility may contact the acute hospital before transfer if applicable/feasible. 3. Nurse will complete an inter-facility, transfer form and attach copies of the following documents from the resident medical record: a. Face Sheet b. Advance Directive information/POLST c. Current Physicians Order, H & P, Med Sheet, copies of lab and/or x-rays, and other pertinent records as required 4. These records may not be sent with the resident		

	who was transferred via 911. 5. A copy of the inter-facility transfer form needs to be retained in the medical record. 6. Nurse will coordinate ambulance or other transport arrangements. 7. Send only crucial person items (hearing aids, dentures, glasses) with resident but such should be reflected in the transfer paper. All other personal items should be inventoried, packed, and placed in a secure location. 8. Nurse will inform Dietary Department, Business Office and Housekeeping Department of discharge. 9. Resident's room/bed will be disinfected and be cleaned ready for resident to come back or new resident's admission. Documentation: 1. Nursing is to write a discharge nursing note, including: a. Date and time of transfer		

	b. Physician notification **c. Condition of resident including but not limited to skin, vital signs, LOC, ADL support** **d. Date and time of notification of family/responsible party** **e. Method of transport and by whom** **f. Disposition of personal belongings, medication 7 days bed hold (for Medical Residents) Non-Medical Residents will have to pay privately if bedhold is approved by resident/responsible party**		

GREENFIELD
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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Admission / Readmission

Date Started: 4/27/25 Time (From): 10:15 Am Time (To): 10:45 Am Length: ____

Presented by: Teresa Cardinas [signature]
Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
MELVIN RIMANDO	[signature]	RN/DON
MARINA MARTINEZ	[signature]	
Veneranda Demaya	[signature]	DSS
Jazzmique Williams	[signature]	MARKETING
Johnwin Cid	[signature]	MDS/LVN
Arnulfo B Vidad	[signature]	AN Adm
Maria Antipord	[signature]	Admission
Annabelle S Marquez	[signature]	Med Rec
Oliver Ordonio	[signature]	RDM
CARL LONGWYN	[signature]	
SUSAN PANGILINAN	[signature]	SSD

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: P+P on Readmission w/ 48 Hours

Date Started: 5/5/25 Time (From): 10:00 am Time (To): 10:30 am Length: 30 min

Presented by: Theresa Cardinas Administrator
Signature / Title

Program: Orientation ☐ In-service ☑ POC

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
SUSAN PANGILINAN	[signature]	RCD
Veneranda Demayo	[signature]	DSS
Jazzmine Williams	[signature]	MARKETING
Malou Antiporda	[signature]	Admission/CS
Arnulfo B Vidad	[signature]	RN DON
JOHNWIN Cid	[signature]	MDS/LVN
Annabelle S Manegan	[signature]	Med Rec
Aive Ordonia	[signature]	BOM
MELVIN Rumawan	[signature]	BSD
Fernando Camarillo Jr.	[signature]	Maint. Supervisor

POLICY AND PROCEDURE ON RE-ADMISSION WITHIN 48 HOURS

PURPOSE

To facilitate the re-admission process for residents.

POLICY

It is a policy of this facility to re-admit residents who were transferred from the acute hospital upon the order of a physician. This facility shall accept and retain only those residents for whom it can provide adequate care.

It is also the policy of this facility to continue the resident's old chart if the resident is readmitted within 48 hours of discharge.

PROCEDURE

1. Notify all departments about time of resident's re-admission.
2. The Medical Records Designee shall pull out the resident's old chart in the Medical Records Department to the Nursing Station for resident's readmission within 48 hours.
3. The admitting nurse shall review the resident's admitting orders from the hospital transfer sheets and the previous physician's orders. The admitting nurse shall notify the primary physician via telephone of the resident's re-admission to the facility and of the medication & treatment order changes if any and the continuation of the resident's previous medication & treatment if ordered.
4. Documentation of the physician's order, whether prior or new, shall be reflected in the physician's order sheet.
5. The re-admission nursing assessment shall be completed on admission.
6. The admitting nurse shall review all prior care plans for any additional problems and changes in plan of care related to re-admission.

Tittle

LESSON PLAN

PROGRAM: Re-Admission Procedure	**LOCATION: Greenfield Care Center of Fairfield**
CLASS TITILE: Resident Readmission within 48 hours	**LENGTH OF TIME: 1 hour**
INSTRUCTOR: Melvin Rimando, RN/DSD	**AUDIENCE: Licensed Nurses**

PERFORMAMANCE STANDARD / OBJECTIVE	COURSE CONTENT	TEACHING METHODS	EVALUATION
Participant will be able to: Know and understand policy and procedure of Re-admission to facility within 48 hours	**POLICY AND PROCEDURE ON RE-ADMISSION WITHIN 48 HOURS** PURPOSE To facilitate the re-admission process for residents. POLICY It is a policy of this facility to re-admit residents who were transferred from the acute hospital upon the order of a physician. This facility shall accept and retain only those residents for whom it can provide adequate care. It is also the policy of this facility to continue the resident's old chart if the resident is readmitted within 48 hours of discharge. PROCEDURE 1. Notify all departments about time of resident's re-admission. 2. The Medical Records Designee shall pull out the resident's old chart in the Medical Records Department to the Nursing Station for resident's readmission within 48 hours. 3. The admitting nurse shall review the resident's admitting orders from	Lecture and Discussion	Question and Answer

	the hospital transfer sheets and the previous physician's orders. The admitting nurse shall notify the primary physician via telephone of the resident's re-admission to the facility and of the medication & treatment order changes if any and the continuation of the resident's previous medication & treatment if ordered. 4. Documentation of the physician's order, whether prior or new, shall be reflected in the physician's order sheet. 5. The re-admission nursing assessment shall be completed on admission. 6. The admitting nurse shall review all prior care plans for any additional problems and changes in plan of care related to re-admission.		

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Bedhold Policy

Date Started: 5/7/25 Time (From): 10:05 AM Time (To): 10:35 AM Length: _____

Presented by: Teresa Collins, Administrator
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
Venerando Demayo		DSS
Fernando Camarillo Jr.		Maint. Supervisor
JOHNWIN CUB		MAINTENANCE
JESSA PANGILINAN		SSD
Armilfi B Vidad		LVN
CLARE LLENEVLYN		LP
Olive Ordonia		ROM
MARIA ANTIPOLO		Admission

Bed Hold Notice

POLICY

It is a policy that this facility shall inform the resident, or the resident's representative, in writing of the right to exercise the bed hold provision under the State Plan (7 days for California), at the time of admission, and at the time of transfer for hospitalization-or therapeutic leave.

A copy of this notice shall become a part of the-resident's health record at the time of transfer and this shall be the responsibility of the:

- □ Admission Coordinator
- □ Social Service Designee
- □ Other:

PROCEDURE

1. The resident or the resident's representative shall be informed, in writing, of their right to exercise the bed hold provision of seven (7) days. Each notice shall include information that a non-Medicaid eligible resident will be liable for the cost of the-bed-hold days, and that insurance may or may not cover such costs. This information shall be provided at the time of admission and transfer to a general acute care hospital or for a therapeutic leave.

2. If the bed hold option is exercised, the resident or the representative shall notify the facility within twenty-four (24) hours after being informed of the right to have the bed held. A non-Medicaid resident or the representative shall be liable to pay reasonable charges, not to exceed the resident's daily rate for the bed hold period.

3. If the resident's attending physician notifies the facility in writing that a Medicaid resident's stay in the general acute care hospital is expected to exceed seven (7) days, the facility shall NOT be required to maintain the bed hold.

4. The facility shall readmit a Medicaid resident requiring SNF services as agreed upon by the resident and/or surrogate decision maker, immediately upon the first availability of a bed in a semiprivate room when his/her hospitalization or therapeutic leave exceeds the bed hold period.

Tittle

LESSON PLAN

PROGRAM: Bed Hold	**LOCATION: Greenfield Care Center of Fairfield**
CLASS TITILE: Bed hold policy	**LENGTH OF TIME: 1 hour**
INSTRUCTOR: Melvin Rimando, RN/DSD	**AUDIENCE: ALL Licensed Nurses**

PERFORMAMANCE STANDARD / OBJECTIVE	COURSE CONTENT	TEACHING METHODS	EVALUATION
Participant will be able to: Understand the importance of bedhold policy	**Bed Hold Notice** POLICY It is a policy that this facility shall inform the resident, or the resident's representative, in writing of the right to exercise the bed hold provision under the State Plan (7 days for California), at the time of admission, and at the time of transfer for hospitalization-or therapeutic leave. A copy of this notice shall become a part of the-resident's health record at the time of transfer and this shall be the responsibility of the: □ Admission Coordinator □ Social Service Designee □ Other: PROCEDURE 1. The resident or the resident's representative shall be informed, in writing, of their right to exercise the bed hold provision of seven (7) days. Each notice shall include information that a non-Medicaid eligible resident will be liable for the cost of the-bed-hold days, and that insurance may or may not	Lecture and Discussion	Question and Answer

	cover such costs. This information shall be provided at the time of admission and transfer to a general acute care hospital or for a therapeutic leave. 2. If the bed hold option is exercised, the resident or the representative shall notify the facility within twenty-four (24) hours after being informed of the right to have the bed held. A non-Medicaid resident or the representative shall be liable to pay reasonable charges, not to exceed the resident's daily rate for the bed hold period. 3. If the resident's attending physician notifies the facility in writing that a Medicaid resident's stay in the general acute care hospital is expected to exceed seven (7) days, the facility shall NOT be required to maintain the bed hold. 4. The facility shall readmit a Medicaid resident requiring SNF services, immediately upon the first availability of a bed in a semiprivate room when his/her hospitalization or therapeutic leave exceeds the bed hold period.		

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Elopement

Date Started: 4/14/26 Time (From): 2:30pm Time (To): 3pm Length: _____

Presented by: Ramirez RN QA nurse
Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
Armando B Vidal		RN DON

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Elopement Assessment, Monitoring

Date Started: 4/29/25 Time (From): 9:30 AM Time (To): 10:15 AM Length: ______

Presented by: Theresa Cadimas
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
MELVIN RIMANDO	[signature]	RN/DSD
ZARINA MARTINEZ	[signature]	
Veneranda Demayo	[signature]	DSS
Jazzniare Williams	[signature]	MARKETING
Arnulfo B Vidad	[signature]	RN DON
Marion Antipuesto	[signature]	Admission
Johnwin Cid	[signature]	MDS/LVN
Annabelle S Mangune	[signature]	Med Rec
Olive Ordonia	[signature]	BOM
Carie Lumeria	[signature]	TP
SUSAN PANGILINAN	[signature]	SSD

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: P + P on Resident Safety Plans

Date Started: 5/5/25 Time (From): 10:30 AM Time (To): 11:00 AM Length: 30 min

Presented by: Theresa Cardinas, Administrator
Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
SUSAN PANGILINAN	[signature]	SSD
Venerando Demayo	[signature]	DSS
MELVIN RIMANDO	[signature]	DSD
Jazmique Williams	[signature]	MARKETING
Malou Cutung	[signature]	Admission
Arnulfo B Vidad	[signature]	RN DON
JOHNWIN Cis	[signature]	MDS/LVN
Annabelle S. Mangini	[signature]	Med Rec
Olive Ordonia	[signature]	ADM
Fernando Camarillo Jr.	[signature]	Maintenance. Superv.

POLICY AND PROCEDURE ON RESIDENT SAFETY PLANS

POLICY

To develop plan for resident safety which could be adverse event or potential adverse event that is determined to be preventable and health-care-associated infections as defined by the National Healthcare Safety Network or Healthcare Associated Infection Advisory Committee that is determined to be preventable.

PROCEDURE

Facility safety plan includes but not limited to establishing:

1. Safety Committee composed of Medical Director, Administrator, DON, DSD, Dietary Supervisor, Maintenance Supervisor, SSD, and other QA members.
2. Safety Committee will meet monthly which could be in conjunctions with monthly QA meeting.
3. It will discuss any resident safety events for the month, analyzes the root cause on reported resident safety events.
4. It reviews the implementations of interventions and corrective actions for resident safety events and the training of personnel and health care practices provided to them.
5. Safety Committee will make recommendations to minimize if not totally eliminate future events and finally it.
6. Reviews and revise resident safety plans yearly or more often as necessary for effectiveness of the system.

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Resident's Safety / Sitters

Date Started: 5/5/25 Time (From): 10:30 am Time (To): 11:00 am Length: 30 min

Presented by: Teresa Calimag, Administrator

Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
JUAN PANGILINAN	[signature]	USD
Venerando Demayo	[signature]	BSS
MELVIN FUNAISEN	[signature]	PSD
Jazzniqve Williams	[signature]	MARKETING
Malou Aromula	[signature]	Admiss, Sn
Arnulfo B Vidad	[signature]	RN DON
JOHNWIN CIN	[signature]	LVN/MDS
Annabelle C Marigmu	[signature]	Med Rec
Olive Ordonia	[signature]	BOM
Fernando Camarillo	[signature]	Maint. Supervisor

GREENFIELD
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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Management

Course Title: ELOPEMENT : RISKS & MANAGEMENT (WANDERGUARD SYSTEM)

Date Started: 4/24/15 Time (From): 7:50P Time (To): 8:07P Length: 17 min

Presented by: MELVIN RIMANDO, RN DSD
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Title	Name	Signature
Administrator	Theresa Cadimas	
DON	Arnulfo Vidad	
MDS	Johnwin Cid	
Rehab	Abu Jacob	
IP	Clarita Naval	
Social Services	Susan Pangilinan	
BOM	Olivia Ordonia	
Maintenance Dir	JR Camarillo	
Activity Director	Cristina Cerna	
Admission	Malou Antiporda	
Medical Record	Annabelle Mangune	
Payroll	Therese Borja-falani	
DSD	Melvin Rimando, RN	
DSD	Erlinda Biaco-Rimando,RN	
LVN	VILMA CABAL	
LVN	ELIZA ANN	

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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

License Nurses In-service Attendance Record

Course Title: ELOPEMENT. risks and Management

Date Started: 4/24/25 Time (From): 1:30 P Time (To): 2:00 P Length: 10 min

Presented by: MELVIN RIMANDO
Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
Lovedeep Kaur	Lovedeep Kaur	RN
Daisy Shahid	Daisy Shahid	RN
Sonia Thakur		RN
Rajbir Kaur		RN
Victoria Palma		RN
Pragya Kaphle		RN
Pauline Mpuekela		RN
Nisha Tripathi		RN
Klranjit Kaur		RN
Lany Magtoto		RN
Renee Mallari		RN
Eliza Amir		LVN
Rosario Padilla		LVN
Angelica Shipman		LVN
Pawandeep Kaur	Pawandeep Kaur	LVN
Imelda Cain		LVN
Vilma Cabal	Vilma Cabal	LVN
Pamela Pascua		LVN
Azeezah Jackaron		RN
Clare Llewelyn		LVN

GREENFIELD
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1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Elopement Risks Precautions & Procedures & Documentation

Date Started: 5/5/25 Time (From): 11:00 am Time (To): 11:30 am Length: 30 min

Presented by: [signature] Administrator
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
SUSAN PANGILINAN	[signature]	SDD
Venerranda Demayo	[signature]	DSS
MELVIN RIMANDO	[signature]	DSD
Jazznique williams	[signature]	MARKETING
Arnulfo B Vidad	[signature]	RN DON
JOHNWIN CIN	[signature]	MDS/LVN
Annabelle S. Mangune	[signature]	Med Rec
Olive Ordonia	[signature]	BOM
Fernando Camarillo Jr.	[signature]	Maint. Supervisor

Elopements

POLICY:

It is the policy of this facility that nursing personnel must report and investigate all reports of missing residents

PROCEDURES:

1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical.

2. Should an employee observe a resident leaving the premises, he/she should:

    a. Attempt to prevent the departure
    b. Attain assistance from other staff members in the immediate vicinity, if necessary
    c. Instruct another staff member to inform the charge nurse or director of nursing services that a resident has left the premises
    d. Be courteous in preventing the departure and in returning the resident to the facility.

3. Upon return of the resident to the facility, the director of nursing services or charge nurse should:

    a. Examine the resident for injuries
    b. Contact the attending physician and report what happened
    c. Contact the resident's legal representative (sponsor) and inform him/her of the incident
    d. Complete and file an incident report
    e. Make appropriate notations in the resident's medical record.

4. Should an employee discover that a resident is missing from the facility, he/she should:
    a. Determine if the resident is out on an authorized leave or pass. If not;
    b. Make a thorough search of the building(s) and premises. If not located;
    c. Inform the administrator and the director of nursing services
    d. Inform the resident's legal representative (sponsor)
    e. Inform the attending physician
    f. Inform law enforcement officials

g. If necessary, notify volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.)
h. Provide search teams with resident identification information.
i. Make an extensive search of the surrounding area.

5. Upon return of the resident to the facility, the director of nursing services or charge nurse should:
   a. Examine the resident for injuries
   b. Contact the attending physician and report findings and conditions of the resident. Follow orders;
   c. Inform the resident's legal representative (sponsor)
   d. Inform search teams that the resident has been located
   e. Complete and file an incident report
   f. Make appropriate entries into the resident's medical record.

Constant 1:1 Observation may be ordered by a physician or psychiatrist for Residents who are at risk for falls, elopement, pulling out lines or tubes, behavioral issues, suicidal tendencies, resident safety, self infliction of harm, abuse or other safety needs based on a residents individualized Plan of Care.

Procedure

- Resident Safety Companion/Sitters are used to maintain safe and effective resident care only after a careful assessment of need for Constant Observation and after all alternative measures have been considered.
- Every resident who exhibits Behaviors and/or a risk of harming themselves or others deserves a timely, accurate and thorough assessment, identifying their unique needs, which will form a plan of care.
- Non-pharmacological interventions outlined in a resident's plan of care that are reflective of the resident's history, health care needs and safety, and that an interdisciplinary team can provide, are preferred over Constant Observation by a Resident Companion.
- An important part of providing Person-Centered Care to residents with Behaviors or Safety needs is finding out the resident's likes and dislikes, past employment, hobbies and other aspects of their history. Obtaining this information from those who know the resident best and including it in a plan of care helps Staff provide better care.
- The RN, Nurse Assessment Coordinator or designee should involve the charge nurse/team lead or DSD/clinical nurse educator in addressing the resident's Behaviors and in their care planning early in the resident's stay as part of the baseline Care Plan.
- SSD should integrate the resident's circle of support (family and/or substitute decision maker) and encourage them to be involved in care discussions and care planning in accordance with the resident's wishes and consent. The interdisciplinary team members **who know the resident well** should also be included in the plan of care discussions, if possible.
- The decision to use Constant Observation should take into consideration the potential risk of intrusion, invasion of privacy, and risk of making certain Behaviors worse, with the resident's clinical need for safety and therapeutic benefits. Promoting a therapeutic environment and building relationships is crucial when caring for residents who are at risk of harming themselves or others. It is also important to consider the resident's culture and language when choosing to use a Resident Safety Companion/Sitter.
- Resident Safety Companion/Sitters are used for Constant Observation, and may perform other duties and responsibilities **as determined by the Center**. Resident Safety Companion/Sitter should only perform duties and responsibilities that they have been approved, trained and communicated by the facility based on licensure certification, if applicable.
- The Charge nurse should inform the Resident Safety Companion/Sitter of relevant interventions in the resident's plan of care including any safety devices and share tips about the resident's history and unique needs

(such as how to communicate with the resident, best approach with the resident, etc.).

- Specific tasks outside the scope and practice of the Safety Companion/Sitter are not to include independently bathing the resident or assisting the resident with activities of daily living such as bathing, toileting or transferring unless this was explicitly communicated as a Resident Safety Companion/Sitter's duty/role by the facility DSD or designee in writing based on certification and competency by the appropriate licensing board (CNA). Otherwise, the Resident Safety Companion/Sitter **may only help** the resident with activities of daily living **in collaboration with the resident's assigned CNA.**
- The Resident Safety Companion/Sitter acts under the direction of the resident's assigned Charge nurse, DSD or designee.
- If a Resident Safety Companion/Sitter holds a dual role (e.g. a Certified Nursing Assistant (CNA) and Resident Safety Companion/Sitter to a resident) they are still expected to work under the direction of the Supervisor/Charge Nurse/DSD, but may perform duties such as personal care that is within their scope of employment.
- The Resident Safety Companion/Sitter is expected to follow relevant infection control practices including COVID-19 protocols as an essential caregiver and testing requirements
- The Resident Safety Companion/Sitter should not leave the resident alone for any reason until a relief person has replaced them, as arranged by the nurse.
- The charge nurse/Supervisor or designee must designate/assign a staff member to replace the Resident Safety Companion/Sitter during their break to ensure a continuation of Constant Observation.
- The Resident Safety Companion/Sitter should not accompany the resident off the unit for any reason without the approval of the nurse assigned to the resident.
- If a Primary Care Physician or Psychiatrist orders time limited Constant Observation measures, the Physician must also discontinue the intervention when appropriate.
- The attending physician, psychiatrist and/or the interdisciplinary team should communicate regularly to ensure the appropriate use of a Resident Safety Companion/Sitter and when it is deemed appropriate to discontinue. Communication should include:

    - Why a Resident Companion/Sitter is needed for a particular resident-whether for a behavioral or safety reason;
    - What plan of care interventions are in place to gradually eliminate the need for a Resident Safety Companion/Sitter, and
    - A daily review of the continued need for a Resident Companion/Sitter

GREENFIELD
CARE CENTER OF FAIRFIELD, LLC

1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

CNA

Course Title: ELOPEMENT RISK / WANDERGUARD SYSTEM

Date Started: 04/24/25 Time (From): 7:50 Time (To): 8:07PM Length: _____

Presented by: ~~Michael Marges LVN/DSD~~ MELVIN ARMANDO R.

Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	CNA Number	Signature	Title
Cleofe Surio	00608200		CNA
Nathaniel Pascua	01140265		CNA
Lucille Arterberry	00814294		CNA
Edwing Angeles	00583110		CNA
Luzviminda Cabuen	01161307		CNA
Ziola Salazar	00415333		CNA
Maria Maldonado	00784092		CNA
Ernesto Castro	00607238	Ernesto V. Castro	CNA
Generoso Refugio	00755594		CNA
Kulwinder Mahal	00645168	Kulwinder Mahal	CNA
Lula Kassa	00752355		CNA
Evelyne Ardiente	00408900		CNA
Genene Kebere	00652280		CNA
Regina Sironen	01139701		CNA
Kelly Peña	01162929		CNA
Romulo Raga	00644612		CNA
Yajaira (Yaya) Noriesta	00726641		CNA
Emilie Carrion	00648334		CNA
Singh, Shalu	01255369		CNA
Tirados, Luke Errol	01147889		CNA
Erick Contreras	01248692		CNA
Anthony Surio	01193851		CNA

NURSE BI RESPONSIBLE

CNA/LCNA

GREENFIELD
CARE CENTER OF FAIRFIELD, LLC

1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

CNA

Course Title: ELOPEMENT RISK / MGT. / WANDERGUARD SYSTEM

Date Started: 9/24/24 Time (From): 7:30 Time (To): 8:00PM Length: ______

Presented by: MELVIN DERUMA ~~Michael Marges LVN~~/DSD
Signature / Title

Program: Orientation ☐ In-service ☐

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	CNA Number	Signature	Title
Charize Khankab	01282949		CNA
Shayla Davis-Watson	00770398		CNA
Tasia Dominique	01256673		CNA
Kelvin Sanchez	01288939		CNA
Deborah Layne	00387456		CNA
Chanell Goetz	01309586		CNA
Dawn Willams	0117987		CNA
Zeydy Lira.		[signature]	CNA
Melissa S. Montemayor		Melissa S. Montemayor	CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA
			CNA

GREENFIELD
CARE CENTER OF FAIRFIELD, LLC

1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

In-service Attendance Record

Course Title: Wanderguard
P + P + Management

Date Started: 5/5/25 Time (From): 11:30 am Time (To): 12:00 PM Length: ______

Presented by: Theresa Carlinos, Administrator
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
SUSAN PANGILINAN	[signature]	DND
Veneranda Demayo	[signature]	DSS
MELVIN RUMALDO	[signature]	DSD
Jazzmine Williams	[signature]	MARKETING
Arnulfo B Vidad	[signature]	RN CON
JOHNWIN CID	[signature]	MDS/LCN
Annabelle S. Mangune	[signature]	Med Rec
Olive Ordonia	[signature]	BOM
Fernando Camarillo Jr.	[signature]	Maint. Supervisor

Policy and Procedure on Wanderguard

Facility attempts to meet needs and provide services to residents admitted in the facility. In this connection a wanderguard equipment is installed to have surveillance to residents who have tendency to wander out from the facility aimlessly.

All residents who are assessed to be aimlessly wandering out to the facility without resident/resident representative consent and MD order will be wearing a wanderguard bracelet.

Once resident with wanderguard leaves the facility, the wanderguard alarm will be activated. The staff at this time will be alerted that the resident is trying to go out from the facility. A staff will immediately proceed to the area where the alarm is activated to assist resident by redirecting him/her to proper direction.

Above policy and procedure is being implemented in the facility for resident's safety measure.

GREENFIELD
CARE CENTER OF FAIRFIELD, LLC

1260 Travis Boulevard, Fairfield, CA 94533 Tel (707) 425-0669 Fax (707) 425-6617

Maintenance/Housekeeping & Activity In-service Attendance Record

Course Title: Wanderguard System

Date Started: 5/5/25 Time (From): 11:30 am Time (To): 12:00 p.m Length: 30 min

Presented by: Teresa Calimes, Administrator
Signature / Title

Program: Orientation ☐ In-service ☑

In-service: Attach Lesson Plan with behavioral Objective, core curriculum, method(s) of teaching, and method of evaluation.

Print Name	Signature	Title
Fernando Camarillo JR		Main. Asst
Oscar Pineda	Pineda	Main. Asst
Maria Castro		Laundry Asst
Mariana Mendoza-Gomez		Laundry Asst
Farm Saechao		Laundry Asst
Avtar Gir		Laundry Asst
Maria Figeuroa		Housekeeper
Tonya Goins		Housekeeper
Anita Kumar		Housekeeper
Maria Anguiano		Janitor
Nancy Lopez		Janitor
Mina Hafizi		Janitor
Rosalba Nava		Janitor
Loida Alinea		Act. Asst/CNA
Bernadette McAdams		Act. Asst/CNA
Immalyn Llanes		Act. Asst
Maira Cerna Jimenez		Act. Asst

WANDERING RESIDENT ALARM BAND MANAGEMENT

1. All residents will be assessed for risk of elopement upon admission, quarterly, with significant change in condition MDS assessments and when behaviors indicate.

2. Appropriate staff will monitor resident whereabouts including the monitoring of responses/reactions to events/activity in surroundings at time of wandering and report unusual behaviors to supervisor immediately.

3. Facility uses multi-faceted approaches to assure resident safety:

   a. Environmental such as but not limited to:
      i. Alarmed doors
      ii. Alarmed bracelets
      iii. Camera surveillance
      iv. Signage
      v. Elopement prevention drills
      vi. Missing person drills, etc.

   b. Communication such as but not limited to:
      i. Resident photographs at reception desk
      ii. Written notification to appropriate departments regarding at-risk residents etc.
      iii. Binder with a Log to List of Residents on Alarm Bands. Binder to include Photograph and Face Sheet and date alarm band will expire.

   c. Staff education regarding responsibility to identify, report, and intervene related to wandering/elopement risk such as but not limited to:
      i. Anticipate resident needs based upon wandering triggers and patterns
      ii. Acknowledge resident's behavior as an attempt to communicate needs
      iii. Encourage verbalization, identify etiology and recognize feelings etc.

4. All residents will have a mechanism for being identified, i.e., name bands and compliance will be monitored.

5. Support and identify need for wandering, and develop individualized activity plan in response, which is detailed in the resident's care plan, i.e., ambulation program, movement, exercise, and dance.

6. Residents with Alarm Bands will have a physician order and care plan. Assessment will be done quarterly, following assessment schedules.

7. Maintenance is required to check door alarm system monthly. Alarm band company tester will be used to test individual arm bands daily or per manufacturer recommendation.

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Once resident with wanderguard leaves the facility, the wanderguard alarm will be activated. The staff at this time will be alerted that the resident is trying to go out from the facility. A staff will immediately proceed to the area where the alarm is activated to assist resident by redirecting him/her to proper direction.

Above policy and procedure is being implemented in the facility for resident's safety measure.

LESSON PLAN

PROGRAM: Elopement/ Wanderguard system	**LOCATION: Greenfield Care Center of Fairfield**
CLASS TITILE: Elopement (What to do if your resident is missing)	**LENGTH OF TIME:1 hour**
INSTRUCTOR: Melvin Rimando RN/DSD	**AUDIENCE: ALL staff**

PERFORMAMANCE STANDARD / OBJECTIVE	COURSE CONTENT	TEACHING METHODS	EVALUATION
Participant will be able to: • Understand how to properly report this to the right person in order for it to give proper attention & help that the resident need. • Understand the process on what to do when the resident elope from the facility. • Understand the importance of Wanderguard use	**Elopement Risk Precautions and Procedures:** **POLICY** It is the policy of the facility to identify residents who are wanderers or who are a threat to leave the facility unattended without the knowledge of the facility staff. In the context above, wanderer is defined as a resident who attempts to roam inside the vicinity of the facility which could result to leaving the building without direction as where to be headed to. Wanderer can also be a resident that has gone out of the facility and could not find out the way back where he/she comes from. It could also mean rambling aimlessly and finally goes out without any staff or personnel even related family members knowing that a resident had left the facility. **Purpose**: To ensure the resident's safety utilizing the least restrictive means available.	Lecture and Discussion Question and Answer	Staff members to verbalize understanding of the in-services To verbalize what to do to when a missing resident is identified.

	PROCEDURE 1. Obtain information during pre-admission or admission conferences with the resident and or family regarding any history of exit seeking/ or the potential for elopement. 2. Exit seeking behavior will be recorded in the medical record. 3. A plan of care will be developed and implemented with specific approaches and a goal for the resident who is exit seeking or has a history of elopement. 4. The resident's name, picture, and face sheet are placed in the "EMR System" located at the nurse's stations, for those residents assessed to be candidate or have potential to elope or wander. 5. Staff is responsible for knowing or recognizing the resident who has exit seeking behavior to intervene as needed. **When a resident is believed to be missing, the following steps will be implemented:** 1. The charge nurse shall be alerted that the resident is missing. 2. The charge nurse or designee shall alert staff about the resident elopement or missing. All employees are to report to the nurse's station. The charge nurse/supervisor will explain the situation and designate where each staff person is to search. 3. Search the building: closets, showers, bathrooms and grounds thoroughly. A thorough search of the resident care unit and other immediate areas. 4. An internal alert system, such as an overhead page to inform staff that a resident is missing and to implement immediate response procedures. (CODE PINK) 5. If the facility search is unsuccessful, the surrounding streets and yards will be searched. 6. If the resident is not found within the 2 hours, notify the local Police, Administrator and RP. 7. Give the police a description and a current photo of the missing resident.		

	8. The charge nurse/supervisor, Administrator or DNS shall call the family explaining the situation and what is being done to find the resident. Encourage them to assist if they are able. 9. If resident is not found, within 24 hours even with the assistance of police department or if found and resident sustains injury, Department of Public Services will be notified in 24 hours. 10. When the resident is located, the charge nurse/supervisor will announced that the resident is found or located. Previously contacted persons shall be notified that the resident has been located. 11. Upon return of the resident, the resident will be assessed for injuries and any physical and mental changes. The outcome of the evaluation will be documented in the medical record and in the care plan as needed. The attending physician will also be notified with completion of medical evaluation and provision of treatment as indicated. 12. The medical record will also reflect an analysis of the events leading up to the elopement and interventions to prevent another occurrence. Prevention methodologies will also be reflected in the care plan. Documentation will be done timely to reflect actions taken that promotes accurate recollection of event details. 13. Timely root cause analysis will be done with multidisciplinary team **Policy and Procedure on Wanderguard** Facility attempts to meet needs and provide services to residents admitted in the facility. In this connection a wanderguard equipment is installed to have surveillance to residents who have tendency to wander out from the facility aimlessly. All residents who are assessed to be aimlessly wandering out to the facility without resident/resident representative consent and MD order will be wearing a wanderguard bracelet. Once resident with wanderguard leaves the facility, the wanderguard alarm will be activated. The staff at this time will be alerted that the resident is trying to go out from the facility. A staff will immediately proceed to the area		

	where the alarm is activated to assist resident by redirecting him/her to proper direction. Above policy and procedure is being implemented in the facility for resident's safety measure.		

Elopement Risk Assessment *EVA* - V 2

Resident:	**Location:**	**Medical Record #:**
Date of Birth:	**Gender:**	**Score:**
Category:	**Physician:**	**Facility:**
Allergies:		
Diagnoses:		

1. Observation Information

A. Observation Date:

2.

Description

3. Observation Detail

ELOPEMENT RISK ASSESSMENT

I.POTENTIAL RISK FACTORS/RESIDENT STATUS

1. Is the resident cognitively impaired with poor decision-making skills (i.e. intermittent confusion,cognitive,deficits or disoriented?)
   ○ 1. Yes ○ 2. No
2. Does the resident have a pertinent of Dementia,OBS,Alzheimer's,delusions,Hallucinations,Anxiety disorder, Depression,Manic Depression,Schizophrenia
   ○ 1. Yes ○ 2. No
3. Does the resident ambulate independently,with or without the use of an assistive device (including a wheelchair?)
   ○ 1. Yes ○ 2. No
4. Does the resident have a history of elopement while at home?
   ○ 1. Yes ○ 2. No
5. Does the resident have a history of leaving the facility without need of supervision?
   ○ 1. Yes ○ 2. No
6. Does the resident have a history of leaving the facility without informing staff?
   ○ 1. Yes ○ 2. No
7. Has the resident verbally expressed the desire to go home,packed belongings to go home or stayed near exit door?
   ○ 1. Yes ○ 2. No
8. Does the resident wander aimlessly (i.e. confused,moves without purpose,may enter other's room and explores others' belongings?)
   ○ 1. Yes ○ 2. No
9. Is the wandering behaviour a pattern or routine tied to the resident's past (i.e. worked the 3rd shift,taking long walks or seeking someone they cannot find?)
   ○ 1. Yes ○ 2. No
10. Has the resident been recently admitted or re-admitted (within the past 30 days) and is not accepting the

situation?

1. Yes 2. No

11. Does the resident receive any medications that increase restlessness and agitation?

1. Yes 2. No

12. Is this a new behavior,has there been any changes in the resident's status or routine? (i.e. medication, illness, pain, infection, personnal)

1. Yes 2. No

13. Has the family/responsible Party voiced concerns that would indicate the resident may have wandering tendencies or try to?

1. Yes 2. No

4. Observation Detail (Continuation)

II.SUMMARY OF ASSESSMENT

A. Is the resident at risk for Elopement at this time? (Note: Acuity Score and Acuity Category will Automatically be calculated based on your response to the questions above)

Did you answer YES to question 4, 6, 8 or 13? If you answered YES, the resident is "AT HIGH RISK FOR ELOPEMENT." For patients that are AT HIGH RISK FOR ELOPEMENT, please proceed with implementation of a care plan and reevaluate quarterly and with significant change of condition.

B. Additional Comments

Signature **Date**

Facility	Greenfield Care Center of Fairfield	Pharmacy	PHARMERICA	Physician	Dhugga, Gurpreet Singh
Allergies	No Known Allergies				
Unscheduled "Other" Orders					
Advance Directive	Code Status: Full code				

Sched for May 2025	Hours	Thu 1	Fri 2	Sat 3	Sun 4	Mon 5	Tue 6	Wed 7	Thu 8	Fri 9	Sat 10	Sun 11	Mon 12	Tue 13	Wed 14	Thu 15	Fri 16	Sat 17	Sun 18	Mon 19	Tue 20	Wed 21	Thu 22	Fri 23	Sat 24	Sun 25	Mon 26	Tue 27	Wed 28	Thu 29	Fri 30	S
ASA BBX: May cause increased risk of CV thrombotic events, MI, CVA every shift -Start Date- 12/10/2022 2300	Res	0	0	0	0	0	0	0	0																							
	Day	√ lks	√ lks	√ cp	√ lks	√ arj	√ lks	√ lks	√ cp																							
	Res	0	0	0	0	0	0	0																								
	Eveni	√ ds	√ ds	√ ds	√ arj	√ arj	√ ds	√ ds																								
	Res	0	0	0	0	0	0	0																								
	Night	√ icai	√ st	√ st	√ st	√ st	√ arj	√ icai																								
Monitor for s/s of bleeding, bruising and thromboembolism every shift -Start Date- 12/09/2022 2300	Res	0	0	0	0	0	0	0	0																							
	Day	√ lks	√ lks	√ cp	√ lks	√ arj	√ lks	√ lks	√ cp																							
	Res	0	0	0	0	0	0	0																								
	Eveni	√ ds	√ ds	√ ds	√ arj	√ arj	√ ds	√ ds																								
	Res	0	0	0	0	0	0	0																								
	Night	√ icai	√ st	√ st	√ st	√ st	√ arj	√ icai																								
monitor wander guard placement q shift every shift -Start Date- 05/05/2025 1500	Day	X	X	X	X	X	√ lks	√ lks	√ cp																							
	Eveni	X	X	X	X	√ arj	√ ds	√ ds																								
	Night	X	X	X	X	√ st	√ arj	√ icai																								

Chart Codes / Follow Up Codes

—— Follow Up Codes ——
√=Administered
I=Ineffective
E=Effective
U=Unknown
H=On Hold By Physician

—— Chart Codes ——
(Refer to the last page of the report for a complete list of chart codes)
OBA=Group Observed - All
OBI=Observed Individual
OBP=Group Observed - Partial
1=Away from home with meds
11=Out On Pass With Meds
2=Drug Refused
3=Absent from home
4=Pulse below 60/min

Init	Name	Signature	Init	Name	Signature		Name	Signature
						Checked By 1st		
						Checked By 2nd		
						Checked By 3rd		

MONITORING SIDE EFFECT/BEHAVIORS/BBW								
Admit Date		DOB		Unit		Room		Location

Facility	Greenfield Care Center of Fairfield	Pharmacy	PHARMERICA	Physician	Dhugga, Gurpreet Singh
Allergies	No Known Allergies				
Diet	REGULAR diet REGULAR DIET texture, THIN LIQUIDS consistency				
Unscheduled "Other" Orders					
Medical Conditions	EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS(G40.909), ALLERGIC RHINITIS, UNSPECIFIED(J30.9), HISTORY OF FALLING(Z91.81), PAROXYSMAL ATRIAL FIBRILLATION(I48.0), VITAMIN DEFICIENCY, UNSPECIFIED(E55.9), SPRAIN OF UNSPECIFIED LIGAMENT OF UNSPECIFIED ANKLE, SEQUELA(S93.409S), UNSPECIFIED INJURY OF HEAD, INITIAL ENCOUNTER(S09.90XA)				
Advance Directive	Code Status: Full code				

Sched for	Hours	Thu 1	Fri 2	Sat 3	Sun 4	Mon 5	Tue 6	Wed 7	Thu 8	Fri 9	Sat 10	Sun 11	Mon 12	Tue 13	Wed 14	Thu 15	Fri 16	Sat 17	Sun 18	Mon 19	Tue 20	Wed 21	Thu 22	Fri 23	Sat 24	Sun 25	Mon 26	Tue 27	Wed 28	Thu 29	Fri 30	S
monitor wander guard function weekly on Friday one time a day every Fri -Start Date- 05/09/2025 0800	Day 0	X	X	X	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X	X		
MONITOR NUMBER OF HOURS OF SLEEP 3-11 & 11-7 every evening and night shift -Start Date- 04/21/2025 1500	HRS	3	1	3	3	2	1	2																								
	Eveni	√ ds	√ ds	√ ds	√ arj	√ arj	√ ds	√ ds																								
	HRS	6	6	6	6	6	6	6																								
	Night	√ icai	√ st	√ st	√ st	√ st	√ arj	√ icai																								

Chart Codes / Follow Up Codes		Init	Name	Signature	Init	Name	Signature		Name	Signature
—— Follow Up Codes ——	OBP=Group Observed - Partial							Checked By 1st		
√=Administered	1=Away from home with meds							Checked By 2nd		
I=Ineffective	11=Out On Pass With Meds							Checked By 3rd		
E=Effective	2=Drug Refused									
U=Unknown	3=Absent from home									
H=On Hold By Physician	4=Pulse below 60/min									
—— Chart Codes ——		MONITORING SIDE EFFECT/BEHAVIORS/BBW								
(Refer to the last page of the report for a complete list of chart codes)										
OBA=Group Observed - All		Admit Date		DOB		nit		Room		Location
OBI=Observed Individual										

Resident:

Order Details

Order Date: *

Order Category: Other *

Communication Method: (•) Phone ( ) Verbal ( ) Prescriber written ( ) Prescriber entered *

Ordered By: * *(Current Primary Physician: Gurpreet Dhugga)*

Description: apply wander guard secondary to high risk for elopement *

Order Type: Standard Other - [MAR] *

Order Summary:

apply wander guard secondary to high risk for elopement

Additional Information

⊟ Scheduling Details

Add Schedule: Routine | PRN | One Time Only | STAT

⊞ Audit Details

Close

Greenfield Care Center of Fairfield
1260 Travis Boulevard, Fairfield, CA 94533
Tel. (707) 425-0669 Fax (707) 425-6617

Notice of Proposed Transfer/Discharge (Unplanned) Log

Discharge Date	Patient Name	Reason for transfer	Rp Notified Y/N	Md Notified Y/N	Transfer to	Bedhold offered and explained Y/N	Notice of Proposed trans/dis. completed Y/N	Faxed to Ombudsman w/conf. Y/N	L.N. Responsible