STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555517	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kern Valley Healthcare District Dp Snf	6412 Laurel Ave Lake Isabella, CA 93240

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on observation, interview, and record review, the facility failed to implement their policy and procedure (P&P) on ELOPEMENT (when a resident leaves the facility without the knowledge of the staff)/WANDERING (moving from place to place without a fixed plan) to evaluate for elopement, initiate a care plan (document that outlines the specific needs, goals, and interventions for a resident) and notify the physician for one of three sampled residents (Resident 1) who expressed and attempted to leave the facility. These failures resulted in Resident 1 eloping and sustaining a fall outside of the facility which resulted in a fracture (a partial or complete break of the bone) to the left hip requiring surgical intervention. Findings: During a review of Resident 1's ADMISSION RECORD (AR), dated 11/7/24, the AR indicated, Resident 1 was admitted to the facility on [DATE]. Resident 1 diagnoses including muscle weakness, anxiety (feeling of fear, dread, and uneasiness) and bipolar disorder (mental disorder where the person was having extreme mood changes). During a review of Resident 1's admission Minimum Data Set (MDS- an assessment tool) under the section Brief Interview for Mental Status (BIMS- an assessment of cognition [how well a person thinks, remembers, and learns]), dated 11/14/24, the BIMS indicated, Resident 1 had a score of 12 (cognition [how well a person thinks, remembers, and learns] moderately impaired). During a review of Resident 1's admission Elopement Risk Evaluation (ERE), dated 11/7/24, the ERE indicated, not applicable (no score- not indicated if Resident 1 was a low risk or high risk for elopement). During a review of Resident 1's Progress Notes (PN), dated 11/2024, the PN indicated the following: a. 11/9/24 - At 3:12 a.m. Resident 1 told a nurse (not specific who) I want to go home, my Son (sic) is going to pick me up .Resident (1) did tried (sic) to open double door (toward outside street), but unable to push open. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. 11/9/24 - At 6:04 p.m. Resident (1) was very angry, stating ' you are keeping me prisoner here.' Resident (1) attempted to enter other residents' room, (staff) redirected her to her room and In (sic) the processes (sic) . Resident (1) has been attempting to walk around (without) any assistance, disrespecting staff, and other resident. She (Resident 1) also attempted to enter (other area of facility), her son works in (other area of facility), screaming and cursing at him as well. c. 11/10/24 - At 4:33 p.m. (Resident 1) attempting to leave facility, with no shoes or socks on and was being physically aggressive towards staff when staff was trying to redirect (Resident 1). Staff was finally able to get (Resident 1) to sit in chair and bring her back to the hallway by (her room). d. 11/10/24 - At 8:01 p.m. Resident (1) . [was] Exit seek[ing]. Told me to call the cops. Continued to exit seek and cuss staff out. Resident educated again and she continued to cuss and yell at staff. e. 11/11/24 - At 11:29 p.m. (Resident 1) attempted to elope. (Director of Nursing) and (Certified Nursing Assistant- not identified) and cart nurses (not identified) were able to redirect (Resident 1) after several minutes of (encouragement). f. 11/15/24 - At 2:35 a.m. Resident (1) up out of her bed trying (to) leave (facility), when staff trying to redirect (Resident 1) began hitting and kicking the double doors on hall . screaming ' Help, somebody help me their holding me prisoner.' (Resident 1) was helped to nurses (sic) station. g. 11/15/24 - At 8:05 a.m. Resident (1) is showing small signs of getting use to staff and being on unit, then mood changes and resident (1) wants to elope from facility. h. 11/16/24 - At 7:30 p.m. at (6:25 p.m.), a (CNA- not identified) informed me (that the) resident (1) was not in her room. I searched the unit. At (6:29 p.m.) .all available staff was looking for (Resident 1). i. 11/17/24 - At 7:35 a.m. report from day cart nurse 11/16/24 regarding an elopement from (Resident 1). At approximately (8:00 p.m.) 11/16/24 resident (1) was returned to our facility. Resident was assessed and found two small abrasions (wearing off the skin, usually caused by a scrape or a brush burn). One to left shoulder and one to right knee. Resident (1) is alert and oriented. Resident (1) refused treatment and Is (sic) comfortable in her bed. j. 11/17/24 - At 2:04 p.m. Resident (1) having left hip pain and requesting Tylenol. Having a hard time moving around. k. 11/17/24 - At 5:49 p.m. While In the radiologist (someone that specializes in x-rays [medical imaging]) room (Resident 1) told the radiologist that she jumped a fence last night. Radiologist informed this nurse that (Resident 1) had a (left hip fracture). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/25/24 at 11:25 a.m. with Director of Nursing (DON), DON stated on 11/16/24 at approximately 6:30 p.m. she received a phone call from Licensed Vocational Nurse (LVN) 1, Resident 1 had eloped from the facility. DON stated on 11/16/24 at approximately 8 p.m. (approximately one and a half hours after elopement) Resident 1 was found across the street from the facility at a church in front of the glass doors lying on the grass. DON stated Resident 1 was brought back (by staff) to the facility and started complaining of left hip pain on 11/17/24 (2:04 PM). DON stated Resident 1 sustained a left hip fracture and had a surgery. During a review of Resident 1's acute hospital, Emergency Documentation (ED), dated 11/17/24, the ED indicated, Resident 1 here due to (hip) fracture. Patient ran away from her (facility) and as she jumped over a fence, landed incorrectly. Complaining of left hip pain. Admit to trauma center (a hospital unit that specializes in treating patients with life- threatening injuries) with Ortho (Orthopedic- a bone specialist). The Surgical Documentation (SD), dated 11/18/24, indicated, Resident 1 is a female who resides in (facility). She (Resident 1) attempted to ' escape', apparently by jumping a fence and fell and broke her left hip. recommended (hip surgery). The Progress Notes (HPN), dated 11/19/24, indicated, Resident 1 had a left hip hemiarthroplasty (a surgical procedure where half of the joint was replaced). During an observation and interview on 11/25/24 at 11:50 p.m. with Resident 1, in Resident 1's room, Resident 1 was noted lying in her bed and stated she left the facility without telling anyone on 11/16/24, because she felt better and wanted to go to her son's home. Resident 1 stated she climbed a fence where the church was located (across from the facility) and hurt herself (left hip). During a concurrent interview and record review on 11/25/24 at 1:31 p.m. with Assistant Director of Nursing (ADON), Resident 1's Electronic Medical Record (EMR), dated 11/2024 was reviewed. There was no care plan initiated and documented evidence the physician was notified after Resident 1 attempted to elope on 11/9/24. ADON confirmed the findings there was no care plan initiated and documented evidence the physician was notified after Resident 1 attempted to elope on 11/9/24. ADON confirmed the ERE dated 11/7/24, did not indicate a score or if Resident 1 was a low risk or high risk for elopement. ADON stated the ERE should indicate if Resident 1 was a low risk or high risk for elopement. ADON stated there was no risk for elopement assessment or evaluation noted after Resident 1 attempted to elope from the facility on 11/9/24. ADON stated Resident 1 should have been re-assessed for risk of elopement when she attempted to elope from the facility on 11/9/24. ADON stated a re-assessment for elopement would have triggered the staff to call the physician for appropriate interventions such as a wander guard (safety monitoring device). During an interview on 11/25/24 at 1:38 p.m. with DON, DON stated an elopement risk assessment should be done upon admission, every quarter, and after any attempts to elope from the facility. DON stated she does not believe the staff [not specified] knew to implement the policy. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, ELOPEMENT/WANDERING dated 2/21/17, the P&P indicated, The facility evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process. Based on results of the Wandering Risk Scale, care plan interventions to manage wandering and/or exit seeking behaviors are initiated/implemented. Residents deemed at risk to elope or have.poor safety awareness . are accompanied by family, responsible party, or a facility staff member when leaving the facility for appointments and/or outings. a change in wandering/exit seeking behavior, or after an actual elopement attempt, the resident who is deemed at risk to elope is evaluated by a licensed nurse using the Wandering Risk Scale. Resident Monitoring System .The facility obtains a physicians order for the use of the device (wander guard) prior to application and after consent is received.