STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056035	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHAFTER NURSING CARE	**140 EAST TULARE AVENUE SHAFTER, CA 93263**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Detect elopement (leaving the facility without notice) in a timely manner, 2. Report elopement to the Department per policy and procedure, and, 3. Report elopement to physician, for one (Resident 1) of four residents when Resident 1 did not return from [MEDICAL TREATMENT] (a procedure where toxins are filtered out of the blood) treatment that was performed outside the facility. This failure had the potential for serious harm to the resident as his whereabouts were unknown, and the outside temperature was approximately 100 degrees Fahrenheit (F, a unit of temperature measurement). Findings: During a review of Resident 1's Care Plan, dated 6/7/20, the Care Plan indicated, At risk for elopement related to: Anger at placement in living center. Resident states 'I am leaving, going back to the mission.' During a review of Resident 1's Progress Notes, dated 6/11/20, at 12:09 PM, the Progress Notes indicated, Resident picked up by Valley Transportation services for transportation to [MEDICAL TREATMENT] at ([MEDICAL TREATMENT] treatment center 30 miles away in) Bakersfield. every Tuesday, Thursday, and Saturday with Chair Time of 12:30 PM. During a review of Resident 1's Progress Notes, dated 6/11/20, at 12:09 PM, the Progress Notes indicated Resident 1 was out for his [MEDICAL TREATMENT] appointment. During a review of Resident 1's ([MEDICAL TREATMENT] Treatment Center) Post Treatment note, dated 6/2/20, the Post Treatment note indicated Resident 1's post [MEDICAL TREATMENT] vital signs were taken at 4:17 PM. At 6:03 PM, the Progress Notes indicated Resident 1 returned to the facility from his [MEDICAL TREATMENT] appointment at 6:03 PM. During a review of Resident 1's ([MEDICAL TREATMENT] Treatment Center) Post Treatment note, dated 6/4/20, the Post Treatment note indicated Resident 1's post [MEDICAL TREATMENT] vital signs were taken at 4:17 PM. The Progress Notes dated 6/4/20 did not indicate when Resident 1 returned from [MEDICAL TREATMENT]. During a review of Resident 1's ([MEDICAL TREATMENT] Treatment Center) Post Treatment note, dated 6/6/20, the Post Treatment note indicated Resident 1's post [MEDICAL TREATMENT] vital signs were taken at 4:38 PM. The Progress Notes dated 6/6/20 did not indicate when Resident 1 returned from [MEDICAL TREATMENT]. During a review of Resident 1's Progress Notes, dated 6/9/20, at 6:42 PM, the Progress Notes indicated Resident 1 returned from [MEDICAL TREATMENT] at 6:42 PM. During an interview on 8/20/20, at 8:40 AM, with RN 1, RN 1 stated that Resident 1 was noted to be missing from the facility on 6/11/20 during evening medication pass, around 9 PM. RN 1 stated the [MEDICAL TREATMENT] treatment center closes at 5 PM. During a review of Resident 1's Progress Notes, dated 6/11/20, at 10:16 PM, the Progress Notes indicated, Resident was noticed as not having been returned to facility by 2100 (9 PM) from [MEDICAL TREATMENT]. Clinic and transportation service were not reachable by phone, staff searched facility and neighborhood, and (administration) were notified about attempts to track down resident. Desk nurse made contact with Mission homeless shelter in Bakersfield and found resident had gone there this afternoon requesting a bed. Resident to be discharged as AMA (against medical advice). During a review of Resident 1's Progress Notes, dated 6/11/20, at 10:30 PM, the Progress Notes indicated, Resident was reported not at facility by (Licensed Vocational Nurse) LVN. Transport and [MEDICAL TREATMENT] contacted x 3 (three times) however no response as [MEDICAL TREATMENT] closes at 5 PM. Code Orange initiated; all staff searched for resident throughout facility. In addition, staff was sent out to inspect nearby locations from facility. At that time one LVN was designated to call hospitals to see if resident could have been sent out to hospital from [MEDICAL TREATMENT]. In this time, Shafter Police Department (SPD) was contacted and informed of missing resident, stated officer would be coming to facility to collect report. After calling SPD, Shelter (Mission) at Bakersfield was called however no response at first attempt. Call then received from Mission stating (Resident 1) had 'walked in asking for a bed.' Informed stated he was provided bed and was in stable condition. Resident dc (discharged) as AMA. During a review of the Report of Suspected Dependent Adult/ Elder Abuse (SOC 341), dated 6/12/20, sent to the Department from the [MEDICAL TREATMENT] treatment center, the SOC 341 indicated, Pt (patient) did not show up for [MEDICAL TREATMENT] treatment yesterday at this facility. Today . was told pt (patient) never returned from [MEDICAL TREATMENT] and he was discharged AMA (against medical advice). During a review of Resident 1's Progress Notes, dated 6/12/20, at 11:37 AM, the Progress Notes indicated, As ([MEDICAL TREATMENT] treatment center) was not reachable last night, writer called ([MEDICAL TREATMENT] treatment center) again to know how patient left AMA. ([MEDICAL TREATMENT] treatment center) informed that patient was indeed dropped off via transport in parking lot, however as soon as van left, resident left from parking lot and did not enter [MEDICAL TREATMENT] premises. During a concurrent interview and record review, on 8/18/20, at 4:18 PM, with the Administrator, Resident 1's Progress Notes, dated 6/11/20, at 10:16 PM, were reviewed. The Progress Notes indicated that on 6/11/20, Resident 1 was noted by staff to be missing from the facility by a Licensed Vocational Nurse at approximately 9 PM, or approximately 2.25 to 3 hours after he normally returns to the facility after his [MEDICAL TREATMENT] appointments. During a review of the online website Weather Underground, it indicated the temperature high for this area on 6/11/20 at 4:54 PM was 100F. During a concurrent interview and record review, on 8/18/20, at 4:18 PM, with the Administrator, Resident 1's Progress Notes, dated 6/11/20, were reviewed. The Progress Notes lacked documentation of notification of Resident 1's physician regarding his elopement. The Administrator validated that no documentation was found in the medical record of notification of Resident 1's physician. During an interview on 8/18/20, at 4:18 PM, with the Administrator, the Administrator stated, I can't remember if he contacted the Department regarding this occurrence. During a review of the Facility's Policy and Procedure titled Elopement Guidelines, dated 10/15, it indicated, If a resident is discovered missing or is suspected of having eloped, the charge nurse takes the following steps. Notify the resident's attending physician. During a review of the Facility's Policy and Procedure titled Elopement Guidelines, dated 10/15, it indicated, The Executive Director shall notify: . State agency, as necessary by state requirement.

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