STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555479	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DELANO DISTRICT SKILLED NURSING FACILITY	**1509 TOKAY STREET DELANO, CA 93215**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the plan of care for one of three sampled residents (Resident 1) when: 1. Facility did not anticipate Resident 1's need to purchase items from outside of the facility. This failure resulted in Resident 1 eloping from the facility for eight times. 2. Facility did not perform health condition and body assessments for Resident 1 upon returning to the facility after an elopement. This failure had the potential to result in unidentified harm and untreated injury to Resident 1. Findings: 1. During a review of Resident 1's Nurse's Notes (NN): a. The NN, dated 5/24/20, at 7:18 AM, indicated, At around 5:39 AM, (Resident 1's room) door was open, when I checked, he is not inside. According to the Maintenance (staff) he found him in (store) along highway where he used to go at around 6:10 AM. b. The NN, dated 5/24/20, at 2:18 PM, indicated, Resident (1) is noted to have episode of elopement at 12 noon and was found at (store) at 12:15 PM by staff member. c. The NN, dated 5/28/20, at 6:14 AM, indicated At 6:14 AM received report from the CNA (Certified Nursing Assistant) in front that resident (1) went out and staff could not stop him (Resident 1), he continued to walk. (Resident 1) said he wants to go to (store). Resident (1) wants to exchange his lottery ticket. d. The NN, dated 6/5/20, at 7:01 AM, indicated, Approximately 5:30 AM, alarm on front door sounded. CNA responded to door and found resident and went outside. Resident was asked to come inside. He refused. A different CNA was sent outside to watch resident. Approximately five minute later she lost sight of him. Security arrived and located him on (avenue). Security walked him to the store. After making purchases, he agreed to get ride back to facility. e. The NN, dated 6/7/20, at 7:46 AM, indicated, When checked his room, resident (1) is not around, code green announced at around 7:40 AM. Resident (1) came back at around 7:46 AM, carrying a brown bag of soda. f. The NN, dated 6/14/20, at 1:43 PM, indicated, (Staff) informed that (Resident 1) left and started walking outside the parking lot at around 12:25 PM. Staff went looking for him. At around 12:43 PM, (staff) found him close to (gasoline station). He said he wanted to go to the store and go to (restaurant). g. The NN, dated 6/20/20, at 4:20 PM, indicated, Resident (1) want to sit at front patio, (staff) was with him, then suddenly he was gone. Two staff followed him, he was walking so fast. He does not want to come back to the facility. He wanted to go to (store) to buy lottery (tickets) and soda. h. The NN, dated 6/26/20, at 10:51 AM, indicated, It was reported by the (staff) in the front that resident (1) left the facility around 8:55 AM. Two staff followed him. He was followed to the (store) by (highway). He tried to purchase two beers, upon the staff redirection to purchase something else and discourage to drink the beer, the resident punched the staff on her left chin and proceeded to physically assault her. The resident (1) also poured beer to the staff and drank the other one. During an interview on 7/21/20, at 10 AM, with the Activity Director (AD), AD stated she was not aware of the care plans of the facility regarding Resident 1's elopement incidents. She stated she was not involved in fulfilling Resident 1's needs to go out and make purchases from a store outside of the facility resulting in multiple elopements. AD stated she did not address the need of lottery tickets the resident (1) continually go to buy them in stores. During a review of Resident 1's Social Services Notes (SSN), dated 5/26/20, the SSN indicated, The resident (1) is noted to have multiple lottery tickets. During an interview on 7/21/20, at 10:10 AM, with Social Services Director (SSD), SSD stated, Resident (1) went out to buy alcohol and lottery tickets. We don't cater on those needs. During a review of Resident 1's Minimum Data Set (MDS), dated [DATE], the MDS indicated, Resident 1 had a BIMS (Brief interview for Mental Status) score of 9 (score of 8-12 means moderately impaired cognition). The MDS indicated, Resident 1 was able to walk. Resident 1's Admission Record (AR), dated 6/26/20, indicated, Resident 1 had [DIAGNOSES REDACTED]. During a review of Resident 1's Care Plan (CP), dated 1/29/18, the CP indicated, High risk for elopement due to: independent with ambulation, poor cognition. Elopement score: 20. Interventions/Tasks: Anticipate needs based on wandering triggers and/or pattern. Position (Staff responsible): Activity Assistant, Certified Nursing Assistant, Licensed Nurse, Social Worker. Provide and offer company to assure safety. 2. During a review of Resident 1's Care Plan (CP), dated 2/10/20, the CP indicated, If found within 30 minutes in unstable conditions/refuses to return call (agency) and emergency depending on resident health/mental condition. Resident 1's Nurses's Notes (NN) dated 5/24/20 and 6/26/20 was reviewed. There was no documentation of Resident 1's assessment of health condition. During an interview on 9/10/20, at 12:13 PM, with Director of Nursing (DON), DON stated, body assessments (health condition) were not done on 5/24/20 and 6/26/20 elopment incidents. During a review of the facility policy and procedure (P&P) titled, Elopement/Wandering Resident, dated 11/29/17, the P&P indicated, 1. All residents who are at risk for harm of wandering and/or elopement will be assessed by the DON, Charge Nurse, or Nursing Supervisor. 5. Should elopement, or an attempt to elope occur, the contributing factors and attempted interventions shall be documented in the resident's medical records. 6. An IDT meeting and/or special care conference with resident's family shall be held to review/discuss attempted interventions and shall recommend additional interventions as to prevent/minimize resident from eloping. 11. If an injury occurs during resident's elopement or if not found within 30 minutes, additional notifications to the following agencies shall be made: Department of Public Health, b. Ombudsman.

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

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.