STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A208	A. Building B. Wing	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shandin Hills Behavior Therapy Center	4164 North 4th Avenue San Bernardino, CA 92407

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** 44142 Based on observation, interview, and record review, the facility failed to provide a safe environment with adequate monitoring and supervision for one out of the three residents (Resident 1) with impaired impulse control, insight, and judgment. Resident 1 had a psychiatric diagnosis of severe mental and emotional disorder and managed to elope (run away secretly) from the facility without staff's knowledge. This failure resulted in Resident 1 eloping from the facility on February 6, 2023, and Resident 1 was not found. Resident 1 had a history of elopement resolved on April 26, 2019. This current elopement has the potential for Resident 1 to sustain injury, fall, exposure to heat, cold, dehydration, drowning, getting hit by car and even death. Findings: A phone interview was conducted on February 8, 2023, at 12:11 PM, with the Administrator in training, regarding a facility reported incident of an elopement. He stated, Resident 1 was outside in the yard with the staff for social event. When residents were outside, staff did not count the residents who went outside for the social event. Resident 1 was left outside, and he hid behind the old vending machines. He broke the latch of the back gate and took off. The Administrator in training stated, they immediately searched premises, nearby stores, and parks and did not find resident 1. The Administrator in training further stated, Resident 1 was last seen by the staff at 3:00 PM on February 6, 2023. On February 8, 2023, at 2:27 PM, during the tour of the facility with the Program Director (PD) there were three working door alarms noted on the unit, three locked chain linked fence gates, and approximately 14 feet high chain linked fence was noted around the building. During a concurrent interview with the PD stated, they believe Resident 1 was hiding behind the shed, he broke the laundry room gate latch and escaped to the street. The PD further stated, facility staff went to nearby stores and parks looking for Resident 1 on February 6, 2023 at 4:06 PM. They did not find Resident 1. During an interview on, February 8, 2022, at 3:10 PM, with a Mental Health Counselor (MHC), she stated, a Certified Nursing Assistant (CNA 2) made rounds and noted Resident 1 was missing on February 6, 2023 at 4:06 PM. They searched on the unit, in the yard and did not find Resident 1. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on, February 8, 2022, at 3:30 PM, CNA1 stated, when they searched, Resident 1 was not on the unit. During a telephone interview on, February 23, 2022, at 9:55 AM, with CNA 2, she stated, she last saw Resident 1 during her rounds on February 6, 2023, at 3:00 PM, Resident 1 was in the dining room and at 4:06 PM, she did not see the Resident 1 on the unit. CNA 2 informed the charge nurse, and the charge nurse informed the Program director and the Administrator in training. CNA 2 went out in the car with another programmer, searched side streets and a nearby store as soon as they found out Resident 1 was missing. Nobody was able to locate Resident 1. A review of Resident 1's clinical records indicated, Resident 1 was admitted to the facility on [DATE], with the diagnoses of schizoaffective disorder unspecified (mental illness that affects moods and thoughts) and insomnia unspecified (difficulty in falling asleep). A review of Resident 1's Nursing Progress Notes, dated, February 6, 2023 at 5 PM, indicated, Approximately 4:00 PM, nursing staff noted Resident 1 was not in the unit while conducting the hourly rounds as scheduled. Staff immediately notified CN, and an immediate head count was initiated, safety check on all rooms, toilets, bathrooms, and closets was done. Staff searched the yard adjacent to back door, no one was seen in the yard or observed on the roof deck .staff drove around the neighboring streets in vehicles with no resident in sight. A review of Resident 1's History and Physical Examination , dated September 5, 2020, indicated Resident 1 has fluctuating capacity to understand and make decisions. A review of Resident 1's Brief Interview for Mental Status (BIMS, an interviewing tool used to determine resident's ability to think) completed on December 7, 2022, indicated, Resident 1's, BIMS score of 15 which means cognition is intact (a BIMS score scale 0 to 7 points is severely impaired cognition, 8 to 12 is moderately impaired, and 13 to 15 is intact cognition). A review of Resident 1's Doctor's Progress Notes, dated February 6, 2023, indicated Resident 1 with poor impulse control, insight, and judgment was partially impaired A review of Facility's document, Quality Assurance Performance Improvement (QAPI) on February 7, 2023, indicated, A resident was able to leave the facility after the fresh air break in unit 2. The staff supervising the yard during break did not notice the resident was still out in the yard when they entered the facility. The staff supervising the yard did not have and account for the residents in the yard during break . A review of facility's policy and procedure (P&P) titled, Elopement of Resident, effective date March 22, 2022, the P&P indicated, Purpose: To provide a process for managing residents at risk for elopement. Policy: A resident whose does not have capacity who leaves the facility unaccompanied .3. Unwitnessed Elopement: 3.1. Notify the supervisor that the patient is missing. 3.2 Supervisor will alert all staff of missing patient with an announcement to activate missing patient protocol . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of facility's Policy titled, Safety and Supervision of Residents, revised date July 2017, the policy indicated, Policy Statement: Our facility strives to make the environment as free form accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy interpretation and Implementation . Systems Approach to Safety 1. The facility- oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment . A review of facility's document name Supervision Level Protocol And Guidelines. Undated, it indicated, Protocol, The interdisciplinary team will continually evaluate the need for increased supervision of residents who present with cognitive, behavioral, medical, or other conditions that put them or others at risk. The team will provide increased levels of supervision as appropriate to ensure optimal resident safety and outcome. General Supervision: For all residents who do not have another supervision level recommended by IDT, general supervision will be maintained at all times. Residents on general supervision can move around the facility at will, except in areas that are designated as nonresident areas for safety reasons. Guidelines: .4. When residents are under general supervision, they are expected to stay in the building except when following standard polices for leaving (e.g., therapeutic pass, outing, appointments, and hospital stays). A staff member entering/exiting a secured a secured resident area is responsible for detecting any resident away from attempts to leave without permission. The staff member should verbally redirect the resident away from the area and alert other staff members for assistance so they can intervene to keep the resident safe .