STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555350	A. Building B. Wing	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Grove Post Acute	1618 Laurel Avenue Redlands, CA 92373

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36321 Based on observation, interview, and record review, the facility failed to ensure a homelike environment was provided for 1 of 22 residents' (Resident 1) when he was readmitted to Unit 2 (Locked Memory Unit) and the unit had an overwhelming smell. This failure potentially resulted in Resident 1 not having a safe, clean, and homelike environment affecting his psychosocial well-being. Findings: A record review of Resident 1's face sheet (contains demographic information) reflects he was admitted to the facility on [DATE] with diagnosis (DX) which includes nontraumatic intracerebral hemorrhage (type of stroke caused by bleeding within the brain) and heart disease (damage in the heart's major blood vessels). During a review of Resident 1's facility preadmission record, dated May 18, 2021, indicating Resident 1 had a DX of cognitive communication deficit (occurs after a stroke affecting attention, memory, organization, problem solving, and reasoning). During an interview on May 27, 2021, at 3:09 PM, with the Unit Manager (UM 1), the UM 1 stated he was working when Resident 2 was readmitted on [DATE] from [Name of the Hospital]. The UM 1 stated Resident 1 admitted to Unit 2 locked memory care unit because he had just eloped. The UM 1 further stated Resident 1's family was very upset the night he was readmitted having concerns with the lighting, smells, and the cleanliness of the unit. The UM 1 confirmed the family was so upset and stated, They signed Resident 1 out Against Medical Advice (AMA- a resident leaving the facility against the advice of the attending physician). During a telephone interview on May 28, 2021 at 9:30 AM, with Resident 1's Responsible Party (RP), the RP stated Resident 1 was readmitted to [Name of the Facility] Unit 2 (locked memory unit). The RP stated Unit 2 was dark, and dirty. Resident 1's room smelled like urine and feces was smeared on the walls. The RP further stated he was not going to leave his family member in that environment and signed him out AMA. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Unit 2 on May 30, 2021 at 12:30 PM, in the presence of the Administrator (ADM), Unit 2 is divided into two sections. A female side and a male side. The Unit is locked and has a keypad with a code to get in and out of the Unit. Residents were finishing up with lunch. The all-female side was clean, and no feces spotted on the walls or the floors. No odors were detected. Upon entering the all-male unit, it had a strong unpleasant smell. Male Residents' were observed wandering around the unit with their briefs exposed. No feces were spotted on the floors or the walls. During an interview on May 30, 2021 at 12:50 PM, with the Administrator (ADM), the ADM stated Resident 1's family did not give Unit 2 a chance. He knows it is a big shock for families when they first visit the Unit. When asked about the urine smell, the ADM stated, We have House Keeping (HK) in the Unit cleaning. The ADM stated HK comes in every day to clean the Unit. I wish I could have met with the family and I think things could have ended differently. When asked if HK is available 24/7, the ADM stated, No they are not. The ADM was asked what staff is instructed to do if a resident urinates in a trash can or smears their feces, the ADM stated, I never thought about that happening. A review on June 1, 2021 at 1:40 PM of Resident 1's Nursing Progress Notes, indicated the following: 1. Dated-May 26, 2021 at 9:30 PM-Despite the nursing team's efforts, Resident 1's RP has decided to have Resident 1 leave the facility AMA. 2. Dated -May 26, 2021 at 9:45 PM-Resident 1's RP arrived to drop off clothing and became upset. Left with Resident 1. Registered Nurse Supervisor (RNS) notified. Family signed AMA paperwork. During a review of the facility's policy and procedure titled,Quality of Life-Homelike Environment, Revised May 2017, indicated . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. Clean, sanitary and orderly environment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36321 Based on observation, interview, and record review, the facility failed to report an unusual occurrence (injuries of unknown source) resulting in serious bodily injury to 1 of 22 resident's (Resident 1) to the California Department of Public Health-(CDPH) according to their policy and procedure after Resident 1 eloped (a dependent resident leaving the facility without observation or knowledge of departure) without staff's knowledge. This failure had the potential to result in jeopardizing the health and well-being of Resident 1. Findings: A record review of Resident 1's face sheet (contains demographic information) reflected he was admitted to the facility on [DATE], with diagnosis (DX) which includes nontraumatic intracerebral hemorrhage (type of stroke caused by bleeding within the brain) and heart disease (damage in the heart's major blood vessels). During a review of Resident 1's facility preadmission record, dated May 18, 2021, indicated Resident 1 had a DX of cognitive communication deficit (occurs after a stroke and affecting attention, memory, organization, problem solving, and reasoning). A review of Resident 1's Nursing Progress Notes, on May 27, 2021 at 1:30 PM, indicated: 1. Note dated May 22, 2021 at 8:47 AM, Alert, confused, and verbally responsive with clear speech. Constantly ambulating per hallways aimlessly stating he is looking for a family member and must be redirected constantly. 2. Note dated May 23, 2021 at 7:19 PM, Received a phone call from a family member stating Resident 1 was found outside of [Name of Facility] from [name of city] Police Department. Taken to [Name of Hospital]. Resident 1 was last seen at 4:00 PM wandering the unit and had to be redirected. Notified the Administrator (ADM) and the Director of Nurses (DON). 3. Note dated May 24, 2021 at 12:21 PM, by Social Services Director (SSD)-Resident 1 left Against Medical Advice (AMA-a resident leaving the facility against the advice of the attending physician) on May 22, 2021. SSD reported the incident to the Ombudsmen (is a public advocate to protect the rights of citizens) and to Adult Protective Services (APS-is a program that strives to have all elders and dependent adults live their lives free from threat and abuse). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 27, 2021 at 1:40 PM, with the Administrator (ADM), the ADM stated Resident 1 left AMA on the evening of May 23, 2021. The ADM stated any Resident not housed on Station 2 (locked Memory Unit) can leave any time they want and, they have a right to decline to sign the AMA form. When asked if staff should be responsible to know where Residents are at all times for their safety, the ADM stated, Yes we should, and I will take responsibility for the fact we did not know that [name of resident] Resident 1 had left the facility. The ADM confirmed the facility did not notify California Department of Public Health (CDPH) when Resident 1 left the facility because, Resident 1 had a right to leave. During a review on May 27, 2021 at 3:10 PM, of Resident 1's discharge summary dated May 25, 2021, from [Name of Hospital] indicated the following: History of Present Illness: Resident 1 was found with Altered level of Consciousness ALOC (ALOC-you are not able to understand or react like you normally do) by the Police from (Name of Facility) with abrasions (cuts or scrapes) to his face. Primary DX is Nontraumatic Subdural Hemorrhage (neurosurgical emergency caused from head trauma). Oriented to person, not place or time. Assessment/Plan- Resident 1 currently residing at a care facility found wandering today. Head Computerized Tomography (CT-x-rays taken from different angels) scan showed a small 1 Millimeter (MM-unit of measure) right subdural hematoma (pooling of blood in the brain). No surgical intervention needed. During a review of the facility list of recent discharges, on May 27, 2021 at 3:15 PM, document dated May 27, 2021, the list of discharges indicates, Resident 1 was listed as discharged AMA home with no home health service on May 24, 2021. During an interview with Licensed Vocational Nurse 1 (LVN 1) at 4:40 PM, LVN 1 confirmed Resident 1 eloped from the facility on the evening of May 23, 2021. LVN 1 stated he frequently wandered and had to be redirected back to his room. LVN 1 also stated Resident 1 would go out to the smoking area often. When asked LVN 1 if those behaviors were concerning, LVN 1 stated she felt Resident 1 could be an elopement risk and informed the ADM. LVN 1 stated she was working when Resident 1 left and stated Certified Nurse's Assistant (CNA's) went to lunch and last saw Resident 1 in the smoking area at around 4 PM. During a concurrent observation on May 27, 2021 at 4:40 PM, with LVN 1 for Unit 1, the alarm on the door to the smoking area was not set. The door from Unit 1 to the smoking area is near the nurse's station. LVN 1 stated, We are not able to observe resident's outside in smoking area unless we are supervising the patio area. The unlocked gait from the smoking patio area leads to a parking lot. A second exit door was observed at the end of the hallway opposite the nurse's station also with no working alarm. This exit leads to a courtyard with a wheelchair ramp leading to a parking lot. During a record review on May 27, 2021 at 5:00 PM, Resident 1's admission Wandering/Elopement Risk Assessment (scores a resident for low, moderate to high risk based on indicators such as orientation, behavior/mood, etc), dated May 21, 2021, the Wandering/Elopement risk assessment for Resident 1 indicated, under the Orientation section, the resident is entered as Forgetful/short attention span. Under Behavior/mood section, it indicates Resident Does not understand surroundings. During a review on May 27, 2021 at 5:05 PM of Resident 1's admission care plans (C/P), indicated no C/P's were developed or initiated for wandering and possible elopement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 30, 2021, at 11:50 AM, with Registered Nurse Supervisor (RNS), the RNS stated if he had resident's admitted with DX of cognitive communication deficit and Nurses Progress Notes indicating resident is disoriented x2 (orientation is assessed for self, place, time and situation) which Resident 1 was alert x2 then RNS stated, Resident's should be monitored for possible elopement risk. During an interview on June 1, 2021, at 5:08 PM, with LVN 6, LVN 6 confirmed Resident 1 needed to be redirected several times back to his room. LVN 6 stated Resident 1 would go to smoking area and staff would redirect him to go back inside. She further stated Resident 1 was last seen by staff between 4 and 4:15 PM on May 23, 2021. He was looking for his girlfriend. She stated she was waiting for facility to send Resident 1 to Unit 2 (locked memory care Unit). LVN 6 stated she suggested to RN supervisor Resident 1 may need to go to locked unit but, could not remember who the RNS was. During a review of the facility policy and procedure titled, Unusual Occurrence Reporting, undated, indicated . As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety or welfare of our residents, employees, and visitors. Allegations of abuse, neglect and misappropriation of resident property: and other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. A written-report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency within 48 hours. During a review the facility's policy and procedure titled, Abuse Investigation and Reporting, dated July 2017, indicated .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source (Abuse) shall be investigated reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Reporting-2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or resulted in serious bodily injury: or b. Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.

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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** 36321 Based on interview, and record review, the facility failed to accurately assess and develop a comprehensive care plan for one three resident's (Resident 1) when staff did not accurately assess Resident 1 as an elopement (a dependent resident leaving the facility without observation or knowledge of departure) risk prior to Resident 1's elopement from the facility. This failure had the potential to jeopardize the health and safety of Resident 1 when the facility was unaware Resident 1 had eloped from facility. Findings: A record review of Resident 1's face sheet (contains demographic information) reflected he was admitted to the facility on [DATE] with diagnosis (DX) which includes communication cognitive deficient (affecting attention, memory, organization, problem solving, and reasoning), nontraumatic intracerebral hemorrhage in hemisphere, subcortical (type of stroke caused by bleeding within the brain) and heart disease (damage in the heart's major blood vessels). During a review on May 27, 2021 at 1:30 PM, of Resident 1's Nursing Progress Note, indicated: 1. Dated May 22, 2021 at 8:47 AM, Alert, confused, and verbally responsive with clear speech. Constantly ambulating per hallways aimlessly stating he is looking for a family member and must be redirected constantly. 2. Dated May 23, 2021 at 7:19 PM, Received a phone call from a family member stating Resident 1 was found outside of [Name of Facility] from Redlands Police Department. Taken to [Name of Hospital]. Resident 1 was last seen at 4:00 PM wandering the unit and had to be redirected. Notified the Administrator (ADM) and the Director of Nurses (DON) 3. Dated May 24, 2021 at 12:21 PM, by Social Services Director (SSD)-Resident 1 left Against Medical Advice (AMA-a resident leaving the facility against the advice of the attending physician) on May 22, 2021. SSD reported the incident to the Ombudsmen (is a public advocate to protect the rights of citizens) and to Adult Protective Services (APS-is a program that strives to have all elders and dependent adults live their lives free from threat and abuse). During an interview on May 27, 2021 at 1:40 PM with the ADM, the ADM stated Resident 1 left AMA on the evening of May 23, 2021. The ADM stated any Resident can leave any time they want and, they can decline to sign the AMA form. When asked if staff should be responsible to know where Residents are at all times for their safety, the ADM stated,Yes we should, and I will take responsibility for the fact we did not know that [name of resident] Resident 1 had left the facility. The ADM confirmed the facility did notify California Department of Public Health (CDPH) when Resident 1 left the facility because, Resident 1 had a right to leave. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 27, 2021 at 3:09 PM, the Unit Manager (UM) confirmed Resident 1 eloped on May 23, 2021. The UM stated he took report from [Name of Hospital] when Resident 1 was ready to be discharged and they informed him, Resident 1 had to be assigned a sitter (compassionate substitute for dealing with challenging Resident's) because he kept getting out of bed and wandering. During an interview with Licensed Vocational Nurse 1 (LVN 1) at 4:40 PM, LVN 1 confirmed Resident 1 eloped from the facility on the evening of May 23, 2021. LVN 1 stated he wandered often and had to be redirected back to his room frequently. LVN 1 stated Resident 1 was looking for someone. When asked LVN 1 if those behaviors were concerning, LVN 1 stated she felt Resident 1 could be an elopement risk and informed Administrator. During a review on May 27. 2021 at 5:00 PM of Resident 1's care plans (C/P), Resident 1 had no C/P's indicated for wandering or elopement on admission. During an interview on May 27, 2021 at 5:10 PM, with the DON, the DON confirmed Resident 1 did not have a C/P initiated for wandering/Elopement on admission because Resident 1 was not an elopement risk. A review of the facility's policy and procedure titled, Wandering and Elopements, dated March 2019, indicated .The facility will identify Residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 38869 Based on observation, interview, and record review, the facility failed to provide monitoring and supervision for one of twelve residents (Resident 1) who was disoriented (having lost one's sense of direction) with wandering behaviors eloped (a dependent resident leaving the facility without observation or knowledge of departure) from the facility through an unlocked gate without staff's knowledge. This failure resulted in Resident 1 suffering from head trauma and serious lacerations to his face and head according to hospital records. An Immediate Jeopardy (IJ a situation that has threatened or is likely to threaten the health and safety of a Resident) was called under 483.5, Quality of Life (refer to F 689 Free of Accident Hazards/Supervision) on May 27, 2021 at 10:41 AM, and verbally notified in the presence 0f the Administrator. Resident 1 was admitted and assessed as a moderate elope risk and the facility failed to provide monitoring and supervision for Resident 1who was disoriented with wandering behaviors eloped through an unlocked gate without staff's knowledge which resulted in serious bodily injuries. The Corrective Action Plan (CAP): Was accepted on May 27, 2021 at 1:20 PM in the presence of the Administrator. Ordered. The CAP steps consisted of Immediate in service for all License Nurses (LN's) and Certified Nurse's Assistant (CNA's). Immediate Intervention for any residents showing any signs and symptoms of wandering/elopement not in lock unit. Ongoing in service to LN's and CNA's are re educated. Update policy and procedure for Wandering/Elopement. All 23 Resident's with Dementia diagnosis not in memory care unit will be re-assessed. All new admission/re admissions will be assessed immediately for signs and symptoms of wandering/elopement. Assistant DON/Unit Managers will be reviewing Change of Condition's (COC) daily for episodes of wandering/elopement. All resident's that have exit seeking behavior will be reassessed. Assisted Director of Nurses (ADON)/ Unit Manager (UM) will review monthly to make sure high risk are addressed for part of Quality Assurance (QA) All Change of Conditions (COC's) with behavior of wandering/elopement will be reported monthly to QA. When all steps of the CAP were reviewed, staff interviews were conducted, observations were made and record reviews were completed, on May 30, 2021 at 1:00 PM the IJ was lifted in the presence on the Administrator. Findings: During a review of Resident 1's facility document entitled, Pre-Admission Record, dated May 18, 2021, indicated, Resident 1 has a diagnosis of cognitive communication deficit (occurs after a stroke among other possible reasons which results in difficulty thinking and how someone uses language.) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the medical record for Resident 1 the document entitled, Admission Record, (shows resident's demographics) indicated, Resident 1 admitted to the facility on [DATE], with diagnoses of intracerebral hemorrhage (bleed in the brain that can cause deficits in attention, verbal and nonverbal learning, short term and working memory, visual and auditory processing, problem solving, processing speed, and motor functioning), hypertension (high blood pressure), heart failure (your heart muscle doesn't pump blood as well as it should), and type 2 diabetes (an impairment in the way the body regulates and uses sugar as a fuel). Resident 1 was assigned to unit 1. During a review of the physician notes from the hospital, dated May 23, 2021, the History of Present Illness indicated, Resident 1 was at the hospital for evaluation due to ALOC (Altered level of consciousness). He was found altered by the police wandering away from the facility [Name of Facility] with a bag containing his belongings .he presents with abrasions to the right cheek. Under Social History his smoking status is listed as Never Smoker. During a review of Resident 1's physician notes from [Name of Hospital], dated May 23, 2021, the record of other imaging indicated, Computerized Tomography (CT uses computers and rotating x ray machines to create cross sectional images of the body) head .radiologist impression: small acute bilateral subdural hematoma (bleeding on both sides of your brain). During a review of the facility list of recent discharges, undated, the list of discharges indicated Resident 1 was listed as discharged AMA (Against Medical Advice when a resident leaves the facility without a physician's consent) to home with no home health service on May 24, 2021. During a review of Resident 1's admission Wandering/Elopement Risk Assessment (scores a resident for low, moderate to high risk based on indicators such as orientation (aware of one's environment to place, time, and people), behavior/mood, etc.), dated May 21, 2021, the wandering/Elopement risk assessment for Resident 1 indicated, a Score of 5 indicating a moderate risk for elopement. Under the Orientation section, the resident is entered as forgetful/short attention span. Under Behavior/mood section, it indicates Resident 1 does not understand surroundings. During a review of Resident 1's admission Fall Risk Assessment, dated May 21, 2021, the Fall Risk Assessment indicates, under level of consciousness/mental status as disoriented. During a review Resident 1's Nursing Progress Note, dated May 22, 2021, at 7:39 PM, the Nursing Progress Note indicated, Resident 1 is Alert, confused and verbally responsive with clear speech. Steady gait and constantly ambulating per hallways aimlessly stating he is looking for a family member and has to be redirected frequently and constantly. During a review of Resident 1's physician progress notes, dated May 21, 2021 to May 24, 2021, indicated no documentation that the physician was notified of Resident 1's disorientation or wandering behavior prior to his elopement. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Nursing Progress Note, dated May 23, 2021, at 7:19 PM, the Nursing Progress Note indicated, Received phone call from family member stating resident is found outside of [Name of Facility] at 1900 (7PM) from [name of city] police department and taken to [Name of Hospital]. Last saw resident was at 1600 (4 PM) walking around unit. Notify .the DON and . The administrator at 1919 (7:19 PM). Both are aware of the situation. During a review of Resident 1's Social Services Note, dated May 24, 2021, at 12:21 PM, the Social Services Note indicated, Resident 1 left AMA on May 22, 2021. Social Services reported incident to Ombudsman and APS (Adult Protective Services). During a review of Resident 1's admission care plans, dated May 12, 20121 indicated no care plans (C/P's) were initiated for Resident 1 being at risk for wandering and elopement risk. During an interview on May 26, 2021, at 11:26 AM, with the Director of Nursing (DON), the DON confirmed if any residents were considered wanderers/elopement risks, we would place them in our locked memory care unit (Unit 2). During an interview on May 26, 2021, at 2:06 PM, with the DON, the DON stated on May 23, 2021 Resident 1 did elope from the facility without staff's knowledge's and did not leave AMA as documented by the SSW but, does not know how he got out. . During an interview on May 26, 2021, at 2:06 PM, with the Administrator (ADM), the ADM stated if residents are not exit seeking then we do place them in our locked memory care unit. The ADM stated, We have 72 hours to validate a resident 's behavior. The ADM stated he is unsure how Resident 1 got out of the facility, it mayhave3 been through the courtyard and up the ramp through an unlocked gate. During an interview on May 27, 2021, at 12:15 PM, with the ADM, he stated he did not know if the doors on unit 1 are locked 24 hours a day/ 7days a week but did know the main entrance was locked at 8pm. During an interview on May 27, 2021, at 1:40 PM, with the ADM, the ADM stated Resident 1 left AMA on evening of May 23, 2021. The ADM stated any Resident not housed on Unit 2 (locked Memory Unit) can leave any time they want, and they have the right to decline to sign the AMA form. When asked if staff should be responsible to know where Residents are always for their safety, the ADM stated, Yes, we should, and I will take responsibility for the fact we did not know that Resident 1 had left the facility. The ADM confirmed the facility did not notify California Department of Public Health (CDPH) when Resident 1 left facility on May 23, 2021 because, Resident 1 had a right to leave. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555350	A. Building B. Wing	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Grove Post Acute	1618 Laurel Avenue Redlands, CA 92373

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on May 27, 2021, at 4:40 PM, with Licensed Vocational Nurse (LVN 1), LVN 1 stated, since Resident 1's admission on May 21, 2021 she felt he was confused and really wanted to leave. He would not stay in his room after redirection. He wanted to go to the smoking area often. LVN 1 stated Resident 1 was an elopement risk and notified the ADM regarding her concerns about Resident 1 at risk for eloping. LVN 1 further stated when one of the Certified Nurse's Assistant (CNA) went to lunch, Resident 1 was seen in the smoking area at around 4:00 PM. During a concurrent observation/Interview on May 27, 2021, at 4:40 PM, with LVN 1 of unit 1, the alarm on the door to the smoking area was not set. The door from unit 1 to the smoking area is near the nurse's station. LVN 1 confirmed, by pointing out the door that staff were unable to observe residents outside in the smoking patio unless staff are in the patio area. The unlocked gait from the smoking patio leads to the parking area. Also, there is another exit at the end of the hallway opposite of nurse's station. This exit has an inactivated alarm that leads to a courtyard with a wheelchair ramp that leads to the parking lot. LVN 1 further confirms these are doors are always unlocked. During an interview on May 30, 2021, at 11:50 AM, with the Registered Nurse Supervisor (RNS), the RNS stated, if I admitted a resident with cognitive communication deficit and nursing progress notes indicating resident was confused x2 (orientation is assessed for self, place, time and situation), then that resident should be monitored for possible elopement risk. The RNS stated there are two doors (smoking and courtyard) on unit 1 where residents can leave but must knock to get back in. The RNS stated the doors are locked at 11:00 PM. During an interview on May 30, 2021, at 12:30 PM, with the ADM, the ADM stated for unit 1 staff do not have to supervise residents when they go out to smoke. The ADM confirmed staff cannot see residents in smoking area. He stated the residents can go to the smoking area at any time. He stated staff check residents every two hours. When asked if this was safe for resident's to be unsupervised, the ADM asked, Should I assign staff to supervise the smoking are. During an interview on June 1, 2021, at 4:20 PM, with CNA 1, CNA 1 stated Resident 1's bed was empty when he arrived on unit 1 for evening shift (3pm to 11pm) on May 23, 2021. CNA 1 stated there were no belongings in his room except a sheet and a pillow. He stated at the time, he thought Resident 1 was outside in the smoking area or with family. During shift change, CNA 1 was told Resident 1 walked out the door to the back patio/smoking area. During an interview on June 1, 2021, at 5:08 PM, with LVN 6, LVN 6 stated Resident 1 needed to be redirected here and there. LVN 6 stated Resident 1 would go to the smoking area and then staff would redirect him to go back inside often. LVN 6 stated his last sighting was between 4 and 4:15 PM on May 23, 2021. Resident 1 was looking for his girlfriend and staff would tell Resident 1 she wasn't at facility. LVN 6 stated she was waiting for the facility to send Resident 1 to unit 2 (locked unit memory care). LVN 6 stated she suggested to RN supervisor Resident 1 may need to go to locked unit. LVN 6 stated she can't remember who the RN Supervisor was. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555350	A. Building B. Wing	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Grove Post Acute	1618 Laurel Avenue Redlands, CA 92373

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's policy and procedure titled, Wandering, Revised March 2019, indicated under Policy Statement ., The facility will identify residents who are at risk of unsafe wandering, risk for wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Also, under Policy Interpretation and Implementation, 1. If identified as at risk for wandering, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner .; c. inform the Charge Nurse or Director of Nursing Services that a resident is attempting to leave or has left the premises. 3. If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass. b. If the resident was not authorized to leave, initiate a search of the building(s) and premises, and c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative, the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies. During a review of the facilities policy and procedure titled, Behavioral Assessment, Intervention and Monitoring, Revised March 2019 indicated under Policy Statement,5. Residents will have minimal complications associated with the management of altered or impaired behavior. Under Policy Interpretation and Implementation, Assessment .3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition including a. Onset, duration, intensity and frequency of behavioral symptoms. 4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. Under Management, 1. The interdisciplinary team will evaluate behavioral symptoms in resident to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately unnecessary, to protect the resident and others from harm.