STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based on observation, interview and record review, the facility failed to protect two of three sampled residents (Resident 1 and 2) from abuse by failing to: 1. Identify Resident 1's behavior of alcohol intoxication (also known as alcohol poisoning, described as drunkenness or negative behavior and physical effects caused by a recent consumption of alcohol) with a habit of leaving the facility and come back drunk. 2. Protect Resident 2 (Resident 1's roommate) from Resident 1 when Resident 1 was cursing and threatening Resident 2 while intoxicated with alcohol. 3. Prevent Resident 1 from hitting Resident 2 when facility staff was aware that Resident 1 was intoxicated with alcohol on 4/5/22. As a result, Resident 2 stated he felt isolated and not safe around Resident 1. These deficient practices had the potential for other residents to be at risk for potential physical and verbal abuse from Resident 1 who manifested behavior of aggression towards others when intoxicated with alcohol. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/27/2018 and readmitted on [DATE] with diagnoses that included gastritis (inflammation of the stomach lining commonly due to excessive drinking of alcohol) with bleeding, lack of coordination, alcohol abuse (excessive use of alcohol) and hematemesis (coughing up blood). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/29/2022, indicated the resident had moderate cognitive impairment (has trouble remembering, concentrating, or making decisions) that required supervision (oversight encouragement or cuing) with one -person physical assist for transfers. The MDS indicated Resident 1 had limitations on one side of the lower extremity which placed the resident at risk for injury. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's untitled care plan dated 11/8/2021, indicated Resident 1 had a behavioral problem with history of cursing, yelling at staff and had short temper. The care plan goal was to ensure Resident 1 had fewer episodes of cursing and staff the facility will encourage the resident to ventilate feelings. During an observation on 4/7/2022 at 1:40 PM, in the presence of the AIT (Administrator in Training), Resident 1 was sitting in a wheelchair in the front lobby getting ready to leave the facility. Resident was observed with a skin cut on the right elbow covered with dried blood, Resident 1 was asked what happened to his right elbow and the resident replied, I fell off the wheelchair the other day (4/5/2022) . Resident 1 refused to elaborate what happened. Resident 1 was asked about the altercation related to Resident 2. Resident 1 stated I do not know what you are talking about, I did not hit anyone or had a fight with anyone. Resident 1 stated, No one messes with me you do not know what I have been to, I will walk over you before you walk all over me. Resident 1 refused to discuss the incident related to resident altercation involving him and Resident 2. Resident 1 proceeded to leave the facility and the AIT informed Resident 1 not to drink while he is out on pass. During a concurrent interview the AIT stated, Resident 1 goes out on pass alone and sometimes returns to the facility intoxicated with alcohol. During an interview on 4/7/22 at 2:56 PM, Resident 2 stated two days ago, Resident 1 rushed him to get out of the restroom because he wanted to use the restroom. Resident 2 stated, Resident 1 smelled like alcohol and was drunk, repeatedly pushed him, hit him on the chest, cursed and yelled at him with profanity and pushed him towards the bed where he landed. Resident 2 stated, since he was admitted to the facility, he did not feel safe to be in the same room with Resident 1 who was often drunk and repeatedly threatened to throw him out on the street and beat him up and kill him because he had seen him in the streets as homeless. Resident 2 stated had never lived in the streets of the city that Resident 1 referred to. Resident 2 stated he felt isolated and not safe around Resident 1 in the facility. A review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). A review of Resident 2's MDS, dated [DATE], indicated the resident had no cognitive impairment and required extensive assistance (resident involved in activity and staff provide weight bearing support) with one-person physical assist on walking and transfers. During an interview with the Certified Nursing Assistant (CNA 1) on 4/7/22 at 2 PM, she stated on 4/5/2022, she witnessed Resident 1 hit and pushed Resident 2 to his bed and continued to scream profanity to Resident 2. CNA 1 stated Resident 2 did not fight back. CNA 1 stated Resident 1 smelled like alcohol and looked like he had been drinking alcohol when the incident occurred. CNA 1 stated, Resident 1 often leaves the facility alone and returns to facility smell like alcohol, drunk and becomes very aggressive towards staff and other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/22 5:50 PM, CNA 2 stated, he witnessed Resident 1 always drunk and brings alcohol to the facility. CNA 2 stated a month ago he found Resident 1 with a bottle of alcohol in his hand after he had fallen on the floor while he was drunk. CNA 2 stated Resident 1 became angry and tried to choke him. CNA 2 stated Resident 1 was not monitored or supervised when he returns to the facility intoxicated with alcohol and was observed yelling at his roommate (Resident 2) and to others on many occasions. CNA 1 stated he had informed the ADM, SSD and the DON multiple times of Resident 1's behavior. During an interview and concurrent record review of Resident 1's clinical record conducted with the Administrator (ADM) on 4/7/22 at 4:29 PM, the ADM stated she was aware of Resident 1's aggressive behavior towards others. ADM explained that Resident 1 was noncompliant with the facility's policy on Out on Pass and returns to the facility intoxicated with alcohol with aggressive behavior towards staff and residents. ADM stated these behaviors placed Resident 1 at risk for altercation with residents and staff. The ADM stated Resident 1 should had been supervised and monitored to prevent abuse. A review of the facility's Policy and Procedure, titled Abuse-Reporting and investigation dated 3/2018 indicated the allegation of abuse, mistreatment, neglect and exploitation or reasonable suspicion of abuse or crime will be thoroughly investigated and if the suspected perpetrator is another resident, separate the residents so they do not interact with each other until circumstances of the reported incident can be clarified. A review of the facility's Policy and Procedure, titled Abuse Prevention, Screening and Training Program dated 7/2018, indicated the Administrator as the abuse prevention coordinator is responsible for coordination and implementation of the facility's abuse prevention, screening, and training program policies. To prevent abuse, the facility will identify, correct, and intervene in situations in which abuse, neglect and mistreatment is more likely to occur.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based on observation, interview and record review, the facility failed to assess and provide treatment of a skin tear on the right elbow for one of two sampled residents (Resident 1). Resident 1 fell off his wheelchair on 4/5/2022 and sustained a skin tear on the right elbow. This deficient practice had the potential to result in worsened skin condition for Resident 1 and the risk of infection. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/27/2018 and readmitted on [DATE] with diagnoses that included gastritis (inflammation of the stomach lining commonly due to excessive drinking of alcohol) with bleeding, lack of coordination, alcohol abuse (excessive use of alcohol) and hematemesis (coughing up blood). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/29/2022, indicated the resident had moderate cognitive impairment (has trouble remembering, concentrating, or making decisions) that required supervision (oversight encouragement or cuing) with one -person physical assist for transfers. The MDS indicated Resident 1 had limitations on one side of the lower extremity which placed the resident at risk for injury. During an observation on 4/7/2022 at 1:40 PM, in the presence of the AIT (Administrator in Training) Resident 1 was sitting on a wheelchair in the front lobby getting ready to leave the facility. Resident 1 had a skin tear on the right elbow covered with dried blood. Resident 1 was asked what happened to his right elbow. Resident 1 stated, I fell off the wheelchair the other day (4/5/2022). Resident 1 refused to elaborate on what happened. During an interview on 4/8/22 at 3:15 PM, the ADON was asked how Resident 1 sustained the skin tear on his right elbow. ADON stated there was no documentation in Resident 1's clinical record that a skin assessment was completed and on how the resident sustained the skin tear on the right elbow. ADON stated there was no documented evidence in Resident 1's clinical record that treatment was provided to the resident's skin tear on the right elbow. During an interview on 4/8/22 at 3:48 PM, Resident 1 stated two days ago (4/5/2022) the breaks on his wheelchair did not work. Resident 1 stated he hit his hip and right arm when he tried to get out of the wheelchair and the wheelchair moved and he fell . Resident 1 claimed his right arm landed on the wheels of the wheelchair which resulted to a skin tear on his right arm. Resident 1 stated he got a scratch on his right arm and hit his hip. Resident 1 stated he currently felt sore on the hip. Resident 1 stated no one assessed him and he got up from the floor alone and unassisted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/22 at 3:25 PM, ADON stated, when Resident 1 returned from Out on Pass (ordered by the physician to go out to the community temporarily from a period of time), the facility staff should have reassessed the resident to determine the resident's condition including skin assessment and to ensure safety. The ADON stated if the resident refused skin assessment from a licensed staff, a different licensed nurse should have done the assessment and document in the clinical record. A review of the facility's Policy and Procedure, titled Out on Pass dated 1/11/2016, indicated the facility will make reasonable effort to ensure the resident safety and uphold resident rights. If the nursing staffs believe the out on pass order conflicts with the resident's plan of care or jeopardizes the resident's health and safety, the nursing staff will hold the out on pass order until the physician/psychiatrist can determine the resident can safely leave the facility. Prior to the resident leaving out on pass the licensed nurse will assess the resident's physical and mental status and will be reassessed when he/she returns to the facility to determine the resident's condition. The licensed nurse will document the time the resident left the facility, the destination when out on pass, contact phone number and expected time of return.

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33670 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was provided necessary behavioral health care and services for the treatment of the resident's emotional, mental and alcohol abuse (A chronic disease characterized by uncontrolled drinking and preoccupation with alcohol) by ensuring: 1. Resident 1 who exhibited aggressive behavior from alcohol intoxication (also known as alcohol poisoning, described as drunkenness or negative behavior and physical effects caused by a recent consumption of alcohol) was monitored and supervised from walking out of the facility and coming back intoxicated (A disturbance in behavior or mental function during or after alcohol consumption). 2. Resident 1's aggressive behavior and mental status was being monitored and supervised to prevent the resident from hitting another resident (Resident 2) after Resident 1 came back to the facility intoxicated on 4/5/2022. 3. Resident 1 was evaluated by a psychiatrist (a medical doctor who specializes in mental health, including substance use disorders. Psychiatrists are qualified to assess both the mental and physical aspects of psychological problems) when a physician's order was placed to evaluate the resident on 3/26/22. 4. Resident 1 was monitored and supervised when the resident violated the out on pass order (an inpatient who is ordered by the physician to go out to the community temporarily from a period of time) that was placed on hold due to the resident consuming alcohol. The resident signed out of the facility on 3/13/2022, 4/2/2022, 4/5/2022 to go to the store. 5. Resident 1's behavior was continually monitored to prevent him from hitting Resident 2 and causing Residents 3 and 4 to feel threatened when Resident 1 returned to the facility intoxicated. These deficient practices had the potential to result in the likelihood that Resident 1 would continue to be intoxicated with alcohol and be verbally and physically aggressive that could lead to fear, and possible injury to other residents if not be treated for behavior and substance use disorder (recurrent use of alcohol or drugs that causes clinically and functionally significant impairment or disability). On 4/7/2022 at 8:31 PM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Administrator (ADM), Director of Nursing (DON) and Social Service Designee (SSD) regarding the facility's failure to provide supervision and monitoring to Resident 1 who violated the facility's policy and procedure on out on pass and returned to the facility intoxicated, verbally and physically abusive towards others. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/8/22 at 5:52 PM, the IJ was removed after the ADM submitted an acceptable removal plan (interventions to correct the deficient practices). The surveyor verified and confirmed the implementations of the removal plan while onsite by observation, interview, and record review. The IJ was removed in the presence of the ADM. The acceptable removal plan was as follows: 1. On 4/7/2022, the Licensed Nurse contacted Resident I's attending physician as Resident 1 exceeded the 2-hour timeframe for out on pass and received an order for out on pass for 4-6 hours for therapeutic event, monitoring of behavior when returning to facility, and to obtain blood alcohol level every time patient goes out on pass. - Completion Date: 4/7/2022 2. On 4/7/202, Resident 1 returned to the facility, was assessed by a Licensed Nurse, and was moved to a different room between 10:30PM to 12AM. 3. On 4/7/2022, the Licensed Nurse contacted Resident I's attending physician and received an order to discontinue out on pass privileges until psychiatrist evaluates him and deems him safe to go out on pass. 4. On 4/7/2022, the Administrator contacted the Psychiatrist and arranged for Psychiatry Evaluation for Resident 1 on 4/8/2022. 5. On 4/7/2022, the DON initiated an in - service education to the staff regarding the policy and procedures related to Out on Pass, Discharge Against Medical Advice, Resident to Resident Altercation, and assessment of residents upon returning from out on pass. This in - service education will be completed by 4/15/2022. Any Licensed Nurses and Certified Nursing Assistants (CNAs) on call or on leave will receive the education upon return to work, and newly hired Licensed Nurses and CNAs will receive training during their orientation period. 6. On 4/7/2022, Resident 2 was assessed by a Licensed Nurse to ensure feeling of safety in the facility. 7. On 4/7/2022, Assistant Administrator and DSD conducted room rounds to ensure that Resident 1 did not have any alcoholic beverages in the room. 8. On 4/7/2022, the Interdisciplinary Team (IDT, a group of diverse health care professionals from different fields), met with the resident to offer alternatives to alcohol cessation, discussed risks and benefits. 9. On 4/7/2022, at 8PM, one on one supervision (the resident's clinical status is unstable enough to require a nurse or doctor to be present and observing/treating them at all times) supervision was initiated for Resident 1. Cross Reference F600 Findings: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/27/2018 and readmitted on [DATE] with diagnoses that included gastritis (inflammation of the stomach lining commonly due to drinking too much alcohol) with bleeding, lack of coordination (results from damage to the part of the brain that controls muscle coordination (cerebellum) or its connections that could be due to alcohol misuse, stroke etc.), alcohol abuse (excessive use of alcohol) and hematemesis (coughing up blood). A review of Resident 1's plan of care, dated 11/8/2021 indicated the resident had a behavioral problem with history of cursing, yelling at staff and had short temper (easily angered). Interventions included for the resident to have fewer episodes of cursing at the staff was for the facility to encourage the resident to ventilate feelings (to express openly). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/29/2022, indicated the resident was assessed with moderate cognitive impairment (has trouble remembering, concentrating, or making decisions) that required supervision (oversight encouragement or cuing) requiring one -person physical assist with transfers. The MDS indicated Resident 1 was assessed having limitations on one side of the lower extremity which placed resident at risk for injury. A review of Resident 1's physician order, dated 3/9/2022, indicated to place a hold on Resident 1's out on pass order due the resident consuming alcohol while out on pass. A review of Resident 1's physician order, dated 3/26/22, indicated to transfer Resident 1 to the hospital for medical clearance and psychiatric (the field of medicine that diagnoses treats, and manages mental disorders and/or addictions) evaluation and treatment if needed. A review of Resident 1's clinical record indicated no psychiatric evaluation was conducted as ordered by the physician or no follow up was made for the resident to receive psychiatric evaluation or treatment from 3/26/2022 to 4/7/2022. A review of the Release of Responsibility While Out On Pass and the physician's order indicated, Resident 1 signed out of the facility on 3/13/2022, 4/2/2022 and 4/6/2022 to go to the store even when the physician ordered to hold the out on pass order on 3/9/2022. A review of Resident 1's plan of care, dated 3/29/2022, indicated Resident 1 was at risk for decreased psychosocial wellbeing, emotional/mental distress, ineffective coping skills, and difficulty adjusting to placement in the facility due to resident had a history of drug and alcohol abuse. To ensure the resident accept staff support and interventions, the facility would do the following: a. Assess resident's coping skills and support system. b. Will be evaluated by psychologist and psychiatrist as needed. c. Provided support visits weekly and as needed to monitor psychosocial wellbeing. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 1's Psychologist Notes, dated 4/1/2022 indicated the justification for the continued treatment was due to ongoing mental health symptoms and decline from baseline. The notes indicated the psychiatrist recommended for the resident to continue to work on, decreasing anger outburst and maintain sobriety (absence of alcohol or other substance use). A review of Resident 1's IDT Note, dated 4/6/2022, timed at 2:35 PM, indicated IDT met with Resident 1 regarding having an altercation with another resident (Resident 2). The note indicated IDT attempted to invite Resident 1 to the care plan meeting and Resident 1 declined, yelling and cursing man why the f . are you guys making it a big deal. He should have not been in my way. The note indicated IDT would respect Resident 1's wishes and would discuss interventions that the staff and Resident 1 can practice avoiding another altercation. The note indicated the staff would monitor Resident 1 for any aggression and to remind Resident 1 that violence was prohibited at the facility and provide a safe environment to Resident 1. A review of Resident 1's clinical record had no documented evidence that the resident's aggressive behavior was consistently monitored every shift. A review of Resident 1's Psychiatrist report, dated 4/8/2022, indicated Resident 1 appeared somewhat paranoid (is the feeling that you're being threatened in some way), with diagnoses that included unspecified mood psychosis (severe mental disorder manifested by loss of contact with reality, including delusions and hallucinations). The report indicated the psychiatrist plan of care indicated to transfer Resident 1 to an inpatient psychiatric unit due to resident was unstable, and to place him on a 5150 hold (a Welfare and Institutions Code, which allows a person with a mental illness to be involuntarily detained for a 72-hour psychiatric hospitalization) due to being Danger to Others (DTO). A review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs) and protein calorie malnutrition (obvious significant muscle wasting, loss of subcutaneous [under the skin] fat due to poor food intake). A review of Resident 2' MDS, dated [DATE], indicated Resident 2 had no cognitive impairment requiring assistance (resident involved in activity and staff provide weigh bearing support) with one-person physical assist on walking and transfers. A review of Resident 3's Admission Record indicated the facility admitted the resident on 3/10/22 with diagnoses that included hip fracture (broken bone of the hip) and hypertension (having high blood pressure). A review of Resident 3's MDS, dated [DATE] indicated the resident had no cognitive impairments and required extensive assistance with one-person physical assistance on bed mobility and toilet use. A review of Resident 4's Admission Record indicated the facility admitted the resident on 11/21/2020 and readmitted to the facility on [DATE] with diagnoses that included idiopathic neuropathy (nerve damage of unknown cause) and osteoarthritis (wearing down of the protective tissue at the ends of bones that results in pain and tightening of the joints) of the knee. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 4's MDS, a standardized assessment and care planning tool) dated 2/17/22 indicated the resident had moderate cognitive impairments. During an observation on 4/7/2022 at 1:40 PM, in the presence of the AIT (Administrator in Training) Resident 1 was observed sitting in the wheelchair in the front lobby getting ready to leave the facility. The resident was observed with a skin cut on the right elbow covered with dried blood. Resident 1 was asked about his right elbow and the resident replied, I fell off the wheelchair the other day. The resident refused to elaborate further regarding the alleged incident. Resident 1 was asked about the altercation related to Resident 2. Resident 1 replied, I do not know what you are talking about, I did not hit anyone or had a fight with anyone. Resident 1 stated, No one mess with me you do not know what I have been to, I will walk over you before you walk all over me. Resident 1 refused to discuss the alleged altercation between Residents 1 and 2. Resident 1 then proceeded to leave the facility and the AIT informed Resident 1 not to drink while he was out on pass. During a concurrent interview the AIT stated, Resident 1 went out on pass alone and sometimes returned to the facility intoxicated. During an interview with the Certified Nursing Assistant (CNA 1) on 4/7/2022 at 2 PM, she stated on 4/5/2022, she heard screaming from Resident 1 and Resident 2's room and witnessed Resident 1 hit and push Resident 2 to his bed while repeatedly screaming at Resident 2 telling him, I am not doing anything to you F you F . you. CNA 1 stated Resident 2 did not fight back and was separated from Resident 1 who smelled like alcohol and looked like he had been drinking alcohol when the incident occurred. CNA 1 stated Resident 1 often left the facility alone and returns to the facility smelling like alcohol, drunk and very aggressive towards other residents and staff when intoxicated. CNA 1 stated Resident 1 was not monitored and supervised closely when he is drunk. During an interview on 4/7/2022 at 2:56 PM, Resident 2 stated that on 4/5/2022, Resident 1 rushed him to get out of the restroom because he wanted to use the restroom. Resident 2 stated, Resident 1 who smelled like alcohol and was drunk, repeatedly pushed him, hit him on the chest, cursed and yelled at him with profanity and told him, F you F you then pushed him towards the bed. Resident 2 stated he did not feel safe to be in the same room as Resident 1 who was often drunk and repeatedly threatened to throw him out on the street and beat him up and kill him. Resident 2 explained Resident 1 often goes out of the facility and returned drunk fighting with staff and residents. During an interview on 4/7/2022 at 4:14 PM, the Licensed Vocational Nurse (LVN 1) stated Resident 1 often left the facility out on pass and came back drunk. LVN 1 stated Resident 1 did not comply with the out on pass policy of the facility and returned to the facility at any time he wanted, often drunk and aggressive towards others. During an interview and concurrent record review of Resident 1's clinical record with Administrator (ADM) on 4/7/2022 at 4:29 PM, ADM stated Resident 1 was noncompliant with the facility's policy and procedure of out on pass and often left the facility and returned back to the facility sometimes drunk and aggressive towards others. The ADM stated on 3/10/2022 she witnessed Resident 1 being aggressive and angry towards others when he was not allowed to go out on pass. ADM stated since Resident 1 was alert, oriented and was self-responsible, he had legal right to go out on pass. The ADM stated there was no documentation that the IDT meeting was conducted to determine if Resident 1 may go out on pass safely. The ADM stated Resident 1 went out on pass without supervision and did not sign in or out when leaving or returning to the facility, puts the resident at risk for fall, accident, and injury. (continued on next page)

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	555852	A. Building B. Wing	04/08/2022

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Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a record review of the Release of Responsibility While Out on Pass, and concurrent interview with the ADON (Assistant Director of Nursing) on 4/7/2022 at 4:44 PM, indicated on 7/31/2021, 3/13/22, 4/2/22, and 4/6/22, Resident 1 left the facility to go to the store without documentation of when the resident returned to the facility. The ADON stated, the facility's staff were supposed to document when residents left the facility and document when they returned to ensure the residents returned safely. During an interview and review of Resident 1's clinical record on 4/7/2022 at 4:48 PM, the Social Service Designee (DSD) stated Resident 1 was noncompliant with care and the last few months Resident 1 had been going out on pass even against the physician's order and comes back to the facility often drunk, with loud voice and aggressive behavior. A review of the following progress notes in Resident 1's clinical record indicated the following: a. On 2/14/2022, timed at 15:07 PM, Resident 1 was found with an alcohol bottle in room at bedside. The SSD and ADM was informed. Resident 1 with aggressive behavior towards CNA and charge nurse and punched CNA on the face and attempted to hit the charge nurse. Police was called and report done. b. On 3/9/2022, timed at 4:24 PM, Resident 1 the (Nurse Practitioner) NP wrote an order to allow Resident 1 to go out on pass to go to the store for 1-2 hours, resident left at 10:35 AM and returned at 12:30 PM. Resident 1 returned to the facility and looked like he had been consuming alcohol. When Resident 1 was asked if he had been consuming alcohol, the resident replied, Do you think I am stupid to tell you if I had any alcohol, what kind of stupid question is that. Resident 1 disrespected the staff and called her names Do not F with me you know how I roll, do not F . with me you know I take care of business. c. On 3/10/2022, timed at 2:01 PM, Resident 1 with unsteady gait and with strong odor of alcohol went to the nursing station and yelling and cursing at the staff. Resident 1 was asked if he had consumed alcohol? Resident 1 replied You cannot prove that, come on prove it to me. I can have you fired. Resident 1 continued to harass charge nurse. Resident 1 approached the staff and stated he wanted to go to the store, when Resident 1 was informed he had no order for out on pass the resident continued to be aggressive and violent towards the staffs and stated, Well I went out yesterday. The NP was called ordered not to out on pass and to be given a 30-day discharge notice to the resident. NP was made aware that Resident 1 was homeless. d. On 3/17/2022, timed at 2:52 PM housekeeping found three empty bottles of alcohol in the trash can, DON and ADM aware. Resident 1 found ordering alcohol through online order but did not go through. e. On 3/26/2022, timed at 12:35 PM, Resident 1 was ordered by the NP to go to the acute care hospital and resident refused and stated there was nothing wrong with him. f. On 4/1/2022, timed at 2:32 PM, SSD and Ombudsman met with Resident 1 to review 30 days discharge plan. Resident 1 was adamant and preferred having his own independent living situation, which was out of the Resident 1's price range. Resident 1 informed SSD to call the Social Security office and go with him so that they can get me more money. g. On 4/6/2022 at 4:46 PM, SSD visited Resident 1 to talk to the resident about the altercation with another resident. Resident 1 did not want to speak to the SSD. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and concurrent record review of Resident 1's medical record, on 4/7/2022 at 4:39 PM, the SSD stated on 3/26/2022 the physician ordered Resident 1 to go to the acute hospital for medical and psychiatric evaluation, but the resident refused. The SSD stated there was no monitoring of Resident 1's behavior or follow up referral to a psychiatrist when Resident 1 continued to have aggressive behavior towards others. The SSD stated Resident 1 was evaluated by a psychologist (A psychologist is a person who specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorder) for behavioral problems due to alcohol use. The SSD stated Resident 1 was not referred or evaluated by the psychiatrist because Resident 1 was not taking any psychiatric medications. During an interview on 4/7/22 at 5:10 PM, the ADM stated, Resident 1 had not returned to the facility, and they have not searched for the resident. The ADM stated she was not aware that the NP ordered Resident 1 not to go out on pass on 3/9/22. During an interview on 4/7/2022 at 5:35 PM, Resident 3 was observed lying in bed. In an interview Resident 3 stated his new roommate Resident 1 kept him awake all night because he was talking and drinking. Resident 3 stated he was afraid Resident 1 will hit and hurt him when he gets drunk just like what he did to his previous roommate (Resident 2). During an interview on 4/7/2022 at 7:14 PM, the ADON stated there was no change of condition report, monitoring of behavior or supervision when Resident 1 returned to the facility with alcohol intoxication. The ADON stated there was no documentation of the monitoring of Resident 1's whereabouts when he was out on pass. The ADON stated, it was important to monitor Resident 1 because, He is aggressive and a possibility that he might hurt or punch staff, or other residents. The ADON stated, when Resident 1 went out on pass, facility staff were supposed to assess for the resident before the resident left and returned to the facility after being out on pass. The ADON stated, there was no documented evidence that Resident 1 was assessed for mental status, behavior, mental alertness and mobility prior to or when he returned to the facility. During a telephone interview on 4/7/2022 at 7:33 PM, Nurse Practitioner (NP) stated she witnessed when Resident 1 returned to the facility intoxicated on 3/25/2022, and the resident was demanding towards facility staff. NP stated the resident would hide his alcohol or come back already drunk and with unusual behavior when returning to the facility. The NP stated she did not remove the hold for the out on pass order for Resident 1 because of the continued noncompliance with not drinking alcohol. The NP stated she should have referred Resident 1 to the psychiatrist because the resident was noncompliant with alcohol use, has a behavior disorder and is a danger to others. During an interview on 4/7/2022 at 7:45 PM the ADM stated Resident 1 returned to facility. During an observation on 4/7/2022 at 7:55 PM, Resident 1 was observed sitting in the wheelchair in his room. During an interview Resident 1 had slurred speech, was irritable and refused to be interviewed. Resident 1 stated he used his wheelchair to return back to the facility. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and concurrent interview on 4/7/2022 at 8:19 PM, Resident 4 was observed sitting in the wheelchair across from Resident 1's room. Resident 4 questioned why Resident 1 was allowed to go out, get alcohol and get drunk. Resident 4 stated when Resident 1 was drunk, the resident was very loud, aggressive, physically, and verbally abusive towards others. Resident 4 stated she felt threatened when Resident 1 returned to the facility drunk because he had no control of his mouth and cursed at everyone. On 4/7/22 at 8:51 PM, the ADON informed the surveyors that Resident 1 was in his room, and he just lost balance and fell on the floor, but he was able to get up from the floor at 8 PM today. During an interview with the Medical Doctor (MD 1) on 4/7/2022 at 9:47 PM, MD 1 stated he wrote an order to allow Resident 1 to go out on pass. MD 1 stated the resident could make decisions and the facility was not a jail. MD 1 stated, We cannot stop him from going out. MD 1 stated, We are working on his psychiatrist consult sooner. MD 1 was unable to recall if Resident 1 was referred to a psychiatrist to treat the Resident 1's behavior. During an interview on 4/8/2202 5:40 PM, CNA 2 stated he witnessed Resident 1 always drunk and brought alcohol to the facility. CNA 2 stated a month ago he found Resident 1 with a bottle of alcohol in his hand after the resident fell on the floor while he was drunk. CNA 2 stated Resident 1 became angry and tried to choke him. CNA 2 stated Resident 1 was not monitored or supervised when he returns to the facility intoxicated. CNA 2 stated he observed the resident yelling at his roommate (Resident 2) and others on many occasions and informed the ADM and the DON multiple times. A review of the facility's policy and procedure, titled Out on Pass dated 1/11/2016, indicated, the facility will make reasonable effort to ensure the resident safety and uphold resident rights. If the nursing staffs believe the out on pass order conflicts with the resident's plan of care or jeopardizes the resident's health and safety, the nursing staff will hold the out on pass order until the physician/psychiatrist can determine the resident can safely leave the facility. Prior to the resident leaving out on pass the licensed nurse will assess the resident's physical and mental status and will be reassessed when he/she returns to the facility to determine the resident's condition. The licensed nurse will document the time the resident left the facility, the destination when out on pass, contact phone number and expected time of return. A review of the facility's policy and procedure, dated 12/1/13, titled Resident Drug and Alcohol Abuse indicated, the facility will provide safe and drug free environment for residents while at the facility by implementing the following: a. The facility has zero tolerance policy for the use of alcohol in the facility or on the ground of the facility without the physician's order. b. The residents whose medical record provides a history of alcohol abuse may be seen by a psychiatrist, as indicated, who will address current behavioral management issues. c. The IDT will review the care plan after it is developed and as needed thereafter. (continued on next page)

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