STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055114	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Hills Nursing Center	7800 Parkway Drive LA Mesa, CA 91942

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40610 Based on interviews and record review, the facility failed to communicate among staff members to refer a resident (Resident 1) to a psychiatrist (psych, a medical doctor who can diagnose and treat mental health conditions) or psychologist (psych, scientific discipline that studies mental states and processes and behavior in humans) who had a behavioral manifestation for one of three sampled residents reviewed for behavioral assessment. This failure had the potential for Resident 1 to become aggressive to other residents and staff. Findings: Resident 1 was readmitted to the facility on [DATE], with diagnoses which included Major Depressive Disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest), per the facility's Admission Record. A record review was conducted of Resident 1. Resident 1's History and Physical (H & P), dated 8/4/24, indicated the attending physician (AP) documented Resident 1 needed further evaluation to determine his mental capacity. Per H&P, Resident 1 had impaired memory and judgment. The H&P indicated, Psychiatric . mood problems . A record review was conducted of Resident 1. Resident 1's minimum data set (MDS - a federally mandated resident assessment tool), dated 2/7/25, indicated Resident 1's brief interview for mental status (BIMS, ability to recall) score was 14/15 (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact). A review of Resident 1's psychiatry notes dated 10/8/24 indicated Resident 1 had fluctuating decision making capacity. The psychiatry notes instructed the facility staff to call psychiatry when Resident 1 had any behavioral issues. A review of Resident 1's social services notes on 2/2/25 completed by Social Services Assistant (SSA) was conducted. The SSA notes indicated Resident 1 expressed to wanting to live with a family member, attempted to elope (leave the facility without notice), twice. There was no documentation Resident 1 was referred to the psychiatry. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's care plan titled, Elopement did not reflect Resident 1 had behavioral issues of attempting to leave the facility on 2/2/25. The care plan did not reflect Resident 1's aggressive behavior towards staff. A review of Resident 1's social services notes on 3/9/25 completed by SSA was conducted. The SSA notes indicated Resident 1 attempted to elope multiple times, became physically aggressive to the SSA and rolled his (Resident 1) wheelchair to another staff member. There was no documentation Resident 1 was referred to a psychiatrist for his aggressive behaviors. A review of Resident 1's social services notes on 3/31/25 completed by Social Services Director (SSD) was conducted. The SSD notes indicated Resident 1 was physically aggressive with another resident. On 4/10/25 at 10:40 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 had aggressive behaviors towards staff. CNA 1 stated Sometimes he runs to people. We don't know what to expect of him. In a day, he will start his day right, then all of a sudden, he will flip, we have to make sure to keep on our toes most of the time. CNA 1 stated Resident 1 attempted to elope several times and run over a staff. CNA 1 stated Resident 1 had a lot of agitation and did not take any explanation that he easily snapped. On 4/10/25 at 10:56 A.M., a joint review of Resident 1's social services notes and an interview was conducted with the SSD. The SSD stated she was not informed of Resident 1's behavior in February 2025. The SSD stated there was no documentation from SSA that Resident 1's behavior was communicated to the charge nurse on 2/2/25. The SSD stated there was no documentation of psych referral for Resident 1 related to Resident 1's aggressive behavior on 2/2/25 and 3/9/25. The SSD stated the process was when residents exhibited behavioral issues, the SS department refer the residents for psych evaluation. The SSD stated she did not see any psych referral for Resident 1. The SSD stated, With his behavior, if he was seen by psychiatrist, it can lessen his behavior but depends on the residents how they will take or if they will take the provider's advice. We won't know since he was not seen or referred. No paper trail that an intervention was done when identified he has behavioral issues early in February. He could have been referred to the psych. On 4/10/25 at 11:56 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 1 had aggressive behaviors towards staff and other residents. The ADON stated SSA should have communicated that Resident 1 had behavioral manifestation to ensure safety for all residents. The ADON stated Resident 1 should have been referred to the psych. A review of the facility's policy titled, Behavioral Difficulties and Patterns, revised 4/2018, indicated, The facility ensures residents not assessed with a mental or psychosocial adjustment difficulty .does not develop patterns of .increased .angry behaviors while resident in the facility .1. Facility personnel monitor residents closely for .b. Assess and plan care for concerns identified .d. Share concerns with the interdisciplinary team (IDT, collaboration of group of professionals for increase patient outcomes) to determine underlying causes . e. Ensure appropriate follow-up assessment .