STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055213	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rialto Post Acute Center	1471 S Riverside Ave Rialto, CA 92376

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 - 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** 47206 Based on interview, and record review, the facility failed to provide one-on-one supervision, (continuous monitoring of residents by a staff for safety reason. This may involve staff member staying within arm's reach at all times) and the wander guard (wander management system designed to help protect residents, particularly those with memory impairment, from elopement) was not applied for one of four sampled residents (Resident 1) who was a recent admit and on parole. These failures resulted in Resident 1's elopement (refers to a resident leaving the facility without permission or staff knowledge) and possibly contributed to his death. Findings: During a review of Resident 1's Admission Record (contains demographic and medical information), it indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (gradual decline in memory, thinking and other cognitive functions) with agitation (a state of being restless, anxious, or stirred up, like feeling overly excited or tense). During a review Resident 1's Internal Medicine Admission History and Physical Note from the General Acute Care Hospital (GACH), with a date of service of [DATE], it indicated Resident 1 .with dementia, recently released from jail, here for placement due to lack of caregivers, unable to care for self . During a review of Resident 1's History of Present Illness (HPI) from the GACH, with a date of service of [DATE], it indicated Resident 1 has a history of major cognitive disorder (mental health conditions that primarily affect cognitive abilities like memory, learning, and problem solving) and was sent to the emergency department due to concerns of dementia. Resident 1 upon evaluation did not understand why he had to come to the emergency department and repeatedly stated, I'm here because you know I was from there and then there's other people over there. Further evaluation suggested Resident 1 believed he was a [AGE] year-old from the 15th century. Social Worker (SW) contacted Resident 1 niece, and she shared that Resident 1 was previously residing in a skilled nursing facility (SNF is a place where people received medical care and rehabilitation after a hospital stay or injury) but had run away and ended up in jail for a parole violation. During a review of Resident 1's Notice of Admission from the GACH, dated [DATE], there was a remark at the very top of the document, which indicated, .needs a wander guard. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Order Summary Report, which includes active orders as of [DATE], it indicated, Apply wanderguard [wander guard] to prevent resident from going out of the facility unassisted. Monitor presence of wanderguard [wander guard] every shift every shift. During a review of Resident 1's Nursing Progress Notes, dated [DATE], at 5:44 PM, documented by Licensed Vocational Nurse (LVN) 1, it indicated, Apply wanderguard [wander guard] to prevent resident from going out of the facility unassisted. Monitor presence of wanderguard [wander guard] every shift every shift wander guard not available. During a review of Resident 1's Nursing Progress Notes, dated [DATE], at 9:29 AM, documented by LVN 2, it indicated On rounds resident was found to be out of bed and absent from facility grounds. Resident was last seen at 0900 (9:00 AM). SB PD [San [NAME] Police Department] notified. Voicemail left with PO [Parole Officer] During a review of Resident 1's Nursing Progress Notes, dated [DATE], at 9:54 AM, documented by Registered Nurse (RN 1), it indicated, Called 911 at 9:30 AM informed of patient [resident] missing, last seen at 9 AM During a review of Resident 1's Nursing Progress Notes, dated [DATE], at 6:38 PM, documented by Registered Nurse Supervisor (RN Supervisor), it indicated, I spoke with [Name of the police investigator] police investigator on the case. To get more information from admission and diagnosis hx [history].The coroner case number is Coroner case [case number]. During a review of Resident 1 ' s Nursing Progress Notes, dated [DATE], at 9:34 AM, documented by Director of Social Services (SW), it indicated, Social services called [Name of responsible party] to follow up. She [responsible party]verbalized that the police found him deceased at a bus stop. Social services expressed condolences and will follow up as needed. During a review of Resident 1's Wander/Elopement Assessment Risk Evaluation (form to complete to determine if an individual requires necessary safety intervention), dated [DATE], it indicated Resident 1 was not at risk for elopement or wandering. The form was completed the same day Resident 1 eloped, and three days after he was admitted to the facility. During an interview on [DATE], at 3:45 PM, with the Director of Nursing (DON), the DON stated the nursing staff attempted to apply the wander guard on Resident 1 during his admission on [DATE]. The DON further stated the wander guard was not working properly so the facility initiated one on one (1:1) monitoring by assigning a Certified Nursing Assistant (CNA) to monitor Resident 1. Upon request, the DON was unable to provide documented evidence to show the one-on-one monitoring was provided to Resident 1. The DON confirmed the wander guard was never used on Resident 1. During an interview on [DATE], at 12:50 PM, with the DON, a request was made to interview the CNA who was assigned to supervise Resident 1 prior to his departure from the facility without staff noticing. The DON stated no one was assigned to Resident 1 at the time. The DON further stated the night supervisor was responsible for monitoring Resident 1 and left around 8:00 AM, after this point, no one else had been assigned to monitor Resident 1, and that is when Resident 1 left. (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 concurrent interview and record review on [DATE], at 1:10 PM, with the DON, the facility's undated document titled, Order Listing Report was reviewed. The Order Listing Report indicated there were eight (8) residents who were at risk for elopement. The DON confirmed the list of these 8 residents assessed and identified by the facility to be at risk for elopement. During a telephone interview on [DATE], at 2:37 PM, with a SB PD Staff (SB PD Staff 1), Staff 1 stated he is only able to disclose limited information over the telephone regarding Resident 1 ' s case, the records indicate Resident 1 was reported missing on [DATE], at 9:27 AM, and was found deceased by a responding police officer at 12:48 PM, roughly 3 hours after reported missing at [address where Resident 1 found] which is about 2.5 miles away from the facility. The staff indicated that if more detailed information is needed, a request should be made by mail or online. However, obtaining the request information may take significant amount of time. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents dated [DATE], the P&P indicted, .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 During a review of the facility's P&P for Elopement and Wandering, dated February 29, 2024, it indicated, . A Wander/Elopement assessment will be completed on all residents upon admission to the facility . An Immediate Jeopardy (IJ represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death) was called under F 689 S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents) on [DATE], at 9:29 AM, after confirming Resident 1 did not receive supervision and monitoring required to keep Resident 1 safe on [DATE], when Resident 1 was found to have eloped from the facility and had been found by the police, deceased at a bus stop, which was 2.5 miles away from the facility, on [DATE], at 12:48 PM. (Roughly 3 hours after he was identified as eloped). An IJ was called in the presence of the Admin, DON, and Assistant Admin, and IJ removal plan (plan which documents the immediate action an entity will take to prevent serious harm from occurring or recurring) was requested. A revised IJ Removal Plan was received and accepted on [DATE], at 2:26 PM, and included the following: 1. Immediate Corrective Action a. On [DATE], [[DATE]] the DON provided a 1:1 in service to RN regarding 1:1 monitoring intervention to ensure it is followed. b. On [DATE], [[DATE]] the DON/ADON [Assistant Director of Nursing] provided in service to the nursing staff regarding 1:1 monitoring intervention to ensure it is followed. c. Ensure all new admissions from [DATE] [[DATE]] have a completed elopement risk assessment. d. On [DATE], [[DATE]] the NHA/CEO [Nursing Home Administrator/Chief Executive Officer] conducted an inspection of current residents with wander guard to check for placement and function (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. On [DATE], [[DATE]] the NHA/CEO provided in service training to Maintenance Staff regarding wander guard alarm. On [DATE], return demonstration of Maintenance by Nursing Home Administrator/ Chief Executive Officer NHA/CEO was conducted and performed well. ii. On [DATE], [[DATE]] Licensed Nursing staff along with the Maintenance, checked all residents with wander guard with the alarm door, All functioning well. Wander guard will be checked by the licensed nurses for placement attached to the resident every shift and for wander guard to be functioning daily. iii. On [DATE], [[DATE]] the licensed nurses re-evaluated the Wander/Elopement Risk of the 8 [eight] residents at high risk for Wandering/Elopement iv. 8 [eight] residents [residents '] high risk for wandering/elopement with wander guard v. Licensed Nurses will conduct visual check of high-risk resident for wandering/elopement every 2 hours indicating location of the resident. e. On [DATE], [[DATE]] a designated RN conducted inspection of current residents on 1:1 monitoring to ensure proper implementation. Resident [Name of Resident] started on 1:1 monitoring every hour by assigned CNA on [DATE] [[DATE]] to determine resident's activity and provide supervision. f. On [DATE],[[DATE]] RN Supervisor conducting actual physical head count of residents during shift to shift [shift-to-shift] endorsements. i. RN Supervisor prints the facility census indicating resident's name, room number and bed assignment. ii. Outgoing RN Supervisor together with the in-coming [incoming] RN Supervisor will conduct actual physical head count during room rounds. iii. Both RN Supervisors will confirm number of actual physical head count by writing the final count in the census print out. Both RNs will sign to confirm actual head count. iv. Completed census with actual head count will be filed in the RN Supervisor binder. The Immediate Jeopardy was removed after the IJ Removal Plan was verified to be implemented through observations, interviews, and record reviews on [DATE], at 3:26 PM, in the presence of DON and ADMIN.