

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER The Bradley Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 980 West Seventh Street San Jacinto, CA 92582	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement effective interventions for one of two residents reviewed for abuse (Resident 1) with known wandering (the act of moving about without a fixed plan, destination, or clear purpose) behavior. This failure resulted in a resident-to-resident altercation after Resident 1 entered Resident 2's room. Findings: On June 19, 2026, a review of Resident 1's face sheet indicated the resident was admitted to the facility on [DATE], with diagnoses which included psychosis (a condition in which a person has difficulty distinguishing what is real from what is not). A review of Resident 1's Minimum Data Set (an assessment tool) dated May 20, 2026, indicated the resident was rarely or never understood. A review of Resident 1's Care Plan Report dated November 24, 2025, indicated the resident demonstrated intrusive behaviors as evidenced by lack of awareness of others' personal space and boundaries due to neurocognitive impairment. Interventions included reality orientation and redirection as needed. The care plan did not include additional interventions after staff observed the resident repeatedly entering other residents' rooms. A review of Resident 1's eINTERACT SBAR (Situation, Background, Assessment, and Recommendation- standardized healthcare communication framework) Summary for Providers dated June 19, 2026, indicated:- Resident 1 was found lying on the floor outside Resident 2's room.- Resident 2 reported Resident 1 hit him with a closed fist.- Resident 2 pushed Resident 1 pushed Resident 1 with open hands to remove him from the room. - Resident 1's physician was notified and ordered transfer to the emergency room for further evaluation. On June 19, 2026, at 1:00 p.m., during a concurrent observation and interview, Resident 2 was in his room, lying in bed, alert and awake. Resident 2 stated Resident 1 came to his room earlier that morning. Resident 2 stated he asked Resident 1 to leave, but Resident 1 did not respond. Resident 2 stated he stood up and attempted to guide Resident 1 out of the room by placing his arms around him. Resident 2 stated Resident 1 then punched him in the chest and head. Resident 2 stated he pushed Resident 1, causing Resident 1 to fall to the floor. Resident 2 stated this was not the first time Resident 1 had entered his room and stated Resident 1 comes into my room all the time. On June 19, 2026, at 1:12 p.m., during an interview, Certified Nurse Assistant (CNA) 1 stated Resident 1 is known to wander and has entered other residents' rooms. CNA 1 stated all staff members are responsible for keeping an eye on Resident 1 but he is so quick that in the blink of an eye he will be somewhere else. On June 19, 2026, at 1:36 p.m., during an interview, Licensed Vocational Nurse (LVN) 1 stated Resident 2 informed her that Resident 1 entered his room. LVN 1 stated Resident 2 attempted to escort Resident 1 out of room, Resident 1 punched Resident 2, and Resident 2 pushed Resident 1. LVN 1 stated Resident 1 wanders the hallways and has entered other residents' rooms before. LVN 1 stated staff conduct hourly rounds and continuously monitor Resident 1 to prevent him from entering other residents' (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 - Minimal harm or potential for actual harm Residents Affected - Few	rooms. On June 19, 2026, at 3:43 p.m., during an interview, LVN 2 stated Resident 2 has wandered since admission. LVN 2 stated she had observed Resident 1 enter other residents' room before and staff redirected him and provided activities. LVN 2 stated other residents called for assistance when Resident 1 entered their rooms. On June 19, 2026, at 4:03 p.m., during an interview, the Director of Nursing (DON) stated this was the first time she had been informed that Resident 1 entered another resident's room. The DON stated she was not aware staff had previously observed Resident 1 entering other residents' room. The DON stated staff should have reported the behavior so it could be monitored and appropriate interventions implemented, including consultation with the psychiatrist to determine whether medication adjustments or other interventions were needed. A review of the facility's facility 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 .the resident's care plan will include strategies and interventions to maintain the resident's safety .		