STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056053	A. Building B. Wing	03/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Post Acute	1311 East Date Street San Bernardino, CA 92404

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 44841

Based on interview, and record review, the facility failed to provide adequate supervision, to a resident identified as having moderate risk of elopement (risk that refers to a situation where a resident, has a moderate likelihood or possibility of leaving the premises without authorization or supervision, wandering away from a controlled environment, which can pose safety risks for the individual) for one of three sampled residents (Resident 1), when Resident 1 ' s elopement and wandering care plan did not address the specific monitoring needs and frequency necessary to minimize the risk or prevent Resident 1 leaving a safe area without the facility ' s awareness on March 6, 2024, and had not been found for more than 72 hours.

This failure had the potential to place Resident 1's health and safety at risk and for him to likely experience some serious adverse outcome, due to exposure of the (outdoor) elements, missed antipsychotic medications (drugs used to treat symptoms of psychosis (mental disorder characterized by a disconnection from reality) and without vital resources such as food, water, and shelter. Resident 1 was placed at high risk for accidents, psychotic outburst (which might lead danger to self and/or others), heat exposure, hypothermia (prolonged exposure to the cold can lead to complete failure of your heart and respiratory system and eventually to death), dehydration and/or other medical complications, including severe injury and even death.

Findings:

A review of Resident 1's clinical record titled, Admission Record (contains medical and demographic information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (mental health disorder including schizophrenia [disorder that affects a person's ability to think, feel, and behave clearly] and mood disorder symptoms), altered mental status, and toxic encephalopathy (a degenerative neurological (nerve cell) (condition that can lead to memory loss, impaired or loss of vision, and altered mental status).

During a review of Resident 1's clinical record from the hospital, dated November 3, 2023, it indicated . Patient [Resident 1] was confused and not able to hold conversation get distracted and walking around . lacks decision making capacity . brought to ER [emergency room] for AMS [Altered Mental Status]. Patient stated he is from Chicago and walked to California and took for him 99 months to reach California .

(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: 056053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2024
NAME OF PROVIDER OR SUPPLIER: Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 1311 East Date Street San Bernardino, CA 92404	

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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 History and Physical (H&P), dated November 17, 2023, it indicated Patient [Resident 1] is not able to make own decision . consider psych eval (also known as Psychiatric diagnostic evaluations; used to determine a patient's mental state and guide recommendations for the best treatment. During a review of Resident 1's psychiatric follow up/progress note, dated February 20, 2024, it indicated . Pt [Resident 1] continue to endorse auditory hallucination [happen when you hear voices or noises that don't exist in reality] . MSE [Mental State Examination] Memory - impaired . Insight [level of understanding] - poor . Judgment [ability to make decisions] - poor . Plan/Recommendation/Intervention. 1) Medication Recommendation: a. Continue Olanzapine [medication used to treat schizophrenia] . schizoaffective/hallucinations. b. Increase Depakote [medication used as mood stabilizer], - schizoaffective/mood lability . 5. Continue to monitor for safety . During a review of Resident 1's Initial Elopement Assessment (a form to complete to determine if an individual requires necessary safety intervention. A score 0-18 used to determine the risk level resident for elopement), completed upon admission, dated November 16, 2023, it indicated Resident 1 had score of 9, which was moderate risk (refers to a situation where a resident, has a moderate likelihood or possibility of leaving the premises without authorization or supervision, wandering away from a controlled environment). A review of Resident 1's Social Service Notes, dated January 4, 2024, at 9:27 AM, indicated .discuss resident [Resident 1] medication and referral to public guardianship per (Public Guardian 1 (PG 1)) . Riverside County, Department of Public Social Services. The resident has no Public Guardian set at this time . During a review of Resident 1's Physician's Order Sheet, dated January 10, 2024, it indicated Resident 1 had an order to receive Zyprexa . 10 MG [milligrams-a unit of measure] (Olanzapine) Give 10 mg by mouth every morning and at bedtime for schizoaffective . A review of Resident 1's Physician's Order Sheet, dated February 20, 2024, it indicated Resident 1 had an order to receive Depakote . Give 500 mg by mouth two times a day for schizophrenia disorder . During a review of Resident 1 ' s Quarterly (completed in 3 months from the last elopement assessment) Elopement Reassessment, dated February 8, 2024, the elopement reassessment indicated Resident 1 had score of 7 (moderate risk). During a review of Resident 1's Minimum Data Set (MDS- part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes), Section GG Functional Abilities and Goals, dated February 12, 2024, the MDS indicated Resident 1 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient/resident completes activity. Assistance may be provided throughout the activity or intermittently) with mobility. During a review of Resident 1's undated Care plan for Self-care deficit: due to need assistance in ADL [activities of daily living]: Impaired cognitive[mental abilities], physical limitation/disability . it indicated the interventions included, .Provide assistance if needed . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 East Date Street San Bernardino, CA 92404	

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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 undated Care Plan for At risk for elopement and wandering out the facility, it indicated the interventions included Check resident's whereabout. The care plan did not specify supervision, monitoring and frequency required for Resident 1. A review of Resident 1's Social Service Note, dated March 6, 2024, at 4:46 PM, indicated IDT (Interdisciplinary team- composed of staff from various disciplines) met to discuss . resident [Resident 1] was missing from his room, per staff [License Vocational Nurse (LVN 1)] the resident was last seen at before 10AM . During a concurrent interview and record review on March 8, 2024, at 3:30 PM with the Director of Nursing (DON) of the Facility's Notification Memo, sent to the San [NAME] District Office, dated March 7, 2024, written by the Administrator, indicated I am reporting an unusual occurrence that occurred yesterday, March 6, 2024. Our resident [Resident 1] eloped from the facility. It was reported to me at approximately 1:30PM [on March 6, 2024] that Resident 1 could not be located in the facility . The administrator directed the RN [Registered Nurse] Supervisor to notify the physician, conservator, and San [NAME] Police Department per policy . Additional calls have been placed to the police and local hospitals today. Additional expanded searches were completed today of the neighborhoods, parks, and homeless encampments . The DON stated Resident 1 was last seen by staff [LVN 1] in the facility at 10:00 AM during the morning routine medication administration. Resident 1 was not identified as missing despite Resident 1 not being present during lunch time. (There was three and a half hours without adequate supervision and Resident 1 had been gone from the facility had not been found for more than 72 hours.) During further interview on March 8, 2024, at 3:45 PM, with the DON, the DON stated Certified Nurse Assistant 1 (CNA 1) was assigned to care for Resident 1 but failed to report to Licensed Vocational Nurse (LVN 1) Resident 1 was not present for lunch when it was served between 12:15- 12:30 PM. The DON further stated CNA 1 assumed Resident 1 was in the restroom. The DON stated CNA 1 should have checked Resident 1's restroom to confirm Resident 1's location and should have checked Resident 1 more frequently throughout the shift. During a follow up interview on March 8, 2024, at 3:50 PM, with the DON, the DON stated she was not aware that Resident 1 had a previous hospitalization record of walking long distance, resulting in altered mental status and fracture, before admitted to this facility. During a concurrent interview and record review on March 8, 2024, at 3:55 PM with CNA 1 of the statement written by Director of Staff Development (DSD)'s when interview with CNA 1, dated March 7, 2024, it indicated CNA 1 said at 8:40 AM on 3/6/24 [March 6, 2024] she passed his breakfast tray, and she woke him [Resident 1] to eat. Then at lunch she delivered his lunch at 12:20 PM the bathroom door was shut but the light was on, so she assumed he is here. She knocked and then went out of the room. At 1:00 PM she went back to see if he was finished. She noticed he never ate his food [lunch meal], she searches the room and then asked her charge nurse [name of LVN 1] if she had seen him. After checking around there is no sign of [name of Resident 1] . CNA 1 stated she should have not assumed Resident 1 whereabout. Furthermore CNA 1 stated she should have checked Resident 1 restroom to make sure he is actually inside and should had check him more frequently, not just during mealtimes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 East Date Street San Bernardino, CA 92404	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on March 8, 2024, at 4:00 PM, with the Social Services Director (SSD), the SSD stated she did not realize that she has not seen Resident 1 all morning until code yellow was announced [facility's code for missing resident] for Resident 1 and while searching Resident 1's room, she noticed that Resident 1's belonging were not in his room. During an interview on March 8, 2024, at 4:05 PM, with LVN 1, LVN 1 stated the last encounter she had with Resident 1 on March 6, 2024, was when she passed his routine morning medication between 9:45 AM to 10:00 AM. LVN 1 further stated, CNA 1 did not report to her that when CNA 1 did not see Resident 1 visually when CNA 1 left Resident 1 lunch tray in his room. LVN 1 stated she did not check on or look for Resident 1 from after the morning medication was passed from 10:00 AM to 1:30 PM after she received report Resident 1 did not eat his lunch and was nowhere to be found. During a phone interview on March 8, 2024, at 4:15 PM, with Receptionist, the Receptionist stated that on March 6, 2024, that she had not seen him all morning, but later she discovered that Resident 1 went missing after the nurses went out the front door to search for him. During a concurrent interview and record review on March 8, 2024, at 4:35 PM with DON, the DON reviewed an undated facility document titled, Certified Nursing Assistant Job Description which indicated . Report to: Charge Nurse. Position Description: A nursing assistant responsible to providing routine nursing care accordance with establish policy and procedures and as may directed by the Charge Nurse, RN Supervisor, Director of Nurses or Administrator, to assure that the highest degree of quality care can be maintain at all times . General Duties and Responsibility: General . Make resident rounds at the beginning of each shift and every 2 hours thereafter to administer quality nursing care . The DON stated the facility did not follow the policy. During a concurrent interview and record review on March 8, 2024, at 4:40 PM with DON, the DON reviewed an undated facility document titled, Charge Nurse Job Description which indicated .Report to: Director of Nursing Services [DNS also known as Director of Nursing (DON)]. Position Description: The Charge Nurse is responsible for staff assignment and provides overall supervision of resident care activities . General Duties and Responsibility: . Supervision . Make resident's round to review physical, medical an emotional status and to implement required nursing intervention . Assure that nursing personal follow establish nursing procedures . The DON stated the facility did not follow the policy. During an interview on March 8, 2024, at 8:20 PM with the Administrator (ADMIN), the ADMIN stated Resident 1 had diminished mental capacity due to his mental health status. The Admin further stated Resident 1 eloped from the facility on March 6, 2024, left with his belongings, and have not been found since. During a concurrent interview and record review on March 8, 2024, at 8:30 PM with LVN 2 , LVN 2 reviewed Resident 1's undated Care plan for At risk for elopement and wandering out the facility and stated checking resident whereabouts meant checking maybe every 30 minutes to an hour. The LVN 2 remained uncertain with the frequency of checking resident's whereabout for residents with risk of elopement and where to document the findings, as no specific direction/guidance was provided. (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 March 8, 2024, at 8:45 PM, with DON, the DON reviewed Resident 1's undated Care Plan for At risk for elopement and wandering out the facility, and acknowledged it did not specify the frequency on how often to check on resident's whereabouts. The DON further stated the staff should do it every hour, and it should be documented to ensure the task was completed. The DON was unable to provide documentation to show Resident 1's whereabouts were checked by the staff. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopement, revised March 2019, the P&P 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 resident . Policy interpretation and implementation. 1. If identified as at risk for wandering, elopement, or other safety issue, the resident's care plan will include strategies and intervention to maintain resident's safety . 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 F689 S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents) on March 8, 2024 at 9:10 PM, after confirming Resident 1 did not receive supervision and monitoring required to keep Resident 1 safe on March 6, 2024 when Resident 1 was found to have eloped from the facility and had not been found for more than 48 hours. An IJ was called on March 8, 2024, at 9:10 PM in the presence of the Director or Nursing (DON), Administrator (ADMIN) and Chief Clinical Officer (CCO). A Corrective Action Plan (CAP- a plan which includes interventions to remove the potential or actual harm of an immediate jeopardy situation) was requested and a preliminary CAP was received on March 9, 2024, at 2:21 PM and included the following: * On 03/07/2024, The Interdisciplinary Team (IDT) reviewed the other two (2) residents who are at risk of elopement including the measures and care plans in place to prevent future elopement. Added Q hour visual checks to be documented frequent visual check log. Kept at nurse's station. * Providing adequate supervision and a safe environment for residents identified as moderate or high risk for elopement, the facility has implemented every hour monitoring of identified residents. Q [every] hour visual checks to be documented frequent visual check log. Kept in Elopement binder at nurse's station. * Licensed Nurses (LNs) and the IDT will assess residents for any possible risk of elopement upon admission, quarterly, annually, and as needed thereafter to ensure necessary interventions are initiated to meet their needs including the provisions of adequate supervision to prevent elopement. * The Elopement Binder located at the Nursing Station which contains a list of residents identified to be at risk for elopement will be updated as necessary by LNs and the IDT. * LNs will conduct huddles at the beginning of every shift to ensure needed information and instructions are communicated and provided to the CNAs to ensure frequent monitoring and adequate supervisions are provided to all residents at risk of elopement., Maintained in Huddle binder at station 1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* LNs and Certified Nursing Assistants (CNAs) in their respective shifts will continue to monitor the whereabouts of residents who are at risk of elopement using the Monitoring Log. Any residents noted with exit seeking behavior will be reported to the ADM and DNS immediately. * During the change of shift, incoming and outgoing Nurses will conduct rounds to ensure residents who are at risk of elopement are in the facility. Any issues identified will be reported to the ADM and DNS immediately. * Starting on 03/09/2024, at 8AM the Director of Staffing Development (DSD) provided in-services to staff regarding the policies and procedures on Wandering and Elopements and Emergency Procedure-Missing Person. All Staff will be in-serviced prior to their next scheduled shift. * Staff will implement the protocol for a missing resident immediately upon discovering that a resident cannot be located in the facility by following the emergency procedure. Emergency Procedure - Missing Resident Policy Statement Resident elopement resulting in a missing resident is considered a facility emergency. 1. Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. 2. Staff will implement the protocol for missing resident immediately upon discovering that a resident cannot be located. * Additional in-services will be provided by the DNS or designee and/or DSD or designee regarding monitoring log put in place. * Maintenance Director or designee will check alarms of all exit doors on a weekly basis to ensure they are properly functioning and record on log. The doors were checked on 3-6-24 and 3-9-24 and logged in the maintenance log located in the maintenance office. The facility submitted an IJ Removal Plan which was reviewed and accepted on March 9, 2024, at 2:21 PM. After observation, interview, and record review, to confirm implementation of the IJ removal plan, without any remaining non-compliance the IJ was lifted while on site on March 10, at 10:57 AM, in the presence of the ADMIN, the DON, and the Medical Records Director (MRD).