STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056186	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centinela Grand Inc	2225 North Perris Boulevard Perris, CA 92571

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:1. 14 of 17 residents reviewed (Resident's 1, 2, 3, 4, 6, 7, 9, 10, 12, 13, 14, 15, 16, and 17) were supervised by the facility staff, as ordered by their physician, during leave of absence passes (LOA); and2. One resident reviewed (Resident 3) did not have sharp objects on the meal trays, as indicated in the residents' care plan.This failure had the potential for:1. Resident's 1, 2, 3, 4, 6, 7, 9, 10, 12,13, 14, 15, 16, and 17 to experience avoidable environment risks, hazards, and accidents; and 2. Placed Resident 3 at risk for self-harm.Findings:On July 30, 2025, an unannounced visit was conducted at the facility to investigate a complaint.1a. On July 30, 2025, Resident 1's medical record was reviewed.Resident 1 was admitted to the facility on [DATE], with diagnoses which included Major depressive disorder (persistent feeling of sadness), paranoid schizophrenia (symptoms of suspicious/mistrust/delusions/hallucination), anxiety (feeling of nervousness) disorder, bipolar disorder (manic and depressive episodes).The history and physical completed by the physician on June 20, 2024, indicated Resident 1 had the capacity to understand and make decisions.The physician orders dated June 20, 2024, indicated .may go on temporary leave of absence with staff for sensory stimulation.The care plan dated July 15, 2025, indicated .Focus.elopement.goal.resident will be kept in safe environment.allow resident to wander within the unit; ensure environment is safe & secure.A review of the facility Leave of Absence Logbook was conducted. The logbook indicated on May 4, May 7, May 27 - 30, June 1, and July 17, 2025, Resident 1 signed out for a leave of absence pass with no documented evidence staff accompanied Resident 1 during the LOA.1b. On July 30, 2025, Resident 2's medical record was reviewed.The admission record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included Major depressive disorder (persistent feeling of sadness), psychosis (loss with reality), extrapyramidal movement disorder (movements related to side effects of antipsychotic medications-medications to treat psychological disorders);The history and physical completed by the physician on June 1, 2025, indicated Resident 2 had the capacity to understand and make decisions.The physician order dated May 2, 2025, indicated .may go for temporary leave of absence with staff for sensory stimulation.A review of the facility Leave of Absence Logbook was conducted. The logbook indicated on May 15, 2025, at 1:00 p.m., Resident 1 signed out for a leave of absence pass with no documented evidence staff accompanied Resident 2 during the LOA.1c. On July 30, 2025, at 12:17 p.m., Resident 3 was interviewed. Resident 3 was alert and oriented. Resident 3 stated during his leave of absence pass on July 20, 2025, he experienced anxiety and right leg pain requiring him to call 911 (emergency services) for assistance. On July 30, 2025, Resident 3's medical record was reviewed.The admission record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included Psychosis (loss of reality), anxiety disorder (feeling nervousness), depression (persistent feeling of sadness), abuse of non-psychoactive substances (excessive use of illegal drug), neuropathy (nerve problem), suicidal ideations (thinking, considering, or planning suicide).The history and physical completed by the physician on July 10, 2025, indicated Resident 3 had the capacity to understand and make decisions.The physician order dated July 10, 2025, indicated .may go on a temporary leave of absence with staff for sensory stimulation .The care plan dated July 1, 2025, indicated .Focus.elopement.goal.resident will be kept in safe environment.allow resident to wander within the unit; ensure environment is safe & secured. The nursing progress notes indicated the following:On July 20, 2025, at 10:38 a.m., Resident 3 left the faciity on pass to the store.On July 20, 2025, at 8:00 p.m., nursing staff contacted Resident 3 via phone and Resident 3 stated he called 911 due to anxiety and right leg pain.On July 21, 2025, at 7:31 a.m., the facility called (name of hospital) and was informed by (name of hospital) staff Resident 3 was on a 5150 hold (72-hour hold for a person experiencing a mental health crisis).On July 23, 2025, at 5:50 p.m., Resident 3 was re-admitted into the facility.A review of the facility Leave of Absence Logbook was conducted. The logbook indicated on July 20, 2025, at 10:30 a.m., Resident 3 signed out for a leave of absence pass with no documented evidence staff accompanied Resident 3 during the LOA.The Leave of Absence Logbook further indicated on June 24, June 25, June 26, July 3, July 7, July 12-19, and July 24-31, 2025, Resident 3 signed out for a leave of absence pass with no documented evidence staff accompanied Resident 3 during the LOA. 1d. On July 30, 2025, Resident 4's medical record was reviewed.The admission record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (persistent feeling of sadness) and psychosis (loss of reality) The history and physical completed by the physician on

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure mental health services were provided when:1. The physician or psychiatrist was not notified for one resident (Resident 3) of Resident 3's concern regarding his methadone addiction and possibly experiencing a relapse; and 2. The facility did not arrange psychological evaluations for 12 of 12 residents reviewed (Resident's 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15).This failure had the potential for Resident's 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15 to have a delay in the necessary care and services to address their behavioral health needs. Findings:1.On July 30, 2025, an unannounced visit was conducted at the facility to investigate a complaint.On July 30, 2025, at 12:17 p.m., Resident 3 was interviewed. Resident 3 was alert and oriented. Resident 3 stated he felt the facility was not addressing his problem with methadone (synthetic opioid medication) addiction.On July 30, 2025, Resident 3's medical record was reviewed.The admission record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included Psychosis (loss of reality), anxiety disorder (feeling nervousness), depression (persistent feeling of sadness), abuse of non-psychoactive substances (excessive use of illegal drug), neuropathy (nerve problem), suicidal ideations (thinking, considering, or planning suicide).The history and physical completed by the physician on July 10, 2025, indicated Resident 3 had the capacity to understand and make decisions.The (Name of Facility - methadone clinic) After Visit Summary dated June 18, 2025, indicated .member stated, I am an addict on methadone my last dose was June 10, 2025 I need .services to help me I am withdrawing from not having my medication.member is willing to enter treatment member has been on methadone since 2016 and is having stronger urges to use.member is high risk for relapse due to his current state of withdrawal from methadone.member lacks coping skills to cope with life on life's terms. member reports he is currently in nursing home for physical health issues.The physician order dated July 16, 2025, indicated .consult/appointment with methadone clinic secondary to opioid use disorder.There was no documented evidence indicating Resident 3's concerns about his methadone addiction, withdrawal, and high risk for relapse were addressed with the physician or the psychiatrist until July 16, 2025, when the physician ordered another consult/appointment be made with the methadone clinic.On August 1, 2025, at 4:32 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the Registered Nurse (RN) supervisor is in charge of reading the residents after visit summary and scheduling follow up appointments. The DON stated, after reading Resident 3's after visit summary dated June 18, 2025, the RN supervisor should have contacted the psychiatrist or the physician regarding Resident 3's high risk of relapse. The DON stated there is no documented evidence that the RN supervisor contacted the psychiatrist or the physician regarding Resident 3.A review of the facility policy and procedures titled Specialized Rehabilitative Services, not dated indicated .mental health services and supportive psychotherapy for mental illness.specialized rehabilitative services will be provided under the written order of a physician.the services will be provided or coordinated by qualified personnel.the care plan for individuals receiving specialized rehabilitative services will be monitored by a licensed professional.specialized rehabilitative services are considered a facility service and included within the scope of facility services.2a. On July 30, 2025, Resident 4's medical record was reviewed.The admission record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (persistent feeling of sadness) and psychosis (loss of reality).The history and physical completed by the physician on August 9, 2024, indicated Resident 4 can make needs known but cannot make medical decisions.The physician order dated July 30, 2025, indicated psychology consult & follow up treatment as indicated & prn (as needed).depression.psychosis.The facility could not provide documented evidence Resident 4 received a psychology evaluation as ordered by the physician.2b.On July 30, 2025, Resident 5's medical record was reviewed.The admission record indicated Resident 5 was admitted to the facility on [DATE], with the diagnoses which included bipolar (manic and depressive episodes) and dementia (loss of intellectual functioning);The history and physical completed by the physician on June 4, 2025, indicated Resident 5 had the capacity to understand and make decisions;The physician order dated June 4, 2025, indicated . psychology consult, treatment, follow up.The psychiatric note dated July 3, 2025, indicated .exhibiting aggressive behavior and is observed talking to himself.continue monitoring and follow ups.plan.supportive psychotherapy.The facility could not provide documented evidence Resident 5 received a psychology evaluation as ordered by the physician.2c.On July 30, 2025, Resident 6's medical record was reviewed.The