

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Laurel Park Behavioral Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 Laurel Avenue Pomona, CA 91768	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 1), who was on a [NAME]-Petris-Short (LPS, a California law enacted in 1969 that regulates the involuntary commitment of individuals with mental health disorders) conservatorship (a legal process where a court appoints a person to make certain decisions for an individual who was deemed gravely disabled [unable to provide for basic needs] due to a mental health disorder), did not elope (the act of leaving a facility unsupervised and without prior authorization) from a secure facility (a building, institution, or location designed and operated with features that physically restrict unauthorized access or the movement of individuals to prevent people from leaving or others from entering) on 7/28/2025 at 9:27 PM by failing to ensure,1. Certified Nursing Assistant (CNA) 1 reported to Licensed Vocational Nurse (LVN) 1 (charge nurse), CNA 1 found Resident 1, unsupervised, past a locked gate and in the facility's parking lot on 7/28/2025 at 9 PM (the parking lot was an unauthorized area to residents at 9 PM) as indicated in the facility's protocol titled, Supervision Level Protocol and Guidelines.2. Adequate supervision was provided to Resident 1 and failing to ensure Resident was placed on one-to-one supervision (1-1 supervision, one staff supervises one resident) on 7/28/2025 at 9 PM, after Resident 1 was found in the parking lot as indicated in the facility's protocol titled, Supervision Level Protocol and Guidelines, the facility's Policy and Procedures (P&P) titled, Elopements, and Safety of Residents.These failures resulted in Resident 1's elopement on 7/28/2025 at 9:27 PM, Resident 1 was not found until 7/29/2025 at 11 PM. Resident 1 was transferred to the General Acute Care Hospital (GACH) on 7/30/2025 at 10:27 AM for an evaluation. Resident 1 tested positive for amphetamines (a class of powerful and addictive stimulant drugs that speed up the central nervous system [the body's processing center: brain and spinal cord], can significantly affect safety by impairing judgement and physical coordination) at the GACH. Resident 1 was at risk for serious harm and injury when Resident 1 tested positive for amphetamines and did not receive regularly scheduled psychotropic, (prescription drugs that affect brain activity and are used to treat mental health conditions) anticonvulsant (prescription drugs used to prevent or treat seizures [sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness]and mood disorders), and anticholinergic (prescription drugs used to treat and regulate bodily functions) medications.On 8/12/2025 at 4:35 PM, while onsite at the facility, the California Department of Public Health (CDPH, the Department) identified an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation. The IJ was called in the presence of the Administrator (ADM), the Director of Nursing (DON), and the Program Director (PD) due to the facility's failure to ensure Resident 1 did not elope from the facility on 7/28/2025.On 8/13/2025 at 3:30 PM, the ADM provided an acceptable IJ Removal Plan (IJRP, a detailed plan that includes interventions to immediately correct the deficient practices in the IJ). While onsite at the facility, the surveyor verified and confirmed the facility's full implementation of the IJRP through observations, interviews, and record review, and determined the IJ situation regarding Resident 1's elopement was no longer present. The surveyor removed the IJ on 8/13/2025 at 6 PM in the presence of the ADM, the DON, the PD, the [NAME] President of Operations (VPO), the Behavioral Health Consultant (BHC), the Medical Director for Behavioral Health Services (MD), and the Clinical Resource Nurse.The acceptable IJRP included the following summarized actions:A. Immediate Corrective Action:1. On 7/28/2025 @ 10:15 PM, LVN 1 noticed resident 1 missing and immediately initiated the Elopement protocol (procedures implemented in the healthcare setting to prevent and manage resident elopement) by conducting a resident headcount and alerted all staff to search for Resident 1 inside and outside the facility. Resident 1 was not located inside the facility and staff started driving around the area.2. On 7/28/2025 @ 10:25 PM, LVN 1 called the police department (PD) to make a missing persons' report. The PD came to the facility, met with the ADM who provided a description of Resident 1, Resident 1's face sheet, medical history, current medication regimen, a picture, and camera footage of Resident 1 [to the PD]. 3. On 7/28/2025 at 11:30 PM, the ADM and LVN 2 contacted Resident 1's family member (FM) 1 regarding Resident 1's elopement. The ADM gave the next of kin the ADM's cellphone number and requested FM 1 to contact the ADM if Resident 1 got in touch with FM 1 or if Resident 1 showed up at FM 1's house.4. On 7/29/2025 the ADM suspended CNA 1 pending the investigation of the incident regarding CNA 1 failing to report to LVN 1 that Resident 1 was in the parking lot</p>		