STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A371	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Wellness and Recovery Center	3062 Churn Creek Rd. Redding, CA 96002

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** 43755 Based on observation, interview, and record review, the facility failed to ensure the safety and security for one of two clients (Client 1) when: 1. The facility security door locking system malfunctioned and Client 1 eloped from the facility. 2. The Temporary-Office Assistant (TOA) did not recognize Client 1 as a client, when she passed through the front lobby and eloped out the front doors. 3. Program Staff (PS, an employee that does activities with clients), saw Client 1 outside the facility and made no inquiries as to why Client 1 was outside. This disregard for client safety allowed Client 1 to go missing from the facility and her whereabouts were unknown for 8 hours, which put Client 1 at risk for injury and exposure to cold weather and had the potential to negatively impact on Client 1's health, safety, and welfare. Findings: A review of the facility's policy titled, AWOL (absent without leave) updated 9/23/24, indicated, If a client goes absent without leave (AWOL), the proper authorities will be notified, and steps taken to hasten their return. 4. In the event an AWOL is witnessed, do not chase the client if not appropriate, as this may lead to impulsive behavior (i.e., running into traffic, etc.); however, efforts may be taken to voluntarily prompt the client to return to the facility. If unable to successfully prompt client to return, attempt to keep visual line of sight on client to support safety. 1.A review of Client 1's Admission Record (undated), indicated Client 1 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a type of psychosis which means your mind doesn't agree with reality). Client 1 had a conservator (a legal arrangement that allows a judge to appoint a guardian to manage the personal and financial affairs of another person) who made life decisions for her. A review of a facility reported incident dated 12/2/24, indicated that on 11/29/24 Client 1 was noted to be missing from the facility at approx. 6:18 pm. Facility reviewed cameras and found Client 1 was able to exit through an automatic locking door that had not sealed at 4:22 pm. (continued on next page)

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	A review of a facility's five day follow up report, dated 11/30/24, documented the shift coordinator initiated notification of missing client (on 11/29/24) to the Administrator at 6:29 pm, the Police Department at 6:34 pm, the Medical Director and Psychiatrist at 6:47 pm, and the Conservator at 6:47 pm. The shift coordinator also initiated staff search outside the facility. [Client name] was not able to be located at that time. A review of Client 1's progress notes dated 11/29/24 at 8:50 pm, showed that Licensed Nurse A (LN A) documented, Nursing staff was notified of [Client 1's name] not attending dinner at approx. 1815 [6:15 pm]. Room checks were completed, and client [Client 1] was unable to be located. During an observation on 12/2/24 at 10:00 am, the facility lobby and south door that led into the client care area was observed. The Administrator (Admin) placed a key in a key slot mounted in the wall to the right of the doors. A faint click sound was heard and then we were able to push open the push bar on the right side of the double doors and enter the client care area. The doors closed behind us and automatically locked. During an interview on 12/2/24 at 10:30 am, Admin indicated that she reviewed video footage of the south door that led into the client care area. The Admin stated, A nurse walked through the south door and into the client care area. The nurse reached back and put her hand on the door to assure it was closed. A few minutes later, at 4:22 pm, Client 1 was noted to push open the south door and walk through it and into the front lobby. Admin indicated the doors can only be opened with a key. Admin indicated that through their investigation of the event it was noted that the magnetic lock on the south door was malfunctioning intermittently. Admin indicated the locking system was replaced the evening of 11/29/24, after the incident and the staff were being educated to always check the doors behind them to make sure the locking system was working. 2. During an interview on 12/2/24 at 12:46 pm, the TOA indicated she was working at the front desk in the front lobby when Client 1 came out the south doors and into the lobby. TOA stated, It was at a time when staff were coming and going because the time clock was up here by the desk. Client 1 came into the lobby thru the door, I smiled, and she smiled back, and I thought she was an employee. TOA indicated she was the only person working at the front desk at that time. TOA stated, I started back in August and am unfamiliar with the residents. During an interview on 12/2/24 at 1:01 pm, the Director of Nursing (DON) indicated TOA did not know the clients. DON stated, She does not need to know the clients but now since this happened, she should have to know the clients. 3. A review of Client 1's progress notes dated 11/29/24 at 8:50 pm, showed that LN A documented, Writer was notified by Program Staff [PS] that [Client 1] was seen outside the lobby doors near the parking lot pacing. During a concurrent interview with the Admin and a record review on 12/2/24 at 12:47 pm, the documented statement of what PS saw, dated 11/30/24, was reviewed. PS documented, He (PS) was walking towards the building and seen [Client 1's name] standing by the mailbox. Then seen [the Central Supply and Scheduling Personal, CSS name] walking out of the facility and thought she was taking her [Client 1] on an outing. [PS name] stated he felt relieved and made his way back into the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Admin on 12/2/24 at 1:00 pm, the Admin indicated that PS should have stopped and at least checked on Client 1. During an interview with CSS on 12/2/24 at 1:15 pm, CSS indicated she was coming up the parking lot from the back door to clock out (in the front lobby). It was about 4:30 pm, on 11/29/24. CSS indicated she did see PS but when she came up to the front breezeway (by the mailbox), she did not see anyone standing there. CSS indicated that she never saw Client 1 and PS did not ask her about Client 1. On 12/2/24 at 1:23 pm, an interview and review of the video footage, dated 11/29/24 at 4:22 pm, was conducted with the DON. The video showed Client 1 standing at the mailbox at the end of the front porch outside of the facility. Client 1 was looking towards the parking lot. PS was viewed coming up behind Client 1 and walking past Client 1. At the same time CSS, looking at her phone, was walking from the back door of the facility and walking up the sidewalk alongside the parking lot towards the left side of Client 1. As soon as PS passed Client 1, Client 1 turns toward the street and walks away from the facility. During an interview on 12/2/24 at 1:26 pm, Admin indicated PS should have stayed with Client 1 and followed their facility policy. A review of Client 1's progress notes dated 11/30/24 at 4:58 am, by LN B, indicated Client 1 was discovered walking down a sidewalk a few blocks from the facility on 11/30/24 at 12:15 am, eight hours after Client 1 left facility.