STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555140	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Court	675 E Bradley El Cajon, CA 92021

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** 40610 Based on observation, interview and record review, the facility failed to identify a trash bin as a means for a resident to elope (leave without notice) the facility for one of one sampled resident (Resident 1). As a result, Resident 1 used the trash bin, jumped off the fence and left the facility unnoticed on 11/4/24. Findings: On 11/5/24, the Department received a facility reported incident (FRI) related to quality of care and resident safety. On 11/6/24, an unannounced onsite to the facility was conducted. Resident 1 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (serious mental illness) and psychosis (a symptom that refers to a loss of touch with reality), per the facility ' s Admission Record. A record review was conducted of Resident 1. Resident 1 ' s History and Physical (H&P), dated 10/23/24, indicated the attending physician documented Resident 1 did not have the capacity to understand and make decisions, and was admitted for Special Treatment Program (STP, a mental health program). A record review was conducted of Resident 1. Resident 1 ' s minimum data set (MDS - a federally mandated resident assessment tool), dated 10/28/24, indicated Resident 1 ' s brief interview for mental status (BIMS, ability to recall) score was 8/15 (a score of 13 to 15 suggests the patient is cognitively [process of acquiring knowledge and understanding] intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment). A record review was conducted of Resident 1. Resident 1 ' s care plan, indicated, .At risk for elopement r/t (related to) involuntary placement .past hx (history) of elopement . The approaches in the care plan did not indicate identification of supplies and equipment that a resident could use as a means to elope. (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	A record review was conducted of Resident 1. Resident 1 ' s change in condition notes dated 11/4/24, indicated, At approximately 10:45 am on 11/04/2024, a staff member noticed a trash bin positioned next to the shed behind building 2. After further inspection of the premises & initiation of code pink, a head count of all residents was done & [name of Resident 1] could not be accounted for. On facility surveillance cameras, resident is seen moving the trash bin towards the shed & using it to jump the south fence at approximately 10:22 am . On 11/6/24 at 9:48 A.M., a joint review of the facility ' s video recording and an interview was conducted with the Director of Nursing (DON). In the video, Resident 1 was observed pulling a trash bin next to the shed, jumped off the trash bin to get to the roof of the shed, then from the roof, Resident 1 jumped off the fence. The incident was timed at 10:21 A.M. to 10:22 A.M. on 11/4/24. The DON stated it was just a matter of few seconds to a minute. The DON stated Resident 1 was nowhere to be found. On 11/6/24 at 10:25 A.M., a joint observation of the shed was conducted with the DON. The shed was next to the facility ' s concrete fence and a white fence which belonged to the apartment complex near the facility. There were mesh wires attached to the sides of the roof and no mesh wires noted to the front part of the roof of the shed. On 11/6/24 at 10:33 A.M., an interview was conducted with the central supply staff (CSS). The CSS stated on 11/4/24 at around 10:40 A.M., he noticed a footprint on top of the trash bin which was positioned next to the shed. The CSS stated he did not know why the trash bin was next to the shed. The CSS stated after searching the area, Resident 1 was not accounted for. On 11/6/24 at 10:42 A.M., an interview was conducted with the Mental Health Worker (MHW). The MHW stated on 11/4/24 at 10 A.M, there was a group activity that was ongoing. The MHW stated Resident 1 rarely joined the group activity and was encouraged to join. The MHW stated he did not notice Resident 1 came out the building. On 11/6/24 at 10:57 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 1 was alert, knew what was going on and oriented. CNA 1 stated Resident 1 was quiet and did not interact to staff or other residents. CNA 1 stated the last time she saw Resident 1 was at 10 A.M. before she went for lunch. CNA 1 stated the staff did hourly rounds/ monitoring of the residents. CNA 1 stated the next hourly round should be at 11 A.M. On 11/6/24 at 11:06 A.M., an interview was conducted with Licensed Nurse (LN 1). LN 1 stated Resident 1 was quiet, isolative, and responded to basic questions like yes, no, fine, and okay. LN 1 stated she last saw Resident 1 on 11/4/24 at 10:10 A.M. LN 1 stated she encouraged Resident 1 to join the group activity. LN 1 stated Resident 1 was nowhere to be found. On 11/6/24 at 12:27 P.M., an interview was conducted with the DON. The DON stated all their residents were high risk for elopement. The DON stated all the trash bins were all outside the fence and that incident just so happened when the kitchen staff used it and the resident used it to jump off the fence. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility ' s policy titled, Behavioral Health Elopement, dated May 2022, .Policy: To maintain a safe and secure environment for all residents. Elopement, or unauthorized departure from the facility, is a serious risk and requires immediate attention. This policy outlines the procedures for preventing, identifying, and responding to elopement incidents in our mental health facility .