

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2024
NAME OF PROVIDER OR SUPPLIER  Del Rosa Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 N Del Rosa Ave. 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)		
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35183</p> <p>Based on interview and record review, the facility failed to prevent elopement (an act or instance of leaving a safe area or safe premises, done by a person with a mental disorder or cognitive impairment) by one of eight residents (Resident 1) with a wander guard system (a wander guard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time. When a resident with a bracelet approaches a monitored door, the system alerts with an audible sound) when Resident 1, who was at risk for elopement, did not have close monitoring of his whereabouts and eloped from the facility through a parking lot gate which automatically opened to vehicles entering and exiting from the facility's parking lot.</p> <p>This failure had the potential to cause Resident 1 to suffer from harm, injury, or possible death while being unsupervised outside of the facility from November 4, 2024, through November 8, 2024.</p> <p>Findings:</p> <p>An unannounced visit was made to the facility on [DATE], at 1:48 PM, to investigate a facility reported incident regarding a resident elopement.</p> <p>A review of Resident 1's face sheet (a document that gives a summary of resident information), undated, indicated an admitted [DATE], with diagnoses that included: encephalopathy (a group of conditions that cause brain dysfunction such as confusion, memory loss, and personality changes), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>A review of Resident 1's Elopement and Wandering Risk Observation/Assessment, dated September 28, 2024, indicated, Reason for the Evaluation, Instructions: Evaluate/Assess the resident status in the seven clinical areas listed below. If the total score is 10 or greater, the resident would be considered At Risk for Wandering or Elopement . Resident 1's score was 18.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555195
		If continuation sheet Page 1 of 4

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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>A review of Patient 1's care plan indicated, Elopement: Resident is at risk for elopement/exit seeking/wandering related to: difficult to redirect, exit seeking behaviors, mood or behavior disorders, psychotropic/mood-altering medications, cognitive deficit-poor safety awareness, impulsivity, wander guard placed on [left] ankle, as per order. Date Initiated: [June 24, 2024], Revision on: [November 6, 2024]. Interventions: Monitor environment for hazards which may increase supervision requirements. Date Initiated: [June 24, 2024], Monitor whereabouts frequently. Date Initiated: [June 24, 2024], Provide redirection as needed. Date Initiated: [June 24, 2024]. Wander alarm as ordered. Date Initiated: [June 24, 2024].</p> <p>During an interview with the Assistant Director of Nursing (ADON) on November 6, 2024, at 1:52 PM, the ADON stated Resident 1 was last observed at the facility on November 4, 2024, at approximately 9 PM and around 10:40 PM, a Certified Nursing Assistant (CNA 1) noticed Resident 1 was not in his room. The ADON stated a search of the facility, the surrounding parking lot area and five-mile radius in the community was conducted but Resident 1 was not located. The ADON stated Resident 1 was admitted on [DATE], and had been assessed as an elopement risk and a wander guard bracelet was placed on his left ankle. The ADON stated the wander guard system was activated on all the facility's exit doors and the automatic parking lot gate; when a resident with a wander guard bracelet went through an exit door or the automatic parking lot gate, an alarm would sound. The ADON stated CNA 1 reported seeing Resident 1 in the outside smoking area around 9 PM and the smoking area was open to the parking lot area. The ADON stated Resident 1 could have walked freely to the automatic parking lot gate and walked through when a vehicle entered or exited because staff did not continuously monitor the automatic parking lot gate. The ADON stated Resident 1's wander guard should have alarmed inside the facility if Resident 1 had walked through the automatic parking lot gate, but staff did not report hearing the alarm on November 4, 2024, between 9 PM and 10:40 PM. The ADON stated Resident 1 could have cut off his wander guard, but the staff did not locate the remains of a wander guard during their search of the facility.</p> <p>During a test of the wander guard system on November 6, 2024, at 2:26 PM, with the ADON, a facility exit door, a few rooms down from Resident 1's room, did not alarm. The ADON confirmed the door did not alarm when tested .</p> <p>During an interview with CNA 1 on November 7, 2024, at 1:10 PM, CNA 1 stated she brought Resident 1's dinner tray to his room for dinner on November 4, 2024, around 6:30 PM and Resident 1 asked her where his coffee was, and she said it was on the dinner tray. CNA 1 stated she checked on Resident 1 at approximately 9 PM and Resident 1 was sitting in the outside smoking area, just sitting there, not smoking, and around 10:40 PM she checked on Resident 1 again and I don't see him. She searched for him in the facility and outside and then she informed the nurse Resident 1 was missing. CNA 1 stated she did not see Resident 1 go outside to the smoking area and did not notice any other residents with him. CNA 1 stated Resident 1 liked to be alone and outside most of the time, and she did not hear the alarm for the automatic parking lot gate sound on November 4, 2024, between 9 PM and 10:40 PM. CNA 1 stated she was surprised Resident 1 was sitting in the smoking area because his usual activity was to walk quickly around the parking lot area, which brought him close to the automatic parking lot gate.</p> <p>During an interview with Resident 1 on November 12, 2024, at 12:30 PM, Resident 1 stated he left the facility through the parking lot gate because he thought the facility was going to send him away to a mental health facility and he did not want to go, so I left. Resident 1 stated he decided to come back because the facility was not going to send him away anymore.</p> <p>(continued on next page)</p>		

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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>A review of the facility's policy and procedure titled Wandering and Elopements, dated March 2019, indicated, Policy Statement: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation: 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>An Immediate Jeopardy (IJ-a situation with the potential to harm the health and safety of the patients) was called under 42 CFR S483.25(d)(2) F 689 Each resident receives adequate supervision and assistance devices to prevent accidents, on November 7, 2024, at 1:45 PM, in the presence of the Administrator (Admin) and the Assistant Director of Nursing (ADON).</p> <p>The Admin and ADON were verbally notified of the IJ situation identified based on the facility's failure to protect Resident 1 from elopement.</p> <p>The facility submitted a corrective action plan which was reviewed and accepted on November 8, 2024, at 1:42 PM, in the presence of the Administrator (Admin).</p> <p>The facility's corrective action plan indicated the following:</p> <p>This letter constitutes a credible allegation by [name of the facility] that the Immediate Jeopardy identified by the California Department of Public Health on [November] 7, 2024 due to the identified resident who eloped from the facility on [November 4, 2024] and currently resident is not located.</p> <p>Immediate Plan of Action for the removal of Immediate Jeopardy</p> <ol style="list-style-type: none"> <li>1. The administrator assigned a staff member to monitor the entrance gate of the facility by the parking lot for 24 hours, [seven] days a week to ensure no other residents could exit from parking lot main gate. The area will be monitored [every]-shift. The assigned staff member will redirect residents to safety. The staff member will contact another staff member to assist as needed, so the area is not left unmonitored.</li> <li>2. There are 7 [seven] residents identified as high risk for elopement risks and these residents are still using a wander guard alarm system</li> <li>3. Assigned Staff checks for the presence of the wander guard as well as the functionality of the wander guard daily.</li> <li>4. IPN [Infection Preventionist Nurse], Case Manager and MDS [Minimum Data Set] staff conducted reassessment on the 7 residents for elopement risks and clarified the orders to reflect Licensed Nurses monitoring of the presence of the wander guard device every shift and notified the responsible party and attending physicians accordingly.</li> <li>5. Assigned Staff to monitor and log the expiration date of the wander guard device weekly.</li> </ol> <p>(continued on next page)</p>		

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