

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555492	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Oak Glen Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9246 Avenida Miravilla Cherry Valley, CA 92223	
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** Based on observation, interview and record review, the facility failed to provide supervision and interventions for one of three residents reviewed for elopement (incident when a resident leaves the facility without authorization or supervision necessary for safety) (Resident 1), after the resident was identified as being at risk for wandering and elopement upon admission. This failure resulted in Resident 1 leaving the facility undetected on June 14, 2026, placing the resident at risk for accidents, serious injury, or death. Findings: On June 30, 2026, at 9:30 a.m., an unannounced visit was conducted at the facility to investigate an incident of elopement. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosis which included, anxiety disorder (nervousness), bipolar disorder (mental disorder), acquired absence of right leg above knee, and Nicotine dependence (cigarettes, uncomplicated). A review of Resident 1's Elopement and wandering risk observation/assessment dated June 5, 2026, indicated, .Score of 14.If the total score is 10 or greater, the resident would be considered at risk for wandering or elopement.Mobility.resident is able to move propel themselves in a wheelchair with some assistance.Cognitive status.resident is disoriented or has period of confusion and or impaired attention but does not wander .Mood and Behaviors:requires frequent reminder/reorientation.other conditions that may impact wandering behavior or risk for elopement. Yes.change in environment, infection.has family or resident representative expressed concerns about the residents wandering tendencies? Yes is checked.verbalized resident will wander and ask others if they have cigarettes.IDT.interventions.has the care plan been initiated/updated to reflect interventions aimed at reducing the risk of unsafe wandering or an elopement? .Yes is checked.Use of wander alarm.No.a wander alarm is NOT indicated.Behavior modification.does not exhibit unsafe wandering or elopement attempts. The Baseline Care Plan dated June 5, 2026, indicated, .health and safety concerns.alert.episodes of confusion.elopement risk.not checked (indicating there was no acknowledgment of the elopement risk). Further review of Resident 1's baseline care plan indicated that the June 5, 2026, assessment identified Resident 1 as being at risk for wandering and elopement. There was no documented evidence that individualized interventions, including increased monitoring or other preventive measures, had been implemented before the June 14, 2026, incident. The History and Physical Examination, dated June 7, 2026, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's progress notes dated June 14, 2026, at 8:45 p.m., indicated, .Resident was observed outside the facility grounds after leaving her room without staff assistance. Resident was noted approaching a vehicle parked near the facility and requesting a cigarette from an individual inside the vehicle. Prior to the incident resident had attended a supervised smoke break and was escorted back to her room by staff and assisted into bed. Nursing staff re-directed resident back to facility. Resident was calm and amenable with re-direction and returned to her room without incident Resident with close visual monitoring q (every) 30 mins (minutes) by all staff. On June 30, 2026, at 1:39 p.m., an interview and record review was conducted with Licensed Vocational Nurse (LVN 1). LVN 1 was assigned to Resident 1, and stated Resident 1 was identified as a wander risk. LVN 1 stated Resident 1's elopement risk assessment (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	was 14 which indicated the resident was at risk for wandering/elopement. LVN 1 stated a care plan should be implemented after an evaluation was conducted to indicate the proper interventions were in place. LVN 1 stated no care plan was initially implemented due to no prior elopement history. LVN 1 stated Resident 1's sister noted possible elopement behavior upon admission, leading to increased monitoring per facility standards. LVN 1 stated an elopement attempt did occur on June 14, 2026, which prompted a care plan and wander guard use (a device which causes an alarm to trigger when a resident wanders close to exit doors). On June 30, 2026, at 2:10 p.m., an interview was conducted with Certified Nursing Assistant (CNA 1). CNA 1 stated Resident 1 was at risk for wandering and currently had a wander guard. CNA 1 stated a 30-minute monitoring log was initiated on June 30, 2026, per supervisor instruction and was unsure why it had not been started earlier. On June 30, 2026, at 2:47 p.m., an interview was conducted with LVN 2, the charge nurse on duty during the June 14, 2026, incident. LVN 2 explained that elopement risks were communicated during nurse huddles (shift reports). LVN 2 stated, before his 7:30 p.m. lunch break, he asked the assigned CNA to watch Resident 1 to prevent wandering. Upon return around 8:00 p.m., he was informed Resident 1 was found outside and returned safely. Resident 1 had no injuries and no prior elopement attempts. LVN 2 was unsure if the CNA sought help monitoring Resident 1 after assisting other residents. LVN 2 indicated he did not review elopement care plan interventions before the incident and learned of a new plan post-incident requiring close monitoring and wander guard use. On June 30, 2026, at 3:22 p.m., an interview was conducted with CNA 2. CNA 2 stated Resident 1 returned from a smoke break at 5:30 p.m., and went to her room where she was last seen before 7:30 p.m. CNA 2 stated she learned from the desk nurse that Resident 1 was outside and responded immediately. CNA 2 stated she found Resident 1 in the east parking lot in a wheelchair, asking for a cigarette, with no one else nearby and away from the main road. CNA 2 stated She was unaware Resident 1 required increased supervision and she was not informed of previous wandering concerns. On June 30, 2026, at 3:57 p.m., an interview was conducted with CNA 3. CNA 3 stated she was assigned to Resident 1 on June 14, 2026, and she was asked to watch Resident 1 while the charge nurse was on break. CNA 3 stated she later learned Resident 1 had again been found outside. CNA 3 stated she was unaware Resident 1 had wandering behaviors or required additional supervision. On June 30, 2026, at 4:24 p.m., an interview and record review was conducted with the Director of Nursing (DON). The DON stated resident are monitored at least every two hours, with increased monitoring based on identified wandering or elopement risk. The DON stated Resident 1's June 5, 2026, elopement evaluation identified the resident as being at risk for wandering and elopement with a score of 14 and that a care plan should have been initiated at that time. the DON stated the care plan was not implemented until after the June 14, 2026, incident. The DON stated there was no alarm sounded when the resident exited the building. the DON stated the lack of a care plan and corresponding interventions created a risk that Resident 1's wandering behaviors would not be appropriately addressed. A review of the policy and procedure titled, Wandering and Elopements dated March 2019, indicated, .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 .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 .		