STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555711	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care on Palm	4768 Palm Avenue Riverside, CA 92501

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** 48240 Based on interview and record review, the facility failed to ensure, for one of four residents, Resident 1, who was identified as at risk for elopement (a resident leaving the facility unsupervised and unnoticed) and was on line of sight (a resident being within the view of staff members) monitoring was supervised by staff. This failure resulted in Resident 1 eloping from the facility on October 13, 2024, which placed Resident 1 at risk for sustaining serious injury such as being struck by a vehicle or death. Findings: On November 5, 2024, at 9:28 a.m., an unannounced visit was conducted at the facility to investigate a facility reported incident. A review of Resident 1's medical record was conducted. The Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included cardiac arrhythmia (irregular heart rhythm) and schizophrenia (mental illness) and that he was under a conservatorship (a legal status which a court appoints another person to act or make decisions for the person who needs help). A review of Resident 1's Admission/Re-admission Data Tool dated October 8, 2024, indicated Resident 1 was at risk for elopement. A review of Resident 1's 72 Hour Monitoring dated October 9, 2024, indicated .Resident being monitored as a new admission. Resident has one-one monitoring for high risk for elopement . A review of Resident 1's Change of Condition -SBAR (Situation, Backgrounds, Assessment, Recommendation - a standardized communication tool) dated October 13, 2024, indicated Resident 1 left the facility without notice or permission and that a Certified Nurse Assistant (CNA) last saw Resident 1 in his room at 9:00 p.m. A review of Resident 1's Change of Condition-SBAR dated October 15, 2024, indicated Resident 1 returned to the facility accompanied by a police officer and was later on transferred to (name of general acute hospital) for further evaluation and behavioral intervention as ordered by the physician. (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	On November 5, 2024, at 11:38 a.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents who had attempted to elope or verbalized they did not want to be at the facility are considered at risk for elopement. LVN 1 stated when residents are identified as at risk for elopement, they start to have precautions in place such as providing 1:1 monitoring (constant observation and care for a single resident) to the resident to ensure that the resident is always in the facility. LVN 1 stated Resident 1 was identified as at risk for elopement upon admission and was on 1:1 monitoring. LVN 1 stated the Certified Nursing Assistants (CNAs) did the 1:1 monitoring, and they rotated with the task hourly. LVN 1 stated Resident 1 attempted to leave the night he was admitted and was placed on 1:1 monitoring. LVN 1 stated Resident 1 eloped from the facility on October 13, 2024, during her shift and she was not sure if the assigned CNA for 1:1 monitoring, CNA 2, was outside Resident 1's room, or if she stepped out. LVN 1 stated CNA 2 could not tell her what happened. LVN 1 stated they looked around the facility and were unable to locate Resident 1. LVN 1 stated Resident 1 could have escaped the facility by jumping off the gate. LVN 1 stated the facility had gates which required a key to enter and exit. LVN 1 stated at the beginning of the shift, Resident 1 was calm and did not have any exit seeking behavior. On November 5, 2024, at 11:58 a.m., during an interview with CNA 1, CNA 1 stated Resident 1 was on 1:1 monitoring. CNA 1 stated on October 13, 2024, he took his ten-minute-break at 8:45 p.m., or 9:00 p.m. and by the time he came back he could not find Resident 1. CNA 1 stated CNA 2 was assigned to do the 1:1 monitoring from 9:00 p.m., to 10:00 p.m. CNA 1 stated CNA 2 was not outside Resident 1's room. On November 5, 2024, at 12:38 p.m., during telephone interview with CNA 2, CNA 2 stated she was working when Resident 1 left the facility. CNA 2 stated Resident 1 was on 1:1 monitoring, and she was supposedly doing the 1:1 on him at the time when staff couldn't find him. CNA 2 stated she did not see Resident 1 leave the facility. CNA 2 stated the practice was that the CNA assigned to Resident 1's run was the CNA who would do the 1:1 monitoring from 9:00 to 10:00 p.m. CNA 2 stated it was CNA 1 who was doing the 1:1 monitoring on Resident 1 at that time. CNA 2 stated CNA 1 was sitting outside Resident 1's room and he was the one who asked where Resident 1 was. On November 5, 2024, at 2:25 p.m., during an interview with Registered Nurse (RN) 1, RN 1 stated residents are identified for elopement by conducting an elopement assessment, which is included in the admission assessment. RN 1 stated when a resident is identified as at risk for elopement, they monitored the resident's whereabouts and initiate a care plan. RN 1 stated Resident 1 wandered around the facility, but she was not aware if he had exit seeking behavior or verbalized he didn't want to be in the facility. RN 1 stated the nurses should be educated on when to use 1:1 monitoring or line of sight. RN 1 stated Resident 1 was on line of sight. RN 1 stated 1:1 monitoring is when a CNA is watching over a resident in close proximity and line of sight was when a CNA is watching over multiple residents and maintaining visual on the residents. RN 1 stated Resident 1 was out of the facility for 29 hours and he could have had an injury, pass out, or get into an accident. RN 1 stated the expectation for staff was to ensure they are watching the residents, most specifically those that are at risk for elopement and falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 5, 2024, at 3:05 p.m., during an interview with the Social Service Director (SSD), the SSD stated Resident 1 would go outside looking for an opportunity to leave or to see if a door was open. The SSD stated she observed Resident 1 doing this on his second day of stay at the facility and she asked him to back inside. On November 8, 2024, at 3:18 p.m., during an interview with the Director of Staff Development (DSD), the DSD stated 1:1 monitoring was when staff goes wherever the resident goes. The SSD stated line of sight was when a resident should be within staff's vision and if the resident is no longer within staff's sight then the staff will have to follow the resident and maintain a visual on the resident. The SSD stated at the time Resident 1 eloped, he was on line of sight. The SSD stated there was no excuse for when Resident 1 eloped and that no one was really paying attention when Resident 1 was on line of sight. The SSD stated when residents are on line of sight, staff should know where the residents are at all times. On November 5, 2024, at 4:11 p.m., during an interview with the Director of Nursing (DON), the DON stated Resident 1 was on line of sight since admission because they do not know what his behaviors were, and to prevent falls. The DON stated the expectation for when a resident is on line of sight is for staff to alert another staff when the resident is going or coming out of an area of supervision. The DON stated it caught them by surprise when Resident 1 eloped. The DON stated she did not have an answer when she was asked how Resident 1 could have eloped if he was on line of sight. A review of the facility's 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. A review of the facility's policy and procedure titled, Safety and Supervision of Residents dated July 2017 indicated .Resident safety and supervision and assistance to prevent accidents are facility wide priorities . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determine by the individual resident's assessed needs .