STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555919	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Manor	100 East 2nd Street Imperial, CA 92251

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980 Based on record review, the facility failed to correlate the Minimum Data Set (MDS) assessment with the elopement risk assessment prior to a facility outing that one resident, Resident 1, attended with four other residents supervised by one Certified Nursing Assistant (CNA). This failure resulted in Resident 1 ' s elopement from the outing and attempts to walk into oncoming traffic. Findings: Resident 1 has been conserved (a court appointed person has legal decision-making authority over another person), and has resided in the secured behavioral health facility since 7/29/2015. Resident 1 was assessed to have a Brief Interview for Mental Status (BIMS, a measure of thinking, learning, remembering, and using judgment) of 11 (moderate impairment) on 2/26/24. Resident 1 ' s admission record indicated diagnoses that included schizoaffective disorder (a mental health disorder that may include false beliefs and visual and auditory perceptions that are not real), mood disorder (a mental health condition that affects emotional state), major depressive disorder (a mental health condition that causes a persistently low or depressed mood), anxiety disorder (a mental health condition in which a person has excessive worry, feelings of fear, dread, and uneasiness), and suicidal ideations (thoughts, wishes and preoccupation with death and suicide). A review of the MDS section E0900 Wandering - Presence & Frequency dated 2/28/24 indicated Behavior of this type occurred 4 to 6 days. A review of facility Risk of Elopement Assessment conducted by the Director of Nursing (DON) dated 3/5/24 indicated, Client is not at risk at this time. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 Resident 1 went on a facility outing to a large store accompanied by four other residents and one Certified Nurse Assistant (CNA). Per the facility report of this event, Resident 1 declined to return to the facility at the end of the outing, ran away from the CNA and attempted to run into oncoming traffic. At approximately 7:20 P.M., four hours and 20 minutes after the CNA lost control of the resident, Resident 1 was found by the facility Social Worker (SW) at a local convenience store. Resident 1 tried to walk into oncoming traffic, then entered a local motel and locked the door. Resident 1 was transported to the local emergency department by 911 and discharged back to the facility on [DATE] at 12:30 A.M. Resident 1 again refused to get a car to be transported back to the facility. Resident was transported to the County Mental Health Crisis Center and remained for two days. Resident 1 returned to the facility on [DATE], two days after he eloped during the outing. A review of the facility policy, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral Assessment, Intervention and Monitoring revised March, 2019 indicated, Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment.

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(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** 46980 Based on observation, interview and record review, the facility failed to provide adequate supervision to Resident 1 who eloped during a facility outing. This failure had the potential for Resident 1 to suffer harm. Findings: Resident 1 has been conserved (a court appointed person has legal decision-making authority over another person) and has resided in the secured behavioral health facility since 7/29/2015. Resident 1 was assessed to have a Brief Interview for Mental Status (BIMS, a measure of thinking, learning, remembering, and using judgment) of 11 (moderate impairment) on 2/26/24. Resident 1 ' s admission record indicated diagnoses that included schizoaffective disorder (a mental health disorder that may include false beliefs and visual and auditory perceptions that are not real), mood disorder (a mental health condition that affects emotional state), major depressive disorder (a mental health condition that causes a persistently low or depressed mood), anxiety disorder (a mental health condition in which a person has excessive worry, feelings of fear, dread, and uneasiness), and suicidal ideations (thoughts, wishes and preoccupation with death and suicide). On 3/12/24 Resident 1 went on a facility outing to a large store accompanied by four other residents and one Certified Nurse Assistant (CNA). Per the facility report, Resident 1 declined to return to the facility at the end of the outing, ran away from the CNA and attempted to run into oncoming traffic. At approximately 7:20 P.M., Resident 1 was found by the facility social worker at a local convenience store. Resident 1 tried to walk into oncoming traffic, then entered a local motel and locked the door. Resident 1 was transported to the local emergency department by 911 and discharged back to the facility on [DATE] at 12:30 A.M. Resident 1 again refused to get a car to be transported back to the facility. Resident was transported to the County Mental Health Crisis Center and remained for two days. Resident 1 returned to the facility on [DATE]. An interview was conducted with the Director of Nursing (DON) on 4/15/24 at 11:10 A.M. The DON stated, (Resident 1) verbalized he wants to be back on the street right now. An interview with Resident 1 was conducted on 4/15/24 at 12:05 P.M. Resident 1 stated, I want to go to Alaska to see (confidential name). I know I can get out of here if I hop the gate in the back and I ' m gonna do it. An observation of a door from the facility to a back yard was conducted on 4/15/24 at 12:25 P.M. The door was unlocked, unalarmed and led to a yard with a gate approximately five feet high. The facility had three prior elopements over the back gate and fence. A high-speed road was noted on the other side of the facility fence. During a ten-minute observation, four residents went through the door into the yard without any staff accompanying or observing them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s care plan for elopement initiated on 8/11/2015 indicated, The resident is an elopement risk/ wanderer. A review of the Minimum Data Set (MDS) section E0900 Wandering - Presence & Frequency dated 2/28/24 indicated Behavior of this type occurred 4 to 6 days. A review of facility Risk of Elopement Assessment conducted by the Director of Nursing (DON) dated 3/5/24 indicated, Client is not at risk at this time. A review of Behavioral Health Services note dated 3/19/24 indicated (Resident 1) wants to go to his home. Was reminded that his home is the nursing facility of (name). Does not want to return there. Does not like that facility either. Resident 1 further stated he wanted to go to Oakland. A review of the facility policy entitled Off-Premises Activities revised June 2018 indicated An appropriately qualified and authorized individual will accompany the activity director/ coordinator during off-premise activities to help care for the residents and tend to any medical or behavioral problems that might arise. Resident safety is a priority when conducting off-premise activities. Residents are properly supervised and monitored for safety at all times during the outing.