STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055036	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Healthcare Center	2625 Maple Ave. Los Angeles, CA 90011

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 - Immediate jeopardy to resident health or safety 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** 47883 Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 5), who had no capacity to understand, had history of elopement (when the resident leaves the premises or a safe area without the facility's knowledge or supervision), and was at risk for wandering and elopement, received the care and supervision needed to prevent elopement by failing to: -Develop a person-centered, comprehensive care plan to include frequency of monitoring Resident 5's location through visual checks, per the At Risk of Elopement care plan. -Review Resident 5's elopement assessment form for accuracy, per the previous IJ removal plan approved on 2/29/2024. -Revise / Update Resident 5's At Risk for Elopement care plan to include monitoring every 15 minutes, per the previous IJ removal plan approved on 2/29/2024. -Ensure adequate staffing for the 11 PM - 7 AM shift on 3/16/2024. As a result of these deficient practices, on 3/16/2024 around 5:15 AM, Resident 5 was found to have eloped from the facility and remains missing. Resident 5 has an increased risk of serious harm or death due to not receiving the physician ordered care, which includes administration of Haloperidol 5 mg (an antipsychotic medication used to treat schizophrenia, hallucinations and delusions) twice a day, Risperidone 3 mg (antipsychotic medication) every 12 hours and Physical Therapy Program for unsteadiness on feet. On 3/20/2024 at 4:15 PM, an Immediate Jeopardy (IJ - a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM) and Director of Nursing (DON) due to the facility's failure to develop a person-centered comprehensive elopement care plan and to implement the care planned interventions to monitor Resident 5's location through visual checks to prevent his elopement from the facility on 3/16/2024. This placed Resident 5 at an increased risk of serious harm or death due to not receiving medications and care. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/22/2024, the facility submitted an acceptable IJ Removal Plan (IJRP - interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP implementation through observation, interview, and record review, the IJ was removed on 3/22/2024 at 7:49 PM, in the presence of the facility's ADM and the Director of Nursing (DON). The facility's IJRP included the following immediate actions: -Resident 5 was identified to have eloped on 3/16/2024 around 5:15 am. Throughout the day and for the next two days, the facility received hourly calls from LAPD, inquiring if resident was found or had returned. Facility staff made several calls to different hospitals inquiring whether the resident was admitted . The undersigned together with a CNA went to several shelters, skid row, medical clinics, restaurants in the area throughout the weekend. As of 3/16/2024, the resident has not been located. - On 3/20 and 3/21/2024, the Director of Nursing and the Administrator reviewed the elopement assessments. As of 3/21/2024, out of 51 residents reviewed for elopement assessment, there were 16 residents identified that remained to be at risk for elopement. - The care plan of the 16 residents identified to be at risk for elopement were reviewed and the plan of care was updated on 3/20/2024 to indicate every 15 minutes visual monitoring of residents. - A dedicated staff for door monitoring was initiated on 3/19/2024 and as of 3/21/2024. There is a staff assigned for the 7-3, 3-11 and 11-7 shift. The door monitor designated staff will be sitting in the area across the front door to monitor and redirect residents who are approaching and walking towards the front doors. Another staff will be assigned when the door monitor staff takes a break for meals or bathroom breaks. -There are three exit doors of the facility, and the three exit doors were serviced for routine maintenance check on 3/19/2024, for another service maintenance check performed on the front doors and were found to be functioning normal. -The Maintenance Supervisor will be performing a daily check of all the three exit doors to ensure that they are functioning starting 3/21/2024. - In-service education was initiated by the Infection Prevention (IP) Nurse on 3/21/2024, at 10:30 am, regarding the Policy & Procedure for Elopement including the identified residents at risk for elopement, the action plan for visual check of residents whereabouts every 15 minutes. The in-service included the new action plan for the updated list dated 3/20/2024 of the identified resident elopement risk that needed every 15-minute visual check of whereabouts, the door monitor staff for additional safety support. Inservice education included documentation of the CNA of the 15-minute visual monitoring for whereabouts of the resident identified to be at risk for elopement. -Additional in-service education will be provided to staff on 3/21/2024 at 3:30 PM until 100% of staff are in-service regarding the plan for monitoring of at risk for elopement resident, the 15-minute visual check plan, the front door monitoring staff and the updated list that is in the binder with resident's pictures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The updated list will be placed at the Elopement Risk Binder and will also contain the pictures of the residents identified to be at risk for elopement for easier identification. -The resident identified to be at risk for elopement will be monitored every 15 minutes and will be documented for the whereabouts in the form titled Visual Check Every 15 minutes which was in place since 2/27/2024 and will continue to use the same form as of 3/21/2024. - The charge nurses will monitor every shift that the identified resident to be at risk for elopement is monitored every shift for their whereabouts by the CNA starting 3/21/2024. -The Elopement at Risk Resident List will be reviewed by the IDT weekly every Friday starting 3/22/2024 x 6 months and the updated list will be placed at the binder. - Any findings from the monitoring of the above plans will be addressed to the QA Committee meeting x 6 months beginning 4/19/2024. The ultimate responsibility is the Administrator. Findings: A review of the Admission Record indicated the facility admitted Resident 5 on 12/12/2023 with diagnoses including encephalopathy (the group of conditions that causes brain dysfunction [can appear as confusion, memory loss and personality change]), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). A review of the History and Physical (H&P), dated 12/13/2023, indicated Resident 5 did not have the capacity to understand and make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 12/18/2023, indicated Resident 5 had severely impaired cognition (decisions poor; cues/supervision required) and needed supervision or touching assistance for eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 5 did not have any wandering behavior. A review of the Elopement Risk Assessment, dated 12/20/2023, indicated Resident 5 did not readily accept nursing home placement and was at risk for elopement. A review of the At Risk for Wandering / Elopement Care Plan initiated on 1/12/2024, indicated this care plan was related to Resident 5's schizophrenia and schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder. Symptoms may occur at the same time or at different times). The care plan goals for Resident 5 were to provide a hazard-free environment and keep him from wandering out of the facility. The interventions indicated to monitor the resident's location through visual checks, redirect him as needed and to speak with Resident 5's family or friends to record all information regarding the resident's history of wandering and areas where he might attempt to go. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to a review of the Progress Note, Intradisciplinary Team Review (IDT) meeting, dated 2/27/2024, Resident 5 was at risk for elopement, with no new attempts while in the facility. The progress note indicated Resident 5 needed simple, clear directions and constant redirection from the staff. A review of the Change of Condition / Situation, Background, Assessment and Recommendation (SBAR) dated 3/16/2024, indicated Resident 5 eloped from the facility on 3/16/2024 around 5:15 AM through the front door, while Licensed Vocation Nurse (LVN) 1 administered medications to another resident. On 3/19/2024 at 11:41 AM, during a phone interview, LVN 1 stated that around 5 AM, Resident 5 was in the hallway and asked about some Ensure (a nutritional supplement). LVN 1 stated he promised Resident 5 that he would come back to him in a few minutes. LVN 1 stated he was administering medication in another resident's room when he heard the front door alarm. LVN 1 stated he quickly went to the front door to find out who was trying to get in or out of the facility, because he did not know that residents could easily open the front door. LVN 1 stated he immediately sent two CNAs outside to look for the resident while he drove around the neighborhood. LVN 1 stated they could not find Resident 5 and reported the incident to the police. LVN 1 stated that on 3/16/2024 during the 11 PM - 7 AM shift, there was only 1 LVN and 3 CNAs for all 52 residents in the facility. LVN 1 stated there was no designated person to monitor the 16 residents with elopement risk and nobody to monitor the front door at 5 AM. LVN 1 stated the CNAs were monitoring the residents for elopement, while also providing the morning diaper changes to the residents. During a phone interview, on 3/19/2024 at 11:51 AM Certified Nurse Assistant 1 (CNA 1) stated that she was taking care of Resident 5 on 3/16/2024. CNA 1 stated Resident 5 required monitoring every 15 minutes due to his risk of elopement. CNA 1 stated that around 5 AM on 3/16/2023, she went with CNA 2 to another resident's room to provide a diaper change. CNA 1 stated when she heard the alarm go off, she went to look for Resident 5 in his room but did not find him there. On 3/19/2024 at 1:46 PM, during a phone interview, CNA 2 stated that on 3/16/2024 around 5 AM she was helping CNA 1 with a diaper change. CNA 2 stated she was taking the dirty linens out from room, when the front door alarm went off. CNA 2 stated she quickly ran to the front and saw there was nobody watching the front door at that time. During a concurrent interview and record review with the Director of Nursing (DON), on 3/19/2024 at 4:35 PM, the DON stated she did not document that she reviewed the elopement risk assessment dated [DATE] for Resident 5 or update the resident's At Risk for elopement care plan to include frequency of monitoring, and per the Immediate Jeopardy Removal Plan (IJRP) approved 2/29/2024. The DON reviewed a document called Visual Check every 15 minutes, dated 3/16/2024, implemented as part of the IJRP, approved 2/29/2024 and stated, Usually the facility had an extra CNA, who was designated to monitor the residents with elopement risk. The DON stated the CNAs were rotating every 30 minutes to provide monitoring for the 16 residents with elopement risk, while other CNAs were providing care to residents with Activities of Daily living (ADLs), but on 3/16/2024 there was no staff designated to monitor the residents with elopement risk. The DON stated that according to the Visual Check every 15 minutes, form dated 3/16/2024, There was to be a designated person to monitor the 16 residents with elopement risk. But there was not. Under the section titled, Name of Person Performing Monitoring, it did not indicate who was monitoring the residents or at what time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/2024 at 5 PM, during interview, the Administrator stated that on 3/16/2024 the facility was short staffed with one LVN and three CNAs for 52 residents which resulted in Resident 5 being able to elope from the facility through the front door. A review of the facility's policy and procedure titled, Wandering and Elopement, revised March 2019, indicated if the resident was identified as at risk for elopement or other safety issues, the resident's care plan would include strategies and interventions to maintain the resident's safety and strive to prevent harm. A review of the facility's policy and procedure (P&P) titled, Routine Resident Checks, revised 7/2013, indicated, staff shall make routine resident checks to help maintain resident safety and well-being. A review of the facility's P&P titled, Safety and Supervision of Residents, revised in 7/2017, indicated residents' safety risks are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. The P&P indicated the facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The P&P indicated resident supervision may need to be increased when there was a change in the resident's condition.