STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care Skilled Nursing Ctr	2725 Pacific Avenue Long Beach, CA 90806

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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45028

Based on interview, and record review, the facility failed to report an allegation of resident to resident physical abuse to the California Department of Public Health (CDPH) and the State Long Term Care Ombudsman ([LTC] public advocate) within the regulated time frame of two hours and they failed to report the results of their investigation to CDPH within five working days of the incident for one of two sampled residents (Resident 4).

This deficient practice resulted CDPH not being aware of the abuse allegation that occurred 1/2024 until 4/2024 and the inability to investigation the allegation. This deficient practice had the potential for pertinent information to be lost and/or forgotten, more allegations of abuse to go unreported and continued abuse to occur.

Findings:

a. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people) schizophrenia (a serious mental disorder in which people interpret reality abnormally), psychosis (when a person has trouble telling the difference between what's real and what's not) and absence of his right leg above the knee.

During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 2/20/2024, the MDS indicated Resident 1 was cognitively intact (a person who can follow two simple commands). The MDS indicated Resident 1 received antipsychotic (medication used to treat hallucinations [sights, sounds, smells, tastes, or touches that a person believes to be real but are not real] and delusions [false beliefs]) and antianxiety (medication used to treat symptoms of anxiety [feelings of fear, dread, uneasiness]) medications.

During a review of Resident 1's Nursing Notes dated 12/8/2023 and timed at 7:59 a.m., the Nursing Notes indicated Resident 4 called the police alleging Resident 1 assaulted him. The Nursing Notes indicated Resident 1 alleged that Resident 4 was verbally aggressive to him.

During a review of Resident 1's Nursing Notes dated 12/8/2023 and timed at 11:41 a.m., the Nursing Notes indicated, following the facility's investigation, the allegations were considered an unusual occurrence.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnosis including paraplegia (a partial or complete paralysis [complete or partial loss of function] of the lower half of the body) and depression (a constant feeling of sadness and loss of interest, which stops one from doing their normal activities). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had the ability to understand and be understood by others. The MDS indicated Resident 4 exhibited behavioral symptoms (e.g. , physical symptoms not directed towards others such as hitting or scratching self, pacing, rummaging, verbal/vocal symptoms like screaming, and disruptive sounds) and was administered antidepressant (medication used to treat depression) and hypnotic (a medication used to induce sleep and treat insomnia [trouble sleeping]) medications. During an interview on 4/20/2024 at 1:07 p.m., Resident 4 stated in 12/2023, while he was in his room, his previous roommate (Resident 1) hit him across the face. Resident 4 stated Resident 1 was always talking to himself and making weird noises, so he told Resident 1 to shut up. Resident 4 stated after he told Resident 1 to shut up, Resident 1 came over to him and hit him across the face. Resident 4 stated, he immediately called the police to report the assault to them. During a review of Resident 4's Clinal Record, the Clinical Record indicated there was no documentation related to the altercation between Resident 1 and Resident 4. During a review of the facility's Verification of Incident Investigation/Administrative Summary dated 12/8/2023, there was no documentation indicating CDPH or the Ombudsman was notified of the incident. During an interview on 4/19/2024 at 3:48 p.m., the Social Services Director (SSD) stated she investigated the allegation of physical and verbal abuse which occurred on 12/8/2023 between Resident 1 and 2, however it was determined by the previous Administrator (ADM 2) that the incident was not reportable to CDPH or the Ombudsman because it was considered an unusual occurrence. The SSD stated all allegations of abuse should be reported to CDPH and the Ombudsman within two hours of the allegation. During an interview on 4/20/2024 at 12:50 p.m., ADM 1 stated during the incident between Resident 1 and Resident 4 (12/8/2023), the facility had a different ADM at that time (ADM 2), and ADM 2 did not report the incident to CDPH or the Ombudsman because based on the facility's investigation, ADM 2 considered the incident an unusual occurrence and not an allegation of abuse because the facility was not able substantiate the allegation. During a review of the facility's Policy and Procedure titled, Alleged of Suspected Abuse and Crime Reporting, revised 10/2022, the P&P indicated it is the responsibility of all employees to immediately report to the facility administrator, and to other officials in accordance with Federal and State law, any incident of suspected or alleged abuse. The P Facility Administrator, or designee, shall report investigative findings to officials in accordance with State law, including the State Licensing & Certification agency, within five working days of the incident.

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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** 45028 Based on interview and record review, the facility failed to ensure a resident, who was under conservatorship (a legal status in which a judge appoints a person [conservator] to manage the financial and personal affairs of a minor or incapacitated person) with a history of elopement (an unauthorized departure of a patient from an around-the-clock care setting without the facility's knowledge and supervision), and assessed as high risk for elopement, did not elope from the facility for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1 did not elope from the facility twice, the first time on 1/19/2024 and again 4/13/2024. 2. Ensure Resident 1 was not placed in a room with access to an outside patio with a door that opened to an alley. The door's alarm, when sounded, was faint and could be heard only when in close proximity to it and would shut off within five seconds after activation. 3. Have a system in place to alert staff when the facility's front entrance/exit door as well as the rehabilitation patio door was opened, to prevent residents from leaving the facility without staff knowledge. 4. Develop and implement a care plan for Resident 1 when Resident 1 was identified as a risk for elopement on 12/29/2023. 5. Ensure a care plan was developed to address Resident 1's risk for elopement with appropriate time sensitive interventions that defined frequent visual checks and documentation of times when Resident 1 was monitored. 6. Develop and implement a care plan for Resident 1's refusal to wear and taking off his wander guard bracelet (a device placed on a resident that triggers an alarm alerting staff that a resident is close to a door to prevent the resident from leaving unattended). As a result of these deficient practices, Resident 1 eloped from the facility and was missing for 11 hours on 1/19/2024 and eloped from the facility again on 4/13/2024. These deficient practices placed Resident 1 at risk for exposure to harsh environmental conditions (rain and/or cold), hypothermia (a dangerously low body temperature), injury from motor vehicle accidents, medical complications related to his diagnosis of paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people) schizophrenia (a serious mental disorder in which people interpret reality abnormally) and psychosis (when a person has trouble telling the difference between what's real and what's not) without receiving prescribed medication, lack of food with the risk of malnutrition (health problems that may arise due to lack of nutrients), dehydration (abnormally low fluid levels in the body), and possible death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/18/2024 at 4:38 p.m., 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 the Director of Nursing (DON) due to the facility's failure to assess, monitor and supervise Resident 1 to prevent his elopement from the facility on 4/13/2024. On 4/22/2024 at 3:53 p.m., the facility submitted an acceptable IJ Removal Plan ([IJRP]) interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 4/22/2024 at 5:52 p.m., in the presence of the facility's ADM and DON. The facility's IJRP included the following immediate actions: 1. The facility will follow residents' care plan interventions that requires frequent visual checks every hour, every 30 minutes, or every 15 minutes depending on the patient's needs and document monitoring of the resident on the facility's Frequent Observation Flow sheet. 2. The facility staff were reeducated on 4/1/4/2024 on the facility's elopement policy and procedure (P&P) with an emphasis on monitoring and providing supervision to residents who are at risk for elopement according to their plan of care. The ADM, DON and Department heads were in-serviced on 4/18/2024 on the same. 3. An Elopement binder was created and will be placed at nursing station one. The Elopement binder will include resident's face sheets, photos, interventions specific to elopement, and wander guard manufacturing guidelines. 4. On 4/18/2024 all licensed staff will receive an in-service on the development, evaluation, and revision of a care plan as needed to ensure care plans identify the residents' needs in order to prevent elopement including goals, interventions, and implementation with documentation of interventions. 5. The licensed nurses will check residents' Wander Guard placement every shift and check the function of the Wander Guard with the manufacturer recommended tester once a week for all residents assessed with risk of elopement. The findings will be documented in the electronic Medication Administration Record (eMAR). The Director of Staff Development (DSD) or designee will monitor for compliance with elopement risk care plan interventions including validation of Wander Guard placement and alarm function three times a week. 6. On 4/19/2024 the ADM in collaboration with the Maintenance Supervisor (MS) placed an audible alarm on the facility's front entry/exit door and the kitchen exit door. A lock was placed on the patio exterior exit gate preventing further use of the door for entering and exiting. 7. The MS or designee will monitor the alarm function daily and report any findings to the Administrator for appropriate corrective actions. 8. The licensed nurses will check all exit door alarms every shift and document the results on the Exit Door Alarms Check Log. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. The facility front doors will be unlocked and unarmed each day at 9 a.m., and armed at 5 p.m. During the time when the front doors are open, a receptionist will be present in the front lobby. If there is no receptionist present, then front entry doors will stay locked from outside entry the alarm will be armed. 10. On 4/18/2024, the facility staff were educated on the facility's elopement P&P with an emphasis on residents who are identified as elopement risk and are seen outside of the facility The facility staff will intercept the resident to ensure the resident safety and to encourage and assist the resident to return to the facility. The staff will not leave the resident unattended until help is secured. 11. On 4/19/2024, the ADM and DON were reeducated on the facility's elopement P&P with an emphasis on reporting elopement within 24 hours to all appropriate entities. The facility will report all elopements within 24 hours according to Federal and Title 22 regulations. Findings: During a review of Resident 1's General Acute Care Hospital (GACH) Face Sheet, the Face Sheet indicated Resident 1 was brought to the GACH for a mental health evaluation, after being taken into custody and arrested breaking into a car. Resident 1 was admitted to the GACH on 5/17/2023 with a diagnosis of psychosis. Resident 1 was subsequently placed on a 5150 72-hour hold (an involuntary detention of an adult who is experiencing a mental health crisis) due to Resident 1's incoherent statements, Resident 1's inability to explain a safety plan and being found inappropriate for voluntary hospitalization . During a review of Resident 1's Psychiatric Evaluation from the GACH, dated 5/18/2023, the Psychiatric Evaluation indicated Resident 1 made bizarre statements including hearing demons and angels fighting and hearing voices tormenting him, telling him to walk into traffic, or overdose (taking more than the usual recommended amount of something, often medicine or drugs). The Psychiatric Evaluation indicated Resident 1 stated, I just feel like dying. During a review of the GACH's Discharge Summary, dated 11/17/2024 and timed at 7:33 p.m., the Discharge Summary indicated Resident 1's chief complaint was wanting to harm himself. The Discharge Summary indicated Resident 1's baseline level (an initial measurement of a condition taken at an early point in time that is used for comparison over time to look for changes) was disorganized (odd, bizarre behavior such as smiling, laughing, or talking to oneself or being preoccupied/responding to internal stimuli). During a review of Resident 1's facility's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, psychosis, and absence of his right leg above the knee. During a review of Resident 1's Conservatorship documents dated 11/22/2023, the Conservatorship documents indicated Resident 1 was gravely disabled (a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter) as a result of a mental health disorder (a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Elopement Evaluation dated 12/29/2023, the Elopement Evaluation indicated Resident 1 scored one (a score of one or higher indicates a risk of elopement). During a review of Resident 1's clinical record, the Care Plan section, indicated there was no care plan in place addressing Resident 1's history of elopement or his elopement risk, as assessed on 12/29/2023. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 2/20/2024, the MDS indicated Resident 1 was cognitively intact (a person who can follow two simple commands). The MDS indicated Resident 1 received antipsychotic (medication used to treat hallucinations [sights, sounds, smells, tastes, or touches that a person believes to be real but are not real] and delusions [false beliefs]) and antianxiety (medication used to treat symptoms of anxiety [feelings of fear, dread, uneasiness]) medication. During a review of Resident 1's Order Summary Report (Physician's Orders), the Physician's Orders indicated Resident 1 was receiving the following medications as ordered: 1. On 11/17/2023 - Divalproex Sodium 250 milligrams ([mg] a unit of measurement), once a day for seizures. 2. On 11/20/2023 - Risperidone 2 mg, twice a day for psychosis as manifested by visual hallucinations. 3. On 11/29/2024 - Invega 6 mg once a day for psychosis manifested by sudden angry outbursts. During a review of the facility's undated floor plan, the floor plan indicated Resident 1's room had access to an outside patio which had direct access to an alley. During a review of Resident 1's Situation Background, Assessment, and Recommendation ([SBAR] a communication tool between members of the health care team about a patient's condition) Elopement Report of Incident, dated 1/20/2024 and timed at 12:12 a.m., the SBAR indicated Resident 1 left the building (1/19/2024) without informing the staff. During a review of Resident 1's Nurses Notes dated 1/20/2024 and timed at 1:30 a.m., the Nurses Notes indicated on 1/19/2024 at 10:40 p.m., Resident 1 was seen sitting at the nurses' station. The Nursing Notes indicated at around 11:30 p.m., Resident 1 was not in his room nor in the building. The Nursing Notes indicated the surrounding area was searched and the resident was not located. During a review of Resident 1's Nurses Notes dated 1/20/2024 and timed at 11:20 a.m., the Nursing Notes indicated Resident 1 was accompanied back to the facility on [DATE] around 11 a.m., after being found at a laundromat, 0.4 miles away from the facility (approximately 11.5 hours after Resident 1 went missing). A physician's order was obtained to place a wander guard on Resident 1 for monitoring. During a review of Resident 1's Physician's Order dated 1/20/2024, the Physician's Order indicated to check placement of the wander guard bracelet every shift and check its function every week. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Elopement Evaluation dated 1/20/2024, the Elopement Evaluation indicated Resident 1 scored six (a score of 6 indicated Resident 1 was a high elopement risk). During a review of Resident 1's Care Plan, dated 1/20/2024, the Care Plan indicated Resident 1 was identified as a high risk for elopement related to a history of elopement and irritable behaviors as evidenced by excessive pacing for no apparent reason. The Care Plan's goal indicated Resident 1 would be safe while at the facility through a review date of 5/14/2024. The Care Plan's interventions included relocating Resident 1 closer to the nursing station for better monitoring and visual checks as needed, and to check Resident 1's wander guard placement and functioning. During a review of Resident 1's Social Service Notes dated 1/26/2024 and timed at 12:53 p.m., the Social Service Notes indicated Resident 1 verbalized to his Conservator that he had a plan to leave the facility when staff was not around. During a review of Resident 1's Social Service Notes dated 1/26/2024 and timed at 3:59 p.m., the Social Service Notes indicated Resident 1 verbalized he would escape if nobody was looking. During a review of Resident 1's Nursing Note, dated 1/31/2024 and timed at 6:30 p.m., the Nursing Note indicated Resident 1's wander guard was found on Resident 1's dresser. The Nursing Note indicated Resident stated the wander guard drove him crazy when he wore it, especially when the alarm went off when he went outside to smoke. During a review of Resident 1's Medication Administration Record (MAR) Note, dated 1/31/2024 and timed at 8:05 p.m., the MAR Administration Note indicated Resident 1 refused to wear the wander guard. During a review of Resident 1's clinical record, the Care Plan section indicated there was no Care Plan in place addressing Resident 1's behavior of taking his wander guard off or refusing to wear his wander guard. During a review of Resident 1's Physician's Order dated 3/30/2024, the Physician's Order indicated to administer Ativan 1 mg every 12 hours as needed for irritability as evidenced by excessive pacing for no apparent reason. During a review of Resident 1's MAR dated 4/2024, the MAR indicated Resident 1 received Ativan for irritability as evidenced by pacing for no apparent reason on the following dates and times: 1. On 4/1/2024, at 2:45 p.m. 2. On 4/2/2024, at 3 a.m. 3. On 4/3/2024, at 4:02 a.m. 4. On 4/5/2024, at 4:06 a.m. 5. On 4/6/2024, at 7:48 p.m. 6. On 4/8/2024, at 7:38 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/16/2024 at 6:27 p.m., the licensed vocational nurse (LVN 1) stated on 1/20/2024 Resident 1 eloped from the facility around 11:30 p.m. LVN 1 stated the facility staff did not know how Resident 1 eloped from the facility. LVN 1 stated on 4/13/2024 around 7:30 p.m., she heard CNA 1 yelling that Resident 1 was outside of the facility crossing the street. LVN 1 stated she did not recall hearing an alarm sound during her shift, but she did see Resident 1's wander guard lying on his bedside table, and it looked as if Resident 1 had ripped it off. During an interview on 4/17/2024 at 10:25 a.m., the MDS Nurse (a nurse who collects and assesses information for the health and well-being of residents) after reviewing Resident 1's Elopement Evaluation dated 12/29/2023 and Nursing Notes dated 1/31/2024, stated a care plan related to Resident 1's elopement risk should have been created as well as a care plan addressing Resident 1's behavior of refusing to wear his wander guard bracelet and taking it off. During an interview on 4/17/2023 at 12:02 p.m., the DON stated all staff are responsible for the safety of the residents, and anything could happen to a resident when they elope from the facility. The DON stated she was aware Resident 1 had a history of elopement, but they could not hold a resident against their will. During an interview on 4/18/2024 at 2:28 p.m., Resident 5 stated on 4/10/2024, Resident 1 had a court hearing to determine if he (Resident 1) could leave the facility. Resident 5 stated when Resident 1 returned from his court hearing, he was upset because he wanted to leave the facility and the court would not let him leave. Resident 5 stated Resident 1 carried a backpack which looked full and told him (Resident 5) I always gotta be ready to leave at any time. During an interview on 4/18/2024 at 4:21 p.m., with the ADM and the DON, the ADM stated, there was a potential for Resident 1 to be injured and/or killed since his whereabouts and health status were unknown. The DON stated, Resident 1 was not taking his psychiatric medications, and there was a potential for him to harm others and/or himself. During a telephone interview on 4/25/2024 at 1:53 p.m., Resident 1's Conservator stated Resident 1 was appointed a psychiatric conservatorship 12/2021 because of Resident 1's mental health disorder and being gravely disabled. The Conservator stated Resident 1 had no plan for self-care and could be a danger to himself and/or other's if he did not continue his medication regimen. The Conservator stated Resident 1 had a history of elopement which was discussed with the facility prior to his admission on 11/17/2023. The Conservator stated Resident 1 also had a history of alcohol and illegal drug abuse which placed Resident 1 at further risk of harming himself and/or others because he could consume substances not prescribed to him and he was not taking his prescribed medications. During a review of the facility's P&P titled, Incident & Accident Management Policy, revised 10/2011, the P&P indicated the purpose is to promptly acknowledge and manage facility incidents and accidents to ensure the medical needs of affected individuals are identified and addressed; to analyze contributing factors and environmental conditions that may be modified in order to provide a safe environment and reduce incidents of reoccurrence; to provide a process for tracking and trending incident data for improved quality of care and facility safety, as well as reduce legal risk to the facility. The P&P indicated an incident is defined as any event in which an injury was sustained by a resident .or may have the potential to cause injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Care Skilled Nursing Ctr	2725 Pacific Avenue Long Beach, CA 90806

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	During a review of the facility's P&P titled, Elopement and Missing Resident, dated 12/2027, the P&P indicated to monitor and evaluate residents at risk for wandering and elopement. The Interdisciplinary Team (IDT) is responsible for identifying residents at risk for elopement, implementing preventative measures to reduce risk, and provide a process for action if an incident of elopement occurs. The P&P indicated an elopement occurs when a resident leaves the premises or a safe area without authorization or staff notification and/or any necessary supervision to do so. The P&P indicated to initiate interventions to address resident's elopement risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
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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 0867

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45028

Based on interview, and record review, the facility's Quality Assessment and Assurance ([QAA] a committee that develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] a committee that takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to identify Resident 1's elopement (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision) on 1/19/2024. They failed to develop and implement appropriate plans of action to ensure the QAA/QAPI committee systematically implemented and evaluated measures to monitor, review, and analyze data for performance improvement regarding elopements to help prevent the reoccurrence of incidents of elopement and include person-centered interventions for residents who had a history of elopement and/or are assessed as an elopement risk.

This deficient practice resulted in Resident 1 eloping from the facility again on 4/13/2024. This deficient practice had the potential to affect other residents who were assessed as an elopement risk and/or As of 4/22/2024, Resident 1 is still missing.

Findings:

During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people) schizophrenia (a serious mental disorder in which people interpret reality abnormally), psychosis (when a person has trouble telling the difference between what's real and what's not) and absence of his right leg above the knee.

During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 2/20/2024, the MDS indicated Resident 1 was cognitively intact (a person who can follow two simple commands). The MDS indicated Resident 1 received antipsychotic (medication used to treat hallucinations [sights, sounds, smells, tastes, or touches that a person believes to be real but are not real] and delusions [false beliefs]) and antianxiety (medication used to treat symptoms of anxiety [feelings of fear, dread, uneasiness]) medication.

During a review of Resident 1's Conservatorship documents dated 11/22/2023, the Conservatorship documents indicated Resident 1 was gravely disabled (a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter) as a result of a mental health disorder (a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior).

During a review of Resident 1's Elopement Evaluation dated 12/29/2023, the Elopement Evaluation indicated Resident 1 scored one (a score of one or higher indicates a risk of elopement).

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's clinical record, the Care Plan section, indicated there was no care plan in place addressing Resident 1's history of elopement or his elopement risk, as assessed on 12/29/2023. During a review of Resident 1's Situation Background, Assessment, and Recommendation ([SBAR] a communication tool between members of the health care team about a patient's condition) Elopement Report of Incident, dated 1/20/2024 and timed at 12:12 a.m., the SBAR indicated Resident 1 left the building (1/19/2024) without informing the staff. During a review of Resident 1's Nurses Notes dated 1/20/2024 and timed at 1:30 a.m., the Nurses Notes indicated on 1/19/2024 at 10:40 p.m., Resident 1 was seen sitting at the nurses' station. The Nursing Notes indicated at around 11:30 p.m., Resident 1 was not in his room nor in the building. The Nursing Notes indicated the surrounding area was searched and the resident was not located. During a review of Resident 1's Nurses Notes dated 1/20/2024 and timed at 11:20 a.m., the Nursing Notes indicated Resident 1 was accompanied back to the facility on [DATE] around 11 a.m., (approximately 11.5 hours after Resident 1 went missing). A physician's order was obtained to place a wander guard on Resident 1 for monitoring. During a review of Resident 1's Physician's Order dated 1/20/2024, the Physician's Order indicated to check placement of the wander guard bracelet every shift and check it's function every week. During a review of Resident 1's Elopement Evaluation dated 1/20/2024, the Elopement Evaluation indicated Resident 1 scored six (a score of 6 indicated Resident 1 was a high elopement risk). During a review of Resident 1's Care Plan, dated 1/20/2024, the Care Plan indicated Resident 1 was identified as a high risk for elopement related to a history of elopement and irritable behaviors as evidenced by excessive pacing for no apparent reason. The Care Plan's goal indicated Resident 1 would be safe while at the facility through a review date of 5/14/2024. The Care Plan's interventions indicated to relocate Resident 1 closer to the nursing station for better monitoring and visual checks as needed, and to check Resident 1's wander guard placement and functioning. During a review of Resident 1's Social Service Notes dated 1/26/2024 and timed at 12:53 p.m., the Social Service Notes indicated Resident 1 verbalized to his Conservator that he had a plan to leave the facility when staff was not around. During a review of Resident 1's Social Service Notes dated 1/26/2024 and timed at 3:59 p.m., the Social Service Notes indicated Resident 1 verbalized he would escape if nobody was looking. During a review of Resident 1's Nursing Note, dated 1/31/2024 and timed at 6:30 p.m., the Nursing Note indicated Resident 1's wander guard was found on Resident 1's dresser. The Nursing Note indicated Resident stated the wander guard drove him crazy when he wore it, especially when the alarm went off when he went outside to smoke. During a review of Resident 1's Medication Administration Record (MAR) Note, dated 1/31/2024 and timed at 8:05 p.m., the MAR Administration Note indicated Resident 1 refused to wear the wander guard. (continued on next page)

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's clinical record, the Care Plan section indicated there was no Care Plan in place addressing Resident 1's behavior of taking his wander guard off or refusing to wear his wander guard. During a review of Resident 1's SBAR Elopement Report of Incident, dated 4/13/2024 and timed at 7:45 p.m. , the SBAR Elopement Report of Incident indicated Resident was previously seen by staff last at approximately 7:25 p.m. During a review of Resident 1's Nursing Note dated 4/13/2024 and timed at 7:45 p.m., the Nursing Note indicated on 4/13/2024 at around 7:30 p.m., Resident 1 was noted by staff outside of the facility and wheeling himself across the street. The Nursing Note indicated Resident 1's wander guard was discovered ripped and lying on top of Resident 1's side table. The Nursing Note indicated a search for Resident 1 was initiated outside of the facility and Resident 1 was not found. During a concurrent interview and record review on 4/18/2024 at 11:30 a.m., with the Administrator (ADM), the facility's QAA/QAPI Meeting Minutes, dated 3/15/2024, was reviewed. The QAA/QAPI Meeting Minutes indicated there were no incidents of elopement or residents with an elopement risk identified or addressed as a current issue during the QAA/QAPI meeting. The ADM stated an elopement was when a resident was missing from the facility for more than 24 hours and Resident 1 was missing from the facility on 1/19/2024 and was found on 1/20/2024, less than 24 hours and therefore he did not consider leaving the facility as an elopement and did not report to QAA/QA because Resident 1 was found on 1/20/2024 hence why the incident was not reported to the QAA/QAPI. During a review of the facility's Policy and Procedure (P&P) titled, Quality Assurance Performance Improvement Program, dated 11/2017, the P&P indicated one of the programs objectives is to provide a means where quality issues can be identified and resolve though the interdisciplinary approach and effective systems and positive outcomes can be reinforced. An objective of the program is to develop plans of correction and evaluate corrective actions taken to obtain desired results. During a review of the facility's P&P titled, titled Elopement and Missing Resident, dated 12/2017, the P&P indicated an elopement occurs when a resident leaves the premises or a safe area without authorization or staff notification and/or any necessary supervision to do so. The P&P indicated the Administrator report the incident to the facility quality committee for tracking and trending. During a review of the facility's Emergency Response Missing Resident/Elopement, updated 11/2023, the Emergency Response indicated the following procedure is utilized when a resident is determined to be missing. The P&P indicated to report the elopement to the Quality Assurance/Risk/Safety Committee.