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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055160	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion on Pico Healthcare & Wellness Centre, LP	5916 W. Pico Boulevard Los Angeles, CA 90035

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** 45455 Based on observation, interview, and record review, the facility failed to: 1. Ensure staff monitored, supervised, and were aware of the location of one of two residents with wandering behaviors for safety and prevent elopement (leaving the facility unsupervised and without staff knowledge). This deficient practices resulted in Resident 1, eloping (an unauthorized departure of a patient from an around-the-clock care setting) via the facility ' s front reception area doors during the afternoon on 7/3/2024 at 2 pm. Resident 1 was located the same day (7/3/24) at the resident's previous address 3.5 miles away from the facility and Resident 2 leaving the facility, increasing the risk for injury and harm related to accidents. 2. Ensure the wander-guard alarm (a device used as an additional layer of security that allows sensors on doors/exits to alarm if patients at high risk of elopement leave through them) failing to notify staff Resident 2 was leaving facility. This deficient practice had the potential for Resident 2 to elope/exit the facility undetected. Findings: On 7/9/2024 an unannounced visit was made to the facility to investigate a facility reported incident of alleged allegation of an Accident and neglect of a Resident. A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included toxic encephalopathy (a condition in which brain function is disturbed due to different diseases or toxins in the body), alcohol dependence (A long term disease in which a person craves drinks that contain alcohol and is unable to control his or her drinking), psychosis (symptoms that happen when a person is disconnected from reality.), anxiety disorder (disorder involves persistent and excessive worry that interferes with daily activities) and hypertension (high blood pressure). (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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NAME OF PROVIDER OR SUPPLIER Pavilion on Pico Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 5916 W. Pico Boulevard Los Angeles, CA 90035	

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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 Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 7/5/2024 indicated Resident 1's cognition (the mental ability to understand and make decisions of daily living) was severely impaired. required set-up or clean up assistance with eating. The MDS indicated Resident 1 required supervision or touching assistance with upper and lower body dressing and ambulation. A review of Resident 2's Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding, or following directions), alcoholic cirrhosis (to liver damage caused by excess alcohol intake), nicotine dependence(an addiction to tobacco products caused by the drug nicotine), Restlessness and agitation. A review of Resident 2's MDS, dated [DATE] indicated Resident 2's cognition was mildly impaired. The MDS indicated the resident required setup or clean-up assistance for eating, upper and lower body dressing. The MDS indicated Resident 2 was ambulatory. During an observation on 7/9/2024 at 11:55 AM Resident 2, with active wandering behavior and identified as at high risk for elopement, was observed wearing a wander-guard bracelet as the left the facility accompanied by the resident's family member. The family member signed Resident 2 out and exited the facility with Resident 2 for a doctor's appointment. Resident 2's wander-guard bracelet did not trigger the alarm system to notify facility staff that Resident 2 had left the facility. During an interview on 7/9/2024 at 10:42 AM with Certified Nurse Assistant 1 (CNA1), CNA1 stated Resident 1 was alert and was able to make needs known. CNA1 stated the resident was independent with eating, was continent bowel and bladder and ambulatory. CNA1 stated CNA1 noticed that on 7/3/24 at around 2 PM, Resident 1 was not in the dining room where Resident 1 usually stays after lunch. CNA1 stated she looked around the facility but could not find Resident 1. CNA1 stated she asked the facility staff (unidentified) if they had seen Resident 1, but no one had seen Resident 1. CNA1 stated the Minimum Data Set Nurse (MDSN) heard CNA1 asking the whereabouts of Resident 1, and the MDSN initiated code yellow (an overhead page code used by facility when a Resident cannot be found in the facility). CNA1 stated she and facility staff searched for Resident 1 but Resident 1 was not found by the time she clocked out of her shift at 3 PM on 7/3/2024. CNA1 further stated Resident 1 was a high risk for elopement and that the resident had a wander-guard bracelet on the wrist. CNA1 stated no alarms triggered when Resident 1 eloped from the facility. During an observation and interview on 7/9/2024 at 12:13 PM with the Maintenance Supervisor (MS), the MS stated he is responsible for monitoring the function of the Wander-guard system. The MS stated the wander-guard system was implemented by the facility on 3/1/2024 for Residents considered high risk for elopement. The MS stated the facility staff and/or the Director of Nursing (DON) notifies MS when a resident assessed as high risk for elopement is admitted to the facility. The MS stated MS activates an alarm bracelet and places the alarm bracelet resident identified as a [NAME] for elopement. The MS stated MS checks every exit in the facility everyday using a wander-guard alarm to ensure the alarms are functional and would go off when triggered. The MS was unable to answer when asked why the wander-guard alarm at the facility reception entrance did not immediately trigger during a random check except when the entrance door was manipulated on 3 separate occasions and when Resident 2 left the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/2024 at 2:56 PM with the DON, the DON stated on 7/3/2024 at 2 PM, CNA1 was unable to locate Resident 1 in the facility. The DON stated the facility staff were unsuccessful in finding Resident 1 after a code yellow was initiated. The DON stated on 7/3/2024 at 4 PM Resident 1's former landlord called the facility based on Resident 1's identification bracelet and informed the facility that Resident 1 was back at the resident last apartment. The DON stated facility Administrator and Director of staff development (DSD) drove to the address provided by the landlord, picked up Resident 1 and returned the resident to the facility at 5 PM on 7/3/2024. The DON stated Resident 1 did not have the wander-guard bracelet on the resident's wrist. The DON stated Resident 1 said the resident went to her apartment to pay rent. The DON stated Resident 1 was assessed from head to toe, no injuries or issues were identified during the assessment, 72hr was immediately initiated for Resident 1. The DON stated wander-guard did not activate when Resident 1 eloped from the facility using the reception door to exit. A review of facility P&P titled Wandering & Elopement dated 07/2017 indicated, facility will reinforce proper procedures for leaving the facility for Residents assessed to be at risk for elopement. Obtaining a pass out of the facility for proper procedures for Resident leaving the facility. A review of facility P&P titled signaling device dated 10/26/2023 indicated, a signaling device is an intervention utilized as part of a resident's plan of care when they have been identified as being at risk for elopement. Checking placement and functionality of the signaling device will be verified every shift, functionality of the signaling device should be verified daily, alarm functioning of the exit doors will be tested a minimum of weekly.