STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055526	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inglewood Health Care Center	100 S. Hillcrest Blvd Inglewood, CA 90301

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** 47042 Based on interview and record reviews, the facility failed to: 1. Follow their policy and procedure (P&P) titled, Resident Elopement (an instance of a patient or person in care leaving a care facility, or safe area independently without notifying anyone), which indicated, the facility will provide a safe environment and preventive measures for elopement. 2. Follow their policy and procedure (P&P) titled, Safety Supervision of Residents, which indicated, resident supervision is a core component of the systems approach to safety. As a result, one of three resdients, Resident 1, left the facility unsupervised. Findings: A review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated, Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's diagnoses included dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities), anxiety disorder (persistent and excessive worry that interferes with daily activities), hypertension (when the pressure in your blood vessels is too high), and osteoarthritis (a progressive joint disease, in which the tissues in the joint break down over time). A review of Resident 1's History and Physical (H&P), dated 5/20/2024, indicated Resident 1 did not have the capacity for medical decision making due to dementia. A review of Resident 1's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 5/23/2024, indicated Resident 1 was assessed to comprehend most conversation. The MDS indicated Resident 1 required supervision or touching assistance from staff for activities of daily living (ADLs) such as showering, dressing, putting on and off footwear, and needed set up assistance for personal hygiene, oral hygiene and eating. A review of Resident 1's care plan, titled At risk for elopement and wondering out of the facility related to wanting to go home, wandering without purpose, exit seeking behavior due to dementia. The interventions indicated check the resident's whereabouts. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	A review of Resident 1's Elopement Risk Assessment, dated 5/19/2024, the elopement risk assessment indicated Resident 1 was at risk of wandering and elopement. A review of Resident 1's physician's order dated 5/17/2024, the physician's order indicated donepezil (medication to treat certain mental/mood disorders such as dementia) 10 milligrams ([mg] unit of measurement), once daily (QD), amlodipine (high blood pressure medication) 5 mg, 1 tablet daily (QD), potassium chloride (medication to treat hypokalemia [low potassium an important body chemical. this problem can result in fatigue, muscle cramps, and abnormal heart rhythms). An order was placed for a wander guard to the right wrist (a bracelet placed on for elopement precautions). During an interview on 6/20/2024 at 12:10 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 1 was not in the bed when I started my shift, a coworker told me Resident 1 likes to be in the activity room. CNA 2 stated I did not put eyes on Resident 1. CNA2 stated I never heard the alarm from the wander guard go off. During an interview on 6/20/2024 at 1:15 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, the resident was noticed missing at 5:30 p.m. where we immediately called a code, started the search. LVN 3 stated, resdients who are at high risk for wandering have a wander guard placed on them so when they get close to an exit they alarm will sound. LVN 3 stated, no I do not remember hearing the alarm go off. LVN 3 stated, it is important to check and supervise residents at risk for elopement. LVN 3 stated if this is not done it is a safety issue and we need to keep the resdients safe. During an interview on 6/20/2024 at 3:22 p.m., with Director of Nursing (DON), the DON stated, when residents are assessed to be high risk an order is obtained from the physician and a wander guard is placed on the resident. The DON stated a wander guard was placed on Resident 1 on 5/18/2024. The DON stated, when a resident has on a wander guard it should alarm as soon as the resident gets to close to the door, the day Resident 1 left the facility no one heard the alarm go off. The DON further stated the resident was found. A review of the facility's policy and procedure (P&P) titled, Resident Elopement, (undated), the P&P indicated, the facility will provide a safe environment and preventive measures for elopement. A review of the facility's policy and procedure (P&P) titled, Safety Supervision of Residents, (undated), the P&P indicated, Resident safety and supervision and assistance to prevent accidents are company-wide priorities. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Risk factors and environmental hazards include unsafe wandering.