

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Pasadena Grove Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1470 N Fair Oaks Ave Pasadena, CA 91103	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on observation, interview and record review, the facility failed to ensure:</p> <p>1 and 2. Monitoring of placement and function of the WanderGuard (a monitoring device [bracelet] that alarms when a resident tries to exit out of the door) for two of two residents (Resident 1 and 2) as indicated in the physician's order and care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs).</p> <p>3. There was a system in place to test the WanderGuard bracelet for functionality as indicated in the WanderGuard manual.</p> <p>These failures placed Resident 1 and Resident 2 at risk for elopement (when a resident who is incapable of adequately protecting him/herself, departs the health care facility unsupervised and undetected) and risk of injury and harm.</p> <p>Findings:</p> <p>1. A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), schizophrenia (a severe mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions), major depressive disorder (MDD - a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety disorder (a group of mental disorders characterized by significant feelings of fear) and generalized muscle weakness (lack of muscle strength requiring extra effort to move)</p> <p>A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 2/20/2024, indicated Resident 1 has an impaired cognitive (ability to think, remember, reason) skills for daily decision making. Resident 1 required moderate assistance (staff does less than half the effort to complete activity) with eating, oral hygiene and dressing and maximal assistance (staff does more than half the effort) with toileting, bathing and personal hygiene. The MDS also indicated a wander/elopement alarm was used daily for Resident 1.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1's History & Physical (H&P), dated 12/31/2023, indicated Resident 1 does not have the capacity to understand and make decisions.</p> <p>A review of Resident 1's Elopement Risk Assessment, dated 2/15/2024, indicated Resident 1 with an elopement score of 9 (at risk to wander).</p> <p>A review of Resident 1's Order Summary, dated 5/17/2024, indicated an order to monitor the placement and function of WanderGuard every shift started 3/8/2024.</p> <p>A review of Resident 1's Risk for Elopement care plan revised 11/22/2023, indicated for indicated monitoring for placement and function of the wanderguard (to ankle) every shift.</p> <p>During an observation on 5/17/2024 at 2:34 PM at Resident 1's bedside with Licensed Vocational Nurse (LVN), a WanderGuard was observed on Resident 1's right ankle.</p> <p>During a concurrent record review and interview on 5/17/2024 with the Director of Nursing (DON) at 3:27 PM, Resident 1's Medication Administration Records (MAR) for 3/2024 through 5/2024 were reviewed for Resident 1. The DON stated there was no documented evidence on the MAR from 3/2024 through 5/17/2024 of monitoring the placement and function of the WanderGuard as indicated in Resident 1's order summary and care plan. The DON stated there is no documentation to indicate staff have monitored the function and placement of Resident 1's WanderGuard every shift as indicated in the doctor's order.</p> <p>2. A review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility 7/28/2023 with diagnoses that included schizophrenia, bipolar disorder (a mental illness that causes unusual shifts in mood, energy, and concentration), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life), encephalopathy (a broad term for any brain disease that alters brain function or structure) and abnormalities of gait (walking) and mobility (movement).</p> <p>A review of Resident 2's MDS, dated [DATE], indicated Resident 2 has an impaired cognitive skills for daily decision making. Resident 2 required moderate assistance with eating, oral hygiene, toileting, personal hygiene and dressing and maximal assistance (staff does more than half the effort) with bathing. The MDS also indicated a wander/elopement alarm was used daily for Resident 2.</p> <p>A review of Resident 2's Elopement Risk Assessment, dated 4/29/2024, indicated Resident 1 with an elopement score of 9 (at risk to wander).</p> <p>A review of Resident 2's Order Summary, dated 5/17/2024, indicated an order to monitor the placement and function of WanderGuard every shift started 11/6/2023.</p> <p>A review of Resident 2's Risk for Elopement care plan revised 11/9/2023, indicated monitoring for placement and function of the WanderGuard (to right ankle) every shift.</p> <p>During a concurrent observation at Resident 2's bedside and interview on 5/17/2024 at 2:47 PM with Registered Nurse Supervisor (RNS), a WanderGuard was observed on Resident 2's right ankle. RNS stated the wanderguard's battery lasts long and the staff monitor the function by only testing the wanderguard before it is applied to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent record review and interview on 5/17/2024 with Director of Nursing (DON) at 3:35 PM, Resident 2's MAR for 3/2024 through 5/2024 were reviewed for Resident 2. The DON stated there was no documented evidence on the MAR of monitoring the placement and function of the WanderGuard as indicated in Resident 2's order summary and care plan. The DON stated there was no documentation to indicate staff have monitored the function and placement of Resident 2's WanderGuard every shift as indicated in the doctor's order.</p> <p>3. During an interview on 5/17/2024 at 3:41 PM with Administrator, Administrator stated maintenance staff checks the function of the Wanderguard system on the doors, but Administrator was not aware of how the facility monitors the function of the Wanderguard (bracelets) once applied to the residents, and the facility does not have a process to check the function. The Administrator also stated the importance of checking the function is to make sure it works and residents who were at risk of eloping (leaving the facility unknown to the staff) are not able to elope and will be free from injury.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Wanderguard System, dated 2/22/2024, the P&P indicated the purpose of the WanderGuard System is to ensure the safety and security of residents at risk of wandering, the facility will minimize any possible injury because of elopement and the Wanderguard (bracelet) are to be checked daily by every shift and documented on the Resident's MAR.</p> <p>A review of the 430 KHz Adult Transmitter User Guide [Wanderguard], dated 2/14/2022, indicated each transmitter should be tested daily to ensure it is working properly and a documented test of each transmitter must be made each day.</p>		