

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2024
NAME OF PROVIDER OR SUPPLIER Long Beach Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2615 Grand Avenue Long Beach, CA 90815	

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</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** 45777</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident, who was assessed as a high-risk for wandering, did not elope (when a resident leaves a facility without supervision nor authorization) from the facility for one of three sampled residents (Resident 1). The facility failed to:</p> <ol style="list-style-type: none"> Supervise Resident 1 by conducting observations of Resident 1's whereabouts and monitor the resident every shift for episodes of wandering or attempting to elope from the facility as indicted in the resident's untitled Care Plan dated 8/20/2024. Ensure staff responded to the entrance/exit door alarm as Resident 1 was leaving the facility through. Ensure staff followed the facility Procedure and Policy (P&P) titled Wandering Unsafe Resident and have a detailed monitoring plan in place to always know the whereabouts of Resident 1. <p>These deficient practices resulted in Resident 1 leaving the facility unnoticed and placed the resident at risk for unsafe environmental conditions, including extreme heat and/or cold, possible motor vehicle accident, and medical complications such as stroke (a medical emergency a bleeding in the brain due to uncontrolled high blood pressure [force of blood pushing against the walls of blood vessels]) due to missing her high blood pressure medications from 11/4/2024. Resident 1 was found on 11/15/2024 in the neighborhood where her family lives. Resident 1 refused to come back to the facility and refused to be assessed by the Emergency Medical Transport (EMT).</p> <p>On 11/8/2024 at 11:06 a.m., an Immediate Jeopardy ([IJ] a situation in which the facility'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 Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to have a system in place to monitor Resident 1's whereabouts and prevent Resident 1's elopement from the facility.</p> <p>On 11/9/2024 the facility submitted an acceptable IJ removal plan (IJRP). After onsite verification of the IJRP implementation through observation, interviews, and record review, the IJ was removed on 11/9/2024 at 11:06 a.m., in the presence of the ADMIN and the DON.</p> <p>The IJRP included the following immediate actions:</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. As of 11/9/2024, Resident 1 has not returned to the facility. The facility has implemented the following measures to locate the resident:</p> <p>a. Local Police Department was notified. A description of Resident 1 was provided, and a missing person's report was filed on 11/5/2024.</p> <p>b. Local hospitals in surrounding areas have been called and facility staff will continue to call in search of the resident.</p> <p>c. Resident 1's responsible party (RP) was notified on 11/5/2024. The RP stated that she does not expect a call from Resident 1, as Resident 1 usually waits a few days before she contacts family. The DON will call RP daily for updates.</p> <p>d. Staff will continue to search for resident in the vicinity of the facility, as well as in areas that the responsible party has mentioned Resident 1 frequents.</p> <p>2. Assigned a Certified Nurse Assistant (CNA) as a Rounder to document at least every hour to identify the whereabouts of the residents who are assessed as a risk for wandering and elopement. The CNA Rounder will document at least hourly on the Resident Location Tracking log to indicate the location of the residents who are assessed as a risk for wandering and elopement. Started on 11/9/2024.</p> <p>3. Each facility exit door is equipped with a security camera on the outside for monitoring for the safety and wellbeing of the residents. The Administrator, the DON, and/or Registered Nurse (RN) Supervisor will be responsible for monitoring video footage. The RN Supervisor is scheduled 24 hours a day, every day of the week. Started 11/8/2024.</p> <p>4. The front entrance/exit door had an alarm that was not clearly audible due to a second set of glass doors that lead into the building, which muffled the sound of the alarm on the entrance/exit door. After identifying the root cause of the failure (of Resident 1's successful elopement), the glass doors were outfitted with an audible door alarm that will set off a piercing horn sound when a door is opened after the alarm has been activated. When the activated alarm sounds, all staff in the immediate area will attend to it. Started on 11/6/2024.</p> <p>5. A facility staff (Door Monitor) was assigned to provide continuous 24-hour supervision of the exit door located between stations B and C, where staff enter/ exit the facility. Started on 11/8/2024.</p> <p>6. The RN Supervisor will be responsible for activating/ deactivating door alarms. The RN Supervisor is scheduled, every day of the week 24 hours a day starting 11/8/2024. The RN Supervisor will conduct rounds at least every two hours to ensure exit doors are properly secured and alarmed. They will document their findings on the Door Alarm Log.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>7. The DON initiated in-services to licensed nurses, CNAs, and registry staff regarding the facility's systems on resident supervision and elopement prevention for the wander guard (a wearable device that triggers alarms if close by an exit) system, exit door alarms, security cameras, and Resident Location Tracking log starting on 11/8/2024. The DON initiated in-services with non-nursing staff, which includes dietary, housekeeping, activities, and administrative staff, on the facility's systems on resident supervision and elopement prevention. The DON initiated in-services to RN Supervisor regarding conducting rounds at least every two hours to ensure exit doors are properly secured and alarmed and proper use of the Door Alarm Log.</p> <p>8. Staff in-serviced on the need to follow up, develop and implement a care plan for residents who were assessed as a risk for wandering.</p> <p>9. A Resident Location Tracking log was implemented to document the visual checks at least hourly of each resident who is at risk for wandering and elopement. The log indicates the location of the resident during the hourly rounds. A CNA assigned as a Rounder will document at least every hour on the Resident Location Tracking log to identify the whereabouts of the residents who are assigned as a risk for wandering and elopement starting 11/9/2024.</p> <p>10. Each exit door is outfitted with an audible door alarm that will set off a piercing horn sound when a door is opened after the alarm has been activated. The RN Supervisor who is scheduled 24 hours a day will be responsible for activating/ deactivating door alarms. When the activated alarm sounds, all staff in the immediate area will respond to it starting 11/8/2024.</p> <p>11. The DON initiated reassessment of 147 residents in the facility and identified those who are at high risk for wandering and elopement.</p> <p>a. Care plan revisions were done for all 33 residents who were identified as high risk for wandering and elopement on 11/9/2024.</p> <p>b. Developed a list of residents who are at high risk for wandering and elopement. The list is now made available at each station for all incoming staff. At the beginning of each shift, all staff will attend a huddle (a quick meeting to share important information), where the licensed nurse will inform staff of the location of the list. The Director of Staff Development (DSD) and/or designee will inform all registry staff prior to the start of their shift of the location of the list. Started on 11/8/2024.</p> <p>c. At the beginning of each shift, a huddle will be conducted by the licensed nurse to communicate with all incoming staff which residents are at risk for wandering and elopement. Started on 11/8/2024.</p> <p>d. On 11/8/2024, the DON initiated in-services to licensed staff regarding the list of residents who are at risk for wandering and elopement.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Notes dated 11/5/2024, the Progress Notes indicated on 11/4/2024 between 9:30 p.m. and 10:30 p.m., Certified Nursing Assistant (CNA 2) was unable to locate Resident 1 within the facility. On 11/4/2024 at 11:20 p.m., CNA 2 reported that Resident 1 was missing to Licensed Vocational Nurse (LVN 2). CNA 2 and LVN 2 did not find Resident 1 but found Resident 1's wander guard with the strap broken on her bed side table. The facility staff searched for Resident 1 inside the facility and the surrounding areas outside to locate Resident 1 did not find the resident.</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility initially admitted Resident 1 to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a chronic and severe mental disorder that affects how the person thinks, feels, and behaves) unspecified, psychosis (a condition that affects the way your brain processes information), paraplegia (the inability to voluntary move the lower parts of the body) and hypertension (high blood pressure).</p> <p>During a review of Resident 1's history and physical (H&P), dated 8/21/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] resident assessment tool), dated 8/30/2024, the MDS indicated Resident 1 required substantial/maximal assistance (helper lifts or hold trunk of limbs and provides more than half the effort) with putting on and taking off footwear and personal hygiene. The MDS indicated Resident 1 used a wheelchair for mobility.</p> <p>During a review of Resident 1's Initial Wandering assessment dated [DATE], the Initial Wandering Assessment indicated the resident had a history of wandering and required frequent monitoring.</p> <p>During a review of Resident 1's Psychiatric (involving mental illness or its treatment) Follow Up Note dated 10/24/2024, the Psychiatric Follow Up Note indicated Resident 1 had episodes of auditory hallucinations (hearing sounds that are not based in reality).</p> <p>During a review of Resident 1's Physician's Order dated 11/1/2024, the Physician's Order indicated for Resident 1 to receive Amlodipine Besylate Oral tablet 5 milligrams ([mg] a unit of measurement of mass) one time daily for hypertension (high blood pressure).</p> <p>During an interview and record review on 11/7/2024 at 10:39 a.m., with LVN 3 and the Director of Nursing (DON) a, Resident 1's Initial Wandering assessment dated [DATE] was reviewed. The assessment indicated Resident 1 had a score of three which indicated Resident 1 had a history of wandering and required frequent monitoring. LVN 3 stated he did not know what severity a score of three meant. The DON stated that any score above a one indicated a risk for elopement. The DON stated a score of three meant the resident was at high risk for wandering and elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's untitled Care Plan dated 8/20/2024, the Care Plan indicated Resident 1 had a potential for injury and or accidents related to wandering or attempting to leave the facility unassisted. The goals set for Resident 1 included the resident's potential for injury and or accidents related to wandering or attempting to leave the facility would be minimized daily, with a target date of 11/30/2024. The Care Plan interventions included constant observations of Resident 1's whereabouts, monitor for episodes of wandering or attempting elopement every shift (tally by episodes), redirection, cueing as appropriate and apply Wander Guard alarm (system to alarm staff of a potential elopement when resident attempts to get out of the facility) device and monitor Wander Guard device every shift for placement.</p> <p>During a tour of the facility on 11/6/2024 at 11:00 a.m., a total of six exit doors were observed.</p> <p>During an observation on 11/6/2024 at 11:05 a.m. of Door 1, was a front visitor entrance, Door 1 was equipped with a wander guard monitor sensor and a code padlock (needs a pass code to open the doors).</p> <p>During an observation on 11/6/2024 at 11:07 a.m., Door 2 East, Door 2 was equipped with a wander guard monitor sensor and a code padlock.</p> <p>During an observation on 11/06/2024 at 11:10 a.m., of Door 3, Door 3 was equipped with a wander guard monitor sensor and a code padlock.</p> <p>During an observation on 11/06/2024 at 11:12 a.m., of Door 4, Door 4 was equipped with a wander guard monitor sensor and a code padlock.</p> <p>During an observation on 11/06/2024 at 11:15 a.m. of Door 5, Door 5 was located by Resident 1's room and led to the parking lot. The facility staff use Door 5 to enter and leave the building. Door 5 did not need a pass code to be open and to leave through the door one must press the push bar on the door for 15 seconds to unlock the door, and the alarm will sound for 15 seconds then shuts off.</p> <p>On 11/6/2024 at 12:41 p.m., during an interview with CNA 2, CNA 2 stated that staff are supposed to do a head count of the residents every two hours. CNA 2 stated that Resident 1 liked to use her wheelchair to wheel herself in the middle and around the building. CNA 2 stated that staff check the exits for wandering residents when they hear the alarms but there are alarms going off all the time in the facility, she was not sure if someone responded when Resident 1 left.</p> <p>On 11/6/2024 at 1:00 p.m., during an interview with LVN 2, LVN 2 stated that the Wander Guards are used for residents that attempt to elope. LVN 2 stated that the 3:00p.m. - 11:00 p.m. shift had checked the Wander Guards for function on 11/4/2024, and they were functional.</p> <p>During a telephone interview on 11/6/2024 at 1:40 p.m., CNA 1 stated she was Resident 1's nurse on 11/4/2024 from 3:00 p.m. to 10:30 p.m. CNA 1 stated she asked Resident 1 at 9:00 p.m., if she was ready for bed and Resident one refused. CNA 1 stated Resident 1 wanted to stay in her wheelchair which was very unusual. CNA 1 stated the last time she saw Resident 1 when she was sitting at the nursing station which is close to the employee entrance /exit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/7/2024 at 4:58 p.m., the DON stated that the facility relied to much on the Wander Guard system to keep residents from eloping. The DON stated the facility should have also implemented additional interventions such as hourly monitoring of resident's whereabouts, designate staff to monitor the entrance and exits, and designated staff to monitor the hallways. The DON stated there was no documentation to indicate Facility staff were monitoring Resident 1, frequently.</p> <p>During a review of the facility's policy and procedure (P/P) titled Wandering Unsafe Resident undated, the P/P indicated the facility will identify residents at risk for harm because of unsafe wandering (including elopement) and staff will include a detailed monitoring plan, as indicated for residents who are assessed to have a high risk for elopement.</p>