STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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** 36395 Based on observation, interview and record review, the facility failed to prevent elopement (when a resident leaves the facility unsupervised and unnoticed by staff) for one of three sampled residents (Resident 1). For Resident 1, who was assessed as high risk for elopement and had a wander guard bracelet (a monitoring device that would emit an audible alarm to warn staff when a resident leaves the facility), the facility failed to: 1. Respond immediately when the wander guard alarm was triggered and emitted an audible alarm when Resident 1 walked out the front door of the facility on 5/19/24 at 11:53 a.m. and out to the community. 2. Provide Resident 1 with adequate supervision. These deficient practices resulted in Resident 1 eloping from the facility on 5/19/24 at 11:53 a.m. and placed Resident 1 at risk for injuries and harm while out in the community. Findings: A review of the Admission Record indicated the facility admitted Resident 1 on 1/5/24 and readmitted the resident on 2/28/24, with the diagnoses including dementia (loss of the ability for the brain to function in thinking, remembering, and reasoning and can interfere with a person's daily life and activities), delusional disorders (mental illness in which a person have false or unrealistic beliefs), and psychosis (loss of contact with reality). A review of Resident 1's Minimum Data Set (MDS, standardized assessment and care screening tool) dated 4/9/24, indicated Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 needed substantial (helper does more than half the effort) assistance with shower, partial assistance (helper does less than half the effort) with toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene, and supervision (helper provides verbal cues) with eating, oral hygiene, and upper body dressing. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Wandering and Elopement Risk Assessment, dated 4/11/24, indicated Resident 1 was at moderate risk for wandering and elopement behaviors. Resident 1 was able to walk independently and with behavior of seeking exit door or attempting to go out of the facility. Resident 1's physician was notified and gave order to monitor Resident 1 and apply wander guard bracelet on the resident. A review of Resident 1's Physician Orders, dated 4/11/24, at 9:01 a.m., indicated to apply wander guard bracelet to Resident 1's right wrist for monitoring of Resident 1 due to risk for wandering/elopement. A review of Resident 1's Care Plan, initiated on 1/8/24 and updated on 4/11/24, indicated Resident 1 was an elopement risk/wanderer due to disorientation, impairedsafety awareness, and aimless wanders. The care plan goal indicated Resident 1's safety will be maintained, and Resident 1 will not leave the facility unattended. The interventions included [to] apply wander guard bracelet to wrist for monitoring due to risk for wandering/elopement and monitor behavior of wandering every shift. A review of the Nurses Notes dated 5/19/24 at 4 p.m., indicated on 5/19/24 at 12:20 p.m. the certified nursing assistant (CNA) reported that Resident 1 was not found during a routine check. The Notes indicated the facility searched for Resident 1 immediately and could not find Resident 1. The same Notes indicated the facility surveillance camera video recording indicated Resident 1 left the faciity on [DATE] at 11:53 a.m. The police department was notified and at 3:20 p.m., the police found Resident 1. The Police took Resident 1 back to the facility. The Notes indicated, due to dementia, Resident 1 was unable to tell what happened. Resident 1 was assessed and had no injury. Resident 1's primary physician was notified and gave order to transfer Resident 1 to the general acute hospital (GACH 1) for evaluation. A review of the Nurses Notes dated 5/20/24 at 11:48 a.m., indicated Resident 1 was readmitted from GACH 1 on 5/20/24 at 5 a.m. with no new orders. During a telephone interview on 6/17/24 at 12:12 p.m., licensed vocational nurse (LVN 1) stated Resident 1 eloped on 5/19/24 while LVN 1 was on his lunch break. LVN 1 stated Resident 1 was wearing the wander guard bracelet. LVN 1 stated when he returned from his break, he noticed Resident 1's lunch tray untouched and went looking for Resident 1. LVN 1 stated all staff were alerted and searched for Resident 1 inside and outside of the facility but was unable to find Resident 1. LVN 1 stated the police was notified. During a concurrent interview on 6/17/24 at 12:23 p.m., the surveillance camera video recording dated 5/19/24 was reviewed with director of nursing (DON). The video recording showed on 5/19/24 at 11:53:15 a.m., Resident 1 pushed the front door in the reception area, exited the facility, walked down the ramp, opened the gate leading to the main street and had disappeared from the view of the camera at 11:53:58 a.m. The wander guard alarm was heard emitting an alarm and continued to be audible for 43 seconds. No facility staff was seen in the recording. DON stated, when an alarm goes off everybody has to run to see what is going on. (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 6/17/24 at 12:33 p.m., the medical record director (MRD) stated he was at the front desk covering for the receptionist who was at lunch. MRD stated he did not see Resident 1 leave the facility because he was on a phone call. MRD stated when the wander guard alarm was triggered, he thought it was the alarm by the stair/elevator door that was triggered, and he reset the alarm. However, the MRD stated the alarm kept going off , and MRD stated he proceeded to look out the front door in the lobby, looked both ways and did not see anyone. MRD came back inside the facility, reset the alarm, and stayed in the front desk until the receptionist returned from lunch. MRD stated he did not tell anyone that the wander guard alarm had been triggered. MRD further stated he was informed that Resident 1 eloped about 30 minutes after the receptionist returned. MRD stated Resident 1 could have taken the bus and could have been dumped somewhere . MRD stated he should have acted right away when the alarm went off . During the follow-up interview on 6/17/23 at 2:15 p.m., DON stated when the wander guard alarm was triggered on 5/19/24 at 11:53 a.m., the MRD did not tell anyone that the alarm was triggered. DON stated the MRD should have looked in the main nursing station where the alarm display panel was and inform the nurses that the alarm was triggered . but I don't see anyone, can you check if there is any possibility a resident eloped . DON stated when an alarm goes off all staff should respond as soon as possible. DON further stated it is not safe for Resident 1 to go out of the facility by himself. A review of the facility's Policy and Procedure (P&P) titled, Wandering and Elopement, reviewed on 1/19/24, indicated the facility will enhance the safety of residents of the facility. The same Policy also indicated the facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement. Facility staff will reinforce proper procedures for leaving the facility for residents assessed to be at risk of elopement.