

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Long Beach Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Walnut Avenue Long Beach, CA 90813	

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 - 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** 44958</p> <p>Based on interview and record review, the facility failed to ensure a resident, who was newly admitted to the facility, from a psychiatric facility, was supervised, and monitored to prevent one out of three sampled residents (Resident 1) from eloping (leaving a secured institution without notice or permission) from the facility. Resident 1 was last seen in the facility on 10/4/2024 at approximately 8:30 p.m., on the facility ' s patio, smoking. Resident 1 was noted missing on 10/4/2024 at approximately 9 p.m., and found at his family ' s residence, 22 miles away on 10/5/2024 at 5:30 a.m.</p> <p>This deficient practice resulted in Resident 1 eloping from the facility on 10/4/2024 at approximately 9 p.m. and missing for over eight hours. This deficient practice had the potential for Resident 1 ' s whereabouts to continue to be unknown, for Resident 1 to be exposed to excessive drops in temperature, motor vehicle accidents, hunger, dehydration, and death.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and with diagnoses including schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and anxiety disorder (a mental illness causing persistent fear and/or worry).</p> <p>During a review of Resident 1 ' s History and Physical (H/P), dated 9/23/2024, the H/P indicated, Resident 1 did not have the capacity to make medical decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set [(MDS), a standardized assessment and screening tool], dated 9/29/2024, The MDS indicated, Resident 1 was admitted from a psychiatric facility. The MDS indicated Resident 1 was able to understand and be understood by others, with moderate cognitive impairment (ability to register and recall information). The MDS indicated Resident 1 had no functional limitations in range of motion ([ROM] the direction a joint can move to its full potential).</p> <p>During a review of Resident 1 ' s Nurse Progress Note, dated 10/4/2024, the Nurse Progress Note indicated Resident 1 was noted missing after a head count was conducted.</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 - Few</p>	<p>During a review of Resident 1 ' s Nurse Progress Note, dated 10/5/2024 and timed at 7:50 a.m., the Nurse Progress Note indicated Resident 1 arrived at his family ' s house (located approximately 22 miles away from the facility location) at 5:30 a.m., (eight hours and 30 minutes after Resident 1 was found missing from the facility).</p> <p>During an interview on 10/8/2024 at 4:28 p.m., Registered Nurse 1 (RN 1) stated on 10/4/2024 at approximately 9 p.m., she was notified by a staff person (identity unknown), that Resident 1 could not be located during the headcount. RN 1 stated Resident 1 was last seen on the patio during the smoke break at approximately 8 p.m. to 8:30 p.m. RN 1 stated she did not know how Resident 1 eloped from the facility.</p> <p>During a telephone interview on 10/9/2024 at 9 a.m., Resident 1 ' s Responsible Party (RP) stated Resident 1 arrived at her residence on 10/5/2024 at approximately 5:30 a.m., on foot, he appeared weak and incoherent (not able to express themselves clearly). The RP stated she called the facility and spoke with RN 2, who instructed her to take Resident 1 to a General Acute Care Hospital (GACH) for evaluation and treatment.</p> <p>During an interview on 10/10/2024 at 10:42 a.m., the Activity Assistant (AA 1) stated on 10/4/2024 at approximately 8:30 p.m., he saw Resident 1 on the patio during the smoke break after he gave Resident 1 a cigarette. AA 1 stated he was the only staff person on the patio during that time with about 20 residents and he did not see Resident 1 because he (AA 1) was attending to other residents who were waiting to receive and have their cigarettes lit. AA 1 stated it was not sufficient for one staff person to monitor all the residents during smoke breaks. AA 1 stated once Resident 1 received his cigarette he walked behind him (AA 1) and he (AA 1) lost sight of Resident 1, and he did not know how Resident 1 eloped from the facility but thought he might have climbed over a gate on the smoking patio.</p> <p>During an interview on 10/10/2024, at 2:18 p.m., with the DON, the ADM, the Maintenance Supervisor (MS), and the Director of Staff development (DSD), the DON stated it was important for all residents on the patio to be supervised to ensure the residents were safe and secure. The DON, ADM and DSD stated they felt one person monitoring residents on the patio during the smoke break was sufficient to provide adequate supervision to the residents. The DSD stated CNA 1 and a security guard were assigned to make rounds throughout the facility. The DSD stated the nursing staff who work inside the facility were able to see the residents who were on the patio through the windows that overlooked the patio and they had never had a problem with this system. The DSD stated if additional staff were designated to supervise the patio, it would decrease the amount of staff available to attend to the residents who remained inside the facility. The DON, DSD and the ADM stated they did not know where Resident 1 went after being seen on the patio at approximately 8:30 p.m. The ADM and DON stated they did not know how Resident 1 was able to elope from the facility.</p> <p>During an interview on 10/10/2024 at 3:42 p.m., CNA 1 stated on 10/4/2024 she made rounds and conducted a head count every 30 minutes to ensure all residents were accounted for. CNA 1 stated the last time she saw Resident 1 was at approximately 7:45 p.m. before the 8 p.m., smoke break, and at approximately 8:55 p.m., she inspected Resident 1 ' s room and could not locate him. CNA 1 stated she was assigned to monitor the area near Nursing Station 1, not the patio area and viewing the residents on the patio from inside the building through the windows that overlooked the patio did not provide adequate supervision for the residents because the patio has blind spots and at night, it was dark.</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 - Few</p>	<p>During a review of the facility ' s Patio Monitoring Log, dated 10/4/2024, the Patio Monitoring Log indicated at 8 p.m. to 8:30 p.m., one staff person member was assigned on the patio and from 8:30 p.m. to 9 p.m., the Patio Monitoring Log had no designated staff person assigned to the patio.</p> <p>During a review of the facility ' s Follow Up Investigation Report, dated 10/10/2024, the Follow Up Investigation Report indicated Resident 1 possibly scaled the fence and left the facility between 8:45 p.m. to 9 p.m., after the final smoke break.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled, Safety and Supervision of Residents, dated 5/2015, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated resident supervision is a core component of the systems approach to safety, the type and frequency of the supervision may vary among residents and over time for the same resident.</p> <p>During a review of the facility ' s, Facility Assessment (a review of a nursing home's resources and capabilities to care for residents), dated 7/21/2024, the Facility Assessment indicated the facility maintains adequate staffing necessary to ensure shift to shift coverage was provided for all needs and services.</p>		