STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to implement care plan intervention to monitor routinely, one of three residents (Resident 1), to prevent from leaving the facility unsupervised by failing to specify: a. The type of supervision (the act of watching) Resident 1 needed after he eloped (when a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired leaves a care-giving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge) from the facility on 6/19/2024 and 8/24/2024. b. How often Resident 1 would be monitored (watched), daily. This failure resulted in Resident 1 eloping from the facility and placed the resident at risk for medical complications, such as hypertensive crisis (dangerously high blood pressure), diabetic coma (loss of consciousness due to uncontrolled blood sugar), stroke (loss of blood flow to a part of the brain), behavioral crisis (inability to control oneself, becoming a danger to themselves or others), embolism (blockage of blood flow in the body), sepsis (a life-threatening blood infection), malnourishment (lack of food), motor vehicle accident, and death. On 10/21/2024, Resident 1 had still not been found. On 10/16/2023 at 5:10 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of Director of Nursing (DON) and Administrator (Admin) due to the facility ' s failure to implement care plan intervention to monitor Resident 1 routinely, to prevent Resident 1 from leaving the facility unsupervised, for the third (3rd) time. On 10/17/2024 at 4:58 p.m., the facility submitted an acceptable IJ removal plan ([IJRP] interventions to immediately correct the deficient practices). After verification of IJRP implementation through observation, interview, and record review, the IJ was removed onsite on 10/18/2024 at 10:30 a.m., in the presence of the Admin and DON. The IJRP included the following immediate actions: (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1). On 10/16/24, the DON contacted the physicians of residents identified for being at risk for wandering (roaming) /elopement to obtain orders to monitor each resident every (q) 2 hours. On 10/17/24, the DON contacted the physicians of the residents identified with history of elopement to obtain orders to monitor each resident q 1 hour. Residents with history of elopement: Resident 1 - monitor q1 hour Resident 4 - monitor q1 hour Resident 5 - monitor q1 hour Resident 9 - monitor q1 hour Residents identified to be at risk for elopement: Resident 2 - monitor q2 hour Resident 3 - monitor q2 hour Resident 6 - monitor q2 hour Resident 7 - monitor q2 hour Resident 8 - monitor q2 hour Orders were noted and carried out. Rounding during change of shift by outgoing and oncoming nursing staff (Licensed Vocational Nurse [LVN], Registered Nurse [RN], and Certified Nurse Assistant [CNA]) will take place to account for all residents with emphasis on identifying the whereabouts of residents that were at risk for elopement. The LVN or RN will record on the Medication Administration Record (MAR) their visual check of the residents and document in the progress note the location of the residents. Medical Records will audit the MAR for compliance of Licensed Staff documenting on residents who has orders to monitor every 2 hours for risk for wandering/elopement and 1 hour for residents with history of elopement. The audits will be daily for one week, weekly for two weeks and monthly for 3 months (x3) thereafter. Medical Records will report to the Administrator/designee the findings of the audit daily for one week, weekly for two weeks, and monthly x3 thereafter. 2). On 10/16/24 and 10/17/24, the Minimum Data Set (MDS) Coordinator reviewed the care plans for the nine (9) residents identified for being at risk for wandering to ensure residents have measurable interventions. Resident interventions were updated to include interventions such as but not limited to monitor residents ' location every 2 hours or 1 hour, Department Managers Monday through Friday and the RN Supervisor on weekends will provide room visits daily to provide orientation for socialization and sensory stimulation and apply wander guard bracelet by Admissions or Licensed Nurse. Resident Specific Monitoring: Resident 1 - had eloped; care plan will be updated when/if resident returns. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 2 - activities to provide accessory for her to take care of her babies/dolls to provide a sense of comfort. Resident 3 - redirected and reorientate resident that wife has passed away. Resident 4 - activities and social services to offer escort for shopping throughout the week. Resident 5 - reorient resident he has no friends across the street or nearby; reassure resident that everyone who ' s not here with him is okay; activities to distract resident from wandering by offering pleasant diversions such as listening to oldies on the patio and socializing with peers. Resident 6 - provide Restorative Nurse Assistant (RNA) services as ordered, activities and social services to provide escort when resident goes shopping across the street. Resident 7 - activities and social services to escort resident to gardening patio, nonsmoking, or smoking patio for fresh area. Resident 8 - offer resident to be escorted to store/shopping plaza nearby. Resident 9 - distract resident from wandering, offer pleasant diversions, resident usually prefers to stay in room but at times will do activities involving food. 3). Licensed staff to complete wandering/elopement assessments on admission/readmission, quarterly and when a change of condition occurs. The Quality Assurance (QA) Nurse updates the residents special need binders/postings as residents are identified. The Admissions Coordinator updates the facility wanderguard (a wearable device to help track residents who are at risk of wandering) binder located at each station with resident ' s face sheets who were identified to be at risk to elope/ wander and have wander guards applied as needed. Wander guard binder will be checked by Admissions or QA nurse during the weekday and designated RN/LVN on the weekend. All residents who have been identified to be at risk for elopement/wandering will have identifiable pink color name bands. Residents identified to be at risk, will be discussed with facility staff during daily shift huddle and weekday stand-up meetings. This allows facility staff to be aware of residents identified to be at risk for wandering/elopement. Staff will be informed of the pink color name band, special need binder/posting and wander guard binder through in-services held by the Director of Staff Development, QA nurse and/or Administrator. 4). On 10/14/24 the Administrator, DON, Director of Staff Development (DSD) began in servicing facility staff, which included but not limited to Nursing, Housekeeping, Maintenance, Dietary, Department Managers including front door staff and contracted rehab staff, on residents at risk for wandering/elopement and what behaviors to monitor for each resident. Behaviors to monitor for at risk for wandering/elopement: -Aggressive episodes - Angry outbursts - Sitting near exit doors (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident being withdrawn, isolative - Attempts to leave unattended - Resident saying they want to leave for fresh air instead of the patio area - Resident attempting to smoke out front instead of designated patio area - Resident saying they miss their family and want to go see them, and attempts to leave to see them. - Resident saying I ' m not a child, I don ' t need an order to go outside - Resident verbalizing, they want to go somewhere else but not details of where they want to go. - Paranoid or suspicious behavior. Example - resident says they don ' t belong there. The in-service also included facility ' s policy and procedure titled, Wandering & Elopement and Wandering Policy. The in-servicing is on-going. The QA nurse will audit the in-service provided to staff daily and report the findings to the Administrator. The Administrator will ensure all staff on assignment and currently working daily are in-serviced by October 21, 2024. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 1 had diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM-abnormal blood sugar levels), heart failure (a heart disorder which causes the heart not to pump the blood efficiently), chronic (long-term) atrial fibrillation (A-fib, irregular heart beat that increases risk of blood clots), and hypertension (HTN-high blood pressure). The Admission Record indicated Resident 1 had a conservator (a judge-appointed person to act or make decisions for the resident). During a review of Resident 1 ' s care plan titled, Noted with repetitive pacing behaviors; no actual destination or purpose, dated 11/14/2023, the interventions indicated staff will monitor Resident 1 ' s behavior every shift, record and notify the physician if behavioral episodes increased, provide visual checks and frequent (nonstop/constant) monitoring of behavior, remind the resident not to leave the facility unassisted and encourage him to be involved in activities of choice. During a review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 3/22/2024, the MDS indicated Resident 1 had intact cognition (awareness). The MDS indicated Resident 1 did not experience hallucinations (thinking or feeling that something is real, when it is not) or delusions (beliefs that are firmly held and do not align with reality). The MDS indicated Resident 1 was independent with sitting to standing, lying to sitting position, and walking 10 feet. The MDS indicated Resident 1 required supervision with transfer to and from the toilet and with walking 50 feet (a unit of measurement) with two turns and walking 150 feet. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Elopement Evaluation, dated 5/19/2024, the evaluation did not indicate Resident 1 was at risk for elopement or had elopement attempts. During a review of Resident 1 ' s Change in Condition (COC) Evaluation form, dated 6/19/2024 at 6:33 a.m., the COC indicated on 6/19/2024, at night (time not indicated), Resident 1 walked out of the premises with his travelling bag. The COC also indicated Resident 1 was observed walking back and forth the hallway with a travelling bag, stating the facility cannot tell me when and where to smoke, so I walked out the building. The COC indicated the police was notified and 10 minutes later, Resident 1 returned to the building. During a review of Resident 1 ' s Elopement Evaluation, dated 6/19/2024 at 7:33 a.m., (first post elopement evaluation), the evaluation indicated Resident 1 had a history of, or an attempted elopement while at home. The report indicated Resident 1 had a history of leaving the facility without informing staff. The report indicated Resident 1 verbally expressed the desire to go home, packed his belongings and stayed near an exit door. The evaluation report also indicated Resident 1 ' s wandering behavior was likely to affect his safety or wellbeing and that of others. The evaluation ' s clinical suggestions section indicated staff will apply an identification (ID) bracelet on Resident 1, monitor the resident ' s location frequently, use visual barriers such as stop signs, ribbons, and tapes, and notify staff of Resident 1 ' s wandering and elopement risk. During a review of Resident 1 ' s care plan titled Resident left facility this morning without notifying staff, dated 6/19/2024, the interventions indicated the staff will monitor Resident 1 for wandering behavior and provide diversional activities frequently. During a review of Resident 1 ' s Interdisciplinary Team (IDT-group of healthcare professionals, including the resident/ resident representative, working together to provide residents with needed care) meeting notes dated 6/19/2024, the IDT meeting notes indicated Resident 1 stated he eloped so he can smoke cigarettes at his preferred times. The IDT meeting notes indicated Resident 1 was reminded of the facility ' s rules. The IDT meeting notes indicated Resident 1 was offered smoking cessation assistance but refused. During a review of Resident 1 ' s Elopement Evaluation, dated 8/24/2024 (second post elopement evaluation), the evaluation indicated Resident 1 had a history of elopement and attempts to leave the facility. The evaluation indicated Resident 1 verbally expressed a desire to go home, packed his belongings, or stayed near an exit door. The evaluation indicated Resident 1 ' s wandering behavior occurred in a pattern, likely to affect the privacy of others. The clinical suggestions section was left blank with no suggestions on how staff would care for Resident 1 to prevent him from eloping. During a review of Resident 1 ' s care plan titled Resident left the faciity on [DATE] without notifying staff, dated 8/26/2024, the interventions indicated staff will distract Resident 1 from wandering by offering the resident pleasant diversions, structured activities, food, conversation, television, book resident prefers. During a review of Resident 1 ' s care plan titled, Noted with repetitive pacing behaviors, dated 8/26/2024, the interventions indicated the staff will monitor Resident 1 ' s location routinely, monitor the resident for wandering behavior, and provide diversional activities. The care plan indicated the staff will monitor Resident 1 ' s triggers for eloping and de-escalate (calm down) the behaviors. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s physician order dated 8/26/2024, the order indicated to apply a wanderguard bracelet (a wearable device to help track residents who are at risk of wandering) to alert staff if Resident 1 attempted to leave the facility. The physician ' s order indicated to check the wanderguard bracelet ' s placement at the left wrist every shift, monitor the number of attempts to leave the facility every shift, weekly check of wanderguard bracelet to ensure it is functioning properly every day shift every 7 days. During a review of Resident 1 ' s IDT meeting notes dated 8/26/2024, the notes indicated on 8/24/2024, at 12:30 a.m., Resident 1 eloped from the facility, and at 1:15a.m., he was accompanied back to the facility by a staff member. The notes indicated Resident 1 was educated on the dangers and risk of going out alone, and a wanderguard was offered to Resident 1 to remind him not to leave the facility unattended. During a review of Resident 1 ' s COC Evaluation form dated 8/30/2024, the COC indicated Resident 1 left the faciity on [DATE] at around 5:45 a.m., through the front door. The COC indicated the door alarm turned on and two (2) staff members went after Resident 1 and brought Resident 1 back inside the facility. During a review of Resident 1 ' s physician orders for October 2024, the physician order indicated the following: 1. Advair Diskus Aerosol Powder Breath Activated 250 50 microgram (mcg- unit of measurement)/ Fluticasone-Salmeterol 1 inhalation orally two times a day for chronic obstructive pulmonary disease (COPD-lung disease). 2. Aspirin Tablet Chewable 81 milligram (mg - a unit of measurement) 1 tablet by mouth daily for cerebral vascular accident (CVA- stroke) prophylaxis (PPX- prevention). 3. Coreg Tablet 6.25 mg 1 tablet by mouth two times a day for hypertension (HTN- high blood pressure). 4. Digoxin (medication for Atrial-fibrillation ([A-fib] irregular heart rate) oral tablet 125 micrograms (mcg- a unit of measurement) 1 tablet by mouth in the morning. 5. Insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) glargine (long-acting medication for DM) 100 units (measurement for insulin)/milliliter (mL- a unit of measurement) inject 8 units subcutaneously (under the skin) at bedtime for DM 6. Insulin lispro (fast-acting medication for DM) 100 units/mL injected as per sliding scale (dose adjusted based on current blood sugar) subcutaneously before meals and at bedtime for DM 7. Glyburide (medication for DM) tablet 5 mg by mouth in the morning for DM 8. Tiotropium bromide monohydrate (medication for COPD) 1 capsule inhale orally one time per day for COPD (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. Risperidone (medication for schizophrenia) tablet 2 mg by mouth two times per day for schizophrenia manifested by (m/b) auditory hallucinations (hearing sounds that are not real) 10. Benztropine mesylate (medication for movement disorders) 1 mg by mouth two times per day for extrapyramidal symptoms (EPS - uncontrollable movements due to antipsychotic medications) During a concurrent interview and record review on 10/16/2024 at 8:03 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s care plans dated 11/14/2023, 6/19/2024, and 10/15/2024, Elopement Evaluations dated 6/19/2024 and 8/26/2024, Physician Orders dated 8/26/2024 were reviewed. LVN 1 stated the Elopement Evaluation dated 6/19/2024 and 8/26/2024 indicated Resident 1 was at risk of eloping due to Resident 1 ' s past attempts and successful elopements. LVN 1 stated Resident 1 ' s Elopement Evaluations indicated Resident 1 eloped from the facility two times (on 6/19/2024 and 8/24/2024), prior to the third elopement on 10/13/2024. LVN 1 stated Resident 1 ' s care plan dated 11/14/2023 indicated the staff will visually monitor Resident 1 ' s location, Resident 1 ' s behavior, and remind Resident 1 not to leave the facility unassisted. LVN 1 stated staff did not monitor Resident 1 ' s location or wandering behavior. LVN 1 stated the visual checks were not performed or documented in Resident 1 ' s clinical record. LVN 1 stated the interventions in Resident 1 ' s care plan dated 6/19/2024 which indicated staff will monitor Resident 1 ' s wandering behavior and location, were not documented in Resident 1 ' s clinical record. LVN 1 stated Resident 1 ' s care plan regarding elopement was not individualized and not specific to Resident 1 ' s needs. LVN 1 stated Resident 1 ' s physician ' s order dated 8/26/2024 indicated to apply a wanderguard bracelet on 8/26/2024. LVN 1 stated the wanderguard was on the resident but was not incorporated (added) to the care plan until 10/15/2024, after Resident 1 had eloped 10/13/2024 (third elopement). During an interview on 10/16/2024 at 10:50 a.m. with the Director of Nursing (DON), the DON stated the intervention on Resident 1 ' s care plan to monitor for location routinely was vague (unclear) and not measurable. The DON stated the care plan ' s interventions should have been specific on the type of supervision Resident 1 needed and how often the staff had to monitor Resident 1. The DON stated the facility did not know where or when Resident 1 left the facility, or where Resident 1 was, after last seen on 10/13/2024 at 5:30 am. During an interview on 10/16/2024 at 12:37 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 was last seen in the facility on 10/13/2024 at 5:30 a.m. and was discovered missing on 10/13/2024 at 7:30 a.m. CNA 1 stated Resident 1 ' s assigned staff were supposed to always monitor the resident ' s whereabouts and during the change of shift. CNA 1 stated on 10/13/2024 at 7:00 am, no staff monitored Resident 1 during the change of shift. CNA 1 stated Resident 1 had eloped because staff was not monitoring his (Resident 1) location. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 10/16/2024 at 2:18 p.m. with Registered Nurse (RN 2), Resident 1 ' s physician orders for October 2024 and MAR for October 2024 were reviewed. RN 2 stated Resident 1 had no physician order to monitor his (Resident 1) location or his wandering behaviors. RN 2 stated the facility did not monitor Resident 1 ' s location or wandering behaviors, which may have been the reason why the facility did not know where Resident 1 was. RN 2 stated there was no documentation in Resident 1 ' s MAR indicating the resident ' s location. RN 2 stated Resident 1 eloped again because staff was not monitoring him. RN 2 stated Resident 1 ' s elopement placed Resident 1 ' s safety in danger. RN 2 stated, because Resident 1 eloped, Resident 1 missed his daily medications like digoxin, carvedilol, aspirin, insulin, insulin lispro, glyburide, tiotropium bromide, advair diskus aerosol, risperidone and benztropine. RN 2 stated without receiving his daily medications, Resident 1 was at risk for hypertensive crisis, diabetic coma, stroke, behavioral crisis, embolism. RN 2 stated Resident 1 could get struck by vehicles, possibly injured himself, resulting to hospitalization and death. During a concurrent interview and record review on 10/15/2024 at 4:47 p.m. with RN 3, Resident 1 ' s care plan titled, Resident left the facility without notifying staff or having escort, dated 8/24/2024, was reviewed. RN 3 stated the care plan interventions included to monitor for fatigue and weight loss, offer diversions, and monitor the resident ' s location routinely. RN 3 stated, the interventions were not individualized according to Resident 1 ' s needs, who attempted to elope many times. RN 3 stated the intervention should have been specified to monitor the resident ' s location every hour. RN 3 stated the interventions listed on the care plan did not have a physician ' s order, therefore, the monitoring of location routinely was not conducted and documented in Resident 1 ' s MAR. During a review of the facility ' s undated policy and procedure (P&P) titled Wandering & Elopement, the P&P indicated its purpose was to enhance safety of residents in the facility. The P&P indicated the license nurse in collaboration with the IDT, will assess residents upon identification of significant change in condition, resident ' s risk for elopement and preventative interventions for elopement will be documented in resident ' s medical record, will be reviewed, and re-evaluated by the IDT upon change in condition. The P&P indicated the license nurse will implement immediate interventions to prevent further wandering/ elopement by the resident. During a review of the facility ' s undated P&P titled, Care Planning, the P&P indicated the facility must ensure care plans were comprehensive person-centered and were developed based on the resident ' s individual assessed needs. The P&P indicated changes may be made to the comprehensive care plan on an ongoing basis for the duration of the resident ' s stay and reflected to the baseline care plan. The P&P indicated residents ' care plans should describe the services to be provided to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being.