

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2024
NAME OF PROVIDER OR SUPPLIER Victoria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3541 Puente Avenue Baldwin Park, CA 91706	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37198</p> <p>Based on interview and record review, the facility failed to locate one of one sampled resident (Resident 1), who eloped (the act of leaving a facility unsupervised and without prior authorization) from the dialysis center (a facility that provides treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>This deficient practice had the potential to result in compromise to Resident 1's safety and well-being.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/15/2024, with diagnoses that included encounter for surgical aftercare (the medical care a person receives after surgery, including care in the hospital and after discharge) following surgery on the digestive system (a group of organs that break down the foods eaten so they can be absorbed into the body and used for energy and nutrients), end stage renal disease (a permanent condition that occurs when the kidneys are no longer able to function), and dependence on renal dialysis.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/22/2024, the MDS indicated Resident 1 was understood by others and had the ability to understand others. The MDS indicated Resident 1 required the use of a walker. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, upper body dressing, lower body dressing, and personal hygiene.</p> <p>During a review of Resident 1's Care Plan (CP), dated 10/15/2024, the CP indicated Resident 1 was at risk for falls related to unstable gait (walking in an abnormal, uncoordinated, or unsteady manner) requiring an assisted device (walker).</p> <p>During a review of Resident 1's CP, dated 10/15/2024, the CP indicated Resident 1 had chronic pain related to a history of surgery.</p> <p>During a review of Resident 1's CP, dated 10/15/2024, the CP indicated Resident 1 needed hemodialysis related to renal (kidney) failure.</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 0684</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 CP, dated 11/1/2024, the CP indicated Resident 1 left against medical advice (AMA - choosing to leave the hospital/facility before the treating physician recommends discharge). The CP indicated the goal was that Resident 1 will be safe from injury and harm. The CP intervention included to attempt to reach Resident 1 by phone.</p> <p>During a review of Resident 1's Nurses Progress Note (NPN), dated 11/1/2024 at 6:47 pm, the NPN indicated the Licensed Vocational Nurse (LVN) 1 was doing rounds at 5:45 pm and noticed that Resident 1 was not back from dialysis. The NPN indicated LVN 1 contacted the dialysis center at 6 pm and the dialysis center informed LVN 1 that Resident 1 finished dialysis at 4:10 pm. The NPN indicated LVN 1 contacted the transportation service at 6 pm and LVN 1 was informed that when the driver went to pick up Resident 1 from the dialysis center at 3:30 pm, Resident 1 refused to leave with the driver from the transportation service. The NPN indicated Resident 1 told the driver that Someone was already there at the dialysis center to pick up Resident 1.</p> <p>During a review of Resident 1's NPN, dated 11/1/2024 at 9:57 pm, the NPN indicated the facility reported the incident to the police department.</p> <p>During a review of Resident 1's NPN, Resident 1's NPN did not indicate documented evidence of the facility's attempt to locate Resident 1 after the elopement on 11/1/2024.</p> <p>During an interview on 11/5/2024 at 1:13 pm, with LVN 1, LVN 1 stated the dialysis center informed LVN 1 on 11/1/2024 around 7 pm that there was a camera footage from the dialysis center of Resident 1 walking alone and nobody was there to pick up Resident 1. LVN 1 stated the dialysis center is ten minutes away from the facility. LVN 1 stated staff did not go out to the dialysis facility to look for Resident 1. LVN 1 stated if a resident was missing, staff was required to notify the Director of Nursing (DON), search for the resident in the premises, call the police, notify family, attempt to call the resident, and notify the physician. LVN 1 stated staff would search for the missing resident by driving around the area, call the hospitals nearby, and go out to search for the resident. LVN 1 stated Resident 1 could be at risk for accidents, falls, losing consciousness from not having medication or from having low blood pressure, and bleeding from the dialysis catheter (a tubing used for exchanging blood to and from a dialysis machine and a patient).</p> <p>During an interview on 11/5/2024 at 12:50 pm and at 1:40 pm, with the DON, the DON stated after the DON spoke to Resident 1's physician, nothing else was done. The DON stated they did not contact the hospitals to look for Resident 1. The DON stated no one answered the phone when DON contacted Resident 1's phone number. The DON stated according to the dialysis center, there was a camera footage of Resident 1 walking the streets and Resident 1 was not seen getting in a car. The DON stated if elopement happened in the facility, staff would search the facility and surroundings and have staff drive around the streets to look for the resident. The DON stated they would also call the closest hospitals. The DON stated the facility should have still followed up with hospitals and should have kept following up with the police department to locate Resident 1. The DON stated Resident 1 would be at risk for missing dialysis which could lead to fluid overload and kidney complications.</p> <p>(continued on next page)</p>		

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<p>F 0684</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 policy and procedure (P&P) titled, Elopements and Wandering Residents, revised on 12/19/2022, the P&P indicated the procedure for locating missing resident: any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g. internal alert code); the designated facility staff will look for the resident. If the resident is not located in the building or on the grounds, the Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The administrator or designee should also notify the company's corporate office. The DON or designee shall notify the physician and family member or legal representative. The Police will be given a description and information about the resident; include any photos. All parties will be notified of the outcome once the resident is located. Appropriate reporting requirements to the State Survey agency shall be conducted.</p>		