STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555130	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Skilled Nursing & Wellness Centre	6025 Pine Ave Maywood, CA 90270

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 - Minimal harm or potential for actual harm 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** 47858 Based on interview and record review, the facility failed to develop a comprehensive plan of care for one of three sampled residents (Resident 1) by failing to: 1. Develop a plan of care for a resident's known behavior of biting. 2. Develop a care plan for a resident at risk for elopement (when a resident leaves or wanders in a healthcare facility against medical advice). These failures resulted in Resident 1 wandering into Resident 2's room, hitting Resident 2 on the face, attempted to bite Resident 2 on the arm, and throwing a pitcher full of water on Resident 2. Findings: A. A review of Resident 1's Admission Record, indicated Resident 1 was originally admitted to the facility on [DATE], with diagnoses that included dementia (impaired ability to remember, think, or make decisions), anxiety (a feeling of fear, dread, and uneasiness), and abnormalities of gait (ability to walk) and mobility. A review of Resident 1's Minimum Data Set ([MDS]- a standardized resident assessment and care planning tool), dated 5/21/2024, indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 1 required supervision when putting on clothes, performing personal hygiene, bathing, putting on footwear, and required partial assistance when showering. B. A review of Resident 2's Admission Record, indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included diabetes (poor blood sugar control), muscle weakness, and abnormalities of gait and mobility. A review of Resident 2's MDS, dated [DATE], indicated Resident 2's cognitive skills was intact. The MDS indicated Resident 2 required supervision when putting on clothes, performing personal hygiene, bathing, putting on footwear, and required partial assistance (helper performs less than half of the effort) when showering. The MDS indicated Resident 2 did not have behavioral problems or symptoms. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/9/2024, at 11:38 a.m., with Resident 2, Resident 2 stated that he had altercation with Resident 1 one week ago. Resident 2 stated that he was folding his clothes in his room when Resident 1 walked in and grabbed one of his shirts. Resident 2 stated Resident 1 hit the left side of his face, poured water on his shirt, and then attempted to bite Resident 2. During a concurrent record review and interview, on 7/9/2024, at 3:39 p.m., with Registered Nurse (RN) 1, Resident 1's Progress Notes dated 6/2024 were reviewed. The progress notes indicated Resident 1 was being monitored for biting. RN 1 stated Resident 1 was known to bite people. During a concurrent record review and interview on 7/9/2024, at 3:39 p.m., with RN 1, Resident 1's Elopement Risk Assessment, dated 5/21/2024, was reviewed. The 1's Elopement Risk Assessment indicated Resident 1's Elopement Risk score was one (1). The Elopement Risk Assessment indicated a score of one (1) or higher indicated a risk for elopement. During a concurrent record review and interview, on 7/9/2024, at 3:39 p.m., with RN 1, Resident 1's care plans, dated 2024, were reviewed. There was no care plan implemented for Resident 1's known behavior of biting. There was an Elopement Risk Care Plan initiated on 7/2/2024. RN 1 stated that the care plans were important to develop to guide the plan of care for Resident 1. RN 1 stated that a care plan should have been started for Resident 1's behavior of biting to prevent staff and resident harm. RN 1 stated that Resident 1 should have had the Elopement Risk Care Plan initiated on 5/21/2024 when Resident 1 was assessed and identified as an elopement risk on 5/21/2024. RN 1 stated that if there were no care plans implemented for Resident 1's behavior of biting and Resident 1's risk for elopement, there would be a potential for harm for Resident 1, staff, or other residents. A review of the facility's Policy and Procedure (P&P), titled, Comprehensive Person-Centered Care Planning, dated 11/2018, indicated the facility was to ensure a comprehensive person-centered care plan was developed for each resident to reflect the best standards for meeting health, safety, psychosocial, behavioral, and environmental needs for residents. A review of the facility's P&P, titled, Wandering and Elopement, dated 7/2017, indicated that the Interdisciplinary Team would develop a plan of care considering the individual risk factors of the resident.

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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** 47858 Based on observation, interview, and record review, the facility failed to closely monitor a resident with a known history of wandering, aggression, throwing items at staff, and biting for one out of three sampled residents (Resident 1). These failures resulted in Resident 1 wandering into Resident 2's room, hitting Resident 2's face, attempted to bite Resident 2's arm, and throw a pitcher full of water at Resident 2. Findings: A. A review of Resident 1's Admission Record, indicated Resident 1 was originally admitted to the facility on [DATE], with diagnoses that included dementia (impaired ability to remember, think, or make decisions), anxiety (a feeling of fear, dread, and uneasiness), and abnormalities of gait (ability to walk) and mobility. A review of Resident 1's Minimum Data Set ([MDS]- a standardized resident assessment and care planning tool), dated 5/21/2024, indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 1 required supervision when walking, putting on clothes, performing personal hygiene, bathing, putting on footwear, and required partial assistance (helper performs less than half of the effort) when showering. A review of Resident 1's Fall Care Plan, initiated 1/27/2024, indicated the nursing staff interventions were to ensure Resident 1's was monitored, and frequent visual checks were conducted. The care plan indicated nursing staff were to assist and observe when Resident 1 walked throughout the unit and ensure Resident 1's safety awareness was monitored. A review of Resident 1's Wandering Care Plan, dated 1/29/2024, the care plan indicated nursing staff were to provide one to one supervision, monitor the resident as often as possible , and record staff rounds . B. A review of Resident 2's Admission Record, indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included diabetes (poor blood sugar control), muscle weakness, and abnormalities of gait and mobility. A review of Resident 2's MDS, dated [DATE], indicated Resident 2's cognitive skills was intact. The MDS indicated Resident 2 required supervision when walking, putting on clothes, performing personal hygiene, bathing, putting on footwear, and required partial assistance when showering. The MDS indicated Resident 2 did not have behavioral problems or symptoms. During an interview, on 7/9/2024, at 11:38 a.m., with Resident 2, Resident 2 stated that he had altercation with Resident 1 one week ago. Resident 2 stated that he was folding his clothes in his room when Resident 1 walked in and grabbed one of his t-shirts. Resident 2 stated Resident 1 proceeded to hit the left side of his face, threw water at Resident 2, and attempted to bite Resident 2. (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 7/9/2024, at 2:06 p.m., with CNA 1, CNA 1 stated Resident 1 would go into other patient's rooms and grab items that did not belong to Resident 1. CNA 1 stated that Resident 1 should be monitored every 15 minutes because Resident 1 was known to wander. CNA 1 stated there was a possibility staff membersdid not notice Resident 1 walk into Resident 2's room because the CNAs were usually busy caring for many residents. CNA 1 stated if Resident 1 was not supervised adequately, there was a potential Resident 1 could have an unwitnessed fall or have an altercation with another resident. CNA 1 stated if Resident 1 had been assigned to one-on-one supervision, or was monitored more often, the altercation between Resident 1 and Resident 2 may have been prevented. During a concurrent record review and interview, on 7/9/2024 at 3:39 p.m., with Registered Nurse (RN) 1, the facility's Policy, and Procedure (P&P), titled, Resident Safety , dated 4/15/2021, was reviewed. The P&P indicated the facility was to conduct a resident check at least every two hours around the clock by using service personnel, and the person-centered care plan may require more frequent safety checks. RN 1 stated that if supervision was not performed every two hours for Resident 1, there was a possibility that Resident 1 could have eloped, fallen, or gotten into an altercation with another resident. A review of the facility's Policy and Procedure (P&P), titled, Resident Safety , dated 4/15/2021, indicated that the facility was to conduct a resident check at least every two hours around the clock by using service personnel, and the person-centered care plan may require more frequent safety checks. A review of the facility's P&P, titled, Comprehensive Person-Centered Care Planning, dated 11/2018, indicated that the facility was to ensure a comprehensive person-centered care plan was developed for each resident to reflect the best standards for meeting health, safety, psychosocial, behavioral, and environmental needs for residents. A review of the facility's P&P, titled, Elopement Risk Reduction Approaches (undated), indicated the facility was to ensure that residents are free to move about freely, are monitored, and remain safe.