STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Gardena Post Acute	16530 S Broadway Street Gardena, CA 90248

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview and record review, the facility failed to ensure two facility exit doors, the lobby door (Door 1) and front door (Door 2), were secured to prevent the elopement (an unauthorized departure of a resident without the facility's knowledge and supervision) of one of four sampled residents (Resident 1), a resident who had a history of elopement and assessed as high risk for elopement. As a result of these deficient practices, Resident 1 eloped from the facility on 7/3/2024 and was without his medications including olanzapine (medication to treat schizophrenia) 15 milligrams twice a day for ten days. Resident 1 was located by facility staff on 7/13/2024 and subsequently transferred to a general acute care facility (GACH) for further evaluation. At the GACH, Resident 1 was admitted with a diagnosis including acute psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), severe anemia (not enough red blood cells in the body), and Resident 1 received a blood transfusion (process of transferring blood products). According to psychiatric (mental health specialist) consult, Resident 1 was agitated and aggressive was given a sitter (a healthcare worker who will provide continuous supervision to a resident) for safety and placed on a 5150 hold (72-hour involuntary hold in the hospital). The consult indicated Resident 1 required inpatient hospitalization for further stabilization of behavioral symptoms. Findings: During a review of Resident 1 ' s Admission record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly)schizophrenia, type 2 diabetes (problem in the way the body regulates and uses sugar as fuel), and hypertension (when the force of blood pushing against the walls of blood vessels is too high). During a review of Resident 1 ' s Psychiatric Evaluation, dated 6/12/2024, the mental status examination indicated Resident 1 ' s judgement and insight were moderately impaired. The evaluation indicated Resident 1 was disheveled, very disorganized and was a poor historian. The evaluation indicated Resident 1 had delusions (altered reality that is persistently held despite evidence or agreement to the contrary) and auditory hallucinations (when the person hears voices or noises that don't exist in reality). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Gardena Post Acute	16530 S Broadway Street Gardena, CA 90248

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The evaluation indicated Resident 1 was diagnosed with psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review or Resident 1 ' s History and Physical (H&P), dated 6/13/2024, the H&P indicated Resident 1 was unable to communicate/ make decisions for self. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 6/15/2024, the MDS indicated Resident 1 had severe cognitive (ability to learn, remember, understand, and make decision) impairment for skills on daily decision making. The MDS indicated Resident 1 needed set up assistance with eating, supervision (helper provides verbal cues) with oral hygiene, upper body dressing, personal hygiene, and needed partial assistance (helper less than half the effort to complete the task) with toilet hygiene, and lower body dressing. During a review of Resident 1 ' s Admission/Readmission Initial Assessment, 6/11/2024, the assessment indicated Resident 1 was high risk for elopement because Resident 1 was independently mobile and has a history of elopement. During a review of Resident 1 ' s Order Summary Report, active orders as of 7/5/2024, the summary indicated, starting on 6/11/2024, Resident 1 may have wander guard to the left hand to alert staff of resident trying to leave facility unassisted. Resident 1 also had Olanzapine 15 milligrams one tablet orally two times a day for schizophrenia. During a review of Resident 1 ' s Weekly summary, dated 6/30/2024 at 2:38 a.m., the summary indicated Resident 1 was alert and confused. During a review of Resident 1 ' s Situation Background Assessment Appearance Request (SBAR) Communication Form- General, 7/3/2024 at 1:45 a.m., the form indicated the following: a. At 11:00 p.m , Resident 1 was seen lying in bed comfortably watching television in no apparent distress, denied pain or discomfort, and respirations were even and unlabored and no respiratory distress. b. At 12:00 midnight Resident 1 remained in bed, sitting at the edge of the bed watching television. c. At approximately 1:15 a.m. the Certified nurse assistant (CNA) noticed Resident 1 was not in the resident ' s room or restroom and made charge nurse aware. d. At 1 :20 a.m. staff searched for Resident 1 in the facility. Resident 1 ' s wander guard was noted fully stretched on the floor. e. At 1:36 a.m., the police was notified of Resident 1 ' s elopement. f. At 1:52a.m. sheriffs arrived. g. At 2:13 a.m. writer finished giving report to the Sheriff and the Sheriff was made aware Resident 1 was alert and oriented times 2 with episodes of confusion and diagnosed with paranoid Schizophrenia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER West Gardena Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16530 S Broadway Street Gardena, CA 90248	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 GACH Emergency Department Physician note, dated 7/13/2024 at 7:17 p.m., the note indicated facility staff found Resident 1 wandering around the streets and brought in by ambulance to GACH for further evaluation. The note indicated Resident 1had acute psychosis, severe anemia, and type 2 diabetes. Resident 1 received a blood transfusion for the anemia. During a concurrent observation and interview on 7/4/2024 at 9:50 a.m., with Registered Nurse Supervisor (RNS), the left side of the double doors to Door 1 was opened and no alarm was heard. RNS stated the alarm should trigger whenever either door was opened and this time it did not. RNS stated the alarm not triggering was not safe for residents. During a continued observation and interview on 7/4/2024 at 9:50 a.m., with RNS, it was noted that Resident 1 ' s room was right by Door 2. Door 2 was also noted with two unsecure (can be opened without a key or a code) latches. The RNS stated Door 2 does not alarm when opened and at night no one was monitoring the residents exiting Door 2. The RNS stated since Resident 1 removed his wander guard he probably just opened the latches and exited. RNS stated it was not safe to have an unsecure Door 2 because if residents can remove the wonder guard bracelet and open the latches they can leave at night undetected. During an interview with the Maintenance Supervisor (MS) on 7/4/2024 at 12:15 p.m., the MS stated the Door 1 was deactivated and the MS just activated it right now. The MS stated Resident 1 could have also walked out through the Door 1 because the alarm would not have been triggered. During an interview with Licensed Vocational Nurse (LVN)1 on 7/4/2024 at 2:00 p.m., LVN 1 stated at approximately 1 a.m. CNA 4 stated Resident 1 was not in his room or the restroom. After a search was conducted in the facility the [NAME] was notified and three sheriffs also searched in the premises to no avail. During an interview with the Administrator (ADM) on 7/4/2024 at 3:55 p.m., the ADM stated the Door 2 was not safe for the resident ' s safety. The ADM stated the Door 1 should have been triggered when opened. During an observation and interview on 7/5/2024 at 10:28 a.m., with MS, at Door 1, the alarms on the door was observed to have the code or password clearly labeled on the alarms. The MS stated the codes were labeled there so anyone who can read can disarm it if needed; that makes the door alarms unsecure because anyone can punch the code and can exit undetected. MS stated Resident 1 might have exited from here (Door 1) or Door 2. During a concurrent interview and record review with LVN 1, on 7/5/2024 at 10:53 a.m., Resident 1 ' s records were reviewed. Resident 1 ' s Elopement assessment on admission, dated 6/11/2024, indicated Resident 1 was a high risk for elopement. Resident 1 ' s SBAR, dated 7/3/2024, was reviewed, and the SBAR indicated the stretched out and damaged wander guard was observed on the floor. LVN 1 stated Resident 1 should not have left the facility undetected because it was not safe. During an interview with the ADM on 7/5/2024 at 4:00 p.m., the ADM stated the doors should be secure. The ADM stated to prevent further elopements, in services was completed. The ADM stated the facility will install magnetic door locks to Doors 1 and 2. The ADM stated until the locks were installed the facility staff will be assigned to monitor the door area to ensure no residents elope. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER West Gardena Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16530 S Broadway Street Gardena, CA 90248	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled Behavioral Assessment, Intervention and Monitoring, revised 3/2019, the P&P indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with comprehensive assessment and plan of care. Residents will have minimal complications associated with the management of altered or impaired behavior. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. During a review of the facility ' s P&P titled, Environment, Maintenance, revised 12/2009. The P&P indicated the facility shall be maintained in a clean and safe manner. The P&P indicated equipment and supplies must be maintained in good working condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER West Gardena Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16530 S Broadway Street Gardena, CA 90248	

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(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 - Some	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** 44055 Based on interview and record review, the facility failed to implement one of four sampled resident ' s (Resident 1) care plan to ensure Resident 1 was wearing his Wander guard (bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time), and that Resident 1 was not going to leave the premises unassisted. As a result of these deficient practices, Resident 1 eloped from the facility on 7/3/2024 and was without his medications including olanzapine (medication to treat schizophrenia) 15 milligrams twice a day for ten days. Resident 1 was located by facility staff on 7/13/2024 and subsequently transferred to a general acute care facility (GACH) for further evaluation. At the GACH, Resident 1 was admitted with a diagnosis including acute psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), severe anemia (not enough red blood cells in the body), and Resident 1 received a blood transfusion (process of transferring blood products). According to psychiatric (mental health specialist) consult, Resident 1 was agitated and aggressive was given a sitter (a healthcare worker who will provide continuous supervision to a resident) for safety and placed on a 5150 hold (72-hour involuntary hold in the hospital). The consult indicated Resident 1 required inpatient hospitalization for further stabilization of behavioral symptoms. Findings: During a review of Resident 1 ' s Admission record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis including paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) schizophrenia, type 2 diabetes (problem in the way the body regulates and uses sugar as fuel), and hypertension (when the force of blood pushing against the walls of blood vessels is too high). During a review of Resident 1 ' s Psychiatric Evaluation, dated 6/12/2024, the mental status examination indicated Resident 1 ' s judgement and insight were moderately impaired. The evaluation indicated Resident 1 was disheveled, very disorganized and was a poor historian. The evaluation indicated Resident 1 had delusions (altered reality that is persistently held despite evidence or agreement to the contrary) and auditory hallucinations (when the person hears voices or noises that don't exist in reality). The evaluation indicated Resident 1 was diagnosed with psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review or Resident 1 ' s History and Physical (H&P), dated 6/13/2024, the H&P indicated Resident 1 was unable to communicate/ make decisions for self. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 6/15/2024, the MDS indicated Resident 1 had severe cognitive (ability to learn, remember, understand, and make decision) impairment for skills on daily decision making. The MDS indicated Resident 1 needed set up assistance with eating, supervision (helper provides verbal cues) with oral hygiene, upper body dressing, personal hygiene, and needed partial assistance (helper less than half the effort to complete the task) with toilet hygiene, and lower body dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER West Gardena Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16530 S Broadway Street Gardena, CA 90248	

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 - Some	During a review of Resident 1 ' s Admission/Readmission Initial Assessment, 6/11/2024, the assessment indicated Resident 1 was high risk for elopement because Resident 1 was independently mobile and has a history of elopement. During a review of Resident 1 ' s Weekly summary, dated 6/30/2024 at 2:38 a.m., the summary indicated Resident 1 was alert and confused. During a review of Resident 1 ' s Order Summary Report, active orders as of 7/5/2024, the summary indicated the following orders, starting on 6/11/2024: a. May have wander guard to the left hand to alert staff of resident trying to leave facility unassisted. b. Check wander guard placement every shift. c. Monitor Resident 1 for episodes of wandering behavior (a behavioral problem of disorientation and difficulty relating to the environment with aimless or purposeful motor activity that causes a social problem such as getting lost, leaving a safe environment, or intruding in inappropriate places) around hallway and patio every shift. d. Check for wander guard function every Sunday during 7-3 p.m. shift. e. Olanzapine 15 milligrams one tablet orally two times a day for schizophrenia. During a review of Resident 1 ' s untitled care plan, focus indicated Resident 1 was at risk for elopement related to cognitive impairment, and mood and behavioral symptoms, initiated 6/17/2024. The care plan goal indicated Resident 1 will not leave the facility unsupervised. Care plan interventions included: a. May have wander guard on left hand to alert staff if resident was trying to leave the facility unassisted. b. Check wander guard function every Sunday during day shift. c. Check wander guard placement on the left hand every shift d. Monitor Resident 1 for wandering behavior every shift around the hallway and patio. e. Frequent rounds by staff f. Remind resident that he needs to remain in the facility unless family of staff member was with them. During a review of Resident 1 ' s Monitoring side effects/Behaviors/black box (added to the labeling of drugs when serious adverse reactions or special problems occur) warnings for 7/2024, the monitoring indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

a. Starting 6/11/2024, check wander guard placement every shift. On 7/2/2024 night shift, Resident 1 was absent from the facility without meds on 7/2/2024 night shift.

b. Staring on 6/11/2024, monitor Resident 1 for episodes of wandering behavior, around hallway and patio every shift. In 7/1/2024, Resident 1 was observed with this behavior 4 times. On 7/2/2024, Resident 1 was observed wandering 4 times.

During a review of Resident 1 ' s Situation Background Assessment Appearance Request (SBAR) Communication Form- General, 7/3/2024 at 1:45 a.m., the form indicated the following:

a. At 11:00 p.m , Resident 1 was seen lying in bed comfortably watching television in no apparent distress, denied pain or discomfort, and respirations were even and unlabored and no respiratory distress.

b. At 12:00 midnight Resident 1 remained in bed, sitting at the edge of the bed watching television.

c. At approximately 1:15 a.m. the Certified nurse assistant (CNA) noticed Resident 1 was not in the resident ' s room or restroom and made charge nurse aware.

d. At 1 :20 a.m. staff searched for Resident 1 in the facility. Resident 1 ' s wander guard was noted fully stretched on the floor.

e. At 1:36 a.m., the police was notified of Resident 1 ' s elopement.

f. At 1:52a.m. sheriffs arrived.

g. At 2:13 a.m. writer finished giving report to the Sheriff and the Sheriff was made aware Resident 1 was alert and oriented times 2 with episodes of confusion and diagnosed with paranoid Schizophrenia.

During a review of Resident 1 GACH Emergency Department Physician note, dated 7/13/2024 at 7:17 p.m., the note indicated facility staff found Resident 1 wandering around the streets and brought in by ambulance to GACH for further evaluation. The note indicated Resident 1had acute psychosis, severe anemia, and type 2 diabetes. Resident 1 received a blood transfusion for the anemia.

During a continued observation and interview on 7/4/2024 at 9:50 a.m., with RNS, it was noted that Resident 1 ' s room was right by the front door that exits to the parking lot (Door 2). Door 2 was also noted with two unsecure (can be opened without a key or a code) latches. The RNS stated Door 2 does not alarm when opened and at night no one was monitoring the residents exiting Door 2. The RNS stated since Resident 1 removed his wander guard he probably just opened the latches and exited. RNS stated it was not safe to have an unsecure Door 2 because if residents can remove the wonder guard bracelet and open the latches they can leave at night undetected.

During an interview with Licensed Vocational Nurse (LVN)1 on 7/4/2024 at 2:00 p.m., LVN 1 stated at approximately 1 a.m. CNA 4 stated Resident 1 was not in his room or the restroom. After a search was conducted in the facility the [NAME] was notified and three sheriffs also searched in the premises to no avail.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER West Gardena Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16530 S Broadway Street Gardena, CA 90248	

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 - Some	During a concurrent interview and record review with LVN 1, on 7/5/2024 at 10:53 a.m., Resident 1 ' s records were reviewed. Resident 1 ' s Elopement assessment on admission, dated 6/11/2024, indicated Resident 1 was a high risk for elopement. Resident 1 ' s SBAR, dated 7/3/2024, was reviewed, and the SBAR indicated the stretched out and damaged wander guard was observed on the floor. LVN 1 stated Resident 1 should have had the wander guard on. LVN 1 stated Resident 1 should not have left the facility undetected because it was not safe. During an interview with the administrator (ADM) on 7/5/2024 at 4:00 p.m., the ADM stated the doors should be secure and adequate monitoring of high risk for elopement residents should be done. The ADM stated to prevent further elopements, in services was completed. The ADM stated the facility will install magnetic door locks to Doors 1 and 2. The ADM stated until the locks were installed the facility staff will be assigned to monitor the door area to ensure no residents elope. The ADM also stated the facility will ensure monitoring of the high risk for elopement residents were being done by documenting the residents ' whereabouts on an hourly basis. The ADM stated this will be a systematic change that will be immediately implemented. During a review of the facility ' s policy and procedure (P&P) titled Behavioral Assessment, Intervention and Monitoring, revised 3/2019, the P&P indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with comprehensive assessment and plan of care. Residents will have minimal complications associated with the management of altered or impaired behavior. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. During a review of the facility ' s P&P titled Care plans, Comprehensive Person-Centered, care plan policy, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident.

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(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** 44055 Based on interview and record review, the facility failed to implement one of four sampled resident ' s (Resident 1) care plan to ensure Resident 1 was wearing his Wander guard (bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time), and that Resident 1 was not going to leave the premises unassisted. As a result of these deficient practices, Resident 1 eloped from the facility on 7/3/2024 and was without his medications including olanzapine (medication to treat schizophrenia) 15 milligrams twice a day for ten days. Resident 1 was located by facility staff on 7/13/2024 and subsequently transferred to a general acute care facility (GACH) for further evaluation. At the GACH, Resident 1 was admitted with diagnoses including acute psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), severe anemia (not enough red blood cells in the body), and Resident 1 received a blood transfusion (process of transferring blood products). According to psychiatric (mental health specialist) consult, Resident 1 was agitated and aggressive was given a sitter (a healthcare worker who will provide continuous supervision to a resident) for safety and placed on a 5150 hold (72-hour involuntary hold in the hospital). The consult indicated Resident 1 required inpatient hospitalization for further stabilization of behavioral symptoms. Findings: During a review of Resident 1 ' s Admission record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including paranoid (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) schizophrenia, type 2 diabetes (problem in the way the body regulates and uses sugar as fuel), and hypertension (when the force of blood pushing against the walls of blood vessels is too high). During a review of Resident 1 ' s Psychiatric Evaluation, dated 6/12/2024, the mental status examination indicated Resident 1 ' s judgement and insight were moderately impaired. The evaluation indicated Resident 1 was disheveled, very disorganized and was a poor historian. The evaluation indicated Resident 1 had delusions (altered reality that is persistently held despite evidence or agreement to the contrary) and auditory hallucinations (when the person hears voices or noises that don't exist in reality). The evaluation indicated Resident 1 was diagnosed with psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review or Resident 1 ' s History and Physical (H&P), dated 6/13/2024, the H&P indicated Resident 1 was unable to communicate/ make decisions for self. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 6/15/2024, the MDS indicated Resident 1 had severe cognitive (ability to learn, remember, understand, and make decision) impairment for skills on daily decision making. The MDS indicated Resident 1 needed set up assistance with eating, supervision (helper provides verbal cues) with oral hygiene, upper body dressing, personal hygiene, and needed partial assistance (helper less than half the effort to complete the task) with toilet hygiene, and lower body dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
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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	During a review of Resident 1 ' s Admission/Readmission Initial Assessment, dated 6/11/2024, the assessment indicated Resident 1 was a high risk for elopement because Resident 1 was independently mobile and had a history of elopement. During a review of Resident 1 ' s Weekly Summary, dated 6/30/2024 at 2:38 a.m., the summary indicated Resident 1 was alert and confused. During a review of Resident 1 ' s Order Summary Report, active orders as of 7/5/2024, the summary indicated the following orders, starting on 6/11/2024: a. May have wander guard to the left hand to alert staff of resident trying to leave facility unassisted. b. Check wander guard placement every shift. c. Monitor Resident 1 for episodes of wandering behavior (a behavioral problem of disorientation and difficulty relating to the environment with aimless or purposeful motor activity that causes a social problem such as getting lost, leaving a safe environment, or intruding in inappropriate places) around hallway and patio every shift. d. Check for wander guard function every Sunday during 7-3 p.m. shift. e. Olanzapine 15 milligrams one tablet orally two times a day for schizophrenia. During a review of Resident 1 ' s untitled care plan, focus indicated Resident 1 was at risk for elopement related to cognitive impairment, and mood and behavioral symptoms, initiated 6/17/2024. The care plan goal indicated Resident 1 will not leave the facility unsupervised. Care plan interventions included: a. May have wander guard on left hand to alert staff if resident was trying to leave the facility unassisted. b. Check wander guard function every Sunday during day shift. c. Check wander guard placement on the left hand every shift d. Monitor Resident 1 for wandering behavior every shift around the hallway and patio. e. Frequent rounds by staff f. Remind resident that he needs to remain in the facility unless family of staff member was with them. During a review of Resident 1 ' s Monitoring side effects/Behaviors/black box (added to the labeling of drugs when serious adverse reactions or special problems occur) warnings for 7/2024, the monitoring indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Gardena Post Acute	16530 S Broadway Street Gardena, CA 90248

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	a. Starting 6/11/2024, check wander guard placement every shift. On 7/2/2024 night shift, Resident 1 was absent from the facility without meds on 7/2/2024 night shift. b. Staring on 6/11/2024, monitor Resident 1 for episodes of wandering behavior, around hallway and patio every shift. In 7/1/2024, Resident 1 was observed with this behavior 4 times. On 7/2/2024, Resident 1 was observed wandering 4 times. During a review of a document titled Situation Background Assessment Appearance Request (SBAR) Communication Form- General, 7/3/2024 at 1:45 a.m., for Resident 1, the form indicated the following: a. At 11:00 p.m , Resident 1 was seen lying in bed comfortably watching television in no apparent distress, denied pain or discomfort, and respirations were even and unlabored and no respiratory distress. b. At 12:00 midnight Resident 1 remained in bed, sitting at the edge of the bed watching television. c. At approximately 1:15 a.m. the Certified nurse assistant (CNA) noticed Resident 1 was not in the resident ' s room or restroom and made charge nurse aware. d. At 1 :20 a.m. staff searched for Resident 1 in the facility. Resident 1 ' s wander guard was noted fully stretched on the floor. e. At 1:36 a.m., the police was notified of Resident 1 ' s elopement. f. At 1:52a.m. sheriffs arrived. g. At 2:13 a.m. writer finished giving report to the Sheriff and the Sheriff was made aware Resident 1 was alert and oriented times 2 with episodes of confusion and diagnosed with paranoid Schizophrenia. During a review of Resident 1 GACH Emergency Department Physician note, dated 7/13/2024 at 7:17 p.m., the note indicated facility staff found Resident 1 wandering around the streets and was brought in by ambulance to GACH for further evaluation. The note indicated Resident 1had acute psychosis, severe anemia, and type 2 diabetes. Resident 1 received a blood transfusion for the anemia. During a review of GACH Psychiatric consult, 7/14/2024, the consult indicated Resident 1 was agitated and aggressive in the emergency room and Resident 1 was placed with a sitter (a healthcare worker who will provide continuous supervision to a resident) for safety and placed on a 5150 hold (72-hour hold in the hospital). The consult indicated Resident 1 required inpatient hospitalization for further stabilization of symptoms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continued observation and interview on 7/4/2024 at 9:50 a.m., with RNS, it was noted that Resident 1 ' s room was right by the front door that exits to the parking lot (Door 2). Door 2 was also noted with two unsecure (can be opened without a key or a code) latches. The RNS stated that Door 2 does not alarm when opened and at night no one was monitoring the residents exiting Door 2. The RNS stated since Resident 1 removed his wander guard he probably just opened the latches and exited. RNS stated it was not safe to have an unsecure Door 2 because if residents can remove the wonder guard bracelet and open the latches, they can leave at night undetected. During an interview with Licensed Vocational Nurse (LVN)1 on 7/4/2024 at 2:00 p.m., LVN 1 stated at approximately 1 a.m. CNA 4 stated Resident 1 was not in his room or the restroom. After a search was conducted in the facility the [NAME] was notified and three sheriffs also searched in the premises to no avail. During a concurrent interview and record review with LVN 1, on 7/5/2024 at 10:53 a.m., Resident 1 ' s records were reviewed. Resident 1 ' s Elopement assessment on admission, dated 6/11/2024, indicated Resident 1 was a high risk for elopement. Resident 1 ' s SBAR, dated 7/3/2024, was reviewed, and the SBAR indicated the stretched out and damaged wander guard was observed on the floor. LVN 1 stated Resident 1 should have had the wander guard on. LVN 1 stated Resident 1 should not have left the facility undetected because it was not safe. During an interview with the administrator (ADM) on 7/5/2024 at 4:00 p.m., the ADM stated the doors should be secure and adequate monitoring of high risk for elopement residents should be done. The ADM stated to prevent further elopements, in services was completed. The ADM stated the facility will install magnetic door locks to Doors 1 and 2. The ADM stated until the locks were installed the facility staff will be assigned to monitor the door area to ensure no residents elope. The ADM also stated the facility will ensure monitoring of the high risk for elopement residents were being done by documenting the residents ' whereabouts on an hourly basis. The ADM stated this will be a systematic change that will be immediately implemented. During a review of the facility ' s policy and procedure (P&P) titled Behavioral Assessment, Intervention and Monitoring, revised 3/2019, the P&P indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with comprehensive assessment and plan of care. Residents will have minimal complications associated with the management of altered or impaired behavior. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. During a review of the facility ' s P&P titled Care plans, Comprehensive Person-Centered, care plan policy, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident.