

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Colonial Gardens Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 7246 S. Rosemead Blvd. Pico Rivera, CA 90660	

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 - Immediate jeopardy to resident health or safety</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** 48131</p> <p>Based on observation, interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Assess the elopement (to leave unnoticed) risk for one of two sampled residents (Resident 1) who attempted to elope from the facility on 4/30/2024 and 5/23/2024 and was assessed on the Minimum Data Set (MDS, resident assessment and care-screening tool) as having wandering behaviors (when a person leaves a safe area or caregiver, which can be a risk to their safety, also called elopement), per the care plan. 2. Follow its policy and procedures (P&P) titled Interdisciplinary Team Conference (IDT, group of different disciplines working together towards a common goal for a resident) and Elopement Wandering Resident by not holding an IDT meeting to ensure resident ' s safety, after Resident 1 ' s elopement attempts on 4/30/2024 and 5/23/2024. <p>As a result, Resident 1 eloped from the facility on 9/8/2024 and was still missing as of 9/12/2024.</p> <p>On 9/12/2024 at 3:33 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and Director of Nursing (DON) due to the facility's failure assess Resident 1 as high risk for elopement and to conduct IDT meetings after each elopement to prevent Resident 1 ' s elopement from the facility.</p> <p>On 9/13/2024 at 10:44 a.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After onsite verification of the IJRP implementation through observation, interview, and record review, the IJ was removed onsite on 9/13/2024 at 4:17 p.m., in the presence of the ADM and DON.</p> <p>The IJPR included the following immediate actions:</p> <ol style="list-style-type: none"> 1. Staff faxed a missing persons flyer to 90 hospitals in the area on 9/11/2024 and 9/12/2024. Police Departments in the area were notified on 9/11/2024 and continued to help in locating the resident. Resident 1 ' s family member (FM 1), who was also the conservator (a person appointed by the court to manage the personal affairs and finances of an adult who is unable to do so themselves), was also notified. The facility continued to call local hospitals and communicate with police department in search of Resident 1 on a daily basis. <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555715
		If continuation sheet Page 1 of 7

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. The facility was a locked facility (a secure area that prevents residents from leaving at will), and all current residents were affected by this deficient practice. The Elopement Risk Assessment and Elopement Care Plans for all current residents were completed by the IDT on 9/12/2024. Licensed nurses would complete an Elopement Risk Assessment and an Elopement Care Plan upon admission, quarterly, annually, or when any type of elopement episode occurred. Once the elopement assessments were completed, the IDT would meet to review and give recommendations and interventions. Residents that score 10 or higher on the Elopement Risk Assessment would be considered high-risk. A list of residents at high-risk for elopement would be provided to the certified nursing assistants (CNAs) and licensed nurses by the (MDS) Coordinator to be addressed at the daily team huddles. Team Huddles between the licensed nurses and the CNAs would be done at the beginning of each shift to communicate any new residents that have been triggered for high-risk elopement. Any resident that was considered a high-risk would be moved closer to the nurse 's station, given a pink arm band, and a pink door name to identify them as high-risk for elopement.</p> <p>3. Residents identified due to previous elopement attempts were stationed closer to the nurse 's station for closer observation. Hall monitoring would be done every 30 minutes throughout the day. Yard monitoring would be done for any resident that goes outside.</p> <p>4. Licensed nurses were in-serviced on the Elopement Risk Assessments and Elopement Care Plans and the P&P for Elopement on 9/12/2024 and 9/13/2024. Licensed nurses that were not in-serviced would be in-serviced by 9/23/2024. The IDT was in-serviced on 9/12/2024 regarding the Elopement Risk Assessment, the Elopement Care Plan, The Elopement, and IDT Conference P&P. The Elopement Wandering Resident P&P was updated on 9/12/2024 to reflect the new interventions that will be implemented. All staff will be in-serviced on how to identify and monitor any resident that has been identified as high-risk for potential elopement by 9/23/2024.</p> <p>5. The Quality Assurance Performance Improvement (QAPI) for elopement was initiated on 9/12/2024. The QAPI lesson plan objective would be to understand the staff 's role in prevention of elopement and be able to complete the required assessment documentation pre and post of an actual event. The objective of the QAPI would be for the staff member to detect, prevent as much as possible and correct any potential risk factors to ensure the safety of the residents. The facility will receive feedback from all staff if they feel there was a better means of monitoring the resident 's safety and whereabouts. The QAPI will be reviewed throughout the next month for effectiveness. The QAPI will be presented at the next QA Meeting that was scheduled for 9/17/2024 for review and/or recommendations.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Admission Record (face sheet), dated 6/10/2024, the face sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included schizoaffective disorder (a mental health condition that was marked by symptoms, such as hallucinations (seeing, hearing, smelling, tasting, or feeling something that appears to be real but doesn't actually exist), delusions (when a person cannot tell what was real from what was imaginary), and mood disorder (a mental health condition that primarily affects the feelings and moods experienced by an individual) symptoms, bipolar type (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), hypertension (high blood pressure), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), dysphagia (difficulty swallowing), and chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe and worsens over time).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 5/24/2024, the H&P indicated Resident 1 was guarded (cautious) and needed assistance with instrumental activities of daily living (IADLs, complex activities that allow an individual to live independently in a community such as managing medications, paying bills, and cooking meals) and was independent with activities of daily living (ADLs, self-care activities performed daily such as dressing, toileting hygiene, and bathing).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 8/26/2024, the MDS indicated Resident 1 had the ability to understand and be understood by others. The MDS indicated Resident 1 ' s ability to make decisions regarding daily life was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 was independent with eating and required set-up and clean-up assistance for toileting and personal hygiene. The MDS indicated Resident 1 had behaviors of hallucinations, delusions and wandering that occurred one to three days per week. The MDS indicated Resident 1 did not use wander and/or elopement alarm (an alarm used to help prevent people from leaving a safe area or caregiver, worn on the wrist or ankle) or other alarms.</p> <p>During a review of Resident 1's care plan titled, Wandering, dated 4/18/2024, the care plan indicated Resident 1 was at risk for wandering and injury. The care plan indicated the goal was for Resident 1 to wander safely within appropriate areas and have no falls or injury for three months. The care plan indicated staff were to monitor Resident 1 ' s whereabouts, assess the resident ' s risk for elopement and maintain a safe and hazard free environment.</p> <p>During a review of Resident 1 ' s Situation, Background, Assessment, Recommendation (SBAR - a written communication tool that helps provide essential, concise information, usually during crucial situations), dated 4/30/2024 at 2:30 p.m., the SBAR indicated on 4/30/2024 Resident 1 had an attempted Absent without Leave (AWOL - a resident ' s absence from the facility without permission). The SBAR indicated Resident 1 was found walking on the street outside of the facility and transported back to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s care plan titled, Wandering, revised 4/30/2024, the care plan indicated interventions to include increase Gabapentin (medication used to treat for seizures [sudden, uncontrolled burst of electrical activity in the brain], nerve pain, and can also be used to relieve anxiety) 300 milligrams (MG - a unit of measure), Ativan (medication used to treat anxiety) 1 MG every eight hours as needed for 14 days due to agitation (a condition in which a person was unable to relax and be still). The care plan did not indicate any non-pharmacological (a treatment or intervention that does not use medication) interventions to prevent Resident 1 ' s wandering behaviors.</p> <p>During a review of Resident 1 ' s care plan titled, Wandering dated 5/21/2024, the care plan indicated Resident 1 was at risk for wandering, actual wandering, a had a history of elopement and exit seeking behavior. The care plan indicated interventions such as monitoring Resident 1 ' s whereabouts, assess the resident ' s risk for elopement, ensure the resident had an identification band, monitor toileting needs, redirecting, cueing as appropriate and maintain a safe and hazard free environment.</p> <p>During a review of Resident 1 ' s SBAR, dated 5/23/2024 at 2 p.m., the SBAR indicated on 5/23/2024 Resident 1 had an attempted AWOL. The SBAR indicated Resident 1 attempted to leave over the fence of the outside patio and was brought back inside the facility by staff.</p> <p>During a review of Resident 1 ' s care plan titled, Wandering revised 5/23/2024, the care plan indicated interventions including a psychiatric consult as ordered, as needed and document effectiveness.</p> <p>During a review of Resident 1 ' s care plan titled, Inappropriate Behavior, dated 8/31/2024, the care plan indicated Resident 1 had acute wandering, related to increased agitation. The care plan indicated Resident 1 will not injure himself or others daily for three months. The care plan interventions included staff will provide a safe, calm quiet environment/approach, establish daily routine based on input of the resident, assist the resident for ability to control behavior and express needs, and refer to a mental health specialist and review medications monthly.</p> <p>During a review of Resident 1 ' s SBAR, dated 8/31/2024 at 3:30 p.m., the SBAR indicated Resident 1 was exhibiting increased agitation, was sexually inappropriate, delusional, pacing hallways, had exit seeking behaviors (wandering into unfamiliar places to find a way out) and increased risk for elopement. The SBAR indicated Resident 1 ' s family member (FM 1) and Physician and were notified and the Physician ordered for Resident 1 to be transferred to a general acute care hospital (GACH).</p> <p>During a review of Resident 1 ' s Physician and Telephone Orders dated 8/31/2024 at 3:30 p.m., the orders indicated to transfer Resident 1 to a GACH for psychiatry evaluation.</p> <p>During a review of Resident 1 ' s Licensed Personnel Progress Notes dated 9/6/2024 at 1:25 p.m., the progress note indicated Resident 1 was readmitted to the facility from the GACH.</p> <p>During a review of Resident 1 ' s care plan titled, AWOL, dated 9/6/2024, the care plan indicated Resident 1 would have no episodes of leaving the facility every day for 90 days. The care plan interventions indicated to alert all staff that resident was an AWOL risk, frequent visual checks at least every 2 hours, to assess the resident ' s safety and whereabouts, redirect resident when close to the fence, redirect away from the fence, and the yard monitor (staff assigned to observe and frequently check resident ' s whereabouts when outside) would closely watch Resident 1 when on the patio.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s SBAR dated 9/8/2024 at 9:20 a.m., the SBAR indicated a Certified Nursing Assistant (CNA 3) reported he was unable to find Resident 1. The SBAR indicated Resident 1 left the facility AWOL. The SBAR indicated staff searched inside and the surrounding areas outside of the facility but was unable to locate Resident 1. The SBAR indicated FM 1 and the police were notified.</p> <p>During a review of Resident 1 ' s Social Services Progress Note, dated 9/9/2024, the progress noted indicated Resident 1 left the facility AWOL. The progress note indicated Resident 1 broke the window, climbed out and walked out of the back fence.</p> <p>During an observation on 9/10/2024 at 10:31 a.m., Resident 1 ' s room was observed at the far end of the hallway, away from the nursing station and next to a locked exit door leading to the smoking patio. There were no other residents observed residing in the room.</p> <p>During an interview on 9/10/2024 at 10:47 a.m., with the Infection Preventionist (IP) Nurse, the IP stated the staff needed to be in-serviced of AWOL risks for Resident 1. The IP stated frequent visual checks and hourly visual checks should have been done for Resident 1. The IP stated that someone must not have been following the protocol which led to Resident 1 ' s elopement.</p> <p>During an interview on 9/10/2024 at 11:52 a.m., with CNA 2, CNA 2 stated about three months ago he (CNA 2) observed Resident 1 outside in the yard, standing by a bush. CNA 2 stated Resident 1 suddenly ran and jumped over the fence. CNA 2 stated the gate of the fence was locked and he called the Director of Staffing Development (DSD) to assist. CNA 2 stated the DSD got in his vehicle to look for Resident 1. CNA 2 stated the DSD found Resident 1 in the surrounding neighborhood and brought the resident back to the facility. CNA 2 stated staff were expected to do frequent visual checks on Resident 1 and know the resident ' s whereabouts while in the yard.</p> <p>During an interview on 9/10/2024 at 12:55 p.m. with FM 1, FM 1 stated Resident 1 had been known to go AWOL. FM 1 stated Resident 1 was at another facility where he continuously tried to go AWOL, but the previous facility watched Resident 1 very well and he was not able to escape. FM 1 stated Resident 1 had a history of AWOL which was why he was placed in a locked facility.</p> <p>During an interview on 9/10/2024 at 2:24 p.m. with the DSD, the DSD stated Resident 1 ' s biggest risk was going AWOL. The DSD stated he could not recall the date, but he searched for Resident 1 after he eloped when he was first admitted to the facility. The DSD stated he found Resident 1 and bring him back to the facility in his (DSD) car. The DSD stated Resident 1 came to the facility with a history of exit seeking behaviors. The DSD stated Resident 1 attempted to leave the yard on several occasions and jumped the fence twice (unable to recall the dates). The DSD stated a yellow tape was placed across the area where Resident 1 jumped the fence to prevent him from going over the fence. The DSD stated on 9/8/2024 at approximately 9:20 a.m., Resident 1 broke the window in his room and went out of the window. The DSD stated nobody heard the window break. The DSD stated Resident 1 ' s window led to an area of the facility that was not used or monitored by staff. The DSD stated Resident 1 ' s room should have been in an area where the window faced the patio and staff could see when the resident attempted to leave through the window. The DSD stated the trouble with Resident 1 being out was alarming because he cut himself and the facility had not received a call from any of the hospitals indicated the resident was there.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 9/10/2024 at 3:32 p.m., with CNA 3, CNA 3 stated he was assigned to Resident 1 on 9/8/2024. CNA 3 stated Resident 1 received his medications around 7:30 a.m., began walking around the facility. CNA 3 stated Resident 1 went on a smoke break out on the patio at 9 a.m. CNA 3 stated he (CNA 3) went on break, returned at 9:15 a.m. and went to Resident 1 ' s room. CNA 3 stated he got to Resident 1 ' s room about 9:18 a.m. and Resident 1 was not there. CNA 3 stated, CNA 5 reported that she had just seen Resident 1 at 9:20 a.m. walking down the hallway. CNA 3 stated Resident 2, who was in the room next to Resident 1 ' s room, came out of the room and told CNA 3 that he saw blood in the bathroom he shared with Resident 1, at about 9:21 a.m. CNA 3 stated he went to Resident 1 ' s room and observed small drops of blood on the bathroom floor, bathroom sink and on Resident 1 ' s bed. CNA 3 stated he ran out of the room to try and locate Resident 1. CNA 3 stated when he could not find Resident 1, he notified the charge nurse and went back to Resident 1 ' s room. CNA 3 stated when he noticed the broken window. CNA 3 stated he went to his car and searched throughout the neighborhood. CNA 3 stated Resident 1 was nowhere to be found so he returned to the facility. CNA 3 stated when he arrived back to the facility, the police department was there.</p> <p>During a concurrent interview and record review on 9/11/2024 at 9:38 a.m., with the Director of Nursing (DON), Resident 1 ' s care plans titled, Wandering dated 4/8/2024 and 5/21/2024, Inappropriate Behavior, dated 8/31/2024 and AWOL dated 9/6/2024 and the facility ' s Policy and Procedures (P&P) titled Interdisciplinary Team Conference (IDT), undated, and Elopement Wandering Resident undated, were reviewed. The DON stated if a resident eloped and was found, an SBAR or Change of Condition (COC) was supposed to be done on the resident. The DON stated an IDT meeting was only done for residents that eloped and were not found. The DON stated Resident 1 ' s care plan should have had better interventions to meet the resident ' s specific needs. The DON stated the facility was a locked facility, and all residents were considered high risk for elopement, but the elopement and wandering care plans for the Resident 1 did not reflect an individualized care plan for his elopement behaviors. The DON stated the facility did not put residents on 1:1 monitoring (close supervision, to keep the resident within sight at all times to reduce the risk and incidence of harm to the resident) unless they were high risk for elopement. The DON stated Resident 1 should have been considered a high-risk for elopement [JE1] since he had successfully eloped from the facility twice in the past. The DON stated she could not predict Resident 1 would break the window. The DON stated the IDT P&P indicated an IDT meeting will be held after an incident occurred to ensure resident ' s safety and the care plan reviewed and revised. The DON stated the importance of holding an IDT meeting after an incident was to collaborate as a team to formulate interventions and solve problems for the resident. The DON stated, the facility did not hold an IDT after Resident 1 eloped on 4/30/2024 and 5/23/2024. The DON stated Resident 1 ' s elopement care plan indicated an intervention to assess risk for elopement. The DON stated the facility did not do a risk assessment on their residents because all facility ' s residents were considered high risk. The DON stated the risk assessment should not have been checked as an intervention on Resident 1 ' s care plan. The DON stated she has never seen a risk assessment form and the facility has never used one in her [AGE] years of working in the facility. The DON stated if Resident 1 was not found, he can get hurt, he doesn ' t have food to eat, his wound can get infected from the injury, and he can suffer from dehydration, or heat stroke.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>b. During a concurrent observation and interview on 9/12/2024 at 12:01 p.m. with Resident 2, in Resident 2 ' s room, Resident 2 ' s room was observed next to Resident 1 ' s. Resident 2 pointed towards the bathroom he shared with Resident 1 and stated Resident 1 broke the window in his room and then came in the bathroom bleeding. Resident 2 did not recall the exact time or day of the incident. Resident 2 pointed to the areas in the bathroom where the blood was located. Resident 2 also pointed to the direction toward the window in Resident 1 ' s room, stating Resident 1 left the bathroom and walked towards the window. Resident 2 stated he did not hear or see Resident 1 break the window but saw the blood in the bathroom and Resident 1 walking towards his bed. Resident 2 stated he notified the nurse that there was blood in the bathroom.</p> <p>During a review of Resident 2's face sheet, dated 9/20/2024, the face sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which schizoaffective disorder, bipolar type, hypertension, dysphagia, and COPD.</p> <p>During a review of Resident 2 ' s History and Physical (H&P), dated 7/31/2024, the H&P indicated Resident 2 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care planning tool), dated 7/31/2024 the MDS indicated Resident 2 had some difficulty communicating words or finishing thoughts but was able if prompted or given time. The MDS indicated Resident 2 could comprehend most conversation.</p> <p>During a review of the facility ' s undated P&P titled Elopement Wandering Resident, the P&P indicated the facility would modify the resident ' s care plan to indicate the resident was at high-risk for elopement. The P&P indicated an IDT conference would be held after an incident occurred to ensure resident ' s safety.</p> <p>During a review of the facility ' s P&P titled Interdisciplinary Team Conference (IDT), undated, the P&P indicated the facility would initiate an IDT Conference for each resident within 14 days of admission, quarterly, and during any change of condition to review, revise and accelerate the plan of care.</p>		