STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555791	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens Healthcare Center	17650 Devonshire Street Northridge, CA 91325

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 42311 Based on interview and record review, the facility failed to ensure the Responsible Party (RP) or the Resident Representative (RR) of one of three sampled residents (Resident 1), who had a history of dementia (a progressive state of decline in mental abilities), with moderately impaired cognition for daily decision making, and had no capacity to make medical decisions, signed Resident 1's consent forms for the administration of the following: 1. Citalopram (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, loss of interest, and changes in behavior and cognitive function]), 2. Influenza vaccine (also known as the flu shot, protects against the flu [respiratory illness that infect the nose, throat, and sometimes the lungs]), 3. Coronavirus Disease 2019 (COVID-19- respiratory disease is thought to spread from person to person through droplets released when an infected person coughs, sneezes or talks) vaccine. These deficient practices placed Resident 1 at risk for making health care decisions because the facility staff made Resident 1 sign her (Resident 1) own consent forms that she (Resident 1) may not able to understand based on Resident 1's medical condition. Findings: During a record review of Resident 's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/30/2024, with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that affects movement), generalized muscle weakness, neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood) and unspecified (unconfirmed) depression. The Admission Record indicated Family Member 1 (FM 1) and FM 2 were both listed as RPs. During a record review of Resident 1's Progress Notes, dated 12/30/2024, timed at 8:13 p.m., the Progress Notes indicated Resident 1 was confused (unable to think clearly), uncooperative and combative (eagerness to fight) with staff. (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
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Verification of Informed Consent (a process in which a patient or research participant is provided with all the necessary information about a medical procedure, treatment, or research study, and gives their voluntary, informed, and rational permission to proceed) For Psychotropic Medication (drugs that affect the brain and nervous system, altering mood, behavior, and cognitive function), dated 12/30/2024, the Verification of Informed Consent indicated citalopram was ordered for Resident 1. The Verification of Informed Consent indicated Resident 1 signed the form to give consent to the use of citalopram and signed in the presence of Registered Nurse 2 (RN 2). The Verification of Informed Consent did not indicate the name of the physician who obtained consent and date the physician signed the consent. The Verification of Informed Consent indicated the following were discussed and reviewed with Resident 1: I. The reason for the treatment and the nature and seriousness of the resident's illness. 2.The nature of the procedures to be used in the proposed treatment, including their probable frequency and duration. 3.The probable degree and duration (temporary or permanent) of improvement of remission (a decrease in or disappearance of signs and symptoms) expected, with or without such treatment. 4.The nature, degree, duration and probability of the side effects and significant risks (a situation with a high likelihood of causing harm or a negative outcome), commonly known by health professions. 5.The reasonable alternative treatment and risk, and why the health professional is recommending in this particular treatment, and 6. That the resident has the right to accept the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time. During a record review of Resident 1's COVID-19 Immunization (the process of giving a vaccine to a person to protect them against disease) Consent form, dated 12/30/2024, the COVID-19 Consent form indicated Resident 1 signed her (Resident 1) own consent form with RN 2 and gave consent to receiving COVID-19 vaccine. During a record review of Resident 1's Immunization Consent-Influenza Vaccine Information and Consent form, dated 12/30/2024, the Influenza Vaccine Consent form indicated Resident 1 signed her (Resident 1) own consent form with RN 2 and gave consent to receiving Influenza vaccine. During a record review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/1/2025, the H&P indicated Resident 1 can make needs known but cannot make medical decisions. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/2/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 was on antipsychotic (medication used to treat psychosis [a collection of symptoms that affect your ability to tell what's real and what is not] and antidepressant medications (medication used to treat depression). During a concurrent interview and record review on 1/22/2024, at 4:31 p.m., with the Director of Staff Development (DSD), Resident 1's consent forms for citalopram, COVID-19, and Influenza vaccine, dated 12/30/2024 were reviewed. The DSD stated based on the records reviewed, RN 2 should have called the RP and notified of the orders for citalopram, influenza vaccine, and COVID-19 vaccine and obtain a telephone consent. During an interview on 1/22/2025, at 5:12 p.m , the Director of Nursing (DON) stated Resident 1 did not have the capacity to sign the consent. The DON stated Resident 1 cannot sign her (Resident 1) own consent form to take the medication (citalopram) and vaccines (for Influenza and COVID-19). During an interview on 1/23/2025, at 12:32 p.m., the Social Service Director (SSD) stated Family Member 1 (FM 1) was the Responsible Party (RP) and should sign the consent forms. The SSD stated if FM 1 was not present to sign any consent forms, RP should have been called through phone call and have two facility staff as witnesses. The SSD stated Resident 1 could experience side effects from the medications. During a concurrent interview and record review on 1/23/2025, at 1:08 p.m., with the DSD, Resident 1's Progress Notes, dated 12/30/2024 to 1/3/2025, and Immunization Record were reviewed. The DSD stated Resident 1 received the COVID-19 and influenza vaccines on 1/3/2025. The DSD stated she (DSD) verified there was a consent form, and she (DSD) informed the Pharmacy and Pharmacy gave the COVID-19 vaccine and influenza vaccine on 1/3/2025. The DSD stated there was no documentation in Resident 1's Progress Notes that RP was notified. The DSD stated she (DSD) cannot recall if RP was notified. The DSD stated she (DSD) called the RP after the vaccine was administered. The DSD stated RP should have been called and informed before administering the vaccines. The DSD stated the importance of RP consent was for them to be informed of the risk and benefits. During an interview on 1/23/2025, at 2:54 p.m., RN 3 stated Resident 1 cannot sign any consent if they are not cognitively intact. RN 3 stated medication error can happen if Resident 1, who had no capacity to make medical decisions, signs their own consent. During an interview on 1/23/2025, at 3:52 p.m., with the Director of Nursing, the DON stated FM 1 was present at bedside when Resident 1 signed the consent. The DON stated the consents obtained were all valid. During a concurrent interview and record review on 1/23/2025, at 4:20 p.m., with the DSD, the facility's policy and procedure (PnP) titled, Informed Consent, dated 4/4/2024, was reviewed. The PnP indicated, Informed Consent for the use of restraint and psychotropic drug use: (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. The Licensed prescriber shall determine the capacity of the resident to understand and make decisions, If the resident is determined to not have the capacity to make informed decisions, a surrogate decision maker shall be identified E. When an order for the use of restraint(s) (chemical [use of medication to control a person's behavior or movement] and or physical [use of physical contact or a device to limit a person's movement or access to their body]) or new orders or an increase in psychotropic or psychotherapeutic medication, Licensed Nurse shall: i. Verify whether informed consent was obtained from resident or responsible party; and ii. Document the verification process in the resident's clinical records or on the Informed Consent Form F. As need may arise, the facility may facilitate the process of obtaining informed consent for the Licensed prescriber by: 1. Providing the phone number of the Responsible Party. 11. Bringing the resident to the phone to speak to the Attending Physician; or 111. If informed consent cannot be obtained because of a language or communication barrier, the Facility will arrange for an interpreter and documents such in the medical record. G. When the Licensed prescriber prescribes a medical intervention that requires an informed consent, but is unable to obtain informed consent because the physician and/or surgeon determined that the resident lacks capacity to provide informed consent and has no assigned surrogate decision-maker or legal representative, the facility will seek assistance from the Long-Term Care Patient Representative Program for the selection of a public patient representative - to review the prescribed intervention prior to its administration with the facility's interdisciplinary (IDT-a coordinated group of experts from several different fields who work together) team. INFORMED CONSENT FOR PSYCHOTHERAPEUTIC DRUG USE: A. Prior to prescribing a psychotherapeutic medication, the Licensed prescriber shall personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. During a review of facility's PnP titled, Influenza Vaccine, dated 8/2016, and last reviewed on 1/15/2024, the PnP indicated, Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. During a record review of facility's PnP titled, COVID-19 Vaccination, dated 10/31/2024, the PnP indicated, 2. The Resident (or Resident Representative) . have the opportunity to accept or refuse a COVID-19 vaccine. 3. COVID-19 vaccine education, documentation and reporting are overseen by the Infection Preventionist. 6. Residents . are screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine. 7. Resident or Resident Representative . must sign a consent to vaccinate form prior to receiving the vaccine. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation and reporting: 1. The Resident's medical record includes documentation that indicates the following (as applicable): a. That the Resident or Resident Representative was offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine. b. That the Resident or Resident Representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine. c. Signed consent Based on interview and record review, the facility failed to ensure the Responsible Party (RP) or the Resident Representative (RR) of one of three sampled residents (Resident 1), who had a history of dementia (a progressive state of decline in mental abilities), with moderately impaired cognition for daily decision making, and had no capacity to make medical decisions, signed Resident 1's consent forms for the administration of the following: 1. Citalopram (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, loss of interest, and changes in behavior and cognitive function]), 2. Influenza vaccine (also known as the flu shot, protects against the flu [respiratory illness that infect the nose, throat, and sometimes the lungs]), 3. Coronavirus Disease 2019 (COVID-19- respiratory disease is thought to spread from person to person through droplets released when an infected person coughs, sneezes or talks) vaccine. These deficient practices placed Resident 1 at risk for making health care decisions because the facility staff made Resident 1 sign her (Resident 1) own consent forms that she (Resident 1) may not able to understand based on Resident 1's medical condition. Findings: During a record review of Resident ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/30/2024, with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that affects movement), generalized muscle weakness, neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood) and unspecified (unconfirmed) depression. The Admission Record indicated Family Member 1 (FM 1) and FM 2 were both listed as RPs. During a record review of Resident 1's Progress Notes, dated 12/30/2024, timed at 8:13 p.m., the Progress Notes indicated Resident 1 was confused (unable to think clearly), uncooperative and combative (eagerness to fight) with staff. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Verification of Informed Consent (a process in which a patient or research participant is provided with all the necessary information about a medical procedure, treatment, or research study, and gives their voluntary, informed, and rational permission to proceed) For Psychotropic Medication (drugs that affect the brain and nervous system, altering mood, behavior, and cognitive function), dated 12/30/2024, the Verification of Informed Consent indicated citalopram was ordered for Resident 1. The Verification of Informed Consent indicated Resident 1 signed the form to give consent to the use of citalopram and signed in the presence of Registered Nurse 2 (RN 2). The Verification of Informed Consent did not indicate the name of the physician who obtained consent and date the physician signed the consent. The Verification of Informed Consent indicated the following were discussed and reviewed with Resident 1: I. The reason for the treatment and the nature and seriousness of the resident's illness. 2.The nature of the procedures to be used in the proposed treatment, including their probable frequency and duration. 3.The probable degree and duration (temporary or permanent) of improvement of remission (a decrease in or disappearance of signs and symptoms) expected, with or without such treatment. 4.The nature, degree, duration and probability of the side effects and significant risks (a situation with a high likelihood of causing harm or a negative outcome), commonly known by health professions. 5.The reasonable alternative treatment and risk, and why the health professional is recommending in this particular treatment, and 6. That the resident has the right to accept the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time. During a record review of Resident 1's COVID-19 Immunization (the process of giving a vaccine to a person to protect them against disease) Consent form, dated 12/30/2024, the COVID-19 Consent form indicated Resident 1 signed her (Resident 1) own consent form with RN 2 and gave consent to receiving COVID-19 vaccine. During a record review of Resident 1's Immunization Consent-Influenza Vaccine Information and Consent form, dated 12/30/2024, the Influenza Vaccine Consent form indicated Resident 1 signed her (Resident 1) own consent form with RN 2 and gave consent to receiving Influenza vaccine. During a record review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/1/2025, the H&P indicated Resident 1 can make needs known but cannot make medical decisions. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/2/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 was on antipsychotic (medication used to treat psychosis [a collection of symptoms that affect your ability to tell what's real and what is not] and antidepressant medications (medication used to treat depression). During a concurrent interview and record review on 1/22/2024, at 4:31 p.m., with the Director of Staff Development (DSD), Resident 1's consent forms for citalopram, COVID-19, and Influenza vaccine, dated 12/30/2024 were reviewed. The DSD stated based on the records reviewed, RN 2 should have called the RP and notified of the orders for citalopram, influenza vaccine, and COVID-19 vaccine and obtain a telephone consent. During an interview on 1/22/2025, at 5:12 p.m , the Director of Nursing (DON) stated Resident 1 did not have the capacity to sign the consent. The DON stated Resident 1 cannot sign her (Resident 1) own consent form to take the medication (citalopram) and vaccines (for Influenza and COVID-19). During an interview on 1/23/2025, at 12:32 p.m., the Social Service Director (SSD) stated Family Member 1 (FM 1) was the Responsible Party (RP) and should sign the consent forms. The SSD stated if FM 1 was not present to sign any consent forms, RP should have been called through phone call and have two facility staff as witnesses. The SSD stated Resident 1 could experience side effects from the medications. During a concurrent interview and record review on 1/23/2025, at 1:08 p.m., with the DSD, Resident 1's Progress Notes, dated 12/30/2024 to 1/3/2025, and Immunization Record were reviewed. The DSD stated Resident 1 received the COVID-19 and influenza vaccines on 1/3/2025. The DSD stated she (DSD) verified there was a consent form, and she (DSD) informed the Pharmacy and Pharmacy gave the COVID-19 vaccine and influenza vaccine on 1/3/2025. The DSD stated there was no documentation in Resident 1's Progress Notes that RP was notified. The DSD stated she (DSD) cannot recall if RP was notified. The DSD stated she (DSD) called the RP after the vaccine was administered. The DSD stated RP should have been called and informed before administering the vaccines. The DSD stated the importance of RP consent was for them to be informed of the risk and benefits. During an interview on 1/23/2025, at 2:54 p.m., RN 3 stated Resident 1 cannot sign any consent if they are not cognitively intact. RN 3 stated medication error can happen if Resident 1, who had no capacity to make medical decisions, signs their own consent. During an interview on 1/23/2025, at 3:52 p.m., with the Director of Nursing, the DON stated FM 1 was present at bedside when Resident 1 signed the consent. The DON stated the consents obtained were all valid. During a concurrent interview and record review on 1/23/2025, at 4:20 p.m., with the DSD, the facility's policy and procedure (PnP) titled, Informed Consent, dated 4/4/2024, was reviewed. The PnP indicated, Informed Consent for the use of restraint and psychotropic drug use: (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. The Licensed prescriber shall determine the capacity of the resident to understand and make decisions, If the resident is determined to not have the capacity to make informed decisions, a surrogate decision maker shall be identified E. When an order for the use of restraint(s) (chemical [use of medication to control a person's behavior or movement] and or physical [use of physical contact or a device to limit a person's movement or access to their body]) or new orders or an increase in psychotropic or psychotherapeutic medication, Licensed Nurse shall: i. Verify whether informed consent was obtained from resident or responsible party; and ii. Document the verification process in the resident's clinical records or on the Informed Consent Form F. As need may arise, the facility may facilitate the process of obtaining informed consent for the Licensed prescriber by: 1. Providing the phone number of the Responsible Party. 11. Bringing the resident to the phone to speak to the Attending Physician; or 111. If informed consent cannot be obtained because of a language or communication barrier, the Facility will arrange for an interpreter and documents such in the medical record. G. When the Licensed prescriber prescribes a medical intervention that requires an informed consent, but is unable to obtain informed consent because the physician and/or surgeon determined that the resident lacks capacity to provide informed consent and has no assigned surrogate decision-maker or legal representative, the facility will seek assistance from the Long-Term Care Patient Representative Program for the selection of a public patient representative - to review the prescribed intervention prior to its administration with the facility's interdisciplinary (IDT-a coordinated group of experts from several different fields who work together) team. INFORMED CONSENT FOR PSYCHOTHERAPEUTIC DRUG USE: A. Prior to prescribing a psychotherapeutic medication, the Licensed prescriber shall personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. During a review of facility's PnP titled, Influenza Vaccine, dated 8/2016, and last reviewed on 1/15/2024, the PnP indicated, Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. During a record review of facility's PnP titled, COVID-19 Vaccination, dated 10/31/2024, the PnP indicated, 2. The Resident (or Resident Representative) . have the opportunity to accept or refuse a COVID-19 vaccine. 3. COVID-19 vaccine education, documentation and reporting are overseen by the Infection Preventionist. 6. Residents . are screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine. 7. Resident or Resident Representative . must sign a consent to vaccinate form prior to receiving the vaccine. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation and reporting: 1. The Resident's medical record includes documentation that indicates the following (as applicable): a. That the Resident or Resident Representative was offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine. b. That the Resident or Resident Representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine. c. Signed consent

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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** 42311 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a history of dementia (a progressive state of decline in mental abilities), assessed as high risk for fall, had a wandering (moving around without any clear purpose or direction) behavior and had a history of fall, was provided supervision and kept free from accidents by failing to reassess Resident 1 for Elopement Screening (a safety assessment that evaluates a resident's risk of leaving a safe environment without permission) after Resident 1 had triggered (activated) the exit door alarm twice on 12/31/2024 and had a wandering behavior on 1/1/2025. On 1/2/2025, Resident 1 was able to walk two steps outside the facility's exit door (located at the side of the facility equipped with a door alarm that is activated when it is opened and held open for a certain period of time) without staff assistance and without an assistive device (walker- [a mobility aid that helps provide stability and balance while you walk] or wheelchair [a mobility device with wheels that helps people who have difficulty walking around]). This deficient practice resulted to Resident 1's fall on 1/2/2025 at 4:47 p.m., outside of the facility's exit door and requiring transfer to General Acute Care Hospital 2 (GACH 2) on 1/2/2025 at 5:45 p.m. Findings: During a record review of Resident's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/30/2024, with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that affects movement), generalized muscle weakness and neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood). During a record review of Resident 1's Morse Fall Risk Screen (an assessment tool that predicts the likelihood that a resident will fall), dated 12/30/2024, timed at 5:20 p.m., the Morse Fall Risk Screen indicated Resident 1 was a high risk for fall. During a record review of Resident 1's Progress Notes, dated 12/30/2024, timed at 8:13 p.m., the Progress Notes indicated Resident 1 was confused (unable to think clearly), uncooperative and combative (eagerness to fight) with staff. During a record review of Resident 1's care plan for at risk for wandering and elopement related to exit-seeking behavior (when someone attempts to leave a place or roams around without a clear destination), frequently asking to go out, expression of not wanting to stay in the facility, wanders aimlessly, dated 12/30/2024, the care plan indicated the following interventions: 1. Call the attention of the resident and redirect (change the course of direction) when seen going towards the exit door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Assess for need of wander or elopement alarm (also known as wanderguard - a system that uses technology to monitor and prevent residents from wandering off or exiting a building). During a record review of Resident 1's care plan on high risk for fall and injury related to poor judgment, poor safety awareness, attempt to get up unassisted, history of fall, poor balance, and unsteady gait (an abnormal walking pattern characterized by a lack of balance and coordination), dated 12/30/2024, the care plan indicated the following interventions: 1. Remind resident to follow safe technique during transfer and ambulation (walking). 2. Provide assistance needed with transfer and ambulation. During a record review of Resident 1's Physical Therapy Evaluation (PT Eval - a detailed assessment of a resident's condition and needs for physical therapy) and Plan of Treatment, dated 12/31/2024. The PT Eval indicated the reason for the PT referral was due to Resident 1's exacerbation (is the worsening of a disease or an increase in its symptoms) of decrease in strength (a significant worsening or sudden decline in muscle strength), decrease in functional mobility (the ability to move around safely and independently to perform daily tasks), decrease in transfers, reduced ability to safely ambulate, reduced balance, decreased neuromotor control (a loss of the ability to control voluntary movement, posture, and limb orientation) , decreased coordination (when a person has difficulty controlling their muscles and movements), decreased judgment, cognitive deficits (impairments in various aspects of mental functioning, including memory, attention, problem-solving, language, and reasoning), and increased need for assistance from others. The PT eval indicated Resident 1 demonstrated decline in prior level of function, standing balance deficits and decrease cognition impacting safe increase functional transfer and gait. The PT eval indicated a short-term goal that Resident 1 will safely ambulate on level surfaces 90 feet using front wheeled walker (FWW- a mobility aid with two wheels on the front legs and two legs in the back) with contact guard assists (CGA- a type of physical therapy assistance that involves a caregiver providing a light touch to help a person maintain balance or stability). During a record review of Resident 1's Progress Notes, dated 12/31/2024, timed at 4:42 a.m., the Progress Notes indicated Resident 1 who was from room [ROOM NUMBER] had wandered at least twice to the exit door, close to room [ROOM NUMBER], setting off the exit door alarm twice. During a record review of Resident 1's Progress Notes, dated 12/31/2024 timed at 3:08 p.m., the Progress Notes indicated Resident 1 wandered and refused care. The Progress Notes indicated Resident 1 needed redirection multiple times. During a record review of Resident 1's Progress Notes, dated 12/31/2024, timed at 9:08 p.m., the Progress Notes indicated Resident 1 had wandered at the beginning of the shift. During a record review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 1/1/2025, the H&P indicated Resident 1 had a history of Lewy body dementia (is a progressive brain disease that affects thinking, movement, mood, and behavior), and significant physical disability (a condition that affects a person's body's movement, function, or senses). The H&P indicated Resident 1 was a high risk for fall, can make needs known but cannot make medical decisions. (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 record review of Resident 1's Progress Notes, dated 1/1/2025, timed at 1:24 p.m., the Progress Notes indicated Resident 1 was wandering. During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/2/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 used walker and wheelchair in the past seven days for mobility. The MDS indicated Resident 1 needed moderate assistance from sitting to standing position and walking 10 feet. During a record review of Resident 1's Progress Notes, dated 1/2/2025, timed at 4:08 p.m., the Progress Notes indicated Resident 1 had confusion, noted wandering and entering other residents' rooms. During a record review of Resident 1's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident's condition), dated 1/2/2025, timed at 4:47 p.m., the SBAR indicated Resident 1 was found sitting on the floor outside of the facility with redness and swollen face. The SBAR indicated the Physician was notified with order to transfer to the emergency room . During a record review of Resident 1's Multidisciplinary Care Conference (Care Conference), dated 1/2/2025, timed at 4:48 p.m., the Care Conference indicated Resident 1 needed moderate to maximum assistance on most activities of daily living (ADL - routine tasks or activities such as bathing, dressing and toileting a person performs daily to care for themselves). The Care Conference indicated Resident 1 was confused to time and place, ambulatory, needed supervision due to fall risk and wandering. During a record review of Resident 1's Progress Notes, dated 1/2/2025, timed at 5:50 p.m., the Progress Notes indicated Resident 1 was picked up by an ambulance at 5:45 p.m. to be transferred to GACH 2. The Progress Notes indicated Resident 1 was transferred to GACH 2 with scrapes (abrasion - an injury that occurs when your skin rubs off) on the chin, left cheek and left side of the forehead. The Progress Notes also indicated Resident 1 had redness and swollen nose. During a record review of Resident 1's GACH 2's Computed Tomography (CT-a diagnostic imaging procedure that uses a combination of X-rays [the images show the parts of your body in different shades of black and white] and computer technology to produce images of the inside of the body) of the maxillofacial (relating to the mouth, jaw, face, and neck), dated 1/2/2025, timed at 9:21 p.m., the CT indicated a result of comminuted nasal bone fracture (a broken nose where the nasal bones break into multiple pieces) with surrounding swelling (a condition where excess fluid accumulates in the body's tissues or organs). During a record review of Resident 1's GACH 2's Radiology Report, dated 1/2/2025, timed at 9:59 p.m., the Radiology Report indicated a right hand Xray was done that resulted to nondisplaced spiral fracture (a break in a bone that occurs when the bone fragments remain in alignment) base of the right fourth metacarpal (the bone in the right hand that connects the wrist to the ring finger) with minimally displaced oblique fracture of the shaft (a bone fracture where the break occurs at a diagonal angle but the broken bone fragments are only slightly out of alignment, meaning they have not shifted significantly from their normal position) and base of the right fifth metacarpal (the bone in the hand that supports the little finger. (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 record review of Resident 1's Elopement Screening dated 1/3/2025, timed at 12:46 a.m., The Elopement Screening indicated Resident 1 was assessed a high risk for elopement. The Elopement Screening indicated Resident 1 returned from GACH 2 after an earlier (1/2/2025) elopement incident. During a record review of Resident 1's Progress Notes dated 1/3/2025, timed at 4:26 p.m., the Progress Notes indicated the Director of Nursing (DON) documented that he (DON) spoke to Family Member 1 (FM 1), FM 2 and FM 3. The DON documented that the FMs reported that Resident 1 had a history of falls at home. The Progress Notes indicated Resident 1 was transferred to GACH 2 and was diagnosed with fracture in the nasal bone, fourth metacarpal and fifth metacarpal bone fracture. The Progress Notes indicated Resident 1 was a high risk for fall and injuries due to the following: 1. History of multiple falls prior to admission to the Skilled Nursing Facility (SNF). 2. Multiple comorbidities (the condition of having two or more diseases at the same time) such as Parkinson's disease, muscle weakness, intervertebral degeneration (breakdown) of the lumbar area (lower back), hypertension (high blood pressure), anxiety (feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities) and dementia. 3. Use of medications such as hydralazine (medication used to treat high blood pressure), carbidopa-levodopa (medication used to treat Parkinson's disease), citalopram (medication used to treat depression), quetiapine (medication used to treat depression). 4. Decrease safety awareness due to history of dementia. During an interview on 1/22/2025, at 2:16 p.m., with Family Member 1 (FM 1), FM 1 stated she (FM 1) had notified the facility to watch Resident 1 frequently as she had history of falls and had a bed alarm (monitor that alert caregiver whenever a resident is getting up from the bed) while in GACH 1. FM 1 stated that on 1/2/2025 at 2:30 p.m., Resident 1 came out of the facility's emergency exit alone without any staff assistance. FM 1 stated FM 4 was there and saw Resident 1 being assisted back to the facility. FM 1 stated facility staff (name not identified) had informed her (FM 1) that they (facility staff) were not aware that Resident 1 had dementia. FM 1 stated Resident 1 had sustained a fractured nose and fractured right fingers because of the fall and elopement. During an interview on 1/22/2025, at 3:28 p.m., with Physical Therapist (a health professional trained to evaluate and treat residents who have conditions or injuries that limit their ability to move and to physical activities) 1 (PT 1), PT 1 stated Resident 1 was assessed and recommended for rehabilitation (the action of restoring someone to health or normal life through training and therapy after illness) on 12/31/2024. PT 1 stated Resident 1 had a posture with upper body stooping forward when standing but with cues and instructions Resident 1 can stand upright. PT 1 stated Resident 1 was not safe to walk on her (Resident 1) own due to dementia. PT 1 stated Resident 1 needed the support of the FWW. During an interview on 1/22/2025, at 3:40 p.m., with Social Service Director (SSD), the SSD stated Resident 1 was prone (likely to suffer from) to fall because she walks while stooping or leaning forward. SSD stated the facility could not provide a sitter (a caregiver who provides companionship and care to residents who need supervision) because Resident 1 walks. (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 concurrent interview and record review on 1/22/2025, at 4:22 p.m., with the Director of Staff Development (DSD), Resident 1's Fall Risk Assessment and Elopement Screening, dated 12/30/2024, was reviewed. The Elopement Screening, dated 12/30/2024, indicated a score of three (low risk). The Elopement Screening indicated, Diagnosis: Resident 1 had no diagnosis that will affect his or her judgment and safety awareness. The DSD stated Resident 1 had history of dementia and the Elopement Screening answer for diagnosis should be yes with additional score of two, making the total score for Elopement Screening to five which is still low risk. The DSD stated Resident 1 was low risk for elopement and high risk for fall. The DSD stated on 1/2/2025 between 2 p.m., to 2:30 p.m., Resident 1 managed to go to the right hallway and open the emergency exit door close to room [ROOM NUMBER]. The DSD stated an alarm sound was heard and when staff responded she (Resident 1) already sustained an unwitnessed fall. The DSD stated staff assigned that day (1/2/2025) were CNA 2, Licensed Vocational Nurse 2 (LVN 2), and LVN 4. The DSD stated the Physician was notified at 2:53 p.m., with order to transfer to GACH 2. During a concurrent interview and record review on 1/22/2025 at 4:31 p.m., with the DSD, Resident 1's Progress Notes, dated 12/31/2024 and 1/1/2024, were reviewed. The Progress Notes dated 12/31/204 timed at 4:42 p.m., indicated Resident 1 wandered at least twice to the exit door by room [ROOM NUMBER] and set the alarm off twice. The Progress Notes, dated 12/31/2024 timed at 3:08 p.m. indicated Resident 1 was noted wandering, refusing care and needed redirection multiple times throughout the shift. The Progress Notes, dated 12/31/2024 timed at 9:08 p.m., indicated Resident 1 was wandering at the beginning of the shift. The Progress Notes dated 1/1/2025 timed at 1:24 p.m., indicated Resident 1 was noted wandering. The DSD stated they were monitoring her (Resident 1) as she (Resident 1) was placed close to the nursing station. The DSD stated there was no frequency on how often they documented the monitoring. The DSD stated the monitoring would be in the Medication Administration Record (MAR-record of medication received by the resident) or Progress Notes. The DSD stated if Resident 1 was assessed as high risk for elopement, the facility would do an hourly monitoring and apply bed alarm as needed. The DSD stated Resident 1 did not elope but just stepped out of the building. The DSD stated elopement is purposely seeking for an exit. The DSD stated if Resident 1 was reassessed for elopement after 12/31/2024 and 1/1/2025, Resident 1 would be a high risk for elopement and the facility would monitor Resident 1 hourly and document in the MAR, possibly place a bed alarm, and provide a sitter as needed. During a concurrent interview and record review on 1/22/2025 at 5:12 p.m., with the DON, Resident 1's Progress Notes, dated 12/31/2024 timed at 4:42 a.m., 3:08 p.m., and 9:08 p.m., and Elopement Screening questionnaire were reviewed. The Progress Notes indicated Resident 1 wandered at least twice setting off the alarm door at 4:42 a. m. The Progress Notes, dated 12/31/2024 at 3:08 p.m., and 9:08 p.m., indicated Resident 1 had wandered. The DON stated Resident 1 would score 10 (high risk) if reassessed for elopement from score of 1 (cognitively impaired), 2 (diagnosis- has medical diagnosis of dementia) and 5 (has exit seeking behavior). The DON stated elopement risk assessment was done upon admission and after incident of the fall. The DON stated nurses (RN 1, LVN 2 or LVN 3) should have done another elopement screening after 12/31/2024. The DON stated that since Resident 1 would have scored as high risk for elopement, Resident 1 should have a wanderguard, every hour monitoring and documentation of Resident 1's location and whereabouts. The DON stated there should be an hourly documentation prior to Resident 1's fall. The DON stated on 1/2/2025 staff were alerted when the exit door alarm went off. The DON stated the exit door automatically alarms when opened. (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 1/22/2025, at 6:17 p.m., with LVN 2, LVN 2 stated on 1/2/2025, at 2:30 p.m., Resident 1 was found outside. LVN 2 stated 10 minutes before (at 2:20 p.m.), she (LVN 2) was at the nurse's station by the medicine cart and Resident 1 was seated on a wheelchair close to the nurse's station. LVN 2 stated she (LVN 2) went to do her (LVN 2) rounds and when she came back, she (LVN 2) did not see Resident 1. LVN 2 stated two minutes after (at 2:22 p.m.) Resident 1 stood from her wheelchair inside her (Resident 1) room and was looking at LVN 2. LVN 2 informed Resident 1 that she (LVN 2) would attend to Resident 1 after assisting another resident (name not identified) and that was the last time she (LVN 2) saw Resident 1 before the incident. LVN 2 stated five minutes later (2:27 p.m.), Admission Director (ADD) and FM brought Resident 1 who had her (Resident 1) head down, back to the room. LVN 2 stated Resident 1's face was discolored with slight bleeding on the face. LVN 2 stated she (LVN 2) realized that Resident 1 eloped outside and was caught. LVN 2 stated she (LVN 2) went to Resident 1's room and noticed Resident 1's nose was discolored (change in color) and inflamed (red or swollen because of an infection or injury). LVN 2 stated no one saw how Resident 1 fall, when Resident 1 fall and what Resident 1 fell on to. LVN 2 stated there were no prior report that Resident 1 had set the exit alarm door. LVN 2 stated if she had been informed of prior history of setting off the exit door alarm that she (LVN 2) would have frequently check on Resident 1 and monitored her (Resident 1) for elopement. During an interview on 1/22/2025, at 7:22 p.m., with CNA 2, CNA 2 stated she (CNA 2) was the assigned CNA for Resident 1. CNA 2 stated she (CNA 2) was aware and had witnessed Resident 1 get up and walked around, and walked in other residents' rooms. CNA 2 stated when asked what she (Resident 1) was doing in other resident rooms and Resident 1 would reply that she (Resident 1) wanted to go home, and then Resident 1 would ask why she (Resident 1) was there at the facility. CNA 2 stated she (CNA 2) last saw Resident 1 on 1/2/2025 after lunchtime in the dining room with activity staff. CNA 2 stated she (CNA 2) saw MS came between 2:30 to 3 p.m. walking Resident 1 and placed her (Resident 1) in the wheelchair. CNA 2 stated MS reported that Resident 1 had walked outside and had walked out through the exit door. CNA 2 stated LVN 2 was there but she (CNA 2) cannot recall who was the RN that time. During an interview on 1/23/2025, at 11:50 a.m. with the Activity Director (AD), the AD stated she worked on 1/2/2025. AD stated Resident 1 tends to walk back and forth and does not sit still. The AD stated Resident 1 would get up, walked constantly with no specific destination. During an interview on 1/23/2025, at 12:02 p.m., with MS, MS stated on 1/2/2025, Resident 1 went outside of the facility. MS stated he (MS) was walking in the hallway by the nurse's station when the sound of exit door alarm was heard coming from the door close to room [ROOM NUMBER]. MS stated he (MS) run and saw the exit door closing and Resident 1 was standing outside two steps away from the door, bending forward with scratched marks on the left side of her (Resident 1) face. MS stated Resident 1 said she (Resident 1) wanted to go with FM 4. MS stated there were no walker and wheelchair around her (Resident 1).MS stated the exit door alarm would sound if the door was pushed open. MS stated if Resident 1 had a wanderguard, the sound would be heard when resident gets close to the door even without opening the door. MS stated they could have responded faster if resident had a wanderguard and probably prevented the fall. MS stated they had one elopement incident before. (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 concurrent interview and record review on 1/23/2025, at 2:22 p.m., with the DSD, facility's PnP titled, Door Guardian System (also known as wanderguard), dated 1/2025, was reviewed. The PnP indicated, To use a device that will alert the resident and staff of wandering tendency and still maintain resident's optimum function and physical freedom as safely as possible. 1. Residents shall be assessed by the Licensed Nurse on admission, readmission, quarterly (every three months) and annual assessment and when a significant change in condition is identified, post elopement and as needed using the elopement risk tool in PointClickCare (electronic resident health record). 2. If the assessment of the resident shows there is wandering and elopement risk creating a safety issue, the Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together)) and the Licensed Nurse will discuss this issue with the family or responsible party. 3. The Licensed Nurse will also assess the need for the use of the device when resident is exhibiting behavior showing risk for wandering or elopement and needing the use of a device such as the Door Guardian. 4. The IDT will assess the appropriateness of the intervention to address the wandering or elopement tendency to include the ongoing use of the door Guardian 5. The need for the Door Guardian shall be assessed a minimum of quarterly, annual and when a significant change of condition is identified and as needed. 8. Care plans for the residents using the Door Guardian shall include an entry identifying the resident's safety risk and the appropriate interventions, including the use of the Door Guardian. The DSD stated the facility lack (insufficient) implementation on assessing residents need for the use of the device when resident is exhibiting behavior showing risk for wandering or elopement and needing the use of a device such as the Door Guardian or wanderguard. During an interview on 1/24/2025 at 9:57 a.m., with RN 1, RN 1 stated on 12/31/2024 early morning, Resident 1 activated the exit door alarm twice by room [ROOM NUMBER]. RN 1 stated Resident 1 was found twice close to the exit door in room [ROOM NUMBER]. RN 1 stated the exit door was close. RN 1 stated both times Resident 1 mentioned she (Resident 1) was looking for her (Resident 1) clothes. RN 1 stated there were no staff, no wheelchair or walker with her (Resident 1). RN 1 stated Resident 1 was a high risk for fall and could possibly fall if alone in the corner of the hallway with no supervision. During a record review of facility's PnP titled, Wandering and Elopement, dated 3/2019 and last reviewed on 1/15/2024, the PnP indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 1. If identified as at risk for wandering, elopement, or other safety issues. the resident's care plan will include strategies and interventions to maintain the resident' safety.: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555791	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens Healthcare Center	17650 Devonshire Street Northridge, CA 91325

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner. b. get help from other staff members in the immediate vicinity, if necessary; and c. instructs another staff member to inform the charge nurse or director or nursing services that a resident is attempting to leave or has left the premises. During a record review of facility's PnP titled, Managing Fall and Fall Risk, dated 3/2018, and last reviewed on 1/15/2024, the PnP indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 2. Resident conditions that may contribute to the risk of falls include c. delirium (a serious change in mental abilities) and other cognitive impairment, e. lower extremity (legs) weakness; f. poor grip strength; g. medication side effects(an effect of a drug or other type of treatment that is in addition to or beyond its desired effect); h. orthostatic hypotension (a condition where blood pressure drops significantly upon standing up from a sitting or lying position) .3. Medical factors that contribute to the risk of falls include .d. neurological disorders (a wide range of conditions that affect the brain, spinal cord, nerves, and muscles); and e. balance and gait disorders .Resident-Centered Approaches to Managing Falls and Fall Risk, 1.The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had a history of dementia (a progressive state of decline in mental abilities), assessed as high risk for fall, had a wandering (moving around without any clear purpose or direction) behavior and had a history of fall, was provided supervision and kept free from accidents by failing to reassess Resident 1 for Elopement Screening (a safety assessment that evaluates a resident's risk of leaving a safe environment without permission) after Resident 1 had triggered (activated) the exit door alarm twice on 12/31/2024 and had a wandering behavior on 1/1/2025. On 1/2/2025, Resident 1 was able to walk two steps outside the facility's exit door (located at the side of the facility equipped with a door alarm that is activated when it is opened and held open for a certain period of time) without staff assistance and without an assistive device (walker- [a mobility aid that helps provide stability and balance while you walk] or wheelchair [a mobility device with wheels that helps people who have difficulty walking around]). This deficient practice resulted to Resident 1's fall on 1/2/2025 at 4:47 p.m., outside of the facility's exit door and requiring transfer to General Acute Care Hospital 2 (GACH 2) on 1/2/2025 at 5:45 p.m. Findings: (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 record review of Resident's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/30/2024, with diagnoses that included Parkinson's disease (a progressive disorder of the nervous system that affects movement), generalized muscle weakness and neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement