STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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 - Immediate jeopardy to resident health or safety 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** 44443 Based on observation, interview and record review, the facility failed to ensure a resident, who was under conservatorship (a legal status in which a judge appoints a person [conservator] to manage the financial and personal affairs of a minor or incapacitated person) with a history of attempted elopement (an unauthorized departure of a patient from an around-the-clock care setting without the facility's knowledge and supervision), and assessed as high risk for elopement, did not elope from the facility for one of eight sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1, who on 3/23/2024, had attempted to elope from the facility by climbing over the patio's fence, did not elope from the facility on 6/16/2024 by climbing over the patio's fence. 2. Accurately assess Resident 1 for wandering (walk around without any clear purpose or direction) and elopement risk to prevent the resident from leaving the facility unsupervised. Resident 1 attempted to climb over the facility's fence on 3/23/2024 and on 6/16/2024 (2 months and 3 weeks later), he successfully climbed over the patio's fence and has not been found as of 7/8/2024. 3. Ensure on 6/16/2024 at 8:49 p.m. Resident 1 was supervised while he was on Station A patio. 4. Ensure staff followed facility's policy and procedure (P&P) titled, Elopement Risk Assessment which indicated residents should be evaluated upon admission, quarterly, annually and with any significant change of condition. Resident 1's Elopement Risk Assessments dated 2/15/2024 and 6/3/2024, indicated Resident 1 was not assessed for the risk of elopement. 5. Ensure staff responded to the sound of an alarm when door, leading to Station A patio, was opened on 6/16/2024, at 8:49 p.m., and Resident 1 gained the opportunity to walk through the patio door, climb over the fence, and eloped from the facility. (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
	555823	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of these deficient practices, Resident 1 eloped from the facility on 6/16/2024 at 8:51 p.m. and has not been found as of 7/8/2024. These deficient practices placed Resident 1 at risk for exposure to harsh environmental conditions (rain and/or cold), hypothermia (a dangerously low body temperature), injury from motor vehicle accidents, medical complications related to his diagnosis of schizoaffective disorder (a mental condition characterized by abnormal thought processes and unstable mood) without receiving prescribed medication including Valproic Acid (medication for schizoaffective disorder), Abilify (antipsychotic [treat mental disorder] medication), and Lithium (medicine used to treat mental illnesses), lack of food with the risk of malnutrition (health problems that may arise due to lack of nutrients), dehydration (abnormally low fluid levels in the body), and possible death. According to the weather forecast report for the area where the facility was located the air temperature on 6/16/2024 was in the mid 70's degrees Fahrenheit (F) during the day and in the low 60's degrees F at night. https://weather.com According to https://crimegrade.org/safest-places-in- overall crime grade for violent crimes for the area, where the facility was located, the crime grade was F (meaning a violent crime was much higher than the average United States city). On 6/21/2024 at 1:28 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Director of Nursing (DON) due to the facility's failure to assess, monitor and supervise Resident 1 to prevent his elopement from the facility on 6/16/2024. On 6/24/2024 at 4:15 p.m., the facility submitted an acceptable IJ Removal Plan ([IJRP]) interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 6/24/2024 at 8 p.m., in the presence of the facility's Administrator (ADM), DON and Minimum Data Set Nurse (MDSRN). The IJPR included the following immediate actions: 1. The facility created zone mapping with areas of location: Station A by the time clock, exit to the barbeque patio between Stations A and B, and exit at Station B close to the side gate. Staff will be assigned to the designated areas for close monitoring and supervision of the residents. 2. A chair will be provided for an assigned staff (clinical or non-clinical staff) every shift. The purpose of the zone map for the staff was to do a visual check, ensure the resident's safety, and prevent residents from elopement. Responsibility of the assigned staff will redirect the resident to go back inside the facility, and if the resident declines, the staff will notify the nursing staff for further assistance. 3. Developed a Zoning Shift Log for the staff assigned to Station A and Station B to sign in every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Created an hourly monitoring log for residents assessed as high risk for elopement. The licensed staff will document the hourly location of each resident. The Director of Staff Development (DSD) will assign staff for the zoning shift. The Hourly Monitoring Log will be part of the Certified Nurse Assistant (CNA) responsibility in each shift. 5. The unit managers will collect data daily. The unit managers will submit the reports collected daily to the Director of Nursing (DON). 6. Three (3) camera monitors were installed in each station (Station A, B and C). The three existing doors were installed with sound alarms. When the resident opens the door, an alarm triggers a sound to notify staff who can visually check the monitor. Staff (licensed and non- licensed) must proceed to the area (patio) to encourage the resident to go back inside the facility unless a zoning staff member assigned was present. 7. On 6/21/2024 facility installed a mesh surrounding the Station A patio to prevent residents from climbing the fence. 8. Facility requested a quote from a fence company to extend additional three foot angled in Station A patio fence. 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 schizoaffective disorder, insomnia (sleeplessness), and iron deficiency anemia (a condition in which the body does not have a sufficient amount of iron). During a review of Resident 1's History and Physical (H&P), dated 11/21/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 5/30/2024, the MDS indicated Resident 1 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 1 required supervision (oversight, encouragement, or cueing) with eating, oral hygiene, toileting hygiene, showering/ bathing, and upper and lower body dressing, and required partial to moderate assistance with personal hygiene. The MDS indicated Resident 1 required supervision with walking 10 feet, 50 feet with two (2) turns, and 150 feet. During a review of Resident 1's care plan titled, Resident 1 had attempted to elope by climbing over the fence, dated 3/23/2024. There were no interventions to prevent Resident 1's elopement. During a review of Resident 1's Elopement Risk assessment dated [DATE], 3/23/2024, and 6/3/2024 indicated the Elopement Risk assessment dated [DATE] and 6/3/2024, did not illustrate Resident 1 was assessed for the risk of elopement. However, Resident 1's Elopement Risk assessment dated [DATE], indicated Resident 1 was assessed as being at risk for elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's 72-hour Monitoring Notes, dated 6/16/2024, and timed at 9:20 p.m., the 72-hour Monitoring Notes indicated Resident 1 was last seen by CNA (unidentified) at 8:40 p.m., inside his room. The 72-hour Monitoring Notes indicated that at 9:20 p.m., the facility staff were unable to locate Resident 1 in the facility. The 72-hour Monitoring Notes indicated facility staff was alerted to look for Resident 1 inside the facility and surrounding area outside the facility. At 10:45 p.m. facility staff called local general acute care hospital (GACH) for Resident 1's possible admission. At 10:50 p.m., Resident 1's physician was notified. During a concurrent interview, and record review on 6/18/2024, at 5:15 p.m., with the ADM, the facility's recorded video footage for 6/16/2024 was reviewed. The video footage revealed that on 6/16/2024 at 8:49 p. m., CNA 1 was sitting at the Nursing Station A, diagonally across from the Nursing Station A there was a door leading to the patio surrounded by the 'chicken wire' (chain link) fence about 10 feet and 5 inches high. At 8:49 p.m., Resident 1 was seen exiting Station A patio door, located approximately 10-15 feet from Nursing Station A. CNA 1 did not follow Resident 1 outside to the patio area. The recorded video footage illustrated that at 8:51 p.m., Resident 1 was seen climbing over the patio fence and left the facility. The ADM stated the facility was a secured facility (facility secured with locked doors to prevent residents from exiting the premises at will). The ADM stated staff had to check the residents, who were assessed as a high risk for elopement, whereabouts hourly. The ADM stated there were no staff assigned on Station A to monitor patio door as residents were free to walk around and sit in the patio. The ADM stated all residents were at risk of leaving the facility and had to be monitored hourly, to know their whereabouts. During an interview on 6/18/2024, at 6:20 p.m., Unit Manager (UM 1) stated on 6/16/2024 at 8:20 p.m., Resident 1 approached her on Station C and asked for a gauze dressing for his wound (unspecified location). UM 1 stated she told Resident 1 she would see him later when she finished with wound care for another resident. UM 1 stated at 9:20 p.m., she started to look for Resident 1 as the resident had not returned to Station C. UM 1 stated she checked Resident 1's room but he was nowhere to be found. UM 1 stated she directed Licensed Vocational Nurse (LVN 1) to look for Resident 1 in the facility. UM 1 stated UM 2 looked for Resident 1 and the Registered Nurse Supervisor (RNS) called the police. UM 1 stated there should have been staff assigned to Station A patio area when residents go out on the patio, especially at nighttime to ensure residents safety. During an interview on 6/18/2024, at 8:15 p.m., CNA 3 stated, she was the assigned to care for Resident 1. CNA 3 stated she was working on Station C and saw Resident 1 last time in his room at 8:40 p.m. on 6/16/2024. CNA 3 stated Resident 1 was wandering around the facility and was not staying in one place. CNA 3 stated Resident 1 should have been on 1:1 monitoring (staff provides one to one nursing or observation care to a resident for a period of time) so he would have been watched more closely. During an interview on 6/20/2024, at 10:41 a.m., LVN 1 stated, Resident 1 should have been on 1:1 monitoring because Resident 1 walked around the facility a lot and could elope easily. LVN 1 stated there should have been staff to watch the residents when residents were on the patio because the residents could fall or tried to elope like Resident 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent observation and interview on 6/20/2024 at 4:10 p.m., with the Maintenance Supervisor (MS), the MS opened the door leading to Station A's patio and a sound like a doorbell was heard. The MS stated the sound was to alert staff that a resident was exiting outside to the patio. At the time of observation there were no staff observed coming to the patio area to check if a resident was leaving Station A and was going to the patio area. During an interview on 6/20/2024 at 4:40 pm., CNA 1 stated, on 6/16/2024 at around 8 p.m., she was passing snacks and saw Resident 1 walking between Station A and Station B. CNA 1 stated the facility staff were aware Resident 1 was a high risk for elopement. CNA 1 stated Resident 1 should have been on 1: 1monitoring to closely watch him. CNA 1 stated Resident 1 always was on 1:1 monitoring, but on 6/16/2024 Resident 1 was not on 1:1 monitoring, and she does not know why. During an interview on 6/20/2024, at 4:52 p.m., CNA 2 stated on 3/23/2024, he witnessed Resident 1 tried to leave the facility by attempting to squeeze himself in between the metal pole, where the fence was attached, and the building wall, but could not fit. Resident 1 then started walking around on the patio and then suddenly, Resident 1 walked over to another side of the fence, stood there for a minute, and started to climb over the fence. CNA 2 stated he ran and started to climb the fence to stop Resident 1. CNA 2 stated he redirected Resident 1 back into the patio. CNA 2 stated after this incident on 3/23/2024, Resident 1 should have been supervised and monitored every time he goes to the patio as he was a high risk of elopement and would attempt to elope again. During an interview on 6/20/2024, at 5:17 p.m., RNS stated, Resident 1 was a wanderer (moving from place to place without a fixed plan) because he was constantly walking around the facility. The RNS stated residents with high risk for elopement should be supervised to know their whereabouts every hour. The RNS stated the residents (in general) assessed as high risk for elopement should be monitored and supervised hourly to know their whereabouts. The RNS stated a resident, who goes to the patio should be supervised to avoid any incident of elopement or fall. The RNS stated there should be staff present on the patio to watch and monitor the residents. The RNS stated a resident, who assessed as high risk for elopement, should have whereabouts checked every hour and that what staff do hourly. During a concurrent interview and record review on 6/20/2024, at 6:24 p.m., with UM 1, Resident 1's care plan titled, At risk for elopement related to medical condition, schizoaffective disorder, and an attempt to elope by climbing the fence on 3/23/2024, was reviewed. UM 1 stated Resident 1's care plan indicated there were no selected intervention from pre-determined interventions for Resident 1, who had a history of climbing over the fence. UM 1 stated the interventions such as supervise the resident closely (pay special and careful attention to the resident), conduct regular rounds (to do consistent rounds which was hourly), and place Resident 1 on 1:1 monitoring was not selected and not implemented to prevent Resident 1 from elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intercommunity Care Center	2626 Grand Avenue Long Beach, CA 90815

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 6/21/2024, at 12 p.m., with the DON, the DON stated the residents who were a high risk for elopement should have been on 1:1 monitoring. Resident 1 should been on 1:1 monitoring as he had a history of elopement attempt on 3/23/2024. The DON stated she was not aware Resident 1 was not on 1:1 monitoring. The DON stated if Resident 1 would have been on 1:1 monitoring Resident 1 would not eloped. The DON stated the importance of Resident 1 to be on 1:1 monitoring was for his safety. After reviewing Resident 1's care plan and Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) notes, the DON stated there was no documentation indicating IDT meeting was held and an investigation, of Resident 1's elopement attempt on 3/23/2024 was done The DON stated the care plan interventions were not selected to indicate what interventions were in place to prevent Resident 1 from elopement. During a review of the facility's policy and procedure (P&P) titled, 'Elopement Prevention,' ([undated]), indicated, it was the facility's policy to identify residents at risk and intervene accordingly, and to establish a plan of care when the risk factors are present. If a resident is determined to be at risk, a care plan goal with approaches to ensure safety will be implemented as determined by the IDT.