STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555825	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Marino Healthcare Center	6812 N. Oak Avenue San Gabriel, CA 91775

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44636 Based on observation, interview, and record review, the facility failed to provide a safe environment to prevent accidents for one of two sampled residents (Resident 1) by: 1. Facility failed to provide supervision to Resident 1 who was identified by the facility as a low risk for elopement (to leave a secured institution without notice or permission) when the facility exit doors were not supervised and the gate was left open on 4/26/2024. This deficient practice resulted to Resident 1 eloped on 4/26/2024 at 1:48 PM which can result to serious injury, harm, and/ or death. 2. Facility failed to ensure one of four staff (Certified Nursing Assistant 3 - CNA 3) had the competency necessary to care for residents when fire alarm is on. This deficient practice placed Resident 1 and other residents in the facility at risk for elopement. 3. Findings: 1. A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of dementia (progressive brain disorder that slowly destroys memory and thinking skills), schizoaffective disorder (a mental illness that causes loss of contact with reality), and epilepsy (a brain disorder that causes unprovoked, recurrent seizures). A review of Resident 1's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 1/8/2024, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/14/2024, indicated Resident 1's cognitive skills for daily decision making were severely impaired. A review of Resident 1's Elopement Risk Assessment, dated 2/15/2024, indicated Resident 1 was at low risk for elopement. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Head Count and Call Light Check (log to indicate resident's whereabouts and call light check), dated 4/26/2024, indicated a slash sign (punctuation mark) at 2 PM, and the form did not indicate under legend that the slash sign corresponds to a specific location in the facility. A review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR, a technique used to provide a framework for communication between members of the health care team), date 4/26/2024, indicated at 3:15 PM Charge Nurse was not able to locate Resident 1 in his room. The SBAR indicated code yellow (emergency alert regarding missing resident) was paged and staff checked all rooms, restrooms, patios, and outside of the facility, but was unable to locate the resident. A review of Resident 1's General Acute Care Hospital (GACH) Emergency Department (ED) Record, dated 4/26/2024, indicated at 7:10 PM, Resident 1 was brought in by Emergency Medical Services after Resident 1 was found wandering on a private residence and found to be confused and disoriented (to feel lost). The GACH ED Record indicated Resident 1 could not recall why he was walking about, nor where he came from. During an interview on 4/29/2024 at 3:51 PM with the Quality Assurance Nurse (QAN), QAN stated she last saw Resident 1 on 4/26/2024 walking in the hallway after the fire alarm was pulled (pulled by another resident) and fire alarm turned on (not able to recall specific time) in the station where Resident 1's room is. QAN stated when the fire alarm was pulled the exit doors become unlocked since it was a magnetic lock and when the fire alarm was turned off, the exit doors are locked again. QAN stated, after the fire alarm was turned off, Certified Nurse Assistant (CNA) 1 and CNA 2 informed QAN on 4/26/2024 that all residents were accounted for in the station where Resident 1' is located. QAN stated at 3:15 PM QAN and Infection Prevention Nurse (IPN) conducted rounds for the residents and noticed Resident 1 was not in the room or anywhere in the facility. During an interview on 4/29/2024 at 4:37 PM with IPN, IPN stated Resident 1's usual routine was to walk all around the building while carrying a bag. IPN stated she noticed Resident 1 was not in his room when she came on shift (3 PM to 11 PM) on 4/26/2024. IPN stated on 4/24/2024, she did a head count (unable to recall time) with QAN and discovered Resident 1 was missing. IPN stated she asked CNA 1 about Resident 1's whereabout and CNA 1 responded that CNA 1 last saw Resident 1 around 1:30 PM in the activity room. IPN stated she had reviewed the surveillance camera footage, (located in the station where Resident 1's room is) recorded on 4/26/2024 after 1 PM, and the fire alarm was on for about ten minutes. IPN stated during this time, the Maintenance Supervisor (MS) was running in and out of the nursing station trying to turn off the fire alarm with different keys. IPN stated the MS then went to his car to get his copy of the alarm key and when MS came back, the MS left the gate open. IPN also stated according to the surveillance camera footage Resident 1 had left the facility around 1:48 PM through the back door and out through the gate. (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 4/29/2024 at 5:05 PM with the MS, the MS stated Resident 3 had pulled the fire alarm and he needed to reset the fire alarm with the fire alarm key. The MS stated they could not find the alarm key in the station where Resident 1's room is located to turn off the alarm. The MS stated he remembered he had a spare alarm key in his car and went to his care to get it. The MS stated he forgot to lock the gate when he came back inside the facility. The MS stated the alarm rang for about five minutes or more and Resident 1 exited the door at 1:48 PM according to the surveillance camera footage. During a concurrent review of the surveillance camera footage recorded on 4/26/2024 after 1 PM, with the MS, the MS stated Resident 1 opened the exit door, walked to the gate, and went out towards the parking lot. The MS stated the lock pad for the gate must be closed and always locked to prevent residents from eloping. During an interview on 4/29/2024 at 6:35 PM with CNA 4, CNA 4 stated Resident 1 liked to walk all around the facility and stayed in the activities room and the resident liked to push the doors with his arm and body all the time. CNA 4 also stated Resident 1 had always tried to open doors since he was admitted to the facility. CNA 4 stated when the fire alarm goes on, each CNA goes to an exit door since the facility had many doors. and when the fire alarm stops, the staff should immediately count the residents. During a concurrent interview on 4/29/2024 at 7:34 PM with the Director of Nursing (DON) and record review of the facility's Head Count and Call Light Check dated 4/26/2024, the DON stated head count was done every hour since the facility is a psychiatry facility (facility specializing in the treatment of severe mental disorders) to ensure there were no missing residents in the facility. The DON stated the head count on 4/26/2024 indicated Resident 1 was missing at 2 PM. The DON stated CNA 1 needed to report to the Charge Nurse that Resident 1 was not accounted for at 2 PM. The DON stated staff members should check the exit doors for residents when the fire alarm was pulled. The DON stated when she reviewed the camera footage, she did not see any staff members present in the hallway or by the door when Resident 1 exited the facility. The DON stated the MS should check the gate locks frequently to ensure they were locked and were in good functioning order. The DON stated when the gates were not locked, this placed the residents at risk for eloping. During the same interview on 4/29/2024 at 7:34 PM with the DON, the DON stated the policy for routine resident checks should include resident checks done every hour within the eight-hour check. The DON stated resident checks done every hour was to ensure all residents were accounted for. During an interview on 4/30/2024 at 10:58 AM with CNA 1, CNA 1 stated he saw Resident 1 in the activity room around 1:30 PM. CNA 1 stated when Resident 3 pulled the fire alarm (unable to recall exact time), he took Resident 3 to her room and remained with the resident for the remainder of his shift (7 AM to 3 PM). CNA 1 stated he did not know how to explain how his other seven residents were accounted for after the fire alarm was pulled. A review of the facility's Policy and Procedure titled, Routine Resident Checks, revised 7/2013, indicated to ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each eight hours shift. Routine resident checks involve entering the resident's rooms and/or identifying the resident elsewhere on the unit. The person conducting the routine check shall report promptly to the Nurse Supervisor/Charge Nurse any changes in the resident's condition and medical needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Exits or Means of Egress, revised 1/2019, indicated exit doors will remain locked at all times. 2. A review of the Lesson Plan F689 (federal tag, areas of compliance assessed during a Centers for Medicare and Medicaid Services during survey that is pertaining to identifying and providing services to avoid accident) Elopement, dated 4/26/2024, 4/27/2024, and 4/29/2024 indicated participants will be able to verbalize interventions for residents who are identified as risk for elopement. The Lesson Plan also indicated to do visual check of residents during shift and resident care. A review of the in services provided by the Director of Nursing (DON) indicated CNA 3 attended in services as follows: - On 4/26/2024 Elopement Prevention and Safety and Supervision of Residents. - On 4/27/2024 Elopement Prevention. - On 4/27/2024 Safety and Supervision of Residents. During an interview on 4/29/2024 at 6:51 PM with CNA 3, CNA 3 stated she received in services for elopement and safety and supervision of residents. CNA 3 stated all staff should go to the pulled fire alarm when alarming. CNA 3 stated she would inform the Charge Nurse the fire alarm was pulled and stay at the location of the fire alarm. CNA 3 stated she would stay at the fire alarm while it was alarming and was not sure how long she needed to remain at the fire alarm. During an interview on 4/29/2024 at 7:34 PM with the DON, the DON stated she provided in services after Resident 1 eloped on 4/26/2024. The DON stated she informed facility staff they needed to watch all the exit doors, confirm head counts were done for all the residents, and ensure frequent visual checks for residents. The DON stated staff members should check the exit doors for residents when the fire alarm was pulled and not to remain at the fire alarm. A review of CNA 3's Preventing Elopement Acknowledgement, dated 7/31/2023, indicated CNA's responsibility was to protect all residents by preventing elopement and know what to do when a resident leaves the nursing home. A review of CNA 3's Certified Nursing Assistant Job Description, dated 7/31/2023, indicated to participate in fire/disaster drill and safety in service and complies with facility safety program.