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	07/24/2024

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** 48395 Based on observation, interview, and record review the facility failed to supervise and ensure the safety of one (1) of two (2) sampled residents (Resident 1) in accordance with the facility's policy and procedure when Resident 1 left the facility through his window. This failure resulted in Resident 1 eloping (leaving the facility without the staff's knowledge and/or supervision) on 7/23/24 and is not found as of 7/31/24. Findings: 1. During a review of Resident 1's Admission Record, Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (any damage, disease, or disorder that affects the structure or function of the brain) and schizoaffective disorder (mental illness that occurs when someone experiences both schizophrenia and a mood disorder [a mental health condition that affects a person's emotional state or mood] at the same time), bipolar type (a serious mental illness that causes unusual shifts in mood ranging from extreme highs [mania] to lows [depression]). During a review of Resident 1's History and Physical Examination (H&P), dated 6/20/2024, H&P indicated the resident has fluctuating capacity to understand and make decision due to being conserved (when a judge appoints another person to act or make decisions for the person who needs help). During a review of Resident 1's Elopement Risk assessment dated [DATE], the Elopement Risk Assessment indicated Resident 1 was a high risk for elopement with potential interventions including to do frequent monitoring such a checking every hour. During a review of Resident 1's risk for elopement care plan dated 6/20/2024, the risk for elopement care plan indicated Resident 1 was a high risk for elopement. The care plan indicated staff interventions included head count every hour and frequent visual checks. During a review of Resident 1's interdisciplinary team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) conference record dated 6/21/2024, the IDT conference record indicated, Resident 1 is at risk for elopement related to history (hx) of elopement from home and other facility. (continued on next page)

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	During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 6/27/2024, MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 was independent (resident completes activity by themselves with no assistance from a helper) with walking 150 feet, transfers (how resident moves to and from bed, chair, wheelchair, standing position), dressing (how resident puts on, fastens and takes off all items of clothing), personal hygiene and eating. During an interview on 7/24/2024 at 8:20 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the last time she saw Resident 1 was on 7/23/2024 around 11:00 AM in his room sitting on his bed. CNA 1 stated she then went on her lunch break and when she came back to pass the lunch trays, she noticed the resident was gone and the window in the resident's room was broken around 12:10 PM. During an observation on 7/24/2024 at 8:25 AM in Resident 1's room, Resident 1's bedside window was observed to be missing a window pane and was covered with a large plastic panel that was bolted to the part of the intact window pane and nailed to the window frame. During an observation on 7/24/2024 at 8:27 AM in the back area of the station 2 building (station 2 back), Resident 1's window as observed to be missing a window pane and covered with a large plastic panel. Directly across from the resident's window is a private residence and facing the resident's window and to the left was an open area that is not able to be accessed by other residents that stops at a brick wall with a metal fence on top that leads to the street. During an interview on 7/24/2024 at 8:35 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the last time she saw Resident 1 was at 11:30 AM on 7/23/24 in the resident's room. LVN 1 then stated at approximately 12:15 PM, CNA 1 reported to her that while she was passing lunch trays, LVN 1 went to Resident 1's room and found the resident missing. LVN 1 stated Resident 1's window pane was missing and that all staff attempted to look for the resident in the facility and even drove around the area, but the resident was not found. During a concurrent observation and interview on 7/24/2024 at 8:50 AM with Maintenance Supervisor (MS) in Station 2 back, Resident 1's window was observed to be missing a window pane and covered with hard plastic with a gap at the top between the end of top of the plastic panel and the top of the window. MS stated the window as unable to be fixed on 7/23/2024 because the store was closed by the time they got around to trying to fix the window. During an interview on 7/24/2024 at 9:10 AM with the Director of Nursing (DON), the DON stated that CNA 1 was passing lunch trays on 7/23/24 around 12:00 PM when she notified LVN 1 that Resident 1 was missing. The DON stated all room in the facility were searched, and a code yellow (code to alert staff that a resident is missing) was called and that some facility staff went out on foot and drove around the facility within a 5- mile radius and the resident was nowhere to be found. The DON also stated that a head count for all residents is done every hour. During a concurrent observation and interview on 7/24/2024 at 10:20 AM with the DON in Resident 1's room, Resident 1's window was observed to be missing a window pane and covered. The DON stated Resident 1's window is covered with a hard laminate panel that is secured with screws with an approximate five (5) inch gap at the top that is open. The DON stated the window needed to be replaced immediately and that they would have staff monitor the window 1:1 until it is fixed. (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 7/24/2024 at 12:05 PM with SSD, SSD stated Resident 1 was evaluated to be a high risk for elopement since Resident 1's family representative had informed the facility that Resident 1 had previous eloped from another facility. During a concurrent interview and record review on 7/24/2024 at 12:15 PM with CNA 1 and CNA 2, the San [NAME] Manor Head Count and Call Light Check form dated 7/23/2024 was reviewed. The 7/23/2024 San [NAME] Manor Head Count and Call Light Check form indicated the last time Resident 1 was seen was at 11:00 AM. CNA 1 and CNA 2 both stated that head counts are done every hour on shift by the CNAs and they make sure to have eyes on the residents and their location. During a concurrent interview and record review on 7/24/2024 at 1:00 PM with the DON, Resident 1's risk for elopement care plan dated 6/20/2024 was reviewed. The risk for elopement care plan indicated Resident 1 was a high risk for elopement. Staff interventions included head count every hour and frequent visual checks. The DON stated since their facility standard is an hourly head count for all residents, the timing for Resident 1's head count should have been at least every 30 minutes and should have been more specific for the resident since he was a high risk for elopement. During an interview on 8/2/2024 at 10:31 AM with Administrator (ADM), ADM stated as of today, 8/2/2024, Resident 1 has still not been found. During a review of the facility's P&P titled Emergency Procedure - Missing Resident revised August 2018, indicated Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. During a review of the facility's policy and procedure (P&P) titled Wandering and Elopements revised March 2019, indicated, The facility with identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents, and 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's safety. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised March 2022, indicated: A comprehensive, person-centered care plan that includes measurable, objectives and timetables to meet the resident's physical, psychosocial ad functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan: describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.