

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 North Park Avenue Pomona, CA 91768	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure a comprehensive person-centered care plan (CP) was developed and implemented that included appropriate interventions to address individualized needs for one of three sampled residents (Resident 2) in accordance with the facility's policies and procedures (P&P) when the facility determined Resident 2 was at risk for elopement.</p> <p>This failure had the potential to result in unmet individualized needs for Resident 2 and the potential to affect the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated, Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with multiple diagnoses including cellulitis (bacterial skin infection) of right lower limb (an arm or leg) and left lower limb, difficulty in walking, not elsewhere classified and essential (primary) hypertension (high blood pressure).</p> <p>During a review of Resident 2's Elopement Evaluation (EE), dated 7/16/24, timed at 9 p.m., the EE indicated Resident 2 did not have a risk for wandering/elopement identified.</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/23/24, the MDS indicated Resident 2's cognitive (ability to think and process information) skills were intact. The MDS indicated Resident 2 had symptoms of feeling down, depressed or felt hopeless and did not exhibit wandering behavior. The MDS indicated Resident 2 was independent (resident completed all the activities by himself, with or without an assistive device, with no assistance from a helper.)</p> <p>During a review of Resident 2's History and Physical (H&P), dated 8/6/24, the H&P indicated, Resident 2 was able to make decisions.</p> <p>During a review of Resident 2's Progress Notes (PN), dated 9/3/24 timed at 12:10 p.m., the PN indicated Resident 2's room would be changed, and Resident 2 would be moved to Area 1 after Resident 2 and the RP were notified and agreed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 9/3/24, timed at 3:42 p.m., the COC indicated Resident 2 verbalized Resident 2 wanted to go home. The COC indicated Resident 2 would be moved to Area 4 (locked unit) and Resident 2's responsible party (RP) was informed and agreed to a room change.</p> <p>During a review of Resident 2's Behavior Monitoring and Interventions Report (BMIR), dated 9/1/24 through 9/17/24, the BMIR indicated Resident 2 had no elopement or exit seeking behaviors observed.</p> <p>During a concurrent observation and interview on 9/18/24 at 12:20 p.m. with Certified Nursing Assistant 3 (CNA 3) in Area 3, Resident 2 was lying in the first bed (three-bed occupancy room). CNA 3 stated, CNA 3 was monitoring the three residents in the room, including Resident 2 for trying to leave the facility.</p> <p>During a concurrent observation and interview on 9/18/24 at 1:57 p.m. with Resident 2, Resident 2 had a cane and was standing in Area 3's doorway and there was a staff (unidentified) next to Resident 2. Resident 2 stated, Resident 2 wanted to go home I need a release.</p> <p>During an interview on 9/18/24 at 2:05 p.m. with CNA 6, CNA 6 stated, Resident 2's mental status was sometimes he's on, sometimes he's off. CNA 6 stated, Resident 2 liked to stay in bed and also wanted to go out, always saying wants to go home. CNA 6 stated, CNA 6 had not heard Resident 2 express feelings of wanting to elope to CNA 6 or seen Resident 2 eloping, but CNA 6 had heard from staff (in general) and Resident 2 was moved to Area 4. CNA 6 thought the facility was preventing Resident 2 from leaving the facility by placing Resident 2 in Area 4. CNA 6 stated, CNA 6 moved Resident 2 to Area 4 with the help of 2 other staff but could not remember the date of transfer. CNA 2 stated, Resident 2 was moved from Area 4 back to Area 2 after the RP complained. CNA 6 stated, residents (in general) who expressed of wanting to go home or at who were at risk of elopement were not necessarily moved to Area 4 but rather was put on 1:1 monitoring (a type of care that involves keeping a patient under constant observation to reduce the risk of harm, one staff to one patient).</p> <p>During an interview on 9/18/24 at 2:32 p.m. with the Registered Nurse (RN), the RN stated, Resident 2 was at risk of elopement when Resident 2 verbalized wanting to go home. The RN stated, Resident 2 was transferred to Area 4 to prevent Resident 2 from eloping because Resident 2 was ambulatory, he might escape. The RN stated, the residents in Area 4 were residents who had diagnoses of schizophrenia (a serious mental health condition that affects how people think, feel and behave), psychosis (a mental disorder characterized by a disconnection from reality), and bipolar (a mental health condition that affects your moods, which can swing from one extreme to another). The RN stated Resident 2 did not have schizophrenia, psychosis, or bipolar. The RN stated, Resident 2 would probably feel depressed and mad being around residents with these types of behaviors and would feel like Resident 2 was being punished in Area 4. The RN stated, Resident 2 only stayed in Area 4 for three days because the RP did not want Resident 2 to stay in Area 4.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 9/18/24 at 3:01 p.m. with the Assistant Director of Nursing (ADON), Resident 2's medical record was reviewed. The ADON stated, Resident 2 was at risk for elopement because Resident 2 verbalized wanting to go home and was wandering around the facility. The ADON stated, the ADON had not personally observed Resident 2 wandering in the facility. The ADON stated, Resident 2 was moved to Area 4 after discussing the move with the RP. The ADON stated, Resident 2 was in Area 4 from 9/3/24 to 9/9/24. The ADON stated, Area 4 was a locked unit for residents who had dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and residents who were at risk for elopement. The ADON stated, Resident 2 did not have dementia. The ADON stated, not all residents with elopement risks were admitted to Area 4, it's [on] a case by case [basis].</p> <p>During a concurrent interview and record review on 9/18/24 at 4:43 p.m. with the Director of Nursing (DON), Resident 2's medical record was reviewed. The DON stated, the DON could not find a CP that addressed Resident 2's risk for elopement. The DON stated [the purpose of] a CP was to identify a concern or issue and to have goals and interventions. The DON stated, Resident 2's risk for elopement should have been care planned to ensure Resident 2's needs were met.</p> <p>During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, revised date November 2018, the P&P indicated, the facility ensured that a comprehensive person centered CP was developed for each resident and was the policy of the facility to provide person-centered, comprehensive and interdisciplinary care that reflected best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The policy indicated, since the baseline CP was developed before the comprehensive assessment, goals and interventions may change .which was not previously identified on the problem specific CPs used .those changes must be updated on each specific CP and incorporated into the initial or updated baseline CP.</p> <p>During a review of the facility's P&P titled, Wandering and Elopement, effective date 2/10/23, the P&P indicated, the IDT will develop a plan of care considering the individual risk factors of the resident.</p>		