

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555897 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP | | STREET ADDRESS, CITY, STATE, ZIP CODE 1267 San Gabriel Blvd Rosemead, CA 91770 | |

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854</p> <p>Based on observation, interview and record review, the facility failed to monitor and supervise one of three sampled residents (Resident 1), who was identified and assessed at risk for elopement.</p> <p>As a result, Resident 1 eloped from the facility on 4/30/2024, and remained missing until 5/1/2024, when resident was found at a nearby school football field, next to the facility.</p> <p>This failure had the potential for Resident 1 to sustain injuries from being outside the facility with no access to scheduled medications and shelter needed for his condition which could lead to serious injury, serious harm, serious impairment and/or death.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the resident was initially admitted to the facility on [DATE], with the diagnosis of unspecified psychosis (a person ' s thoughts are disrupted and have difficulty recognizing what is real and what is not real), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).</p> <p>A review of Resident 1 ' s Elopement Evaluation dated 3/19/2024, indicated the resident was at risk for elopement.</p> <p>A review of Resident 1 ' s History and Physical dated 3/20/2024, indicated that the resident had fluctuating capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a standardize assessment and care screening tool) dated 3/25/2024 indicated that the resident had severely impaired cognition (the ability or mental action or process of acquiring knowledge and understanding).</p> <p>A review of Resident 1 ' s Change in Condition Evaluation (COC) dated 4/30/2024 timed at 4:00 PM, indicated Resident 1 left the facility without notifying facility staff. The COC indicated Licensed Vocational Nurse (LVN) 1 reported unable to locate Resident 1 ' s whereabouts and initiated a Code [NAME] (response in the event of a missing or eloping resident) as per facility ' s protocol.</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 |
|---|-------|-----------|

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555897 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP | | STREET ADDRESS, CITY, STATE, ZIP CODE 1267 San Gabriel Blvd Rosemead, CA 91770 | |
| 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 5/8/2024 at 11:01 AM, the Administrator (ADM) stated Resident 1 was last seen on 4/30/2024, in the facility between the hours of 3:40 PM to 3:45 PM. The ADM stated Resident 1 was noted missing from the facility during medication pass. The ADM stated facility staff checked the resident 's rooms, closets and checked if the facility 's bolted doors and windows were intact. The ADM stated facility staff were also sent out around the facility premises and drove around the facility 's neighborhood. The ADM stated local law enforcement was called on 4/30/2024 at 5:48 PM, for assistance. The ADM stated the facility 's maintenance staff and local law enforcement went around the whole facility and checked the facility walls, windows, and ceilings, and found no signs of tampering. The ADM stated the next morning on 5/1/2024 at 7 AM, she received a call from the facility staff that Resident 1 was seen at a high school football field next door to the facility. The ADM stated she was told from facility staff that Resident 1 was compliant and walked back to the facility with the facility staff. The ADM stated a body assessment was completed and Resident 1 had no injuries. The ADM stated Resident 1 said he slept next door and came back to the facility because he was hungry. The ADM stated when Resident 1 was asked why he left the facility, he said I don ' t know. The ADM stated facility staff interviewed Resident 1 and asked for demonstration of what he did when he left the facility. The ADM stated Resident 1 kicked the locked door open from the breezeway (passage connecting two buildings or halves of a building) hallway leading to the outdoor rehabilitation area and climbed on the roof of the south building. The ADM stated Resident 1 was sent out to the acute hospital for evaluation the same day (5/1/2024) he returned to the facility.</p> <p>During a concurrent interview and observation of the facility 's breezeway area on 5/8/2024 at 12:12 PM, the ADM stated the breezeway area did not have a staff that was scheduled to monitor the area, prior to Resident 1 's elopement on 4/30/2024.</p> <p>During a concurrent interview and observation of the surveillance monitor/cameras located in the [NAME] Wing Nursing station on 5/8/2024 at 12:33 PM, the ADM stated there was no assigned staff that watches the surveillance monitor/cameras continuously during the day and evening shifts because there were a lot of staff to supervise residents, during the day/evening shifts. The ADM stated that the facility staff was assigned to continuously watch the surveillance monitor/cameras during the night shift only, due to the previous elopement that occurred in the facility the previous year.</p> <p>During an interview on 5/8/2024 at 2:17 PM, LVN 1 stated at around 3:45 PM, he saw Resident 1 in the facility 's breezeway area. LVN 1 stated at 4 PM, during medication pass, he went to look for Resident 1, but could not find him. LVN 1 stated he instructed CNA 1 to look around the building to find Resident 1. LVN 1 stated after a few minutes CNA 1 informed him she could not find Resident 1. LVN 1 stated he reported to the Registered Nurse Supervisor (RNS) 1 and a Code [NAME] was called. LVN 1 stated RN 1 then informed the Director of Nursing (DON), ADM, and the local law enforcement.</p> <p>During an interview on 5/8/2024 at 2:27 PM, CNA 1 stated she performed a head count of residents when she arrived at the facility at 3 PM and no residents were noted missing. CNA 1 stated at 4 PM she performed another head count and Resident 1 was missing. CNA 1 stated she searched every room and could not find Resident 1. CNA 1 stated she reported to LVN 1 and a Code [NAME] was called.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555897 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Monterey Healthcare & Wellness Centre, LP | | STREET ADDRESS, CITY, STATE, ZIP CODE 1267 San Gabriel Blvd Rosemead, CA 91770 | |
| 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 5/8/2024 at 3:24 PM, the ADM stated that on 4/30/2024, after doing a headcount the ADM went through the locked breezeway door into the back patio (outdoor rehabilitation area) and saw chairs stacked up leading up to the roof. The ADM stated when she saw the stacked up chairs she then checked the surveillance monitor located in the [NAME] Wing Nursing station. The ADM stated in the surveillance video she saw Resident 1 ' s head at the corner of the screen climbing up to the roof.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Wandering & Elopement, dated 7/2017 indicated the purpose of the policy was to enhance the safety of residents of the facility. The P&P indicated the facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement.</p> | | |