STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555897	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Healthcare & Wellness Centre, LP	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)
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** 42878 Based on observation, interview and record review, the facility failed to investigate and attempt to locate one of two sampled residents, (Resident 1) who was assessed at risk for elopement, had a history of suicidal ideations, and had fluctuating capacity to understand and make decisions, upon receiving information on 7/13/2024, that Resident 1 was not admitted to the General Acute Care Hospital (GACH 2) on 7/11/2024. As a result, Resident 1 had not been located and currently still missing, after eloping from the ambulance transportation on the way to GACH 2 emergency room (ER). This deficient practice had the potential to result in Resident 1 ' s physical injuries and change in condition that may lead to hospitalization or death. Findings: During a review of General Acute Care Hospital (GACH 1) records indicated Resident 1 was admitted on [DATE] with a diagnosis of Psychosis (mental disorder characterized by a disconnection from reality) and was discharged to Facility on 7/1/2024. During a review of GACH 1 records indicated Resident 1 had worsened symptoms of suicidal ideations (thinking about or planning suicide) with a plan to hang himself. The GACH 1 records indicated that Resident 1 verbalized that when he was taking his psychiatric medication as directed by the physician, the medications were effective. During a review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE] , with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). During a review of Resident 1 ' s History and Physical assessment dated [DATE], indicated Resident 1 had fluctuating capacity to understand and make decisions. (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	During a review of Resident 1 ' s care plan titled, Risk for Wandering/Elopement identification dated 7/02/2024, indicated a goal that Resident 1 would not leave the facility unattended and Resident 1 ' s safety would be maintained. The care plan interventions indicated the facility would identify if there were triggers for wandering/eloping, identify wandering/elopement and de-escalation behaviors. During a review of Resident 1 ' s care plan titled Resident alleges that he was abused by staff with complaints of pain dated 7/11/2024, indicated interventions that included the facility staff would assess for pain, assessed the resident ' s skin, the interdisciplinary team would meet with Resident 1 and inform the physician. The care plan indicated a new order to transfer Resident 1 to the GACH 2 for evaluation. During a review of Resident 1 ' s Hospital Transfer Form dated 7/11/2024, indicated Resident 1 was transferred to GACH 2 on 7/11/2024 timed at 2 PM. The Hospital Transfer Form indicated a risk alert for Resident 1 had agitation with risk to harm self or others and may attempt to exit. The Hospital Transfer Form indicated the report was given by the facility ' s Registered Nurse (RN1) on 7/11/2024 at 1:15 PM to the GACH 2 Registered Nurse (no name). During a review of the Ambulance Record titled Hospital Care Report dated 7/11/2024 indicated Resident 1 was transported from the facility to GACH 2. The Ambulance Record indicated When Ambulance arrived at GACH 2, we opened doors, explained to resident that report, paperwork needed to be given to [GACH 2] nurse in order to register/admit resident to GACH 2. [Resident 1] took of seatbelts and jumped out of ambulance and began running out of GACH 2 parking lot. During a review of the facility provided record indicated a screenshot of a cell phone text message dated 7/13/2024 timed at 10:38 AM, indicated four people were included in a group text message. The group text message indicated a message from Physician 1 stating Where is this patient (Resident 1) now? followed by a text response from the facility ' s Medical Records Director (MRD) on the same date 7/13/2024 (no time) indicating, Good morning, he (Resident 1) was sent out to the hospital. The text message was followed by a response from Physician 1 indicating Which hospital? MRD responded that Resident 1 was in GACH 2. Physician 1 responded and indicated in the group text message Can ' t find, and indicated in the text message Please track and let me know. GACH 2 Liaison responded in the text message and indicated Resident 1 eloped from our emergency room at 5:06 on July 11. During a review of GACH 2 document titled Certification of No Medical Records dated 7/16/2024, indicated GACH 2 had no record Resident 1 was ever treated at GACH 2. The form included Resident 1 ' s name and date of birth. During an interview on 7/23/2024 at 10:40 AM, with the facility ' s Administrator (ADM), the ADM stated Resident 1 was transferred from the facility on 7/11/2024 for medical evaluation due to Resident 1 making claims he was physically abused by 5 people and was in pain. The ADM stated the facility staff conducted a head-to-toe assessment but did not find any injuries. The ADM stated that Physician 1 was notified, and Physician 1 ordered to transfer the resident to GACH 2 for medical clearance just to check if everything was okay. The ADM stated that at first GACH 2 informed the facility that Resident 1 left GACH 2 against medical advice (AMA). The ADM stated that when the ambulance transporters picked up Resident 1 (on 7/11/2024), that was the last time the facility staff saw Resident 1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview, on 7/23/2024 at 10:40 AM, with the facility ' s ADM, the ADM further stated that the facility ' s Admission Coordinator (AC) called GACH 2 on 7/15/2024 for a follow up call and was notified by GACH 2 that Resident 1 was not admitted in GACH 2. The ADM stated that the AC requested for any documentation from GACH 2 ' s emergency room (ER) but GACH 2 only sent the Certification of No Medical Records indicating that the GACH 2 had no records of Resident 1 being treated or admitted at the GACH. During an interview and concurrent record review on 7/23/2024 at 12:10 PM with the AC, the AC stated as per facility practice, she follows up on residents who have been transferred to GACHs for updates. The AC stated he called GACH 2 to follow up on Resident 1 ' s status on 7/15/2024, when she was notified by GACH 2 that there was no record indicating Resident 1 had ever been admitted to GACH 2. The AC stated she notified the ADM who instructed AC to follow up with GACH 2 ' s Medical Records Department and request any documents about Resident 1 from GACH 2. The AC stated when she received GACH 2 ' s document titled Certification of No Medical Records on 7/16/2024, she gave the document to the ADM. During an interview, on 7/23/2024 between the hours of 1 PM to 1:24 PM, the ADM stated she did not follow up with GACH 2 or the Ambulance company, when she was notified by MRD on 7/13/2024, that Resident 1 was not admitted at GACH 2, because it was a Saturday, and the AC would follow up on Monday. The ADM stated that on 7/16/2024, after receiving documentation from GACH 2 indicating there were no records of Resident 1 ever being admitted to GACH 2, the ADM stated she did not follow up or attempt to locate Resident 1 because Resident 1 had been discharged from the facility ' s care, so it would have been GACH 2 ' s responsibility. The ADM stated she did not report to law enforcement because Resident 1 was self responsible. The ADM stated that even if Resident 1 was not self-responsible, Resident 1 would have been GACH 2 ' s responsibility. During the interview, the ADM called the Ambulance company to verify what happen to Resident 1 on 7/11/2024, and was informed that During an interview and concurrent record review on 7/23/2024 at 2:42 PM with the MRD, the MRD stated she was the facility staff in the group text message with Physician 1 on 7/13/2024, GACH 2 Liaison and Physician 1 ' s Case Manager. The MRD stated she received a group text message on 7/13/2024, from Physician 1 asking Resident 1 ' s whereabouts. The MRD stated she replied to Physician 1 with the location of Resident 1 which was in GACH 2. The MRD stated she saw Physician 1 ' s response and was notified that Resident 1 was not in GACH 2. The MRD stated that Physician 1 questioned what happen to Resident 1 and GACH 2 Liaison replied that Resident 1 had Eloped from GACH 2 on 7/11/2024. The MRD stated that Physician 1 asked Physicians ' 1 ' s Case Manager to follow up and locate Resident 1. The MRD stated she notified the facility's ADM on 7/13/2024 that Resident 1 had eloped. The MRD stated she did not document what happened to Resident 1 and notifying the physician and administrator that Resident 1 had eloped. During a follow up interview and record review of the facility ' s policy on 7/23/2024 with the ADM, the ADM stated she had reviewed all of the facility ' s policies and procedures and could not find a policy that included how the facility would ensure a safe resident discharge/transfer from the facility to another facility. During a review of the facility ' s policy and procedures (P&P) titled Resident Safety revised on 4/15/2021, indicated Facility will provide a safe and hazard free environment.