

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  09/20/2024
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 - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36925</p> <p>Based on observation, interview, and record review, the facility failed to prevent two of two residents (Residents 1 and 2) who were assessed at high risk for elopement (an act of leaving a care facility or safe area independently without notifying anyone) from leaving the facility in accordance with the facility's policy for elopement and residents' plan of care by failing to:</p> <ol style="list-style-type: none"> <li>1. Provide adequate monitoring and supervision to ensure Resident 1, who had fluctuating capacity to understand and make decisions, and was assessed at risk for elopement with diagnoses of suicidal ideation (thinking about killing yourself) did not elope from the facility on 9/10/2024 during a change of shift [evening shift and night shift] at 11 PM from Patio I.</li> <li>2. Provide adequate monitoring and supervision to ensure Resident 2, who had no capacity to understand and make decisions, assessed at risk for elopement and with diagnoses of suicidal ideations, did not elope from the facility, on 9/17/2024, during change of shift [night shift and morning shift] at 7 AM from Patio I.</li> <li>3. Ensure the facility thoroughly investigated on how Resident 1 eloped from the facility and provided interventions to prevent another resident, Resident 2, eloping from the same location in Patio I.</li> <li>4. Ensure Patio 1, that is in the front patio, and Patio 2 that is in the back patio, were equally monitored and supervised to prevent residents from elopement.</li> <li>5. Ensure Certified Nursing Assistant (CNA) 5 immediately informed staff that he saw someone climbing the roof near Patio 1.</li> </ol> <p>As a result of these deficient practices, Resident 1 climbed the roof by the facility's main/front patio (Patio I), jumped from the roof out to the facility's parking lot and climbed over the fence. On 9/11/2024, Resident 1 was located and transferred to the hospital for behavior management. On 9/17/2024 (6 days after Resident 1 eloped from the same facility patio) Resident 2 climbed over the same roof by Patio I, and jumped over the fence of the facility's parking lot. Resident 2 has not been found as of 9/19/2024.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The deficient practice had the potential for Resident's 1 &amp; 2 to sustain fall and injury when climbing the roof and struck by motor vehicles. Resident 1 had the potential to be exposed to extreme weather, malnutrition (lack of proper nutrition) and a psychiatric emergency due to a history of suicidal ideations that could lead to death. Resident 2 missed his daily medications including psychotropic medications (medications that affects mood and behavior) that were necessary to ensure he was not a danger to self and others.</p> <p>On 9/19/24 at 1:23 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance [not following rules] with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility's failure to provide adequate supervision to the residents in Patio 1. The survey team notified the Administrator (ADM) and the Director of Nursing (DON) of the IJ situation on 9/19/24 at 1:23 PM, regarding the facility's lack of supervision of the residents in Patio 1 that resulted to the elopement of Residents 1 and 2 from the facility on 9/10/24 and 9/17/24 respectively.</p> <p>On 9/20/24 at 6:34 PM, the ADM provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings).</p> <p>On 9/20/24 at 7:45 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, record review, and determined that the IJ situation was no longer present, the IJ was removed onsite in the presence of the ADM and the DON.</p> <p>The IJ Removal Plan dated 9/20/24 included the following:</p> <p>The facility's immediate action to correct noncompliance that has caused or is likely to cause serious injury, serious harm, serious impairment, or death to Resident 1, who eloped on 9/10/24, but found immediately, and Resident 2 who eloped on 9/17/24 continued to be missing as of 9/19/24.</p> <p>The facility placed a system in place to ensure:</p> <ol style="list-style-type: none"> <li>Residents were monitored and supervised when in Patio 1 at all times, in all three shifts.</li> <li>Heightened awareness on security and oversight of all facility exit doors for all three shifts.</li> <li>Residents at risk for elopement are frequently monitored and their whereabouts are always accounted for.</li> <li>Staff were in-serviced on how to care for residents at risk for elopement.</li> <li>Measures are in place to prevent residents from leaving the facility unsupervised for 22 residents at risk for elopement.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/17 /24, the DON/Designees conducted an audit of the Elopement Binder (the binder used by the facility that list the names of the residents at risk for elopement) to ensure that current residents that are at risk for elopement were included and had a photo identifier unless they refused to have their photo taken.</p> <p>There are currently 21 residents identified to be at risk for elopement. The Elopement Binder was updated to ensure all identified residents are included in the binder.</p> <p>On 9/19/24, the Administrator/designee conducted an observation of the patio area (Patio 1) during the shift change between 7-3 and 3-11 to ensure that the patio is monitored, and residents were always supervised by the staff. No concerns were noted during observation.</p> <p>What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:</p> <p>On 9/19/24, the Administrator and DON initiated an in - service education to RNs, Licensed Vocational Nurses (LVNs), CNAs, Rehabilitation and Activity staffs, Activities, Business Office, Dietary, Housekeeping, Laundry, Maintenance, Receptionist, Social Services, Medical Records staff. regarding the facility's policy and procedures for Wandering and Elopement, with emphasis on the importance of having the patio area always supervised in all three shifts, caring for residents at risk for elopement, and recognizing changes in condition that may potentially increase the risk of residents leaving the facility unsupervised. This in-service will be completed by 9/20/24. Staff on leave or unscheduled will receive education upon return to work.</p> <p>On 9/19/24, DON initiated an in-service to the nursing staff regarding hourly monitoring of residents who are at risk for elopement. This will be documented on the 'Residents who are at Risk for Elopement Monitoring' form. This in-service will be completed by 9/20/24. Staff on leave or unscheduled will receive education upon return to work.</p> <p>CNAs will conduct room rounds hourly every shift to ascertain all residents are accounted for.</p> <p>The Elopement Binder is placed at each Nurses Station and are reviewed with staff during shift change for any concerns, changes, or new admissions. These binders are updated by the DON/Designee as needed.</p> <p>The ADM will be responsible for monitoring and sustaining compliance.</p> <p>Findings:</p> <p>1. A review of Resident 2's Admission Record indicated the facility admitted the resident on 8/1/24 and readmitted the resident on 8/14/24 with diagnoses that included schizophrenia (a serious mental health condition that affects how people think, feel, and behave, with paranoia [mistrust of other people] as one of its most dominant symptoms) and suicidal ideations.</p> <p>A review of Resident 2's History and Physical, dated 8/2024 indicated the resident does not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 5/23/2024, indicated that the resident's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact. The MDS indicated that Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance (a type of assistance where a caregiver places one or two hands on a patient's body to help with balance while the patient performs a task) as resident completes activity and assistance may be provided throughout the activity or intermittently) when performing activities of daily living (ADL) such as eating, toileting, showering, and when performing oral hygiene.</p> <p>A review of Resident 2's care plan, initiated on 8/14/2024, indicated Resident 2 was at risk for wandering and elopement, to ensure the resident does not leave the facility unattended, the interventions included identifying triggers for wandering/elopement attempts, identify if there are patterns and purpose of wandering and monitor the resident's location every hour.</p> <p>A review of Resident 2's Elopement Evaluation (EE) dated 9/11/24 indicated that the resident was recently readmitted (within the past 30 days). Resident 2 also verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door.</p> <p>During a facility tour on 9/18/24 at 11:30 AM, the ADM demonstrated how Resident 2 climbed the roof from the patio to the other side of the building. The building that the residents in the facility occupied had six red doors that led to Patio 1. The patio had a screen fence approximately 12 feet high, with a door equipped with an alarm system, that led to the office of the ADM in another building.</p> <p>During a concurrent interview with the ADM, 9/18/24 at 11:30 AM she stated Resident 2 used the water pipes attached to the wall of the building to climb to the roof and jumped to the other side of the building to escape the facility. The ADM stated that the six red doors that led to Patio 1 remain unlocked 24 hours a day to enable the residents to freely go to the patio whenever they desired. All the doors and leading to the Patio are supposed to be supervised by staff that monitors the Patio 1.</p> <p>During an interview and concurrent record review with Director of Staff Development (DSD) on 9/18/24 at 2:30 PM, she stated on the night shift (11-7 AM), the staff monitoring the breezeway (an architectural feature similar to a hallway that allows the passage of a breeze) also monitors the patio simultaneously. The ADM stated Patio 1 does not have a dedicated staff to monitor the patio (Patio 1) area between 11 PM and 7AM. A review of the Nursing Staff Assignment dated 9/16/24, 11-7 AM shift, indicated that there was no dedicated staff assigned to monitor Patio 1 during the night shift (11-7 AM).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA 5 on 9/18/2024 at 3 PM, he stated he was assigned to monitor the breezeway on 9/17/24 from 7-3 PM. CNA 5 stated that on 9/17/24 between 7:15 - 7:20 AM, he observed a person from the breezeway climbing the roof in Patio 1 and simultaneously heard a Code [NAME] (an emergency code used by the facility to alert the facility staffs that a resident was missing or eloped [leaving the facility without permission or informing the facility] from the facility's paging system. CNA 5 stated he immediately stepped out of the building from the breezeway to confirm what he saw, but the person was not there anymore. CNA 5 stated he did not report to anyone immediately that he observed someone climbing the roof rather, rather he returned to his post while the rest of the staff looked for Resident 2. CNA 5 stated he learned later on from the other staffs that Resident 2 eloped and was missing.</p> <p>During a concurrent interview and observation on 9/18/2024 at 3 PM with CNA 5, CNA 5 stated he was assigned to monitor Patio 1 and the breezeway. CNA 5 stated the location from where he stood along the breezeway did not have a full and clear view.</p> <p>During an interview with Licensed Vocational Nurse (LVN) 4 on 9/19/24 at 12:20 PM, LVN 4 stated during breakfast on 9/17/24 at around 7:15 AM, she found a food tray in the food cart that belonged to Resident 2. LVN 4 stated she looked for Resident 2 everywhere in the building and was unable to locate the resident. LVN 4 then stated she immediately paged Code [NAME] on 9/17/24 at around 7:18 AM.</p> <p>During an observation on 9/19/24 at 3:35 PM, the Maintenance Supervisor (MS) measured the distance from the breezeway where the staff stood to monitor Patio 1 simultaneously. The distance from where the staff stood in the Breezeway to the wall where Resident 2 allegedly climbed to the roof was approximately 97 feet away and the height of the wall was approximately 11 feet and 2 inches.</p> <p>A review of the facility investigation report sent to CDPH, dated 9/23/24, indicated on 9/17/24 during a routine hourly head counts in the morning shift change, Resident 2 was not in his room. The staff informed the licensed nurse, and a Code [NAME] was immediately called at around 7:18 AM that initiated the search for Resident 2. During the search, a member of the search team saw Resident 2 making his way through the football field at the high school adjacent to the facility. The facility called the police on 9/17/24 at 7:27 AM but the resident was nowhere to be found.</p> <p>During an observation of a photo taken at the breeze way from the middle/back position of Patio 1 on 9/19/24 at 12:40 PM indicated the breeze way door frame was blocking full visual of Patio 1.</p> <p>A review of the facility's closed-circuit television (CCTV, also known as video surveillance, is the use of closed-circuit television cameras to transmit a signal to a specific place, on a limited set of monitors) on 9/19/24 at 12:45 PM showed the camera in Patio 1 only captured one side of the patio. The camera does not show side of the patio where Resident 2 climbed to get to the roof of the building.</p> <p>46779</p> <p>2. During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 9/3/2021 and readmitted on [DATE] with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and suicidal ideations (preoccupied thought of hurting or killing self).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a review of a MDS, dated [DATE], indicated Resident 1's had intact cognition (ability to understand and make decisions) and skills for daily decision making. The MDS indicated Resident 1 exhibited little interest or pleasure in doing things and trouble concentrating on things, such as reading the newspaper or watching television on half or more of the day. The MDS indicated Resident 1 also exhibited feeling down, depressed, (severe sadness and hopelessness) and bad about self or being a failure or let self or the family down nearly every day. The MDS indicated Resident 1 was independent with eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, walk 150 feet.</p> <p>A review of the plan of care dated 9/8/2024, indicated Resident 1 was at risk for elopement and wandering with the goal to ensure Resident 1 does not leave the facility unattended. The interventions included the facility will monitor resident's whereabouts every hour and will involve resident in purposeful activity.</p> <p>During an interview on 9/18/24 at 3:35 PM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she worked at the Station A on 9/10/2024 from 3 PM to 11 PM. LVN 3 stated she was inside East Nursing Station's main building around 11 PM on 9/10/2024, when she heard a noise coming from the Patio 1, but she did not see anyone on the ground of Patio 1 when she stepped out to the patio. LVN 3 stated, she heard a noise coming from the roof on the East wing building and she saw Resident 1 on top of the roof.</p> <p>During an observation on 9/19/2024 at 12 PM, Certified Nursing Assistant (CNA) 3 was observed standing in the breezeway. In a concurrent interview, CNA 3 stated all the red colored painted doors in the main building opens to Patio 1 that were never locked so that residents have 24 hours access to Patio 1. CNA 3 stated a staff was assigned to monitor only the Breeze way from 7 AM- 11PM, and another staff was assigned to monitor the Patio 1 from 7 AM to 11 PM. CNA 3 stated from 11 PM-7AM only one staff was assigned to monitor the Breeze way, Patio 1 and the Patio 2 (total three areas). CNA 3 stated she does not have a full visualization of Patio 1 when standing inside the Breeze way because the walls and the front door of the Breeze way blocks the views in certain areas of Patio 1. CNA 3 stated she had to put her head out or step out of the Breeze way to get a full visualization of Patio 1 and Patio 2.</p> <p>During an interview on 9/19/2024 at 1:54 PM, with Registered Nurse (RN) 1, RN 1 stated on 9/10/24 she worked from 3 PM to 11 PM. RN 1 stated at around 11:05 PM, she was in the main building near Patio 1 when LVN 3 from another station notified her that she saw someone on the roof near the Patio 1. RN 1 stated she activated Code [NAME] through the overhead paging system (an audio system that allows for one-way communication to a large audience) and when she ran out of the facility, she found Resident 1 on the driveway of the facility. RN 1 stated in the past she has observed Resident 1 always pacing (walk aimlessly) in the hallways and in Patio 1 during the evenings.</p> <p>During an interview on 9/19/2024 at 2:43 PM, CNA 1 stated Resident 1 always walks around in Patio 1. CNA 1 stated he was assigned to monitor Patio 1 from 3 PM to 11 PM on 9/10/2024 and did not see anyone in Patio 1 before he left in the end of his shift. CNA 1 stated he informed the charge nurse that he was leaving the facility and that there was no staff monitoring Patio 1 when he left the facility on [DATE] between 11: 03 PM and 11:04 PM. CNA 1 stated he did not report to an incoming CNAs before he left the facility because he did not know if any staff was assigned to monitor Patio 1. CNA 1 stated he did not witness Resident 1 eloped from the facility on 9/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 9/19/24 at 3:45 PM, with the Assistant Director of Nursing (ADON), the ADON stated a facility staff assigned to monitor the breezeway from 11 PM to 7 AM, was supposed to stay inside the breezeway to monitor the residents. In an observation of the breezeway with the surveyor, the ADON explained, the staff monitoring the breezeway does not have a full view of Patio 1 if staff are monitoring the breezeway.</p> <p>During an interview on 9/20/24 at 9:07 AM, with LVN 1, LVN 1 stated on 9/10/24 at 11PM until 7 AM on 9/11/24 she was the staff assigned to monitor the Breeze way, Patio 1 and Patio 2. LVN 1 stated the staff monitoring the Breeze way usually stayed inside of the Breeze way, but if there was a resident in Patio 1, the staff goes outside to monitor the resident. LVN 1 stated she did not see anyone in Patio 1 when CNA 1 informed her that he was leaving which was around 11 PM on 9/10/2024. LVN 1 stated she did not see how Resident 1 went on top of the roof of the building. LVN 1 stated Resident 1 eloped because she thought no one would pay attention to her since the staff were busy during the change of the shift at 11 PM on 9/10/2024. LVN 1 stated there were blind spots from the Breeze way to the patio which blocks the view in Patio 1 where Resident 1 eloped from. LVN 1 stated she would not be able to see what was going-on in the patio due to the blind spots to Patio 1.</p> <p>During an observation and interview on 9/20/24 at 9:27 AM, Receptionist 1 stated the facility only had one surveillance camera monitoring Patio 1, but the camera could not capture the view of Patio 1 that was close to the main building where Resident 1 and Resident 2 eloped from. Receptionist 1 stated there was no staff assigned to the front office during the night from 11 PM to 7 AM to monitor the residents leaving from the facility in the front lobby or in Patio 1.</p> <p>During an interview on 9/20/2024 at 11:16 AM, LVN 2 stated when the facility readmitted Resident 1 in 8/2024, Family Member (FM) 1 called and stated Resident 1 had a history of eloping from home and was at high risk for elopement. LVN 2 stated she did not add this information to the nursing progress notes and care plan and did not inform any other staff of the resident's behavior of eloping from home.</p> <p>During a concurrent interview and record review on 9/20/24 at 12PM, with the ADON, Resident 1's Elopement Evaluation (EE), dated 8/9/24 indicated Resident 1 had a history of elopement and an attempted elopement while at home and in the facility. The EE also indicated Resident 1 verbally expressed the desire to go home, packed belongings to go home and stayed near an exit door. The EE indicated Resident 1 wandered aimlessly and likely to affect the privacy of others. The ADON stated based on the EE, dated 8/9/24, Resident 1 was at risk for elopement. A review of the EE, dated 9/3/24, indicated Resident 1 did not have a history of elopement or attempted to elope while at home and in the facility, and was not at risk for elopement. The ADON stated the EE, dated 9/3/24, was not answered correctly. The ADON stated the licensed nurse might have overlooked the facility's documents of Resident 1 when licensed nurse completed the elopement assessment on 9/3/24. The ADON stated the licensed nurses must review a resident's documents and assess the resident's current condition thoroughly and document the actual condition and assessment of the resident accurately.</p> <p>During a concurrent interview and record review on 9/20/24 at 3 PM, with the Administrator (ADM), the Facility Investigation Report, dated 9/11/24, was reviewed. The ADM stated the staff did not see Resident 1 get up to the roof on 9/10/24, and Resident 1 did not tell anyone how and where exactly she climbed up to get to the roof. The ADM stated based on the time and location the noise heard by the charge nurse on 9/10/24 at around 11:05 PM, Resident 1 may have eloped from Patio 1.</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  09/20/2024
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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 9/20/24 at 3:10 PM, with the ADM, Nursing Staff Assignments, dated from 9/10/24 to 9/17/24, the ADM stated only one staff assigned from 11 PM to 7 AM to monitor the breezeway, Patio 1 and Patio 2.</p> <p>During an interview on 9/20/24 at 3:15 PM, the ADM stated resident are kept away from Patio 1 at around 7AM, because the staff washes and cleans the grounds of the patio at the time. The ADM stated the grounds were wet and the facility discourages residents from going out to the Patio 1 to prevent fall and injury.</p> <p>During a concurrent interview and record review on 9/20/24 at 5:20 PM, with the Director of Nursing (DON), the DON stated the Elopement Evaluation of Resident 1 on 8/9/24 and 9/3/24, was not correctly assessed. Residents were supposed to be evaluated as high risk for elopement, and that affected the care of Resident 1 and 2 regarding the risk of elopement.</p> <p>During a concurrent interview and record review on 9/20/24 at 5:25 PM, with the DON, the facility's policy and procedure (P&amp;P) titled, Wandering &amp; Elopement, dated 7/2017, and Resident Safety, dated 4/15/21, were reviewed. The DON stated both versions of the P&amp;P were the most current P&amp;P that the facility followed. The DON stated the accurate assessment and documentation on residents' elopement risk was important so that the appropriate care plan and the intervention could be developed and implemented to prevent elopements. The DON stated providing additional supervision would be the fast and effective way to prevent residents' elopements in the secured facility, including by adding more staff to monitor the front patio and more frequent checking on the residents.</p> <p>A review of the facility's policy and procedure, titled Wandering &amp; Elopement, dated 7/2017, indicated to enhance the safety of residents in the facility, the facility will identify residents at risk of elopement and minimize the possible injury as a result of elopement by ensuring the licensed nurse, in collaboration with the Interdisciplinary Team (IDT- a group of facility staff that help develop the plan of care for the residents) will assess residents upon admission, readmission, quarterly and upon identification of a significant change in condition. The residents at risk of elopement, preventative measures will be documented in the resident's clinical records and will be reviewed and re-evaluated by the IDT. The IDT will develop a plan of care considering the individual's risk factors.</p>		