STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056195	A. BUILDING _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA BREA REHABILITATION CENTER	505 N. LA BREA AVENUE LOS ANGELES, CA 90036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility-Reported-Incident. Facility-Reported-Incident number: 654858-Substantiated Representing the Department: #35004, HFEN The inspection was limited to the specific complaints / facility-reported-incidents investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of facility-reported-incident number 654858.	F 000	La Brea Rehabilitation Center submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with intention that is inadmissible by any third party in civil, criminal action or proceedings against the provider or its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 should be inadmissible in any proceeding on that basis. Description of the monitoring process to prevent occurrence.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide supervision for Resident 1 when he was previously assessed as a high risk for elopement. On 9/13/19, Resident 1 eloped from the skilled nursing facility without their knowledge. This failure has the potential for Resident 1 to	F 689	F689 Immediate Corrective Action: Resident 1 is no longer in the facility	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

NHA 02/20/20

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.

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F 689	Continued From page 1 have an unforeseen injury due to the facility's staff lack of knowledge of Resident 1's whereabouts. Findings: On 9/23/19, at 10:03 a.m., an unannounced visit was conducted at the skilled nursing facility regarding a Quality of Care incident. A review of Resident 1's Admission record indicated, the resident was admitted to the skilled nursing facility on 9/12/19, with diagnoses that included muscle weakness and kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids). A review of Resident 1's History and Physical record dated 9/17/19, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Elopement Risk Assessment record dated 9/12/19, indicated the resident was at risk for elopement. A review of Resident 1's care plan titled "High risk for Fall and Injury related to unsteady gait," initiated on 9/12/19, indicated that the care plan's interventions were to provide a safe environment, frequent reminders regarding safety, and to implement fall precautions. There was no documented evidence of a care plan for elopement risk. A review of Resident 1's Nurses Notes record dated 9/12/19, at 11:24 p.m., indicated the following information: Admitted a 57 year old resident from (hospital's name) with admission diagnoses of hypertension (high blood pressure),	F 689	Continued from Page 1 <u>Identification of other residents that can be affected with the deficient practice:</u> Medical records Director (MRD) conducted chart audits for residents who were assessed as high risk for elopement to ensure that they have care plan for elopement risk to meet their individual needs including providing supervision. No other residents were found to be affected by this deficient practice. <u>Measures that was put in place to ensure deficient practice does not recur:</u> Director Of Nurses (DON)/designee conducted in-service to the licensed nurses on 2/18/20 regarding the policy and procedure for Wandering/Elopement with emphasis on the safety and well being of all residents with a potential for wandering is ensured at all times and that there is a Plan of Care that addresses the issue with specific objectives to meet their individual needs. During the shift huddle, RN supervisors and/or charge nurses shall discuss the residents who were assessed as high risk for elopement and requires supervision. Any findings shall be addressed immediately and report to the DON for follow up.	

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F 689	Continued From page 2 cardiomyopathy (heart disorder), COPD (chronic obstructive pulmonary disease-lung disease causing difficulty breathing), pacemaker (medical device implanted to regulate heart rhythm). Resident is alert but confused. Resident on pureed diabetic diet. Admission orders clarified. Admission care provided and well tolerated. A review of Resident 1's Nurses Notes record dated 9/13/19, at 5:43 p.m., indicated at 3 p.m., all rounds made. Resident not in bed. Asked the outgoing team about resident and was told he left facility AMA (against medical advice). At 4 p.m., called the resident's responsible party (name) and said she did not know resident's whereabouts. She said resident might have left facility due to his dementia and PTSD (post traumatic stress disorder-anxiety disorder). At 5 p.m., called LAPD (city's police department) and reported resident missing via operator. The police verbalized that the facility will be notified as soon as resident is found. (Doctor's name) made aware. On 9/23/19, at 10:06 a.m., the Administrator was interviewed. The Administrator stated that he did not know how Resident 1 exited the building but he may have used the service elevators. The Administrator stated, Resident 1 had a history of going AMA in the past. The Administrator stated, he talked to Resident 1's doctors and his other responsible party who brought him to the hospital. A review of the facility's policy titled "Subject: Wandering/Elopement," revised 9/09, indicated the safety and well being of all residents with a potential for wandering is ensured at all times. Policy: Prior to admission potential wandering residents are assessed. All residents who are at risk for harm because of wandering behavior	F 689	Continued from Page 2 During the daily stand up meeting, the DON and/or designee shall discuss the newly admitted residents who were assessed as a high risk for elopement that they have a care plan for elopement risk. Any findings shall be addressed immediately and report to the DON for follow up. **Monitoring put in place to ensure compliance is sustained:** Medical records director/designee will conduct an admissions audit to ensure elopement risk assessments are completed upon admissions and interventions are implemented based on residents needs. License Nurses will update elopement risk assessments as needed. Interdisciplinary team will review elopement risk assessments and plan of care at quarterly care plan meeting to ensure interventions are in place to meet individual needs. Medical records/designee will report any findings from admission audit and change of condition audit to Director of Nurse or designee. Medical records director or designee will track and trend finding and report out our quarterly Quality Assurance committee for review and recommendations. **Completion Date:** February 21, 2020	

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F 689	Continued From page 3 have a Plan of Care that addresses the issue with specific objectives to meet their individual needs.	F 689		