POC accepted 10/16/18 by: OSOP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055818	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL GARDENS HEALTHCARE	2339 W. VALLEY BLVD. ALHAMBRA, CA 91803

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an investigation of two Entity Reported Incidents (ERIs). ERIs Intake No.: CA553990 and CA00553996 Representing the Department of Public Health: Health Facilities Evaluator Nurse # 36290 The inspection was limited to the specific ERIs investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of ERIs # 553990 and 553996.	F 000	• This Plan of Correction constitutes our written credible allegation of compliance for the deficiencies noted. This facility was on substantial compliance no later than October 12, 2018.	
F 689	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 observation, interview, and record review, the facility failed to prevent elopement (to leave a hospital, without permission (AWOL: absence without leave) from facility premises) for	F 689	• Residents 1 and 2 are no longer residing in the facility as of October 4, 2018. Resident #1 was discharged from facility to Santa Fe Lodge on 9/29/17. Resident #2 was transferred from facility to the Hollywood Community Hospital on 1/22/18 and the sister/resident representative subsequently came to facility to pick up resident #2's personal belongings and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Armando C. Jr | TITLE: ADMINISTRATOR | (X6) DATE: OCT. 11, 2018

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 2 of 4 sampled residents (Residents 1 and 2). The facility failed to: 1. Create an individualized care plan or discuss elopement risks during the Interdisciplinary Team (IDT) meeting held on 9/14/17, for Resident 1 who was at risk for elopement. 2. Resident 2 had a history of elopement and the facility failed to document the incident, develop and update the plan of care to reflect measures that would prevent future elopement 3. After Resident 1 eloped on 9/20/17, the facility implemented a Sentry (door monitoring) system but failed to ensure the assigned staff members remained at the door at all times. These deficient practices resulted in Residents 1 and 2 eloping from the facility where Resident 1 sustained abrasions on his elbows and Resident 2, a head trauma. Findings: On 10/4/17 at 1:56 p.m., a facility visit was made to investigate two entity reported incidents on elopement. a. A review of the Admission Record indicated Resident 1 was admitted to the facility on 8/22/18, with diagnoses that included: muscle weakness, abnormalities of gait (walking) and mobility, alcohol abuse, and anxiety disorder. A review of the Elopement Risk Assessment dated 8/22/17, indicated Resident 1 scored 12 (10 or greater indicates a resident is an elopement risk). Resident 1 expressed a desire to leave facility premises although there had not been an actual attempt to leave. There was no documentation in Resident 1's medical record of	F 689	informed facility that resident #2 will go to another SNF upon discharge from the hospital. • All resident have the potential to be affected by the identified deficient practice. On October 4 and October 5, 2018 the Director of Nursing Services checked the resident charts and records of the 36 current residents in the facility and did not find any other resident with the same deficiency. • Measures that were immediately implemented on September 20, 2017 to address the elopement incidents are as follows: After the elopement incident of resident 1, a Sentry System was created and activated to continuously post a watcher to monitor the main exit door on a 24/7 basis to prevent any	

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F 689	Continued From page 2 a plan of care that address the resident's desire to leave the facility. This was verified by the Medical Record Staff (MRS). Upon review of the Interdisciplinary Team conference Record dated 9/14/17, there was no documented evidence that Resident 1, being an elopement risk, was discussed nor were interventions mentioned in the treatment plan. This was verified by the Director of Nursing (DON). A review of the Licensed Personnel Progress Notes dated 9/20/17, at 12:55 p.m. indicated that during rounds, Resident 1's lunch tray was observed untouched. The facility started looking for Resident 1 throughout the premises and was not found. Resident 1 was last seen at 12/30 p.m. At 1:55 p.m., the facility received a phone call from the hospital and made them aware that Resident 1 was taken to their emergency department via an ambulance. At 4:25 p.m., Resident 1 was readmitted to the facility with scattered abrasions on the right and left elbows. On 10/4/17 at 2:44 p.m., in an interview, Certified Nursing Assistant (CNA 1) stated Resident 1 walked slow and steady. CNA 1 stated on 9/20/17, she cared for Resident 1 and at 12:00 p.m. she left Resident 1's lunch tray in his room. CNA 1 observed Resident 1 walking around the hallway, throughout the entire facility, and talking with the social worker. At 12:30 p.m., CNA 1 went to Resident 1's room to pick up the tray and the food was untouched. CNA 1 and "everyone" looked for Resident 1 in the hallway, inside and out the facility. Resident 1 was not found.	F 689	elopement incident. The DSD provided in-service to the staff on September 20, 2018 to explain the purpose of the Sentry System and to emphasize the importance of keeping the exit door on constant watch continuously 24/7 during the period when the system is in effect, (exh. A). After the elopement of resident 2 on September 20, 2017, the DSD again provided in-services to the staff to strictly comply with their sentry posting assignments to prevent any further unauthorized exit of residents through the main exit door, (exh. B). Facility did not experience any further elopement or any attempt to elope by any resident since after September 20, 2017 and the Sentry System was deactivated on December 30, 2017. To prevent recurrence	

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F 689	Continued From page 3 b. A review of the Admission Record indicated Resident 2 was admitted to the facility on 5/22/17, with diagnoses that included: Parkinson's disease ((PD/a disorder that affects movement), dementia (a decline in mental ability), paranoid schizophrenia (mental disorder characterized by loss of contact with the environment), muscle weakness, abnormalities of gait (walking) and mobility, syncope (fainting), and history of falling. A review of the Elopement Risk Assessment dated 5/22/17, and 9/4/17, indicated Resident 2 scored an eight and was not at risk for elopement. These were the only elopement assessments found in Resident 2's chart. Per Administrator, Resident 2 had no history of eloping from the facility and was not at risk. On 10/4/17 at 3:09 p.m., in an interview, CNA 2 stated on 9/20/18, Resident 2 was irritable, anxious, and only wanted to be by the door. CNA 2 stated she had gone on her break around 6:50 p.m. and left Resident 2 eating dinner in his room in bed. While CNA 2 was still on her break, a staff member made her aware that Resident 2 was missing. CNA 2 stated that three to four months ago, Resident 2 had eloped and was found at a nearby Shakeys. CNA 2 stated Resident 2 and his family refused a wander guard (triggers the door alarm to sound when the resident gets close or passes through) bracelet. There was no documentation in Resident 2's chart of prior elopements other than the 9/20/17 incident. This was verified by the MRS. On 10/4/17 at 3:15 p.m., an observation was conducted. The facility had two doors, the front door that remained unlocked and another door inside the facility that remained locked at all	F 689	and to avoid the same deficient practice from October 4, 2018 and onward, the DON provided in-services starting on October 4, 2018 to the Licensed Nurses and CNAs, (exh. C), to always report and document any and all resident elopement incidents and to strictly observed the Policy of Facility to know the whereabouts, and provided monitoring and supervision of the residents during their respective shifts. Residents must be assessed upon admission, quarterly and yearly thereafter and or as needed. When a resident is identified at risk of elopement, to create and develop a care plan to address the wandering/elopement risk with goals, interventions and approaches to prevent elopement incident. Licensed nurses to check every shift	

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F 689	Continued From page 4 times. On 10/4/17 at 4:00 p.m., an observation was conducted. Resident 2 was alert, in bed, and had an abrasion to the right lower knee and dry scabs on the left lower outer ear lobe. Resident 2 was assisted out of bed by CNA 3 and stood, holding his wheelchair. Resident 2 walked unsteady, slouching and leaning forward as he pushed his wheelchair, almost fell but helped by CNA 3. On 10/4/17 at 4:02 p.m., in an interview, Resident 2 stated he exited the facility through the front door and no staff was seating by the door. Resident 2 stated he took the bus and fell at the bus terminal. A review of the Licensed Personnel Progress Notes dated 9/20/17 at 6:10 p.m., Resident 2 was seen walking around the facility with his wheelchair and sat by the front door smiling. A CNA assisted Resident 2 back to his room and was left stable in his bed with the wheelchair close by. At approximately 7:10 p.m., a CNA reported that Resident 2's wheelchair was found in front of the facility by the entrance and Resident 2 was not seen. The facility/rooms were searched and Resident 2 was not found. At 8:30 p.m., the fire department called the facility to inform them that Resident 2 was found on a street and on the ground. Resident 2 had a laceration (cut) on the head and was transported to the local hospital. A review of the hospital Patient Discharge Instructions dated 9/26/17, indicated the following discharge diagnoses for Resident 2: acute head trauma (sudden damage to the scalp, skull, or brain caused by injury), contusion of knee	F 689	residents who were assessed at risk of elopement and who were provided with wander guard gadgets by using of monitoring logs, (exh. D). the local maintenance will continue to check daily the functions of the door alarm systems with the use of Exit Doors Alarm system and wander-guard monitoring log, (exh. E). • The DON will review and monitor compliance daily and the Health Information Designee (HID) will also monitor compliance in his routine weekly audits. Results of the findings will be discussed in daily QAPI meetings, monthly and quarterly meetings for review, recommendation and corrective action if needed.	

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F 689	Continued From page 5 (bruised), laceration of left ear lobe and scalp. On 9/10/18 at 1:15 p.m., a second visit to the facility was conducted to discuss the elopements that occurred on the same day for Residents 1 and 2. On 9/10/18 at 1:20 p.m., during an interview, the Administrator stated that after Resident 1 eloped on 9/20/17, "most likely through the front door," by 3:00 p.m., the facility had initiated the century system through which an assigned staff member was to monitor the front door at all times. Administrator stated the century system was new and did not work because Resident 2 eloped on the same day when the system was already in place. Administrator stated the staff left the "sentry post" when they heard other residents in the unit shouting and their role was to be by the door at all times. On 9/10/18 at 3:05 p.m., an interview was conducted with Administrator and DON. They stated that during the IDT meeting held on 9/14/17, the team failed to discuss Resident 1's desire to leave the facility (at risk for elopement assessment) and failed to create a care plan. In addition, for Resident 2, the facility should have documented the prior elopement to Shakey incident, created a care plan and an SBAR (situation, background, assessment, recommendation: communication tool), discussed it during the IDT meetings, and updated the elopement assessment that would have indicated Resident 2 was a risk for elopement. On 9/10/18 at 3:08 p.m., in an interview, the DON stated that developing elopement care plans was	F 689	• Completion date: 10/12/18	

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F 689	Continued From page 6 important and interventions that could have been included were: Individualized monitoring/supervision for Residents 1 and 2 throughout the day and would have brought awareness of the potential for elopement to all staff. Upon review of the Sentry System document (undated), it described the system as "A watch and monitoring system implemented by the facility to augment and supplement the current facility wander guard system to prevent elopement from the building thru the exit door. [An] important feature of [the] system is to post a sentry near the exit door on a 24/7 basis [and] compliance [was] monitored by using a log system. A review of the Elopement Prevention and Search policy and procedure revised 1/21/08, indicated that it was the policy of the facility for the staff to know the whereabouts of the residents. Residents who had the tendency or history of wandering were identified in the assessment and re-assessment process. In addition, residents must be assessed upon admission, quarterly and yearly thereafter (and/or as needed), Care plans must address the wandering risk with goals, interventions and approaches, and all exit doors in the facility must have a wander alert system and/or alarm system.	F 689		