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F 000 INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of an entity reported indicates (ERI) during an Abbreviated Standard Survey. ERI number: CA00528981, -Substantiated with no regulatory violations Representing the Department of Public Health: Health Facilities Evaluator Nurse ID: 33528 The Inspection was limited to the specific ERI investigation of an entily reported indicates (ERI) and the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 483." The Inspection was limited to the specific ERI investigation and does not represent the findings of a full inspection of the facility. One deficiency was issued for ERI CA00528691 F 323 483,25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT SS=D I HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that- (1) The resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rails is used, the facility must ensure order installation, use, and maintenance of bed rails, including but not limited to the following elements. FRATORY DIRECTORS CONTRECTION TO THE ADMOSPARE PERIOR CORRECTION CONTRECTION TO THE ADMOSPARE PERIOR OF THE ADM					2023 LAKEWOOD BLVD. DOWNEY, CA 90242	•	
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bed rail. If a bed or side rail is used, the facility and procedure and there were no maintenance of bed rails, including but not limited 1's wandering behavior. RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE Iicensed nurse per facility's policy and procedure and there were no other incidents related to resident 1's wandering behavior.	. `	THE GODISTANCE CEAIC	es to prevent accidents.		Resident 2 is no long	er a resident in	:
to the following elements. 1's wandering behavior. RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE	, u	ped rail. If a bed or si must ensure correct in	es prior to installing a side or lead		licensed nurse per fa	acility's policy there were no	
(X6) DATE	to	o the following eleme	nts.	÷	1's wandering behavior	or.	
(X6) DATE	RATORY DI	RECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVES SIGNATI	IDE			
leficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ing the date of survey whether or not a plan of corrections.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made excitable to the state of the st	leficiency =	1			Adminidate	n.	12012

FORM CMS-2567(02-99) Previous Versions Obsciete

Event ID: 4TYW11

Facility ID: CA940000006

If continuation sheet Page 1 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 04/26/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		555099	B. WING			na	C /14/2017
NAME OF PROVIDER OR SUPPLIER LAKEWOOD HEALTHCARE CENTER			a)	12	REET ADDRESS, CITY, STATE, ZIP CODE 023 LAKEWOOD BLVD. DWNEY, CA 90242 PROVIDER'S PLAN OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XB) COMPLETION DATE
F 323	(2) Review the rist the resident or reinformed consent (3) Ensure that the appropriate for the This REQUIREM by: Based on observe two of two reside was assessed with allway and Resisupervision was a supervision was a result of the wandered into Road and the wandered in memoral and the wandered in the wandered i	sident for risk of entrapment or to installation. Iks and benefits of bed rails with sident representative and obtain prior to installation. The bed's dimensions are a resident's size and weight. ENT is not met as evidenced ration, interview and record failed to provide supervision for ints (Resident 1 & 2). Resident 1 th wandering behaviors in the dent 2 who was on 1:1 able to hit Resident 1. Ifacility's failure, Resident 1 esident 2's room where Resident abused by Resident 2.		323	Identification of other reswith the potential of affected by same practice implemented corrective measured. Licensed Nurses were in-set by Director of Nursing (DO 3/29/2017 regarding wandering elopement and supervision patients with wandering epidents with wandering betwere identified by licensed and wandering elopements were updated facility's policy and proceduscheduled risk assessments. Measures in place to expractice does not recur: Residents identified by the staff with a behavior of going other resident's room will assessed by a licensed Licensed nurse will indicate behavior management and proof safe environment and to that care plan is being follower.	being and sures: rviced N) on ag and n of sodes. havior nurses ement per are on ensure acility ag into be re- nurse. te the ovision ensure	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTER): 04/26/2017
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORN	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		555099	B. WNG	.			C
NAME OF	PROVIDER OR SUPPLIER		<u></u>	STE	RET ADDRESS AID STATE	04	/14/2017
LAKEWO	OOD HEALTHCARE C	ENTER		120	REET ADDRESS, CITY, STATE, ZIP CODE 123 LAKEWOOD BLVD. 1WNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D DE	(XS) COMPLETION DATE
F 323	chair, wheelchair, a dressing, toilet use Resident 1 used a v device.	nd standing position), and personal hygiene. wheelchair as a mobility	F	323	Monitoring system to make solutions are sustained. This plan of correction we integrated into our on-going of assurance process. DON/ december 1.	ill be	
· .	around the facility w	nt 1's Wandering Assessment ted that Resident 1 wanders thile using the wheelchair.		:	will report the findings to committee on monthly basi further recommendations.	$\tilde{\Omega}$	
	and titled, "Dementi Resident 1 had war resident was at risk and impaired judger	at 1's Care Plan dated 3/1/17 ia/Alzheimer's" indicated that idering behavior and the for injury due to wandering ment. The Care Plan indicated in iderform frequent checks on			Completion Date- 05/18/2017		
:	Resident 1 was una	on 3/30/17 at 7:00 a.m., ble to respond to surveyor be the aftercation that occurred besident 2.		1			
j	supervisor (RNS 1)	m., registered nurse stated that Resident 2 swung under 1:1 supervision.					
:	Indicated Resident 2 on 6/29/16 and re-ad 2's diagnoses includ (condition in which a combination of schiz	Ission Record (face sheet) Is was admitted to the facility Idmitted on 3/15/17. Resident Idea schizoaffective disorder I person experiences a I cophrenia symptoms - such I delusions - and mood I such as mania or					
£	(MDS), a resident as	t 2's Minimum Data Set sessment and lated 3/16/17, indicated that				·	

DEPART	PRINTE	D: 04/26/2017					
GENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				O. 0938-0391 ATE SURVEY MIPLETED
	555099		B. WING	3			C .
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	- 5	STREET ADDRESS, CITY, STATE, ZIP CODE	04	4/14/2017
LAKEWO	OOD HEALTHCARE C	ENTER		1	12023 LAKEWOOD BLVD. DOWNEY, CA 90242	•	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T				
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF TAG	ΪX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	(X6) COMPLETION DATE
! !	skills for activities of indicated that Resid assistance from one between surfaces (I standing position), of personal hygiene. Ras a mobility device During a telephone p.m., Sitter 1stated Resident 2's room. Swas trying to preven inside the room, Resident 2 was trying at Resident 2 was to aggressive behave During an interview of director of nursing (I does not have a poli supervision. A review of the facility "Wandering & Elope"	derately impaired in cognitive of daily living. The MDS lent 2 required extensive a staff when transferring oed, chair, wheelchair, and dressing, toilet use, and desident 2 used a wheelchair linterview on 4/1/17 at 2:36 that Resident 1 came inside Sitter 1 stated that while he at Resident 1 from coming sident 2 walked behind Sitter ident 1's left cheek. Sitter 1 as under 1:1 supervision due iters. On 4/14/17 at 3:18 p.m., the DON) stated that, the facility cy and procedures for 1:1 by's revised policy titled, ment" and dated 1/11/16 cility would take for a resident	F	323			
;				:	•		
				i			