STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056326	A. BUILDING _____ B. WING _____	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON CONVALESCENT HOSPITAL	845 S.BURLINGTON AVENUE LOS ANGELES, CA 90057

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI). Facility Reported Incident Number: CA00785868. Representing the Department: Health Facilities Evaluator Nurse(s): 36395. . The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the Facility Reported Incident: CA00785868 (Refer to Ftag 689).	F 000		
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 one of three sampled residents (Resident 1). - Ensure Resident 1 was wearing the wander guard bracelet (bracelet worn to trigger the alarm system at exit doors when resident attempted to	F 689	IMMEDIATE CORRECTIVE ACTION: Resident 1 returned to the facility on 5/23/22 at 11:26am. Patient is ambulatory and continent of bowel and bladder, skin body check done and clear. No need to transfer to hopital at this time. On 5/23/22, The Director of Nursing informed family, the Rampart police department, and DHS that resident is back to the facility with no incident reported by resident, and per body assessment done by facility. On 5/23/22, The Director of Staff Development conducted in-service to all staff regarding Elopement and Wanderguard system policy and procedure.	6/7/2022

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

RN D.O.N 6/7/22

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 leave the facility unsupervised). Resident 1 was identified as a high risk for elopement (occurs when a resident leaves the premises or a safe area). On 5/22/2022, Resident 1 eloped from the facility and was found 24 hours later. These deficient practices had the potential for unsafe environment in the community when Resident 1 left the facility out by herself. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on 4/15/2022 with diagnoses including epilepsy (brain disorder that causes recurring seizures [a sudden rush of abnormal electrical activity in the brain]), hypertension (high blood pressure) and substance abuse (overindulgence or dependence on addictive substances, especially alcohol or drugs. A review of the Minimum Data Set (MDS-standardized care and screening tool) dated 4/22/2022, indicated Resident 1 had short- and long-term memory problems. Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 needed supervision (oversight, encouragement, or cuing) with bed mobility, transfer, walk in room and corridor, locomotion on and off the unit, eating and limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance) with dressing, toilet use personal hygiene and bathing. A review of Resident 1's Elopement Risk Evaluation dated 4/18/2022 at 3:10 p.m.,	F 689	On 5/23/22 upon resident's return the facility provided 1:1 staff supervision to prevent elopement. Resident was place on wanderguard system. On 5/24/22, Social Services Director visited resident to provide psychosocial support and to encourage resident by expressing her feelings. Social Services Director started searching for a secure facility for resident 1. Psychology consult was provided to resident on 5/26/22. Patient was safety discharge on 5/28/22. IDENTIFICATION OF OTHERS: On 5/24/22 and 5/25/22, The ADON have completed elopement risk assessments for all residents and no current resident is at risk for elopement. If any patient is identified as risk for elopement, care plan will be updated and interventions to prevent elopement will be in place.	

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F 689	Continued From page 2 indicated Resident 1 was not at risk for elopement/wandering. A review of Resident 1's Nursing Notes dated 5/16/2022 at 11:12 a.m., indicated Resident 1 was noted pacing back and forth in the hallways, with very short attention span, unable to sit for long periods of time, attempts to get up, unaware of safety and was at risk for leaving safe area. The Notes indicated the interdisciplinary team (IDT) met and recommended use of wander guard bracelet to monitor Resident 1's out of facility movements and alert staff when resident gets close to exit doors. A review of Resident 1's IDT-Need for Wander guard notes dated 5/16/2022 at 12:51 p.m., indicated the purpose of the IDT conference was to enhance Resident 1's awareness of the risk factors associated with self-propelling wheelchair in a non-goal directed/aimless manner. The IDT Notes indicated the facility was close to fast-travelling cars and Resident 1 was reminded to observe the necessary safety precautions while crossing the streets, walking along the sidewalks, alleys and other access that will subject Resident 1 to potential environmental dangers. Resident 1 was confused, does not follow re-direction, and self- propels wheelchair aimlessly. A review of Resident 1's Care Plan for Wander guard, dated 5/16/2022, indicated Resident 1 was at risk for self-injury secondary to aimless non-goal directed ambulation. The goal indicated Resident 1 will not wander out of the facility for three months. Interventions included assess for wandering, IDT for wander guard, place wander guard bracelet, periodic re-assessment, redirect as able, involve in activities as able and notify physician and responsible party of the change of	F 689	MEASURE TO PREVENT RECURRENCE: On 5/24/22, The Administrator and the DON immediately notified the staff of the findings during the DHS visit. DSD educated the staff on the plan of action and gave in-services on elopement/missing resident/ wanderguard policy and procedure. During the in-service, the Administrator, DON, and DSD educated the staff on step by step on missing resident such search grounds and surrounding area. Notify Police, check hospitals, notify responsible party, physician and call CDPH. Return demonstration provided. 1.Monitor resident's whereabout to ensure safe environment 2.Adequate supervision on residentd who are at high risk for elopement based on assessment score 3.Implement elopement care plan useful interventions including: monitor at frequent intervals, IDT elopement risk, family participation in elopement plan. - Complete elopement IDT based on elopement assessment, and review IDT outcome by revising/updating the care plan. - Redirection of resident to alternatives, provided 1:1 if indicated -Notify physician/responsible party of change of condition -Follow monitoring policy, monitoring resident at least every two hours and as needed -Administer medications as ordered by physician	

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F 689	Continued From page 3 condition. A review of Resident 1's Care Plan for elopement risk dated 5/22/2022, indicated Resident 1 was at risk for leaving safe area without authorization secondary to aimless non-goal directed ambulation. The goal indicated Resident 1 will have not leave safe area without authorization. Interventions included provide wander guard bracelet to monitor resident's out of facility movements while alerting staff when she gets close to exit doors, respond promptly when door alarm is activated and redirect resident back to her room or activity room as needed and monitor at frequent intervals. A review of Resident 1's Change of Condition dated 5/22/2022, at 11:56 a.m., indicated Resident 1 was missing and was last seen on 5/22/2022 at 10:30 a.m. A search was conducted for Resident 1 inside and outside the facility but was unable to locate Resident 1. The primary physician, family and the police department were notified. A review of Resident 1's Licensed Nursing Note dated 5/23/2022 at 11:18 a.m. indicated Resident 1's family found Resident 1. At 11:26 a.m., the Note indicated Resident 1 returned to the facility accompanied by the facility administrator. Body check and assessment was done, and Resident 1 had no redness, skin discoloration, bump, swelling and had no complaints of pain. During interview with the assistant director of nursing (ADON) on 5/24/2022 at 9:10 a.m., Resident 1's clinical record was reviewed with the ADON. The ADON stated the facility admitted Resident 1 on 4/15/2022 and the resident's	F 689	4. On 5/20/22,5/27/22, and weekly basis the Activity Director conducts wander guard checks to ensure effectiveness. Resident 1 refused to wear wanderguard on 5/27/22, but facility provided 1:1 supervision at all times until discharge date on 5/28/22. No episodes of elopement reported. The Administrator and the DON will repeat the in-service every month for 3 months to ensure compliance. MONITORING AND INCORPORATION THE QA SYSTEM: The Administrator, the DON and the licensed nurses will make rounds daily to ensure adequate supervision and safe environment. A 1:1 in-service will be provided if there is any finding. The Administrator and the DON will review the weekly wanderguard monitoring logs during daily stand-up meeting to ensure complaince. The DON and designee will attend the resident IDT meetings to ensure that the staff have implemented the elopement care plan.	

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F 689	Continued From page 4	F 689		

Elopement Risk Evaluation indicated the resident had no risk for elopement. However, the ADON stated on 5/16/2022, Resident 1 was noted to be pacing back and forth in the hallway, unable to sit still and was walking in and out of her room. The IDT decided to place a wander guard bracelet because Resident 1 was at high risk for leaving the facility. The ADON stated on 5/22/2022 at 11:56 a.m., the facility was unable to find Resident 1. The ADON stated staff searched for Resident 1 inside and outside the facility and were unable to locate Resident 1. The ADON stated the primary physician, Resident 's family and the police were notified. Resident 1 was found 24 hours later and was returned to the facility on 5/23/2022. The ADON stated it was not safe for Resident 1 to leave the facility alone.

During an observation and concurrent interview, on 5/24/2022 at 9:34 a.m. in the presence of ADON and CNA 1, Resident 1 was not wearing the wander guard bracelet. CNA 1 stated Resident 1 was not wearing the wander guard bracelet and refused to wear it.

During an interview on 5/24/2022 at 10:04 a.m., CNA 2 stated the wander guard alarms were checked every Tuesdays and Fridays. CNA 2 stated Resident 1 "can" remove the wander guard bracelet.

During an interview with the director of nursing (DON) on 5/24/2022 at 11;20 a.m., the DON stated she did not know how Resident 1 eloped from the facility on 5/22/2022. DON stated Resident 1 may have removed the bracelet and left through the front door in the facility lobby.

During a telephone interview on 5/27/2022, at

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F 689	Continued From page 5	F 689		

12:30 p.m., the ADON was unable to find documentation that the licensed staff and CNA's monitor and check if Resident 1 was wearing the wander guard bracelet in a regular basis.

A review of the facility's Policy and procedure titled Care of Wandering Residents (undated) indicated it is the purpose of the facility to protect the wandering resident from injury. Wanderers are to be checked on a regular basis. The Policy indicated the nursing and care duties included:
1. Explaining procedures and their purpose to resident.
2. Continuously reorienting resident to room and belongings.
3. encouraging resident to participate in group activities
4. monitoring the resident's location with visual checks as needed.
During a review of the facility Policy titled Wander guard (undated) indicated the wander guard application will be utilized when a resident has been assessed to need management with wandering to ensure resident's safety. Procedure included:
1. Assess need for wander guard management and document.
2. Obtain order for wander guard application.
3. Explain reason for wander management and wander guard to resident and/or responsible party.