STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056417	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIEW HEIGHTS CONV HOSP	12619 S. AVALON BLVD LOS ANGELES, CA 90061

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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. Facility- Reported Incident: CA00718697 Representing the California Department of Public Health: Surveyor # 42506, Health Facility Evaluator Nurse The inspection was limited to the specific complaints and 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 718697.	F 000	View Heights Convalescent Hospital submits this 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. By submitting this POC, View Heights Convalescent Hospital does not admit or concede the facts and contentions cited or the existence or scope or severity of the deficiencies and conditions cited in the 2567. The POC is submitted to comply with federal and state law. View Heights Convalescent Hospital respects the allegations made in the 2567, have acted and will continue to act to implement this POC. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in civil, criminal action or proceedings against the provider or its employees, agents, officers, directors or shareholders	
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 observation, interview and record review the facility failed to follow its policy and procedures for "AWOL(away without offical	F 689	**Free of Accident Hazards/Supervision/ Devices CFR(s): 483.25(d)(1)(2)** **CORRECTIVE ACTION:** Resident 1 no longer resides at View Heights Convalescent Hospital as of 3/12/2021. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTIONS:** All residents have the potential to be affected. This occurrence was isolated and not found to be widespread. The IDT members (Director of Nursing (DON), Program Director (PD), MDS Nurse,	5/3/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Merly Bunnao, RN	DIRECTOR OF NURSING	4/19/2021

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 permission) / Elopement (running away)" and to implement a resident's care plan for supervision when present in the patio, for one of three sampled residents (Resident 1). Resident 1, who was identified at risk for elopement was not monitored while in the patio area. Resident1eloped from a secured unit from a skilled nursing facility on 12/24/20, around 7 pm. Resident 1 admitted himself to the Emergency Department (ED) at the Veterans Affairs GACH (General Acute Care Hospital) on 1/23/21, for gravely disabled. These deficient practices resulted in Resident 1 eloping from the facility which had the potential to cause harm or death to other wandering residents. Findings: During a review of Resident 1's Admission record indicated the resident was admitted to the skilled nursing facility initially on 10/5/2020 and was re-admitted on 1/25/2021. Resident 1's diagnoses included Schizoaffective disorder (a mental health disorder characterized by altered sense of reality in thought and beliefs, and mood swings of feeling extremely happy and sad), alcohol abuse, homelessness, Cannabis use (A common street and recreational drug that comes from the marijuana plant) and other stimulant (is a chemical or substance that affects one's behavior, mind, and body) dependence(failure to control usage and frequency of use, an intense craving for the drug, increased use over time to obtain the same effects, known as a developed tolerance, and a continued use despite negative repercussions and interference in one's everyday life and functioning).	F 689	Activities Director, and Social Services Director) conducted a review and audit of the accuracy of Elopement/Wandering Scores of 129 residents from 4/12/2021 to 4/15/2021. No similar findings were identified. **MEASURES OR SYSTEMIC CHANGES TO PREVENT REOCCURANCE:** The Director of Nursing (DON), Director of Staff Development (DSD), and/or designee provided in-service and training to nursing staff regarding the facility's policy and procedure titled, "Resident Safety Monitoring", with emphasis on assuring the safety and well being of residents who are at risk for unsafe behavior by monitoring their whereabouts and behavior every fifteen minutes from 2/17/2021 to 2/23/2021 and from 4/12/2021 to 4/16/2021. The RN Supervisor on duty will conduct random checks on the resident's rounding sheet every shift to validate accuracy of documentation of residents' whereabouts. Any identified issues will be corrected immediately and reported to the Director of Nursing (DON). The Director of Staff Development (DSD) and/or designee will conduct skills competency evaluation quarterly on nursing staff focusing on resident observation and monitoring. Any identified issues will be corrected immediately and reported to the Director of Nursing (DON). The IDT members (MDS nurse, Activities Director, and Social Services Director) will review and audit the accuracy of Elopement/ Wandering Scores of residents quarterly and as needed. Any identified issues will be corrected immediately and reported to the Director of Nursing (DON) and Program Director (PD).	5/3/2021 5/3/2021

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F 689	Continued From page 2 During a review of Resident 1's care plan titled "a risk for AWOL related to schizoaffective, initiated on 10/14/20, indicated the goal was to minimize risk for AWOL daily x 90 days. The staff's interventions included to assess for elopement upon admission, quarterly, and PRN (as necessary) using elopement assessment tool ...proceed with AWOL policy and procedure should AWOL occur. During a review of Resident 1's "View Heights Convalescent Hospital Elopement / Wandering scoring dated 12/25/20, after the elopement indicated, an incorrect score of 8 (a score of 10 or higher represents high risk for elopement), which was corrected to the score of 11 on a later date of 2/18/21. During a review of the GACH records dated 01/23/21, Resident 1 informed staff at the hospital that he was homelessness / substance abuse user. Resident 1 was admitted to the GACH on a 5150 hold (involuntary 72-hour hold / stay for psychiatric evaluation). During a review of the facility's Final investigation report dated 12/24/20 through 12/30/20, indicated Resident 1's whereabouts could not be identified during safety rounds at approximately 7 p.m. Facility code "Dr. Search" was immediately announced and an immediate search of the premises and outer perimeter of the facility of the facility was conducted to no avail. Facility activated the Reddinet emergency alert system to communicate the residents missing person status. During a concurrent observation and interview on	F 689	The QA Committee in collaboration with the facility legal counsel will utilize the facility video surveillance system to review the content of the videos for quality assurance purposes and identify ways to improve care and services as needed. Any identified issues will be corrected immediately and reported to the Administrator. **MONITORING PERFOMANCE AND INTERGRATION INTO QAPI SYSTEM:** The Director of Nursing (DON) and/or designee will monitor facility compliance, report findings, and provide a summary trend analysis to QAPI committee quarterly for further evaluation and/or recommendation for six months.	5/3/2021

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F 689	Continued From page 3 12/29/20 at 2:16 p.m., the Director of Nursing stated, video surveillance monitoring is accessed and monitored by the Administrator who was out sick and not at the facility. Visual monitors were observed on each station, showing all areas of the facility including the hallways and patios. During a concurrent observation, interview and record review with the Director of Staff Development on 12/29/20 at 3:34 p.m., noted a missing monitoring log for the South-Back for 12/23/20. During an interview on 12/29/20 at 4:30 p.m., with Certified Nurse Assistant 1 (CNA1) stated, Resident 1 was in the patio on that day ...all doors were locked. During an interview on 12/29/20 at 4:35p.m., with LVN 1 stated, Resident 1 "went through the ceiling in the patio". During an interview on 12/29/20 at 4:39 p.m., RN 1 stated "all residents are monitored for safety, staff should always know where their assigned residents are and if they are safe ...". During a concurrent interview and review of the video footage on 12/29/20 at 5:05 p.m., the Administrator stated, "Resident 1 used a table in the patio to climb up, pushed the fence on the ceiling and eloped". During an interview on 2/18/21 at 10:50 a.m., the program manager stated "the resident was an officer in the military and he has special skills, he was on line of sight monitoring ... he pushed the metal fence in the patio and got away. Staff should be monitoring all residents when they are	F 689		

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F 689	Continued From page 4 in the patio". During a concurrent observation of Resident 1 and interview on 2/18/21 at 1:10 p.m., Resident 1 was standing in front of his room. He was on 1:1 monitoring (close monitoring at all times). Resident 1 stated, "I was not happy staying in the room for almost 2 months because of COVID situation, so I just left". During an interview on 2/18/21 at 1:30 p.m., LVN 2 stated, when a resident is at high risk for elopement, he needs close supervision. A review of the facility's policy titled "Residents Safety Monitoring" indicated, staff has visual observation of the resident and the resident's behavior is constantly being monitored every 15 minutes by staff. The procedure indicated ...at the end of the twenty-four-hour period, the rounds sheet will be placed in the round's binder daily.	F 689		