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| VERMONT HEALTHCARE CENTER | 22035 S. VERMONT AVENUE TORRANCE, CA 90502 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during the investigation of one facility-reported incident.<br><br>Facility-reported incident number: CA00839916.<br><br>Representing the Department: HFEN 45777.<br><br>The inspection was limited to the specific facility-reported incident investigated and does not represent the findings of a full inspection of the facility.<br><br>Two deficiencies were written as a result of facility-reported incident number CA00839916. See Tags F656 and F689. | F 000 | **DISCLAIMER STATEMENT**<br><br>Vermont Healthcare Center makes its best effort to operate in substantial compliance with both Federal and State Law. Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 9, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Vermont Healthcare Center's credible allegation of compliance.<br><br>The facility has submitted this Plan of Correction in order to comply with its regulatory obligation under Title 18 and 19 and to meet the ten (10) days of survey condition mandate. Likewise, the facility does not waive any objections to the merits or form any allegations contained herein. Please note that the facility may contest the merit and/or form of any of the deficiency findings alleged below and may take reasonable steps to appeal them. | 6-8-23 |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights | F 656 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 6/8/23

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 656 | Continued From page 1<br>under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the residents' needs for one of three sampled residents (Residents 1). These deficient practices had the potential to negatively affect the delivery of necessary care and services.<br>Findings:<br>During a review of Resident 1 ' s admission | F 656 | **F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)**<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>A. Upon knowledge of the deficiency, the following corrective actions were taken:<br><br>1. Resident was re-admitted to the facility on 5-9-2023.<br><br>2. MDS reviewed and updated resident's wanderguard care plan on 5-18-23 to a comprehensive person-centered care plan that includes monitoring the residents whereabouts by the licensed nurses.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br><br>All residents have been identified as potentially being affected and no other resident was noted to be affected at this time.<br><br>1. Upon admission, Nursing will complete the elopement risk assessment to identify residents who are at risk for wandering / elopement. | 6-8-23 |

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| F 656 | Continued From page 2<br>record, the admission record indicated Resident 1 was initially admitted to the facility on 1/31/2020. Resident 1 ' s diagnosis included hemiplegia (a severe or complete loss of strength), Hemiparesis (muscle weakness or partial paralysis (complete or partial loss of muscle function), and aphasia (a loss of ability to produce or understand language ) following a cerebral infarction (a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).<br>During a record review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care planning tool), dated 4/11/2023, the MDS indicated Resident 1 was severely impaired in cognitive skills (process of acquiring knowledge and understanding through thought, experience, and senses) for daily decision-making. The MDS indicated Resident 1 required limited assistance (not able to perform or complete the activities of daily living three or more times a week without another person to aid in performing the complete task).<br>During a record review of Residents 1 ' s wander guard care plan initiated 4/21/2021 revised 2/2/2023 and 5/9/2023 indicated to monitor residents whereabouts more often, the interventions does not specify how often to monitor and who is to monitor the wander guard.<br>During a record review of Resident 1 ' s wander guard care plan initiated 4/21/2021 revised 2/2/2023 and 5/9/2023 indicated to monitor the alarm for good working condition. The care plan does not indicate who is responsible.<br>During an interview on 5/15/2023 at 1:20 p.m., with the Director of Nursing (DON), Don verified the wandering care plan did not indicate how long tor how often to monitor Residents. DON also Verified the wander guard care plan indicated to monitor the alarm for good working condition but | F 656 | 2. The facility updated the elopement binder on 5-9-23 for the staff to be aware of the 3 residents who are at risk for elopement. MDS developed and implemented a comprehensive person-centered care plan for each resident with a wandering behavior.<br><br>3. All licensed nurses completed in-service training with the DSD on 5-17-23 in regards to developing and implementing comprehensive person-centered care plan for residents with wandering behavior.<br><br>**What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**<br><br>A. MDS will audit residents' elopement risk assessment on a monthly basis and quarterly thereafter or as needed to ensure that a person centered care plan is developed and implemented for residents with wandering behaviors.<br><br>B. Facility implemented the following procedures:<br><br>1. Maintenance will continue to log the checking and monitoring of the door alarms and the wanderguard alarm on a daily basis or as needed to ensure that it is in good working condition.<br><br>2. Maintenance will check the wanderguard bracelet functionality on a daily basis. | 6-8-23 |

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| F 656 | Continued From page 3<br>not specify who is responsible for monitoring the alarm. The DON stated the care plan is a template from the PCC and should have been more specific to the Resident care. The Don stated the care plan for monitoring the functioning of the alarm is maintenance duty and nursing is responsible for making sure the wander guard arm band is in place and document on. The Don stated the care plan is not person centered and we will focus more on making Residents intervention more specific to that person.<br>During an interview on 5/17/2023 at 2:00 p.m., with the MDS Coordinator (MDS), MDS stated that care plans should be person centered. MDS further stated the care plan on wander guard indicating to monitor the alarm for good working condition is not specific on who is responsible for monitoring.<br>During a review of the policy and procedure (P&P) titled, "Care Plan -Comprehensive ," revised October 2010 indicates an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. | F 656 | 3. Maintenance to turn off the door alarms in the front lobby during business hours from 8:30 am – 8:30 pm and the rear exit doors from 6:00 am - 8:30 pm.<br><br>4. RN Supervisor will turn the alarm back on in the front lobby from 8:30 pm -8:30 am and rear exit doors from 8:30 pm to 6:00 am.<br><br>5. Nursing will check the residents wanderguard bracelet placement every shift on a daily basis.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained.**<br><br>The DSD, SSD and/or designee will monitor any issues or concerns brought up by the residents and staff regarding resident wandering behaviors to ensure that it is addressed on a timely manner.<br><br>Any report / findings will be submitted to the QAPI Committee for further review and evaluation.<br><br>Administrator will monitor for compliance.<br>Corrective action completed on 6-8-23. | 6-8-23 |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced | F 689 | | |

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| F 689 | Continued From page 4<br>by:<br>Based on observation, interview and record review, the facility failed to ensure supervision was provided to prevent elopement (when a resident who is not capable of protecting or caring for themselves leaves the facility without authorization or supervision) for one (1) of three (3) sampled residents (Resident 1).<br>This deficient practice resulted in Resident 1 eloping from the facility.<br>Findings:<br>During a record review of Resident 1 ' s admission record, the admission record indicated Resident 1 was initially admitted to the facility on 1/31/2020. Resident 1 ' s diagnosis included hemiplegia (a severe or complete loss of strength), Hemiparesis (muscle weakness or partial paralysis (complete or partial loss of muscle function), and aphasia (a loss of ability to produce or understand language) following a cerebral infarction (a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it).<br>During a record review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care planning tool), dated 4/11/2023, the MDS indicated Resident 1 was severely impaired in cognitive skills (process of acquiring knowledge and understanding through thought, experience, and senses) for daily decision-making. The MDS indicated Resident 1 required limited assistance (not able to perform or complete the activities of daily living three or more times a week without another person to aid in performing the complete task)with transfer, requires supervision (oversight, encouragement or cueing from staff) with locomotion on unit (how resident moves between locations in his/her room and adjacent corridor on same floor) and locomotion off unit | F 689 | **F 689 Free of Accident Hazards/ Supervision/Devices CFR(s): 483.25(d) (1)(2)**<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>A. Upon knowledge of the deficiency, the following corrective actions were taken:<br><br>1. The Resident was found safe on 5-8-23 and was brought to the hospital for further evaluation.<br><br>2. Resident was readmitted back to the facility on 5-9-23.<br><br>3. DSD immediately conducted an inservice on 5-08-23 with all staff regarding elopement and missing resident protocol.<br><br>4. DSD gave an inservice with the Licensed Nurses on 5-9-23 on how to identify and monitor residents who have wandering behavior or are at risk for elopement.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** | 6-8-23 |

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| F 689 | Continued From page 5<br>(how resident moves to and returns from off-unit locations and moves to and from distant areas on the floor), bed mobility, walking in room and corridor, eating and toilet use.<br>During a record review of Resident 1 ' s Elopement Risk Assessment (a form to determine if an individual requires an alarmed, delayed exit door for a safety intervention), dated 11/2/2020, 5/10/2021, and 5/9/2023 the elopement risk evaluation indicated Resident was at risk for elopement.<br>During a record review of Resident 1 ' s History and Physical (H&P) dated 1/11/2023, the H&P indicated Resident 1 does not have the capacity to understand and make decisions.<br>During a record review of Resident 1 ' s Change of Condition (COC), dated 5/8/2022, the COC indicated on 5/7/2022, at 11:50 a.m., Resident 1 was not in his room and staff searched the facility and surrounding areas of the facility but could not find the resident.<br>During a record review of the Emergency Department Encounter notes dated 5/8/2023, the report indicated a bystander called Emergency Medical Services (EMS), and the police found Resident 1 wandering at The Village in Redondo Beach aphasic (exhibiting loss or impairment of the power to use or comprehend words) and tachycardic (fast heart rate) which was later resolved. The report indicated Paramedics took Resident 1 to the Emergency department (ED) for evaluation and admitted to a general acute care hospital (GACH).<br>During a review of Resident 1 ' s GACH History and Physical (H&P), dated 5/8/2023, and timed at 5:37 p.m., the H&P indicated Resident 1 was noted to have a urinary tract infection (infection in any part of the urinary system), the H&P also indicated Resident 1 was placed in emergency | F 689 | All residents have been identified as potential of being affected by this practice.<br><br>1. There are 3 residents identified to be at risk for elopement. All 3 residents are wearing wanderguard bracelets to alert staff when the residents are near the exit doors or when the resident attempt to leave the facility.<br><br>2. Wanderguard alarms for rear doors 4 and 5 will be installed on 6-11-23. Door alarm on the rear exit door 5 have been installed on 5-18-23 and both doors 4 and 5 alarm will be turned on at 8:30 pm and turned off by 6:00 am by Maintenance. DSD inserviced staff on 5-18-23 to remind staff that the purpose of installing the door alarms and the wanderguard alarms is to notify and alert staff when a resident attempt to leave the facility.<br><br>3. Maintenance will check the wanderguard alarms, wanderguard bracelets and door alarms on a daily basis to ensure that it is in good working condition. The wanderguard alarm system is enabled each day and under no condition that the wanderguard system is to be deactivated.<br><br>4. On a daily basis, nursing staff will continue to monitor residents who have wanderguard bracelets. The Licensed Nurses will check the wanderguard bracelets for placement every shift to ensure safety. | 6-8-23 |

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| F 689 | Continued From page 6<br>department observation status at 6:00 p.m., for evaluation n, reevaluation , labs ,imaging, and transfer back to the facility.<br>During an interview on 5/9/2023, at 12:40 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on 5/8/2023, Resident 1 was on observation for wandering behavior (traveling aimlessly from place to place) but Resident 1 does not have any behavior of leaving the facility for a while. LVN 1 further stated she was not aware of any monitoring of Resident 1 ' s whereabouts.<br>During an interview on 5/9/2023, at 2:00 p.m., with (LVN )2, LVN 2 stated Resident 1 is always wandering and must be redirected. LVN 2 further stated the last time she saw Resident 1 he was in bed at 10:00 p.m., she stated I could not wait for the 11 to 7 a.m. nurse to arrive during shift change so LVN2 left the facility at 11:00 pm. LVN 2stated, we do not have a designated person to make sure the doors are locked, and no one checks if the alarms are working at night as well. LVN 2 stated we rely that the door and alarm are working at night since maintenance works in the morning.<br>During an observation and interview on 5/9/2023 at 2:10 p.m., with Director of Nursing (DON), Don verified door number 4 in rear of building has no wander guard alarm present and remains unlocked. Don also verified Rear door number five has no wander guard alarm and is always open DON stated this is the entrance door for staff coming and leaving work. DON stated the alarm on door 4 remains open because the noise keeps the Residents awake at night. Don also stated there is no designated person to check if the door alarm is working at night. DON unable to say why the alarm should be on at night time.<br>During an interview on 5/10/2023, at 2:47 p.m., | F 689 | **What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur:**<br><br>A. Upon admission, licensed nurses will assess and evaluate resident if they are high risk for elopement. Once determined, licensed nurses will inform MD to obtain an order for a wanderguard bracelet which will be applied to the resident to ensure safety and to alert staff should the resident attempt to leave the facility.<br><br>B. The QAPI nurse will provide continuing education to all licensed nurses once a month for the next 3 months and quarterly thereafter or as needed to ensure that proper assessment, documentation and monitoring are implemented and that attending physicians, resident representative/ family are notified of the resident wandering behavior on a timely manner.<br><br>C. MDS will check / audit charts of residents who are high risk for elopement in the next 3 months and quarterly thereafter or as needed to ensure that appropriate interventions are implemented in a timely manner.<br><br>D. Activity staff to continue to reassess resident for preferred activities and implement or monitor an activity (individual or group) programs tailored for the resident with wandering behavior. | 6-8-23 |

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| F 689 | Continued From page 7<br>with (LVN) 3, LVN 3 stated I made rounds on 5/9/2023 at 23:50 p.m., Resident was not in his room. He stated when shift starts, we usually endorse care and go room to room LVN 3 stated that he arrived late and did not do have a chance to make rounds with the outgoing nurse. LVN 3 stated he checks to make sure the wander guard alarm is on the Resident ' s wrist every shift.<br>During an observation and interview on 5/10/2023, at 11:47 a.m., with Maintenance Supervisor (MS) 1, arrive to the rear door number 4 he turned on the alarm then turned it off. MS stated that is how he check to see if the door alarm is functioning properly. MS stated there is no wander guard alarm on door 4 and stated there has never been wander guard alarm there since he has been employed.<br>During an observation and interview on 5/10/2023 at 11:50 a.m., with MS, MS verified the rear door number 5 has no wander guard alarm present and the door does not close completely. MS further stated, this is the door where staff enter and exit the building to the parking lot it is my job is to monitor the alarm on all five doors daily and make sure they are working properly. MS stated, there has never been a wander guard alarm on the rear exit doors. MS stated when I am off from work at 6 p.m. I do not know who monitors the door alarm in the evening there is no one appointed.<br>During an interview on 5/10/2023, at 12:48 p.m., with Maintenance (M) 1, M1 stated he works on the weekends and checks alarm on all five doors. M1 verified door number four and five at the rear does not have wander guard alarms present. M1 stated he does not know who monitor the doors after he leave the facility.<br>During an interview on 5/15/2023, at 12:08 p.m., with Registered Nurse Supervisor (RN), RN | F 689 | **How the facility plans to monitor its performance to make sure that solutions are sustained.**<br><br>The DSD, SSD and/or designee will monitor any issues or concerns brought up by the residents and staff to ensure that it is addressed on a timely manner.<br><br>Activity Director to report on the monthly QAPI meeting regarding residents actual participation during activities.<br><br>DON will report and submit to the QAPI Committee the updated list of residents who are high risk for elopement for further review and evaluation.<br><br>Administrator will monitor for compliance. Corrective action completed on 6-8-23. | 6-8-23 |

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| F 689 | Continued From page 8<br>stated she arrive to the facility early around 9:45 p.m. on 5/7/2023 and sat on the couch in the lobby until my shift starts at 11:00 p.m. RN stated there is no assigned person who make sure the door and alarms are working at night. The rear back door where staff enters and exit the facility into the parking lot, they also use it to sit in their cars and take a break. RN further stated I must remind my night staff to close the rear door completely, this is very dangerous if it was left open because anybody from the outside can just get in the building. She stated the night of 5/7/2023 the rear back door was not locked and never closes completely. RN stated if nurses enter and close the door it should close completely but if it doesn ' t the door should be repaired.<br>A review of the facilities ' policy and procedure (P&P) titled, Wander guard alarm policy revised 2020, The wander guard alarm system is an essential tool for ensuring residents at the facility are always safe and secure.<br>All exit doors in the hallway are equipped with an alarm system to notify staff when wander guard residents attempt to leave the facility without notification. To ensure these residents are provided with the highest level of safety and security, the facility has instituted the following policy:<br>1.The wander guard alarm system must be enabled each day. Under no condition is the wander-guard system to be deactivated (turned-off). | F 689 | | 6-8-23 |