STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055041	A. BUILDING _____ B. WING _____	C 06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL CARE SKILLED NURSING CTR	2725 PACIFIC AVENUE LONG BEACH, CA 90806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00782667 Representing the Department: Health Facilities Evaluator Nurse(s): 44634 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were identified for the complaint number: CA00782667.	F 000	Preparation and/or execution of this plan of correction does not consitiute admission or agreement by the provider of the truth of the facts alleged and concerns set forth on the correction is prepared and/or executed solely because required by provisions of health regulations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609	Resident 1 was placed on 1:1 monitoring immediately and wanderguard while the facility was replacing the alarm code of the facility's back door on 03/30/22. Staff were in-serviced by the DON & DSD on 06/28/22 the importance of reporting resident's elopement from the facility to the Department of Public Health (DPH). Interdisciplinary Team (IDT) reviewed reported incident reports on 06/28/22 and no other incidents/events were found to be affected by the same deficient practice. Interdisciplinary Team (IDT) will review incident reports in the morning meeting and determine if the incident is an unusual occurrence and/or the incident is reportable. Administrator or DON will be notified immediately for any unusual occurrence in the facility.	06/30/22

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

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F 609	Continued From page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a report was made to the Department of Public Health (DPH) when one sampled resident (Resident 1) eloped ((leaving unsupervised, undetected, without authorization) from the facility. On 3/30/2022 Resident 1 used an alarm code to the facility's back door to elope from the facility for an unknown length of time without the knowledge or approval of facility staff. Resident 1's elopement was not reported to the DPH. This deficient practice resulted in the inability for the DPH to investigate Resident 1's elopement in a timely manner and had the potential for the investigation's findings to be compromised. Findings: During a review of Resident 1's admission record, the record indicated Resident 1 was admitted to the facility on 4/2/21 with diagnosis that included respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide),subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), traumatic brain injury (damage to the brain that disrupts normal functioning caused by an outside force, typically such as a violent blow to the head), and motor vehicle accident pedestrian versus car.	F 609	Administrator or DON will review incident reports 5 times a week for 3 month/s and determine if the incident is reportable. Any findings will be discussed in the morning meeting and will be reported to the QA&A monthly x 3 months for any further interventions.	

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F 609	Continued From page 2 During a review of Resident 1's Minimum Data Set (MDS) a comprehensive assessment and care screening tool, dated 4/1/22, the MDS indicated resident 1 had moderate cognitive (ability to learn remember, understand and decisions) impairment for daily decision making, was totally dependent on staff for bathing, required extensive assistance with eating, toilet use, and personal hygiene, required limited assistance with bed mobility, transfers, dressing, and walking, and required daily use of a wander/elopement alarm. During a review of Resident 1's Care Plan, dated 7/4/21 and revised 3/30/22 the Care Plan indicated Resident 1 was a risk for elopement, had exit seeking behavior, and eloped from the facility on 3/30/22. During a review of Resident 1's general nursing note, dated 3/30/22, the nurisng note indicated the Infection Preventionist Nurse (IPN) heard Resident 2 screaming for help at the southeast end of the facility. The nursing note indicated the IPN witnessed Resident 1 outside the facility walking on 27th street. Resident 1 was returned to the facility through the front door where her wanderguard bracelet triggered the door alarm. The nursing not indicated Resident 1 reported to the IPN she knew the alarm code and let herself out through the back door near room 30. The nursing note indicated the Medical Doctor, Director of Nursing (DON), and Social Services were notified of the incident. During an interview on 4/29/22, at 1:35 p.m., the Director of Nursing (DON) stated she was not in the facility at the time Resident 1 eloped. The DON stated the IPN called her cell phone and informed her of resident 1's elopement. The DON stated resident 1 wears a wanderguard because she is at risk for elopement and the wanderguard	F 609		

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F 609	Continued From page 3	F 609		

is used to notify staff if resident 1 tries to leave the facility. The DON stated it is not safe for resident 1 to leave the facility alone, she can possibly get hurt or injured. The DON stated she interviewed resident 1 and resident 1 stated she knew the code to the door alarm and was able to turn the alarm off and exit the building. The DON stated after resident 1 was returned to the facility she was placed on 1 to 1 monitoring while the maintenance supervisor arranged to have the door code changed. The DON stated resident 1's elopement was not reported to the DPH because resident 1 was brought back to the facility unharmed.

During an interview on 4/29/22, at 2:10 p.m., the Administrator (ADM) stated an elopement is when a resident leaves the facility alone or without the knowledge of staff. The ADM stated the Wanderguard is used for residents' safety; to alert staff if a resident is at risk for elopement and attempts to leave the facility. The ADM stated he was informed the resident tried to leave the facility, but he was not aware resident 1 eloped so he did not report the incident to the DPH.

During a review of the facility's policy and procedure (P&P) titled, "Elopement and Missing Residents," dated 2017, the P&P indicated, Elopement occurs whenever a resident leaves the premises or a safe area without authorization or staff notification and/or any necessary supervision to do so. The ADM reports the incident to the State/Licensure Agency according to regulation and facility Quality Control committee for tracking and trending.

During a review of the facility's policy and procedure (P&P) titled, "Incident Management Policy," dated 2017, the P&P indicated, all incidents involving residents will be documented, investigated, and reported so to meet all

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F 609	Continued From page 4 regulatory requirements. An incident is defined as an event in which any happening that is not consistent with the routine operation of the facility has or may have the potential for causing harm.	F 609		
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 interviews and record review, the facility failed to ensure one sampled resident (Resident 1) who was at risk for eloping (leaving unsupervised, undetected, without authorization) wore a wanderguard (a bracelet worn by resients that triggers an alarm if a resident attempts to leave a safe area) and had a history of wandering throughout the facility, did not have knowledge of the alarm code which was used to elope from the facility on 3/30/2022. This deficient practice resulted in Resident 1 using the facility's alarm code to disable the door and elope from the facility for an unknown length of time. This deficient practice had the potential for Resident 1 to be seriously harmed or injured while out of the facility alone and unsupervised. Findings: During a review of Resident 1's admission record, the record indicated Resident 1 was admitted to the facility on 4/2/21 with diagnosis that included respiratory failure (condition in which the blood	F 689	Resident 1 was placed on 1:1 monitoring immediately and wanderguard while the facility was replacing the alarm code of the facility's back door on 03/30/22. Residents in the facility were assessed by the RN Supervisor and/or designee on 06/28/22 and no other residents were found to be affected with the same deficient practice. Staff were in-serviced by DON and DSD on 06/28/22 about the facility's policy on the care of residents with exit seeking behavior/ elopement risk to ensure adequate supervision is provided and free of accident hazards as possible. Interdisciplinary Team (IDT) will review and assess residents for elopement risk or exit seeking behavior upon admission and change in behavior/condition as needed. Any residents meeting the criteria for elopement risk will be placed close to nursing station if room is available for close monitoring. Wanderguard will be applied to resident's extremity per facility's policy. DON or designee will review clinical records of new admits or residents with change in behavior/condition weekly for 3 month/s. Any findings will be discussed in the morning meeting and will be reported to the QA&A monthly x 3 months for any further interventions.	06/30/22

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F 689	Continued From page 5	F 689		

does not have enough oxygen or has too much carbon dioxide), subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), traumatic brain injury (damage to the brain that disrupts normal functioning caused by an outside force, typically such as a violent blow to the head), and a motor vehicle accident pedestrian versus car.

During a review of Resident 1's Minimum Data Set (MDS), a comprehensive assessment and care screening tool, dated 4/1/22, the MDS indicated resident 1 had moderate cognitive (ability to learn remember, understand and make decisions) impairment for daily decision making, was totally dependent on staff for bathing, required extensive assistance with eating, toilet use, and personal hygiene, required limited assistance with bed mobility, transfers, dressing, and walking, and required daily use of a wander/elopement alarm.

During a review of Resident 1's Care Plan, dated 7/4/21 and revised 3/30/22, the Care Plan indicated Resident 1 was at risk for elopement, had exit seeking behavior, and eloped from the facility on 3/30/22.

During a review of Resident 1's general nursing note, dated 3/30/22, the nursing note indicated the Infection Preventionist Nurse (IPN) heard Resident 2 screaming for help at the southeast end of the facility. The nursing note indicated the IPN witnessed Resident 1 outside the facility walking on 27th street. Resident 1 was returned to the facility through the front door where her wanderguard bracelet triggered the door alarm. The nursing note indicated Resident 1 reported to the IPN she knew the alarm code and let herself out through the back door near room 30. The nursing note indicated the Medical Doctor, Director of Nursing (DON), and Social Services

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F 689	Continued From page 6	F 689		

were notified of the incident.
During an interview on 4/29/2022, at 12:53 p.m., the Director of Social Services (DSS) stated the IPN reported to her on 3/30/2022 that Resident 1 left the facility by herself, unsupervised. The DSS stated she spoke with Resident 1 following the incident and informed Resident 1, she is not allowed to leave the facility by herself.
During a review of Resident 2's admission record, the admission record indicated Resident 2 was admitted to the facility on 11/18/16 with diagnosis that included hypertension (HTN - high blood pressure), obesity (excessive body fat), tobacco use, transient ischemic attack (TIA - brief episode of neurologic [relating to the nervous system] dysfunction), and major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).
During a review of Resident 2's MDS, dated 3/15/22, the MDS indicated Resident 2 had intact cognition.
During an interview on 4/29/22, at 1:10 p.m., Resident 2 stated on 3/30/22 she was lying in her bed and saw resident 1 through her window, outside the building on 27th street by herself. Resident 2 stated she screamed for help and the IPN came running into her room. Resident 2 stated she informed the IPN that resident 1 was outside by herself, and the IPN ran outside to get Resident 1.
During an interview on 4/29/22, at 1:35 p.m., the Director of Nursing (DON) stated she was not in the facility at the time Resident 1 eloped. The DON stated the IPN called her cell phone and informed her of Resident 1's elopement. The DON stated Resident 1 wears a wanderguard because she wanders the facility, has exit seeking behavior, and is at risk for elopement.

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F 689	Continued From page 7 The DON stated the wanderguard is used to notify staff if Resident 1 tries to leave the facility. The DON stated it is not safe for Resident 1 to leave the facility alone, she can possibly get hurt or injured. The DON stated she interviewed Resident 1 and Resident 1 stated she knew the alarm code to the door, and she was able to turn the alarm off and exit the building. The DON stated after Resident 1 was returned to the facility she was placed on 1 to 1 monitoring while the maintenance supervisor arranged to have the door code changed. During a review of the facility's policy and procedure (P&P) titled, "Elopement and Missing Residents," dated 2017, the P&P indicated, Elopement occurs whenever a resident leaves the premises or a safe area without authorization or staff notification and/or any necessary supervision to do so. The ADM must report the incident to the State/Licensure Agency according to regulation and facility Quality Control committee for tracking and trending.	F 689		