DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/06/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. BUILDING ______ B. WING ______	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4853 W. WASHINGTON BL., LOS ANGELES, CA 90016

(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 Incident: CA00776260 Representing the California Department of Public Health: Surveyor# 45028, Health Facility Evaluator Nurse The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were issued for complaint CA00776260.	F 000	**Disclaimer:** The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as our written credible allegation of compliance.	
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	F 609	**F 609 Reporting of Alleged Violations** **Immediate Corrective Action:** a. Immediately, RN Supervisor and Staff searched the area for Resident#1. RN Supervisor notified LAPD, and Resident #1 was found by LAPD on 3/5/2022 and was sent to acute hospital for evaluation. Resident #1 was then discharged home, and has not been at our facility as of 3/5/2022. b. Upon notification, on 5/9/2022, the Quality Assurance Consultant gave a 1:1 Inservice to the Administrator	3/5/2022. 5/9/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Eccle (signature) TITLE: Administrator (X6) DATE: 5/15/22

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056753	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4883 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 609	Continued From page 1 accordance with State law through established 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 report an incident of elopement (when a resident who is not capable of protecting or caring for themselves leaves the facility unsupervised and unnoticed, potentially coming to harm) in a timely manner per the facility ' s policy for one (1) of three (3) sampled residents (Resident 1). This deficient practice resulted in the delay in an investigation by the Department of Public Health (DPH) and had the potential to negatively affect the safety residents in the facility. Findings: During a review of Resident 1 ' s admission record, the admission record indicated Resident 1 was initially admitted to the facility on 2/2/2022 and re-admitted on 2/25/2022. Resident 1 ' s diagnoses included white matter disease (wearing of tissue in the largest and deepest part of the brain due to aging, which can result in memory loss, imbalance immobility in older age), schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave), signs and symptoms involving cognitive functions and awareness (multiple mental abilities that include	F 609	regarding the policy of Unusual Occurrence, Missing Resident and Elopement requirement in association with notification to CDPH and the Ombudsman within 24 hours, and that a complete investigation shall be submitted within 5 days to CDPH. **Identification of Others:** Residents at risk for elopement that have the potential to be affected were reviewed immediately by the DON, ADON, Medical Records and Administrator. There were no noted unusual occurrence incidents that had to be reported to CDPH as of 5/14/2022. **Measures to Prevent Recurrence:** a. The Administrator, DON and DSD gave in-services to the staff from 5/9/22 to 5/13/22 regarding the Missing Resident, Elopement, and Unusual Occurrence Policies and Procedures, and the protocol regarding notification to CDPH and Ombudsman must be completed within 24 hours, and that a complete investigation will be submitted within 5 days to CDPH by	5/14/2022 5/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055763	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4853 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 609	Continued From page 2 learning, thinking, reasoning, problem solving, decision making, memory, attention and language comprehension), and cognitive communication deficit (difficulty with thinking and how someone uses language which may occur after a stroke, tumor, or brain injury). During a review of Resident 1 ' s Minimum Data Set ([MDS]), a standardized assessment and care planning tool), dated 2/9/2022, 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 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 (how resident moves to and returns from off-unit locations and moves to and from distant areas on the floor). During a review of Resident 1 ' s Elopement Risk Evaluation dated 2/28/2022, the elopement risk evaluation indicated Resident was at risk for elopement. During a review of Resident 1 ' s History and Physical (H&P) dated 2/28/2022, the H&P indicated Resident 1 had the capacity to understand and make decisions. During concurrent interview and record review on 3/11/2022 at 11:05 a.m., with the Administrator (ADM), the ADM stated the facilities record titled "Admissions/Discharges To/From," dated 2/9/2022 to 3/11/2022 indicated Resident 1 was discharged Against Medical Advice ([AMA]), when	F 609	the Administrator, DON and DSD. b. A CQI Incident Fax Cover document was implemented by the DON and Administrator on 5/13/2022 for the staff to be able to properly notify CDPH in a timely manner in regards to Elopement, Missing Resident, Unusual Occurrence, and other forms of abuse. **Monitoring Performance:** The Administrator and the DON will discuss and analyze the incident reports during the daily stand-up meeting, to ensure that all Unusual Occurrences will be reported to the CDPH within twenty-four hours. The Administrator and DON will present the recapitulations of the findings to the monthly QA meeting for 3 months for review and action as indicated as of 5/14/2022.	5/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056753	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4953 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 609	Continued From page 3 a resident chooses to leave a facility before the healthcare team recommends discharge from the facility), on 3/4/2022. ADM stated the Admissions/Discharges To/From record was incorrect because Resident 1 eloped. ADM stated Resident 1 ' s elopement was not reported to the DPH because "I thought since the Registered Nurse Supervisor (RN) filed a police report, and the resident was found on 3/5/2022, we did not have to notify any other agency." During a review of the facility ' s Policy and Procedure (P/P) titled, "Missing Resident", undated, the P/P indicated when a resident eloped from the facility, the facility would notify the California Department of Public Health (CDPH) within 24 hours and must send a follow up letter to CDPH. During a review of the facility ' s P/P titled, "Unusual Occurrences", undated, the P/P indicated the facility is to report unusual occurrences to the local health department within 24 hours of each occurrence. The P/P indicated the Administrator shall call the local Health Department and must confirm it in writing within 24 hours of its occurrence. The P/P also indicated a complete investigation shall be attempted within five days.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655	F 655 Baseline Care Plan Immediate Corrective Action: Resident #1 no longer resides at the facility. Upon notification, the DON gave a 1:1 Inservice to the MDS staff on 5/13/22 regarding the policies and procedures for the Baseline Care Plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065783	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4883 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 656	Continued From page 4 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 656	<u>Identification of Others:</u> All newly admitted Residents have the potential to be affected by this deficient practice, and the plan of correction has been implemented in association with these residents. Medical Records immediately conducted a care plan audit and all residents had the appropriate base line care plan documentation, and there were no other issues identified. <u>Measures to Prevent Recurrence:</u> a. The DON and DSD gave in-services to the licensed nurses regarding Baseline Care Plan policy and procedures, with emphasis on the importance of developing the baseline care plan and addressing all identified concerns from 5/9/2022 to 5/14/2022. b. The IDT will continue to review all new admissions daily during clinical meeting after stand up to ensure compliance as of 5/14/2022. <u>Monitoring Performance:</u> The Medical Records Director or designee will conduct an audit of	5/14/2022 5/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056753	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4953 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 655	Continued From page 5 failed to develop a baseline care plan addressing identified wandering/elopement concerns for one (1) of three sampled (3) sampled residents (Resident 1). This deficient practice resulted in delayed provision of necessary care and services and Resident 1 eloping from the facility. Findings: During a review of Resident 1 ' s admission record, the admission record indicated Resident 1 was initially admitted to the facility on 2/2/2022 and re-admitted on 2/26/2022. Resident 1 ' s diagnoses included white matter disease (wearing of tissue in the largest and deepest part of the brain due to aging, which can result in memory loss, imbalance immobility in older age), schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave), signs and symptoms involving cognitive functions and awareness (multiple mental abilities that include learning, thinking, reasoning, problem solving, decision making, memory, attention and language comprehension), and cognitive communication deficit (difficulty with thinking and how someone uses language which may occur after a stroke, tumor, or brain injury). During a review of Resident 1 ' s Minimum Data Set ([MDS]), a standardized assessment and care planning tool), dated 2/9/2022, 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 supervision (oversight, encouragement or cueing from staff)	F 655	previous days admission in association with the Baseline Care Plan policy and procedure requirement on a monthly basis to ensure compliance. Findings of non-compliance will be presented to DON, MDS Lead Coordinator and the Quality Assurance Committee immediately as of 5/14/22. The DON will present the recapitulations of the findings, and any non-compliance will be corrected and followed up in the monthly QA meeting for review and action as indicated.	5/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055763	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4863 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 655	Continued From page 6 with locomotion on unit (how resident moves between locations in his/her room and adjacent corridor on same floor) and locomotion off unit (how resident moves to and returns from off-unit locations and moves to and from distant areas on the floor). During a review of Resident 1 ' s Elopement Risk Evaluation dated 2/26/2022, the elopement risk evaluation indicated Resident was at risk for elopement. During a review of Resident 1 ' s History and Physical (H&P) dated 2/28/2022, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a concurrent interview and record review on 3/11/2022 at 3:55 p.m., with Director of Staffing Development (DSD), of Resident 1 ' s baseline care plan, dated 2/28/2022, DSD stated there was no baseline care plan addressing Resident 1 ' s wandering and elopement risk. During a concurrent interview and record review on 3/11/2022 at 4:35 p.m., with Minimum Data Set Nurse ([MDS], nurses who assesses, monitors, documents residents ' health and collaborates with other healthcare professionals to create care plans for residents), MDS stated, "I do not see a care plan for elopement or wandering for this resident. MDS stated the facility would update the care plan to add an area for elopement and wandering. MDS also stated upon re-admitting Resident 1, the facility had fourteen (14) days to review and revise resident ' s care plan. MDS added that before the comprehensive care plan was reviewed, Resident 1 eloped. MDS stated if a baseline care plan was	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055763	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4953 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 655	Continued From page 7 developed and implemented Resident 1 might not have eloped. During a review of the facility ' s Policy and Procedure (P/P) titled "Baseline Care plan" undated, the P/P indicated the facility would develop a baseline care plan within the first 48 hours of admitting a resident to the facility. The P/P indicated the baseline care plan would provide effective and person-centered care to promote care continuity, communicate among staff, increase residents ' safety and safeguard against adverse events that could occur right after admitting a resident to the facility. During a review of the facility ' s Policy and Procedure (P/P) titled, "Care of Wandering Residents", undated, the P/P indicated a plan of care shall address the wandering.	F 655		
F 689 SS=G	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 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	F 689	<u>F 689 Free of Accident Hazards/Supervision/Devices:</u> <u>Immediate Corrective Action:</u> a. Immediately, the RN Supervisor and Staff searched for Resident #1 in the area. RN Supervisor then notified LAPD. Resident was located by LAPD and sent to acute hospital for evaluation. Resident #1 is no longer a resident at our facility and was discharged as of 3/5/2022. b. The Administrator, DON and DSD immediately notified the staff of	3/5/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056783	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4853 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 689	Continued From page 8 residents (Resident 1). The police found Resident 1 in a parking lot bloody, bruised, disheveled and wearing diapers, a sweater, socks and shoes. This deficient practice resulted in Resident 1 eloping from the facility, being found 8 hours later, bloody, bruised, and disheveled, and was admitted to a general acute care hospital (GACH). Findings: During a review of an incident report dated 3/5/2022 from the Adult Protective Services (APS), the report indicated police officers found Resident 1 bloody, bruised, and disheveled, mumbling and unable to provide any information. The report indicated Paramedics and the Police Department (PD) were called and the resident was placed on a 5150 hold (placing someone in a mental health facility for treatment without their permission) and admitted to a general acute care hospital (GACH). The report also indicated, Resident 1 ' s diagnosis included Alzheimer ' s and a history of wandering. According to the report, the resident wandered out of the facility on 3/5/2022. The report also indicated there were concerns the facility was accepting individuals with Alzheimer ' s and dementia but was not providing proper supervision to the residents. During a review of Resident 1 ' s admission record, the admission record indicated Resident 1 was initially admitted to the facility on 2/2/2022 and re-admitted on 2/25/2022. Resident 1 ' s diagnoses included white matter disease (wearing of tissue in the largest and deepest part of the brain due to aging, which can result in memory loss, imbalance immobility in older age),	F 689	the findings and gave In-services on 5/9/2022 to 5/13/2022 regarding the Missing resident, Unusual Occurrence, and Elopement policy. Identification of Others: a. Residents at risk for Elopement that have the potential to be affected by the deficient practice were Immediately identified by the DON, Administrator and Medical Records as of 5/14/2022. 2 out of 122 residents were identified to be at Risk for Elopement, and were placed in the CQI High Risk Checklist. b. A CQI High Risk Elopement CheckList was distributed to each Nursing Station on 5/13/2022 by Medical Records so staff are aware of Residents who have a tendency to elope. This list will be generated and updated by Medical Records on a weekly basis to ensure compliance. Measurements to Prevent Recurrence: a. The DON and DSD gave in services to staff from 5/9/22 to 5/13/2022 regarding the Missing Resident,	5/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055753	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4863 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 689	Continued From page 9 schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave), signs and symptoms involving cognitive functions and awareness (multiple mental abilities that include learning, thinking, reasoning, problem solving, decision making, memory, attention and language comprehension), and cognitive communication deficit (difficulty with thinking and how someone uses language which may occur after a stroke, tumor, or brain injury). During a review of Resident 1 ' s Minimum Data Set ([MDS]), a standardized assessment and care planning tool), dated 2/9/2022, 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 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 (how resident moves to and returns from off-unit locations and moves to and from distant areas on the floor). During a review of Resident 1 ' s Elopement Risk Evaluation dated 2/26/2022, the elopement risk evaluation indicated Resident was at risk for elopement. During a review of Resident 1 ' s History and Physical (H&P) dated 2/28/2022, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Social Services ' Progress Record dated 2/28/2022, at 9:15 a.m.,	F 689	Elopement and Unusual Occurrence policies and procedure requirements with an emphasis on Supervision and team strategies to prevent resident elopement. b. An Elopement QAPI was implemented by the Administrator and DON on 5/13/2022 to ensure preventive measures, proper supervision, education, audits are evaluated for compliance. The IDT Team has reviewed all residents who are at risk for Elopement and plan of care has been updated, and reevaluated as needed on a monthly basis to ensure compliance by 5/14/2022. c. Certified Nurse Assistants will be responsible as part of their shift to ensure plan of care documentation to address each Resident's location every 2 hours as of 5/14/2022. Medical Records will be responsible to audit for compliance on a weekly basis. d. The DON implemented Daily CQI logs to monitor the residents for potential elopement on 5/9/2022. The Licensed door monitoring Log	5/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055763	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4863 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 689	Continued From page 10 the Social Services ' Progress Record indicated Social Services Designee (SSD) observed Resident 1 going into other residents ' restrooms and SSD redirected Resident 1 to use the designated restroom his (Resident 1 ' s) room. During a review of Resident 1 ' s Change of Condition (COC), dated 3/4/2022, the COC indicated on 3/4/2022, at 8:30 p.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. During a review of Resident 1 ' s Emergency Department Triage Report, dated 3/5/2022 and timed at 1:14 p.m., the Emergency Department Triage Report indicated Resident 1 was disoriented to person, confused, lacked cognitive ability to make relevant decisions, had a laceration on his left cheek, dirt on his face, and superficial lacerations (shallow and is in the outer layer of the body affecting only the skin) to his extremities. During a review of Resident 1 ' s GACH Wound Care Initial Assessment, dated 3/6/2022 and timed at 10:42 a.m., the Wound Care Initial Assessment indicated Resident 1 had a wound care consult for abrasions on the face, arms, and legs. During a review of Resident 1 ' s GACH History and Physical (H&P), dated 3/6/2022 and timed at 7:27 p.m., the H&P indicated Resident 1 was noted with multiple scabs on bilateral cheeks, and both upper and lower extremities. The H&P also indicated Resident 1 appeared disheveled (untidy), confused, and disoriented. The H&P also indicated Resident 1 was admitted to the medical	F 689	will be completed every shift to ensure the door alarms are on at all times as of 5/14/2022. The Alarm Door Logs will be reviewed by the ADON, DON or designee during the during daily stand-up meeting to prevent potential resident elopement. e. A Supervisor Door Alarm Monitoring CQI Log was also implemented by the Administrator and DON to check each station's door alarm is on at all times as of 5/14/2022. f. A High Risk Elopement Binder checklist was given to each nursing station and front door personnel, by the DON and ADON with a picture and names of residents who are at high risk for elopement, so staff can easily recognize and redirect residents if needed as of 5/14/2022. g. Residents who are at risk for elopement will be given a Wanderguard Sensor that will initiate the Wanderguard alarm when resident is within proximity to the specified exit at all times as of 5/14/2022.	5/14/2022 5/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056783	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4863 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 689	Continued From page 11 floor for an altered mental status. During an interview on 3/11/2022, at 2:35 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on 3/4/2022, Resident 1 was not wearing a wander guard (bracelet worn by residents who are at risk for wandering or eloping that triggers alarms and can lock monitored doors to prevent the residents leaving unattended). LVN 1 stated Resident 1 should have had a wander guard to prevent the resident from leaving the facility unsupervised. During an interview on 3/11/2022, at 3:18 p.m., with SSD, SSD stated, Resident 1 used to remove his clothes, wander around the nurses ' station frequently, and required frequent redirection. SSD stated Resident 1 attempted to leave the facility one time and as soon as the resident pushed the front door open, the alarm went off, and Resident 1 just stood in the doorway. During an interview on 3/11/2022, at 4:22 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated, Resident 1 always tried to escape (leave) and had left the yellow zone (designated area for residents suspected to have the corona virus [deadly respiratory infection that is easily crossed from person to person]) station CNA 1 stated in the evening of 3/4/2022, around 7 p.m., she saw Resident 1 walking around the yellow zone, and the moment she could not see the resident, she heard the door alarm go off in the sub-acute area and that ' s when she realized Resident 1 had exited the facility. CNA 1 stated she notified an unidentified nurse and ran after Resident 1 but couldn ' t find the resident.	F 689	Monitoring Performance: The DON, ADON, and the RN Supervisors will make daily rounds to ensure adequate supervision of the residents. A 1:1 in service will be provided if there are any findings. The Administrator, DON, and the ADON will review the daily monitoring logs during daily stand-up meeting to ensure compliance. The DON and IDT Members will also review findings in the monthly Elopement Risk QAPI. The Administrator and the DON will present the recapitulations of the findings to the monthly QA meeting for review and action as indicated by 5/15/22.	5/15/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056753	A. BUILDING _____ B. WING _____	C 03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD MANOR CONV.HOSPITAL	4853 W. WASHINGTON BL. LOS ANGELES, CA 90016

(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 689	Continued From page 12 During a concurrent interview and record review of Resident 1 ' s Medication Administration Record (MAR), on 4/12/2022 at 10:42 a.m., with Assistant Director of Nursing (ADON), ADON stated the MAR indicated, on 3/5/2022, at 9 a.m., Resident 1 did not receive the following medications as ordered by his physician: Amlodipine Besylate (blood pressure medicine) 10 milligram ([mg] unit of measurement), Colace (softener stool) 100mg, Multivitamin with Mineral (vitamin supplement) 1 tablet, and Seroquel (medicine for mental health disorders) 100 mg. ADON also stated not taking his medications as ordered could lead to a decline in Resident 1 ' s health. During a concurrent interview and record review, on 4/18/2022, at 1:44 p.m., with ADON, of Resident 1 ' s Order Summary Report, dated 3/1/2022, ADON stated the Order Summary Report indicated there was no order to monitoring Resident 1 ' s whereabout. ADON stated there was no care plan to address Resident 1 ' s wandering behaviors. During a review of the facility ' s Policy and Procedure (P/P) titled, "Care of Wandering Residents", undated, the P/P indicated the purpose of the policy was to protect wandering residents from injury, continuously reorienting resident to room, and monitoring the resident ' s location with visual checks as needed.	F 689		