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

PRINTED: 12/27/2018
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
	056143	A. BUILDING _____ B. WING _____	C 12/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE HEALTHCARE & WELLNESS CENTRE	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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F 000	INITIAL COMMENTS The following reflects the findings of Department of Public Health during the investigation of a facility reported incident (FRI) during an abbreviated standard survey. FRI Number: CA00486545 Representing the Department of Public Health: Surveyor ID: 36385, RN, HFEN The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for facility reported incident number CA00486545.	F 000	RECEIVED JAN 08 2019 By _____ Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise	F 279	F279 CORRECTIVE ACTION(S): Resident 2 was no longer in the facility. In-service provided by the Director of Nursing and MDS nurse to all licensed staff on 12/27/2018-1/5/2019 regarding Comprehensive Care Planning. HOW TO IDENTIFY OTHER RESIDENTS: Care plans of all residents identified with Elopement Risk were reviewed by the Director of nursing and MDS nurse on 12/17/2018-1/5/2019. No other Residents were affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Wayne Whitehead	ADMINISTRATOR	01-03-2019

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 279	Continued From page 1 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its policy and develop a care plan that described the approaches and interventions to be provided for one of three sampled residents (Resident 2). Resident 2, who was ambulatory and confused, was identified as an elopement (to leave the facility without supervision) risk. This deficient practice placed Resident 2 at risk for elopement and injury. Findings: A review of Resident 2's Admission Record (Face sheet) indicated the resident was admitted to the facility on March 15, 2016. Resident 2's diagnoses included abnormalities of gait and mobility, muscle weakness, hypertension (high blood pressure), Type 2 diabetes mellitus (abnormal blood sugar), schizophrenia (mental disorder characterized by abnormal social behavior), and bipolar disorder (brain disorder that causes mood shifts). A review of Resident 2's Elopement Risk Assessment, dated March 16, 2016, indicated Resident 2 had a score of 8. According to this assessment tool, a total score of 8 or greater was considered a high risk for elopement.	F 279	SYSTEMIC CHANGES: Medical Records Designee will audit Residents care plans weekly in a manner conforming to the facility's policy and procedure "Comprehensive Person –Centered Care Planning". MDS nurse will review and check residents care plans during admission, quarterly assessments, change of condition/ updated diagnosis, to ensure that care plans are revised and developed based on residents current medical condition with individualized resident- centered specific needs along with attainable intervention and goals.	

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F 279	Continued From page 2 A review of Resident 2's Minimum Data Set (MDS), a standardized assessment and screening tool, dated March 22, 2016, indicated the resident had moderate cognitive (thought process) impairment. During an interview on May 4, 2016, at 9:20 a.m., the Director of Nursing (DON) stated that the facility had an elopement assessment form (tool) to be completed. The DON stated the staff were to assess the residents to determine risk for elopement and that a score of eight or above indicated a resident was at risk for elopement. On May 4, 2016 at 10:15 a.m. during an interview and concurrent record review, the DON verified there was no care plan in the clinical record to address Resident 2's risk for elopement. During an interview, on May 4, 2016 at 10:18 a.m., the MDS coordinator stated she did not find a care plan for Resident 2's elopement risk. A review of the facility's policy on Wandering and Elopement, dated January 11, 2016, indicated for the resident's at risk for elopement, preventative interventions would be documented in the resident's medical record, and would be reviewed and re-evaluated by the interdisciplinary team ([IDT] a group of health care professionals from diverse fields who collaborate toward a common goal for the resident). The policy also indicated that the IDT would develop a plan of care considering the individual risk factors of the resident.	F 279	MONITORING PROCESS: The Director of Nursing will track any trends or concerns regarding Comprehensive Person-Centered Care Plan and Documentations; this will be communicated to the QA and A committee for further evaluation and recommendations monthly. If it is determined that we have accomplished the objectives in the POC above and the result are successful, then the facility will consider the matter resolved x 3 months.	
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 3 CFR(s): 483.25(h) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 a resident's plan of care and provide adequate supervision to ensure a resident who was confused and dependent on the staff and had a high risk for elopement (to leave the facility without supervision/permission) did not leave the facility unsupervised for one of three sampled residents (Resident 1). Resident 1, who had a diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), left the facility unsupervised. This deficient practice resulted in Resident 1 being missing for 11 days and later being found in a general acute care hospital (GACH) sustaining a laceration (deep cut) on the back of the head which required surgical sutures (staples). Findings: A review of Resident 1's Admission Records	F 323	F323 CORRECTIVE ACTION(S): In-service provided by Director of Nursing on 12/27/2018-1/5/2019 to all nursing staff regarding the Policy and Procedure of Wandering and Elopement. To enhance the safety of residents of the facility. Resident #2 is no longer in the facility as of 5/1/2016. HOW TO IDENTIFY OTHER RESIDENTS: All residents Elopement Assessment were reviewed by the Director of Nursing, MDS nurse and Charge Nurse on 12/27/2018-1/5/2019 to ensure their needs are met as determined by plan of care. No other resident were affected.	

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F 323	Continued From page 4 indicated the resident was admitted to the facility on April 7, 2016. Resident 1's diagnoses included hypertension (high blood pressure), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures [uncontrolled activity in the brain, which causes sudden irregular movement of the body]). A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and screening tool, dated April 14, 2016 indicated the resident had severe cognitive (thought process) impairment. A review of Resident 1's Elopement Risk Assessment, dated April 8, 2016, indicated a score of 8, due to intermittent confusion and being ambulatory (walk) independently. The Risk Assessment form indicated a total score of 8 or greater, the resident should be considered at risk for potential elopement from the facility. A review of Resident 1's care plan titled, "Elopement Precautions," dated April 8, 2016, with a goal for the resident to have no episode of leaving the facility unsupervised daily. The staff's approach plan included: constant monitoring of the resident's whereabouts and to maintain a safe and hazard free environment. A review of Resident 1's "Interdisciplinary Team (IDT) Conference Record" ([IDT] a group of health care professionals from diverse fields who collaborate toward a common goal for the resident), dated May 2, 2016, indicated that on May 1, 2016, at approximately 6 p.m., Resident 1 went missing from the facility.	F 323	SYSTEMIC CHANGES: Special needs list will be discussed and endorsed by licensed nurses to in-coming licensed nurses during huddle system every shift, to ensure all residents that are elopement risk are properly monitored and visually accounted for. Elopement binder is available at nurse's station and will be updated accordingly by Licensed Nurses. Wander system checked every shift by licensed staff MONITORING PROCESS: The Director of Nursing will track any trend or concerns related to baseline care plans; this will be communicated to the QA an A committee for further evaluation and recommendation monthly. If it is determined that we have accomplished the objectives in the POC above and the results are successful, then the facility will consider the matter resolved for 3 consecutive months.	

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F 323	Continued From page 5 On May 2, 2016, the facility reported to the Department of Public Health (DPH) that Resident 1 eloped from the facility. On May 12, 2016 (11 days after going missing), DPH received a fax from the facility indicating Resident 1 was found at a general acute care hospital (GACH). A review of the GACH's "Emergency Documentation," dated May 3, 2016, and timed at 3:44 p.m., indicated Resident 1 was brought to the GACH by a law enforcement, after a ground level fall ([GLF] fall to the floor). It was unclear of how Resident 1 sustained the fall. The ER note indicated Resident 1 had a one-centimeter (cm) laceration to the occipital area (back) of the head with a hematoma (swelling of clotted blood). The ER note indicated Resident 1 was confused, spoke incoherently (without logical or meaningful connection), and did not answer questions appropriately. A review of the ER Nursing Progress notes from the GACH, dated May 3, 2016, and timed at 4:17 p.m. (16:07), indicated Resident 1 was having an episode of tonic-clonic (jerking movements, followed by stiffness) seizure activity. The Nursing Progress Note further indicated on the same day, at 5:51 p.m. (17:51), the resident had the occipital laceration repair with staples ([for wound closure] did not indicate how many staples) and was placed on cervical spine ([the first 7 bones of the spine {vertebrae}] are efforts to prevent movement of the spine in those with a risk of a spine injury) and seizure precautions (interventions used to minimize injuries during seizure activity). During an interview on May 12, 2016 at 3:50 p.m.,	F 323		

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F 323	Continued From page 6 the GACH's Social Worker (SW) stated that Resident 1 was altered (confused) when he first arrived at the hospital and was identified as a John Doe (name given to patients whose identities could not be verified at time of admission). The SW stated when Resident 1's condition became stable he was able to let the hospital's staff know who he was and the hospital's staff called the family, who verified that Resident 1 was missing from the skilled nursing facility. During a tour of the facility on May 4, 2016 at 8:25 a.m. with Licensed Vocational Nurse 1 (LVN 1), the East middle building side doors were observed to be unlocked. The main East middle building doors opened out to the smoking patio. There were ambulatory (able to walk independently with or without an assistive device) and wheelchair-bound residents observed going in and out of the doors. The doors also had no wander guard alarm (a door alarm that operates by monitoring motion through a doorway or hallway, by sending an audible alert, to prevent wandering) installed. At 9 a.m., on May 4, 2016, during a tour of the facility grounds with the Administrator, there was an opened area observed between the skilled nursing facility (for residents who required higher level of medical care) east building and the adjacent Assisted Living (for residents who are more independent, but required some assistance with daily activities) area which was shared by both facilities. From the opened area, there was a walkway from the Assisted Living that led to a gate that opened onto a main street. The gate was observed to be unlocked from the inside of the facility. During a concurrent interview, the	F 323		

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F 323	Continued From page 7 Administrator stated the Assisted Living residents had keys to come into the facility, but did not need keys to go out. During an interview on May 4, 2016 at 9:15 a.m., the Administrator stated the East middle building entrance never had a wander guard alarm on the door since she started working at the facility in 2011. On May 4, 2016 at 9:30 a.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated that Resident 1 was "a little confused" but knew where he was. CNA 1 stated that Resident 1 would sit in a chair on the outside patio. CNA 1 stated that on May 1, 2016, she observed the resident sleeping in his Geri-chair (type of medical chair that reclines) in the East middle building lobby when she left to go home at approximately 3 p.m. During an interview on July 19, 2016 at 1:15 p.m., the facility's Activity Assistant (AA) stated that she was working as the smoking monitor (a person who monitors residents during smoking breaks) the day Resident 1 eloped from the facility. The AA stated that the last time she saw Resident 1 was on May 1, 2016 at approximately 4 p.m., sitting in the patio corner "where he sat all the time." A review of a "Missing Person Report" from the local law enforcement, dated May 1, 2016, indicated that the facility reviewed the video surveillance system and saw Resident 1 walking out of the facility at 5:45 p.m., northbound onto the main street and then out of sight. The report indicated a redacted (blocked out) name that indicated the resident (Resident 1) had made several statements about wanting to leave the	F 323		

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F 323	Continued From page 8 facility and go home.	F 323		