CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

POC accepted
Abigail D. Bonnies
7/3/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555088	A. BUILDING B. WING	06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIDELITY HEALTH CARE	11210 Lower Azusa Rd, El Monte, CA 91731-1412 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during a Licensure Complaint visit: CLASS AA CITATION -- PHYSICAL ENVIRONMENT 95-2005-0009371-F Complaint(s): CA00259599 Representing the Department of Public Health: Surveyor ID # 07598, HFE I The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F323 42 CFR § 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 was not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe resident environment, adequate supervision and assistive devices for Resident A, who had a history of elopement and had exhibited unsafe wandering. Although Resident A was wearing a "WanderGuard", bracelet, Resident A eloped from the facility unnoticed and was found dead on the freeway several hours later with his "WanderGuard", still in place on his wrist. Findings:		Fidelity Health Care Center makes its best efforts to operate in full compliance with both the Federal and State regulations. Nothing included in this plan of correction is an admission otherwise. Fidelity Health Care Center has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objections to the merits or form of allegation contained herein. The submission of this plan of correction constitutes our allegation of compliance. F323 42 CFR / 483.25 (h) a. Immediate Temporary Corrective Action included the following: • In-Service provide to all staff regarding elopement preventive measures on 2/19/11 by Nursing Consultant and Director of Staff Development. • All Residents identified as being at risk for wandering activity continued on hourly watch.	3-18-2011

Event ID:6M4I11 7/3/2012 11:57:04AM

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	Continued From page 1 On [redacted] 2011, an unannounced visit was made to the facility to investigate an entity reported incident regarding a resident who wandered out of the facility on [redacted] [redacted], 2011, and was later found dead on a freeway. A review of a letter addressed to the Department submitted by the administrator indicated that a full internal investigation was in process. However the facility investigation report reviewed by the evaluator did not include a description or conclusion on how Resident A exited the building undetected by facility staff and/or the wander-guard system. Resident A was a 76-year old male who was admitted to the facility on [redacted] 2011, with diagnoses that included rheumatoid arthritis, hypertension, anxiety, insomnia, and senile dementia. A wandering risk assessment dated [redacted], 2011, which was conducted as a part of the facility's admission protocol, indicated that Resident A was ambulatory and able to walk alone and was considered at risk for wandering. The Plan of care developed was for staff to conduct visual checks at least every two hours. The review of Resident A's licensed nurses' notes indicated that on [redacted]11, the Resident was reported as being missing around 12 noon and was later returned to the facility by the police department around 10pm. The facility did not develop any monitoring checks prior to the first elopement on [redacted]/11.		• Re-directable Residents provided with at least hourly monitoring by Licensed and/or C.N.A. staff. No Non-re-directable Residents were identified requiring one-on-one supervision. • All active Wander Guard bracelets were checked by Social Service Designee on 2/18/11 to ensure proper function. • All Residents re-screened by Licensed Nurse for elopement risk on 2/18/11. • Licensed Nursing continued practice of checking all Residents with Wander Guard bracelets each shift to ensure proper, secure placement. • Additional C.N.A. and/or Licensed Nurse staffing provided each shift to closely monitor and re-direct Residents at risk for elopement. • Temporary Door Alarm installed on door near Rehabilitation Room on 2/18/11.	3-18-2011

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	Continued From page 2 A second wandering assessment was then done on [redacted]/11, and the Resident was determined to be at risk for wandering. The plan of care developed to reduce the risk associated with wandering included: * To apply a "WanderGuard" * Monitor every hour * Transfer to a room far away from a door. A review of the resident's medical record revealed the resident was transferred from room 2 (located near the main entrance in the front of the building) to room 19 (located in the back of the facility) on [redacted]/2011. A review of Resident A's medical record dated [redacted] 2011, revealed the following timed entries: 5:00 pm- Resident A was found sitting on his bed in his room waiting for his dinner tray. 5:15 pm- CNA reported that resident was nowhere to be seen. The licensed nurse looked for him around the facility. 5:17 pm- The licensed nurse asked four nursing aides to start looking for the resident within a five mile radius from the facility. 5:19 pm- The remaining nurse aide staffs were instructed to start searching for resident in every room and within facility vicinity including alleys and parking lots. 5:21 pm- An attempt was made to contact the Daughter of Resident A. There was no answer and therefore, a voice mail message was left stating to call the licensed nurse back.		Permanent Corrective Action includes the following: • 3 Additional Wander Guard Sensors and Control Unit ordered on 02/25/12. • All exit doors equipped with functioning Wander Guard System. b. The Facility Administrator will monitor for compliance with corrective action through random weekly rounds. The Director of Nursing, Director of Staff Development and Medical Records Director shall monitor for continued compliance of Nursing Departments' corrective action through monthly audits and report any concerns immediately to the Facility Administrator to ensure immediate corrective action. All issues identified will be presented to the monthly Quality Assurance Committee for review and recommendations.	3-18-2011

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	Continued From page 3 8:15 pm- Police Officer arrived at the facility to provide a case number. 10:51 pm- Received phone call that Resident A was hit by a car on the freeway and died." During an interview with Employee 1, a certified nurse assistant, on [redacted], 2011, at 4:00 p.m., regarding the second episode of Resident A wandering out of the facility on [redacted], 2011, he stated that on [redacted], 2011, at 5:00 p.m., during dinner time, he saw that Resident A had his clothes on and was carrying a small suitcase. Employee 1, a certified nurse assistant, stated that he redirected Resident A and told him to go back to his room since it was time for dinner, and that he would bring Resident A's dinner tray to him so he could eat his dinner. Employee 1, a certified nurse assistant, stated that when he saw that Resident A's food tray was not on the cart, he went to the kitchen to get Resident A's tray. Employee 1, a certified nurse assistant, stated that fifteen minutes later, he returned to Resident A's room with his food tray and noticed that Resident A was missing from his room. During an interview with Employee 2, on [redacted], 2011, he stated that Resident A had wandered out once before on [redacted], 2011, but came back the same day. Employee 2, stated that Resident A was returned to the facility by the police department around 10 pm. A "Wander-Guard" bracelet had been put on his wrist after that first episode.		c. A description of the monitoring process to prevent recurrence of the deficiency: • All door alarms checked daily by Maintenance Supervisor to ensure proper function. Any issues identified shall be reported immediately to the Facility Administrator for timely corrective action. Logs maintained and reviewed by Administrator during random weekly rounds. • All active Wander Guard bracelets were re-checked for proper placement by Licensed Nursing each shift and continued to record in the Medication Administration Record (M.A.R.) • All active Wander Guard bracelets checked by facility Social Worker at least monthly for proper placement, function, review of expiration date and location and Wander Guard Monitoring Log maintained.	3-18-2011

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	Continued From page 4 The evaluator conducted an inspection of the building on February 18, 2011, at 4:00 p.m., and observed five exit doors. Two of the doors had "WanderGuard" alarms installed on them (the exit doors located at the main entrance and the kitchen) while the other three (the exit doors located between rooms 4 and 5, 30 and 31 and rehabilitation room and MDS office) did not have the "WanderGuard" alarms but had a buzzer-like key lock alarm connected to the door. Two of the three doors mentioned above (the exit doors located between rooms 4 and 5 and 30 and 31) operated in such a way that, when the door is opened, a buzzer would initiate an auditory alarm. The only way to turn off the buzzer would be to insert a key in the key hole of the buzzer installed mechanism on the door to turn it off. A review of the facility's wander guard log sheet on February 18, 2011, revealed that the "WanderGuard" doors were tested every 7 days and on February 14, 2011, the log sheet indicated they were working. The exit door by the rehabilitation room and MDS office did not have any kind of an alarm or WanderGuard system. During a second interview with the Employee 2, on June 3, 2011, at 1:30 pm, he stated that at the time of the elopement of Resident A on [redacted], 2011, there was no alarm system, "WanderGuard" system or buzzer-like alarm system installed on the exit door located by the rehabilitation room and MDS office and that was the location from which the resident probably escaped. He also stated that there should have been an alarm system installed		• Wander Risk Assessment completed by Licensed Nursing staff for all new admission and readmission Residents upon admission, quarterly and as needed. • All Residents refusing to wear or removing their Wander Guard Bracelet and are identified to be at risk for elopement are provided one-on-one supervision by C.N.A., Licensed Nursing and/or designated staff until such time that they can be transferred to an appropriate setting. • All staff in-service provided by Director of Staff Development at least annually.	3-18-2011

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	Continued From page 5 on that exit door. Employee 2, further stated during the interview that the system would be more completely secure if all five doors had "WanderGuard" units installed. Employee 2 stated that he had tried without any success to get approval from the owner to buy "Wander-Guard" sensor units for all of the remaining exit doors since his date of hire on August 5, 2010. Employee 2 also said that the resident's WanderGuard bracelets are tested by the social service designee and a copy of the log sheets documenting the tests were given to him and that the "WanderGuard System" was tested monthly. "During a review of the log sheets for the testing of the "WanderGuards," the facility was unable to provide any written documentation to indicate that the Wander-Guard bracelet assigned to Resident A had been tested before it was placed on him. A review of the manufacturer's instructions indicate to test each signaling device before using and to thereafter, test the device daily and record the results in the resident's record. Based on an interview with the Director of Nurses on March 8, 2012, at 2:00 p.m., she stated the "WanderGuard" device applied to Resident A was a brand new device. A review of the facility's policy titled "WanderGuard" dated 2010 indicated that the social service staff will check the "WanderGuard" every month and as needed for proper functioning and expiration date, and will replace the battery of the "WanderGuard" as needed. The social service staff could not be			3-15-2011

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	Continued From page 6 interviewed because the staff no longer worked at the facility. Employee 1, a certified nurse assistant, stated in an interview on February 18, 2011, that he did not hear the sound of the alarm between the time he saw Resident A sitting on his bed and the time he returned to the room with his dinner tray. A review of the facility's policy on wandering effective 2008, indicated to use alarm systems and door alarms, and "WanderGuard" bands. It also indicated to use visual barriers such as stop signs, yellow ribbon curtain, and to cover door knobs. The DON stated during an interview on March 8, 2012, at 2:00 p.m., that there were two other residents who were wanderers at the time of the incident. A review of the photographs included in the [redacted] collision report dated [redacted] 2011, that was obtained from the State highway patrol revealed that, Resident A was wearing a "WanderGuard" bracelet on his right wrist at the time that he was hit by the motor vehicle. The location of the accident was on Interstate [redacted], 975 feet south of lower [redacted] road. This was approximately two miles from the facility. The time of the collision was [redacted], 2011, at 6:20pm. This was one hour and five minutes after Resident A was determined to be missing from the facility. A review of the Coroner's medical report dated [redacted] 2011, indicated that the immediate			3-15-2011

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	Continued From page 7 cause of death of Resident A was [redacted], with the [redacted] occurring from an [redacted] between [redacted] and a [redacted]. Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistive devices, and to maintain a safe and secure environment for Resident A, who had a history of elopement and had exhibited unsafe wandering in violation of the regulation, including but not limited to: Not ensuring that the WanderGuard alarm system was fully installed on all five exit doors in the facility to ensure that Resident A, who had a wander guard bracelet in place, did not elope from the facility unnoticed. These violations presented a substantial probability that death or serious physical harm would result and was a direct proximate cause of the death of Resident A.			3-18-2011

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