STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056415	A. Building B. Wing	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to develop and implement a resident-centered care plan (document that outlines care to rendered to resident) for one of two sampled residents (Resident 1) and ensure the resident had a detailed monitoring plan to address Resident 1's wandering (walking around aimlessly without a fixed plan) within the facility and a prior elopement attempt (when a resident who is not capable of protecting or caring for themselves leaves the facility without authorization). This deficient practice resulted in Resident 1 eloping from the facility on 10/10/2022 at approximately 6:30 p. m. which placed the resident at high risk for exposure to harsh environmental conditions with potential for harm or even death. Findings: During a review of Resident 1 ' s Admission Record, dated 10/11/2022, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included schizophrenia (serious mental disorder in which people interpret reality abnormally that impairs daily functioning). During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 9/16/2022, the MDS indicated Resident 1 ' s cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 1 required supervision with eating, bed mobility, transfer, and required one person assistance for dressing, toilet use, and personal hygiene. During a review of Resident 1's Admission and Data tool, Elopement Risk Assessment, dated 3/14/2022, the tool indicated Resident 1 was at risk for elopement a exhibited by the following behaviors: 1. Resident 1 does pace, wander, try to get out the door, find family or friend, perceive they may need to be doing something other than what they are doing. 2. Resident 1 was independent and mobile. During a review of Resident 1's medical records, there was no documented evidence an elopement care plan was initiated on 3/14/2022 after Resident 1 was noted to have high risk elopement behavior as identified in the elopement risk assessment tool completed upon admission assessment on 3/14/2022. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nurses Progress Note dated 8/23/2022 at 6:31 p.m., the note indicated Resident 1 was paranoid (characterized by suspiciousness) throughout the day and was noted with rapid audible tangential (a person constantly digresses to random, irrelevant ideas and topics) speech thinking that his medications were 'rat poison.' The note indicated Resident 1 was wandering in and out from the smoking patio telling passersby's that he likes the poison. The note indicated staff stated this was Resident 1's normal behavior. During a review or Resident 1's medical records, there was no documented evidence a care plan was developed addressing the resident's wandering on 8/23/2022 after Resident 1 was noted to be independently mobile and wandering in and out from the patio. During a review of Resident 1's Change of Condition (COC) Evaluation dated 10/2/2022 at 5:09 p.m., the COC indicated resident (Resident 1) attempted to leave the facility, open up the door and stood there. During a review of Resident 1's Nurses Progress Note dated 10/2/2022 at 5:34 p.m., the note indicated Resident 1 was alert and oriented to self and mostly sat in the lobby throughout the shift and was back and forth to the patio. The note indicated Resident 1 attempted to leave the facility, and when asked why by staff the resident made a nonsense remark. During a review of Resident 1's medical records, there was no documented evidence an elopement care plan was initiated addressing the resident's post elopement attempt on 10/2/2022. During a review of Resident 1's Nurses Progress Note dated 10/10/2022 at 6:31 p.m., the note indicated Resident 1 was observed with some confusion. The note indicated at 5:50 p.m. (on 10/10/2022), the front door alarm was heard, and no residents were visualized in the lobby or outside. The note indicated a resident head count was completed, and Resident 1 was identified as missing. During a concurrent interview with Licensed Vocational Nurse (LVN) 2 and record review of Resident 1's nurses progress notes (dated 10/2/2022 at 5:34 p.m.) on 10/13/2022 at 8:43 p.m., LVN 2 confirmed on 10/2/2022 at 5:34 p.m., Resident 1 was confused and was pacing in and out of the patio and lobby. Resident 1 then walked briskly towards the door with an intention to exit but LVN 2 stopped the resident. Per LVN 2, an elopement care plan was not created. During a concurrent interview with the MDS Nurse (MDSN) and record review of Resident 1's medical records on 10/14/2022 at 11 a.m., the MDSN confirmed the following: 1. According to progress notes, Resident 1 attempted to leave the facility on 10/2/2022. The MDSN stated Resident 1 ' s behavior should have been addressed with a care plan and a continuous detailed monitoring plan. 2. Resident 1 ' s Admission Elopement Risk assessment dated [DATE] indicated Resident 1 paced, wandered, tried to get out the door, tried to find family or friends, and perceived he needed to be doing something other than what he was doing. The assessment indicated Resident 1 was independent and mobile. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 1 ' s Elopement Risk Assessments completed on 3/14/2022, 10/2/2022 and 10/11/2022 were incorrect because it should have identified Resident 1 as at risk for elopement based on the criteria indicated on the tool. Criteria indicated when yes option was selected for one or more of the questions, a resident may be considered at 'AT RISK' for elopement. Resident 1 was at risk for elopement and should have had a detailed continuous monitoring plan, care plan, and at least visual monitoring for patients. During a concurrent interview with the Director of Nursing (DON) and record review of Resident 1's medical records on 10/14/2022 at 12:45 p.m., the DON confirmed Resident 1 ' s care plan should have addressed the resident ' s elopement risk with a detailed plan to prevent elopement from the facility. During a record review of the facility ' s undated policy and procedure (P&P) titled, ' Wandering, Unsafe Resident, the P&P indicated staff should identify residents who were at risk for harm because of unsafe wandering (including elopement). The P&P indicated staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety will be included in the resident's care plan. During a review of facilities P&P titled Care Plans, Comprehensive Person-centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated the care plan would include the following: a. Include measurable objectives and timeframe's; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Incorporate identified problem areas; d. Incorporate risk factors associated with identified problems. Per the P&P, assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. During a review of facility's undated P&P titled, Missing resident, the P&P indicated it was the facility's policy to protect the safety of residents through early assessment of their risk for exit seeking behaviors. Once identified, the facility will mitigate the risk by preparing an individualized care plan in accordance with policies. Care plan is reinforced with clear communication among staff, residents, families, volunteers, and visitors regarding resident's supervision needs.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review, the facility failed to supervise and prevent the elopement (when a resident who is not capable of protecting or caring for themselves leaves the facility without authorization) of one of two sampled residents (Resident 1) who was cognitively (ability to think and reason) impaired and displayed behaviors of wandering (walking around aimlessly without a fixed plan) in the facility, and had previously attempted to elope on 10/2/2022. On 10/10/2022 the facility ' s security alarm sounded, the facility ' s staff conducted a count for all residents and Resident 1 was identified as missing from the facility. This deficient practice resulted in Resident 1 eloping from the facility on 10/10/2022 at approximately 6:30 p. m. which placed Resident 1 at high risk for exposure to harsh environmental conditions including excessive heat during the day and or cold during the night, at risk for being hit by a car, and medical complications including malnutrition (lack of proper nutrients [molecules in food that are needed for growth and energy]), dehydration (not enough water in the body), stroke (blockage of blood to the brain), heat stroke (body is overheating) and possible death. As of 10/14/2022, Resident 1 was still missing from the facility. On 10/14/2022 at 1:19 p.m., during an unannounced visit, an Immediate Jeopardy ([IJ] a situation in which the facility ' s noncompliance with one or more requirements of participation has cause, or is likely to cause, serious injury, harm impairment or death to a resident) was identified due to the facility ' s staff failing to develop and implement an elopement care plan that included supervision and to monitor Resident 1 after his first elopement attempt on 10/2/2022. Resident 1 eloped from the facility on 10/10/2022 without staff knowledge, placing Resident 1 at risk for serious injury or death. The IJ was called in the presence of the Administrator (ADMIN) and the Director of Nursing (DON). On 10/17/2022 at 10:38 a.m., the ADMIN submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). The IJ was removed on 10/17/2022 at 11:09 a.m., after observations, interviews, and record reviews were completed to confirm implementation of the IJRP while onsite. The acceptable IJRP included the following, the whereabouts of Resident 1 was unknown, so the IJRP was for residents at risk for elopement still in the facility: a. On 10/10/2022 through 10/15/2022, the ADMIN and the Director of Staff Development (DSD) conducted in-services for all staff regarding the facility ' s elopement policy and procedure, elopement risks, Wander guard system (a resident wears a device, and an alarm is activated when the device was near the wander guard sensors installed in exits), and response time from when the door alarm was activated. b. On 10/14/2022, the DSD and DON conducted elopement drills (a practice of emergency procedures to be used in case of a resident elopement) for staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. On 10/15/2022, the DON and Minimum Data Set Nurse (MDSN) identified 12 residents who were ambulatory (able to walk) with or without assistive devices and 27 residents were found to have diagnosis of dementia (residents with impaired ability to think and make decisions) and/or Alzheimer ' s disease (brain disorder). Two (2) of the 12 residents were found to be at high risk for elopement. d. Effective 10/15/2022, a staff member will be assigned 24 hours at the front lobby to monitor the front door until the Wander guard system is installed. e. Effective 10/15/2022, the certified nurse assistants (CNA) will do a head count on their specific residents every two (2) hours and the charge nurse will audit at the end of the shift for sixty (60) days. f. Effective 10/15/2022, Maintenance or designee will check the West, North, and Front doors daily to make sure all alarm systems are working properly. g. Elopement risk assessment will be completed on admission for all residents and at least quarterly, or if change of condition occurs by a licensed staff designee. h. If the resident was identified as high risk for elopement, a Wander guard bracelet device will be used, or resident will be place on one-to-one (continuous staff observation to safeguard resident) monitoring (continuous staff observation to safeguard resident) if Wander guard bracelet was not available. All high risk for elopement residents will not be placed in a room with a sliding door that leads to the outside of the facility. On 10/16/2022, sliding door stoppers were placed in eight (8) rooms with sliding doors leading to the outside of the facility, where a resident or wheelchair cannot pass through. Individualized elopement care plans will be initiated for the high-risk residents. i. All residents identified to be at risk for elopement will be reviewed by the Interdisciplinary Team ([IDT] group of different disciplines working together towards a common goal of a resident) on the following business day (Monday-Friday), quarterly and as needed. j. Medical records will audit all elopement risks assessments for all residents identified as high risk for elopement weekly for eight weeks to ensure elopement assessments were conducted and a care plan was in place for elopement. k. The IJRP will be presented at the next scheduled Quality Assurance (QA) committee meeting on 10/27/2022. Ongoing findings from audits will be reported to the Quality Assurance Performance Improvement (QAPI, team focuses on facility ' s issues) / QA monthly meetings for at least six months. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included schizophrenia (serious mental disorder in which people interpret reality abnormally that impairs daily functioning), type 2 diabetes (body does not regulate glucose [sugar] properly), essential hypertension (high blood pressure), attention to colostomy (surgical opening of the colon [stoma] through the abdomen the opening has a pouch to collect stools), and cataract (a condition in which the lens of the eye becomes cloudy making it difficult to see). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 9/16/2022, the MDS indicated Resident 1 ' s cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 1 required supervision with eating, bed mobility, transfer, and required one person assistance for dressing, toilet use, and personal hygiene. During a review of Resident 1's Admission and Data Tool, Elopement Risk Assessment, dated 3/14/2022, the tool indicated Resident 1 was at risk for elopement. The tool indicated Resident 1 paced, wandered, tried to leave through the door, and to find family or friend. The tool indicated Resident 1 was independent and mobile. During a record review of Resident 1's care plan titled, Using psychotropic (drugs that affect mental state) medication chlorpromazine and olanzapine (medications for schizophrenia), initiated on 3/14/2022, the care plan indicated to monitor/record occurrence for target behavior symptoms and specify if pacing and or wandering. During a review of Resident 1's medical records, care plans, the care plans indicated there was no documented evidence a plan of care for elopement was initiated on 3/14/2022, after Resident 1 was noted to have high risk behavior for elopement and as identified on the elopement risk assessment tool completed upon admission (Dated 3/14/22). During a review of Nurses Progress Note dated 8/23/2022 at 6:31 p.m., the note indicated Resident 1 was paranoid (characterized by suspiciousness) throughout the day and was noted with rapid audible tangential (a person constantly digresses to random, irrelevant ideas and topics) speech thinking that his medications were rat poison The note indicated Resident 1 was wandering in and out from the smoking patio telling passersbys that he likes the poison. The note indicated staff stated this was Resident 1's normal behavior. During a review of Resident 1's medical records, care plans, the care plans indicated there was no documented evidence a plan of care for elopement was initiated on 8/23/2022 after Resident 1 was noted to be independently mobile and wandering in and out of the patio with behaviors indicative of a risk for elopement. During a review of Resident 1 ' s Los Angeles County Superior Court Conservatorship Re-evaluation Physician ' s Declaration (when a court appoints someone to manage financial and personal affairs) document, executed on 8/2/2022 and signed by two (2) physicians, the document indicated Resident 1 was evaluated on 7/19/2022 and diagnosed with schizoaffective (a combination of symptoms of schizophrenia and mood disorder), bipolar type (mental disorder). The document indicated the following for Resident 1: 1. Presents with a history of delusional (distorted reality) thoughts agitation, disorganized thoughts, mood swings. 2. Poor decision making, and lack of appropriate judgement place him at risk for not meeting his basic needs. 3. Displays a history of challenges with compliance with declining medications or hygienic needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Does not have the capacity of knowingly and intelligently accepting or refusing prescribed medication. 5. Does not have the capacity to complete an affidavit of voter registration and vote. 6. Does not have the privilege of possessing a license to operate a motor vehicle. 7. Possession of a firearm or other deadly weapon by the resident presents a danger to his/her safety or to another person. During a review of Resident 1's Change of Condition Evaluation dated 10/2/2022 at 5:09 p.m., the evaluation indicated the resident (Resident 1) attempted to leave the facility, open up the door and stood there. During a review of Resident 1's Nurses Progress Note dated 10/2/2022 at 5:34 p.m., the note indicated Resident 1 was alert and oriented to self, mostly sat in the lobby throughout the shift and was back and forth to the patio. The note indicated Resident 1 attempted to leave the facility and when asked by staff why, the resident made a nonsense remark. During a review of Resident 1's Elopement Risk Evaluation dated 10/3/2022 at 11:07 a.m., the elopement risk evaluation indicated Resident 1 was not identified as at risk for elopement. There was no documented evidence a plan of care for elopement was initiated after Resident 1 ' s elopement attempt on 10/2/2022. During a review of Resident 1's Progress Notes dated from 10/5/2022 to 10/10/2022, the progress notes indicated there was no documented evidence Resident 1 was being monitored by staff for elopement and wandering behaviors. During a review of Resident 1's Nurses Progress Note dated 10/10/2022 at 6:31 p.m., the note indicated Resident 1 was observed with some confusion. The note indicated at 5:50 p.m. on 10/10/2022, the front door alarm was heard, and no residents were visualized in the lobby or outside. The note indicated a resident head count was completed and Resident 1 was identified as missing. During a review of Resident 1's physician ' s orders dated 10/10/2022, the orders indicated Resident 1 was receiving the following medications: 1. Atorvastatin (medication used to decrease lipids [fats] in the blood]) 20 milligrams ([mg] unit of measurement) one tablet by mouth at bedtime for antihyperlipidemic (to decrease lipids [fats] in the blood). 2. Benztropine Mesylate (medication used to treat psychosis [severe mental disorder when people loose contact with reality]) 0.5 mg one tablet by mouth two times a day. 3. Chlorpromazine tablet (medication used to treat schizophrenia (schizophrenia (serious mental disorder in which people interpret reality abnormally that impairs daily functioning) manifested by auditory/visual hallucinations [apparent perception of something not present]) 100 mg one tablet by mouth two times a day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Glimepiride tablet (medication used to treat diabetes) 2 mg one (1) tablet by mouth two (2) times a day. 5. Levothyroxine Sodium Tablet (medication used to treat hypothyroidism [when body does not have enough thyroid hormones [hormones that control the way body converts food to energy]) 50 micrograms ([mcg] unit of measurement) one (1) tablet by mouth in the morning. 6. Lithium Carbonate Capsule (for behavior management for restlessness and agitation) 300 mg one capsule by mouth two (2) times a day. 7. Metformin (medication used to manage diabetes) 500 mg one (1) tablet by mouth three times a day. 8. Olanzapine Tablet (medication used to treat schizophrenia manifested by agitation and striking staff) 20 mg one tablet by mouth one (1) time a day. During a concurrent observation and interview with Certified Nurse Assistant (CNA) 1 on 10/13/2022 at 7:16 p.m., during an observation the alarm system in the front lobby was triggered but shut off within five (5) seconds. There were no staff observed in the lobby and adjacent nursing station, the emergency medical services (EMS) personnel and three residents seated on their wheelchairs were observed in the front lobby. At 7:24 p.m. (8 minutes later), CNA 1 entered the lobby area and checked on the residents. CNA 1 stated she did not hear the alarm because she was in a resident room (four rooms down from the lobby and nursing station). CNA 1 stated the staff assignment did not indicate to monitor the lobby area. During an interview with Licensed Vocational Nurse (LVN) 1 on 10/13/ 2022 at 7:30 p.m., LVN 1 stated Resident 1 was last seen on 10/10/2022 at approximately 5:30 p.m. eating dinner in his room. LVN 1 stated from 5:50 p.m. to 6 p.m., she heard the front lobby alarm and immediately went to the front door but did not see anyone inside or outside the facility. LVN 1 stated a headcount was completed and at 6 p.m., Resident 1 was identified as missing. According to LVN 1, the Director of Nursing (DON) was notified, and search parties were formed. LVN 1 stated when staff were unable to locate Resident 1, the police was notified, and a missing person report was filed. During a concurrent interview and record review on 10/13/2022 at 8:43 p.m. with LVN 2, Resident 1's Nurses Progress Notes dated 10/2/2022 at 5:34 p.m. was reviewed. LVN 2 stated on 10/2/2022 at 5:34 p.m., Resident 1 was confused and was pacing to and from the patio and lobby. LVN 2 stated Resident 1 then walked briskly towards the door with an intention to exit but LVN 2 stopped the resident. LVN 2 stated an elopement care plan was not created. During a review of Resident 1's Nurses Progress Note dated 10/2/2022 at 5:34 p.m., the note indicated Resident 1 was alert and oriented to self and the resident mostly sat in the lobby throughout the shift and walked back and forth to the patio. The note indicated Resident 2 attempted to leave the facility and when asked why Resident 1 was trying to leave, the resident made a nonsense remark. During an interview with the Social Services Assistant (SSA) on 10/14/2022 at 9:44 a.m., the SSA stated the front lobby coverage was seven days a week from 8:30 a.m. until 5 p.m. or 6 p.m. (varies). The SSA stated from 5 p.m. to 8:30 a.m., no one was assigned to monitor the front lobby. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's Front desk Coverage October schedule (handwritten by SSA), the schedule indicated there was no coverage for the lobby after 5:00 p.m. and sometimes 6:00 p.m. until 8:30 a.m. daily. During a review of the facility's Staffing Sheet dated 10/10/2022 and 10/13/2022, the sheet indicated there was no specific staff assigned to the front lobby. The assignment sheet did not indicate front lobby monitoring as part of staff duties. During an interview with CNA 2 on 10/14/2022 at 10:35 a.m., CNA 2 stated she was assigned to Resident 1 ' s care. CNA 2 stated Resident 1 was usually in the lobby or walking around without an assistive device, talking to himself, and ' in his own world. CNA 2 stated Resident 1 could not carry a conversation and he was unable to take care of himself. During a concurrent interview and medical record review of the Elopement Risk Assessments dated 3/14/2022, 10/2/2022 and 10/11/2022, with the MDS Nurse (MDSN) on 10/14/2022 at 11 a.m., The MDSN verified Resident 1 was mostly confused, conserved, and was unable to take care of himself. MDSN stated Resident 1 ' s behavior on 10/2/2022 should have been addressed with a care plan and a continuous detailed monitoring plan. The MDSN verified Resident 1 ' s Elopement Risk Assessments completed on 3/14/2022, and 10/3/2022, were incorrect because it should have identified Resident 1 as at risk for elopement based on the criteria indicated on the elopement tool. During a concurrent interview and record review with the DON on 10/14/2022 at 12:45 p.m., Los Angeles County Superior Court Conservatorship dated 8/2/22, indicated Resident 1 was under Conservatorship and had a mental disorder and was not able to care for himself. The DON stated Resident 1 was only monitored for three (3) days (from 10/2/2022 to 10/4/2022) after his elopement attempt on 10/2/2022. The DON stated Resident 1 ' s care plan should have addressed the resident ' s elopement risk with a detailed plan to prevent elopement from the facility. The DON stated Resident 1's Elopement Evaluation Risk Tool dated 10/2/2022 and 10/13/2022 should have indicated Resident 1 was high risk for elopement because of the resident ' s attempt to leave the facility and/or because Resident 1 displayed wandering behavior in the facility. During a record review of the facility ' s undated policy and procedure (P&P) titled, ' Wandering, Unsafe Resident, the P&P indicated staff should identify residents who were at risk for harm because of unsafe wandering (including elopement). The P&P indicated staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement. During a review of the facility ' s P&P, updated August 2018 and titled, Emergency Procedure-Missing Resident, the P&P indicated residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. During a review of facility's undated P&P titled, Missing resident, the P&P indicated it was the facility's policy to protect the safety of residents through early assessment of their risk for exit seeking behaviors. Once identified, the facility will mitigate the risk by preparing an individualized care plan in accordance with policies. Care plan is reinforced with clear communication among staff, residents, families, volunteers, and visitors regarding resident's supervision needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056415	A. Building B. Wing	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Post Acute Care Center	3611 East Imperial Highway Lynwood, CA 90262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 44055 Based on observation, interview, and record review, the facility failed to ensure the alarm system was working properly. This deficiency had the potential to result in resident elopements (when a resident who is not capable of protecting or caring for themselves leaves the facility without authorization) and compromise the safety of all residents. Findings: During an observation of the facility's lobby on 10/13/2022 at 7:16 p.m., an unidentified paramedic opened the front door for a visitor (Surveyor). The alarm was triggered but shut off within five (5) seconds. There was no staff observed in the lobby and/or the nursing station adjacent to the lobby, however the paramedic and three unidentified residents seated on their wheelchairs was observed in the lobby. During an observation and concurrent interview on 10/13/2022 at 7:24 p.m., Certified Nurse Assistant (CNA) 1) entered the lobby and randomly checked the residents present. CNA 1 stated she did not hear the alarm because she was in a resident room (four rooms down from the lobby). During an interview with the Director of Nursing (DON) on 10/14/2022 at 12:45 p.m., the DON confirmed the paramedic should not have opened the door for any outsiders. The DON stated the alarm should not shut off prematurely as well. According to the DON, this was a security breach. During a review of the facility's undated document titled, User manual for wireless door/ window security alarm, the manual indicated the host of the arm mode will be triggered for thirty seconds simultaneously if the door is opened. The host stops after thirty (30) seconds and triggers again after thirty (30) seconds and again after 15 seconds and it continues in the periodic mode until either the door is properly closed or to disarm the host using a remote control. During a review of the Facility Assessment Tool revised 12/28/2021, the tool indicated the facility will ensure equipment was maintained to protect and promote the health and safety of residents.