STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555565	A. Building B. Wing	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Artesia Palms Care Center	11900 E. Artesia Blvd. Artesia, CA 90701

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 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** 39085 Based on observation, interview and record review, the facility failed to ensure one of one resident (Resident 1), who had a history of elopement (leaving unsupervised, undetected without authorization) and was preoccupied in leaving the facility, did not elope, by failing to: 1. Ensure Resident 1, who had a diagnosis that included schizophrenia (a mental illness causing a break from reality, delusions [beliefs not based in reality], hallucinations [seeing, hearing feeling or smelling something that does not exist]) and was provided with close monitoring and supervision. 2. Ensure the staff was creating a diversional (the act or an instance of diverting or turning aside; deviation; distracts the mind) interventions, as per the resident's plan of care, when Resident 1 was seen pacing, packing her bags, and verbalizing she wanted to leave twice that day (6/1/2021). 3. Ensure the facility's environment was safe and secure to prevent Resident 1 from leaving unnoticed. This deficient practice resulted in Resident 1, who was schizophrenic (mental disorder involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion [things not real]) and required supervision to meet her needs, eloping and going missing for 12 days from 6/1/2021 at 11:30 p. m. to 6/13/2021. This had the potential for the resident to suffer mental, physical, psychosocial (relating to the interrelation of social factors and individuals thought and behavior) and medical harm due to being unsupervised and being without her daily significant medications to control the diabetes mellitus ([DM] condition in which the body no longer produces enough insulin [hormone] or cells stop responding to the insulin that is produced, so that glucose in the blood cannot be absorbed into the cells of the body) and antipsychotic medications to control her mental behaviors. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a facility reported incident (FRI) investigation, on 6/11/2021 at 1:29 p.m., An Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident), was identified and declared under F689 (supervision to prevent accidents). The facility's staff failed to provide close monitoring for Resident 1, who expressed she wanted to leave, and the staff saw Resident 1 packing her bags without the staff intervening. The IJ was called in the presence of the Administrator (ADM), Assistant Administrator (Asst. Admin) and Assistant Director of Nursing (ADON) and notified of the immediate action needed and the seriousness to Resident 1's health and safety. On 6/11/2021 at 7:39 p.m., the facility submitted an acceptable Plan of Action ([POA] to correct the non-compliance) and the IJ was lifted on 6/13/2021 at 1:25 p.m., after the team verified, while onsite, the POA was implemented through observation, interview, and record review as follows: 1. A root cause analysis was conducted on how Resident 1 was able to elope. 2. A 24-hour security was established to monitor the facility premises as of 6/2/2021. A gate and egress (mean of exit) security staff implemented a monitoring plan to ensure all points of exit are secured. Security staff walk the interior and exterior perimeter of the facility and physically check fences and exits, including sending email alerts to the Administrator daily. 3. The Assistant Administrator and Regional Clinical Director (RCD) initiated reeducation on 6/11/2021 for the dietary staff, housekeeping supervisor, maintenance supervisor, central supply clerk, and security staff regarding deliveries and monitoring of egress through the delivery/pick up process. The dietary supervisor initiate in-services on 6/12/2021 to the dietary staff. 4. The ADON initiated reeducation on 6/11/2021 to the nursing staff regarding residents' supervision to prevent, minimize and or reduce the potential for elopement and resident safety. 5. The ADON and the Director of Nursing (DON) initiated reeducation on 6/11/2021 to the nursing staff and to the Department managers on the Quality Circle Rounds (beginning of the day visual inspection within the facility) including observation of doors, screens, and windows to ensure equipment is in good working order. 6. The ADON initiated reeducation on 6/11/2021 regarding reviewing, revising, and updating resident care plans for residents verbalizing or attempting to elope from the facility, ensuring residents are monitored closely and visual checks are enforced, and to initiate a Change of Condition and notify the physician if a resident was exit seeking. 7. The RCD completed an audit of wandering assessments and care plans on 6/11/2021 and residents' wandering assessments. The resident's wandering assessments were discovered as incomplete and were corrected and /or initiated on 6/11/2021 by the MDS coordinator nurse and the RCD. For residents with high-risk assessment results, care plans were audited and or initiated to ensure that appropriate safety interventions were identified and implemented in accordance with the resident's risk-assessment by the RCD and the ADON on 6/12/2021. To ensure monitoring for safety, a list of high-risk residents (score above 10) was provided to staff on 6/12/2021. Resident wander scores: 0-4 low, 5-9 moderate, 10+ high risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Audits of the facility's window screens were completed on 6/11/2021. The Assistant Maintenance Director will order and purchase screens. Appointments were scheduled for screen replacements or repairs with an outside vendor on 6/14/2021 and 6/15/2021. 9. Signage has been posted at the deliver gates on 6/2/2021 to ensure staff are present during deliveries/pick-ups and do not leave the area in order to monitor the security of the gates through the entire delivery and pick up process. 10. An audit of the integrity of the gates were conducted on 6/2/2021 with the Maintenance Supervisor (MS) to ensure that all gates and fencing are in proper repair. Maintenance staff will be responsible for rounding daily to ensure the gates and fencing are properly secured. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, chronic obstructive pulmonary disease ([COPD] a lung disease that causes shortness of breath and coughing) and schizophrenia. The Face Sheet indicated Resident 1 was under conservatorship (a court appointed person to manage a person finance, medical, and personal affairs). During a review of Resident 1's History and Physical (H/P), dated 5/18/2021, the H/P indicated Resident 1 was admitted from a psychiatrist hospital and had a history of elopement. During a review of Resident 1's Order Summary Report dated 5/12/2021, the Report indicated Resident 1 was an AWOL (absent without official leave, missing) risk. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 5/16/2021, the MDS indicated Resident 1's cognition (thought process) was intact, and required assistance with activities of daily living, such as eating, toileting, and required a one-person assist for personal hygiene and getting dressed. During a review of Resident 1's History and Physical (H/P), dated 5/18/2021, the H/P indicated Resident 1 had a history of elopement. A document titled Wandering Risk Assessment (WRA) dated 5/12/2021, the WRA indicated Resident 1 had a high score of 17 which indicate the resident had a high risk for elopement. The WRA scale was as follow: 0-4 low risk, 5-9 moderate risk, and 10+ was a high risk. During a review Resident 1's physician's orders, dated 5/12/2021, the physician's orders included the following medications: 1. Insulin Lispro Solution: (a fast-acting medication that enables the body to process blood sugar (BS) inject subcutaneously (into the fat layer under the skin) as per sliding scale (set of instructions for administering insulin dosages based on specific blood glucose readings) before meals and at bedtime for Diabetes Mellitus (DM) with ranges. 2. Lantus Solution (a long-acting medication that helps the body to process blood sugar), inject 18 units subcutaneously at bedtime for DM. (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 clinical record for the assigned task for the certified nursing assistant (CNA), dated 5/12/2021, the task indicated for the CNA to complete visual checks and location monitoring every two (2) hours for safety. During an interview on 6/22/2021 at 2:02 p.m., CNA 1 (works 7-3p.m.) stated she was assigned to residents in the building Resident 1 was housed. CNA 1 stated the day Resident 1 eloped (6/1/2021) two CNAs had called in sick, so the facility was short-staffed and not all residents were assigned a CNA. During a concurrent interview and review of Resident 1's Task Assignment, on 6/10/2021 at 4:30 p.m., the ADON stated Resident 1 should have been monitored every two hours and documented by the assigned staff in the Tasks section of the electronic medical record (EMR). The ADON stated monitoring included visual checks of the resident's location in the facility. A review of Resident 1's documentation of Tasks for 6/1/2021 (the date Resident 1 eloped) indicated the resident was in her room up to 19:47 p.m. (7:47 p.m.), as that was the last time the staff documented Resident 1's whereabouts. The ADON acknowledged Resident 1 was not being monitored every two hours as indicated on the Task Documentation and should have been. The ADON stated Resident 1's location should have been continuously monitored and documented at regular intervals. During a telephone interview on 6/11/2021 at 3:44 p.m., Resident 1's conservator stated Resident 1 had eloped from the last two facilities she was residing. The conservator stated the last time Resident 1 eloped she was found down unconscious in another city. During an interview on 6/11/2021 at 4:46 p.m., the ADON acknowledged Resident 1 had verbalized twice to staff (unspecific staff) that she wanted to leave the facility on 6/1/2021. The ADON stated if a resident verbalized they wanted to leave the facility, the charge nurse or the CNA should have found out why she wanted to leave, provided reality orientation, call the physician to notify them the resident has verbalized wanting to leave the facility. The ADON stated, on 6/1/2021 at 11:33 p.m., the facility's staff could not locate Resident 1, after a search in the resident's assigned room, throughout the building, the facility's grounds, and the perimeter of the facility. During a concurrent interview and a review of a document titled, Elopement Timeline, dated 6/11/2021 and timed at 10:53 p.m., completed by the Assistant Administrator (AA 2) on 6/12/2021 at 1:08 p.m., AA2 stated the staff (unspecific staff) had reviewed the facility's surveillance video (close watch kept over someone or something: supervision for monitoring of behavior, activities) but had not identified how or when Resident 1 eloped. During a concurrent interview and observation of the facility's surveillance video on 6/12/2021 at 1:15 p.m., with the Maintenance Assistant Supervisor (MAS) the following events on 6/1/2021 were observed: 8 p.m.: Resident 1 was pacing in the hallway outside her room wearing a black dress with flowers and socks. 9:20 p.m.: Resident 1 was observed going into her room. 9:39 p.m.: Resident 1 came out of her room wearing white tennis shoes, and a blue hoodie. (continued on next page)

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