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	03/09/2023

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** 45743 Based on observation, interview and record review, the facility failed to provide supervision and follow the facility ' s policy and procedure titled, Safety and Supervision of Residents, to ensure one of three sampled residents (Resident 1) did not elope (leaving a secured institution without notice or permission) from a locked unit in the facility. The policy indicated the care team would determine the individuals ' assessed needs for the type and frequency of the resident ' s supervision. Resident 1 was admitted to the facility on [DATE] at 11:30 am., to a locked unit and discovered missing on 3/4/2023 at approximately 10: 45 pm. Resident 1 was in the facility for approximately 11 hours. According to licensed vocational nurse (LVN) 2, all new admissions are closely visually monitored for 72 hours to screen the residents ' behavior. As a result, Resident 1 eloped from the facility on 3/4/2023 and remains missing. This deficient practice resulted in Resident 1 leaving the facility with the potential of being exposed to severe environmental conditions including excessive cold, possible motor vehicle accident, medical complications including malnutrition (health problems that may arise due to lack of nutrients [substances found in food necessary for the body to function normally]), dehydration (abnormally low fluid levels in the body), stroke (injury to brain tissue caused by hypertension [abnormally high blood pressure]) due to missing routine medications including high blood pressure medication, and mood stabilizer medication. On 3/8/2023 at 4:22 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 called in the presence of Administrator (ADMIN) and the Director of Nursing (DON) due to the facility's failure to have a system in place to prevent a new admission, Resident 1, that was on 72 hour close monitoring, from eloping from the facility ' s locked unit. On 3/9/2023 at 3:56 p.m., the facility submitted an acceptable IJ removal plan (IJRP, interventions to immediately correct the deficient practices). After onsite verification of IJRP implementation, through observation, interviews, and record reviews, the IJ was removed on 3/9/2023 at 4:23 p.m., in the presence of the DON. The IJPR included the following immediate actions: (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	a. In-Service of facility staff on 3/7/23 regarding: - Staff to be more vigilant when opening exit doors to ensure no residents within immediate surroundings, checking the door behind to ensure it is locked/engaged, and any unfamiliar individual not wearing uniforms/name badge will not be allowed to go through exit doors without verification or supervision. - Staff to wear name badges appropriately and should be visible while at workplace. - Licensed nurses will obtain a photograph of every new admission facility-wide in the absence of Activities staff. Activities staff will download pictures of new admissions the next business day. - Residents identified with moderate risk for elopement will be monitored visually, every 2 hours, through a Behavior Mapping Tool in Point of Care (electronic documenting system), under Certified Nurse Assistant (CNA) -Task. CNAs are to report to charge nurses in any new onset or increase episode of wandering behavior. - High risk residents will be monitored hourly utilizing Behavior Mapping Tool. CNAs are to report to charge nurses in any new onset or increased episodes of wandering behavior. - Each CNA is assigned to 9-10 residents all throughout the facility to care and monitor to ensure residents are supervised and kept safe. The director of nursing/ director of staff development will review staffing projections (staffing needs assessments) and adjustments will be made as appropriate for high demand/high acuity residents. b. All 4 identified exit doors throughout the facility will be monitored hourly for functionality to ensure exit doors are locking/engaging properly. These exit doors are entrances/exits that employees use as passageways to leave/enter the facility or move between units, namely: Palm Court and Palm Grove (locked unit). These four exit doors are identified as follows: Palm Court Main lobby, Palm Court after-hours entrance/exit door (behind Administrator ' s office), Palm Court East (passage going to Palm Grove/locked unit), and Palm Grove entrance/exit. c. Current staff including those from the registry, administration, dietary, housekeeping, rehab, etc. will be in-serviced (on items a. and b. above) by the director of nursing or designee, and no staff will be allowed to report to work assignments until in-service is completed. Facility will complete 100% staff in-service by 3/10/2023. Staff on per diem status, unavailable or on vacation will receive in-service training through the phone if able, until such will return to work then a face-to-face training will be done. d. During new hire orientation and annual performance evaluation, staff will receive training on facility ' s wandering/elopement policy and procedures, resident ' s safety, monitoring of resident ' s whereabouts and providing adequate supervision. The administrator will randomly review 5 employees' files monthly to audit evidence of training during the next 3 months. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. For pre-admission screening, DON will ensure elopement risk and residents with history of suicidal ideations ' documents are reviewed before a new admission is accepted. A plan will already be in place, discussed with the Interdisciplinary Team (IDT- each resident ' s health care team) if necessary, and communicated to nursing staff (including registry staff) before the resident is transferred to the facility. Any referral for new admission/readmission with active suicidal ideation will be denied placement until a clearance from psychiatrist is obtained. f. Any in-house resident experiencing suicidal ideation will be immediately placed on 1:1 monitoring until transfer to a more appropriate setting is done. g. The Environmental supervisor will check all windows, exit doors, emergency exits, perimeter fence and gates for proper functioning daily. Administrator will review log weekly for the next 3 months. h. Department heads will conduct exit door staff compliance checks to at least 10 random staff members weekly for 3 months to ensure staff entering or exiting locked doors are keeping residents safe and preventing them from eloping - any issues will be communicated to administrator or director of nursing for immediate resolution for the next 3 months. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility ' s locked unit on 3/4/2023 with diagnoses including paranoid schizophrenia (a mental disorder often characterized by abnormal social behavior and failure to recognize what is real), hypertension, anxiety (Feeling nervous, restless or tense, having a sense of impending danger, or panic) and insomnia (sleep disorder that makes it difficult to sleep). During a review of Resident 1 ' s General Acute Care Hospital (GACH - where Resident 1 was transferred) Psychiatric Evaluation (PE) dated 2/7/2023, the PE indicated that Resident 1 had been expressing feelings of helplessness, hopelessness, worthlessness with suicidal thoughts with intent to walk in traffic or overdose. During a review of Resident 1 ' s elopement risk assessment (ERA) dated 3/04/2023, the ERA indicated Resident 1 scored 7 (score of 7 indicated the resident was a moderate risk for elopement). During a review of Resident 1's physician ' s order dated 3/4/2023, the physician ' s order indicated lisinopril (blood pressure medication) 10 milligrams ([mg] unit of measurement), 1 tablet by mouth one time day, divalproex sodium (mood stabilizer medication) 500mg to be given 3 times a day and risperidone (medication for schizoaffective [symptoms including the minds break from realty, and severe mood swings] disorder) 2mg to be given twice a day manifested by paranoid schizophrenia. During a review of Resident 1 ' s Care plan (C/P) dated 3/4/2023. The C/P indicated Resident 1 was at risk for wandering/elopement with a score of 7- moderate risk. Goals set for Resident 1 indicated Resident 1 will not have episode of seeking exits, resident ' s safety will be maintained through the review date (next assessment date), 3/6/2023 and that the resident will not leave the facility unattended through the review date. Interventions included: clearly identify Residents ' room and bathroom to avoid going to other resident ' s bathroom, engage resident in purposeful activity to keep self-busy and monitor whereabouts closely. (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 Nursing Progress Note (NPN) dated 3/5/2023 at 2:39 a.m., the NPN indicated that at 10:45 p.m. (on 3/4/2023), Resident 1 was reported missing to the local sheriff department. During an interview on 3/7/2023 at 9:44 a.m., Certified Nursing Assistant (CNA) 3 stated CNAs are assigned an area (each) to monitor, the three areas are the east and west hallways and the patio (areas in the locked units with exits). CNA 3 stated monitoring was done due to the unpredictable behavior (exit seeking, altercations, or accidents) of the residents in the locked unit. During an interview on 3/7/2023 at 10:25 a.m., with the Maintenance Supervisor (MS), the MS stated the exit doors require at least 300-400 pounds of pressure to be opened and that they can be opened in event of emergency. The MS states that all the exit doors require a key to be opened and the only people that have keys are staff members. During an interview on 3/7/2023 at 12:21 p.m., with LVN 2, LVN 2 stated new admissions need to be closely monitored for 72 hours to screen the residents ' behavior and the result of monitoring needed to be documented. LVN 2 stated the purpose of monitoring new admissions was because residents in this (locked) unit can be aggressive and show exit seeking behavior because the residents are in a new and unfamiliar environment. During an interview on 3/7/2023 at 4:06 p.m., with Registered Nurse (RN) 2, RN 2 stated that the locked unit was fully staffed, a CNA was stationed in each hallway and patio, if a resident was able to leave the unit, staff should have been able to see the resident leave. RN 2 also stated there was no picture of Resident 1 in his medical record, and it would have helped identify Resident 1. During a phone interview on 3/7/2023 at 4:37 p.m., with LVN 1, LVN 1 stated Resident 1 was last seen around 8:30 p.m. on 3/4/2023, which was the last smoke break for the evening. LVN 1 stated that Resident 1 ' s elopement put him at risk for getting hurt, hit by a vehicle or can get sick from exposure to extreme weather. During an interview on 3/8/2023 at 9:30 a.m., with the admissions coordinator (AC), the AC stated the admissions staff and the nursing staff collaborated on which unit to place a new resident in. Factors in making that decision are age, medical history, and any other details that nursing receives during report. Resident 1 was placed in the locked unit due to him being young and the resident ' s suicidal history. During a concurrent observation and interview on 3/8/2023 at 1:17 p.m., CNA 4 was observed monitoring the exit door of the locked unit, CNA 4 stated someone should be watching the hallways and exit doors and we (CNAs) cannot leave the area unattended. CNA 4 stated if there was a need to leave an exit unattended, then the charge nurse needs to be notified or one of our colleagues (facility ' s staff). During a concurrent interview and record review on 3/8/2023 at 2:20 p.m., with the DON, the DON stated a staff member should be monitoring the patio, and the east and west hallways at all times. The document titled Nursing Staffing Assignment and Sign In dated for 3/4/2023 indicated that seven CNAs were on shift when Resident 1 eloped from the facility. The DON stated there was more than enough staff to monitor the unit and the staff weren ' t properly monitoring the exits. The DON stated that the safety of all residents is the responsibility of all staff members. (continued on next page)

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