STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555297	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-HEMET	**1717 WEST STETSON AVENUE HEMET, CA 92545**

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 -** Minimal harm or potential for actual harm **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** Based on observation, interview, and record review, the facility failed to ensure a resident did not elope (leave the facility without permission), for one of two residents reviewed for elopement (Resident 1), when: 1. The facility did not provide adequate supervision when Resident 1 had a change of condition; 2. The exit door alarm did not activate when the exit door near room [ROOM NUMBER] was opened without putting in the code; and 3. The facility staff did not respond when the exit door alarm at the Bistro (activity room located at Station 2) went off. These failures resulted in Resident 1 leaving the facility without permission, which placed Resident 1 at risk for serious injury or death. Findings: On July 2, 2020, 9:56 a.m., an unannounced visit to the facility was conducted to investigate a facility reported incident of elopement. On July 2, 2020, at 10:52 a.m., Certified Nurse Assistant (CNA) 1 was interviewed. She stated all the exit doors have alarms. She stated the exit door alarm should go off if the code was not put in prior to opening the exit door. On July 2, 2020, at 11:03 a.m., a concurrent observation of the location of the incident and interview with Licensed Vocational Nurse (LVN) 1 was conducted. LVN 1 was observed to exit the front lobby door and walked towards the sidewalk where Resident 1 was found. The walkway from the front lobby was observed to be going downhill. Two electrical poles were observed by the sidewalk. The sidewalk was observed beside a street where vehicles were passing by. A cemented walkway was observed from the sidewalk going uphill to two exit doors at the facility. LVN 1 stated on April 5, 2020, at around 6:45 a.m. to 7 a.m., when he was driving to the facility for work, he noticed Resident 1 was at the sidewalk beside the facility's building. He stated Resident 1 was wearing a hospital gown and was sitting in her wheelchair. He stated Resident 1 was waving her hands to the cars passing by. He stated he drove to the facility's North parking lot and ran towards Resident 1. LVN 1 stated he talked to Resident 1 to go inside the facility but Resident 1 did not want to go with him. He stated Resident 1 continued to wheel herself at the sidewalk away from the facility. He stated Resident 1 was confused and told him she was kidnapped and was brought in the facility against her will. LVN 1 stated he was able to convince Resident 1 to come back inside the facility. He stated he called LVN 2 (charge nurse of the night shift) and informed her Resident 1 was outside of the facility. He stated LVN 2 was not aware Resident 1 went out of the facility. He stated he asked her to open one of the exit doors near nurse station 2 so he could take Resident 1 back into the facility. On July 2, 2020, at 11:25 a.m., Resident 1's room and the exit door near her room were observed with LVN 1. Resident 1's room was observed to be the second to the last room near the exit door away from the nurse station. LVN 1 was observed to press the exit door to open it and the alarm went off. The alarm sound was loud. LVN 1 was observed to open the exit door near Resident 1's room. A walkway was observed going down straight to the sidewalk at the side of the facility (where Resident 1 was first found by LVN 1 on April 5, 2020. In a concurrent interview with LVN 1, he stated the sound of the alarm was louder than the sound when he and another licensed nurse (he was not sure which one) tested the exit door alarm near room [ROOM NUMBER], on April 5, 2020, after he brought Resident 1 to the facility. On July 2, 2020, at 11:30 a.m., LVN 3 was observed to go to the exit door near Resident 1's room. Concurrently, the nurse station was observed to have a panel located at the wall. The panel was observed to have a red light next to a sign door by room [ROOM NUMBER]. In a concurrent interview with LVN 3, she stated she went to the exit door because she heard the exit door alarm went off on the panel at the nurse station (when LVN 1 opened the exit door). She stated the red light on the panel would turn on to indicate at which exit door alarm was triggered. She further stated the alarm could be heard and seen at all of the nurse stations (nurse stations 1, 2, and 3). On July 2, 2020, at 1:35 p.m., the Director of Nursing (DON) was interviewed. She stated the alarm of the exit door will go off if somebody went out of the door without putting in the code. She stated the alarm would continue to sound until the code was put in. She stated LVN 2 (night shift charge nurse) and LVN 4 (morning shift charge nurse on April 5, 2020) did not hear the alarm on April 5, 2020, when they were endorsing between 6:30 a.m. to 7 a.m. On July 2, 2020, at 2;55 p.m., CNA 2 was interviewed. She stated she worked the morning shift of April 5, 2020. She stated she arrived to work at nurse station 2, at around 6:30 a.m., and she did not hear the exit door alarm. She stated she did not know Resident 1 was outside the facility until LVN 1 brought her inside the facility. On July 6, 2020, Resident 1's record was reviewed. Resident 1 was admitted on [DATE], with the [DIAGNOSES REDACTED]. The Medical History/Physical Examination, dated March 21, 2020, indicated Resident 1 was oriented to person, place, and time. The Minimum Data Set (MDS - standardized assessment tool), dated March 27, 2020, indicated a BIMS (Brief Interview of Mental Status) score of 13 (a score of 13-15 indicated the resident's cognition/mental process was intact). The following progress notes indicated Resident 1's change of condition: a. April 1, 2020, at 4:45 a.m. - .patient (Resident 1) yellng out and walking around with her walker and most of her belongings, asked patient where was she going? patient (sic) stated I have been released and I would like to go find my son and daughter .patient then started to cry saying I am lost and I dont (sic) know where I am at . b. April 1, 2020, at 10:03 a.m. - .LN (licensed nurse) reported patient's increased confusion and low BP (blood pressure) to (name of physician) . c. April 2, 2020, at 8:35 a.m. - .Patient hallucinating, talking to someone in the room that is not there. Patient states she was kidnapped by the FBI and is locked in prison . d. April 3, 2020, at 3:59 p.m. - .The patient is having hallucinations and she is very confused . e. April 3, 2020, at 6:02 p.m. - .Pt (patient) remains confused and disoriented, was observed pulling off oxygen and trying to get out of bed . f. April 4, 2020, at 1:34 a.m. - .LN was doing rounds, upon entering room PT noted sitting on floor next to the TV (television) with legs out in front of her with back against the wall .PT noted to be alert with confusion . g. April 5, 2020, at 5:53 a.m. - .continues to be alert with confusion .up most of the night in bed, at times calling out . h. April 5, 2020, at 8:05 a.m. - .Police called at around 6: 55 (sic) AM (a.m.) to notify that a patient in wheelchair was out in front of the building waving at cars passing by. Immediately went out of the buidling to check but no one was there. Went back to check if someone is missing from the facility. On station 2, patient was just brought in by a licensed nurse around 6:54 AM. Patient was seen by licensed nurse when he was coming in and went to take the patient back to facility through the door near the PT (physical therapy) room. Patient verbalized that she wants to go home . i. April 5, 2020, at 8:01 p.m. - .Presenting to IDT (Interdisciplinary Team - a group of healthcare professionals who work together for the common goal of the resident) due to resident's change of condition, with hallucination, possible contributing factors of her fall incident and elopement incident. Resident had incident that was found outside the facility on the back area, resident's room was closed to 2 (two) exit areas which was in bistro (activity room) and by rehab (rehabilitation) area .On 4/2/20 (April 2, 2020), resident had change of condition of having hallucination, confused .Unable to tell the staff during interview where she went out or what door .The door's alarm was on, when the licensed nurse came in with the resident, licensed nurse did not put the code and the door alarmed . On July 7, 2020, at 1:09 p.m., LVN 1 was interviewed. He stated on April 5, 2020, at around 7 a.m., he and another staff checked the exit door near room [ROOM NUMBER], immediately after the incident. He stated he pushed the exit door at that time and

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

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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She stated the sound of the alarm would continue until the code was put in to disarm it. On July 8, 2020, at 10:12 a.m., CNA 3 was interviewed. She stated she worked morning shift on April 5, 2020. She stated she did not hear the exit door alarm go off on April 5, 2020. On July 8, 2020, 11:50 a.m., the DON was interviewed. She stated the facility process for identifying a resident at risk for elopement was to assess for history of elopement and behavior of confusion and exit-seeking. She stated once the facility identified a resident was at risk for elopement, safety measures would be initiated such as close supervision and application of wanderguard (a device used to alert that a person was trying to leave the premises) . The DON stated the facility did not consider Resident 1's behavior on April 1, 2020 (yelling out, walking around with walker with most of her belongings, crying, and saying I am lost and I don't know where I am,) as a risk for elopement. She stated there was no elopement risk assessment initiated for Resident 1 after April 1, 2020. The DON stated Resident 1 would have received more supervision if she was moved closer to the nurse station. On July 9, 2020, at 2:10 p.m., LVN 2 was interviewed. She stated while endorsing with LVN 4, on April 5, 2020, at around 6:40 a.m., she heard the Bistro alarm go off at the panel at the nurse station (different from the interview with the DON on July 2, 2020). She stated the sound of the alarm stopped less than 10 seconds later. LVN 2 stated she did not check the exit door by the Bistro, on April 5, 2020, neither did she ask any staff to check the exit doors after hearing the alarm. She stated the exit door was not checked because the alarm sounded then stopped quickly and she thought a staff went out of the exit door without putting the right code. LVN 2 stated the nurse should go to the exit door to check if a resident went out when the exit door alarm went off. On July 10, 2020, at 2:00 p.m., the DON was interviewed. She stated the staff should check the exit door as soon as possible when the alarm goes off. The DON stated the staff should check the exit door regardless of the duration of the alarm. She stated the staff should have checked the exit door if they heard the alarm on April 5, 2020, to ensure a resident did not leave out of the facility. The DON stated the slope by the exit door near Resident 1's room was scary and anyone in a wheelchair could roll down, end up in the street, and be hit by passing vehicles. On August 7, 2020, at 10:41 a.m, the Director of Maintenance (DM) was interviewed. He stated the distance from the exit doors to the location where Resident 1 was found were measured, as followed: a. From the front lobby exit door to the sidewalk at the end of the driveway - 136 feet; b. From the exit door near room [ROOM NUMBER] to the sidewalk - 175 feet; c. From the electrical poles in the sidewalk where Resident 1 was found by LVN 1 to the end of the facility property line - 30 feet; and d. From the front lobby exit door to the sidewalk where Resident 1 was found by LVN 1 - 166 feet. On August 7, 2020, at 1:42 p.m., the Registered Nurse Supervisor (RNS) was interviewed. The RNS stated she was the RNS during the night shift of April 4, 2020, for nurse stations 1, 2, and 3. She stated on April 5, 2020, at around 6:55 a.m., while she was at nurse station 1, she received a call from a police and informed her of a resident seen outside of the facility. She stated she went out of the facility throught the lobby door and did not see any resident outside. She stated she checked nurse station 1 and no resident was missing. She stated she checked nurse station 2 and found out Resident 1 was just brought inside the facility by another licensed nurse who found Resident 1 outside by the sidewalk. She stated she did not hear nor see an exit door alarm go off from the panel at the nurse station 1. She stated she interviewed Resident 1 who was unable to tell her how she got out of the facility. She stated she thought Resident 1 could have gone out of the exit door near room [ROOM NUMBER]. She stated she checked the exit door near room [ROOM NUMBER] together with LVN 1 after talking to Resident 1. She stated they pushed the exit door without putting in the code and did not hear the alarm go off (different from the interview with LVN1). She stated she expected the alarm to go off and hear a loud sound once the exit door was pushed open without putting in the code. She stated the alarm at the exit door near room [ROOM NUMBER] was not working. She stated if the alarm was not working, the staff should make a report to the maintenance department to be checked and to prevent any resident to go out of the facility without permission. She stated she did not make a report to the maintenance department about the non-working exit door alarm near room [ROOM NUMBER]. On July 10, 2020, at 2 p.m., a policy and procedure on alarm response was requested from the DON. On July 13, 2020, a facsimile (telephonic message) was received from the DON indicating the facility did not have a policy on responding to exit door alarms. The facility policy titled, WANDERING AND EXIT SEEKING, dated 2015, was reviewed. The policy indicated, .the interdisciplinary team works to identify the trigger and structures the plan of care to meet the need of the patient specific trigger, preferably prior to the onset of wandering or exit seeking .Not all patients who attempt to leave the center have memory loss .Patients are evaluated upon admission for a history of, or risk factors for wandering and, or exit seeking .Interventions that may be considered include .patient room placement in relation to egress doors (an exit designed to allow the occupants of a building to evacuate safely during an emergency) .personal security bracelets .Elopement occurs when a resident leaves the premises or a safe area without authorization .and, or any necessary supervision to do so .Patients may be identified as at risk when one or more of the following risk factors are present .demonstrates behavioral symptoms indicating desire to exit, e.g. packing of belongings .Exit doors and stairwell doors are alarmed .