STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KEI-AI LOS ANGELES HEALTHCARE CENTER	**2221 LINCOLN PARK AVE LOS ANGELES, CA 90031**

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 implement the care plan of one of three sampled residents (Resident 1), who had a high risk for elopement. This deficient practice resulted in Resident 1 leaving the secured unit without staff knowledge, exposing Resident 1 to potential danger while out in the community. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Elopement Screening, dated 7/18/19 at 10 p.m., indicated Resident 1 was cognitively impaired. Resident 1 had an exit seeking behavior/expression of wanting to go home. The screening form indicated to refer to the Interdisciplinary Team (IDT). A review of Resident 1's History and Physical, dated 7/19/19, indicated the resident did not have the capacity to understand and make decisions. A review of the Minimum Data Set (MDS, an assessment and screening tool) dated 7/25/19, indicated Resident 1 needed one person physical assistance with activities of daily living (ADLs). A review of Resident 1's Care Plan dated 8/7/19, indicated a problem of risk for wandering or elopement related to history of elopement with exit seeking behavior. The interventions included to assess/record/report to the physician risk factors for potential elopement such as wandering, repeated requests to leave the facility and statements such as I'm leaving, and 'I'm going home. A review of the Progress Notes, dated 10/12/19, at 8:20 p.m., indicated at around 2:30 p.m., Resident 1 came to the nurses' station and requested to call her next of kin (NOK). After the phone call, Resident 1 told registered nurse (RN 1) that her NOK will pick her up that evening. The notes indicated at 5:30 p.m. Resident 1 could not be found. The police and Resident 1's responsible party were notified. A review of Resident 1's Progress Notes, dated 10/12/19, at 9:40 p.m., indicated the facility searched for Resident 1 and around the neighborhood but could not locate Resident 1. The notes indicated, RN 2 and the facility driver went to Resident 1's residence and found Resident 1 at her home. A review of the facility camera surveillance photos, dated 10/12/19, indicated Resident 1's NOK entered the facility at 2:37 p.m. and left the facility at 2:45 p.m. with Resident 1. During an interview on 11/15/19, at 11:20 a.m., RN 1 stated on 10/12/19, Resident 1 requested RN 1 to dial a telephone number. RN 1 stated Resident 1 was talking on the phone in another language. When Resident 1 was finished talking on the telephone, Resident 1 stated her NOK will come later in the evening to pick her up. RN 1 stated she did not believe Resident 1 because Resident 1 had stated this many times before, but NOK had never showed up. During a telephone interview on 11/22/19, at 4:10 p.m., RN 2 stated no one saw Resident 1's NOK in the facility on 10/12/19. RN 2 stated she helped look for Resident 1 but could not find her. RN 2 stated she and the facility driver went to Resident 1's address and found Resident 1 at her residence alone. During a telephone interview on 12/6/19 at 12:23 p.m., the DON agreed that the elopement risk should have been discussed during the IDT on 7/29/19. The DON stated there was no monitoring of Resident 1's behavior and Resident 1 stating that she wants to go home. The DON agreed the care plan was not implemented. A review of Elopement Policy with a revised date of 6/2017, indicated the IDT will review risk factors and interventions to manage elopement during the initial, quarterly and annual assessment and when a significant change of condition was identified. A review of the facility policy titled, Care Plans, Comprehensive Person- Center, with a revised date of 12/2016, indicated the comprehensive, person centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psycho social well-being.

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.