STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555249	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA CLIFF HEALTHCARE CENTER	**18811 FLORIDA ST HUNTINGTON BEACH, CA 92648**

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, medical record review, and facility P&P review, the facility failed to provide adequate supervision and safe environment for one of three sampled residents (Resident 3) who was at high risk for elopement. * The facility staff who witnessed Resident 3 attempting to elope from the facility failed to notify the charge nurse or nurse supervisor. Resident 3 was not reevaluated to address the need for further interventions to mitigate the resident's elopement attempts. This failure resulted in Resident 3 eloping from the facility 7/15/2020. Findings: Review of the facility's P&P titled Elopement/Unsafe Wandering revised March 2020 showed the staff shall promptly report any resident who is trying to leave the premises or is suspected of being missing to the Charge Nurse or Supervisor to evaluate the need for further interventions. On 7/17/20 at 0908 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated he and another family member received telephone calls from facility staff on 7/15/20, informing them Resident 3 eloped from the facility. Family Member 1 stated according to the facility staff, Resident 3 had walked out of the facility unsupervised, and was found about one block away from the facility by a nearby restaurant employee. Resident 3 was escorted back to the facility by the police. On 7/17/20 at 1420 hours, Resident 3 was observed sitting on her wheelchair next to her bed. A Wanderguard (an electronic device worn on the resident's wrist or ankle to alert staff if a resident goes beyond a sensing device at the doorway) was observed on Resident 3's left ankle. Medical record review for Resident 3 was initiated on 7/17/20. Resident 3 was readmitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 3 had severe cognitive impairment. Review of the Elopement/Wandering Evaluation dated 10/21/2019 and 5/28/2020, showed Resident 3 was a high risk for elopement. Review of the Order Summary Report showed the following physician's orders [REDACTED]. Notes showed a Social Services entry by the SSD dated 7/8/20, showing the activities staff had reported Resident 3 punched the activities staff in the face while she was trying to redirect the resident who was attempting to exit out of the facility through the front door. Documentation showed Resident 3 was noted to be agitated with increased episodes of exit-seeking behavior. There was no documentation to show the licensed nurses were notified about Resident 3's elopement attempts and increased episodes of exit-seeking behaviors. The resident was not evaluated for the need for further interventions to prevent future elopement attempts. Additional medical record review failed to find documentation to show the Resident 3's physician was notified of Resident 3's elopement attempt, increased agitation, and increased episodes of exit-seeking behaviors. Review of Resident 3's plan of care showed a care plan problem to address Resident 3's risk for elopement/wandering was created on 3/20/18. The care plan problem showed Resident 3 had four previous elopement attempts on 3/20, 4/2, 4/6 and 4/24/18. The care plan did not show the elopement attempt made by Resident 3 on 7/8/2020 and there were no new interventions in place to address the increased episodes of exit-seeking behavior. Review of the Progress Notes showed a nursing entry dated 7/15/2020 at 1230 hours, showing Resident 3 was spotted at the gas station across the street by a facility staff member. On 8/25/2020 at 1135 hours, a telephone interview and concurrent medical record review for Resident 3 was conducted with the SSD. The SSD was asked whether she notified the unit supervisor or the charge nurse regarding the elopement attempts of Resident 3 on 7/8/2020. The SSD stated, no she did not notify the charge nurse or unit supervisor regarding Resident 3's elopement attempts. The SSD stated she thought the Activities Director reported the incident to the charge nurse. On 8/18/2020 at 1419 hours, a telephone interview and concurrent medical record review for Resident 3 was conducted with the Activities Director. The Activities Director confirmed she witnessed Resident 3 attempt to elope from the facility on 7/8/20. The Activities Director stated she reported the incident to the SSD and notified a licensed nurse, but could not remember who it was. However, there was no documentation in the resident's medical record of that she notified the DDS and licensed nurse of the elopement attempt. The Activities Director stated it was her first time redirecting a resident who tried leaving the facility. The Activities Director stated the incident was considered a change in the resident's behavior and should have been reported. On 8/18/2020 at 1433 hours, a telephone interview was conducted with LVN 8. LVN 8 stated he was the charge nurse assigned to Resident 3 on 7/8/2020. LVN 8 stated he was not made aware of Resident 3's attempt to leave the facility unsupervised or the resident's increased episodes of exit-seeking behaviors. LVN 8 stated if he had known of the incident, he would have generated a change in condition report, notified the physician, and re-evaluated the resident's elopement risk and implemented interventions. LVN 8 verified the elopement attempt on 7/8/2020, was not addressed, and contributed in Resident 3 being able to elope from the facility on 7/15/2020.

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.