STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056435	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HYDE PARK HEALTHCARE CENTER	**6520 WEST BLVD. LOS ANGELES, CA 90043**

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 that one out of two residents (Resident 1) who was assessed as a high risk for elopement (leaving a facility, unsupervised, undetected and without authorization or permission), had exhibited behavior of elopement and was being monitored every 15 minutes, eloped from the facility without supervision and was located eight minutes later. These deficient practices had the potential to expose Resident 1 to hazards, accidents, injuries and/or death. Findings: A review of Resident 1's Elopement Risk Assessment, dated 3/13/2020, indicated Resident 1 had a score of 12. According to the Elopement Risk Assessment, a score of 10 or more indicated a high risk of elopement. The assessment indicated Resident 1 attempted to elope from the facility and was redirected back to the facility. A review of Resident 1's History and Physical (H/P), dated 3/14/2020 indicated Resident 1 had a fluctuating capacity to understand and make decisions. A review of Resident 1's Admission Record (face sheet), indicated Resident 1 was initially admitted to the facility on [DATE] and last re-admitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Elopement Risk Assessment, dated [DATE]20 indicated Resident 1 had a score of 13. According to the Elopement Risk Assessment, a score of 10 or higher indicated a high risk for elopement. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's care plan, dated [DATE]20 and titled, Elopement, At risk for injuries secondary to elopement the staff's interventions to monitor Resident 1's location with visual checks at least every two hours, frequent visual checks, camera surveillance, wander guard bracelet, anticipate the resident's needs based upon wandering behavior and a monitoring aide. A review of Resident 1's Elopement Monitoring Log, dated 3/23/2020 indicated the following: At 3 a.m. indicated Resident 1 attempted to leave the facility and was stopped by the Certified Nursing Assistant (CNA). At 3:15 a.m. Resident 1 was wandering around the hallways in the facility. At 3:30 a.m. Resident 1 was wandering around the hallways in the facility. At 3:45 a.m., Resident 1 was outside of the facility and a code green (an emergency code used denote the activation of an emergency plan; missing resident) was called. A review of an untimed Situation, Background, Assessment and Recommendation ((SBAR) an internal communication form), dated 3/23/2020 indicated Resident 1 eloped from the facility at 3:08 a.m. was returned back to the facility and placed on close monitoring. A review of the facility's investigative report, indicated after an observation of the facility's surveillance video, on 3/23/2020 at approximately at 3:03 a.m., Resident 1 was observed near Nursing Station 2 and entering the dining room. According to the facility's investigative report, on the same day at 3:09 a.m. Resident 1 was observed exiting from the facility's north gate, sounding the alarm on the gate. The investigative report indicated the staff reacted to the alarm, began searching the surrounding area at 3:12 a.m., and a few moments later Resident 1 was located. The report indicated on the same day at approximately 3:16 a.m., Resident 1 was returned to the facility. A review of Resident 1's History and Physical (H/P), dated 3/14/2020 indicated Resident 1 had a fluctuating capacity to understand and make decisions. On 3/23/2020 at 4:48 p.m., during an interview, Resident 1 stated a nurse took her out of the facility, was placed into a car and was kidnapped. Resident 1 stated she was outside of the facility for over three minutes. On 3/24/2020 at 9:57 a.m., during a telephone interview, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was an elopement risk, was being monitored for eloping and wore a wander guard bracelet on her right wrist. LVN 1 stated Resident 1 was ambulatory, did not require assistance with walking, but at times utilized a wheelchair. LVN 1 stated on [DATE] at 3:05 a.m. Resident 1 walked into the dining room and at the same time LVN 1 stated he was sitting at Nursing Station 1, when the wander guard alarm sounded off. LVN 1 stated he immediately went to the dining room and did not see Resident 1, but the sliding door that leads to the patio was open. LVN 1 stated Resident 1's wheelchair was observed at the gate of the facility that leads to the driveway. LVN 1 stated when Resident 1 trigger the door alarms it would be because she wanted a cigarette and was placed on an elopement monitoring. On 3/25/2020 at 10:38 a.m., during a concurrent observation of the facility's recorded surveillance video and interview with the facility's Vice President of Operations (VPO), the surveillance video indicated on 3/23/2020 at 3:03 a.m. Resident 1 walked pass Nursing Station 2 and entered the dining room. On the same day at 3:06 a.m., Resident 1 exited from the dining room through the sliding glass door to the outdoor patio while sitting in a wheelchair. On the same day at 3:08 a.m., Resident 1 exited the facility through a gate that lead to the driveway of the facility, simultaneously the staff began a search. On the same day at 3:12 a.m., a car was observed leaving from the facility's driveway, at 3:16 a.m. a car returned to the driveway of the facility and Resident 1 was escorted back into the facility by the staff. According to the VPO, Resident 1 was located at a car wash next door to the facility and Resident 1 stated she was following the smell of cigarettes. A review of the facility's surveillance video, Resident 1 was out of the facility for a total of eight (8) minutes from 3:08 a.m. to 3:16 a.m. On 3/25/2020 at 12 p.m., during a concurrent observation of Resident 1's monitoring log dated 3/23/2020 and interview, the Director of Nursing (DON) stated Resident 1's monitoring log indicated at 3 a.m. indicated Resident 1 attempted to leave the facility and was stopped by the Certified Nursing Assistant (CNA), at 3:15 a.m. Resident 1 was wandering around the hallways in the facility, at 3:30 a.m. Resident 1 was wandering around the hallways in the facility and at 3:45 a.m., Resident 1 was outside of the facility and a code green was called. The DON stated there were a discrepancy between the facility's surveillance video and Resident 1's monitoring log and was not sure why the Certified Nursing Assistant (CNA) documented the wrong times. The DON stated the CNA probably documented inaccurate became confused with the timing when Resident 1 attempted to leave the facility. A review of the facility's policy and procedure, dated 11/2018 and titled Wandering and Elopement, indicated wandering is going to one location to another aimlessly without a plan or definitive purpose. The purpose of the policy is to enhance the resident's safety. The policy indicated a person-centered approach/intervention to prevent and or divert wandering behavior will be included in the plan of care. The policy did not indicate how residents at risk for wandering or who had wandering behaviors would be monitored and supervised.

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.