STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056104	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE VILLA HEALTH CARE CENTER	**9028 ROSE STREET BELLFLOWER, CA 90706**

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 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's staff failed to provide oversight and monitoring for one of five sampled residents (Resident 1) resulting in an elopement (an act or instance of leaving a safe area or safe premises) from the facility. As a result of this deficient practice, Resident 1 eloped into the surrounding neighborhood unsupervised, and sustained a laceration to the forehead and a subarachnoid hemorrhage((SAH)bleeding in the space between the brain and the surrounding tissues that cover the brain) after a fall. As a result of the facility's system failure to provide oversight and monitoring Residents 2, 3, 4 and 5, were at risk for harm related to the resident's unsupervised wandering (traveling aimlessly from place to place) and/or elopement behavior(s) and at risk of not having safety needs met. Findings: A review of Resident 1's Admission Record indicated the resident was initially admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 1/13/20, indicated the resident had moderate cognitive (ability to process thoughts) impairment. A review of Resident 1's History and Physical, dated 1/7/20, indicated Resident 1 did not have the capacity to understand and make decisions and is diagnosed with [REDACTED]. During a telephone interview on 3/19/20 at 11:52 a.m., Resident 1's family member (FAM1) stated she received a telephone call from Licensed Vocational Nurse (LVN1) on 3/18/20 at 8:25 a.m FAM1 stated LVN1 informed her that Resident 1 had eloped from the facility, was found a couple of blocks away, and was taken to General Acute Care Hospital (GACH). FAM1 stated that during the initial meeting with the facility on 1/8/2020, she informed the Director of Nursing (DON) and the Social Service Director (SSD) of Resident 1's history of eloping from their residence on several occasions. During a telephone interview on 3/19/20 at 12:15 a.m., FAM1 stated she visits Resident 1 everyday and his sensor pad bed alarm only works intermittently. FAM1 stated there was no sensor pad alarm on Resident 1's wheelchair. During a concurrent observation and interview on 3/19/20 at 11:27 a.m., Maintenance Supervisor (MS1) stated the facility's front door alarm does not activate when exiting the facility. MS1 exited the facility and the door alarm did not activate. During an interview on 3/19/20 at 11:42 a.m., the DON stated Resident 1 does not have orders for a Wanderguard. DON stated the facility's front door alarm is only activated by Residents wearing a Wanderguard and the front door alarm will not activate for regular traffic. During a review of a video surveillance tape dated 3/18/20 and timed at 7:47 a.m. with Social Service Director (SSD), Resident 1 was observed exiting the facility through the facility's front door unsupervised. No receptionist was observed at the front desk located next to the facility's front door. SSD stated Someone is supposed to be at the receptionist desk at all times. I'm not sure why no one was there. During an interview on 3/19/20 at 12:55 p.m., the Receptionist (REC1) stated I start at 9:30 a.m. and there is no one at this desk from 7:00 a.m. to 9:00 a.m The front door is locked from the outside and the nurses monitor the front door from the nurse's station during this period. During an interview on 3/19/20 at 1:10 p.m., Certified Nursing Assistant (CNA1) stated Resident 1 is confused at times and must be redirected. CNA1 stated Resident 1 has orders for a sensor pad bed alarm and a sensor pad wheelchair alarm. CNA1 stated the charge nurse and herself are responsible for ensuring the bed alarms are turned on and functioning. CNA1 stated Resident1's bed alarm was not turned on at the beginning of her shift. CNA1 stated she forgot to check Resident 1's bed alarm because she was in a rush and there was so much going on. CNA1 stated she noticed Resident 1 not in his room at 7:45. CNA1 stated she notified LVN1 at this time. During a concurrent observation and interview on 3/19/20 at 3:47 p.m., LVN2 stated that Resident 1 had Dementia, was confused and forgetful, and needed reorientation many times. LVN2 stated Residents who have Dementia and are confused should be monitored for elopement. LVN2 stated Resident 1 was not monitored for elopement. LVN2 stated that the receptionist desk located at the front door is not staffed from 5:00 p.m. through 9:00 a.m LVN2 stated we monitor the front door from the nursing stations. LVN2 was escorted to nursing station 1 and nursing station 2 to demonstrate front door observation. LVN2 acknowledged she could not see the front door from nursing station 1 or nursing station 2. During an interview on 3/19/20 at 4:20 p.m., SSD stated she was in a meeting with FAM1, the DON, and the Case Manager (CM). SSD stated FAM1 may have mentioned Resident 1 leaving FAM1's house and FAM1 is concerned with Resident 1 being at home. SSD stated Resident 1 has Dementia and has episodes of confusion and forgetfulness. During a telephone interview on 3/23/20 at 1:36 p.m., LVN1 states Resident 1 had orders for sensor pad bed and wheelchair alarms. LVN1 states that he assumed Resident 1's bed alarm was turned on and he did not check the alarms when he started his shift at 7:00a.m. on 3/18/20. LVN1 acknowledged that Resident 1's bed alarm was not turned on at 7:42 a.m. on 3/18/20. LVN1 stated he was notified by F1 on 3/18/20 at 8:25 a.m. that Resident 1 was found in the street and was taken to GACH. A review of Resident 1's Elopement/Wandering Evaluation dated 1/6/20, timed at 6:56 p.m., indicated Resident 1's predisposing disease as Dementia (a condition characterized by decline in memory, problem solving skills, and other thinking skills that affect a person's ability to perform everyday activities) and indicated Resident1 has episodes of intermittent confusion. A review of Resident 1's Physician Orders, dated 2/29/20 and timed at 3:13 p.m., indicated an order for [REDACTED]. A review of FD1 Prehospital Case Report indicated on 3/18/20 at 8:01 a.m., Resident one was found sitting on the sidewalk with a laceration to his head. The Prehospital Case Report indicated Resident one was transported to GACH. A review of Resident 1's GACH Emergency Department (ED) notes dated 3/18/20 at 8:49 a.m. indicated Resident 1 was admitted to ED with [MEDICATION NAME] head trauma (head injury) and left [MEDICAL CONDITION] (wound produced by tearing of soft tissue). A review of Resident 1's Computed Tomography Scan (CT) performed by GACH, indicated a left frontal cortical hemorrhagic contusion (area of bleeding on surface of the brain). A review of the facility's Policy and Procedure (P & P) titled, Resident Rights. Abuse: Prevention of and Prohibition Against, revised 11/28/2017, indicated It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation. The policy also indicated The Facility will engage in training and orienting its new and existing nursing staff on topics which relate to the delivery of care in the post-acute setting. Topics of such training will include, but not be limited to: wandering or elopement type behaviors. The policy defines neglect as the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
F 0609 **Level of harm** - Actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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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F 0609 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview, and record review, the facility failed to report one of five-sampled residents (Resident 1) elopement to the Department of Public Health (DPH) within two (2) hours from the time the incident occurred. This deficient practice had the potential to place Residents 2, 3, 4 and 5, at risk for harm related to the resident's unsupervised wandering (traveling aimlessly from place to place) and/or elopement behavior(s). Findings: A review of Resident 1's Admission Record indicated the resident was initially admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 1/13/20, indicated the resident had moderate cognitive (ability to process thoughts) impairment. A review of Resident 1's History and Physical, dated 1/7/20, indicated Resident 1 did not have the capacity to understand and make decisions and is diagnosed with [REDACTED]. During a telephone interview on 3/19/20 at 11:52 a.m., Resident 1's family member (FAM1) stated she received a telephone call from Licensed Vocational Nurse (LVN1) on 3/18/20 at 8:25 a.m FAM1 stated LVN1 informed her that Resident 1 had eloped from the facility, was found a couple of blocks away, and was taken to General Acute Care Hospital (GACH). FAM1 stated that during the initial meeting with the facility on 1/8/2020, she informed the Director of Nursing (DON) and the Social Service Director (SSD) of Resident 1's history of eloping from their residence on several occasions. During a concurrent observation and interview on 3/19/20 at 11:27 a.m., Maintenance Supervisor (MS1) stated the facility's front door alarm does not activate when exiting the facility. MS1 exited the facility and the door alarm did not activate. During an interview on 3/19/20 at 11:42 a.m., the DON stated Resident 1 does not have orders for a Wanderguard. DON stated the facility's front door alarm is only activated by Residents wearing a Wanderguard and the front door alarm will not activate for regular traffic. During a review of a video surveillance tape dated 3/18/20 and timed at 7:47 a.m. with Social Service Director (SSD), Resident 1 was observed exiting the facility through the facility's front door unsupervised. No receptionist was observed at the front desk located next to the facility's front door. SSD stated Someone is supposed to be at the receptionist desk at all times. I'm not sure why no one was there. During an interview on 3/19/20 at 12:55 p.m., the Receptionist (REC1) stated I start at 9:30 a.m. and there is no one at this desk from 7:00 a.m. to 9:00 a.m The front door is locked from the outside and the nurses monitor the front door from the nurse's station during this period. During an interview on 3/19/20 at 1:10 p.m., Certified Nursing Assistant (CNA1) stated Resident 1 is confused at times and must be redirected. CNA1 stated she noticed Resident 1 not in his room at 7:45. CNA1 stated she notified LVN1 at this time. CNA1 stated If we notice a Resident missing, we are supposed to report the incident to our charge nurse and begin looking for the Resident. During a concurrent observation and interview on 3/19/20 at 3:47 p.m., LVN2 stated that Resident 1 had Dementia, was confused and forgetful, and needed reorientation many times. LVN2 stated Residents who have Dementia and are confused should be monitored for elopement. LVN2 stated Resident 1 was not monitored for elopement. LVN2 stated that the receptionist desk located at the front door is not staffed from 5:00 p.m. through 9:00 a.m LVN2 stated we monitor the front door from the nursing stations. LVN2 was escorted to nursing station 1 and nursing station 2 to demonstrate front door observation. LVN2 acknowledged she could not see the front door from nursing station 1 or nursing station 2. During an interview on 3/19/20 at 4:20 p.m., SSD stated she was in a meeting with FAM1, the DON, and the Case Manager (CM). SSD stated FAM1 may have mentioned Resident 1 leaving FAM1's house and FAM1 is concerned with Resident 1 being at home. SSD stated Resident 1 has Dementia and has episodes of confusion and forgetfulness. During an interview on 3/19/20 at 5:40 p.m., DON stated she did not report Resident 1's elopement on 3/18/20 to The Department of Public Health (DPH) because Resident 1 had already been located. DON stated she completed the State of California Report of Suspected Dependent Adult/Elder Abuse (SOC 341) today. During a telephone interview on 3/23/20 at 1:36 p.m.,. LVN1 stated he was notified by F1 on 3/18/20 at 8:25 a.m. that Resident 1 was found in the street and was taken to GACH. LVN1 stated he immediately notified the Administrator, DON, Physician, and Resident 1's family member. LVN 1 stated he did not notify DPH because It is not in my instructions to notify DPH. A review of the SOC 341 dated 3/19/20, indicated DON reported Resident 1's elopement to FAM1 and the local Ombudsman on 3/19/20. A review of Resident 1's Progress Note, dated 3/18/20, and timed at 12:32 p.m., indicated Licensed Vocational Nurse (LVN)1 documented at 8:25 a.m., F1 rang the facility doorbell and notified LVN1 that Resident 1 was found walking in the street with a wound to his head. F1 informed LVN1 he transported Resident 1 to GACH emergency room and notified Resident 1's daughter. A review of FD1 Prehospital Case Report indicated on 3/18/20 at 8:01 a.m., Resident one was found sitting on the sidewalk with a laceration to his head. The Prehospital Case Report indicated Resident one was transported to GACH. A review of Resident 1's GACH Emergency Department (ED) notes dated 3/18/20 at 8:49 a.m. indicated Resident 1 was admitted to ED with [MEDICATION NAME] head trauma (head injury) and left [MEDICAL CONDITION] (wound produced by tearing of soft tissue). A review of Resident 1's Computed Tomography Scan (CT) performed by GACH, indicated a left frontal cortical hemorrhagic contusion (area of bleeding on surface of the brain). A review of the facility's Policy and Procedure (P & P) titled, Elopement indicated the facility's policy does not include instructions to notify DPH within a specific time frame if the facility determines a Resident has eloped.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's staff failed to properly supervise one of five sampled residents (Resident 1) resulting in an elopement (an act or instance of leaving a safe area or safe premises) from the facility. As a result of this deficient practice, Resident 1 eloped into the surrounding neighborhood unsupervised, and sustained a laceration to the forehead and a subarachnoid hemorrhage((SAH)bleeding in the space between the brain and the surrounding tissues that cover the brain) after a fall. As a result of this deficient practice, the facility did not meet Resident 1's physical, mental, and psychosocial needs. Findings: A review of Resident 1's Admission Record indicated the resident was initially admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 1/13/20, indicated the resident had moderate cognitive (ability to process thoughts) impairment. A review of Resident 1's History and Physical, dated 1/7/20, indicated Resident 1 did not have the capacity to understand and make decisions and is diagnosed with [REDACTED]. During a telephone interview on 3/19/20 at 11:52 a.m., Resident 1's family member (FAM1) stated she received a telephone call from Licensed Vocational Nurse (LVN1) on 3/18/20 at 8:25 a.m FAM1 stated LVN1 informed her that Resident 1 had eloped from the facility, was found a couple of blocks away, and was taken to General Acute Care Hospital (GACH). FAM1 stated that during the initial meeting with the facility on 1/8/2020, she informed the Director of Nursing (DON) and the Social Service Director (SSD) of Resident 1's history of eloping from their residence on several occasions. During a telephone interview on 3/19/20 at 12:15 a.m., FAM1 stated she visits Resident 1 everyday and his sensor pad bed alarm only works intermittently. FAM1 stated there was no sensor pad alarm on Resident 1's wheelchair. During a concurrent observation and interview on 3/19/20 at 11:27 a.m., Maintenance Supervisor (MS1) stated the facility's front door alarm does not activate when exiting the facility. MS1 exited the facility and the door alarm did not activate. During an interview on 3/19/20 at 11:42 a.m., the DON stated Resident 1 does not have orders for a Wanderguard. DON stated the facility's front door alarm is only activated by Residents wearing a Wanderguard and the front door alarm will not activate for regular traffic. During a review of a video surveillance tape dated 3/18/20 and timed at 7:47 a.m. with Social Service Director (SSD), Resident 1 was observed exiting the facility through the facility's front door unsupervised. No receptionist was observed at the front desk located next to the facility's front door. SSD stated Someone is supposed to be at the receptionist desk at all times. I'm not sure why no one was there. During an interview on 3/19/20 at 12:55 p.m., the Receptionist (REC1) stated I start at 9:30 a.m. and there is no one at this desk from 7:00 a.m. to 9:00 a.m The front door is locked from the outside and the nurses monitor the front door from the nurse's station during this period. During an interview on 3/19/20 at 1:10 p.m., Certified Nursing Assistant (CNA1) stated Resident 1 is confused at times and must be redirected. CNA1 stated Resident 1 has orders for a sensor pad bed alarm and a sensor pad wheelchair alarm. CNA1 stated the charge nurse and herself are responsible for ensuring the bed alarms are turned on and functioning. CNA1 stated Resident1's bed alarm was not turned on at the beginning of her shift. CNA1 stated she forgot to check Resident 1's bed alarm because she was in a rush and there was so much going on. CNA1 stated she noticed Resident 1 not in his room at 7:45. CNA1 stated she notified LVN1 at this time. During a concurrent observation and interview on 3/19/20 at 3:47 p.m., LVN2 stated that Resident 1 had Dementia, was confused and forgetful, and needed reorientation many times. LVN2 stated Residents who have Dementia and are confused should be monitored for elopement. LVN2 stated Resident 1 was not monitored for elopement. LVN2 stated that the receptionist desk located at the front door is not staffed from 5:00 p.m. through 9:00 a.m LVN2 stated we monitor the front

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) door from the nursing stations. LVN2 was escorted to nursing station 1 and nursing station 2 to demonstrate front door observation. LVN2 acknowledged she could not see the front door from nursing station 1 or nursing station 2. During an interview on 3/19/20 at 4:20 p.m., SSD stated she was in a meeting with FAM1, the DON, and the Case Manager (CM). SSD stated FAM1 may have mentioned Resident 1 leaving FAM1's house and FAM1 is concerned with Resident 1 being at home. SSD stated Resident 1 has Dementia and has episodes of confusion and forgetfulness. During a telephone interview on 3/23/20 at 1:36 p.m., LVN1 states Resident 1 had orders for sensor pad bed and wheelchair alarms. LVN1 states that he assumed Resident 1's bed alarm was turned on and he did not check the alarms when he started his shift at 7:00a.m. on 3/18/20. LVN1 acknowledged that Resident 1's bed alarm was not turned on at 7:42 a.m. on 3/18/20. LVN1 stated he was notified by F1 on 3/18/20 at 8:25 a.m. that Resident 1 was found in the street and was taken to GACH. A review of Resident 1's Elopement/Wandering Evaluation dated 1/6/20, timed at 6:56 p.m., indicated Resident 1's predisposing disease as Dementia (a condition characterized by decline in memory, problem solving skills, and other thinking skills that affect a person's ability to perform everyday activities) and indicated Resident1 has episodes of intermittent confusion. A review of Resident 1's Physician Orders, dated 2/29/20 and timed at 3:13 p.m., indicated an order for [REDACTED]. A review of FD1 Prehospital Case Report indicated on 3/18/20 at 8:01 a.m., Resident one was found sitting on the sidewalk with a laceration to his head. The Prehospital Case Report indicated Resident one was transported to GACH. A review of Resident 1's GACH Emergency Department (ED) notes dated 3/18/20 at 8:49 a.m. indicated Resident 1 was admitted to ED with [MEDICATION NAME] head trauma (head injury) and left [MEDICAL CONDITION] (wound produced by tearing of soft tissue). A review of Resident 1's Computed Tomography Scan (CT) performed by GACH, indicated a left frontal cortical hemorrhagic contusion (area of bleeding on surface of the brain). A review of the facility's Policy and Procedure (P & P) titled, Resident Rights. Abuse: Prevention of and Prohibition Against, revised 11/28/2017, indicated the policy defines neglect as the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
F 0689 **Level of harm -** Immediate jeopardy **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's staff failed to ensure one of five sampled residents (Resident 1), who had a history of [REDACTED]. [REDACTED]. These deficient practices resulted in Resident 1 being found in the surrounding neighborhood, by a passerby, sitting on the sidewalk with a [MEDICAL CONDITION] (deep cut). The Fire Department was called, and the paramedics transferred Resident 1 to the general acute care hospital (GACH), and the resident was diagnosed with [REDACTED]. The facility had a system failure in providing supervision for a resident who was at risk for elopement due to unsupervised wandering (traveling aimlessly from place to place) behaviors. Resident 1, who was identified on a care plan as being at risk for harm related to the resident's episodes of going out of the facility unaccompanied, wandering (traveling aimlessly from place to place) and elopement behaviors. On 3/19/2020 at 5:25 p.m., the Administrator (ADM) and the Director of Nursing (DON), were notified 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), which was declared under F689. The facility's Administrator (ADMIN) and Director of Nursing (DON) were notified of the immediacy and seriousness to the resident's health and safety being threatened. On 3/20/2020 at 3:21 p.m., the facility submitted an acceptable Plan of Action (POA). The IJ was lifted on 3/20/2020 at 3:40 p.m., after the team verified and confirmed, while onsite, the POA was implemented through observation, interview and record review as follows: a. Staff in-service was conducted on 3/19/2020. All staff to be in-serviced by 3/21/2020. The in-service training included management of confused residents and residents with dementia at high risk for elopement/wandering and monitoring of functionality of Sensor Alarms and Tab Alarms. b. The DON/Designee will conduct an elopement drill for each shift on 3/20/2020. c. The facility initiated a binder at the receptionist desk that included photos, face sheets, and descriptions for each of the high-risk residents for staff awareness. d. The DON/Designee will conduct elopement drills every six months and the results will be taken to their monthly Quality Assurance (QA) Committee meetings for trending and recommendations. e. Ongoing education will continue with random testing on elopement procedures with focus on monitoring and supervision of residents that are at risk for elopement and unsafe wandering and the coordination of care amongst all staff providing care to facility residents. f. The DON/Designee will review all new resident admissions within 24 hours to identify any risk factors for elopement or unsafe wandering to ensure that all interventions to mitigate those risk factors have been care-planned and communicated to the staff. g. All residents will be assessed for elopement upon admission and assessed quarterly. h. The DON/Designee will ensure employees receive education related to elopement risk and management of high-risk residents upon hire and annually. i. The Maintenance Supervisor/Designee will check the Wander Guard (bracelet placed on residents that will alarm s when the resident is near an exit door) and door sensor functionality every week. j. The Licensed Nurses will monitor placement and function of each Wander Guard bracelet every shift and document on the treatment administration record (TAR). k. The Licensed Nurses will monitor placement and function of each Sensor and Tab Alarm every shift and document on the TAR. l. The Administrator will present a summary of all elopement related interventions to the QA Committee for review and recommendations monthly. Findings: A review of Resident 1's Admission Record indicated the resident was initially admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Elopement/Wandering Evaluation, dated 1/6/2020 and timed at 6:56 p.m. indicated Resident 1's predisposing disease of dementia indicated Resident 1 had episodes of intermittent confusion. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 1/13/2020 indicated the resident had moderate cognitive impairment. A review of Resident 1's History and Physical, dated 1/7/2020 indicated Resident 1 did not have the capacity to understand and make decisions and was diagnosed with [REDACTED]. A review of Resident 1's care plan, dated 1/6/2020 and titled, At Risk for falls related to dementia and difficulty in walking with episodes of going out of the facility unaccompanied. The staff's interventions included to anticipate the resident's need; keep call light in reach and encourage resident to use for assistance as needed; maintain the bed in the lowest position and use an alarm device in the resident's bed and wheelchair. A review of Resident 1's Physician Orders, dated 2/29/2020 and timed at 3:13 p.m., indicated an order for [REDACTED]. know Resident 1. The Fireman informed the charge nurse that Resident 1 was transferred to the general acute care hospital (GACH). A review of Resident 1's Prehospital Care Report (Fire department/paramedics report) indicated on 3/18/2020 at 7:55 a.m., they were dispatched and arrived at the scene at 8:01 a.m. The report indicated Resident 1 was found by a passerby sitting on the sidewalk with a laceration over the left eye and was transported to the nearest trauma center. The chief complaint was documented as [MEDICATION NAME] traumatic injury and the resident's vital signs (blood pressure, heart rate, respirations) were within normal limits (WNLs). A review of Resident 1's GACH Emergency Department (ED) notes dated 3/18/2020 and timed at 8:49 a.m. indicated Resident 1 was admitted to ED with [MEDICATION NAME] head trauma ((BHT) head injury) with a left [MEDICAL CONDITION] with pain radiating to the head. The history and physical (H/P) indicated Resident 1 was found down near a convalescent facility with confusion but was able to follow simple commands. Resident 1 had a Computed Tomography Scan ((CT)) use of combination of x-rays and computer images to see inside the body) performed at the GACH, which showed a left-sided scalp and forehead skin swelling and hematoma (a localized swelling filled with blood caused by a break in the wall of a blood vessel) and a left frontal cortical hemorrhagic contusion (area of bleeding on surface of the brain). The H/P indicated Resident 1's scalp laceration was repaired, and wound closure done in the ED. A review of Resident 1's Nurse's Progress Note, dated 3/18/2020 and timed at 12:32 p.m., indicated Licensed Vocational Nurse (LVN 1) documented at 8:25 a.m., a fireman (F1) rang the facility's doorbell and notified LVN 1, Resident 1 was found in the street with a wound to his head. LVN 1 documented F1 informed LVN 1, Resident 1 was transported to a GACH's emergency room and Resident 1's family member was notified. On 3/19/2020 at 11:27 a.m., during a concurrent observation and interview, the facility's Maintenance Supervisor (MS) stated the facility's front door alarm does not activate when exiting the facility. On observation, the MS exited the facility's door and the door alarm did not activate. On 3/19/2020 at 11:52 a.m., during a telephone interview, Resident 1's family member (FM 1) stated she received a telephone call from LVN 1 on 3/18/2020 at 8:25 a.m. informing her that Resident 1 had eloped from the facility and was found a couple of blocks away from the facility and was taken to a GACH. FM 1 stated during her initial meeting with the facility on 1/8/2020, she informed the DON and the Social Service Director (SSD) of Resident 1's history of eloping from their residence on several occasions. FM 1 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056104	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE VILLA HEALTH CARE CENTER	**9028 ROSE STREET BELLFLOWER, CA 90706**

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 **Residents Affected -** Few	(continued... from page 3) visited Resident 1 every day and his sensor pad bed alarm only worked intermittently (sometimes) and there was no sensor pad alarm on Resident 1's wheelchair. On 3/19/2020 at 11:42 a.m., during an interview, the DON stated Resident 1 does not have orders for a Wander Guard (an electronic device that will activate near a door with the sensor). The DON stated the facility's front door alarm would only be activated by residents wearing a Wander Guard and the front door alarm will not activate for regular traffic. A review of the facility's video surveillance dated 3/18/2020 and timed at 7:47 a.m., with the SSD, Resident 1 was observed exiting the facility through the facility's front door unsupervised. There was no receptionist observed at the front desk located next to the facility's front door. The SSD stated Someone is supposed to be at the receptionist desk at all times. I'm not sure why no one was there. On 3/19/2020 at 12:55 p.m., during an interview, the facility's receptionist stated, I start at 9:30 a.m. and there is no one at this desk from 7 a.m. to 9 a.m. The front door is locked from the outside and the nurses monitor the front door from the nurse's station during that period. On 3/19/2020 at 1:10 p.m., during an interview, Certified Nursing Assistant 1 (CNA1) stated Resident 1 was confused at times and had to be redirected. CNA1 stated Resident 1 had orders for a sensor pad bed alarm and a sensor pad wheelchair alarm. CNA1 stated she and the charge nurse were responsible for ensuring the bed alarms were turned on and functioning. CNA1 stated Resident 1's bed alarm was not turned on at the beginning of the shift. CNA1 stated she forgot to check Resident 1's bed alarm because she was in a rush and there was so much going on. CNA1 stated she noticed Resident 1 was not in his room at 7:45 a.m. on 3/18/2020 and she notified LVN 1 at that time. On 3/19/2020 at 3:47 p.m., during a concurrent observation and interview, LVN 2 stated Resident 1 had dementia, was confused and forgetful, and needed reorientation many times. LVN 2 stated residents who had dementia and are confused should be monitored for elopement. LVN 2 stated Resident 1 was not monitored for elopement. LVN 2 stated the receptionist desk located at the front door was not staffed after 5 p.m. daily until the next morning. LVN 2 stated, We monitor the front door from the nursing stations. LVN 2 went to Nursing Stations 1 and 2 to demonstrate how she could view the front door. LVN 2 acknowledged she could not see the front door from Nursing Station 1 or 2. On 3/19/2020 at 4:20 p.m., during an interview, the SSD stated she participated in the initial meeting with FM 1, the DON, and the Case Manager (CM). The SSD stated FM 1 May have mentioned the resident (Resident 1) leaving FM 1's house and FM 1 is concerned with Resident 1 being at home. The SSD stated Resident 1 had dementia and had episodes of confusion and forgetfulness. On 3/23/2020 at 1:36 p.m., during an interview, LVN 1 stated Resident 1 had orders for sensor bed pad and wheelchair alarms. LVN 1 stated he assumed Resident 1's bed alarm was turned on and he did not check the alarms when he started his shift at 7 a.m. on 3/18/2020 (the day of elopement). LVN 1 acknowledged Resident 1's bed alarm was not turned on at 7:42 a.m. on 3/18/20. LVN 1 stated he was notified by a fireman on 3/18/2020 at 8:25 a.m. that Resident 1 was found in the street and was taken to a GACH. A review of the facility's undated Policy titled, Elopement-Policy and Assessment/Prevention, under procedures indicated Assessment and Identification of Wandering Residents and the importance of obtaining the history of behaviors, including wandering; will be obtained prior to admission. This can be accomplished during the pre-admission inquiry from family, hospital records, or physician's history.