STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND PARK CONVALESCENT HOSPITAL	**2312 WEST 8TH STREET LOS ANGELES, CA 90057**

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe environment for one of three sampled residents (Resident 1,) who required staff supervision due to periodically confused mental status. This deficient practice resulted in R1 wandering out of the facility and out in into the community, where she stayed for an entire night. Findings: A review of the Admission Record indicated R1 was a [AGE] year-old female, admitted to the facility with a history of dementia on 8/6/20 with a medical history of [REDACTED]. A review of R1's Minimum Data Set (a tool for resident assessment) dated 8/14/20, indicated the facility staff had assessed and documented the mental status of R1 as cognitively intact. A review of R1's SBAR Communication Form and Progress Note, dated 8/15/20 at 9:30 pm, indicated the facility staff noticed that R1 as missing and searched the facility building and premises, notified 911, the physician for R1 and the responsible party for R1. A review of R1's Licensed Nurses Progress Notes, dated 8/16/20 at 7 am, indicated, at 7 am on 8/16/20, the facility did not know the location or status of R1 and at 7:25 am on 8/16/20 the daughter of R1 called and informed the facility that she has a tracking device on the cell phone of R1 and informed the facility of the location. The facility sent staff to find and bring R1 back to the facility. At 8:45 am, the facility staff and R1 arrived back at the facility and the facility staff assessed and documented R1 as safe, stable condition. Body check done and informed the responsible party of R1 of her return and condition. A review of R1's Resident Care Plan, dated 8/16/20, indicated R1 was at risk for elopement and a Care Plan for Wandering behavior/going of the facility unattended. During an observation and concurrent interview on 8/28/20 at 3:10 pm, R1 was sitting up in her bed in her room, watching television without signs of distress. R1 stated, I am very good, thank you. The DON stated R1 mainly speaks Cantonese but sometimes speaks clear English in short sentences. During an observation and concurrent interview on 8/28/20 at 3:15 pm, all of the doors of the facility were closed and the main entrance had a staff member seated at a desk that checks the temperatures of all visitors and staff upon entry and exit to the facility. There was a high fence that surrounds the facility premises that had two gates, both of which were locked and did not open when shaken or pushed. The DON stated R1 eloped from the facility by dressing in all white, similar to the kitchen staff and when the kitchen staff was leaving the kitchen in a group to leave for the day, R1 joined in their group and left the facility with them. During an interview on 9/3/20 at 1:20 pm, the DON stated that R1 had periodic confusion and that for R1 to wander out of the facility without supervision was dangerous and had the potential to result in R1 being seriously injured and dying. The DON acknowledged that R1 could have wandered into a street and been hit by a car, assaulted by another person, fallen and sustained an injury and R1 could have been unable to seek help due to her periodic confusion. During an interview on 9/3/20 at 4:45 pm, Family Member 1, stated she was very very worried and scared for Resident 1. We looked and looked and looked for her and we didn't sleep. It was a terrible ordeal. A review of the facility's policy and procedure titled, Elopements, undated, indicated if an employee observes a resident leaving the premises, he/she should attempt to prevent the departure in a courteous manner; get help from other staff members in the immediate vicinity, if necessary.

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.