STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055862	A. BUILDING _____ B. WING _____	04/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROSE GARDEN HEALTHCARE CENTER	1899 N RAYMOND AVE PASADENA, CA 91103

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 0636 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately reflect mental assessment on the minimum data set (MDS, a standardized assessment and care-screening tool) for one of five sampled residents (Resident 1). This deficient practice resulted in inaccurate assessment and placed the resident at risk for not receiving personalized care as needed. Findings: A review of Resident 1's Admission Record indicated the facility initially admitted the resident on 12/24/19 and readmitted the resident on 2/3/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 12/31/19, indicated Resident 1 was able to repeat three words, and state correct year, month, and day, and able to recall three words. The MDS indicated the resident needed one-person physical support when walking and transferring and is steady walking and turning around. A review of Resident 1's Wandering Risk Assessment form dated 2/4/2020 at 7:52 a.m. with Licensed Vocational Nurse 2 (LVN 2), indicated Resident 1 had early dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with daily life) and was forgetful with short attention span. During a telephone interview on 2/21/2020 at 7:47 a.m., LVN 5 stated Resident 1 based on the Wandering Risk Assessment form dated 2/4/2020 at 7:52 a.m., the resident was confused but alert to name, date. LVN 5 stated the resident does not understand his overall medical condition nor able to make decisions. LVN 5 stated Resident 1 needed reminders to perform and complete activities of daily living (shower, grooming and hygiene). LVN 5 stated the Admission Assessment record dated 2/7/2020, indicated Resident 1 was alert to person and disoriented to place and time. LVN 5 stated for the MDS assessment, she reviewed Resident 1's [DIAGNOSES REDACTED]. LVN 5 stated the purpose for MDS assessment was to develop a plan of care and provide personalized resident care for Resident 1.
F 0689 **Level of harm -** 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: 1. Properly supervise Resident 1 who had a history of [REDACTED]. 2. Ensure Resident 1 was using a wander guard (a tracking device worn by residents designed to prevent them from leaving a facility unaccompanied) and initiate and update a care plan for wandering behavior to prevent the resident from eloping from the facility. Resident 1, who did not have the capacity to make decisions, eloped from the facility on 2/14/2020 at 1:32 p.m. On 2/14/2020 at 1:55 p.m., a Good Samaritan (GS) notified a facility staff that Resident 1 fell on the sidewalk, in front of a church, one mile away from the facility. This deficient practice resulted in Resident 1 sustaining an abrasion (scraping or wearing something away) on the left elbow, a laceration (a deep cut or tear in skin) on the left eyebrow, swelling and discoloration (change in color of the skin) below the left eye. Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) on the same day for further evaluation and treatment. Findings: A review of Resident 1's Admission Record indicated the facility initially admitted the resident on 12/24/19 and was readmitted the resident on 2/3/2020, with [DIAGNOSES REDACTED]. A review of Resident 1's care plan initiated on 12/25/2019 and revised on 2/14/2020 indicated the resident was at risk for wandering/elopement. The goals were for Resident 1 to have no episode of wandering/elopement and no injury. The care plan interventions included for staff to identify time of day wandering/elopement attempts occur. The interventions did not indicate how facility staff would monitor Resident 1 in the facility. A review of Resident 1's History and Physical (H&P), dated 12/26/2019, indicated the resident had no capacity to make decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 12/31/19, indicated Resident 1 was able to repeat three words, and state correct year, month, day and able to recall three words. However, Resident missed some part/intent of message but comprehended most conversation, and had difficulty communicating some words or finishing thoughts but able if prompted or given time. The MDS indicated the wandering, placed Resident 1 at risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility). The MDS indicated Resident 1 required one-person physical assist for walking and transferring, and did not use a wheel chair or walker for mobility. A review of Resident 1's Fall Risk Assessment, dated 2/3/2020, indicated the resident was assessed as high risk for fall with a score of 10 (a score of 10 or greater considered at high risk for potential falls). A review of Resident 1's Wandering Risk Assessment, dated 2/4/2020, indicated the resident had early dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with daily life) with short attention span and was forgetful. The assessment indicated Resident 1 received antipsychotic medications (medication for mental illness) and the facility admitted the resident within the last month. The assessment indicated Resident 1 was at risk for wandering. A review of the facility's undated policy titled, Wandering, Unsafe Resident, indicated the facility would identify residents at risk for harm because of unsafe wandering including elopement. The policy indicated staff would assess at risk individuals for potentially correctable risk factors to maintain safety. The resident care plan would indicate the resident is at risk for elopement or safety issue with interventions to maintain the resident's safety including a detailed monitoring plan. A review of the facility's video footage, dated 2/14/2020, with the Medical Records (MR) staff and the Director of Nurses (DON), indicated Resident 1 was standing near the exit door, was passed by CNA 4, and CNA 5 passed by Resident 1 on the hallway. A staff was standing on Station West hallway at station. The video footage indicated Resident 1 exited the facility using the exit door near Station West on 2/14/2020 at 1:32 p.m. A review of GACH's Emergency Documentation, dated 2/14/2020, indicated Resident 1 was somewhat inappropriate verbally during neurologic assessment. A review of the Nurses' Progress Notes, dated 2/14/2020, timed at 1:35 p.m. with LVN 2 indicated Resident 1 was not found in the facility. The notes indicated a GS notified a facility's staff (unidentified male staff) that Resident 1 fell on the sidewalk and was bleeding. The notes indicated Resident 1 hit his head on the sidewalk sustaining a left eye laceration measuring 2 centimeters (cm) x 0.5 cm, left lower eye discoloration, and left elbow abrasion measuring 1 cm x 0.7 cm. The notes indicated Resident 1 was transferred to GACH 1 on 2/14/2020 at 6:26 p.m. for further evaluation. During an interview on 2/14/2020 at 9:38 p.m., Licensed Vocational Nurse 1 (LVN 1) stated the facility readmitted Resident 1 from the same GACH 1, two weeks ago. LVN 1 stated Resident 1 was oriented to name, place, Responsible Party 1's (RP 1) name, but the resident was forgetful. LVN 1 stated the resident wandered around the facility frequently. LVN 1 stated any new admitted /readmitted residents including Resident 1 are at risk for elopement due to new environment and unfamiliar staff. LVN 1 stated Resident 1 needed monitoring for elopement on the initial admitted d 12/24/19 and did not know why. During an interview on 2/14/2020 at 10:31 p.m., Certified Nurse Assistant 2 (CNA 2) stated in the past, when I took care of Resident 1, LVN 1 instructed her to monitor Resident 1 due to the resident was a wanderer and he wanted to leave the facility. A

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) review of GACH 1's Emergency Department Report dated 2/14/2020 indicated Resident 1 sustained a mechanical fall where he fell forward hitting his left face. The resident denied loss of consciousness and no pre-[MEDICAL CONDITION] symptoms (consisting of lightheadedness, muscular weakness, blurry vision, and feeling faint). The report indicated Resident 1 had a left elbow contusion, left arm abrasion, and periorbital ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising). The resident was taking Eliquis (blood thinner medication that can cause bleeding). A review of GACH 1's Visit Information dated 2/15/20 indicated Resident 1's [DIAGNOSES REDACTED]. A review of the GACH 1's Computerized Tomography (CT, special x-ray tests that produce cross-sectional images of the body) of Resident 1 head, dated 2/15/2020 at 12:13 a.m., indicated bilateral mastoid (bone in the ears) and middle ears effusions (abnormal fluid collection), and no acute (sudden) intracranial (inside the head) process (no findings/no changes). A review of Resident 1's Admission/Readmission Data Collection, dated 2/15/20 indicated, the facility readmitted the resident to the facility from GACH 1 on 2/15/20 at 2:58 a.m. with [DIAGNOSES REDACTED]. Resident 1 had left elbow abrasion, measuring 1 cm and 0.7 cm, swelling and discoloration on the left lower eyelid, and left eyebrow laceration, measuring 2 cm by 0.5 cm. During an interview on 2/15/2020 at 12:05 p.m., LVN 3 stated Resident 1 was alert and oriented to person but not to place. LVN 3 stated Resident 1 wandered around the facility and often asked staff to make phone calls to RP 1. LVN 3 stated prior to Resident 1's elopement, the resident verbalized that he wanted to visit RP 1. During an observation on 2/15/2020 at 12:31 p.m., Resident 1 was wearing a wander guard bracelet and was standing near the main entrance door. Resident 1 was walking slowly with a waddle gait (walk with short steps and a clumsy swaying motion). Resident 1 had dressing on the left eyebrow with discoloration and swelling below the left eye. During a concurrent interview, Resident 1 stated he tried to look for RP 1 and went on a job search, but he fell on a concrete sidewalk. Resident 1 stated he was hurt due to the fall and now he has mild pain. During a telephone interview on 2/15/2020 at 12:59 p.m., the GS stated on 2/14/2020 at around 2:05 p.m., she heard someone say Help, Help and saw Resident 1 on the sidewalk in front of a church. The GS stated she walked with Resident 1 to her house and placed a towel to the resident's left eye to stop the bleeding. The GS stated Resident 1 complained of dizziness so she sat the resident on a chair. The GS stated Resident 1's bracelet indicated the resident was at the facility so she contacted the facility and facility's staff picked up the resident up within 10 minutes. A review of a map for a walking direction indicated the distance from the facility to the church, where Resident 1 fell , was one mile and 19 minutes' walk. During a concurrent interview and review of Resident 1's wandering/elopement care plan, dated 12/25/2019, and the facility's policy, titled Wandering, Unsafe Resident, with the DON on 2/15/2020, at 1:06 p.m., she stated the staff was not monitoring Resident 1. The DON stated Resident 1, who was at risk for fall, has [DIAGNOSES REDACTED]. A review of the facility's policy and procedures titled, Safety and Supervision, revised in 7/2017, indicated the care team shall target interventions to reduce resident individual risks related to hazards in the environment, including adequate supervision. The policy includes monitoring the effectiveness of interventions by ensuring interventions were implemented correctly and consistently, and that resident risks and environmental hazards included unsafe wandering. A review of the facility's undated policy titled Wander Guard System, indicated the purpose was to provide a safe mechanism for residents who are at risk for wandering, eloping and /or exit-seeking a safe environment, and to initiate a 1:1 supervision until a wander guard device is placed on the resident.