STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK AVENUE HEALTHCARE & WELLNESS CENTER	**1550 NORTH PARK AVENUE POMONA, CA 91768**

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 interview and record review, the facility failed to provide adequate supervision for one of three sampled residents (Resident 1), who was mentally confused, a high risk for elopement (leaving without being observed or staff's knowledge of departure), and left the facility three times alone. This deficient practice placed the resident at a high risk for possible injury due to leaving the facility in a confused state of mind and being reported to the police as missing. Findings: A review of Resident 1's Face Sheet indicated the resident was admitted to the facility on [DATE], with the admitting [DIAGNOSES REDACTED]. A review of Resident 1's Elopement Risk Assessment Form dated 12/27/19, indicated, Resident 1 was identified as a high risk for elopement due to periods of confusion and able to walk on his own. The Interdisciplinary Team (IDT-a group of healthcare providers from different fields who work together or toward the same goal to provide the best care or best outcome for a patient or group of patients) recommended securing the unit secondary to Resident 1's increased risk of elopement. A review of a Minimum Data Set (MDS- a standardized assessment and care-screening tool), dated 1/3/2020, indicated the resident (Resident 1) had difficulty communicating some words or finishing thoughts, and understands most conversations. Resident 1 required limited assistance with staff providing guidance for dressing, bathing, transferring and ambulation. A review of Resident 1's care plan titled, Continuous Pacing (walked out to parking lot), dated 1/9/2020, indicated interventions were to have a psychiatric consult and to keep resident away from the doors, and have hallway monitors to be aware of Resident 1's location. A review of Resident 1's care plan titled, Attempted To Leave The Facility Ground, dated 2/4/2020, indicated, interventions included to monitor every 30 minute rounds to ensure whereabouts of Resident 1. Ensure the staff are monitoring doorway exits when workers are on the unit. A review of Resident 1's Monitor the Resident Every Half Hour Sheet dated 2/7/2020, indicated Resident 1 was monitored by staff at 6:30 p.m., and there was no entry in the log at 7 p.m. A review of the Change of Condition form, dated 2/7/2020, indicated at 7 p.m., the Certified Nursing Assistant (CNA) was unable to find Resident 1. At 7: 30 p.m., the police were notified. At 9:23 p.m., Resident 1's daughter called and notified the facility Resident 1 was found and taken to La Puente Police Department. At 10:19 p.m., Resident 1 was returned to the facility and assessed with [REDACTED]. On 2/4/20, Resident 1 was found outside the facility. The resident (Resident 1) was confused and stated he wanted to see someone, then he said something about an appointment. The resident was paced on 30 minute observation. On 3/20/20, at 1:48 p.m., during an interview with the Director of Nurses (DON) he stated, Resident 1 left the facility and walked outside alone on three separate occasions without supervision. On 1/9/2020, Resident 1 walked out the locked unit, without supervision, and was found outside in the facility's parking lot. On 2/4/2020, Resident 1 walked out the locked unit, for the second time, without supervision and was found in the facility's parking lot. On 2/7/2020, Resident 1 walked out the facility unnoticed by staff for the third time. Resident 1 could not be found and the local police department was notified. The police found Resident 1 in the city of La Puente, California, about 15 miles away from the facility. On 5/4/20, at 11:30 a.m., during an interview with the DON, he was notified of the findings. A review of the facility's policy and procedure (P&P) titled, Wander & Elopement (undated), indicated, The facility will identify residents at risk for elopement and minimize injury as a result of the elopement. The interdisciplinary Team (IDT) will develop a plan of care considering the individual risk factors of the resident. Specific cues to which the resident may respond to divert wandering behavior will be included on the care plan.

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.