STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055078	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWAY HILLS NURSING & REHABILITATION	**7760 PARKWAY DRIVE LA MESA, CA 91942**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently implement care plan interventions related to wandering (when a person move from place to place without purpose) to avoid elopements (when a person leaves a safe area without anyone being aware) for one of three residents (1), reviewed for wandering behavior. As a result, Resident 1 was located by police five hours later lying in a 15-foot ravine. Findings: Resident 1 was admitted on [DATE], with diagnoses, which included dementia (memory loss with impaired reasoning), per the facility's Admission Record. On 2/10/20, Resident 1's clinical record was reviewed: Resident 1's quarterly Minimal Data Set (MDS-an assessment tool) dated 1/14/20, had a cognitive assessment (mental processes of perception, memory, judgment, and reasoning), score of 00, indicating Resident 1 was severely impaired. Resident 1's Wandering/Elopement Risk Assessment, dated 7/12/19, was reviewed. Licensed Nurse 4 (LN) documented Resident 1's elopement risk score at a 6, which indicated the resident had moderate risk for wandering and elopement. According to the facility's Interdisciplinary Team (IDT) meeting, dated 1/15/20 at 11:22 A.M., Resident 1 had exit seeking behavior and was found on 1/14/20 at 3:45 P.M. sitting on the ground in the facility's parking lot. Resident 1 told staff she was waiting for her children to arrive from school. Resident 1 had abrasions on both knees and a small bruise on her right shin. The IDT recommended an intervention of Q (every) 1 hour monitoring to be added to a current care plan, titled Altered Behavioral Symptoms, dated 7/15/19, .Wandering episodes/exit seeking behavior manifested by saying that she needs to pick up her children from school. Resident 1's reassessment for Wandering/Elopement Risk, dated 1/15/20, was reviewed. LN 3 documented Resident 1's elopement risk score at a 12, which indicated the resident was at high risk for wandering and elopement. Resident 1's nursing Progress Notes were reviewed. LN 3 documented on 2/7/20 at 1:10 P.M., around 11:55 A.M., CNA (certified nursing assistant) notified writer that unable to locate resident .Missing person report filed . LN 3 documented on 2/7/20 at 2:57 P.M., police located Resident 1, and the resident was being transported to the hospital for evaluation. Resident 1's Q 1 hour Check forms were reviewed from 1/16/20 through 2/7/20. Resident 1's visual hourly checks were not documented on: 1/16/20 from 6 P.M. through 11:30 P.M. 1/28/20 from 12 A.M. through 6:30 A.M. 2/5/20 from 12 A.M. through 6:30 A.M. 2/7/20, Resident 1 was last checked at 9:30 A.M. and the remaining form was blank. On 2/10/20 at 1:26 P.M., an interview was conducted with the Director of Social Services (DSS). The DSS stated Resident 1 had eloped once before. The DSS stated the facility did not use wander guards (a bracelet tracking device that alarms when a person tries to leave a certain area). On 2/10/20 at 1:58 P.M., an interview and record review was conducted with LN 3. LN 3 stated Resident 1 had tried to leave the facility before, but the resident was always stopped by staff before exiting the building. LN 3 reviewed Resident 1's one-hour check documents and stated, the one-hour visual checks were not done consistently and they should have been. On 2/10/20 at 2:41 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the facility was to conduct one-hour checks on Resident 1 indefinitely, until she could be placed in a more secure setting. The DON stated it was not right that there were gaps in the hourly checks, because it indicated no one was monitoring Resident 1. The DON stated Resident 1 eloped and was at risk of injury, because the plan of care had not been consistently implemented. On 2/20/20 at 1:54 P.M., a phone interview was conducted with CNA 2. CNA 2 stated she was responsible for monitoring Resident 1 on 2/7/20. CNA 2 stated she last saw Resident 1 after 9:00 A.M., sitting near the nurse's station. CNA 2 stated she kept Resident 1's hourly check document at the nurse's station, for a reminder. CNA 2 stated around 10 A.M. she took her lunch break and the LNs had always completed the form when she was busy with other residents or on her breaks. CNA 2 stated sometime after 11:30 A.M. she realized she had not seen Resident 1 and she started searching. CNA 2 stated when Resident 1 could not be located, she notified the charge nurse. On 2/28/20 at 10 A.M., a telephone interview was conducted with police officer 5 (PO 5). PO 5 stated the facility waited three hours to report Resident 1 missing. PO 5 stated Resident 1 was located approximately five hours after she was last seen by staff at the facility. PO 5 stated Resident 1 was located lying head first down a steep 15-foot ravine, after being located by the police helicopter. PO 5 stated Resident 1 was dressed in pajamas, and was incoherent when found. PO 5 stated paramedics responded and Resident 1 was transported to the hospital. According to the facility's policy, titled Safety and Supervision of Residents, dated July 2017, Individualized Resident-Centered Approach to Safety .3. The care team shall target interventions to reduce individual risk . 4. Implementing interventions .a. Communicating specific interventions to all relevant staff; .d. Ensuring the interventions are implemented .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a person-centered care plan to address an actual elopement (when a person leaves a safe area without anyone being aware) for one of three residents (Resident 1) reviewed for wandering behavior (when a person move from place to place without purpose). As a result, Resident 1 eloped for a second time and required hospitalization after being located down a ravine five hours later. Findings: Resident 1 was admitted on [DATE] with diagnoses, which included dementia (memory loss with impaired reasoning), per the facility's Admission Record. On 2/10/20, Resident 1's clinical record was viewed: Resident 1's quarterly Minimal Data Set (MD'S-an assessment tool) dated 1/14/20, had a cognitive assessment (mental processes of perception, memory, judgment, and reasoning), score of 00, indicating Resident 1 was severely impaired. Resident 1's Wandering/Elopement Risk Assessment, dated 7/12/19, was reviewed. Licensed Nurse 4 (LN) documented Resident 1's elopement risk score at a 6, which indicated the resident was at moderate risk for wandering and elopement. According to the facility's Interdisciplinary Team (IDT) meeting, titled Fall Committee Note, dated 1/15/20 at 11:22, Resident 1 had exit seeking behavior and was found on 1/14/20 at 3:45 P.M. sitting on the ground in the facility's parking lot. Resident 1 told staff she was waiting for her children to arrive from school. Resident 1 had abrasions on both knees and a small bruise on her right shin. The IDT recommended one intervention of Q (every) 1 hour monitoring to be added to a current care plan, titled Altered Behavioral Symptoms, dated 7/15/19, .Wandering episodes/exit seeking behavior manifested by saying that she needs to pick up her children from school. Resident 1's Wandering/Elopement Risk Assessment, dated 1/15/20, was reviewed. LN 3 documented Resident 1's elopement risk score at a 12, which indicated the resident was at a high risk for wandering and elopement. There was no care plan that had been developed for elopement. Resident 1's Progress Notes were reviewed. LN 3 documented on 2/7/20 at 1:10 P.M., around 11:55 A.M., CNA (certified nursing assistant) notified writer that unable to locate resident .Missing person report filed . LN 3 documented on 2/7/20 at 2:57 P.M., local police located Resident 1, who was being transported to

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the hospital for evaluation. On 2/19/20 at 2:48 P.M., an interview was conducted with LN 4, who was listed as a member of Resident 1's Fall IDT meeting on 1/15/20. LN 4 stated Resident 1 had attempted to leave the facility before, but was always re-directed prior to exiting. LN 4 stated the IDT meeting should have focused more on interventions specific for elopement and dementia behavior. LN 4 stated if they had developed a care plan for elopement, related to dementia, more interventions would have been developed and implemented. On 2/19/20 at 2:35 P.M., an interview and record review was conducted with LN 3. LN 3 stated she participated in Resident 1's IDT Fall Committee meeting on 1/15/20. LN 3 stated Resident 1 had attempted to leave before, but was always stopped. LN 3 stated the IDT note should have been titled Elopement, not falls, because the fall was the result of an elopement. LN 3 stated Resident 1's care plan for wandering should have been revised to read elopement. LN 3 stated Resident 1's care plan was not person-center focused to address the specific issue of elopement and adequate interventions were not developed. According to the facility's policy, titled Care Plan, Comprehensive Person-Centered, dated December 2016, The Interdisciplinary Team (IDT), .develops and implements a comprehensive, person-centered care plan . 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of the disciplinary process .