STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555816	A. BUILDING _____ B. WING _____	**05/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAWNDALE HEALTHCARE & WELLNESS CENTRE LLC	**15100 S PRAIRIE LAWNDALE, CA 90260**

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 observation, interview, and record review, the facility failed to provide adequate monitoring and supervision for one of three sampled residents (Resident 1). Resident 1 who was assessed with [REDACTED]. This deficient practice resulted in the elopement of Resident 1 which placed the resident at risk for serious harm, injury, impairment, or death. Findings: On 11/7/19 at 10: 00 a.m., an unannounced visit was made to the facility to investigate a facility reported incident regarding Resident 1 who eloped from the facility and was found at a General Acute Care Hospital emergency room , 15 miles away from the facility. A review of Resident 1's Admission Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 10/22/19, indicated Resident 1's cognition (process of acquiring knowledge and understanding) was moderately impaired. The MDS indicated Resident 1 required extensive assistance with two person physical assist for transferring and extensive assistance with one person physical assist for dressing, toilet use and personal hygiene. The MDS indicated Resident 1 was not steady and only able to stabilize with staff assistance when walking, turning around and with surface to surface transfer. The MDS indicated Resident 1 was using a walker and wheelchair as mobility device. A review of the history and physical examination [REDACTED]. During an interview with the facility's Director of Nurses (DON) on 11/7/19 at 10:23 a.m., DON stated, staff were to monitor and supervise each resident every two hours. DON stated that at the time of elopement, there was no alarm that went off to alert the staff that Resident 1 eloped from the facility. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 11/7/19 at 10:29 a.m., LVN 1 stated that the facility does use wanderguard, but at the time of elopement of Resident 1, the wanderguard alarm system on the facility entrance door was not operational. During an interview with the facility's Director of Staff Development (DSD) on 11/7/19 10:45 a.m., DSD stated nursing staff were trained to monitor and supervise residents every 2 hours. DSD stated, Certified Nursing Assistants (CNAs) were trained to identify residents who were at risk for elopement. DSD stated, at the time Resident 1 left the facility, the alarm did not go off to alert the staff that the resident eloped. During an interview with Registered Nurse Supervisor (RN1) on 11/719 at 10:56 a.m., she stated, nursing staff were to make rounds every 2 hours to check the residents. RN1 stated, at the time she left the facility after work on 11/4/19 at around 6:30 p.m., she did not see Resident 1 and there was no alarm that went off to alert the staff that Resident 1 eloped from the facility. On 11/7/19 at 11:00 a.m., an observation of the facility's video surveillance footage with the facility's administrator indicated, Licensed Vocational Nurse 2 (LVN 2) had his head down on 11/4/19 at 6:39 p.m., while Resident 1 passed by him and exited in the facility front entrance. There was no alarm that was heard by LVN 2 and there was no action taken by LVN 2 to address Resident 1 leaving the facility. During an interview with the facility's Administrator (ADM) on 11/7/19 at 11:05 a.m., he confirmed that on 11/4/19 at 6:39 p.m., via surveillance video footage, Resident 1 walked passed by LVN 2 and exited in the front entrance of the facility. ADM stated, LVN 2 had his head down while charting and no alarm was triggered to alert LVN 2 that Resident 1 had eloped. During an interview with Maintenance Supervisor (MS) on 11/7/19 at 11:25 a.m., MS stated, he did not check the door alarm on 11/4/19. MS stated he checked and inspected the door alarm for functionality for the month of October 2019 but did not do an inspection for the month of November. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's Change in Condition Note, dated 10/20/19 at 2:00 p.m., indicated Resident 1 had multiple episodes of attempting to get up unassisted, constant fidgeting, striking out and physically aggressive towards staff. A review of Resident 1's Change in Condition Note, dated 11/4/19 at 6:45 p.m., indicated Certified Nursing Assistant 1 (CNA 1) was about to provide bedside care to Resident 1 but noticed that Resident 1 was not on his wheelchair and was not in the bathroom. CNA 1 informed Licensed Vocational Nurse (LVN 1) of the incident. A review of Resident 1's Nurse's Notes, dated 11/4/19 at 6:45 p.m., indicated Resident 1 was reported missing by CNA 1. A review of Resident 1's Nurse's Notes, dated 11/4/19 at 8:40 p.m., indicated facility staff placed a call to local police department to report that Resident 1 had eloped from the facility and was missing. A review of Resident 1's Nurse's Notes, dated 11/4/19 at 9:45 p.m., indicated facility staff received a call from general acute care hospital (GACH) to verify that Resident 1 was found. A review of Resident 1's Interdisciplinary Team Conference Review note, dated 11/5/19, indicated on 11/4/19 at 9:45 p.m., LVN 1 received a phone call from General Acute Care Hospital to inform that Resident 1 was in their hospital emergency room . A review of Resident 1's Care Plan titled, Cognitive Loss, dated 10/17/19, indicated facility staff were to monitor Resident 1 for changes in mental status and report to MD as indicated, give clear explanations of treatment, and to provide reality orientation. A review of Resident 1's Care Plan titled, Behavior/[MEDICAL CONDITION] Medication Care Plan, dated 10/17/19 indicated facility staff were to assess Resident 1 for pain or discomfort, determine triggers and deescalating techniques and educate staff, and minimize environmental stressors (e.g. alteration in customary location or daily routine, unfamiliar care provider, hunger thirst, excessive noise, inadequate/inappropriate staff response, physical barriers). A review of the facility's policy and procedure titled Elopement Risk Reduction Approaches, revised November 2012 indicated after conferring with fire and other appropriate officials, the facility will minimize the risk of elopement by installing non intrusive alarm systems that alert staff to resident exiting.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE