STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. BUILDING _____ B. WING _____	**04/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RECHE CANYON REGIONAL REHAB CENTER	**1350 RECHE CANYON RD COLTON, CA 92324**

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 ensure a physician order [REDACTED]. Findings: An unannounced visit was conducted on August 29, 2019, at 7:15 PM, to investigate an incident involving Resident 1 who left the facility without notice on August 29, 2019. The facility reported, Resident 1 was confused and was witnessed by a non-staff, got into someone's car and left the facility. A review of Resident 1's clinical record, the face sheet (contains demographic information) indicated Resident 1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Health Status Note, dated August 26, 2019, at 5:57 PM, documented by Licensed Vocational Nurse (LVN 1), indicated resident (Resident 1) is on monitoring for behavioral/agitation episode. Resident was agitated and stated that she had wanted to be d/c (discharged) home, Resident was noncompliant, called the sister (Resident 1's sister), Resident had spoken with the sister, Resident was confronted by social services, resident spoke with them and MD (Medical Doctor) notified with new order for wonder (wander) guard, resident is laying in bed. frequent visual checks. During a telephone interview and review of Resident 1's clinical record, with LVN 1, on March 24, 2020, at 2:25 PM, LVN 1 stated he received a physician order [REDACTED]. He stated I don't see any orders. LVN 1 stated I'm not sure if I was able to carry it out. I can't remember. He further stated a wander guard is usually ordered for residents who are high risk of eloping and verified Resident 1 had showed agitation and verbalizing wanting to be discharged . He stated it is important to carry out this telephone orders timely, to ensure the well-being and safety of the residents. A review of Resident 1's Health Status Note, dated August 29, 2019, at 1:00 PM, documented by LVN 2, indicated, Last time seen resident (Resident 1) 1300 (1:00 PM). Resident get out of bed ambulating in front of nurses station Undersigning (LVN 2) and supervisor re directed resident to her room [ROOM NUMBER] A .ADON Call undersigning and informed That resident had Elopement. Undersigning Went to resident room and searching other room, not founded, all personal belongings in the room. Resident wearing color full flower dress. A review of Resident 1's Incident Note, dated August 29, 2019, at 5:52 PM, documented by the Case Manager (CM), indicated CM received phone call from man identifying as patient's (Resident 1's) significant other, (Name and Telephone number of Resident 1's Significant Other) According to man, Patient just showed up at her high school friend's house. Man then stated, I'm going to go down there and see if she is in fact there and then I'll call you back. During a review of Resident 1's Alert Note, dated August 29, 2019, at 7:30 PM, documented by the Director of Nursing (DON), indicated Resident (Resident 1) was observed being dumped out of a car on the facility property by the street. I (DON) responded, and found resident laying on the floor without shoes. 911 was called and transported to the hospital. During a follow up interview with the DON, on March 24, 2020, at 2:50 PM, the DON stated There's an order for [REDACTED]. Physician .1. Verbal telephone orders may only be received by licensed personnel (e.g., RN, LPN/LYN, pharmacist, physician, etc.). Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record . During a review of an undated facility document titled Job Description and Performance Standards for Charge Nurse, it indicated 18. Administer and document direct resident care, medications and treatments per physicians' orders and accurately record all care provided.

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.