STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. BUILDING _____ B. WING _____	06/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOLLYWOOD PREMIER HEALTHCARE CENTER	**5401 FOUNTAIN AVE. LOS ANGELES, CA 90029**

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and services to one of two sampled residents (Resident 1). For Resident 1 who was identified as high risk for elopement (leaving the facility unsupervised and unnoticed), the facility failed to: 1. Provide appropriate interventions (assess needs) when Resident 1, for six days, refused to take the medications the primary physician ordered, resisted nursing care, and showed aggressive behavior towards staff. 2. Implement plan of care for psychiatry and psychology consults as needed. 3. Develop a plan of care addressing Resident 1's high risk for elopement. These failures resulted in Resident 1 eloping from the facility and two days later being found by a bystander (someone who observes an event or incident) who called the paramedics. Resident 1 was face down in the street on a cold rainy night, 12 miles from the facility. Resident 1 was taken to the general acute hospital emergency room (GACH ER) and died the same day, due to having been exposed to cold weather. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. activities), and [MEDICAL CONDITION] (characterized by persistently depressed mood or loss of interest in activities causing significant impairment in daily life). A review of the Elopement Risk Evaluation, dated [DATE] at 11:12 p.m., indicated Resident 1 had an elopement risk of 16 (score of 10 or higher is considered at risk for elopement). The evaluation indicated Resident 1 had an episode of staying near exit door but no episode of trying to get out from the facility and per Resident 1's family had a history of [REDACTED]. A review of the Initial History and Physical, dated [DATE], indicated Resident 1 did not have the capacity to understand and make decisions. According to a review of the Order Summary Report for [DATE], Resident 1's primary physician ordered the following medications: [REDACTED]. 2. [MEDICATION NAME] tablet delayed release (an anticonvulsant, for [MEDICAL CONDITION]) 500 mg, by mouth at bedtime. 3. [MEDICATION NAME] (helps remove water and salt from the body by producing urine) 20 mg by mouth one time a day for high blood pressure. 4. Atorvastatin (helps remove certain bad fats from the blood) 20 mg by mouth at bedtime. 5. [MEDICATION NAME] (an antipsychotic medication, treats mental or mood disorder that improves thinking, mood and behavior) two mg by mouth, two times a day for [MEDICAL CONDITION] manifested by refusal of care. 6. [MEDICATION NAME] sodium (makes bowel movements softer and easier to pass) one tablet once a day 7. Multivitamin tablet (supplement) one tablet once a day. 8. Senna (for bowel management) 8.6 mg. one tablet by mouth at bedtime. A review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. In addition, the MAR indicated [REDACTED]. A review of Resident 1's Care Plan dated [DATE], indicated Resident 1 was at high risk for physical and social decline due to refusing to bathe/shower, refusing to change clothes, refusing medications and refusing to wear the wander guard (bracelet worn that would trigger an alarm in the exit doors when resident attempts to leave the facility unsupervised). The care plan goal indicated Resident 1 will have no adverse effects or complications from non-adherence or rejection of care. The care plan interventions included approach resident calmly and unhurriedly, explain risks and benefits, monitor episodes of refusal and notify the physician. A review of the Care Plan dated [DATE], indicated Resident 1 used [MEDICATION NAME] due to [MEDICAL CONDITION] manifested by refusal of care. One of the interventions included psychiatry or psychology consult as needed. A review of the Care Plan dated [DATE], indicated Resident 1 had a [MEDICAL CONDITION] disorder (a disorder in which nerve cell activity in the brain is disturbed). The intervention included give [MEDICATION NAME] 500 mg by mouth at bedtime and psychiatry and psychology consults as needed. A review of the Progress Notes dated [DATE], at 5:30 a.m. indicated Resident 1 was offered the PPD skin test but again refused. Resident 1 also refused vital signs check. At 1:34 p.m., Resident 1 was offered medications and care but refused. The Notes indicated the purpose of the medications were explained to Resident 1 using a translator but Resident 1 refused strongly. A review of the Progress Notes dated [DATE] at 3:24 p.m., indicated during the morning shift Resident 1 was observed walking around the facility and remained in the front lobby. When approached, resident screamed and cursed staff, refused care and medications. The Progress Notes indicated the facility tried to call the primary physician but were unable to leave a message because the physician's voicemail was full. At 4:13 p.m., the notes indicated Resident 1 refused to take all medications as ordered by the physician, PPD skin test, refused all nursing care and vital sign checks. A review of the Resident Monitoring Log dated [DATE], indicated Resident 1 was in the lobby at 11 p.m. On [DATE], Resident 1 remained in the lobby from 12 a.m. to 4 a.m. According to a review of the Progress Notes dated [DATE], at 6 a.m., Resident 1 was sitting in the chair in the facility lobby on [DATE] at 11 p.m. Resident 1 was encouraged to go to bed but refused. The progress notes indicated staff checked Resident 1 every thirty minutes. At 4 a.m., Resident 1 was observed sleeping soundly in the lobby. At 4:30 a.m., certified nursing assistant (CNA) reported that Resident 1 was not in the lobby. The progress notes indicated facility staff searched for Resident 1 inside the facility and within five mile radius but were unable to locate Resident 1. The police, Resident 1's family, and physician were notified. A review of the Progress Notes dated [DATE] to [DATE] indicated the facility called several general acute care hospitals (GACH) to find out if Resident 1 had been admitted but were unable to find Resident 1. A review of the Progress Notes, dated [DATE], at 9:53 p.m., indicated the facility received a call from the coroner's office (a government official that conducts or investigate the manner of or cause of death and investigates or confirms the identity of an unknown person who has been found dead) that the deceased body of Resident 1 was at the morgue and had been confirmed by Resident 1's family. A review of the Prehospital Care Report Summary, dated [DATE], indicated the paramedics found Resident 1 on [DATE], at 4:47 a.m., face down, on the sidewalk on a cold rainy night. The Care Report Summary indicated Resident 1 had extreme hypothermia (a medical emergency that occurs when your body loses heat faster than it can produce heat, causing a dangerously low body temperature) with weak and rapid pulse, shallow respirations, [MEDICATION NAME] head trauma to eyebrow and face. While being transported to the GACH emergency room (ER), Resident 1 stopped breathing and had no pulse. Cardio [MEDICAL CONDITION] resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) was started. A review of the GACH ER Documentation dated [DATE], indicated Resident 1 arrived at the ER at 5:05 a.m. and was intubated immediately on arrival. Resident 1 was hypothermic (when body loses heat faster than it can produce heat, causing a dangerously low body temperature below 95 degrees Fahrenheit (F) or 35 degrees Celsius (C). Normal body temperature is 98.6 F (37C). Resident 1 had a core body temperature (the temperature of the internal environment of the body) of 78.8 F (26C). Resident 1 was placed under warm blankets and warm solution given into the bladder through the indwelling catheter (a flexible tube inserted into the bladder that drains urine). The ER Documentation indicated a warming solution was also given to the orogastric tube (OGT, small tube inserted into the mouth that travel down to the stomach for feeding and medication administration). Resident 1's temperature increased to 88.7 F (31.5 C) but remained pulseless. Further resuscitation was deemed futile and Resident 1 was pronounced dead at 5:51 a.m. A review of the Autopsy Report dated [DATE], indicated that on [DATE], Resident 1 was found unresponsive on the sidewalk. Resident 1's clothes were soaked in

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) water. The report indicated Resident 1 died of hypothermia due to environmental exposure and that Resident 1 had multiple scrapes on both knees, chest, middle finger of the left hand and face. There were numerous upper extremities bruises. There was evidence of [MEDICATION NAME] trauma to the head in the form of scalp bleeding and skull surface bleeding. The autopsy report indicated Resident 1 had a [MEDICAL CONDITION] side of the ribs, from the second to tenth rib. A review of weather data indicated on [DATE], the temperature was between 47 F to 56 F with heavy rain. During a telephone interview and concurrent record review of Resident 1's clinical record, on [DATE], at 11:22 a.m., registered nurse supervisor (RNS 1) stated Resident 1 was admitted on [DATE] and refused all the medications ordered by the primary physician from [DATE] to [DATE], six consecutive days. RNS 1 stated when Resident 1 refused the wander guard Resident 1 was placed on hourly monitoring. RNS 1 stated Resident 1 needed a psychiatric consultation because Resident 1 had mental disorder and was admitted with [MEDICAL CONDITION] medications (used to treat the symptoms of mental disorders, reduce disability and prevent relapse). RNS 1 stated Resident 1 did not have an order for [REDACTED]. The facility's MD stated Resident 1 could have a psychiatrist consult because Resident 1 had mental disorder and was prescribed with [MEDICAL CONDITION] medications. The MD stated residents with [MEDICAL CONDITION] medications when admitted to the facility should automatically have a psychiatrist consult. During a telephone interview on [DATE], at 8:12 a.m., Resident 1's clinical record was reviewed with RNS 2. RNS 2 stated there was no physician order for [REDACTED]. During a telephone interview on [DATE], at 7:54 a.m., Resident 1's care plan and elopement risk was reviewed with RNS 2. RNS 2 stated Resident 1's elopement risk was 16 which means a high risk for elopement. RNS 2 stated there was no care plan created addressing the risk of elopement. During a telephone interview on [DATE], at 7:15 a.m., licensed vocational nurse 1 (LVN 1) stated the front door of the facility was kept locked during the night. On [DATE], LVN 1 stated he mistakenly left the key in the front entrance lock. A review of the facility's policy titled, Wandering, Unsafe Resident, with a revised date of ,[DATE], indicated staff will identify residents who are at risk for harm because of unsafe wandering. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. The policy indicated interventions to try to maintain safety such as detailed monitoring plan will be included. A review of the facility's policy titled, Requesting, Refusing and/or Discontinuing Care of Treatment, with a revised date of ,[DATE], indicated if a resident requests, discontinues or refuses care or treatment, the unit manager, charge nurse or director of nursing services will meet with the resident to: 1. Determine why the resident is requesting, refusing or discontinuing care or treatment. 2. Try to address the resident's concerns and discuss alternative options 3. Discuss the potential outcomes or consequences (positive and negative) of the resident's decision. A review of the facility's undated policy titled, Psychotherapeutic Drug Management Program, indicated the physician's responsibility included obtains psychiatric consultation as resident's clinical condition requires.