STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056477	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EASTLAND SUBACUTE AND REHABILITATION CENTER	**3825 DURFEE AVE EL MONTE, CA 91732**

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 prevent one of three sampled residents (Resident 1), who had a history of [REDACTED]. Resident 1 who was incapable of independent living, was missing from the facility on 3/2/18, and was found later by the facility's staff walking on the busy street. The resident refused to come back to the facility. These deficient placed the resident at risk for serious harm, injury, impairment, or death. Findings: On 3/5/18 at 3:50 p.m., an unannounced visit was made to the facility to investigate a facility reported incident regarding resident safety. A review of Resident 1's General Acute Care Hospital (GACH) Progress notes dated 2/10/18, indicated Resident 1 had [DIAGNOSES REDACTED]. Resident 1's Progress Notes further indicated that Resident 1 was questionably hallucinating and did not make any sense when he was talking. A review of Resident 1's GACH Progress notes dated 2/10/18, indicated Resident 1 had been to the hospital before and took off and had been brought in by the security guard. Resident 1's Progress Notes further indicated due to his behavior, Resident 1 had a one-to-one sitter. A review of Resident 1's Admission Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. and reasoning ability of a person). A review of Resident 1's History and Physical, dated 2/16/18, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Licensed Progress Notes, dated 2/17/18 and timed at 7:08 a.m., indicated Resident 1 wandered in the facility and outside the building by the front of the lobby. A review of Resident 1's License Nurse Record, dated 2/17/18 and timed at 10 p.m., indicated that Resident 1 strongly refused to wear the Wander Guard. Resident 1's care plan dated 2/17/18 identified the problem of wander out of the facility. The resident's care plan goal was will have no episode of wandering from the facility daily for the next 90 day. One of the staff's approaches included to place resident on 1:1 monitoring for the eight hours after wandering. Resident 1's Psychiatric Evaluation, dated 2/19/18, indicated Resident 1 had poor immediate, recent, and remote memory/cognition. Further review of Resident 1's Psychiatric Evaluation indicated Resident 1 had delusions and a history of suicidal attempts. This evaluation also indicated the resident was incapable of independent living, had poor coping and social skills. A review of Resident 1's Psycho-social Assessment Form, dated 2/19/18, under No identifiable Problems at this Time indicated lock (sic) facility for placement for security and safety. A review of Resident 1's Minimum Data Set (MDS), a standardized resident assessment and care screening tool, dated 2/23/18, indicated Resident 1's cognition was severely impaired and had a Brief Interview for Mental Status (BIMS) score of 6 (8-15=interviewable). Resident 1 required limited assistance with a one-person physical assist for transferring, walking in room, and walking in corridor. Under Section E0900: Wandering- Presence & Frequency, Resident 1's MDS indicated Resident 1 exhibited wandering behavior which occurred for 1-3 days. A review of Resident 1's Multidisciplinary Progress Record, dated 3/2/18 and timed at approximately 8:05 a.m., indicated, Resident (Resident 1) attempted to go out the front of the facility but resident (Resident 1) was redirected to go to his room and resident (Resident 1) followed and went to his room. Will cont (continue) to visually monitor resident (Resident 1). A review of Resident 1's Multidisciplinary Progress Record, dated 3/2/18 and timed at approximately 11 a.m., indicated Resident 1 was no longer inside the facility. A review of the facility's record titled, Interview Record dated 3/2/18 indicated one of the facility's staff was driving to get food, (did not indicate the time) the staff saw Resident 1 walking on the street. The record indicated the staff opened his car door and asked the resident to get in the car, but the resident said, No leave me alone. A review of Resident 1's record titled, Monitoring for Wandering q (every) shift, dated 3/2/18 indicated the resident had two incidents of elopements. There was no record to indicate Resident 1 was placed on 1:1 monitoring during the first eight hours after the resident was found wandering on 3/2/18 at 8:05 a.m., as stated in the resident's care plan dated 2/17/18. During a facility tour with the director of nursing (DON) on 3/5/18 at 4:10 p.m., Resident 1's room (room [ROOM NUMBER]) was observed next to the nursing station and next to a door leading out to the parking lot. During an interview with a certified nursing assistant 1 (CNA 1) on 3/5/18 at 4:50 p.m., CNA 1 stated that Resident 1 goes to the patio and bought food from the vending machine. CNA 1 also stated that all CNAs check on Resident 1. During an interview with a licensed vocational nurse 1 (LVN 1) on 3/5/18 at 5 p.m., LVN 1 stated that Resident 1 was trying to leave through the front door around 8 a.m. prior to his elopement. Resident 1 asked LVN 1 to buy him food and then Resident 1 went to the patio around 10 a.m. to 10:10 a.m. LVN 1 stated that Resident 1 refused a Wander Guard (a bracelet that alerts staff when a resident exits the facility) and has attempted to leave the facility several times. LVN 1 further stated that Resident 1 never verbalized that he wanted to leave the facility. During a phone interview with CNA 2 on 6/13/18 at 9:08 a.m., CNA 2 stated that Resident 1 was a wanderer and the staff would tell him to, Come here and Don't go too far. CNA 2 further stated that Resident 1 went out of the building because he wanted coffee. A review of the facility's undated policy and procedure titled, Missing Resident indicated once a resident's risk for exit seeking behaviors was identified, the facility would take steps to mitigate (lessen) that risk through and (sic) individualized care plan and good communication between staff, visitors and families regarding supervision needs.

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.