STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555596	A. BUILDING _____ B. WING _____	**03/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKSIDE HEALTH AND WELLNESS CENTER	**444 W LEXINGTON EL CAJON, CA 92020**

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 ensure Resident 1 was monitored during an outdoor activity. As a result, Resident 1 eloped from the facility and was at risk for physical and psychosocial harm. Findings: Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 7/23/19 at 1:45 P.M., an interview was conducted with the Director of Nursing (DON). Per the DON, Resident 1 had been outside at an activity with an Activity Assistant (AA). Resident 1 had been sitting with another resident, away from the location of the activity and was not in sight of the AA. A second resident, Resident 2, had assisted Resident 1 in climbing over the fence to get away from the facility. The DON stated Resident 1 was at high risk for elopement (likely to try to escape), so she should have been monitored closely. On 7/23/19 at 2:20 P.M., a concurrent observation and interview of the outdoor area was conducted with the DON. Five residents were outdoors with the AA, participating in an activity. A six-foot fence surrounded the outdoor area. A black hose was attached to the fence at approximately 18 from the ground. The hose was attached to each fence segment with a clamp. Four large diameter trees (approximately 24) were spaced between the activity area and the property's rear fence. The DON demonstrated how Resident 1 may have hidden from the AA behind a tree, then with Resident 2's help, have stepped onto the hose and been boosted over the fence. On 7/23/19 at 2:35 P.M., an interview was conducted with the Director of Maintenance (DM). Per the DM, the black hose is a sprinkler hose used by their gardening service. The DM stated the facility did not use it, and he was unaware it could be a safety concern in terms of elopement. The DM stated he will call the gardening service to find out if the hose could be removed for safety. On 7/23/19 at 2:50 P.M., an interview was conducted with the AA. The AA stated she had five residents outside for a music activity on 7/20/19 when the elopement occurred. The AA stated Resident 1 had moved to a bench to speak to Resident 2, and was not a part of the activity although she had initially gone outside to attend the music activity. The AA stated at some point, Residents 1 and 2 had moved behind a tree, out of view, and Resident 2 had boosted Resident 1 over the fence. The AA stated she did not know if Resident 1 used the black hose to get over the fence as the incident occurred out of her view. The AA stated the expectation is to keep all residents where they can be seen, but this had not happened on 7/20/19. On 7/23/19 at 3:40 P.M., an interview was conducted with the DM. The DM stated the gardening service had informed him the hose served no purpose and could be removed. The DM stated the hose, and all clamps, had been removed from the fence. On 7/23/19, a record review was conducted with the DON. The following documents were reviewed: Elopement/Wandering Evaluation: Resident 1 was deemed high risk for elopement. The DON stated that indicated Resident 1 was considered likely to elope from the facility, so she should have been monitored closely at all times. Per the DON, all staff should be aware Resident 1 was at risk for elopement. Activity Assistant job outline: the document lists .Don't leave Residents unattended always leave them with a CNA (certified nursing assistant) or staff member . Per the DON, the AA did not follow the job outline. Policy: Per a facility policy, titled Elopement, and revised 6/2013, It is the policy of this facility to provide a safe environment .The facility will plan their care to prevent .elopement . Per the DON, the AA did not ensure a safe environment for Resident 1. On 3/24/20 at 12 P.M., a telephone interview was conducted with the Activity Director (AD). Per the AD, the AA had not followed the protocol for monitoring all residents. The AD stated the AA should have had all residents within her line of sight at all times, or should have gotten help while she checked on Resident 1 and Resident 2. Per the AD, That might have kept the elopement from happening. The AD stated the facility now follows the process of no more than five residents per staff member, and no additional elopements had occurred.

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.