YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE

CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE

### SECTION 1424 NOTICE

CITATION NUMBER: 94-2330-0011435-F

Department of Public Health

Page 1 of 8

Date: 05/06/2015 Time: 1290

Type of Visit : Complaint Investig.

Incident/Complaint No.(s) : CA00413475

				·				
Licensee Name:	Vernon Healthcare Center, LLC							
Address:	1037 W. Vernon Avenue	Los Angeles, CA	90037					
License Number:	97000025	Type of Ownership:	Limited Liability Company					
Facility Name: Address: Telephone: Facility Type:	VERNON HEALTHCARE 1037 W Vernon Ave (323) 232-4895 Skilled Nursing Facility	CENTER Los Angeles, CA 90		apacity: 99				
Facility ID:	970000050		·					
SECTIONS	CLASS AND NATURE OF \	/IOLATIONS	PENALTY ASSESSMENT \$20,000.00 trebled to \$60,000.00	DEADLINE FOR COMPLIANCE 5/6/15 5:00 p.m.				
323	CLASS A CITATION PAT	TIENT CARE						
	F323 - 42 CFR 483.25 (h)(2). Accidents. The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.							
	On 9/18/14 at 8:15 a.m., an unannounced visit was made to the facility to investigate an entity reported incident regarding an alleged resident to resident abuse that occurred on 8/16/14, when Resident 1 hit Resident 2 in the stomach.							
	The facility failed to provide adequate supervision to Resident 1 by failing to:							
	1. Identify the hazards and risks of the resident's wandering behavior.							
	2. Implement the one-to-one (1:1) monitoring or supervision (an assigned staff supervises and closely watches/monitors a resident at all times) according to the plan of care that was developed to manage the resident's wandering behavior.							
	Resident 1, who had der language, judgment, and residents, Resident 4, 5, was able to enter the roo the left eye area of his fa	of female nd 9/20/14, and 3, and hit him on						
Name of Evaluator:			ithout admitting guilt, I hereby ackr ceipt of this SECTION 1424 NOTI					
Zosima Gaerlan HFEN			nature: Alucin	Vinta				
	Likuma Curum gurue			Dashington				

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

## SECTION 1424 NOTICE

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Department of Public Health Page 2 of 8 Date: 05/06/2015 Time: <u>129</u>

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	The facility placed Resident 1 on 1:1 supervision on 9/8/14 to prevent him from hitting other residents and staff. On 9/18/14, Resident 1 was able to enter inside the room of Resident 5 and 6 by himself. On 9/20/14, Resident 1 was able to enter inside the room of Resident 4 by himself. These female residents, Resident 4, 5, and 6, felt threatened that Resident 1 might hit them. Resident 4 was scared that Resident 1 might do something inappropriate to her.
	This failure resulted in psychological harm to the female residents, who felt threatened by Resident 1's behavior, and had the potential to result in physical harm to Resident 1 himself and to other residents.
	A review of Resident 1's clinical record indicated the resident was admitted to the facility on 4/25/14, was transferred to the hospital on 8/20/14, and was re-admitted to the facility on 8/24/14 with diagnoses that included dementia and end stage renal (kidney) disease.
	According to the quarterly review assessment Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/30/14, Resident 1 was able to make his needs known and was able to understand others usually. He was moderately impaired (decisions poor; cues/supervision required) in cognitive skills for daily decision making, and required limited assistance (resident highly involved in the activity; staff provide guided maneuvering) in walking and during locomotion.
	The clinical record indicated Resident 1 was transferred to the hospital on 8/20/14 due to generalized weakness and anemia (the blood lacks healthy red blood cells). Resident 1's history and physical from the hospital, dated 8/20/14, indicated that at the time of the hospital admission, Resident 1 was noted to be severely confused, wandering off out of his room in the hallway with unsteady gait. Another hospital record of consultation, dated 8/1/14, indicated that Resident 1 appeared to wander the hallways without any direction. A progress note, dated 8/22/14, indicated Resident 1 had been wandering the hallways aimlessly. Resident 1 was discharged back to the facility on 8/24/14.
· · · ·	The re-admission assessment of Resident 1, dated 8/24/14 at 12:55 p.m., indicated Resident 1 was confused and had poor safety judgment.
	According to the Elopement Risk Assessment, dated 8/24/14, Resident 1 was assessed as being at risk for potential elopement from the facility. The assessment indicated the resident was ambulatory with or without a device. There was no risk

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SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS						
	assessment conducted to identify the hazards and risks of Resident 1's wandering inside the facility or inside other residents' rooms.						
	The Change of Condition Notes, dated 9/8/14, indicated that Resident 1 was placed on a 1:1 monitoring, to prevent Resident 1 from striking out staff and other residents, after a surveyor informed a staff that Resident 1 hit staff members and Resident 2.						
	According to the administrator, during an interview on 9/21/14 at 3:50 p.m., a surveyor brought to her attention a CNA note, dated 8/16/14 at 6:30 p.m., which indicated that Resident 1 hit Resident 2 in the stomach and a security staff at the front door. The CNA note indicated Resident 1 also hit CNA 1 with a closed fist four (4) times and twisted the CNA's right arm and right index finger, and Resident 1 continued to wander in and out of other resident's rooms. The administrator stated, during another interview on 9/18/14 at 11:30 a.m., Resident 1 had wandered in the room of Resident 2 and punched Resident 2 in the stomach.						
	The facility conducted an investigation of the incident that occurred on 8/16/14 and interviews with Resident 4 and 5 on 9/9/14. According to the interview record, Resident 4, an alert female resident, stated that Resident 1 wandered most of the evening. Resident 5, another alert female resident, stated Resident 1 had wandered inside her room at 3 a.m. in the morning and sat at the foot of her bed. Resident 5 stated Resident 1 came in her room, sat on her bed, and fell asleep. Resident 5 stated she had seen Resident 1 put up his fist at the staff when the staff tried to re-direct him and she had also seen Resident 1 strike a staff on two (2) different occasions.						
	The psychiatrist progress notes, dated 9/10/14, indicated that Resident 1 was confused and disorganized, and wandered into other residents' rooms.						
	The facility's letter to the Department, dated 9/12/14, indicated it was brought to the administrator's attention on 9/11/14 that Resident 3 had discoloration on his left eye area and the source of the injury was unknown.						
	During an interview with Resident 13 (the roommate of Resident 3, a cognitively impaired male resident), on 9/20/14 at 1 p.m., the resident stated that during the evening shift at 7 p.m., while he was lying in bed, he saw Resident 1 wandering at the hallway and entering their room. Resident 1 sat on Resident 3's bed while Resident 3 was sleeping. Resident 3 woke up and tried to move his leg to get Resident 1 out of his bed. Resident 13 stated Resident 1 got mad and punched Resident 3 on his left eye						

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SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	which resulted in the discoloration on the left eye area. Resident 13 stated a female certified nursing assistant (CNA) came inside their room and took Resident 1 out of the room.
	The plan of care, dated 9/12/14, indicated that Resident 1 had dementia, had no capacity of making decisions, wanders, confused, resists care, disrobes, and had a history of hitting another resident. The resident goals were to decrease the episodes of wandering and to minimize his risk. One of the interventions was placing the resident on "one-on-one episode" or 1:1 supervision/monitoring. Prior to 9/12/14, the facility did not develop a plan of care to address and manage the resident's behavior of wandering inside other residents' rooms.
	The facility's policy and procedure titled, "Wandering & Elopement," dated 1/1/12, indicated that it was the policy of the facility to identify resident at risk for elopement and minimize any possible injury as a result of the elopement. The facility's policy and procedure did not address the procedures to identify the hazards and risks of a wandering behavior, and manage the residents at risk for wandering inside the facility or inside other residents' rooms.
	During an interview, on 9/18/14 at 2:40 p.m., CNA 3 stated that Resident 1 wanders into female residents' rooms and everyone knew he is a wanderer and that he wanders into female rooms. CNA 3 stated Resident 1 wandered during the day and night.
	During an interview, on 9/20/14 at 10:05 a.m., Licensed Vocational Nurse (LVN) 1 stated since Resident 1 was admitted to the facility, she heard reports that Resident 1 wandered in other residents' rooms.
	On 9/18/14 at 9:15 a.m., during a concurrent interview with Resident 5 and 6, alert female residents who shared the same room, they stated Resident 1 had entered their room several times and had also entered other residents' rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff when the staff tried to get him out of another resident's room.
	On 9/18/14 at 9:20 a.m., during an interview, Resident 5 stated there was one incident when Resident 1 climbed on her bed at 3 a.m., sat at the foot of her bed with his legs spread open and facing her, and she had to call staff to get Resident 1 out of her room.
	During a concurrent interview, Resident 6 stated Resident 1 had entered her room and

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#### **SECTION 1424 NOTICE**

SECTIONS

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94-2330-0011435-F	Date: 05/06/2015 Time: 1 1 1
CLASS AND NATURE OF VIOLATIONS	
ate her food on her bedside table. Resident 6 stated her food because she would not fight him. Resident buy her food because she would not fight Resident	6 stated she would just ask staff to
On 9/18/14 at 11:30 a.m., during an interview, the a that Resident 1 had wandered in the room of Reside stomach, but she had no knowledge Resident 1 was rooms.	ent 2 and punched Resident 2 in the

On 9/18/14 at 2:25 p.m., the clinical record of Resident 1 was reviewed with Registered Nurse (RN) 1. RN 1 stated, during a concurrent interview, that Resident 1 was placed on 1:1 supervision and this was a nursing intervention from the plan of care dated 9/12/14. RN 1 stated Resident 1 wandered in the facility but she was not aware he was wandering inside female residents' rooms.

On 9/20/14 at 11 a.m., during an interview, Resident 4, an alert female resident, stated Resident 1 had entered her room more than four (4) times in the past and it happened during the day and night. Resident 4 stated there were times that she had to use the call light for the staff to get Resident 1 out of her room and there were times staff followed Resident 1 inside her room to get him out of her room. Resident 4 stated Resident 1 had attempted to climb on her bed a couple of times and she had to use the call light for staff to get him out of her room. Resident 4 also stated her roommate, Resident 16, had said before "Get off my bed" to Resident 1, when Resident 1 tried to climb on Resident 16's bed.

During the course of the interview, Resident 4 stated Resident 1 was by himself inside her room "last night," estimating the time it happened as past midnight of 9/20/14. Resident 4 stated she used the call light so staff would go inside her room and get Resident 1 out of her room.

Resident 4 stated a female staff entered her room to get Resident 1 out of her room after she pushed her call light. Resident 4 stated Resident 1 walked all the way inside her room without staff beside him. Resident 4 stated she felt scared by the presence of Resident 1 inside her room because she did not know what he (Resident 1) would do next and she had seen Resident 1 hit staff who tried to get him out of the room. Resident 4 stated she felt threatened that Resident 1 might hit her or do something inappropriate to her. Resident 4 stated she had a broken back, she could not lift her right arm, and she could not do anything to defend herself.

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Department of Public Health Page 6 of 8 Date: 05/06/2015 Time: 1:29p

ECTIONS /IOLATED	CLASS AND NATURE OF VIOLATIONS
	On 9/20/14 at 11:25 a.m., during an interview, CNA 4 stated she was the assigned sitter (1:1 monitor) for Resident 1. CNA 4 stated she did not receive any report from the CNA of the outgoing shift that Resident 1 had wandered inside a female resident's room. CNA 4 stated that if there was anything unusual that occurred during the previous shift, she would get a report from the outgoing sitter. An attempt to interview Resident 1 was conducted after the interview with CNA 4, but Resident 1 did not answer the questions that were asked.
	On 9/20/14 at 2 p.m., during an interview, Resident 5 and 6 stated that Resident 1 entered their room by himself last Thursday, 9/18/14, at 8 p.m. and he just stood in front of their closets. Resident 5 and 6 stated they had to call a staff member who was passing by at the hallway to get Resident 1 out of their room. Resident 5 and 6 stated they felt threatened by the presence of Resident 1 inside their room because he might hit them.
	The clinical record of Resident 1 was reviewed with the director of nursing (DON) on 9/20/14 at 1:15 p.m. According to the DON, she did not see any documentation that Resident 1 had wandered inside another resident's room. The DON stated that at a minimum, she expected the staff to communicate when a resident wandered inside another resident's room.
	The DON stated that conducting an assessment and developing a care plan should be ongoing and could be done anytime. The DON stated the facility did not have a form to use as a tool for assessing and identifying the residents at risk for wandering inside other residents' rooms, and the "Elopement Risk Assessment Form" was the only form/tool the facility had. The DON also stated that Resident 1 did not have a plan of care developed to address his wandering behavior inside another resident's room until 9/12/14.
	On 9/20/14 at 4:20 p.m., the administrator and the DON were informed that the facility's policy and procedure titled "Wandering & Elopement," dated 1/1/12, that they submitted, only addressed residents at risk for elopement. The administrator and DON could not provide any other policy and procedure that addressed the identification and management of residents at risk for wandering inside the facility, specifically inside other residents' rooms.
	A review of the physician's order, dated 9/20/14 and timed at 5:15 p.m., indicated an

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Date: 05/06/2015 Time: 1:29

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS						
	order to transfer Resident 1 to a hospital for evaluation due to his behavior of being a danger to others secondary to his aggressive behavior.						
	According to the nursing notes, dated 9/20/14, the resident left the facility and was transported to the hospital at 7:15 p.m.						
	A review of Resident 2's clinical record indicated the resident was admitted to the facility on 6/18/14 with diagnoses that included dementia and psychosis (a mental disorder). Resident 2's admission assessment MDS, dated 6/25/14 indicated Resident 2 was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance (resident involved in activity, staff provide weight bearing support) when walking, and required limited assistance (resident moves between locations).						
	A review of Resident 3's clinical record indicated the resident was re-admitted to the facility on 3/21/14 with admitting diagnoses of dementia. The MDS, 8/13/14, indicated Resident 3 was moderately impaired with his cognitive skills for daily decision making and required extensive assistance with activities of daily living.						
	A review of Resident 4's clinical record indicated the resident was admitted to the facility on 4/21/14 and was re-admitted on 5/2/14 with diagnoses that included hyperlipidemia (high cholesterol) and hypertension (high blood pressure). The admission assessment MDS, dated 5/9/14, indicated was alert and able to make her needs known, unable to walk, needed extensive assistance in bed mobility, dressing, and toilet use, and she was totally dependent on staff for transfers.						
	A review of Resident 5's clinical record indicated the resident was admitted to the facility on 5/5/14 and was re-admitted on 8/27/14 with diagnoses that included congestive heart failure (CHF, a condition that occurs when the heart is unable to pump enough blood to meet the needs of the body's tissues). The quarterly review assessment MDS, dated 8/12/14, the resident was alert and able to make her needs known, and needed supervision in performing activities of daily living.						
·	A review of Resident 6's clinical record indicated the resident was admitted to the facility on 2/7/14 and was re-admitted on 6/22/14 with diagnoses that included congestive heart failure (CHF). The admission assessment MDS, dated 6/28/14, indicated the resident was alert and able to make her needs known, needed limited assistance in walking, and required extensive assistance in bed mobility and transfers.						

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ITATION NUMBER:	94-2330-0011435-F	Date: 05/06/2015 Time: 1:29p
SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	
	facility on 3/21/14 with diagnoses that inclu	dicated the resident was re-admitted to the ided hypertension (high blood pressure). The was alert and able to make his needs known.
	A review of Resident 16's clinical record in facility on 4/8/11 and was re-admitted on 6 dementia. The MDS, dated 8/27/14, indica cognitive skills was moderately impaired, a activities of daily living.	/29/14 with diagnoses that included ted the resident's speech was clear, her
	Therefore, the facility failed to provide ade	quate supervision to Resident 1 by failing to:
	1. Identify the hazards and risks of the resi	dent's wandering behavior.
	2. Implement the one-to-one (1:1) monitori supervises and closely watches/monitors a care that was developed to manage the re	resident at all times) according to the plan of
	This failure presented either an imminent of or a substantial probability that death or se	langer that death or serious harm would result rious physical harm would result.

Department of Public Health

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# Reminded & acapited by 5/6/15

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY PARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>1</sup> A. BUILDI		(X3) DATE SUR COMPLET	
		055167		B. WING	<u></u>	09/21	1/2014
	ROVIDER OR SUPPLIER HEALTHCARE CENTER		EET ADDRESS, 7 W Vernon A		ZIP CODE Igeles, CA 90037-2415 LOS ANG	ELES COUNTY	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPF	OULD BE CROSS-	(X5) COMPLETE DATE
	of Public Health during visit: CLASS A CITATION – 94-2330-0011435-F Complaint(s): CA00413 Representing the Depa Surveyor ID # 28070, H The inspection was lime event investigated and findings of a full inspect F323 - 42 CFR 483.2 must ensure that eas supervision and as accidents. On 9/18/14 at 8:15 a made to the facility incident regarding a abuse that occurred hit Resident 2 in the st The facility failed to Resident 1 by failing to 1. Identify the haza wandering behavior. 2. Implement the supervision (an as closely watches/mon	3475 artment of Public Health: HFEN lited to the specific facility does not represent the ction of the facility. 25 (h)(2). Accidents. Th ach resident receives a ssistance devices to m.m., an unannounced of to investigate an entity n alleged resident to on 8/16/14, when Re- tomach.	n e facility adequate prevent visit was reported resident sident 1 vision to resident's coring or ses and Il times)		Vernon Healthcare Center response and Plan of Corre the requirements under sta law. The plan of correction in accordance with specific requirements. It shall not admission of any alleged d or any liability. The provid plan of correction with the it is inadmissible by any th civil, criminal action or pro- against the provider or its agents, officers, directors, o The provider reserves the r challenge the cited findings the provider determines th findings are relied upon in adverse to the interests of t either by the governmenta- third party.	ction as part of te and federal is submitted regulatory be construed as eficiency cited der submits this intention that ird party in any occeedings employee, or shareholders. ight to s if at any time at the disputed a manner he provider	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE / /	/ TITLE		(X6) DATE
- anti	1 1/0	Ni-	NHA	5/10/15
By signing this document I am acknowledging receipt of the entire citation nacket	Page(s) 1 thru 13		· · · · · ·	

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 13

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. Except for nursing homes, the findings 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
055167				B. WING	·	09/21	/2014	
				RESS, CITY, STATE, ZIP CODE non Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLET DATE	
	manage the resident's Resident 1, who If function that affects judgment, and behave the rooms of female and 16, at various 9/20/14, and was able resident with dement the left eye area of 9/20/14 (exact date un The facility placed R 9/8/14 to prevent hir and staff. On 9/18/14 inside the room of R 9/20/14, Resident 1 room of Resident residents, Resident 4 Resident 1 might hit that Resident 1 might that Resident 1 might to her. This failure resulted female residents, wh 1's behavior, and the physical harm to Re- residents. A review of Resident the resident was administration was transferred to the re-admitted to the fail that included deme (kidney) disease.	had dementia (los memory, thinking vior), was able to e residents, Reside s times between le to enter the roo- ia, Resident 3, and f his face two we determined). esident 1 on 1:1 su m from hitting oth s, Resident 1 was Resident 5 and 6 by was able to enter 4 by himself. Th f, 5, and 6, felt the them. Resident 4 ht do something in psychological no felt threatened had the potential esident 1 himself a nt 1's clinical reco nitted to the facility e hospital on 8/20/	ss of brain g, language, wander into ent 4, 5, 6, 4/25/14 and m of a male d hit him on beks prior to upervision on her residents able to enter r himself. On er inside the nese female reatened that was scared inappropriate harm to the by Resident to result in and to other ord indicated r on 4/25/14, r d, and was ith diagnoses	F 323	What corrective action ( accomplished for the res affected by the deficient On 9/20/14 at approx. 51 of Residents Resident 1 a was notified of these reside wandering into other res and the facility's limited at their behavior. The Physis subsequently received to residents to another facil Resident 1 was discharge Medical Center at around responsible party was inf in agreement. Resident 2 was discharge California Hollywood at The responsible party was was in agreement.	sident(s) practice? 5pm the doctor and Resident 2 dents risk for ident's rooms ability to manage ician order was transfer both ity. d to Brothman d 7:30pm. The ormed and was d to So. around 6:30pm.	09/20/14	

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		(X1) PROVIDER/SUPPLIE					VEY D	
		055167		B. WING		09/21	21/2014	
	ER OR SUPPLIER LTHCARE CENTER		STREET ADDRESS, 1037 W Vernon A	, ,	ZIP CODE Igeles, CA 90037-2415 LOS ANGE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX ŤAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	OULD BE CROSS-	(X5) COMPLET DATE		
Mi as Re wa cu da as sta du Th tra ge he phe tha 1 v ou Ar 8/: wa Re 8/: Wa Ro Re Co Co Ac	inimum Data S isessment and carriesident 1 was able to under o derately imp res/supervision rec illy decision ma isistance (resident aff provide guided uring locomotion. The clinical recor- ansferred to the meralized weakness that the time of the meralized weakness that the time of the was noted to be s it of his room in nother hospital re- 1/14, indicated fra ander the hallwa ogress note, dated ta been wanded esident 1 was disc 24/14 at 12:55 p.m. infused and had pool	e planning tool), day to make his needs stand others usuall paired (decision quired) in cognitive aking, and requir highly involved in the maneuvering) in v d indicated Resid hospital on 8/20 is and anemia (the cells). Resident 1's ospital, dated 8/20/1 the hospital admissic severely confused, w the hallway with un record of consultar that Resident 1 ap tys without any of a 8/22/14, indicated ring the hallways charged back to the ssessment of Reside n., indicated Reside	standardized ted 7/30/14, known and y. He was as poor; skills for red limited the activity; walking and dent 1 was 0/14 due to blood lacks history and 4, indicated on, Resident andering off steady gait. tion, dated opeared to direction. A Resident 1 aimlessly. e facility on ent 1, dated dent 1 was Assessment,		How will another resider residents having the pote affected by the same defi be identified, and what c will be taken On 9/20/14, other residen assessed by the Licensed N risk of wandering. There residents identified at risk What immediate measure changes will be put into p that the deficient practice 1. An In-service was 3-11 Staff by the DSD, DN Nurse regarding the facilit drafted policy and proced wandering residents with emphasis on the screening monitoring and escalation of those at risk for wander service will be continued to other shift until the facility done. 2. Residents upon ac admission, quarterly, ann needed will be assessed by Nurse using the Wanderin tool. Residents at risk for y be identified by wearing a	ential to be cient practice orrective action ts will be Vurses for the were no other for wandering. s and systemic lace to ensure does not recur? initiated on IS and the QA ty's newly ures for special g, assessment, n of plan of care ring. This in- o be given to y staff are all limission, re- nally and as the Licensed ag assessment wandering will	09/20/14	

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	055167	B. WING		09/21/2014	
AME OF PROVIDER OR SUPPLIER /ERNON HEALTHCARE CENTER	STREET ADDRESS		IP CODE eles, CA 90037-2415 LOS ANGELES	COUNTY	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLET DATE
assessment indicated with or without a assessment conducted risks of Resident 1's inside other residents' The Change of C indicated that Resided monitoring, to preve- staff and other resided a staff that Resided Resident 2. According to the action on 9/21/14 at 3:50 p attention a CNA not which indicated that the stomach and a The CNA note indicated with a closed fist CNA's right arm Resident 1 continued resident's rooms. T another interview Resident 1 had wand and punched Residen The facility conduc- incident that occur with Resident 4 and interview record, for resident, stated that the evening. Resident	Condition Notes, dated 9/8/14, dent 1 was placed on a 1:1 nt Resident 1 from striking out lents, after a surveyor informed ent 1 hit staff members and dministrator, during an interview .m., a surveyor brought to her bte, dated 8/16/14 at 6:30 p.m., t Resident 1 hit Resident 2 in security staff at the front door. ated Resident 1 also hit CNA 1 four (4) times and twisted the and right index finger, and to wander in and out of other he administrator stated, during on 9/18/14 at 11:30 a.m., lered in the room of Resident 2	F 323	<ul> <li>Those residents who can remore green band will have a green spreads sheet by the head of the 3. Residents determined of wandering shall be referred further assessment and escalate plan of care.</li> <li>4. If the facility is unable effectively control a resident's behavior, the IDT will conside developed a plan for placemer resident to another more secures.</li> <li>5. Signs in the facility will as a reminder to staff concerning meaning of the green ID.</li> <li>A description of the monitor and positions of persons responsitoring. How the facility monitor its performance to e corrections are achieved and The plan of correction must implemented, evaluated for effectiveness, integrated into assurance program</li> <li>1. Department Manage making observation rounds, who in their observation is performance to be an candidate for inclusion</li> </ul>	pecial bed. to be risk to IDT for ion of their to wandering r and at of the red facility. Il be posted ing the <b>ing process</b> <b>ponsible for</b> <b>y plans to</b> <b>ensure</b> <b>sustained.</b> <b>be</b> <b>the quality</b> rs, when will report nent, any tions may	09/20/14

(ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) ML A. BUIL		(X3) DATE SUR COMPLETE				
	055167			3	09/21	09/21/2014		
				SS, CITY, STATE, ZIP CODE IN Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) her room at 3 a.m. in the morning and sat at the foot of her bed. Resident 5 stated Resident 1 came in her room, sat on her bed, and fell asleep.		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOULD BE CROSS-	(X5) COMPLET DATE		
			1 came asleep.	residents wandering in t during observation rour	e are other heir room	Ongoing		
	Resident 5 stated she had seen Resident 1 put up his fist at the staff when the staff tried to re-direct him and she had also seen Resident 1 strike a staff on two (2) different occasions.			placement of ID green b special needs sheet on re at risk for wandering.	and/green	Ongoing		
	indicated that Re	sychiatrist progress notes, dated 9/10/14 ed that Resident 1 was confused and nized, and wandered into other residents		of residents wandering a admission, re-admission annually and as needed 5. The DNS/design	n, quarterly, for completion.	Ongoin		
		it was brought to ion on 9/11/14.that Resi n his left eye area a	o the dent 3	random resident wande in the next 3 months to compliance. 6. The Administra compliance to the new y	ensure ator will report wandering policy	Ongoin Monthly		
	During an interview with Resident 13 (the roommate of Resident 3, a cognitively impaired male resident), on 9/20/14 at 1 p.m., the resident stated that during the evening shift at 7 p.m., while he was lying in bed, he saw Resident 1 wandering at the hallway and entering their room. Resident 1 sat on Resident		sident), during lying in hallway	to the monthly QAA co further recommendatio suggestions.				
3's bed while Resident 3 was sleeping. Resident 3 woke up and tried to move his leg to get Resident 1 out of his bed. Resident 13 stated Resident 1 got mad and punched Resident 3 on his left eye which resulted in the discoloration on the left eye area.		dent 3 ident 1 it 1 got e which e area.						
	assistant (CNA) car Resident 1 out of the	a female certified ne inside their room ar room. dated 9/12/14, indicate	nd took					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION .	(X3) DATE SUR COMPLET	
	OVIDER OR SUPPLIER HEALTHCARE CENTER	STREET ADDRE	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE ACTION REFERENCED TO THE APP	ON SHOULD BE CROSS-	(X5) COMPLETE DATE
	making decisions, w disrobes, and had resident. The resident episodes of wander One of the intervention "one-on-one episode Prior to 9/12/14, the of care to address behavior of wandering The facility's pol "Wandering & Elope that it was the por resident at risk for possible injury as a facility's policy and procedures to identifi wandering behavior,	mentia, had no capacity of anders, confused, resists care, a history of hitting another ing and to minimize his risk ons was placing the resident on " or 1:1 supervision/monitoring, facility did not develop a plan s and manage the resident's inside other residents' rooms. icy and procedure titled, ement," dated 1/1/12, indicated blicy of the facility to identify elopement and minimize any result of the elopement. The procedure did not address the fy the hazards and risks of a and manage the residents at iside the facility or inside other				
	stated that Resid residents' rooms a wanderer and that	on 9/18/14 at 2:40 p.m., CNA 3 lent 1 wanders into female nd everyone knew he is a ne wanders into female rooms ent 1 wandered during the day			·	
	Licensed Vocational Resident 1 was adm	w, on 9/20/14 at 10:05 a.m. Nurse (LVN) 1 stated since nitted to the facility, she heard t 1 wandered in other residents				
Event ID:V	VN3911	5/6/201	5 8:4	7:47AM		

District         A BUILDING         BUILDING         District         Opj21/2014           NAME OF PROVIDER OR BUPPLEN VERNON HEALTHCARE CENTER         STREET ADDRESS, GITV. STATE. 2P CODE         ID37 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY           VAI D PRETX         BUMMARY STATEMENT OF DEPICIENCES         D PROVIDER'S PLAN OF CORRECTIVA REACH CORRECTIVA ON BIOLID BE CINCENTING INFORMATION         D TAG         PROVIDER'S PLAN OF CORRECTION (RACH CORRECTIVA EXILIANT OF OPERICENCES)         D PRETX         PROVIDER'S PLAN OF CORRECTION (RACH CORRECTIVA EXILIANT OF OPERICENCES)         D(0)           ON         91/81/14 at 9:15 a.m., during a concurrent interview with Resident 5 and 6, alert female residents who shared the same comon, they stated Resident 1 and end their room several times and had also entered other resident's rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff when the staff tred to get him out of another resident's rooms.         N         N           On 9/18/14 at 9:20 a.m., during an interview, Resident 1 dimbed to all staff to get Resident 1 out of her room.         D         N         N           During a concurrent interview, Resident 1 bit and ble. Resident 6 stated she up vould it of him room.         D         N         N         N           On 9/18/14 at 11:30 a.m., during an interview, Resident 1 time betable. Resident 1 bit stated she up vould it of him room.         D         N         N           On 9/18/14 at 11:30 a.m., during a interview, R(N) 1. N I stated, during a concurrent interview with Registe	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
VERNON HEALTHCARE CENTER         1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY         CM, ID MEERX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENT WINST BE RECEDED BY FULL REGULATORY OR LSC DESTITYING METORATION)       D PRETX TAG       PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APROPRIATE DEFICIENCY)       (X)         On       9/18/14 at       9:15 a.m., during a concurrent interview with Resident 5 and 6, alert female residents who shared the same room, they stated Resident 1 shad entered their room several times and had also entered other residents 'rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff when the staff theid to get him out of another resident's room.       On 9/18/14 at       9:20 a.m., during an interview, Resident 1 climbed to call staff to get Resident 1 out of her room.       Figure a concurrent interview, Resident 6 stated she just allowed Resident 1 to eat her food because she would not fight Resident 1.       Stated her wood main interview, the administrator stated she was aware that Resident 1 had wandered in the room of Resident 1 and no knowledge Resident 1 was wandering inside female residents' rooms.       In 9/18/14 at       13:0 a.m., during an interview, the administrator stated she was aware that Resident 1 had wandered in the room of Resident 2 and no knowledge Resident 1 was wandering inside female residents' rooms.       In 9/18/14 at       2:25 p.m., the clinical record of Resident 1 was previewed with Registered Nurse (RN) 1. RN 1 stated, during a concurrent interview, that Resident 1 was placed on 1:1 supervision and       In Her Vision Administrator stated, State			055167		· · · · · · · · · · · · · · · · · · ·	09/2	1/2014
Image: TAG     REACH CORRECTIVE ACTION BIOLUD BE CROSS- REPERVED TO THE APPROPRIATE DEFICIENCY     COMPLETE DATE       On     9/18/14 at 9:15 a.m., during a concurrent interview with Resident 5 and 6, alert female residents who shared the same room, they stated Resident 1 and entered their room several times and had also entered other resident's rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff When the staff tried to get him out of another resident's room.     On 9/18/14 at 9:20 a.m., during an interview, Resident 1 dimbed on her bed at 3 a.m., sat at the foot of her bed with his legs spread open and facing her, and she had to call staff to get Resident 1 out of her room.     During a concurrent interview, Resident 6 stated Resident 1 in the food because she would not fight thim. Resident 6 stated she just allowed Resident 1.     Stated state and the same room of Resident 1 had wandered in the room of Resident 1 had wandered 1.     Stated state and the same room of Resident 1 had wandered in the room of Resident 2 him out fight Resident 1.     Stated she would had the stated she would has at staff to buy her food because she would not fight Resident 1.     Stated she would had the the somach, but she had no knowledge Resident 1 was wandering inside female residents' rooms.     On 9/18/14 at 2.25 p.m., the clinical record of Resident 1 was reviewed with Registered Nurse (RN) 1. RN 1 stated, during a concurrent interview, that Resident 1 was placed on 1:1 supervision and     Amount and the stated on ther was the stated female residents' norms.						NGELES COUNTY	
<ul> <li>interview with Resident 5 and 6, alert female residents who shared the same room, they stated Resident 1 had entered their room several times and had also entered other residents' rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff when the staff theid to get him out of another resident's room.</li> <li>On 9/18/14 at 9:20 a.m., during an interview, Resident 5 stated there was one incident when Resident 1 became combative by hitting staff when the staff theid to get him out of another resident's room.</li> <li>On 9/18/14 at 9:20 a.m., during an interview, Resident 5 stated there was one incident when Resident 1 othed on her bed at 3 a.m., sat at the foot of her bed with his legs spread open and facing her, and she had to call staff to get Resident 1 out of her room.</li> <li>During a concurrent interview, Resident 6 stated Resident 1 had entered her room and ate her food on her bedside table. Resident 6 stated she just allowed Resident 1 to eat her food because she would not fight him. Resident 6 stated she would just ask staff to buy her food because she would not fight Resident 1.</li> <li>On 9/18/14 at 11:30 a.m., during an interview, the administrator stated she was aware that Resident 1 had wandered in the room of Resident 2 and punched Resident 1 was wandering inside female residents' rooms.</li> <li>On 9/18/14 at 2:25 p.m., the clinical record of Resident 1 was reviewed with Registered Nurse (RN) 1. RN 1 stated, during a concurrent interview, that Resident 1 was placed on 1:1 supervision and the room of the review.</li> </ul>	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION	N SHOULD BE CROSS-	COMPLETE
that Resident 1 was placed on 1:1 supervision and		interview with Resi residents who shares Resident 1 had enter and had also ent Resident 5 and 0 combative by hitting him out of another resi On 9/18/14 at 9:2 Resident 5 stated th Resident 1 climbed of foot of her bed with her, and she had to of her room. During a concurren Resident 1 had enter on her bedside tab allowed Resident 1 would not fight him just ask staff to buy not fight Resident 1. On 9/18/14 at 11:30 administrator stated in punched Resident 2 no knowledge Resi female residents' room On 9/18/14 at 2:25 Resident 1 was resident 1	ident 5 and 6, alert female d the same room, they stated ered their room several times ered other residents' rooms. 5 stated Resident 1 became staff when the staff tried to get dent's room. 0 a.m., during an interview, here was one incident when n her bed at 3 a.m., sat at the his legs spread open and facing call staff to get Resident 1 out it interview, Resident 6 stated red her room and ate her food ble. Resident 6 stated she just to eat her food because she . Resident 6 stated she would y her food because she would e a.m., during an interview, the she was aware that Resident 1 the room of Resident 2 and in the stomach, but she had ident 1 was wandering inside ns. 5 p.m., the clinical record of viewed with Registered Nurse				
			placed on 1:1 supervision and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055167	(X2) MULTII A. BUILDING B. WING	G	CTION (X3) DATE SUR COMPLETE 09/21	
	ROVIDER OR SUPPLIER	STREET ADDRES		ZIP CODE geles, CA 90037-2415 LOS A	ANGELES COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTIO REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
	dated 9/12/14. RN the facility but is wandering inside ferr On 9/20/14 at 1 Resident 4, an Resident 1 had enter times in the past and night. Residen she had to use th Resident 1 out of staff followed Resid out of her room. If attempted to climb and she had to use out of her room roommate, Residen my bed" to Residen climb on Resident 16 During the course stated Resident 1 of used the call light s and get Resident 1 of Resident 4 stated at to get Resident 1 of her call light. Res all the way inside him. Resident 4	of the interview, Resident 4 was by himself inside her room ating the time it happened as 9/20/14. Resident 4 stated she so staff would go inside her room				

		(X1) PROVIDER/SUPPLIE		(X2) MULTIF		(X3) DATE SUF COMPLET		
		055167 B. WING		09/2	1/2014			
	1			EET ADDRESS, CITY, STATE, ZIP CODE 7 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEEDED BY		FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTIO REFERENCED TO THE APPF	N SHOULD BE CROSS-	(X5) COMPLETE DATE	
	next and she had tried to get him out she felt threatened th do something inapp stated she had a bro right arm, and she c herself. On 9/20/14 at 11:25 4 stated she was th for Resident 1. CNA any report from the Resident 1 had wand room. CNA 4 stated unusual that occurred would get a report attempt to interview	of the room. Resident 1 migloropriate to her. ken back, she could ould not do anythin a.m., during an int he assigned sitter A 4 stated she did CNA of the outgoi lered inside a fema d that if there w d during the previou from the outgoin Resident 1 was cor	ent 4 stated thit her or Resident 4 d not lift her to defend erview, CNA (1:1 monitor) not receive ng shift that ale resident's ras anything us shift, she g sitter. An nducted after					
	<ul> <li>the interview with CNA 4, but Resident 1 did not answer the questions that were asked.</li> <li>On 9/20/14 at 2 p.m., during an interview, Resident 5 and 6 stated that Resident 1 entered their room by himself last Thursday, 9/18/14, at 8 p.m. and he just stood in front of their closets. Resident 5 and 6 stated they had to call a staff member who was passing by at the hallway to get Resident 1 out of their room. Resident 5 and 6 stated they felt threatened by the presence of Resident 1 inside their room because he might hit them.</li> <li>The clinical record of Resident 1 was reviewed with the director of nursing (DON) on 9/20/14 at 1:15 p.m. According to the DON, she did not see any documentation that Resident 1 had wandered inside another resident's room. The DON stated</li> </ul>				7:47AM			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING		09/2	1/2014
NAME OF PROVIDER OR SUPPLIER VERNÓN HEALTHCARE CEN	TER	STREET ADDRESS 1037 W Vernon		IP CODE Jeles, CA 90037-2415 LOS ANG	ELES COUNTY	
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIE: CIENCY MUST BE PRECEEDED BY RY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETE DATE
communicate v another resident The DON stat and developing could be done did not have a and identifying inside other re Risk Assessmen facility had. The did not have a	imum, she expected to when a resident want s room. ed that conducting an a care plan should be anytime. The DON state form to use as a tool fo the residents at risk for sidents' rooms, and the nt Form' was the only the DON also stated that plan of care developed to avior inside another residents	ered inside assessment ongoing and d the facility or assessing or wandering "Elopement form/tool the Resident 1 o address his				
DON were info procedure titled 1/1/12, that residents at ris and DON coul procedure that management of inside the the residents' rooms A review of the	physician's order, dated	policy and ment," dated addressed administrator r policy and fication and r wandering nside other				
Resident 1 to behavior of bei his aggressive b According to th	o.m., indicated an order a hospital for evaluation ng a danger to others a ehavior. he nursing notes, dated e facility and was transp	due to his secondary to 9/20/14, the				

TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA J PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
	9	055167		B. WING			09/	21/2014
1	OVIDER OR SUPPLIER HEALTHCARE CENTER		STREET ADDRESS, 1037 W Vernon A			-2415 LOS ANGE	LES COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	(EACH CORF	IDER'S PLAN OF COR RECTIVE ACTION SHO D TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETE DATE
	psychosis (a men admission assessm indicated Resident a cognitive skills for extensive assistance staff provide weight and required limited activity, staff provi locomotion (how the locations). A review of Resident the resident was mailed 3/21/14 with admitting	nitted to the facility nat included dem tal disorder). Re- ent MDS, dated 2 was moderately daily decision-makin (resident involved bearing support) wh assistance (resident de guided maneu ne resident move nt 3's clinical recom- re-admitted to the	on 6/18/14 entia and sident 2's d 6/25/14 impaired in ng, needed in activity, en walking, involved in uvering) in s between rd indicated facility on nentia. The					
Event ID:W	moderately impaired daily decision mak assistance with activitie A review of Resider the resident was adm and was re-admitted included hyperlipide hypertension (high b assessment MDS, alert and able to mal walk, needed extens dressing, and toilet dependent on staff for	with his cognitive king and required es of daily living. Int 4's clinical recom- nitted to the facility on 5/2/14 with dia- mia (high choles lood pressure). The dated 5/9/14, ind ke her needs knowr ive assistance in b use, and she	e skills for extensive rd indicated on 4/21/14 gnoses that iterol) and e admission icated was h, unable to ed mobility,		7:47AM			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ) PLAN OF CORRECTION UMBER.			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		055167		B. WING		09/2	1/2014
	OVIDER OR SUPPLIER HEALTHCARE CENTER	1	STREET ADDRESS, 037 W Vernon A		IP CODE eles, CA 90037-2415 LOS A	NGELES COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPR	N SHOULD BE CROSS-	(X5) COMPLETE DATE
	indicated the resident her needs known, walking, and require mobility and transfers. A review of Resident the resident was 3/21/14 with diagnos (high blood pressur indicated the resident his needs known. A review of Resident the resident was ad and was re-admitted	mitted to the facility on 8/27/14 with diag heart failure (CHF, i he heart is unable eet the needs of erly review assessm resident was alert an win, and needed sup faily living. Int 6's clinical record mitted to the facility on 6/22/14 with diag heart failure (Chent MDS, dated it was alert and able needed limited assist d extensive assistant int 13's clinical record re-admitted to the es that included h re). The MDS, dated it was alert and able net 16's clinical record mitted to the facility on 6/29/14 with diag The MDS, dated ent's speech was moderately impaired	on 5/5/14 gnoses that a condition to pump the body's nent MDS, nd able to pervision in d indicated on 2/7/14 gnoses that CHF). The 6/28/14, le to make sistance in nee in bed d indicated facility on the 8/6/14, le to make d indicated facility on the 8/6/14, le to make				
Event ID:W	VN3911	And the second sec	5/6/2015	8:4	7:47AM		

		(X1) PROVIDER/SUPPLIE		(X2) MULTI		(X3) DATE SUF COMPLET	
		055167		B. WING		09/2	1/2014
1	ROVIDER OR SUPPLIER HEALTHCARE CENTER		STREET ADDRESS, 1037 W Vernon A		IP CODE Jeles, CA 90037-2415 LOS AN	IGELES COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETE DATE
	living. Therefore, the facilit supervision to Resider 1. Identify the hazar wandering behavior. 2. Implement the of supervision (an as closely watches/mon according to the plar manage the resident's This failure presents that death or serio substantial probabil physical harm would re	at 1 by failing to: rds and risks of the signed staff super- itors a resident and of care that was of wandering behavior. red either an immini- pus harm would in ity that death	e resident's conitoring or ervises and t all times) developed to nent danger				
Evient ID:V			5/6/2015	8:4	7:47XW	Parana and Approximation and a second	