STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055540	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Monica Health Care Center	1320 20th Street Santa Monica, CA 90404

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on interview and record review the facility failed to revise the care plan after elopement (a form of unsupervised wandering that leads to the resident leaving the facility) and after a fall for one of three sampled residents, (Resident 1). This deficient practice may cause knowledge deficit among staff regarding specific interventions developed to ensure Resident 1 does not elope or fall again. Findings: On 3/18/2024 The California Department of Public Health (CDPH) received a facility reported incident indicating Resident 1 eloped from the facility on 3/14/2024. A. A review of Resident 1's Face Sheet indicated the facility originally admitted this [AGE] year old male on 10/18/2022 and most recently on 12/29/2023 with diagnoses including Syncope and collapse (losing consciousness and falling down), Dementia (a progressive or persistent loss of intellectual functioning and memory impairment), Anxiety (a feeling of worry, nervousness or unease), Essential Hypertension (high blood pressure), Gastroesophageal reflux disease (GERD- indigestion), history of falling. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/22/2024 indicated Resident 1's cognition (the mental ability to make decisions of daily living)was moderately impaired. Resident 1 required supervision or touching assistance with ambulation (walking). Resident 1 required maximal assistance (helper does more than half the effort to complete the task) for bathing and toileting. Resident 1 required a walker. Resident 1 had a wander/elopement alarm, bed and wheelchair alarm to notify staff when movement is detected. Lastly, this assessment indicated Resident 1 had no wandering behavior. A review of Resident 1's physician order dated 10/19/2022 with no end date indicated may apply Wand bracelet Alarm (bracelet placed on resident that activates alarm when close to exit door to alert staff) to remind resident not to leave the facility alone, monitor for placement and function every shift. A review of Resident 1's Elopement Risk assessment dated [DATE] indicated Resident 1 was at risk for elopement. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's GACH Emergency Provider note dated 3/14/2024 indicated Resident 1 walked into the Emergency Department appearing confused stating. he was there to see some new friends . Resident 1 continued to ramble nonsense; clothing appeared torn but otherwise appeared well kept. The note further indicated the police arrived shortly after Resident 1 was taken back to the facility. A review of Resident 1's GACH Cat Scan (CT-Scan- computed tomography- a diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce images of the inside of the body) of the head result dated 3/14/2024 indicated no injuries. Lastly, the note indicated LVN 1 arrived to take Resident 1 back to the facility. A review of Resident 1's Elopement Risk assessment dated [DATE] indicated Resident 1 was at risk for elopement. A review of Resident 1's Interdisciplinary Team (IDT) Care Conference Notes dated 3/18/2024 indicated the director of nursing (DON), the director of social services (DSS), the attending physician, the director of rehabilitation (DOR) and Resident 1's representative met to discuss elopement and discharge planning. The overall discharge plan indicated to discharge Resident 1 to a locked facility. No other plan or interventions were noted. A). During a concurrent interview and record review on 3/19/2024 at 3:50 p.m. with the Director of Nursing (DON), Resident 1's care plan dated 10/22/2023 titled, At risk for elopement indicated a goal to decrease resident's risk for elopement and wandering out of facility and included interventions to allow resident to move around the halls and gently redirect back to supervised areas, frequent visual checks on patient's whereabouts, may apply wander bracelet alarm to remind resident not to leave facility alone, offer alternative placement and to provide activities that will divert resident's attention from wandering. The DON stated, the new interventions we came up with was to monitor Resident 1's whereabouts every hour for 72 hours and to start working on placement into a locked facility . We did notice Resident 1 had a pattern of going to the Administrators office and walking around saying he has a business meeting but honestly, we did not discuss and interventions for this behavior . It is important that interventions are specific to the residents because they all have different needs. The new interventions should have been updated on the care plan, but I forgot to do that . B) A review of Resident 1's Situation Background, Assessment and Recommendation (SBAR- a structured communication framework that can help teams share information about the condition of a patient) form dated 10/1/2023 indicated Resident 1 had an un-witnessed fall with no injury. B) During a concurrent interview and record review on 3/19/2024 at 3:50 p.m. with the Director of Nursing (DON), Resident 1's care plan dated 10/22/2023 titled, At risk for fall indicated a goal Resident will be free of falls. During a concurrent interview and record review on 3/20/2024 at 4:00 p.m. with the medical records director (MRD), Resident 1's nursing progress notes and all care plans dated 10/1/2023-12/29/2023 were reviewed. The MRD, There are no care plan indicating actual fall dated in October 2023 and there are no IDT notes regarding a fall dated 10/2023 . During an interview on 3/20/2024 at 4:05 p.m. The DON stated, we should have had an IDT after the fall and updated the care plan, I forgot about the care plan . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures titled, Comprehensive Plan oof Care, dated 8/17/2021 indicated: The comprehensive plan of care must: Address the resident's individual needs, strengths, and preferences. Reflect current standards of professional practice. Reflect interventions to meet both short term and long-term resident goals. Include interventions to prevent avoidable decline in function or functional level. Reflect the company's efforts to provide alternative methods when a resident wishes to refuse certain treatments or services. Include interventions to attempt to manage risk factors. Reflect the resident's goals and wishes for treatment. Be developed by an interdisciplinary team that includes the attending physician, a registered nurse, and other appropriate staff as determined by the resident's needs. Be periodically reviewed and revised by the interdisciplinary team as changes in the resident's care and treatment occur. Re-evaluate and modify care plans: As necessary to reflect changes in care, services, and treatment. Quarterly, and With significant change in status assessment.

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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** 42342 Based on observation, interview, and record review the facility failed to provide supervision for a resident identified at risk for elopement (a form of unsupervised wandering that leads to the resident leaving the facility) complete quarterly elopement risk assessments for one of three sampled residents (Resident 1). This deficient practice may have caused Resident 1 to elope and subsequently be found approximately one hour later at the general acute care hospital (GACH). Findings: A review of Resident 1's Face Sheet indicated the facility originally admitted this [AGE] year old male on 10/18/2022 and most recently on 12/29/2023 with diagnoses including Syncope and collapse (losing consciousness and falling down), Dementia (a progressive or persistent loss of intellectual functioning and memory impairment), Anxiety (a feeling of worry, nervousness or unease), Essential Hypertension (high blood pressure), Gastroesophageal reflux disease (GERD- indigestion), history of falling. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/22/2024 indicated Resident 1's cognition (the mental ability to make decisions of daily living)was moderately impaired. Resident 1 required supervision or touching assistance with ambulation (walking). Resident 1 required maximal assistance (helper does more than half the effort to complete the task) for bathing and toileting. Resident 1 required a walker. Resident 1 had a wander/elopement alarm, bed and wheelchair alarm to notify staff when movement is detected. Lastly, this assessment indicated Resident 1 had no wandering behavior. A review of Resident 1's physician order dated 10/19/2022 with no end date indicated may apply Wand bracelet Alarm (bracelet placed on resident that activates alarm when close to exit door to alert staff) to remind resident not to leave the facility alone, monitor for placement and function every shift. A review of Resident 1' Elopement Risk assessment dated [DATE] indicated elopement risk assessment was completed after wandering behavior and Resident 1 was at risk for elopement. A review of Resident 1's Elopement Risk assessment dated [DATE] indicated Resident 1 was at risk for elopement. A review of Resident 1's care plan dated 10/22/2023 titled, At risk for elopement included interventions allow resident to move around the halls and gently redirect back to supervised areas, frequent visual checks on patient's whereabouts, may apply wander bracelet alarm to remind resident not to leave facility alone. A review of Resident 1's physician order dated 1/24/2024 sensor pad alarm in bed, may have bed alarm to remind resident not to get up unassisted and monitor proper placement and function every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's physician order dated 1/24/2024 indicated sensor pad alarm in wheelchair may have bed alarm to remind resident not to get up unassisted and monitor proper placement and function every shift. A review of the facility nursing assignments (direct care) dated 3/14/2024 timed 3:00 p.m. to 11:00 p.m. indicated one Registered Nurse (RN) supervisor, One Licensed Vocational Nurse (LVN) assigned to station #1 and one LVN assigned to station #2. Lastly 6 certified nursing assistants (CNA) total; 3 assigned to station #1, 2 assigned to station #2 and 1 split between both stations. A review of Resident 1's GACH Emergency Provider note dated 3/14/2024 indicated Resident 1 walked into the Emergency Department appearing confused stating. he was there to see some new friends . Resident 1 continued to ramble nonsense; clothing appeared torn but otherwise appeared well kempt. The note further indicated the police arrived shortly after Resident 1 was taken back to the facility. A review of Resident 1's GACH Cat Scan (CT-Scan- computed tomography- a diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce images of the inside of the body) of the head result dated 3/14/2024 indicated no injuries. Lastly, the note indicated LVN 1 arrived to take Resident 1 back to the facility. On 3/18/2024 The California Department of Public Health (CDPH) received a facility reported incident indicating Resident 1 eloped from the facility on 3/14/2024. During an interview on 3/19/2024 at 9:40 a.m. The Administrator (Adm) stated, After he returned, I told the nurses if they get busy to put the extra Covid Cart (a large cart on wheels identical to a medication cart) in front of the back door to block the exit and pay attention to the alarms . We should not be blocking exits with the cart but I told them to put it there to keep Resident 1 from getting out again . During a concurrent observation and interview on 3/19/2024 at 11:07 a.m. with Resident 1, inside of room, sitting up at edge of bed attempting to stand up and grab walker, alarm sounded and LVN 2 looked inside of room asked Resident, where are you trying to go? and Resident 1 stated, I may need to go to the drug store , LVN 2 disabled bed alarm. Resident 1 stated. Yes, I left and went for a walk, someone stole my car, but someone drove me back . Resident 1 was unable to remember the details of the elopement. During an interview on 3/19/2024 at 11:24 a.m. LVN 2 stated, I have been here since Resident 1 was first admitted to this facility . Resident 1's dementia has been progressing and he would always walk around saying he had to go to a business meeting and walk to the Adm's office (located right next to back doors at station #2) and talk real estate with her then go back to his room . I have seen him walk towards the door and when the alarm went off he would say I'm leaving guys then the activity director (AD) would take him out for a walk but that does not happen anymore because he became increasingly weaker after he contracted Covid last year and no longer wanted to go outside . He has the wander bracelet, bed and chair alarm to prevent him from eloping . He usually stops when he gets to the door and hears the alarm, the bed alarm is also loud and should stop him, I was not aware he left from the back door . Every shift I check to make sure the wander bracelet is on his ankle, and I walk him to the door to ensure it alarms to check the placement and function of the wander bracelet . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/19/2024 at 11:40 a.m. with LVN 2, a wander bracelet was placed at back door and a soft pitched constant beeping was heard. The back door was opened, and a doorbell chime was heard and louder than the wander bracelet. LVN 2 stated, You cant hear the wander bracelet alarm from the front station #1 that is why there should always be someone at station #2 . LVN 2 stated, Yes we were supposed to be documenting his whereabouts every hour I have not done it today that is my bad . LVN 2 then disabled alarm using the keypad next to door. During an interview on 3/19/2024 at 12:19 p.m. the RN stated, I was the supervisor on 3/14/2024 from 3:00 p. m. to 11:00 p.m. we only had four CNA's I am not sure if someone called off or if we were short staffed . There is one charge nurse assigned to both stations and they pass medications . If LVN 1 was in room [ROOM NUMBER] passing medications she does not have a line of sight to the nursing station #2 or the back doors . I usually sit at station #1, when I make rounds, I flip a switch to lock the front door at station#1 because we also have residents there that are at risk for elopement, and I do not usually sit at station#2 . That night I was having my break at 7:23 p.m. LVN 1 informed me Resident 1 was missing so I came out of the break room and heard a fast, loud alarm then instructed them to call the police and I helped to look for him . When he returned the Adm told us to put the cart in front of the back door to block the exit to prevent Resident 1 from eloping again and to monitor his whereabouts every hour . If they are not going to put a lock on the back door then they should assign someone to guard the back door . During an interview on 3/19/2024 at 12:25 p.m. the RN stated, we should check to see if wander bracelet is on the resident every shift, I am not sure how to check if the wander bracelet is functioning, I have not been oriented on that. During a telephone interview on 3/19/2024 at 12:49 p.m. LVN 1 stated, I was the charge nurse on 3/14/2024 from 3:00 p.m. till 11:00 p.m. and my duties were to pass medications on station 2 which is the back station . LVN 1 stated, At around 7:00 p.m. I took my cart to room [ROOM NUMBER] to pass medications to those residents, there was no one sitting at the nursing station #2, no one really sits there. While I was in room [ROOM NUMBER], the volume on the tv in the room was very loud because both residents are very hard of hearing. I came out of the room at about 7:30 p.m. and I heard a different kind of alarm that did not sound like a call light. The alarm was not very loud, but I could hear it when I came out of the room, so I walked to the back doors. The doors were completely closed so I opened them and heard the alarm for the door, I did not know the code to turn it off, so I came back inside and started checking each room. Resident 1's room is three doors down from that exit door so when I got to the room, I noticed Resident 1 was not there, and the walker was gone. There was no one sitting at nursing station #2 which is right across from Resident 1's room. I ran to the front nursing station #1 to alert everyone that Resident 1 was missing, and we all began to look for him and called the police . At around 8:00 p.m. we got a call from the GACH stating Resident 1had walked into the emergency department to meet a friend , they did a CT scan of is head and it was normal . I did see the wander bracelet on his left ankle . I check every shift to see if the wander bracelet is on Resident 1 but I do not walk him to the door to see if it is functioning, I don't know if that should be done, I am not sure how to check if the wander bracelet is functioning maybe someone above me should know . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/19/2024 at 1:25 p.m. the CNA assigned to Resident 1 on 3/14/2024 from 3:00 pm. To 11:00 p.m. stated, I usually have anywhere between 10-13 residents that night I had 13 residents I am not sure if anyone called off . I saw Resident 1 at 7:00 p.m. standing in front of his room in the hall talking with another resident . I usually go on my break at 7:00 p.m. but that night I went at 7:30 p.m. because another CNA had just come back . At about 7:35 p.m. I someone came into the break room and said Resident 1 was missing and there was an alarm going off, I did not hear the alarm while in the break room . When I saw him at 7:00 p.m. there was no one sitting at station #2 . The next night I was in serviced on elopement and told to respond to alarms, we have been monitoring his whereabouts every hour and I have seen a brown cart placed at the back door, I think it is there to stop him from getting out of that door again . Yes I do think this could have been prevented if there was someone at station #2 to stop him from leaving . During a telephone interview on 3/19/2024 at 1:30 p.m. LVN 1 stated, After the elopement were given an in service (education) on elopement and the CNAs were told to ensure they rotate their break times . At the time Resident 1 eloped I think there was one CNA on break and the other CNA was about to go to break. I did not know they were on break. Resident 1 gets confused at night and walks around a lot saying he has to go to a business meeting and has walked towards the back doors. I think this could have been avoided if the CNAs would have communicated their break times to me, then I could have made sure someone was there to watch Resident 1. LVN 1 stated, he did not have a one-to-one sitter assigned to him. LVN 1 stated, When Resident 1 returned we started to document his whereabouts every hour and I think they wanted to put one of the carts in front of the back door, I don't know if that's a fire safety hazard but there has been a cart placed in front of the back door because it does not lock. During a concurrent interview and record review on 3/19/2024 at 3:26 p.m. with the Director of Nursing (DON), Resident 1's every hour safety watch dated 3/15/2024 timed at 7:00 a.m. to 2:00 p.m., 3/16/2024 timed at 3:00 p.m. to 11:00 p.m., 3/18/2024 timed at 4:00 p.m. to 3/19/2024 12:00 a.m. and 3/19/2024 timed 12:00 a.m. to 12:00 p.m. was reviewed and noted blank. The [NAME] stated, I called the nurses over the weekend to remind them to complete every hour documentation of Resident 1's whereabouts, they should have been documenting the Resident's location every hour and putting their initials it should have been done for at least 72 hours after Resident 1 eloped . I do think this could have been avoided because Resident 1 had alarms and when the alarms were heard they should have checked the patient and he should have been monitored after dinner, the charge nurse was with another resident is what I heard, I did not conduct the interviews . The charge nurses have a wander guard bracelet in the medication cart, they can use that bracelet and hold it next to the doors to ensure the alarms are working. The charge nurse should be doing this every shift as well as documenting which part of the body the bracelet is located . The DON was asked how staff ensures the wander bracelet the resident is wearing is functional and stated, the charge nurse should bring the resident to the door to ensure the alarm is functioning every shift . During a concurrent interview and record review on 3/19/2024 at 3:26 p.m. with the DON, Resident 1's Elopement Risk Assessment form dated 12/29/2023 indicated Resident 1 was not at risk for elopement was reviewed. The DON stated, Resident 1 was still on wander bracelet at this time, this was done when he was readmitted back to the facility and he was still at risk, I would have to talk to the person who completed the assessment to find out why they indicated he was not at risk . This assessment should be completed at admission and when something happens or if they elope . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled, Resident Elopement dated 7/14/2023 indicated: Procedure 1. Elopement Risk Assessments form will be completed for all residents upon admission, readmission, quarterly and with significant changes. 2. Any resident identified to be at risk for elopement will have a wander guard band placed if applicable. 3. Any resident showing to be at risk for elopement will have completed the Elopement Identification Form with attached photo. Attempted Elopement 1. Should an employee observe an attempted elopement, he/she will: a) Be courteous in preventing the departure and in returning resident to the facility. b) Obtain assistance from other staff members in the immediate vicinity, if necessary c) Instruct another staff member to inform the charge nurse or director of nursing services that a resident has left the building. Missing Resident 1. Should employee discover that a resident is missing from the facility, he/she should: a) Determine if the resident is out on an authorized leave or pass. If not; b) Notify Administrator and Director of Nursing Immediately c) Make a through search of the building and premises, If not located 2. The Administrator, Director of Nursing, or designee will: a) Notify the resident's repr3eentative or legal representative. b) Notify attending physician. c) Notify Sheriff or local police department. d) If necessary, notify volunteer agencies. e) Provide search teams with resident identification information. f) Make extensive search of the surrounding area. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Audible Door Alarms 1. When audible alarms sound, employee will check the door. 2. If there is no resident in sight, the employee will seek assistance from another employee to search the vicinity inside the facility adjacent to alarming door. 3. If there is no resident inside the nearest area, the employee will search outside of the door, parking lot, exit area, or other adjacent areas. If there are two or more employees who respond to the alarm, a simultaneous search for the resident will be conducted within the nearby vicinity to help locate the resident. 4. The charge nurse or the nursing supervisor will conduct a resident count to ensure that the residents are all accounted for. A review of the facility's policy and procedures titled, Safety Supervision of Residents dated 9/24/2023 indicated: Procedure: Individualized, Resident-Centered Approach to Safety 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The Interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff b. Assigning responsibility for carrying out interventions c. Providing training as necessary d. Ensuring that interventions are implemented and e. Documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring interventions are implemented correctly and consistently. b. Evaluating the effectiveness of the interventions (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Modifying or replacing interventions as needed d. Evaluating the effectiveness of new or revised interventions Systems Approach to Safety 6. The facility-oriented and resident oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 7. Resident Supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 8. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.