

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>055952</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/24/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>TORRANCE CARE CENTER WEST, INC</b>		STREET ADDRESS, CITY, STATE, ZIP <b>4333 TORRANCE BLVD TORRANCE, CA 90503</b>	
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 0609  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on interview and record review, the facility failed to ensure that an incident of an elopement was promptly reported to the Department of Public Health (DPH) in accordance to the the facility's policy and procedure, for one of three sampled residents (Resident 1). This deficient practice increased the potential to result in serious harm. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] after eloping from the facility. Resident 1's [DIAGNOSES REDACTED], in young children, enlarging the head and sometimes causing brain damage), hypertensive [MEDICAL CONDITION] without heart failure (refers to heart problems that occur because of high blood pressure that is present over a long time). A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 7/11/2020 indicated Resident 1 understand, clear comprehension. MDS indicated Resident 1 needs extensive one person assist for toileting, dressing, and personal hygiene. A review of the physician's orders [REDACTED]. A review of Resident 1's physician's history and physical examination [REDACTED]. A review of Resident 1's Background Investigation, indicated on 7/24/20 around 4:30 p.m., Resident 1 was talking to a nursing staff that Resident 1 wanted to go to the general acute care hospital (GACH), as he states feeling weak. Staff prepared for transfer of Resident 1, calling physician, transportation, GACH, Resident 1 left without notice or signing out. On the same day, 7/24/20 Resident 1 was observed sitting in the back patio around 4:30 p.m., and by 5 p.m. dinner, Resident 1 could not be located in the facility. The residents physician, law enforcement and responsible person were notified. On 7/24/20 at 7:45 p.m., GACH called and stated that Resident 1 is the hospital in stable condition and will return shortly. A review of Resident 1's nurse's notes dated 7/24/20 at p.m., indicated Resident complained of being weak and something else. Vital signs taken. Blood pressure was 131/78, Pulse 76, Respiration 20, Temperature 98.1, O2 saturation 96% room air. Physician made aware with order to transfer to GACH, responsible party made aware, called for transportation. A review of Resident 1's nurse's notes dated 7/25/20 11p.m.- 7a.m. shift (time unspecified) Resident 1 was received via gurney, alert, and responsive to stimuli. Breathing is even and unlabored. Noted with periods of confusion. No complaint of pain. On 72 hours monitoring. Vital signs taken. Blood pressure 126/78, Pulse 84, Respiration 18, Temperature 97.8, denies pain. On 7/29/2020 at 9 a.m., Resident 1 was observed in bed sleeping. On 7/29/2020 at 10:30 a.m., during an interview, the DON stated she was made aware of the on Resident 1 elopement by the GACH. The DON stated an investigation was conducted and it was found that Resident 1 left the facility without signing out. DON stated Resident 1 is self-responsible for medical decisions. DON stated that the facility should have reported the elopement to the department. A review of the facility's undated policy titled, Elopement, indicated that if Resident 1 was not located , notify the Administrator and the Director of Nursing Services, Resident 1 's legal representative, the Attending Physician, law enforcement officials, the Department of Public Health.</p>		

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.