STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056286	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAYFLOWER GARDENS CONVALESCENT HOSPITAL	**6705 COLUMBIA WAY LANCASTER, CA 93536**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive plan of care with measurable objectives and appropriate interventions for two out of two sampled residents (Residents 1 and 2) who got into a physical altercation on 9/4/2020. As a result, there were no new interventions developed to prevent further fights between the residents. Findings: a. A review of Resident 1's Admission Record indicated the facility originally admitted the resident on 9/03/2019 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 9/14/2020, indicated Resident 1 was unable to make decisions and communicate needs. A review of the Nurses Notes dated 9/4/2020 indicated at 11:40 a.m., Residents 1 and 2 got into a physical altercation. During an interview and concurrent record review of Resident 1's care plans with the Director of Nursing (DON) on 9/18/2020 at 11:45 a.m., the DON stated there was no care plan regarding Resident 1's resident to resident altercation. The DON stated there should have been a care plan regarding Resident 1's resident to resident altercation and interventions developed to prevent further altercations. b. A review of Resident 2's Admission Record indicated the resident was originally admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE], indicated the resident had memory problems and was unable to make decisions. On 9/18/2020 at 11:45 a.m., during an interview with the DON and concurrent review of Resident 2's clinical record, the DON stated there was no care plan regarding Resident 2's resident to resident altercation. DON stated there should have been a care plan regarding Resident 2's resident to resident altercation. A review of the facility's policy dated 11/11/2016, on Comprehensive Care Plans, indicated the purpose of the policy was to ensure each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs. A resident's care should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity of care. It is the policy of the facility to promote seamless interdisciplinary care for residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain complete medical records by failing to document a change of condition and physician notification note related to a resident-to-resident altercation for two of two sampled residents (Residents 1 and 2). This deficient practice resulted in an incomplete clinical record. Findings: a. A review of Resident 1's Admission Record indicated the facility originally admitted the resident on 9/03/2019 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 9/14/2020, indicated Resident 1 was unable to make decisions and communicate needs. A review of the Nurses Notes dated 9/4/2020 indicated at 11:40 a.m., Residents 1 and 2 got into a physical altercation. A review of Resident 1's Progress notes - Late Entry dated 9/8/2020 for 9/4/2020 had no indication of the physician was notified of the physical altercation occurred on 9/4/2020. On 9/18/2020 at 11:45 a.m., during an interview with the Director of Nursing (DON) and concurrent review of Resident 1's nursing documentation, the DON stated there was no change of condition documented regarding the resident-to-resident altercation for Resident 1. The DON stated the procedure is to complete change of condition and notification to the doctor and the responsible party. b. A review of Resident 2's Admission Record indicated the resident was originally admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE], indicated the resident had memory problems and was unable to make decisions. A review of Resident 2's Nursing Documentation note dated 9/4/2020 indicated Residet 2 and Resident 1 were on a physicial altercation without change of condition noted for Resident 2. A review of Resident 2's progress notes-Late Entry dated 9/8/2020 for 09/4/2020 had no indication the physician was notified. On 9/18/2020 at 11:45 a.m., during an interview with the DON and concurrent review of Resident 2's nursing documentation, the DON stated there was no change of condition documented regarding the altercation between the residents. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, revised 8/2006, indicated facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing payments, resident right, etc.). Documentation of Changes in Medical Record The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Protocol for Notifying Attending Physician of Changes in Resident's Medical/Mental Condition.

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.