| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **056190** | A. BUILDING _____ B. WING _____ | **04/15/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **CHANDLER CONVALESCENT HOSPITAL** | **525 SOUTH CENTRAL AVENUE GLENDALE, CA 91204** |

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) |
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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure the safety of one of three sampled residents (Resident 1) by not following the physician's orders [REDACTED]. Resident 1 who was assessed as at risk for elopement and fully ambulatory,(able to walk) eloped from the facility on 5/31/19 without a wander guard. This deficient practice placed the resident at risk for harm and injury. Findings: A review of an Admission Record indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the History and Physical dated 1/23/19, indicated Resident 1 had no capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 4/29/19, indicated Resident 1's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. The MDS indicated Resident 1 was independent with bed mobility, walking, and locomotion (how resident moves) and required limited assistance for activities of daily living (dressing, toilet use, personal hygiene, and bathing). A review of Resident 1's physician (MD) order, dated 1/23/19, indicated to apply wander guard to alert staff if resident tries to elope. A review of Resident 1's elopement risk assessment, dated 4/25/19, indicated the resident was at risk for elopement. A review of Resident 1's care plan titled Wander Guard, dated 1/31/19, indicated the resident will remain in the facility without episode of wandering out. The interventions included to utilize wander guard to alert staff of resident mobility and safety and provide adequate monitoring of whereabouts. A review of Resident 1's care plan titled Elopement, dated 4/25/19, indicated the resident was at risk for elopement related to dementia as evidenced by episode of wandering around the facility without rational purpose, episode of going towards exit door unintentionally, episode of trying to get out of the door without purpose, and impaired cognition. The care plan goal indicated, the resident will be safe/free from falls/injuries. The interventions included to monitor wander guard placement and function every shift. A review of the facility form titled SBAR (Situation, Background, Appearance, Review) Communication Form (change of condition form), dated 5/31/19, indicated Resident 1 eloped. The nursing notes indicated at 6:30 p.m., Certified Nursing Assistant (CNA) could not find Resident 1. On 6/13/19 at 12:35 p.m., during a record review and concurrent interview, the Social Service Designee (SSD) reviewed Resident 1's wander guard log and stated, the wander guard was removed from Resident 1 on 3/29/19 due to hospital transfer. The SSD stated she was responsible in monitoring and checking the wander guard and Resident 1 had no wander guard from 3/29/19 to 5/31/19. Resident 1 eloped from the facility on 5/31/19. On 6/13/19 at 1:05 p.m., during a record review and concurrent interview, Registered Nurse 1 (RN 1) reviewed Resident 1's medical record from 3/29/19 to 5/31/19 and was unable to find a physician's orders [REDACTED]. There was no documented evidence that Resident 1 had wander guard on 3/29/19 to 5/31/19. RN 1 stated, Resident 1 returned to the facility on same day from the hospital and all previous orders should be followed unless discontinued by the MD. RN 1 stated, Resident 1 should have had a wander guard per physician's orders [REDACTED]. A review of the facility's undated policy and procedure titled, Wander Guard Resident Monitoring System indicated, it is the policy of the facility to use a wrist band monitoring device (wander guard) for all residents who have been evaluated and documented as having a potential for wandering outdoor or away from the facility. The objective is to provide a safe, secure environment for residents who maybe prone or with history of leaving the facility unattended. Social Service will monitor each bracelet by testing periodically to ensure that the bracelets are working and wander guard system is in good condition. |
| F 0693<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to administer enteral feeding (tube feeding (TF)- is the delivery of nutrients through a feeding tube directly into the stomach) as ordered by the physician (MD) for one of three sampled residents (Resident 2). This deficient practice placed the resident at risk for weight loss. Findings: A review of an Admission Record indicated Resident 2 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 6/6/19, indicated Resident 2's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 2 was totally dependent to staff for dressing, eating, toilet use, personal hygiene, and bathing. The MDS indicated Resident 2 had a feeding tube and had no weight loss of five percent (%) in the last month or loss of ten % in the last six months. A review of Resident 2's physician's orders [REDACTED]. A review of Resident 2's care plan, dated 5/31/19, indicated the resident had a feeding tube. The care plan goal indicated, the resident will receive calorie and nutritional requirement daily. The interventions included to provide enteral feeding as ordered. On 6/13/19 at 9:00 a.m., during an observation and concurrent interview with Licensed Vocational Nurse 1 (LVN 1), Resident 2's TF was hung on 6/13/19 at 12 a.m. (nine hours ago) at 60ml/hr. There was 1,300 ml of TF formula left on the TF bottle. The TF bottle full content was 1,500 ml. LVN 1 stated, 200 ml of TF was infused for nine hours and it should have infused 540 ml (difference of 340 ml) by the time of the observation. LVN 1 stated, the TF was not given to Resident 2 as ordered by the physician. A review of Resident 2's Medication Record for June 2019 indicated, the resident received continuous GT feeding of Glucerna 1.2 calories formula at 60 milliliter per hour (ml/hr) for 20 hours via enteral feeding pump. There was no documented evidence in the Medication Record that Resident 2's TF was stopped or placed on hold for any reason. On 6/25/19 at 3:50 p.m., during an interview, the Director of Nursing (DON) stated, the licensed nurse should check if the right amount of TF was given per physician's orders [REDACTED]. A review of the facility's policy and procedures titled, Gastrostomy Feedings, dated 8/19/13, indicated to provide nourishment and medications to resident requiring feeding through a gastrostomy tube. The procedure included to administer feeding and set pump at rate ordered. |

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.