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 _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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)
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** Based on observation, interview and record review, the facility failed to provide appropriate supervision and residents' safety for two of five sampled residents (Resident 1 and 2), who were at high risk for elopement (resident leaving the facility without authorization). Resident 1 eloped from the facility on 10/17/19. Resident 2 eloped from the facility on 10/18/19. The facility failed to: 1. Ensure that Registered Nurse 1 (RN 1) and Certified Nursing Assistant 1 (CNA 1), Resident 1's direct care providers, were aware that Resident 1 was high risk for elopement. 2. Provide education to the resident and the staff regarding Resident 1's special needs to prevent Resident 1's elopement and minimize wandering episodes as indicated in the resident's care plan. 3. Follow facility's policy and procedures on safety and supervision for Resident 1. 4. Identify hazards and risks in the environment that enabled Resident 1 to elope. 5. Ensure the wander guard (security system that monitors wandering residents or high-risk patients within set borders to guarantee their protection) were functioning properly for Residents 1 and 2. These deficient practices threatened the residents' safety. Findings: An unannounced visit to the facility was conducted on 10/18/19 regarding the Resident Safety. A review of Resident 1's Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS-a care assessment and screening tool) dated 9/27/19, indicated Resident 1's Brief Interview for Mental Status (BIMS-cognition screening tool) score was 7, indicating severely impaired cognition. A review of Resident 1's Elopement Risk Assessment, dated 9/21/19, indicated Resident 1 was high risk for potential of elopement from the facility. A review of Resident 1's Initial Care Plan, dated 9/21/19, indicated the resident was at risk for wandering or eloping related to previous history of elopement. The Care Plan indicated Resident 1 eloped from another facility. The care plan goal was to minimize episodes of wandering or elopement and possible injuries. The interventions indicated to provide education to resident, responsible party and staff regarding special care needs. A review of Situation, Background, Assessment, Recommendation (SBAR-Communication Form) and Progress note, dated 10/17/19, indicated, at 6:55 pm, CNA 1 reported that Resident 1 was not on his bed or in bathroom when CNA 1 about to collect the dinner tray. CNA 1 reported that Resident 1 was lying on his bed when CNA 1 went to his room to serve dinner tray. Facility's elopement protocol such as checking all rooms and reporting to police department was initiated. At 11 p.m., Police Department have not found Resident 1. A review of Resident 1's Hospital Patient Note dated 9/18/19, indicated Resident 1 came to emergency room after being found by his nursing home staff at a nearby park. It was indicated that he is possibly developing dementia and was prescribed to start low dose [MEDICATION NAME] (drug used to treat certain mental disorders; drug that decreases excitement in the brain) for agitation and confusion that leads to wandering. During an interview on 10/18/19 at 1:10 pm, CNA 1 stated it was not communicated to him that Resident 1 was considered a high risk for elopement and he was unaware of Resident 1's history of eloping. CNA 1 stated he dropped off Resident 1's dinner tray at approximately 5:30 pm and then continued to provide care for another resident requiring feeding assistance. When CNA 1 went to check on Resident 1 in his room, Resident 1 was not there. CNA 1 stated he looked in Resident 1's bathroom and around the facility, and also notified RN 1. CNA 1 and facility staff were unable to locate Resident 1. CNA 1 further stated if he had known Resident 1 had a history of [REDACTED]. During a concurrent observation and interview on 10/18/19 at 1:10 p.m., room [ROOM NUMBER] (Resident 1's room) was located adjacent to the rear exit door. CNA 1 stated that the rear exit door was accessible from the inside and outside. During an interview on 10/18/19 at 2:40 p.m., Licensed Vocational Nurse (LVN) 1 stated at the time of the incident, he was a desk nurse for station 1 and 2. LVN 1 stated there were no alarms triggered at that time. LVN 1 stated he did not communicate to CNA 1 regarding Resident 1 being a high risk for elopement. During a telephone interview on 10/18/19 at 3:01 p.m., Registered Nurse (RN) 1 stated she was not aware about the elopement history of Resident 1 and did not have any specific instructions for CNA 1 to prevent the resident who is at high risk for elopement, since a wander guard was in place. During an interview on 10/22/19 at 3:50 pm, Social Services Director (SSD) stated that Resident 1 used to live in an assisted living facility and Resident 1's family member (FM) mentioned that Resident 1 had eloped multiple times and the police wound find him at the parks. b. A review of Resident 2's Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS-a care assessment and screening tool) dated 7/26/19 indicated Resident 2 was independent for bed mobility, transfers, walk in room and corridor and required supervision with eating and toilet use. Resident 2 required limited assistance with dressing with one-person physical assist. A review of Resident 2's Elopement Risk Assessment, dated 7/21/19 and 10/19/19, indicated a high risk for the potential of elopement from the facility. A review of Resident 2's Plan of Care, dated 5/7/19, indicated a wander guard was utilized to alert the staff of a resident's mobility and safety. The care plan goal was for Resident 2 to be able to remain in the facility without any episodes of wandering out of the facility. The interventions included utilizing the wander guard and providing additional monitoring for Resident 2's whereabouts. During a concurrent observation on 10/18/19 at 3:26 p.m., Resident 2 was not in his room when the surveyor and Minimum Data Set Coordinator (MDS) went to test the function of the Wander Guard bracelets. After conducting a search, facility staff were unable to locate Resident 2. During an interview on 10/18/19 at 4:03 pm, CNA 2 stated that Resident 2 was in the dining room at approximately 1:30 p.m. and was then seen going towards his room at approximately 2 pm. CNA 2 stated there were no alarms triggered at that time. During a telephone interview on 3/9/20 at 11:55 a.m., LVN 2 stated he remembered watching the surveillance video on 10/18/19 and saw a resident who left prior to his shift (7-3 shift), but was unsure who the resident was. LVN 2 stated for residents who are high risk for elopement, he would communicate with CNAs by doing a huddle before the start of the shift and instruct CNAs to perform frequent visual monitoring like every 15 minutes. A review of Facility's followed up investigation report letter dated 10/23/19, indicated Administrator (ADM) determined that there may have been a system malfunction during the time that the resident left the facility. It indicated that the technician from wander guard company found a possible glitch in the coding of the transmitters receiving the signal from the wander guards. A review of the facility's policy titled, Safety and Supervision of Residents, dated 12/2007, indicated: Resident-oriented approach to safety by implementing interventions to reduce accident risks and hazards must include the following: 1. Communicating specific interventions to all relevant staff. 2. Assigning responsibility for carrying out interventions. 3. Ensuring that interventions are implemented.

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.