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 _____	**10/05/2020**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide resident centered care by: 1. Failing to obtain a urinary specimen (a procedure used for diagnostic test) timely for Resident 1, for one out of the three sampled residents. 2. Failing to accurately document an elopement risk assessment (Wander Data Collection Tool) for Resident 1. These deficient practices placed Resident 1's well-being at risk and for the resident not to receive appropriate care and/or treatment in a timely manner. Findings: 1. A review of the Admission record indicated Resident 1 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 12/6/2019, indicated Resident 1 was severely impaired cognition. The MDS record indicated Resident 1 was independent with bed mobility, transfers, walking in room, toilet use, and personal hygiene. Resident 1 required supervision with locomotion off unit and eating and required limited assistance while eating. MDS indicated Resident 1 was always continent with urine (ale to control their bladder). A review of Resident 1's Physician's/Telephone Orders Audit, dated 1/30/20, indicated the resident was to receive a UA C&S (urine analysis and culture & sensitivity). During a concurrent telephone interview and record review, on 3/23/2020, at 6:07 p.m., with Registered Nurse 1 (RN1), RN1 stated the urine was collected on 2/5/2020. RN1 stated the physician's orders [REDACTED]. RN1 stated there was no documentation in Resident 1's record for the reason why there was a delay in collecting the urine specimen. RN1 stated the nursing staff should have documented the reason why urine specimen was not collected timely. RN1 stated nursing staff received the results of the UA on 2/6/20 and was faxed to the physician the same day, at 2:15 p.m. RN 1 stated the physician did not respond to the faxed results that day. RN 1 stated that they received physician orders [REDACTED]. A review of Resident 1's Medication Administration Record, [REDACTED]. 2. A review of the Wander Data Collection tool, dated 12/3/19, indicated Resident 1 was not a wander/elopement risk. During an interview and concurrent record review with the MDS Coordinator (MDS) on 3/24/2020, at 10:35 a.m., the MDS confirmed she assessed and documented on the Wander Data Collection Tool, dated on 3/3/2020. The MDS stated that the resident was a definite risk for elopement. Resident 1 is supposed to be a definite risk for elopement based on the criteria. This was an inaccurate assessment. During a phone interview and concurrent record review with the Director of Nurses (DON) on 3/24/2020, at 11:30 a.m., she stated that the Wander Data Collection tool, was inaccurately documented and that Resident 1 was at risk for elopement. During a phone interview review with the DON on 3/24/2020, at 12:200 p.m., she stated the elopement incident was avoidable. If the assessment was done correctly the proper interventions would have been in place to prevent the elopement. During a review of the facility's policy titled Elopement Risk Identification, dated 4/5/2005, indicated the purpose of the policy is to promote a safe environment for skilled nursing residents who may be at risk for injury or harm as a result of elopement. The policy further indicates a customized Elopement Prevention Plan (EPP) shall be developed for every resident individual deemed to be an Elopement risk. Each EPP shall address and respond to the Elopement risk on an individual-specific bases,

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.