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 _____	**06/11/2020**

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 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe and appropriate discharge for one of three sampled residents (Resident 1), who has dementia (is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease) and was at risk for elopement (leaving facility without notice), by failing to identify Resident 1's need to transfer to a secured facility (a facility that has locked exit doors). The facility discharged Resident 1 to a Board and Care (a lower level of care where residents receive a room and general supervision) which was not appropriate for the resident's condition and/or safety. This deficient practice resulted in Resident 1 leaving the Board and Care and resulted in the resident reported as a missing person, which had the potential for the resident to sustain serious harm, injury and/or death. Findings: On 4/22/20 at 9:40 a.m., an unannounced visit was made to the facility to investigate a complaint. A review of Resident 1's Admission Face Sheet indicated Resident 1 admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. activities). A review of Resident 1's quarterly Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 1/29/20, indicated Resident 1 made self-understood and understood others, and was moderately impaired in daily decision making. Resident 1 required supervision from staff for dressing, eating, and toileting. During an interview on 4/22/20 at 10:20 a.m., the Social Services Director (SSD) stated Resident 1 was independent, ambulatory and a high functioning resident that needed a lower level of care. During a telephone interview on 4/22/20 at 4:22 p.m., a Certified Nursing Assistant 1 (CNA 1) stated Resident 1 does not listen when you tell her to go to her room and does not follow instructions. During a telephone interview on 4/23/20 at 10:18 a.m., the Co-Owner (CO 1) from the Board and Care stated Resident 1 went for a walk and was gone from the facility for three to four hours. CO 1 contacted the local police department and filed a missing person's report. The police informed CO 1 that the police picked up Resident 1 and took the resident to a General Acute Care Hospital (GACH). CO 1 stated their facility is an independent home. CO 1 stated that monitoring and supervision is minimal at best and the clients can leave the house and must be back home by 9 p.m. CO 1 stated Resident 1 would go for walks and come back. CO 1 stated that they are not a secured facility. During a telephone interview on 4/23/20 at 11:33 a.m., a Licensed Vocational Nurse 2 (LVN 2) stated Resident 1 had a wander guard (a device to help monitor residents who have dementia allowing them to have freedom within the facilities while giving them security). LVN 2 stated Resident 1 walked around in the facility and would try to go to the front of the building. LVN 2 stated the wander guard would alarm and alert the staff that Resident 1 was trying to leave. LVN 2 stated staff would stop her from leaving. During a phone interview on 4/23/20 at 3:33 p.m., the Director of Nursing (DON) stated Physician 1 was aware that Resident 1 wandered and attempted to elope. The DON stated Resident 1 really wanted to walk and their facility does not allow residents to go outside the building unassisted. The DON stated based on the facility's assessment, it was appropriate for Resident 1 to be at an independent living facility. During a telephone interview on 4/24/20 at 8:29 a.m., Physician 1 stated Resident 1 wandered and would get out of the building. Physician 1 stated it was unsafe for Resident 1 living in the skilled nursing facility because it was on a main street. Physician 1 stated that Resident 1 could get run over or killed if she wandered and/or eloped from the facility. Physician 1 stated Resident 1 needed to be in a secured facility and would recommend a residential care facility that had a secured area for residents with a dementia behavioral unit. During a telephone interview on 4/24/20 at 10:55 a.m., SSD stated she informed Resident 1 regarding the planned discharge on 2/26/20. SSD stated Resident 1 had the capacity to understand and stated Resident 1 would say she is good, but SSD does not understand because she does not speak Resident 1's language. SSD stated she was not aware that Resident 1 needed to go to a specific lower level of care, such as a secured unit or secured facility. SSD stated her job was to make sure Resident 1 was going to is safe and appropriate lower level of care facility. SSD stated she was supposed to check out the facility for Resident 1 prior to discharge but did not because of Covid-19 (an infectious disease caused by a newly discovered coronavirus) restrictions. SSD stated that CO 1 told her it was a safe place for Resident 1. During a telephone interview on 4/27/20 at 10:47 a.m., the DON stated the Interdisciplinary Team (IDT) determined where the resident will go after discharge. The DON stated the placement for Resident 1 is acceptable because that is what the physician's orders [REDACTED]. A review of Resident 1's Nurses Notes, dated 3/29/20 timed from 7 a.m. to 3 p.m., indicated Resident 1 had two instances of elopement attempts witnessed and that the facility staff redirected the resident. A review of Resident 1's Situation Background Assessment Recommendation (SBAR, a framework for communication between members of the health care team) Communication Form, dated 3/28/20, indicated Resident 1 had increased elopement attempts and increased agitation. A review of Resident 1's Elopement Risk Assessment, dated 3/28/20, indicated Resident 1's score was 32. A score of 10 or greater indicated a resident would be at risk for elopement. A review of Resident 1's care plan titled, Wander Guard, dated 5/7/19, indicated one of the goals was for Resident 1's safety will be monitored and be free of injury. A review of Resident 1's care plan titled, Discharge Planning, dated 2/25/20, indicated one of the goals was to find a safe/appropriate placement for Resident 1. A review of Resident 1's Physician's Notes, dated 4/2/20, indicated it was ok to discharge Resident 1 to a lower level of care. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's Nurses Notes, dated 4/14/20, indicated Resident 1 transferred to Board and Care on 4/14/20 at 2:11 p.m. A review of the facility's policy and procedure titled, Discharge Summary and Plan, with a revision date 11/2014, indicated when a discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The Care Planning/IDT would develop the post-discharge plan with the assistance of the resident and his or her family. The post-discharge plan would include identity of specific resident needs after discharge (for example, personal care, sterile dressing, physical therapy, and etcetera). A review of information from the Board and Care's website, (retrieved on 4/27/20 from http://www.familycaremanor.com) indicated the board and care offered personalized assistance, supportive services and [MEDICATION NAME] care in a home like atmosphere that allowed the freedom and independence you desire. The website indicated it is the perfect alternative for seniors who can no longer live on their own home, yet do not need 24-hour professional medical supervision.

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.