POC Accepted
5/4/2022 - #44526

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056190	A. BUILDING _____ B. WING _____	C 03/22/2022

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

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an investigation of a Facility Reported Incident (FRI). FRI Intake number: CA00771384 Representing the Department of Public Health: Surveyor #44526, Health Facilities Evaluator Nurse The inspection was limited to the specific FRI investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of FRI #771384.	F 000	Chandler Convalescent Hospital makes its best effort to operate in full compliance with both the Federal and State regulations.Nothing included in the Plan of Correction is an admission otherwise. Chandler Convalescent Hospital has submitted this Plan of Corrections in order to comply its regulatory obligations and does not waive any objection and does not waiver any objection to the merits or from any allegations contained therein..Please note that Chandler Convalescent Hospital may contest to the merits or form of any deficiency or findings alleged below and may take reasonable steps to appeal them.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609	This Plan of Correction constitutes our written credible allegation of compliance for the deficiency noted in the FRI intake number CA00771384 How corrective action will be accomplished for those affected by the deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Julius Cayetano, MBA — ADMINISTRATOR — 3-30-22

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F 609	Continued From page 1 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report a possible abuse including an injury of unknown source to other officials and adult protective services (the Police Department) for one of one sampled resident (Resident 1). Findings: On 2/7/22, an onsite visit was conducted to the facility to investigate an injury of unknown source reported by the facility. A review of Resident 1's admission face sheet, indicated the resident was admitted to the facility on 1/26/21, with diagnoses that included diabetes (elevated blood sugar), hypertension (elevated blood pressure), major bipolar disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and dementia (a medical condition caused by abnormal brain changes). A review of Resident 1's Minimum Data Set (MDS/a standardized assessment and screening tool) dated 12/17/21, indicated Resident 1 has a severe impaired cognition, required extensive assistance in Activities of Daily Living (ADL)	F 609	Resident 1 right eye peri-orbital discoloration which cause was allegedly unknown was treated conservatively per doctors order. The RN Supervisor, Charge nurse and the CNA assigned during the alleged incident were given an in-service education initiated on 1-27-22 and as often as necessary by the DSD with regards to the facility Policy and Procedure on Resident Abuse and corresponding prompt reporting as appropriate determination dictates within 2 hours to mandated entities that includes Police Department, ombudsman office and the Department of Public Health as required. How the facility will identify other residents having potential to be affected by the same deficient practice. Other residents were potentially affected by the deficient practice, nevertheless, DSD regularly in- service staff on the facility Abuse Prevention and Reporting as indicated. Within 2 hours if determined as an Abuse Incident and within 24 hours for any other non abuse incidents that does not involve any significant physical injury	

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F 609	Continued From page 2 which included transfers, and toileting and could not walk. A review of Resident 1's change of Condition (COC) dated 1/27/22, indicated a discoloration to the right eye. Resident denies any pain or discomfort and was reported to the physician. A review of Resident 1/s Acute Hospital's record dated 1/28/22, indicated the resident was brought from the SNF with report that patient hit her head on tray sustaining right eye discoloration. Patient was unable to relate what happened due to cognitive impairment. During an interview on 2/7/22 at 8:36am, the Director of Nursing (DON) stated Resident 1 had a small skin discoloration on the right periorbital area on 1/27/22. DON stated she reported this to the Ombudsman and Department of Public Health the same day but did not report to the Police. She also stated she conducted a thorough investigation but staff did not know what happened. DON asked Resident 1, but the resident did not remember anything. DON further stated she did not report this to the Police because the event was not an abuse but rather an accident. In an interview with Resident 1's roommate on 2/7/22 at 8:47am, the roommate stated she has no idea how Resident 1 got a black eye. She stated when she woke up, Resident 1 already has a black eye and that she did not hear screams nor noises On 2/7/22 at 9:58am, in an interview, the Director of Social Services (DSS) stated she was not on when the event occurred. When she returned to	F 609	All residents had a thorough skin check by the Treatment Nurses on a weekly basis to determine if they have skin integrity issues. No other resident were found affected by the same deficient practice as Resident 1 No findings that required Abuse prompt reporting as indicated. Measure and Systemic changes to be in place to ensure the deficient practice do not reoccur. The DON have implemented a STOP and WATCH policy initiated on 1-27-22 wherein staff were trained to be vigilant and observant on any change of condition to a resident that includes but not limited to Skin bruises, skin tears and wounds, and any observable change of Conditions to a resident. They are mandated to report immediately to their supervisors, DON and Administrator as applicable Any findings that may constitute a resident Abuse shall be reported promptly to the required entities as mandated by the State and Federal regulations. How facility plans to monitor its performance to make sure that solutions are sustained.	

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F 609	Continued From page 3 work, she saw Resident 1 with her eye bruised. She stated she asked the staff what had happened, and they really didn't know. During an interview on 2/10/22 at 12:05pm, Certified Nurse Assistant (CNA 2) stated she saw Resident 1 in bed sleeping at 7:00am and during breakfast around 7:14 or 7:30am, She fed the resident who was fine and hungry. Around 10:00am, when she was giving the resifdent a shampoo in the shower room, she noticed a lump in the corner of the resident's right eye. She stated she reported this to the Charge Nurse. In an interview on 2/24/22 at 10:36am, Licensed Vocational Nurse (LVN 2) stated she was the Charge Nurse during that shift and she does not know what happened to Resident 1. She stated CNA 2 did report the bruise to her which she subsequently, reported to the RN Supervisor and DON. A review of the facility's policy and procedure titled, "Abuse Reporting & Inveswtigation" updated November 2018, indicated the facility will: report ALL allegations of abuse as required by law and the appropriate agencies within 2 hours. The facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, exploitation, misappropriation of resident property, or injuries of an unknown source when appropriate. Notification to Outside Agencies includes to report to the Ombudsman, CDPH Licinsing and Certification, APC, and Law Enforcement.	F 609	Quality Assurance will be conducted weekly x 4 weeks then monthly thereafter until no similar deficient findings is observed in two months. The DON will monitor any findings and will report to the QAA committee during monthly Quality Assurance meetings. Completion Date: 3-30-22	

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POC due: 4/1/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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