STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055153	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEBELLO CARE CENTER	**1035 W BEVERLY BLVD MONTEBELLO, CA 90640**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to prevent two of four sampled residents (Residents 2 and 3) from being hit by Resident 1, who had a history of [REDACTED]. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility 1/21/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 2/5/19 indicated Resident 1's cognition was severely impaired and had physical behavior symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing). A review of Resident 1's Change of Condition Evaluation forms indicated that: - On 2/6/19 around 12:15 p.m. Resident 1 stood up from her wheelchair in the hallway and picked up a cup of coffee and threw it at Resident 4, no injury upon assessment. - On 2/8/19 at 9:33 p.m., Resident 1 was walking down the hallway and attempted to hit CNA 2 with her fist. - On 3/23/19 at 4 p.m., Resident 1 was being wheeled back to her room. Resident 1 was physically aggressive and resisted to care. - On 4/3/19 at 4 p.m., Resident 1 was walking down the hallway and talking to herself. Resident 1 saw Resident 2 and hit him on the chest. - On 4/11/19 at 3:20 p.m., Resident 1 was sitting in the hallway in front of her room, she suddenly stood up and walked aggressively toward Resident 3. Resident 1 was too fast and hit Resident 3 on her left upper chest. A review of the Progress Notes/Care Plan Meeting dated 2/12/19 indicated Resident 1 was taking [MEDICATION NAME] (medication to treat [MEDICAL CONDITION]) for [MEDICAL CONDITION] that was manifested by physical aggression and striking out. This care plan did not have intervention that included a monitoring system to prevent Resident 1 from hitting other residents, verified by Director of Nursing (DON). A review of the facility's policy and procedure, titled, Customer at Risk (CAR) Meeting (care plan meeting), undated, indicated that the purpose of the policy was to improve customer service by consistently addressing patient's problems and needs in an effective interdisciplinary fashion. The center nurse executive (DON) and medical director are responsible for implementation, maintenance, and ongoing evaluation of an active and effective customer (resident) at risk. On 4/9/19 at 2:20 p.m., during an interview, Certified Nursing Assistant 1 (CNA 1) stated that she worked the morning shift (7 a.m. to 3 p.m.) and at times, Resident 1 became aggressive with moments of confusion. CNA 1 stated that this behavior usually occurred toward the end of the morning shift. CNA 1 stated that Resident 1 thought someone was out to get her and trying to take her husband. On 4/9/19 at 2:50 p.m., during an interview, CNA 2 stated that on 4/3/19, Resident 1 got up from her wheelchair, walked passed Resident 2 and then smacked Resident 2 on the chest with an opened hand. CNA 1 stated that Resident 1's physical aggression was constant during the evening shift (3 p.m. to 11 p.m.). CNA 1 stated Resident would get up abruptly and hit other residents. Resident 1 was placed by the nursing station and someone was always in the nursing station. CNA 1 stated that there was no system and schedule for staff to monitor Resident 1. CNA 1 stated that she worked around her available time to monitor Resident 1. On 4/18/19 at 1:19 p.m., during an observation, Resident 1 was sitting on her wheelchair in the hallway and in front of the nursing station and there was no staff assigned to watch the resident. On 2/12/20 at 11:32 a.m., during an interview, Director of Nursing (DON) stated that some of the interventions that could have been implemented after Resident 1's physical aggressive episode during the evening shift included: alternating visual check monitoring between the LVNs and CNAs. DON stated a CNA could visually check Resident 1 for one hour an LVN would do the next hour, this would ensure Resident 1 was monitored every hour. On 2/12/20 at 12:28 p.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated that most of the time, Resident 1 had physical aggressive episodes after 3 p.m. and was always placed in front of the nursing station. LVN 1 stated that this behavior should have been added to the physical aggression care plan and specific interventions should have been implemented during the evening shift. A review of the facility's policy and procedure, titled, Abuse Prohibition with the effective date of 4/1/3 indicated that the facility prohibited physical abuse. The policy's purpose was for the staff to do all that is within their control to prevent occurrences of abuse. If the suspected abuse is resident to resident: the facility will provide adequate supervision, identify residents who have a history of disruptive or intrusive interactions, and the facility should seek alternative placement for the patient exhibiting the abusive behavior, if warranted.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan for one of four sampled residents (Resident 1) that include measurable objective with individualized interventions and did not update the resident's care plan to reflect a physical aggressive episode on 3/23/20 with more episodes during the 3-11 p.m. shift. This deficient practice had the potential to result in the resident's physical decline and harm to other residents. Findings: A review of Admission Record indicated Resident 1 was admitted to the facility 1/21/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 2/5/19 indicated Resident 1's cognition was severely impaired and had physical behavior symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing). A review of Resident 1's care plan initiated 2/6/19 indicated Resident 1 exhibits or has the potential to exhibit physical behaviors as evidenced by physical aggression toward others and a goal was for Resident 1 not to harm others by the next review (care plans reviewed every three months). This care plan did not include the physical aggression incident that occurred 3/23/19, Director of Nursing (DON) confirmed. A review of the Change in Condition Evaluation dated 3/23/19 indicated that Resident 1 was being physically aggressive, and resisting to care. On 4/18/20 at 3:46 p.m., during an interview, DON stated that Resident 1's care plan should have been updated after every physical aggression incident. DON stated that the purpose of a care plan was to address issues and to have an individualized, measurable, and specific interventions. On 2/12/20 at 12:28 pm., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated that most of Resident 1's physical aggression episodes happened during the 3-11 p.m. shift. LVN 1 stated that she did not add this information to the physical aggression care plan. LVN 1 stated that it should have been added to the care plan so that different interventions were added and implemented during the 3-11 p.m. shift. A review of the facility's policy and procedure, titled, Person-Centered Care Plan revised 3/1/18 indicated that a comprehensive person-centered care plan must be developed for each resident and communicated to appropriate staff. The care plan is reviewed and revised by the interdisciplinary team after each assessment and as needed to reflect the response to care and changing needs and goals of the residents.

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