STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST GARDENA POST ACUTE	**16530 S BROADWAY STREET GARDENA, CA 90248**

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 interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from verbal abuse by Certified Nursing Assistant 4 (CNA 4). This deficient practice resulted in Resident 1 being verbally abused and placed other residents at risk for continued verbal abuse from CNA 4. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated the resident was initially admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 11/25/2019, indicated that Resident 1 was able to understand and make herself understood and had normal cognition (thought process). During an interview, on 1/2/2020 at 11:33 a.m., Resident 1 stated that on 12/21/2019, she and Certified Nursing Assistant (CNA 4) had an altercation. Resident 1 stated that she asked CNA 4 to get her meal tray and CNA 4 told her, B---h, get your nurse to do it. Resident 1 stated she responded by calling CNA 4 a b---h. Resident 1 stated that CNA 4 told her to look into the mirror and you will see a b---h. Resident 1 stated that CNA 1, Charge Nurse 1 (CN 1), and CN 2 witnessed the incident. Resident 1 stated that as long as CNA 4 was not around her she felt safe. During an interview, on 1/2/2020 at 12:30 p.m., CNA 1 stated that on 12/21/2019 at approximately 5:30 p.m., she heard Resident 1 and CNA 4 screaming. CNA 1 stated when she approached the area, CN 1 and 2 were standing there as CNA 4 and Resident 1 were arguing. CNA 1 stated she heard Resident 1 call CNA 4 a b---h. CNA 1 stated CNA 4 replied to Resident 1 look in the mirror and you will see a b---h. CNA 1 stated CNA 4 also told Resident 1 to mind your own f--king business. CNA 1 stated she attempted to calm Resident 1 down by talking to her. CNA 1 stated that CN 1 stated to Resident 1 you two should handle this later because we have visitors, and CN 2 stated Oh my G-d. CNA 1 stated that herself, CN 1, nor CN 2 reported the incident on 12/21/2019. CNA 1 stated when she returned to work on [DATE]19, she reported the incident to the Administrator (ADMIN). CNA 1 stated that she knew she was supposed to report the incident immediately to the ADMN but did not. CNA 1 stated I'm sorry. A review of Resident 1's Nurses' Note, dated [DATE]19 and created at 9:54 p.m., indicated Resident 1 reported to the Social Service Director (SSD) that she was verbally abused by one of the staff (CNA 4). During an interview, on 1/2/2020, at 1:15 p.m., the SSD indicated that on [DATE]19, Resident 1 told her she had been verbally abused. The SSD stated she informed the ADMN. SSD stated that the ADMN was unaware of the altercation and that CN 1 and CN 2 did not report the altercation to ADMN. During an interview, on 1/2/2020 at 2:26 p.m., the ADMN stated that on [DATE]19, CNA 1 reported the verbal altercation between Resident 1 and CNA 4 to him. ADMN stated that CNA 4 did not report to work on 12/23/19 because she had been taken off the schedule. ADMN stated that he attempted to call CNA 4 on 12/23/19 and CNA 4 did not answer his phone call. ADMN stated that CNA 4 returned his telephone call on 12/24/2019 and during this conversation CNA 4 stated that she called Resident 1 a b---h and that he suspended CNA 4 at that time. ADMN stated that he does not have written documentation regarding the suspension of CNA 4. During a review of CNA 4's time sheet, dated 1[DATE]19, the time sheet indicated that on 12/21/2019 CNA 4 worked from 2:11 p.m. to 10:15 p.m. and on 12/22/2019 CNA 4 worked from 2:20 p.m. to 10:20 p.m. During a review CNA 4's Employee Status Change Form (ESCF), dated 12/30/2019, the ESCF indicated that CNA 4's last day of employment at the facility was 12/22/2019 and CNA 4's effective termination from employment date was 12/30/2019. A review of the facility's undated policy titled, Abuse and Neglect Prevention Management, indicated that in the event of an allegation of abuse, the named employee will be suspended immediately pending an investigation by the Administrator, the Director of Nursing Services, and Social Services.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the verbal abuse for one of three sampled residents (Resident 1) to the Department of Public Health (DPH) within twenty-four (24) hours from the time the incident occurred. This deficient practice had the potential for Resident 1 to experience continued abuse and negative psychosocial outcomes. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated the resident was initially admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool, dated 11/25/2019, indicated Resident 1 was able to understand and make herself understood and had normal cognition (thought process). During an interview, on 1/2/2020 at 11:33 a.m., Resident 1 stated that on 12/21/2019, she and Certified Nursing Assistant 4 (CNA 4) had an altercation. Resident 1 stated that she asked CNA 4 to get her meal tray for her and CNA 4 told her, b---h, get your nurse to do it. Resident 1 stated she responded by calling CNA 4 a b---h. Resident 1 stated that CNA 4 told her to look into the mirror and you will see a b---h. Resident 1 stated that CNA 1, Charge Nurse 1 (CN 1), and CN 2 witnessed the incident. During an interview, on 1/2/2020 at 12:30 p.m., CNA 1 stated that on 12/21/2019 at approximately 5:30 p.m., she heard Resident 1 and CNA 4 screaming. CNA 1 stated that when she approached the area, CN 1 and CN 2 were standing there as CNA 4 and Resident 1 were arguing. CNA 1 stated that she heard Resident 1 call CNA 4 a b---h. CNA 1 stated that CNA 4 replied to Resident 1 look in the mirror and you will see a b---h. CNA 1 stated CNA 4 also told Resident 1 to mind your own f--king business. CNA 1 stated she attempted to calm Resident 1 down by talking to her. CNA 1 stated that CN 1 stated to Resident 1 you two should handle this later because we have visitors and CN 2 Stated Oh my G-d. CNA 1 stated that herself, CN 1 nor CN 2 reported the incident on 12/21/2019. CNA 1 stated when she returned to work on [DATE]19, she reported the incident to the Administrator (ADMIN). CNA 1 stated that she knew she was supposed to report the incident immediately to the ADMN but she did not. CNA 1 stated I'm sorry. A review of the Nurses' Note, dated [DATE]19 and created at 9:54 p.m., indicated that Resident 1 reported to the Social Service Director (SSD) that she was verbally abused by one of the staff (CNA 4). During an interview on 1/2/2020, at 1:15 p.m., the SSD indicated that on [DATE]19 Resident 1 told her she had been verbally abused. The SSD stated she informed the Administrator (ADMN). The SSD stated that the ADMN was unaware of the altercation and that CN 1 and 2 did not report the altercation to the ADMN. During an interview on 1/2/2020, at 2:26 p.m., the ADMN stated that on [DATE]19, CNA 1 reported the altercation between Resident 1 and CNA 4 to him. ADMN stated he reported the altercation to the [ST] Department of Public Health (CDPH) and the Ombudsman at that time. ADMN stated that CNA 4 did not report to work on 12/23/19 because she had been taken off the schedule. ADMN stated that he attempted to call CNA 4 on 12/23/19 and CNA 4 did not answer his phone call. ADMN stated that CNA 4 returned his telephone call on 12/24/2019 and during this conversation CNA 4 stated that she called Resident 1 a b---h and that he suspended CNA 4 at that time. ADMN stated that he did not have written documentation regarding the suspension of CNA 4. During an interview on 1/2/2020, at 3:15 p.m., with CN 1, CN 1 stated that she did not

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555410	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST GARDENA POST ACUTE	**16530 S BROADWAY STREET GARDENA, CA 90248**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) report the altercation between Resident 1 and CNA 4 on 12/21/2019 to the ADMN because she did not hear what was said between Resident 1 and CNA 4 and she did not think the altercation rose to the level of abuse. A review of the Fax result report, dated [DATE]19 indicated that the ADMN sent faxes to the Ombudsman on [DATE]19 at 5:28 p.m., and to the CDPH on [DATE]19 at 5:32 p.m A review of the SOC 341 (abuse reporting form) filed by the facility, dated [DATE]19 (two days after the incident) indicated that suspected verbal abuse between Resident 1 and CNA 4 was reported by the ADMN on [DATE]19. A review of the facility's undated policy titled, Abuse and Neglect Prevention Management, indicated that alleged violations involving mistreatment, neglect, or abuse are immediately reported to the Administrator and the Director of Nursing
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to create a care plan following a significant change which identified an allegation of employee to resident verbal abuse for one of three sampled Residents (Resident 1). This deficient practice had the potential for Resident 1 to experience continued abuse. Findings: A review of Resident 1's Face Sheet (Admission Record) indicated the resident was originally admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), a standardized care screening and assessment tool dated 11/25/2019, indicated that Resident 1 was able to understand and make herself understood and had normal cognition (thought process). During an interview on 1/2/2020, at 11:33 a.m. with Resident 1, Resident 1 stated that on 12/21/2019 she and Certified Nurse Assistant 4 (CNA 4) had an altercation. Resident 1 stated that she asked CNA 4 to get her tray for her and CNA 4 told her b----h get your nurse to do it. Resident 1 stated that she responded by calling CNA 4 a b---h. Resident 1 stated that CNA 4 told her to look into the mirror and you will see a b---h. Resident 1 stated that CNA 1, Charge Nurse 1 (CN 1), and CN 2 witnessed the incident. During an interview on 1/2/2020, at 12:30 p.m., with CNA 1, CNA 1 stated that on 12/21/2019 at approximately 5:30 p.m. she heard Resident 1 and CNA 4 screaming. CNA 1 stated that when she approached the area, CN 1 and 2 were standing there as CNA 4 and Resident 1 were arguing. CNA 1 stated that she heard Resident 1 call CNA 4 a b----h. CNA 1 stated that CNA 4 replied to Resident 1 look in the mirror and you will see a b---h. CNA 1 stated CNA 4 also told Resident 1 to mind your own f-----g business. CNA 1 stated she attempted to calm Resident 1 down by talking to her. CNA 1 stated that CN 1 stated To Resident 1 you two should handle this later because we have visitors and CN 2 Stated Oh my G-d A review of the Nurses' Note, dated [DATE]19 and created at 9:54 p.m., indicated that Resident 1 reported to Social Service Director (SSD) that she was verbally abused by one of the staff. During an interview on 1/2/2020, at 1:15 p.m., with SSD, SSD indicated that on [DATE]19 Resident 1 told her she had been verbally abused. SSD stated she informed the ADMN. During a concurrent interview and record review of Resident 1's medical record with the SSD on 1/2/2020 for the months of November and December 2019, the SSD confirmed that there were no care plans created relating to abuse or psycho-social development. During a concurrent interview and record review on 1/2/2020 at 1:54 p.m. with the Director of Nursing (DON), the DON stated that the facility must create a new care plan to address the resident's emotional state and the resident's psycho-social well being after the resident has been subjected to verbal abuse. The DON stated that the facility must also add new interventions to any older care plans regarding abuse and psycho-social well being. During a review of Resident 1's care plans, the DON acknowledged that the facility had not created any new care plans nor made any updates to any of Resident 1's existing care plans regarding abuse or psycho-social outcomes. A review of the facility's undated policy titled Abuse and Neglect Prevention Management indicated on page seven that the facility system to follow up on altercations will place an emphasis on preventing future altercations. This system includes care plan updates to incorporate individualized recommendations from the formal incident review process, in addition to immediate updates that may have occurred at the time, prior to the altercation. The policy also indicated that a multidisciplinary approach to the development of individualized behavior care plans, including social services, recreational activities, and external consultations will be implemented and that care plans will be updated with the identified actions that took place after an allegation of abuse has occurred.