STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055531	A. BUILDING _____ B. WING _____	**05/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACHSIDE POST ACUTE	**22520 MAPLE AVENUE TORRANCE, CA 90505**

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 maintain an environment free of verbal abuse from Certified Nursing Assistants 1 and 2 (CNAs 1 and 2) for one of two sampled residents (Resident 1) who required total assistance with activities of daily living ((ADLs) daily self-care activities such as bathing, toileting, and grooming). This deficient practice had the potential for Resident 1 at risk to be verbally abused. Findings: A review of Resident 1's Face Sheet (admission record) indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS), an assessment and care-screening tool, dated 2/18/20 indicated Resident 1 had severe impairment in cognitive skills (thought process) and required total assistance for dressing, eating, toilet use and personal hygiene. A review of Certified Nursing Assistant 4's (CNA 4) Abuse allegation report, dated 3/4/20 indicated the Social Services Assistant (SSA) walked out of the staff break-room when she was approached by CNA 4. CNA 4 asked SSA whom she should report abuse to while remaining anonymous. The SSA asked CNA 4 what abuse she was trying to report and CNA 4 then explained to the SSA that she had received an audio recording where she could hear both CNAs 1 and 2 verbally abusing a resident (Resident 1). CNA 4 informed SSA that it was given to her by Resident 2 who was previously discharged from the facility. CNA 4 stated that Resident 2 was going to report it but also gave her the audio recordings just in case. SSA immediately reported the alleged abuse to the Social Services Director (SSD). The SSD then reported the alleged abuse to the Director of Nursing (DON) and Administrator. The Development Staff Director (DSD) called CNA 4 for a statement. CNA 4 gave a statement to the SSA, SSD, DSD, DON and Administrator and gave the voice recording to the Administrator. According to the report, CNAs 1 and 2 were immediately put on investigative suspension. A review of Resident 1's Abuse investigation report, dated 3/6/20 indicated CNA 4 reported to the facility that Resident 2, a previous resident in the facility reported to CNA 4 regarding an allegation of verbal abuse involving CNAs 1 and 2 and Resident 1. The report indicated, CNAs 1 and 2 were immediately placed on investigative suspension on 3/4/20. Local police department was contacted by the SSD and police officer informed the SSD that he would not file a report on their end since both patients were no longer in the facility. The Administrator conducted a telephone interview on 3/6/20 with Resident 2 who stated that CNAs 1 and 2 went into his room to take care of Resident 1 and heard both CNAs 1 and 2 talking to Resident 1 in an unprofessional manner. Resident 2 further stated he felt it was inappropriate and started recording the incident on his phone. Resident 2 stated he did not report the incident to the facility staff because he already reported it to the Department of Health twice, via telephone and email sometime in October 2019. The report indicated that based on the investigation of the audio recording and Resident 2's interview the verbal abuse did occur. Staff re-education on Abuse Prevention and Reporting was immediately initiated on 3/5/20, and the facility decided to separate the work relationship with both CNA 1 and CNA 2. On 3/6/20 at 3:10 p.m., during a review of audio recordings of the alleged abuse and concurrent interview, in the presence of the Director of Nursing (DON), the DON stated the mocking and verbal abuse sounded bad. On 3/6/20 at 3:50 p.m., during an interview, Licensed Vocational Nurse 2 (LVN 2) stated both CNAs 1 and 2 had a tendency to make side comments regarding their residents. LVN 2 stated based on her experience working with CNAs 1 and 2, they were known to have attitudes towards their designated work assignments and responsibilities. On 3/6/20 at 4:13 p.m., during an interview, Registered Nurse (RN 2) Supervisor stated both CNAs 1 and 2 were known to show a peculiar attitude towards the charge nurses, RN supervisor and to some other staff as well and I have reported it to the previous DON and previous administrator. On 3/27/20 at 8:30 a.m., during a telephone interview, Resident 2 stated that he recorded the conversation because he felt that both CNA 1 and CNA 2 was verbally abusive to Resident 1. Resident 2 stated he could not see everything because the curtain was drawn but Resident 2 heard everything and it was recorded on his cellular phone. Resident 2 stated that it was not the first time that happened and he felt sorry for Resident 1 and that was why Resident 2 started recording the conversation. On 3/27/20 at 8:50 a.m., during a telephone interview, the DON stated that the facility fired both CNA 1 and CNA 2 and reported the abuse incident to the CNA Board. On [DATE] at 9:55 a.m., during a telephone interview, CNA 4 stated that she did not personally witness the verbal abuse incident because it was reported to her by Resident 2. CNA 4 stated CNA 2 always had an attitude with whoever she worked with. CNA 4 stated she personally listened to the audio recordings and it was terrible and abusive. CNA 4 stated that no one had the right to treat any resident in any abusive manner, even if they have dementia, they are human beings and the nature of the job was to take care of sick people. CNA 4 stated the staff should be caring and [MEDICATION NAME]. A review of the facility's policy and procedure titled, Abuse and Neglect Prohibition Policy, dated 9/2018 indicated it was the facility's policy to prohibit abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property for all residents through the following; prevention of occurrences, identification of possible incidents or allegations which needs investigation, reporting of incidents, investigations, and the facility's response to the results of their investigation. The purpose was to ensure that facility staff were doing all that was within their control to prevent occurrences of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, and misappropriation of property for all residents.

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.