STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056326	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BURLINGTON CONVALESCENT HOSPITAL	**845 S.BURLINGTON AVENUE LOS ANGELES, CA 90057**

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 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure social services intervention / monitoring / follow up were implemented for one (two) of two sampled residents (Resident 1 and Resident 2), following an altercation, where both residents sustained minor injuries. This deficient practice caused an increased risk to negatively impacting the residents mental and psychosocial health. Findings: On November 20, 2019, an unannounced visit was made to the facility for the investigation of a facility reported incident regarding a resident to resident altercation. a. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated October 25, 2019, indicated Resident 1 was usually able to make himself understood and usually able to understand others. According to the MDS, Resident 1 was severely impaired, and had verbal behavioral symptoms directed towards others (e.g., threatening, screaming and cursing at others). The resident required extensive assistance with one person physical assist for locomotion on/off the unit. A review of Resident 1's SBAR dated November 3, 2019, indicated a resident to resident altercation when Resident 1 and Resident 2 were noted in the bathroom fighting. Resident 2 was lying on the floor while Resident 1 was sitting on top of Resident 2's legs. Both residents were immediately separated. Resident 1 was noted with scratches on the head, forehead with small amount of blood, and scratches on the neck and left knee. A review of Resident 1's Interdisciplinary Team Conference, dated November 4, 2019, related to the incident (altercation), indicated Resident 1 had a potential for further conflicts and emotional distress. The risk factors included his mental diagnoses, poor impulse control and history of verbally abusive behaviors, calling people names, saying derogatory remarks. b. A review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE], indicated the resident was usually able to make himself understood and usually able to understand others. According to the MDS, Resident 2 had moderately impaired cognition and required limited supervision for locomotion on/off the unit. A review of Resident 2's SBAR dated November 23, 2019, indicated a resident to resident altercation between Resident 2 and Resident 1. The notes indicated Resident 2 was noted with nose bleeding, a bruise on the nose, right side of the face and forehead and swelling on the left eye with red spots. The resident also complained of generalized body pain. A review of the facility's Investigation Report dated November 3, 2019, indicated Resident 1 and Resident 2 were both observed on the floor in their room. Resident 1 was observed sitting on top of Resident 2's legs. The residents were separated and both Resident 1 and Resident 2 were assessed with [REDACTED]. Resident 2 was transferred to the general acute care center (GACH) and then discharged home. A review of the IDT Conference Record for Resident 2 dated November 4, 2019, related to the incident indicated Resident 2 sustained nose bleeding, skin discolorations on the nose, right side of the face and forehead, and swelling around the left eye. The resident was transferred to the hospital for evaluation and further management but later returned to the facility with a new [DIAGNOSES REDACTED]. The notes indicated the risk factors included a history of provocative behavior-getting into other residents' private space, calling them names, saying racial slurs and derogatory remarks. On November 20, 2019, at 9:29 a.m., in an interview, the Assistant Director of Nursing (ADON) stated Resident 1 was [MEDICAL CONDITION], had episodes of anger, insulting others and was short tempered. On November 20, 2019, at 9:47 a.m., during an interview, the Director of Nursing (DON) stated, following a resident to resident altercation, social services staff meet with the residents involved and conduct follow up visits for at least 72 hours to make sure the residents' feel safe and were not in any distress. The DON acknowledged there were no social service notes found in Resident 1's medical record indicating the DSS met or made an attempt to meet with Resident 1 following the altercation with Resident 2 on November 3, 2019. During an interview on November 20, 2019, at 10:20 am, the Director of Social Services (DSS) stated, following a resident to resident altercation, residents were monitored by social services for 72 hours to ensure the resident feels safe and was not in any distress. The DSS could not provide any documented evidence that an attempt was made to interview Resident 1. According to the DSS any interview or any attempts to interview a resident should be documented in the medical record. The DSS stated Resident 1 had refused to be interviewed. A review of the Job Description for the job title Social Worker, dated March 14, 2014, indicated the social worker's essential duties and responsibilities, included the following: - Ensures that residents receive psychosocial assessments at admission, upon change of condition and/or annually. - Provides direct psychosocial intervention. - Implements social service interventions that achieve treatment goals, address resident needs, link social supports, physical care and physical environment to enhance quality of life.

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.