STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056159	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHERMAN VILLAGE HCC	**12750 RIVERSIDE DRIVE NORTH HOLLYWOOD, CA 91607**

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	**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 to the State Agency (the Department) an incident of abuse allegation made by one of three sampled residents (Resident 3) against another resident (Resident 1). This resulted in a delay of an onsite inspection by the Department to ensure the safety of the residents and to ensure the abuse allegation was investigated. Findings: A review of Resident 3's Admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 3's Minimum Data Set (MDS- a standardized assessment and care-screening tool) dated 6/14/19, indicated the resident was able to understand and make decisions. On 7/15/19 at 2:15 p.m., during an interview, Resident 3 stated that his previous roommate (Resident 1) threw water at his face. Resident 3 stated the staff removed Resident 1 from his room after the incident. On 7/15/19 at 2:29 p.m., during an interview, the Administrator stated she was aware of the incident in which Resident 1 threw water at Resident 3 and confirmed it was not reported to the Ombudsman (public advocate in charge of representing the interest of the residents) and the State Agency. A review of the facility's policy and procedure titled, Abuse Allegation Reporting dated 8/2018, indicated the Administrator/Abuse Coordinator will report all alleged violations to the State Agency within 24 hours and the Ombudsman within 48 hours.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to investigate an alleged abuse incident for one of three sample residents (Resident 3). This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from abuse. Findings: A review of Resident 3's Admission Record indicated the facility originally admitted the resident on 5/18/17 with last readmission 5/17/19 with [DIAGNOSES REDACTED]. A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 6/14/19, indicated the resident was able to understand and make decisions. During an interview with Resident 3 on 7/15/19 at 2:15 p.m., Resident 3 stated his previous roommate (Resident 1) threw water at his face. Resident 3 stated that the staff removed Resident 1 from his room after the incident. A review of Resident 3's nursing notes, care plan and interdisciplinary notes, indicated there was no documentation about the abuse allegation. On 7/15/19 at 2:29 p.m., during an interview, the Administrator stated she was aware of the incident in which Resident 1 threw water at Resident 3. The Administrator stated they informed the local law enforcement and the Psychiatric Emergency Team (PET) but did not conduct a thorough investigation of the incident and the nurses did not document the incident of abuse. A review of the facility's undated policy and procedure titled, Abuse Allegation Investigation, indicated that the facility is to ensure that a complete and thorough investigation is conducted for all allegations of abuse.
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 comprehensive person-centered plan of care for two of three sampled residents (Residents 1 and 2) regarding a resident to resident altercation that occurred. This deficient practice had the potential to lead to further incidents of resident to resident abuse. Findings; A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/22/19 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 6/20/19 indicated the resident was able to understand and make daily decisions. A review of Resident 1's Social Service Notes dated 7/1/19, indicated that on 6/29/19 there was an incident reported that Residents 1 and 2 had a verbal altercation. A review of Resident 1's Care Plans indicated no documented care plan developed to address Residents 1 and 2's altercation on 6/29/19. A review of Resident 2's Admission Record indicated the facility admitted the resident on 6/1/18 with [DIAGNOSES REDACTED]. A review of Resident 2's Care Plan indicated no documented care plan developed to address Residents 1 and 2's altercation on 6/29/19. During an interview with the Administrator on 7/15/19 at 1:03 p.m , the Administrator confirmed there was no care plan developed for the resident-to-resident altercation. A review of the facility's policy and procedure titled The Resident Care Plan, undated, states that the facility is to provide an individualized nursing care plan and to promote continuity of resident care.

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.