STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555578	A. BUILDING _____ B. WING _____	**10/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOLIDAY MANOR CARE CENTER	**20554 ROSCOE BLVD CANOGA PARK, CA 91306**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the needed care and services that were resident centered, for Resident 1 by: 1. Failing to monitor Resident 1 after an alleged Certified Nurse Assistant (CNA) to resident abuse. 2. Failing to provide Resident 1 psychosocial support by the Social Services Director (SSD). These deficient practices had the potential to result in decreased quality of care and services for Residents 1 which placed the resident at risk for not receiving psychosocial support for further protection from abuse. Findings: a. A review of Resident 1's Admission Record indicated the facility readmitted the resident on 2/18/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 11/1/2019, indicated Resident 1 had severely impaired cognition (knowledge and understanding through thought, experience and senses). The MDS record indicated Resident 1 required extensive assistance from staff with bed mobility, transfer, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. A review of Resident 1's SBAR Communication Form (Situation, Background, Assessment, Recommendation-a technique that can be used to facilitate prompt and appropriate communication), dated 2/12/2020, indicated an investigation of alleged abuse was reported to the IDT (Interdisciplinary Team-healthcare team facilitating communication) on 2/12/2020 at 11:20 a.m. A review of Resident 1's IDT Notes, dated 2/13/20, at 2:27 p.m., indicated that there was an alleged perpetrator (CNA) on Saturday, 2/08/2020, at 8 p.m. Per Resident 1's Responsible Party (RP) when she visited the resident, a CNA hit her head and stomped her feet on 2/08/2020. A review of Resident 1's Care Plan titled, Risk/Potential for emotional distress related to alleged abuse, dated 2/12/2020, indicated for facility staff to monitor for pain or change in condition every shift for 72 hours. During an interview and concurrent record review with Registered Nurse 1 (RN1), on 2/26/2020, at 10 a.m., RN1 was unable to find documented evidence that monitoring was done after the alleged abuse allegation for Resident 1. RN1 stated after a change in condition, the nursing staff should be monitoring the resident every shift for 72 hours. RN 1 stated that staff needed to monitor if there were any changes in condition related to the specific event. A review of facility's policy titled Acute Condition Changes- Clinical Protocol, revised December 2015, indicated the staff will monitor and document the resident's progress and responses to treatment. b. During an interview and concurrent review with SSD on 2/26/2020, at 10:41 a.m., the SSD was unable to find documented evidence of social services notes regarding the alleged allegation of abuse. The SSD stated after an alleged allegation of abuse, the social services department should provide psychosocial support such as room visits to ensure the psychosocial wellbeing of the resident. During an interview and concurrent review with Medical Records Assistant (MRA), on 2/26/2020, at 11:17 a.m., the MRA was unable to find evidence of social services notes related to the allegation of abuse on 2/26/2020. A review of facility's policy titled Charting and Documentation, revised April 2008, indicated all services provide to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.

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