

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER St. John of God Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE 2468 South St Andrews Place Los Angeles, CA 90018	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832</p> <p>Based on observation, interview and record review, the facility failed to:</p> <p>1. Ensure one of three sampled residents (Resident 1) was free from abuse when CNA 1 grabbed Resident 1's wrist.</p> <p>This deficient practice had the potential for Resident 1 to have psychological distress and caused Resident 1 to experience feelings of humiliation and disrespect.</p> <p>Findings:</p> <p>During an interview, on 6/12/2024 at 8:40 a.m., Resident 1 was observed sitting in her wheelchair watching tv. Resident 1 stated on 6/2/2024 at 4:00 a.m., while in bed, she had pressed the call light for assistance to the restroom. Resident 1 stated CNA 1 entered the room and appeared very angry. Resident 1 stated CNA 1 grabbed her left wrist, placed her in her wheelchair and wheeled her to the restroom. Resident 1 stated she told CNA 1 she was too rough and started crying.</p> <p>A review of Resident 1's Admission Record (face sheet) indicated the resident was admitted to the facility on [DATE]. Resident 1's diagnoses included acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), difficulty in walking (the inability to walk properly), encephalopathy (a disease in which the brain is affected by an infection or toxins), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>A review of Resident 1's history and physical (H&P- a formal and complete assessment of a resident 's past and current illness) dated 3/6/2024, indicated Resident 1 was able to make decisions for activities of daily living.</p> <p>A review of Resident's 1's Minimum Data Set (MDS- a comprehensive assessment and care screening tool), dated 3/8/2024, indicated Resident 1 was cognitively intact with daily decision making. Resident 1 required moderate to maximal assistance (one-to-two-person help) with toileting, bathing, and lower body dressing.</p> <p>A review of the facility's 5-day conclusion letter, undated, indicated on 6/2/2024 between 4:00 a.m.-5:00 a.m. , Resident 1 alleged a night shift CNA (CNA 1) had been 'very rough' with her while providing toileting care.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview, on 6/12/2024 at 10:10 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 1 always asked to use the restroom during the night. CNA 1 stated Resident 1 said I am an old lady; you are being too rough with me. CNA 1 stated she then apologized to Resident 1.</p> <p>During an interview, on 6/12/2024 at 10:35 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 had mentioned to her that CNA 1 was rough with her. LVN 1 stated Resident 1 did not explain the detail of what had occurred.</p> <p>During an interview, on 6/12/2024 at 11:25 a.m., with the Social Services Director (SSD), SSD stated Resident 1 was cognitively alert. SSD stated the incident was initially reported by Resident 1's daughter during a phone call. SSD stated Resident 1 explained how she rang the call light to use the restroom. SSD stated Resident 1 explained CNA 1 entered to room and asked what assistance was needed. SSD stated Resident 1 informed her that CNA 1 grabbed her arm in a rough way to where her wristband fell off.</p> <p>During an interview, on 6/12/2024 at 12:15 p.m., with the Director of Nursing (DON), the DON stated no type of abuse was tolerated in the facility. The DON stated she assessed Resident 1 after being informed of the incident. The DON stated there were no injuries and no pain or further complaints from Resident 1.</p> <p>A review of the facility's policies and procedures, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021 and revised 3/2024, indicated to 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to a. facility staff; and Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident 's symptoms.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832</p> <p>Based on observation, interview and record review, the facility failed to:</p> <p>1. Follow its policy and procedure (P&P), titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021 and revised 3/2024, which indicated the facility did not condone any form of resident abuse or neglect for one of three residents (Resident 1).</p> <p>As a result, this violation had the potential to place Resident 1 and other residents at risk of further abuse.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record (face sheet) indicated the resident was a [AGE] year-old female, admitted to the facility on [DATE]. Resident 1's diagnosis ' included acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), difficulty in walking (the inability to walk properly), encephalopathy (a disease in which the brain is affected by an infection or toxins), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>A review of Resident 1's history and physical (H&P- a formal and complete assessment of a resident ' s past and current illness) dated 3/6/2024, indicated Resident 1 was able to make decisions for activities of daily living.</p> <p>A review of Resident's 1's Minimum Data Set (MDS- a comprehensive assessment and care screening tool), dated 3/8/2024, indicated Resident 1 was cognitively intact with daily decision making. Resident 1 required moderate to maximal assistance (one-to-two-person help) with toileting.</p> <p>During a telephone interview, on 6/12/2024 at 10:10 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 1 always asked to use the restroom during the night. CNA 1 stated Resident 1 said I am an old lady; you are being too rough with me. CNA 1 stated she then apologized to Resident 1. CNA 1 further stated handling residents roughly can be abuse.</p> <p>During an interview, on 6/12/2024 at 12:15 p.m., with the Director of Nursing (DON), the DON stated no type of abuse was tolerated in the facility and grabbing could be considered abuse.</p> <p>A review of the facility's policies and procedures, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021 and revised 3/2024, indicated to 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to a. facility staff; and Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident ' s symptoms.</p>		