STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055526	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inglewood Health Care Center	100 S. Hillcrest Blvd Inglewood, CA 90301

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** 49906 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 2) was free from physical abuse by Resident 1 by failing to: 1. Follow Resident 2 ' s Care Plan and physician ' s order to monitor and address episodes of aggressive and abusive behaviors. 2. Revise and individualize (tailoring to the resident) the Care Plan for Resident 2 who had a history of altercations and aggressive behaviors. 3. Ensure Residents 1 and 2 who had prior resident-to resident altercation on 7/29/2024, were separated. 4. Follow the facility ' s Policy and Procedure titled, Abuse Prevention Program which indicates the facility would protect residents from abuse. These deficient practices resulted in Resident 1 being physically abused by Resident 2 on 8/18/2024, sustained a hematoma to the forehead (collection of blood that forms outside of the blood vessel) and had the potential to other injuries including intracranial hemorrhage (bleeding within the skull) and fractures (broken bones). Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including psychotic disorder (a mental illness that causes people to lose touch with reality and have abnormal perceptions and thinking), mood [affective] disorder (a group of mental health conditions that cause significant disruptions to a person ' s emotions), dementia (loss of intellectual abilities that affects a person ' s ability to think, remember, and reason). (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set ([MDS] a standardized care assessment and care screening tool) dated 7/18/2024, the MDS indicated Resident 1 had severe cognitive (the ability to think and reason) impairment. The MDS indicated Resident 1 was needed supervision or touching assistance from staff for Activities of Daily Living (ADLs) such as personal hygiene, lower body dressing, sit to stand (ability to come to a standing position from sitting in a chair), and walking 150 feet (Once standing, the ability to walk at least 150 feet in a corridor or similar space. During a review of Resident 1 ' s Observation Detail List Report and SBAR (Situation, Background, Assessment and Recommendation) dated 7/29/2024. The SBAR indicated another resident (Resident 2) slapped Resident 1 on the right eye. During a review of Resident 1 ' s SBAR dated 8/18/2024, the SBAR indicated Resident 1 had a resident-to-resident altercation (with Resident 2) causing injury. The SBAR indicated Resident 1 was pushed to the floor (by Resident 2) and sustained swelling to the left side of the forehead. During a review of Resident 1 ' s General Acute Care Hospital (GACH) H&P dated 8/19/2024, the GACH H&P indicated Resident 2 was admitted for a fall after being pushed by a resident at the facility. The H&P indicated fell during the resident altercation and a hematoma formed on her forehead. During an interview 9/3/2024 4:40 pm with Certified Nursing Assistant 1 (CNA) 1 stated Resident 1 was seen walking without a wheelchair in the hall, CNA 1 went to get a wheelchair and when she returned approximately two minutes later Resident 1 was standing in front of Resident 2 ' s room. CNA 1 stated Resident 2 stood up from his wheelchair and pushed Resident 1 and hit her head on the floor. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Schizophrenia (mental illness that affected a person ' s thoughts, feelings, and behaviors), and cerebral infarction (loss of blood and oxygen to part of the brain). During a review of Resident 2 ' s Physician Order dated 3/27/2024, the order indicated to monitor behavior of outburst of anger and agitation towards staff and residents and notify the physician accordingly for further interventions when indicated. During a review of Resident 2 ' s Physician ' s Order dated 5/24/2024, the order indicated to monitor behavior, s/s of delusions, hallucinations, disorganized thinking and notify the physician for further interventions when indicated. During a review of Resident 2 ' s Care Plan for Behavioral Symptoms dated 6/18/2024, the Care Plan indicated Resident 2 was physical abusive to others, short tempered with angry outbursts, and verbally abusive cursing at staff. The Care Plan nursing approach indicated to monitor Resident 2 ' s behaviors: s/s of delusions, hallucinations, disorganized thinking and notify the physician accordingly for further interventions when indicated every shift. The Care Plan also indicated nursing to monitor for outbursts of anger and agitation towards staff and residents and notify the physician accordingly for further interventions when indicated every shift. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 had physical (i.e. hitting, kicking, pushing, scratching, grabbing, abusing others) and verbal (i.e. threating, screaming, cursing) behavioral symptoms directed towards others. The MDS indicated Resident 2 ' s current behavior status was worse compared to prior assessment. The MDS also indicated Resident 2 was independent for ADLs such as bed mobility, sit to stand and transfer (ability to transfer to and from a bed to a chair or wheelchair). During a review of Resident 2 ' s SBAR dated 7/29/2024, the SBAR indicated Resident 2 slapped another resident ' s (Resident 1) right eye. During a review of Resident 2 ' s Care Plan for Negative/Untoward Event dated 7/29/2024, the Care Plan indicated Resident 2 swung his left hand and hit another resident (Resident 1). The Care Plan indicated nursing approach indicated to neutralize the situation by separating involved parties. During a review of Resident 2 ' s Behavior Monitoring Administration History dated 8/2024, the Behavior Monitoring indicated to Monitor behavior of Delusions of persecutions thinking staff was against him causing extreme agitation. The Behavior Monitoring indicated Resident 2 had 3 episodes 8/14/2024 morning shift (7:00 a.m.- 3:00 p.m.), 2 episodes on 8/15/2024, 8/16/2024 and 8/17/2024 night shifts (11:00 p.m.- 7:00 a.m. shift). The Behavior Monitoring also indicated Resident 2 was redirected with unchanged outcome. During a review of Resident 2 ' s Nurses Notes, the Notes indicated there was no documentation to indicate Resident 1 ' s behaviors were addressed according to Resident 2 ' s Care Plan and physician ' s orders. During a review of Resident 2 ' s SBAR dated 8/17/2024 at 6:15 p.m., the SBAR indicated Resident 2 had physical aggression. The SBAR indicated Resident 2 slapped an unnamed Licensed Vocational Nurse (LVN) on the right side of the face and neck as the LVN was trying to enter the resident ' s room. The SBAR indicated the physician was notified and gave an order to monitor the Resident 2. During a review of Resident 2 ' s SBAR dated 8/18/2024 at 2:22 p.m., the SBAR indicated Resident 2 had a resident-to-resident altercation resulting in the other resident (Resident 1) sustaining an injury. During an interview on 9/3/2024 at 1:35 p.m. with LVN 1, LVN 1 stated Resident 2 could be physically aggressive. LVN 1 stated she would made sure Resident 2 got what he wanted to calm him down. During an interview on 9/3/2024 at 1:55 pm with Registered Nurse (RN) 1, RN 1 stated Resident 1 would have outbursts if he did not get what he wanted. RN 1 stated Resident 2 did not want to wait, and he would curse and was aggressive. During an interview on 9/3/2024 at 2:20 pm, the Director of Nursing (DON) stated Resident 1 has some agitation but is redirectable and Resident 2 has hit staff before. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent Record Review and Interview on 9/13/2024 at 1:12 pm with LVN 2, LVN stated Resident 2 would throw water on the floor or yell at nurses and curse for no reason. Also stated Resident 1 and Resident 2 were on monitoring at the time of the incident and when they are seen getting close, they were separated. LVN 2 stated, It was hard to keep Resident 1 in one place because Resident 1 walked around the facility. During a concurrent Record Review and Interview on 9/18/2024 at 3:17 p.m. with the Director of Nursing (DON), Resident 2 ' s Behavior Monitoring and Care Plans were reviewed. The DON stated Resident 2 was redirectable however could be agitated and aggressive when the resident did not get what he wanted. The DON stated Resident 1 and Resident 2 had a previous altercation on 7/29/2024 and should have been kept separated and not be in contact with each other without supervision. The DON stated separating the residents was important to ensure the safety of the residents. The DON stated, the physician should have been notified because Resident 2 had behaviors of agitation on 8/14/2024- 8/16/2024 and interventions were ineffective on 8/15/2024 and 8/16/2024. The DON stated the physician should have also been contacted because Resident 2 had behaviors on consecutive days. The DON stated there was no documentation to indicate the physician was notified or other interventions were provided when redirecting was not effective. The DON stated it was important to address the resident ' s behaviors and notify the physician so the team and physician could evaluate the behavior and identify other interventions that could assist the resident. The DON also stated Resident 2 ' s Care Plan was not individualized and should have indicated the resident ' s triggers of behaviors such as not receiving what the resident wanted right away and the type of supervision the resident needed; however, the Care Plan did not include these information. The DON stated it was important to individualize the Care Plan to ensure the facility identified specific and detailed needs of the resident. During a review of the facility ' s undated P&P titled, Behavior Assessment, Intervention and Monitoring, the P&P indicated, the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. The P&P indicated safety strategies will be implemented immediately if necessary to protect the resident and others from harm. The P&P also indicated interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs. During a review the facility ' s undated P&P titled, Abuse Prevention Program, the P&P indicated, residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The P&P indicated as part of the abuse prevention, the administration will: protect residents from abuse by anyone including, other residents, implement P&P to aid the facility in preventing abuse, neglect or mistreatment of the residents and implement measures to address factors that may lead to abusive situations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s undated P&P titled, Safety Supervision of Residents indicated the care team shall target interventions to reduce individual risks related to hazards in the environment including adequate supervision. The P&P indicated implementing interventions to reduce accident risks and hazards include communicating specific interventions to all relevant staff, ensuring interventions are implemented and documenting interventions. The P&P also indicated monitoring the effectiveness of interventions shall include ensuring interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying, or replacing interventions as needed and evaluating the effectiveness of new or revised interventions. The P&P also indicated resident supervision is a core component of the system approach to safety and the type and frequency of resident supervision is determined by the individual residents assessed needs.