STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Palos Post-Acute Care Center	1430 West 6th Street San Pedro, CA 90732

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 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** 46537 Based on observation, interview, and record review, the facility failed to implement residents' care plan interventions for one of three sampled residents (Residents 1), who had wandering (walking around slowly in a relaxed way or without any clear purpose or direction) behavior to monitor Resident 1's whereabouts. This failure resulted in Resident 1 entering her previous room after Resident 1 had alleged physical altercation (a dispute between individuals in which one or more persons sustain bodily injury arising out of the dispute) with her previous roommate. 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 last re-admission was 4/16/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and repeated falls. During a review of Resident 1's History and Physical (H&P), dated 10/28/2024, the H&P indicated, Resident 1 had no capacity to make decision due to dementia. During a review of Resident 1's Minimum Data Set (MDS - a mandated resident assessment tool), dated 10/25/2024, the MDS indicated Resident 1 moderate assistance (Helper does less than half the effort) from one staff for roll left and right, sit to lying, lying to sitting, sit to stand, chair/bed-to-chair transfer, and wheel her wheelchair 150 feet. During an observation on 11/12/2024, at 11:20 a.m., in activity room, Resident 1 was wheeling herself around the room and went out to hallway without assistance from staff. During an interview on 11/12/2024, at 11:27 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated, Resident 1 had alleged physical altercation with roommate and moved to different room to prevent future incident. CNA 1 stated, Resident 1 should not enter previous room for same reason. CNA 1 stated, she checked Resident 1's location from time to time, but she did not document. CNA 1 stated, she did not see Resident 1 enter her previous room today. CNA 1 stated, she noticed Resident 1 was wandering the hallway sometimes. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/2024, at 1:11 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, Resident 1's whereabouts should be monitored regularly, since she was involved in recent alleged physical altercation with her previous roommate to prevent further altercations for safety as care plan indicated. LVN 1 stated, Resident 1 had dementia and she tried to go back to her previous room a few times. LVN 1 stated, staff did not document hourly rounding. LVN 1 stated, she did not notice that Resident 1 entered her previous room. LVN 1 stated, it was important to follow and to implement interventions from care plan to prevent further incident. LVN 1 stated, the care plan would be updated with new incident or problem to prevent recurrent episodes. During an interview on 11/12/2024, at 1:49 p.m., with Social Service Director (SSD), SSD stated, staff should have monitored Resident 1's whereabouts as indicated in care plan. SSD stated, Resident 1 was alleged perpetrator (the individual alleged to have abused, neglected, or exploited the alleged victim) during physical altercation. SSD stated, implementing intervention of monitoring Resident 1's whereabouts was important to keep both Resident 1 and her previous roommate separated for safety. During a concurrent interview and record review on 11/12/2024, at 4:15 p.m., with Administrator (ADM) in the conference room, Surveillance Camera Footage, dated 11/12/2024 from 9:00 a.m. to 11:15 p.m. was reviewed. The Surveillance Camera Footage indicated, Resident 1 entered her previous room where she had physical altercation with her previous roommate at 10:50 a.m. ADM stated, Surveillance Camera Footage indicated 10:50 a.m., but actual time was 9:50 a.m. due to day light saving (the practice of moving clocks ahead by one hour in the spring and back by one hour in the fall to make better use of daylight hours during the summer). ADM stated, staff should have monitored and documented Resident 1's whereabouts. ADM stated, Resident 1 should have not entered her previous room where the alleged victim stayed. ADM stated, Resident 1's care plan indicated staff should monitor Resident 1 because of safety. ADM stated, it was important to implement care plan interventions because it provides a detailed and effective personalized outline of care to be provided, that helps improve residents' quality of life and ensure their safety. During a review of Resident 1's Care Plan (CP), revised 11/12/2024, the CP Focus indicated, Wandering-Resident 1 is at risk for wandering related to disorientation to place as evidenced by wanders aimlessly. The CP goal indicated; Resident 1's safety will be maintained by target date of 1/16/2025. The CP interventions indicated, Resident 1 needs constant visual checks and check Resident 1's whereabouts every hour. During a review of Resident 1's Care Plan (CP), revised 10/30/2024, the CP Focus indicated, Resident 1 had physical altercation with roommate on 10/25/2024. The CP goal indicated; Resident 1's aggressive behavior will be effectively managed by target date of 11/7/2025. The CP interventions indicated, Maintain a safe distance from other resident during episodes of aggression to prevent physical harm and separate Resident 1 from alleged victim. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated revised 3/2022, the P&P indicated, Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the P&P titled, Resident-to-Resident Altercations, dated revised 9/2022, the P&P indicated, Policy Interpretation and Implementation . 2. Behaviors that may provoke a reaction by residents or others include . b. physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects . e. wandering into others' rooms/space .If two residents are involved in an altercation, staff . f. make any necessary changes in the care plan approaches to any or all of the involved individuals; g. document in the resident's clinical record all interventions and their effectiveness.