Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055704 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/31/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Angels Nursing Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 415 S Union Avenue Los Angeles, CA 90017 | |

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) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454<br><br>Based on interview and record review, the facility failed to implement a comprehensive care plan that meets the care/services based on the resident's individual assessed needs for one of five sampled residents (Resident 1 [R1]) by failing to ensure that a comprehensive CP was implemented for R1 risk for elopement (leaving the facility unsupervised and without staff knowledge).<br><br>This deficient practice had the potential to result negative impact on residents' health and safety, as well as the quality of care and services received.<br><br>Cross Reference F689<br><br>Findings:<br><br>A review of R1's Admission Record indicated R1 was originally admitted to the facility 8/17/2021 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).<br><br>A review of R1's History and Physical dated 10/18/2023, indicated R1 does not have the capacity to understand and make decisions.<br><br>A review of the Minimum Data Set (MDS - a standardized comprehensive assessment and care screening tool), dated 5/30/2024, indicated R1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were moderately impaired and required assistance from staff with walking and R1 does not use a wheelchair.<br><br>A review of R1's Wandering & Elopement Risk Assessment, dated 10/18/2023 indicated, R1 is a moderate actual risk with recent observable evidence of wandering that involves wandering that is not easily ended or diverted. The Wandering & Elopement Risk Assessment on 10/18/2023 also indicated, R1 had a history of elopement and being a wanderer.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of R1's Care Plan for episodes of elopement and aggressive behavior, initiated on 10/17/2023 and revised on 7/23/2024 indicated, an intervention including to investigate reports, and assess level of mental status of the resident.<br><br>A review of R1's Care Plan for Actual Episode of Wandering and subsequent transgression or unplanned exits of facility's safety precaution and injury prevention policy by successful attempt of elopement, initiated on 10/17/2023 indicated a goal of, be free of injury or unplanned exits.<br><br>A review of R1's Care Plan for risk for fall-related to constant pacing, poor safety awareness, initiated on 7/23/2024 indicated an intervention including to monitor whereabouts every hour.<br><br>A review of the Resident 1's Situation Background Assessment Recommendation (SBAR - a written or verbal communication tool used to provide essential and concise information, usually during crucial situations) dated 7/17/2024, the SBAR indicated, at 8:20 p.m., patient (R1) complained of chest pain, insisted to be transfer to the hospital . at 8:30 p.m., called 911 (a phone number used to contact the emergency services) for assistance . at 8:40 p.m., Paramedics (a healthcare professional trained in the medical model, whose main role has historically been to respond to emergency calls for medical help outside of a hospital) came, report given . at 8:50 p.m., R1 left the facility via 911 to GACH 1.<br><br>During an interview with Licensed Vocational Nurse 2 (LVN 2) on 7/31/2024 at 12:48 p.m., LVN 2 stated, that on 7/17/2024, R1 was observed walking out of the facility through the front gate. LVN 2 stated, R1 wanted to leave the facility and go to the hospital for medications. LVN 2 stated, she did not document in R1's Progress Notes about what happened on 7/17/2024 with R1 and she did not call and notify R1's MD regarding the incident with R1.<br><br>During an interview with Treatment Nurse 1 (TXN 1) on 7/31/2024 at 1:08 p.m., TXN 1 stated, she saw R1 walking out of the facility on 7/17/2024. TXN 1 stated, she tried to stop and convince R1 from leaving the facility but R1 got aggressive, so she ended up walking with him (R1) on the street alongside him. TXN 1 stated, she did not document this incident in R1's Progress Notes. TXN 1 stated, she did not call R1's MD regarding this incident as well.<br><br>During an interview with Director of Nursing (DON) on 7/31/2023 at 1:59 p.m., DON stated, on 7/17/2024, R1 attempted to elope and left the facility. The DON stated, R1 was verbally aggressive, walked few blocks from the facility and did not want to come back when staff tried to talk to him. The DON stated, R1 got tired and complained of chest pain after walking and staff called 911. The DON stated, this incident should have been documented in the progress notes with an Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) meeting initiated after the incident. DON further stated, R1's CP regarding risk of elopement should have been implemented.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of facility's policy and procedures (P&P) titled, Elopement, date implemented 2/9/2024, indicated, the licensed nurse most familiar with the incident will document in the resident's medical record how the elopement occurred. The facility will make necessary reports to state agencies in compliance with policy. When an individual who departed without following proper procedures returns to the facility, the DON or licensed nurse should examine the resident for any possible injuries; notify the attending physician' and notify the resident's responsible party . The IDT with input from the licensed nurse, will conduct a thorough review of the elopement, document its findings in the IDT notes, and update the Care Plan to prevent a recurrence.<br><br>A review of the facility's P&P titled, Care Planning, date implemented 2/9/2024 indicated, to ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454<br><br>Based on interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1 [R1]) was properly supervised to prevent elopement (leaving the facility unsupervised and without staff knowledge) by failing to:<br><br>1. Implement the facility's policy and procedures (P&P) regarding elopement.<br><br>2. Implement the comprehensive care plan for actual episode of wandering and previous successful attempts of elopement.<br><br>These deficient practices resulted in R1 eloping on 7/17/2024 and was transferred to general acute care hospital 1 (GACH 1) due to chest pain.<br><br>Findings:<br><br>A review of R1's Admission Record indicated R1 was originally admitted to the facility 8/17/2021 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).<br><br>A review of R1's History and Physical dated 10/18/2023, indicated R1 does not have the capacity to understand and make decisions.<br><br>A review of the Minimum Data Set (MDS - a standardized comprehensive assessment and care screening tool), dated 5/30/2024, indicated R1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were moderately impaired and required assistance from staff with walking and R1 does not use a wheelchair.<br><br>A review of R1's Wandering & Elopement Risk Assessment, dated 10/18/2023 indicated, R1 is a moderate actual risk with recent observable evidence of wandering that involves wandering that is not easily ended or diverted. The Wandering & Elopement Risk Assessment on 10/18/2023 also indicated, R1 had a history of elopement and being a wanderer.<br><br>A review of R1's Care Plan for episodes of elopement and aggressive behavior, initiated on 10/17/2023 and revised on 7/23/2024, indicated, an intervention including to investigate reports, and assess level of mental status of the resident.<br><br>A review of R1's Care Plan for Actual Episode of Wandering and subsequent transgression or unplanned exits of facility's safety precaution and injury prevention policy by successful attempt of elopement, initiated on 10/17/2023, indicated a goal for R1 to be free of injury or unplanned exits.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of R1's Care Plan for risk for fall-related to constant pacing, poor safety awareness, initiated on 7/23/2024, indicated an intervention including to monitor whereabouts every hour.<br><br>A review of the Resident 1's Situation Background Assessment Recommendation (SBAR - a written or verbal communication tool used to provide essential and concise information, usually during crucial situations) dated 7/17/2024, the SBAR indicated, at 8:20 p.m., patient (R1) complained of chest pain, insisted to be transfer to the hospital . at 8:30 p.m., called 911 (a phone number used to contact the emergency services) for assistance . at 8:40 p.m., Paramedics (a healthcare professional trained in the medical model, whose main role has historically been to respond to emergency calls for medical help outside of a hospital) came, report given . at 8:50 p.m., R1 left the facility via 911 to GACH 1.<br><br>During an interview with Licensed Vocational Nurse 2 (LVN 2) on 7/31/2024 at 12:48 p.m., LVN 2 stated, on 7/17/2024, R1 was observed walking out of the facility through the facility's front gate. LVN 2 stated, R1 wanted to leave the facility and go to the hospital for medications. LVN 2 stated, she did not document in the Progress Notes about what happened on 7/17/2024 and she did not call and notify R1's MD regarding the incident.<br><br>During an interview with Treatment Nurse 1 (TXN 1) on 7/31/2024 at 1:08 p.m., TXN 1 stated, she saw R1 walking out of the facility on 7/17/2024. TXN 1 stated, she tried to stop and convince R1 from leaving the facility but R1 got aggressive, so she ended up walking with him (R1) on the street alongside him. TXN 1 stated, she did not document this incident in the Progress Notes. TXN 1 stated, she did not call r1's MD regarding this incident as well.<br><br>During an interview with Director of Nursing (DON) on 7/31/2023 at 1:59 p.m., the DON stated, on 7/17/2024, R1 attempted to elope and left the facility. DON stated, R1 was verbally aggressive, walked few blocks from the facility and did not want to come back when staff tried to talk to him. The DON stated, R1 got tired and complained of chest pain after walking and staff called 911. The DON stated, this incident should have been documented in the progress notes with an Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) meeting initiated after the incident.<br><br>A review of facility's policy and procedures (P&P) titled, Elopement, date implemented 2/9/2024, indicated, the licensed nurse most familiar with the incident will document in the resident's medical record how the elopement occurred. The facility will make necessary reports to state agencies in compliance with policy. When an individual who departed without following proper procedures returns to the facility, the DON or licensed nurse should examine the resident for any possible injuries; notify the attending physician' and notify the resident's responsible party . The IDT with input from the licensed nurse, will conduct a thorough review of the elopement, document its findings in the IDT notes, and update the Care Plan to prevent a recurrence. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454<br><br>Based on interview and record review, the facility failed to ensure appropriate competencies to provide nursing and related services to assure resident safety by failing to maintain and update basic life support/ Cardiopulmonary Resuscitation (BLS/CPR) certification to one of eight sampled facility staff (Certified Nursing Assistant 1- CNA1).<br><br>This deficient practice had the potential to place resident at risk of not getting proper immediate care during a life-threatening situation.<br><br>Findings:<br><br>During a record review of CNA1's staff file, indicated CNA1's BLS/CPR was missing.<br><br>During an interview with the Director of Nursing (DON) on [DATE] at 2:21 p.m., the DON stated that staff files should be updated and that staff BLS/CPR certification should be updated and filed.<br><br>A review of facility's policy and procedures (P&P), titled, Personnel Records, reviewed on ,d+[DATE], P&P indicated, facility maintains certain records for each employee which are directly related to his/her employment.<br><br>A review of facility job description (JD), titled, CNA, undated, P&P indicated CNAs are required to be certified in CPR. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454<br><br>Based on interview and record review, the facility failed to ensure that one of five sampled resident (Resident 1-R1's) psychotropic medication regimen was managed and monitored to promote or maintain the highest practicable mental, physical, and psychosocial well-being by failing to:<br><br>1. Ensure a behavior monitoring for episodes of anxiety specific for R1's Ativan (anti-anxiety medication) use was properly ordered and implemented.<br><br>2. Ensure a behavior monitoring for episodes of psychosis specific for R1's Depakote (anti-psychotic medication) use was properly ordered and implemented.<br><br>These failures had the potential to place R1 at risk of receiving unnecessary medications and/or overuse of medication; and at risk for adverse consequences while taking psychotropic medications.<br><br>Findings:<br><br>During a review of R1's Admission Record indicated R1 was originally admitted to the facility 8/17/2021 and was readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).<br><br>During a review of R1's History and Physical dated 10/18/2023, indicated R1 did not have the capacity to understand and make decisions.<br><br>During a review of the Minimum Data Set (MDS - a standardized comprehensive assessment and care screening tool), dated 5/30/2024, indicated R1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was moderately impaired and requiring assistance from staff with walking and R1 does not use a wheelchair.<br><br>During a review of R1's Order Summary Report (OSR), dated 7/22/2024, the OSR indicated a physician order for the following for R1:<br><br>Ativan 0.5 milligram (mg - unit of measurement) tablet by mouth (PO) every eight hours as needed for restlessness as evidenced by verbalization of distress related to generalized anxiety.<br><br>Depakote delayed release (DR) 500 mg PO two times a day for Bipolar/Mood Disorders (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs)manifested by poor impulse control.<br><br>Anti-anxiety behavior monitoring-Monitor behavior for generalized anxiety manifested by aggressive behavior (yelling or uncontrolled behavior) every shift tally by hashmarks.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Anti-psychotropic behavior monitoring-Monitor behavior for psychosis manifested by delusions as evidenced by verbalization of needing to go to the hospital every shift and tally by hashmarks.<br><br>Anti-psychotropic behavior monitoring-Monitor behavior for schizophrenia manifested by aggressive behavior every shift and tally by hashmarks.<br><br>Anti-psychotropic behavior monitoring-Monitor behavior for schizophrenia manifested by hearing voices and talking to self every shift and tally by hashmarks.<br><br>Anti-psychotropic behavior monitoring-Monitor behavior for schizophrenia manifested by paranoia (irrational and persistent feeling that people are 'out to get you' or that you are the subject of persistent, intrusive attention by others) as evidenced by overly concerned over his health every shift and tally by hashmarks.<br><br>During a concurrent interview and record review with the Director of Nursing (DON) on 7/31/2024 at 2:21 p.m. , the DON stated that all psychotropic medications should have behavior monitoring specific to the resident's behavior as ordered with the psychotropic medications to be able to properly monitor the behavior.<br><br>During a review of facility's policy and procedures (P&P) titled, Behavior Management, dated 2/9/2024, P&P indicated, that facility is responsible for providing behavioral health care and services that create an environment that promotes emotional and psychosocial well-being to meet each resident's needs and include an individualized approaches to care.<br><br>During a review of facility's P&P, titled, Psychotherapeutic Drug Management, revised 5/17/2024, P&P indicated, that the facility will promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, promote resident safety and security, and to enhance the resident's ability to interact positively with his/her environment. P&P indicated that the facility will also ensure that the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed conditions. P&P also indicated, that the nurse staff will be responsible to monitor the presence of target behaviors on a daily basis. |