

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 12/17/2024
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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836</p> <p>Based on interview and record review, the facility failed to revise a bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) care plan on a quarterly basis for one of three sampled residents (Resident 1). This deficient practice had the potential to negatively affect the provision of care and services for Resident 1.</p> <p>Findings:</p> <p>A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including bipolar disorder, anxiety (feelings of worry), and schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/22/2024, indicated Resident 1 had moderate cognitive impairment (difficulty with complex tasks and occasional confusion) but was able to make her needs known. The MDS further indicated Resident 1 had delusions (false belief) and was taking antipsychotic medication.</p> <p>A review of the altered behavior pattern care plan for Resident 1, revised 5/25/2024, indicated Resident 1 had altered behavior related to bipolar disorder with a goal to reduce the episodes of behaviors. The care plan interventions included to approach the resident in a calm and friendly manner and to administer lithium carbonate (a medication that is used to treat bipolar disorder) as ordered.</p> <p>During an interview with the Director of Nursing (DON) on 12/17/2024 at 1:30 PM, the DON stated that resident care plans should be updated when there was a change of condition, quarterly, and as needed. The DON further stated it was important to have an updated plan of care for a resident so that the interventions and goals were appropriate.</p> <p>A review of the facility ' s policy and procedure titled, Care Planning, dated 2/9/2024, indicated the comprehensive care plan must be periodically reviewed and revised by a team of qualified persons after each assessment, including the quarterly review assessments.</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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