STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	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)
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** 50714 Based on observation, interview, and record review the facility failed to provide protection from physical abuse for one out of three sampled residents (Resident 2), by failing to: 1. To follow facility policy and procedures (P&P) titled Behavior-Management, dated 2/9/2024, and document Resident 1's specific identified aggressive behaviors. Resident 1 had aggressive behaviors 17 out of 28 days in February 2025, the type of aggressive behaviors was not documented. 2. Update care plan and interventions to address increase in aggression and behavioral changes quarterly and with changes in condition (COCs) and after identified aggressive behaviors as per facility P&P titled Behavior-Management dated 2/9/2024, and P&P titled Care Planning dated 2/9/2024. As a result on 2/25/2025, Resident 1 hit Resident 2 on the chest, after Resident 2 refused to give Resident 1 money. This deficient practice had the potential for Resident 2 to feel unprotected and suffer physical and/or psychosocial harm (any situation or factor that can negatively impact someone's mental health, well-being, or emotional state). Findings: During a review of Resident 1's admission record, the admission record indicated the facility originally admitted the resident on 8/17/2021 and readmitted the resident on 7/22/2024, with the diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought), generalized anxiety disorder (you are worrying constantly and can't control it), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/22/2025, the MDS indicated Resident 1 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 1 hallucinated (when you experience something seeing, hearing, smelling, tasting, or feeling something that isn't there, but your mind believes it is real). (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 history and physical (H&P) dated 7/23/2024, the H&P indicated Resident 5 was anxious, had a labile affect (someone experiences unpredictable and rapid shifts in their emotions, often seeming out of proportion to the situation), and had paranoid/persecutory delusions (fixed, false beliefs that someone is being harmed, harassed, or conspired against, despite proof or information that shows something is not true). The H&P indicated Resident 1 had a history of aggression, insomnia (trouble falling asleep or staying asleep), inadequate attention/concentration (having trouble focusing on tasks, easily getting distracted, and struggling to maintain your focus for any length of time), with impaired judgement (when someone struggles to make good decisions or understand the consequences of their actions, potentially leading to risky or inappropriate behavior) and impaired insight (when someone struggles to understand or recognize that they have a mental health problem or that their behavior is abnormal, even when it's obvious to others). The H&P indicated diagnoses of bipolar disorder and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). The H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's psychiatric progress note dated 12/5/2025, the psychiatric progress note indicated Resident 1 had intermittent (something that happens on and off) auditory (relating to or involving the sense of hearing) hallucinations, partially impaired (difficulty controlling) impulse control, insight, and judgement. The psychiatric progress note indicated Resident 1 was a high risk for decompensation (a person starts to experience a worsening of their symptoms and struggles to cope) if Resident 1's medication was lowered or discontinued. During a review of Resident 1's facility's situation, background, assessment and recommendation (SBAR) report dated 2/25/2025, the SBAR indicated Resident 2 was in his wheelchair at the doorway of the room he shared with Resident 1. The SBAR indicated Resident 1 approached Resident 2 and indicated Resident 1 told Resident 2 he was not going to let him fuck with him. The report indicated Resident 2 got up and Resident 1 hit him on the left side of his chest. The SBAR indicated Resident 1's physician ordered the facility to transfer Resident 1 to the hospital for behavior evaluation. During a review of Resident 1's physician Order Summary Report (OSR) dated 3/3/2025, the OSR indicated the facility was to give Resident 1 Haloperidol (a medication used to treat nervous, emotional, and mental conditions like schizophrenia) 5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) three times a day for schizophrenia and to monitor Resident 1 for aggressive and confrontational (behaving in an angry or unfriendly way that is likely to cause an argument) behavior toward staff. (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 1's care plan titled, The resident has altered (changed or modified in some way) behavior problems and schizophrenia, dated 7/23/2025, the care plan indicated the staff were to focus on Resident 1's aggressive and confrontational behavior towards staff, the resident's repetitive health concerns, hearing voices, talking to self, and poor impulse control (struggling to resist urges or acting without thinking about the consequences, often leading to actions that are harmful). The care plan goal was for Resident 1 to have a decrease in aggressive behaviors. The care plan interventions included giving Resident 1 Lurasidone (used to treat symptoms of mental disorders, such as schizophrenia) 40 mg, Haloperidol 5 mg, Ativan (a medication to treat anxiety) 0.5 mg, and Depakote Delayed Release Tablet (treat manic [abnormally elevated or irritable mood, increased energy and activity, and potentially impulsive or risky behaviors] episodes (something that happens) related to bipolar disorder in adults) 500 mg. The care plan indicated the interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) were last updated 7/23/2024 During a review of Resident 1's care plan titled, the resident is on antipsychotic medication (a class of drugs used to treat symptoms of psychosis like hallucinations and delusions, primarily in conditions like schizophrenia and bipolar disorder) for episodes of delusions dated 7/2/23/2025, the care plan indicated a goal for Resident 1 to limit his aggressive behavior to zero to one episode of aggressive and confrontational behavior toward staff a day or zero to one episode a week. The care plan interventions included encouraging Resident 1 to be involved in activities, for staff to listen to Resident 1 and address concerns, for staff to refocus Resident 1's inappropriate behavior (offensive behavior), and to monitor the side effects of antipsychotic medication. The care plan also indicated the staff would monitor Resident 1's behavior and summarize it monthly for the physician to evaluate. The care plan indicated the interventions were last updated 7/23/2024. During a review of Resident 1's Medication Administration Record (MAR), date the month of February 2025, the MAR indicated Resident 1 initially had an order for Haloperidol 5 mg by mouth twice a day then Resident 1's physician increased the Haloperidol to 5 mg three times a day on 2/25/2025. The MAR indicated the facility documented Resident 1 had aggressive behavior toward staff as follows: Day shift Resident 1 had one instance of aggressive behavior on 2/1/2025, 2/2/2025, 2/4/2025, 2/5/2025, 2/11/2025, 2/12/2025, 2/13/2025, 2/14/2025, 2/15/2025, 2/17/2025, 2/20/2021, 2/21/2025, 2/22/2025, 2/23/2025, 2/24/2025, and 2/28/2025. Evening shift Resident 1 had one instance of aggressive behavior on 2/1/2025, 2/3/2025, 2/4/2025, 2/13/2025, 2/14/2025, 2/15/2025, 2/19/2025, 2/20/2025, 2/21/2025, 2/27/2025, and 2/28/2025. Night shift Resident 1 had one instance of aggressive behavior on 2/3/2025, 2/4/2025, 2/13/2025, 2/19/2025, 2/20/2025, 2/25/ 2025, 2/26/2025, and 2/27/2025. During a concurrent observation and interview on 3/3/2025 at 12:32 PM with Resident 1 in Resident 1's room, Resident 1 was observed to be irritable (easily annoyed, frustrated, or angered, and may react with a short temper or quick impatience). Resident 1 stated he was arguing with Resident 2 when Resident 2 got up from his wheelchair and Resident 1 thought Resident 2 was going to hit him. Resident 2 stated he then hit Resident 1. (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 admission record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with the diagnoses of multiple rib fractures (broken bones) on the left side, pneumonia (an infection of the lungs), history of falls, and unspecified fracture of the lumbar vertebra (a break or crack in one of the bones in your lower back). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 2 did not have any behavior issues. The MDS indicated Resident 2 used a walker and a wheelchair. During a review of Resident 2's H&P dated 11/8/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. The H&P indicated Resident 2 had rib fractures and a history of falls. During a review of Resident 2's care plan titled, resident to resident altercation, dated 2/25/2025 indicated the goal of the care plan was for Resident 2 to feel safe. The care plan interventions included anticipating Resident 2's needs, getting a psychiatric consultation (evaluation), intervening (to become involved in a situation to try and change it, often to help or improve it, or to stop something from happening) to protect resident rights and safety, and monitoring/modifying (changing) behaviors. During a review of Resident 2's SBAR dated 2/25/2025, the SBAR indicated Resident 2 was sitting in his wheelchair at the doorway in the room he shared with Resident 1. The SBAR indicated Resident 1 approached Resident 2 and stated, you want to fuck with me but I'm not going to let you. The SBAR indicated Resident 2 stood up and Resident 1 raised his hand and struck Resident 2 on the left side of his chest. The SBAR indicated Resident 2 lost his balance and sat on the trash can behind him. The SBAR indicated the RN supervisor placed herself between the residents. The SBAR indicated both residents were moved to different rooms. The SBAR indicated Resident 2's physician was notified, and an order was received for a psychiatric evaluation. During a review of Resident 2's psychiatric evaluation dated 2/25/2025, the psychiatric evaluation indicated Resident 1 had an altercation with another resident. The psychiatric evaluation indicated Resident 2 was frequently approached by a resident (Resident 1) asking Resident 2 for money and when the resident said no, the other resident (Resident 1) became angry. The psychiatric evaluation indicated Resident 2 had no previous psychiatric history. During a concurrent observation interview on 3/3/2025 at 12:23 PM with Resident 2 in front of Resident 2's room, Resident 2 stated Resident 1 asked him for money for soda and Resident 2 refused to give Resident 1 money. Resident 2 stated Resident 1 left and then came back and stated Resident 1 was upset so Resident 2 stool up from his seat and was immediately hit in the chest by Resident 1. Resident 2 stated he did not sustain any injuries. An observation of Resident 2's chest did not show and bruising, redness, or visual signs or injury. (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 Follow-Up Investigation Report dated 3/2/2025, the report indicated Registered Nurse Supervisor 1 (RNS 1) witness Resident 1 struck Resident 2 in the chest causing Resident 2 to lose his balance and then sat himself on the trash can behind him. The report indicated Resident 2 usually gave Resident 1 a dollar when Resident 1 asked him for money. The report indicated on 2/25/2025 Resident 1 asked Resident 2 for money but Resident 2 refused and Resident 1 became upset. The report indicated Resident 2 was moved to a different room. The report indicated the facility transferred Resident 1 to the hospital for psychiatric evaluation and treatment. During an interview on 3/3/2025 at 12:47 PM with the Director of Rehabilitation (DR), the DR stated she saw Resident 1 on the day of the incident (2/25/2025), come out of his room and was upset and rambling (talking in a way that is long-winded, confused, and often wanders off the main topic). She stated Resident 1 went back to the room Resident 1 and Resident 2 shared. She stated she saw Resident 2 stand up and saw Resident 1 take a swing at Resident 2. During an interview on 3/3/2025 at 3:42 PM with the Director of Nursing (DON), the DON stated the facility staff had been documenting Resident 1's behavior on the MAR, Resident 1's Haloperidol was increased from 5 mg twice a day to 5 mg three times a day on 2/26/25, the day after Resident 1 hit Resident 2. The DON stated the facility did not call the doctor right away because the facility would report it to the doctor at the end of the month. The DON stated Resident 1's behavior was normal for the resident. During an interview on 3/4/2025 at 8:21 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated if a resident had been aggressive, the facility staff should have called the resident's physician about the behavior. LVN 2 stated the doctor usually reviewed the resident's medication at the end of the month. LVN 2 stated the facility updated a resident's care plan monthly, quarterly (every 3 months), and for a change in condition. LVN 2 stated Resident 1's care plan was not revised until Resident 1 hit Resident 2. LVN 2 stated if the care plan was not updated or revised, the staff would not be able to tell if the care plan interventions were effective or if the care plan was still appropriate for the resident. LVN 2 stated the facility's care plan for Resident 1 was not effective in managing his behavior. During a concurrent interview and record review on 3/4/2025 at 8:36 AM with the DON, Resident 1's care plan titled The resident is on anti-psychotic medication for episodes of delusions aeb verbalization of chest pain and needing to go to the hospital, hearing voices & talking to self-related, confrontational and verbally aggressive to staff related to schizophrenia with an intervention indicating The resident will manifested behavior will be limited to 0-1 episodes per day 0-1 times a week dated 7/23/2024, was reviewed. The DON reviewed Resident 1's MAR for February 2025 indicating Resident 1 had multiple episodes of being aggressive with staff. The DON stated the facility should have been updating Resident 1's care plans every 3 months and for a change in condition. The DON stated the facility staff had not been documenting Resident's care plan interventions and it would be difficulty for the facility staff to assess the effectiveness of the interventions if the staff did not document them. During an interview on 3/4/2025 at 10:16 A M with Resident 1's PGC, the PGC stated Resident 1 had enough funds for soda and the facility should have been directing Resident 1 to the facility's social worker or other staff when he approached other residents for money. (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 P&P titled Abuse Prevention and Prohibition Program dated 2/9/2024, the P&P indicated each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property (to take possession of something that belongs to someone else without the right to do so). The P&P indicated the facility would train staff regarding appropriate interventions to deal with aggressive and/or catastrophic reactions (an over-the-top, sudden, and often disruptive emotional or behavioral outburst that someone experiences when feeling overwhelmed or unable to cope with a situation, even if it seems minor to others) of residents. The P&P indicated residents identified by staff as being self-injurious or exhibiting abusive behavior that requires professional services not provided in the Facility (e. g., mental health services), will be reviewed by the IDT (Interdisciplinary Team is a group of professionals with different skills and backgrounds who work together to provide comprehensive care for a patient, focusing on the patient's needs and goals) and/or physician. The P&P indicated Resident assessments (a process by which nursing home staff identifies your health care needs, daily schedules and habits, and likes and dislikes) and care planning are performed to monitor resident needs and address behaviors that may lead to conflict (serious disagreement and argument about something). During a review of the facility's P&P titled Care Planning dated 2/9/2024, the P&P indicated the care plan purpose was to ensure that a comprehensive person-centered (prioritizing the individual's needs, preferences, and values in all aspects of care, support, and treatment, ensuring a holistic and personalized experience) Care Plan is developed for each resident based on their individual assessed (evaluated) needs. The P&P indicated 'the Baseline (starting point) Care Plan will be updated to reflect changes in the resident's condition or needs occurring prior to the development of the Comprehensive Care Plan (a detailed roadmap outlining all aspects of a patient's care, including medical, nursing, and other health-related activities, to ensure their needs are met). The P&P indicated The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive Admission Assessment (a thorough examination of a patient's health history, physical condition, and psychosocial factors, conducted upon admission to gain a complete understanding of their needs), and must be periodically (from time to time) reviewed and revised (something has been changed or updated) by a team of qualified persons after each assessment, including the comprehensive and quarterly (something that happens or is done every three months, or four times a year) review assessments. During a review of the facility P&P titled Behavior-Management, dated 2/9/2024, the P&P indicated the purpose of the P&P was to ensure facility staff performs an appropriate assessment of the resident's behavioral symptoms and implement (to put a plan, idea, or policy into action) appropriate interventions before and after the resident begins taking psychotherapeutic (medicines used to treat mental health conditions) medications. The P&P indicated When a resident exhibits (shows) adverse behavioral symptom (yelling, hitting, resisting care, etc.), Licensed Nursing Staff will document the behaviors in the medical record, noting the time the behavior(s) occur, antecedent events (something that happens before a behavior or action, and can potentially trigger or influence it), possible causal (causes) factors and interventions attempted. The P&P indicated when the resident exhibits behaviors, the Licensed Nurse will document the resident's medical record and include the following as indicated: i. Any precipitating factors (triggers or events that directly lead to or worsen a problem, illness, or behavior) ii. Interventions used to redirect behavior (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. The resident's response to the intervention iv. Notification of Attending Physician (a medical doctor who is responsible for the overall care of a patient) and responsible party (the person who is financially responsible for paying the patient's medical bills, often the patient themselves, but sometimes a parent, guardian, or other designated individual) as indicated. v. Update the plan of care as indicated.