STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056192	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Post Acute Care Center	21521 S. Vermont Avenue Torrance, CA 90502

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to immediately report a resident-to-resident altercation to the California Department of Public Health (CDPH), and the State Long Term Care Ombudsman (an agency that assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) within the regulated time frame of two hours, for two of two sampled residents (Resident 1 and Resident 2). This deficient practice resulted in CDPH ' s inability to investigate the allegations of abuse timely and had the potential for other allegations of abuse to go unreported. a. During a review of the Resident 1 ' s Admission record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage (a stroke caused by a ruptured blood vessel), hemiplegia (severe muscle weakness) and hemiparesis (muscle weakness) following cerebrovascular disease (group of disorders that affect blood supply to the brain) affecting the dominant right side, frontal lobe (responsible for functions ex: emotions, memory) and executive function (set of cognitive skills that helps control behavior) following cerebral infarction (disruption of blood flow to the brain), abnormalities of gait and mobility, and hypertension (high blood pressure). During a review of Resident 1 ' s Minimum Data Set [(MDS) a federaly mandated resident assessment tool], dated 6/14/2024, the MDS indicated Resident 1 ' s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 1 required maximal assistance on all aspects of activities of daily living (ADL: bathing, transferring, personal hygiene, oral hygiene) except for eating which required supervision. The MDS indicated Resident 1 utilized a wheelchair and walker for mobility and had one impairment on both the upper and lower extremities (arms and legs). The MDS indicated Resident 1 did not have any physical behavioral symptoms (hitting, kicking) or verbal behavioral symptoms (threatening others, screaming, or cursing at others). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including [NAME] ' s encephalopathy (unusual type of memory disorder due to lack of vitamin that helps convert food into energy), difficulty walking, schizoaffective disorder (mental health condition that causes delusions (altered reality), hallucinations (hearing, seeing something that is not real), and mood disorders: depression, mania), muscle weakness, and dementia (progressive loss of memory, thinking, and remembering) without behavioral disturbance (range of conditions such as agitation, distress) , and hypertension (high blood pressure). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills were moderately impaired. The MDS indicated Resident 2 required moderate assistance in transferring from chair/bed to chair, walking, toilet/shower transfer and performing oral/toilet/personal hygiene. The MDS indicated Resident 2 utilized a wheelchair and walker for mobility and did not have any impairments on both the upper and lower extremities. During a review of an untitled Care Plan (CP) initiated on 6/28/2024, the CP indicated Resident 1 had an episode of verbally aggressive and threatening behavior. The CP interventions included to take resident away from triggering events of person and identify cause(s) ex. is resident in pain?, is hungry? and try to resolve/eliminate cause. During a review of the Medication Administration Record (MAR: electronic document that shows what medication was administered to the resident), the MAR indicated Resident 1 had a verbally aggressive and threatening behavior on 6/30/2024 in the evening, threatening behavior on 7/10/2024 in the day and evening, and had verbally aggressive behaviors from 7/10/2024 to 7/17/2024 throughout the day. During a review of a COC dated 8/20/2024, the Change of Condition (COC) indicated Resident 1 had physically aggressive/striking behavior, attempting to strike another resident, and was verbally aggressive toward staff and other residents. During a review of the Interdisciplinary Team (IDT: group of specialized individuals that meet with the resident/family to discuss ways to promote optimal patient care outcomes) Conference dated 8/20/2024 at 2:09p.m., the IDT conference indicated Resident 2 ' s family expressed they were uncomfortable with Resident 1 as he has been cursing at them when they visit Resident 2 but did not report it to anyone since they let is pass. During an interview on 9/22/2024 at 9:34am with FM 2 and FM 3 (FM 3), F 2 stated she and F 3 usually visit Resident 2 on Tuesday and Wednesday and indicated on 8/20/2024, Resident 1 was in the wheelchair and blocked the door so Resident 2 could not enter the room. FM 2 stated herself and FM3 were both in the room and Resident 1 started yelling and cussing at Resident 2 and the staff. FM 2 stated Resident 2 came back into the room and had no idea what was going on and went to the office for the IDT meeting. FM 2 stated they made a report to the office since they were scared for Resident 2 as Resident 1 was making threatening remarks. FM 3 stated when she reported this to the nursing station, the staff informed her they cannot make Resident 1 change rooms and did not want to move Resident 2 out since he has been there for several years and is very familiar with where eveything is. FM 3 stated the staff told them it would depend on whether Resident 1 would agree to the room change. During a review of the facilities incident Investigation Summary Reports, their was no investigation summary report for the incident of verbal abuse by Resident 1 on Resident 2 on 8/20/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/18/2024 at 1:52p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 was verbally aggressive to Resident 2. LVN 1 stated Resident 1 stated stated he hates Resident 2. LVN 1 stated she and CNA 1 witnessed the incident on 8/20/2024 and indicated she was walking in the hallway and Resident 2 was in his wheelchair trying to get inside the room on the left side of the door and Resident 1 in his wheelchair was on the right side of the door. LVN 1 stated Resident 1 suddenly screamed, was threatening, trying to hit, and was cursing at Resident 2. LVN 1 stated she intervened before Resident 1 hit Resident 2. LVN 1 stated she notified the doctor, Administrator (ADM), Director of Nursing (DON), Registered Nurse Supervisor 1 (RNS 1), and Resident 1 was sent out to the hospital. LVN 1 stated this incident occurred arounf 2:00p.m. and indicated Resident 1 never mentioned to her about any abuse allegations. LVN 1 stated getting yelled at, cussed at, and threatened is considered harassment and verbally abusive. LVN 1 stated this incident is verbal abuse and it would have to be reported. LVN 1 stated it should be reported so ithe incident can be investigated and the residents can be monitored. During a concurrent interview and record review of the IDT meeting notes dated 8/2/2024 on 9/18/2024 at 4:37p.m. with the Administrator (ADM), the ADM stated when there is a resident-to-resident verbal or physical altercation, you investigate the incident, speak to the residents, the individual who reported it, witnesses, and report it to the Department of Public Health (CDPH), ombudsman, and the police. The ADMN stated there are different types of abuse which includes financial, physical, and verbal abuse. The ADM stated FM 3 indicated she was scared Resident 1 would hurt Resident 2. The ADM stated Resident 1 had aggressive behaviors towards Resident 2 and that is considred abuse. During an interview and record review on 9/19/2024 at 1:07p.m. with the Director of Nursing (DON), the DON stated abuse is anything that inflicts injury on another individual either mentally, physically, emotionally, or financially. The DON stated when there is a resident-to-resident physical or verbal altercation, they are separated, identify why the resident had an aggressive behavior, notify the doctor, the family, do a COC, monitor the resident if the resident is verbally aggressive, and create a care plan.The DON stated Resident 1's yelling, screaming, and threatening is a part of his behavior. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P), titled, Abuse Program Policy and Procedure revised on 6/20/2024, the P&P indicated the facility shall uphold resident ' s right to be free from verbal, sexual, physical, mental abuse, corporal punishment, and involuntary seclusion. Verbal Abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. Facility shall also institute procedures that allows for identification, correction, and intervention in situations in which abuse, neglect and/or misappropriate of resident property is more likely to occur .areas of identification, correction and intervention may include but not limited to, facility environment, staffing and supervision of staff, identification of residents with potential for behavioral symptoms and manifestations that may lead to conflict or anger through comprehensive assessment, care planning, and monitoring. Any incidence or occurrences that may constitute abuse shall be recorded on the Incident Report Form and reported to Director of Nurses, Facility Administrator .immediately after and/or no later than 24 hours after the identification of the unusual occurrence or events constituting abuse or probably abuse. Facility Administrator shall be responsible for reporting of all alleged and substantiated violations to the stage agency and all other agencies as required. Facility shall report the incident by calling the DHS within 24 hours of the knowledge of such incident; followed by a letter explaining the circumstances surrounding the incident. Facility Administrator shall be responsible for overall implementation of corrective measures and plan of action; including but not limited to determining necessary systemic changes .to prevent further occurrences of said violations. During a review of the facility ' s policy and procedure (P&P), titled, Resident Rights, undated, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights including the resident's right to be free from abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to implement its abuse policy and procedure by failing to investigate a resident-to-resident altercation between two of two sampled residents (Resident 1 and Resident 2). This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from ongoing or further abuse. a. During a review of the Resident 1 ' s Admission record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage (a stroke caused by a ruptured blood vessel), hemiplegia (severe muscle weakness) and hemiparesis (muscle weakness) following cerebrovascular disease (group of disorders that affect blood supply to the brain) affecting the dominant right side, frontal lobe (responsible for functions ex: emotions, memory) and executive function (set of cognitive skills that helps control behavior) following cerebral infarction (disruption of blood flow to the brain), abnormalities of gait and mobility, and hypertension (high blood pressure). During a review of Resident 1 ' s Minimum Data Set [(MDS) a federaly mandated resident assessment tool], dated 6/14/2024, the MDS indicated Resident 1 ' s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 1 required maximal assistance on all aspects of activities of daily living (ADL: bathing, transferring, personal hygiene, oral hygiene) except for eating which required supervision. The MDS indicated Resident 1 utilized a wheelchair and walker for mobility and had one impairment on both the upper and lower extremities (arms and legs). The MDS indicated Resident 1 did not have any physical behavioral symptoms (hitting, kicking) or verbal behavioral symptoms (threatening others, screaming, or cursing at others). During a review of the Resident 2 ' s Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including [NAME] ' s encephalopathy (unusual type of memory disorder due to lack of vitamin that helps convert food into energy), difficulty walking, schizoaffective disorder (mental health condition that causes delusions (altered reality), hallucinations (hearing, seeing something that is not real), and mood disorders: depression, mania), muscle weakness, and dementia (progressive loss of memory, thinking, and remembering) without behavioral disturbance (range of conditions such as agitation, distress) , and hypertension (high blood pressure). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills were moderately impaired. The MDS indicated Resident 2 required moderate assistance in transferring from chair/bed to chair, walking, toilet/shower transfer and performing oral/toilet/personal hygiene. The MDS indicated Resident 2 utilized a wheelchair and walker for mobility and did not have any impairments on both the upper and lower extremities. During a review of an untitled Care Plan (CP) initiated on 6/28/2024, the CP indicated Resident 1 had an episode of verbally aggressive and threatening behavior. The CP interventions included to take resident away from triggering events of person and identify cause(s) ex. is resident in pain?, is hungry? and try to resolve/eliminate cause. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Medication Administration Record (MAR: electronic document that shows what medication was administered to the resident), the MAR indicated Resident 1 had a verbally aggressive and threatening behavior on 6/30/2024 in the evening, threatening behavior on 7/10/2024 in the day and evening, and had verbally aggressive behaviors from 7/10/2024 to 7/17/2024 throughout the day. During a review of a COC dated 8/20/2024, the Change of Condition (COC) indicated Resident 1 had physically aggressive/striking behavior, attempting to strike another resident, and was verbally aggressive toward staff and other residents. During a review of the Interdisciplinary Team (IDT: group of specialized individuals that meet with the resident/family to discuss ways to promote optimal patient care outcomes) Conference dated 8/20/2024 at 2:09p.m., the IDT conference indicated Resident 2 ' s family expressed they were uncomfortable with Resident 1 as he has been cursing at them when they visit Resident 2 but did not report it to anyone since they let is pass. During an interview on 9/22/2024 at 9:34am with FM 2 and FM 3 (FM 3), F 2 stated she and F 3 usually visit Resident 2 on Tuesday and Wednesday and indicated on 8/20/2024, Resident 1 was in the wheelchair and blocked the door so Resident 2 could not enter the room. FM 2 stated herself and FM3 were both in the room and Resident 1 started yelling and cussing at Resident 2 and the staff. FM 2 stated Resident 2 came back into the room and had no idea what was going on and went to the office for the IDT meeting. FM 2 stated they made a report to the office since they were scared for Resident 2 as Resident 1 was making threatening remarks. FM 3 stated when she reported this to the nursing station, the staff informed her they cannot make Resident 1 change rooms and did not want to move Resident 2 out since he has been there for several years and is very familiar with where eveything is. FM 3 stated the staff told them it would depend on whether Resident 1 would agree to the room change. During a review of the facilities incident Investigation Summary Reports, their was no investigation summary report for the incident of verbal abuse by Resident 1 on Resident 2 on 8/20/2024. During a concurrent interview and record review on 9/18/2024 at 1:52p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 was verbally aggressive to Resident 2. LVN 1 stated Resident 1 stated stated he hates Resident 2. LVN 1 stated she and CNA 1 witnessed the incident on 8/20/2024 and indicated she was walking in the hallway and Resident 2 was in his wheelchair trying to get inside the room on the left side of the door and Resident 1 in his wheelchair was on the right side of the door. LVN 1 stated Resident 1 suddenly screamed, was threatening, trying to hit, and was cursing at Resident 2. LVN 1 stated she intervened before Resident 1 hit Resident 2. LVN 1 stated she notified the doctor, Administrator (ADM), Director of Nursing (DON), Registered Nurse Supervisor 1 (RNS 1), and Resident 1 was sent out to the hospital. LVN 1 stated this incident occurred arounf 2:00p.m. and indicated Resident 1 never mentioned to her about any abuse allegations. LVN 1 stated getting yelled at, cussed at, and threatened is considered harassment and verbally abusive. LVN 1 stated this incident is verbal abuse and it would have to be reported. LVN 1 stated it should be reported so ithe incident can be investigated and the residents can be monitored. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of the IDT meeting notes dated 8/2/2024 on 9/18/2024 at 4:37p.m. with the Administrator (ADM), the ADM stated when there is a resident-to-resident verbal or physical altercation, you investigate the incident, speak to the residents, the individual who reported it, witnesses, and report it to the Department of Public Health (CDPH), ombudsman, and the police. The ADMN stated there are different types of abuse which includes financial, physical, and verbal abuse. The ADM stated FM 3 indicated she was scared Resident 1 would hurt Resident 2. The ADM stated Resident 1 had aggressive behaviors towards Resident 2 and that is considred abuse. During an interview and record review on 9/19/2024 at 1:07p.m. with the Director of Nursing (DON), the DON stated abuse is anything that inflicts injury on another individual either mentally, physically, emotionally, or financially. The DON stated when there is a resident-to-resident physical or verbal altercation, they are separated, identify why the resident had an aggressive behavior, notify the doctor, the family, do a COC, monitor the resident if the resident is verbally aggressive, and create a care plan.The DON stated Resident 1's yelling, screaming, and threatening is a part of his behavior. During a review of the facility ' s policy and procedure (P&P), titled, Abuse Program Policy and Procedure revised on 6/20/2024, the P&P indicated the facility shall uphold resident ' s right to be free from verbal, sexual, physical, mental abuse, corporal punishment, and involuntary seclusion. Verbal Abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. Facility shall also institute procedures that allows for identification, correction, and intervention in situations in which abuse, neglect and/or misappropriate of resident property is more likely to occur .areas of identification, correction and intervention may include but not limited to, facility environment, staffing and supervision of staff, identification of residents with potential for behavioral symptoms and manifestations that may lead to conflict or anger through comprehensive assessment, care planning, and monitoring. Any incidence or occurrences that may constitute abuse shall be recorded on the Incident Report Form and reported to Director of Nurses, Facility Administrator .immediately after and/or no later than 24 hours after the identification of the unusual occurrence or events constituting abuse or probably abuse. Facility Administrator shall be responsible for reporting of all alleged and substantiated violations to the stage agency and all other agencies as required. Facility shall report the incident by calling the DHS within 24 hours of the knowledge of such incident; followed by a letter explaining the circumstances surrounding the incident. Facility Administrator shall be responsible for overall implementation of corrective measures and plan of action; including but not limited to determining necessary systemic changes .to prevent further occurrences of said violations. During a review of the facility ' s policy and procedure (P&P), titled, Resident Rights, undated, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights including the resident's right to be free from abuse.