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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Healthcare Center	230 E Adams Blvd Los Angeles, CA 90011

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44309 Based on interview, and record review, the facility failed to develop a baseline care plan for one of two sampled residents (Resident 1) within 48 hours of resident's admission. Resident 1 did not have a baseline care plan within 48 hours of admission to the facility. This deficient practice had the potential for delayed administration of necessary care and services. Findings: A review of Resident 1 ' s Admission Record (Face Sheet) indicated the facility admitted the resident on 5/22/2024, with diagnoses including anxiety disorder (a condition with excessive worry and fear that interferes with daily activities), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and screening tool) dated 5/25/2024, indicated the resident's cognitive skills (ability to think, learn, remember, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 required partial/moderate assistance for toileting hygiene, lower body dressing, showering/bathing, and walking 10 feet. A review of Resident 1's physician History and Physical (H&P) dated 5/23/2024, indicated that Resident 1 did not have medical decision-making capacity. During a concurrent interview and record review on 7/3/2024 at 1:19 PM, with the facility's Director of Nursing (DON), Resident 1's baseline care plan was reviewed. The DON stated staff started to complete Resident 1's base line care plan on 5/23/2024. However, only the dietary section of base line care plan was completed. The DON stated Resident 1's base line care plan was not complete. The DON further stated licensed nurses were required to complete a resident's base line care plan upon admission. The DON stated she did not know the time frame that staff were required to complete the base line care plan. During a concurrent interview and record review on 7/3/2024 at 1:25 PM, with the MDS Coordinator (MDSC), Resident 1's baseline care plan was reviewed. The MDSC stated a base line care plan needed to be completed within 48 hours of resident's admission to the facility. The MDSC stated Resident 1's base line care plan was not completed upon admission and the potential outcome was the inability to meet resident immediate care needs. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Care Plans-Baseline, revised December 2016, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The intradisciplinary Team (IDT- a group of health care professionals who work together to provide care) will review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs including, but not limited to the following: initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services.

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F 0740

Level of Harm - Actual harm

Residents Affected - Few

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

44309

Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had diagnosis of schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves, may have grandiose delusions [strong beliefs of things that are untrue]) and history of wandering was provided with the necessary behavioral health care as indicated in the comprehensive assessment. The facility failed to:

-Monitor Resident 1 for schizophrenic behavior each shift, per the Physician's Order.

- Evaluate the care plan interventions for their effectiveness and update or revise the interventions based on resident's behavior and needs.

-Develop an appropriate care plan for Resident 1's Wandering, and provide supervision, including the frequency.

-Anticipate Resident 1's needs and intervene when the resident gets agitated before agitation escalates, per the Potential to Demonstrate verbally / physically Abusive Behaviors care plan related to schizophrenia.

As a result, on 6/14/2024, Resident 1 wandered the facility, entered Resident 2's room, and after being told to leave the room, Resident 1 hit Resident 2 in the face causing Resident 2's lip to bleed.

Findings:

A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident on 5/22/2024, with diagnoses including anxiety disorder (a condition with excessive worry and fear that interferes with daily activities), and schizophrenia.

A review of Resident 1's Admission / Readmission Data Tool dated 5/22/2024, indicated the resident was independently mobile, paced (walk at a steady and consistent speed, especially back and forth and as an expression of one's anxiety), wandered (to walk around slowly in a relaxed way or without any clear purpose or direction), and tried to leave the facility. The form indicated Resident 1 had a history of wandering and was not readily accepting nursing home placement.

A review of Resident 1's At Risk of Elopement (leaves the facility, presenting an imminent threat to the resident's health and safety because resident was too impaired to make a decision to leave) care plan initiated on 5/22/2024, indicated the resident was a wanderer due to his impaired (weakened) safety awareness. The care plan interventions indicated to distract Resident 1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, to identify types of wandering such as purposeful, aimless (without purpose and direction), or escapist wandering (the state of having wandering and imaginative thoughts in order to escape from reality), and to provide structured activities such as toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A review of the Physician's Orders dated 5/22/2024, indicated to administer haloperidol (Haldol - a medication used to treat certain mental / mood disorders such as schizophrenia) oral tablet one milligram, three times a day for schizophrenia manifested by constant pacing. A further review of the physician's orders dated 5/22/2024, indicated to monitor Resident 1's schizophrenic behavior during each shift. A review of Resident 1's History and Physical (H&P) dated 5/23/2024, indicated the resident did not have medical decision-making capacity. According to a review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 5/25/2024, Resident 1's cognitive skills (ability to think, remember, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 had schizophrenia diagnosis and was taking antipsychotic medication (the main class of drugs used to treat psychosis [a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality] and other mental and emotional conditions. The MDS further indicated Resident 1's current behavior, care rejection or wandering was worse when compared to prior assessment. A review of Resident 1's Potential to Demonstrate verbally / physically Abusive Behaviors care plan dated 5/30/2024 indicated this was related to psychosis (a collection of symptoms that affect the mind, with some loss of contact with reality), schizophrenia, ineffective coping skills and poor impulse control (lacking the ability to maintain self-control). The care plan interventions indicated to access and anticipate Resident 1's needs, evaluate for side effect of the medications, give the resident as many choices as possible about care and activity, and to intervene when the resident gets agitated before agitation escalates. A review of the Situation Background Assessment and Recommendation Form (SBAR) dated 6/14/2024, indicated Resident 1 displayed physical aggression towards another resident (Resident 2), and that per Certified Nursing Assistant 1's (CNA 1) report, Resident 1 swung at Resident 2 and struck Resident 2 in the mouth. The SBAR indicated Resident 2 was subjected to physical aggression by Resident 1, and fell . Upon assessment, Resident 2 had discoloration on the inside of his lower lip. The SBAR form indicated Resident 2 asked Resident 1 to leave the room, Resident 1 swung at him and struck him in the lip. Resident 1's physician was informed of the incident and a new order was made to transfer Resident 1 to the emergency room (ER) for psychiatric evaluation. A review of Resident 2's Skin Observation Tool dated 6/14/2024, indicated a cut measuring less than one centimeter (a metric unit of length) on Resident 2's upper lip. A review of Resident 1's Medication Administration Record (MAR) for the month of June 2024, indicated the resident did not display any schizophrenic behavior, such as constant pacing. During an observation on 7/3/2024 at 8:10 AM, Resident 1 was observed walking in the hallway with his walker. Resident 1 appeared confused, did not answer any questions, and continued walking. (continued on next page)

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Level of Harm - Actual harm

Residents Affected - Few

During a concurrent observation and interview on 7/3/2024 at 9 AM, inside Resident 2's room, Resident 2 was observed sitting on his wheelchair next to his bed. Upon observation, there were no visible injuries or wound to Resident 2's lip. Resident 2 stated, About 2 weeks ago Resident 1 entered my previous room. Resident 1 always walks in the hallways and sometimes entered my previous room. He does not understand. I told him to leave the room. He began swinging his arms and he left the room. The police came and talked to me. Resident 2 stated, I did not press charges against Resident 1. This was the first time that Resident 1 was swinging his arms at me. He did not mean to hit me. His arm might have accidentally struck me on the face.

During an interview on 7/3/2024 at 10:57 AM, CNA 1 stated, I was not assigned to either Resident 1 nor Resident 2. I heard commotion in the hallway. I saw Resident 1 swinging his arms and striking Resident 2 on his shoulders. I called for help, and I tried to separate them. I noticed Resident 2 was bleeding at the mouth. CNA 1 stated Resident 2 told her that Resident 1 hit his mouth. CNA 1 stated she always sees Resident 1 walking in the hallways.

During a concurrent interview and record review on 7/3/2024 at 2:30 PM, with MDS Coordinator (MDSC), Resident 1's care plans were reviewed. The MDSC stated she revised Resident 1's at risk for elopement care plan today (7/3/2024) because Resident 1 was only wandering in the hallways and not attempting to exit the facility. The MDSC stated Resident 1's risk for elopement care plan did not have any interventions to monitor the resident. The MDSC stated Resident 1 was a wanderer, he sometimes entered other residents rooms and staff were required to perform frequent visual monitoring for him to prevent him from exiting the facility or entering other residents rooms.

During a concurrent interview and record review on 7/3/2024 at 2:45 PM, with the facility's Director of Nursing (DON), Resident 1's care plans were reviewed. The DON stated Resident 1's risk for wandering care plan initiated on 5/22/2024, did not include any individualized person-centered interventions for the resident, indicating how and how often staff were monitoring Resident 1. The DON stated Resident 1 was always wandering in the hallways and he needed to be monitored closely by staff. The DON stated Resident 1's care plan intervention of distracting the resident from wandering by offering structured activities was not effective and staff were required to evaluate care plan interventions for their effectiveness and update or revise the interventions based on resident's behavior and needs. The DON stated the potential outcome of not developing a person-centered care plan with effective interventions for a resident who was constantly wandering and pacing was safety issues and harm to other residents.

During a concurrent interview and record review on 7/3/2024 at 2:55 PM, with the DON, Resident 1's MAR for June 2024 was reviewed. The DON stated based on licensed staff documentation, it appears that Resident 1 did not display any schizophrenic behavior such as constant pacing during the month of June. The DON stated this documentation was inaccurate because Resident 1 was constantly wandering and pacing. The DON stated licensed staff were required to monitor and document Resident 1's conduct, condition, and behavior and this was an inaccurate reflection of the resident's true condition.

A review of the facility policy and procedure titled,Wandering and Elopement, revised March 2019, indicated the facility would identify residents who were at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.

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F 0740 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy and procedure titled, Abuse and Neglect-Clinical Protocol, revised March 2018, indicated the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The physician and staff will address appropriate causes of problematic resident behavior where possible, such as mania (extremely elevated and excitable mood usually associated with bipolar disorder), psychosis, and medication side effects. A review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised December 2016, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (the interrelation of social factors and individual thought and behavior) and functional needs was developed and implemented for each resident. The comprehensive person-centered care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents were ongoing and care plans were revised as information about the residents and the residents' condition change.