STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	09/19/2024

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

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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 0600 Level of Harm - 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** 45524 Based on interview and record review, the facility failed to protect the resident ' s right to be free from neglect (the failure to provide healthcare services necessary to avoid physical harm, pain, mental anguish, or emotional distress) for one of four sampled residents (Resident 1). On 9/4/2024, Resident 1, who was cognitively impaired (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), was left unattended with his body partially uncovered, while lying and crawling on the floor of the facility hallway for approximately 59 minutes. This deficient practice resulted in Resident 1 being subjected to neglect while under the care of the facility. On 9/4/2024, Certified Nursing Assistant (CNA) 2, Licensed Vocational Nurse (LVN) 3, Staff 10, CNA 9, Staff 11, Staff 12, Staff 13, Registered Nurse Supervisor (RNS) 2, and Staff 14 watched and allowed Resident 1 to crawl and lay on the floor with Resident 1 ' s body partially uncovered without providing assistance, comfort, and safety to Resident 1. Based on the reasonable person concept (hypothetical [suggested], average person's reaction to the actual circumstances of alleged illegal activities) due to Resident 1 ' s severely impaired cognition (ability to think and make decisions), an individual subjected to neglect has lifetime psychological (mental or emotional) effects including feelings of embarrassment and humiliation. Findings: During a review of the General Acute Care Hospital (GACH) narrative notes dated 8/21/2024 indicated, Resident 1 was confused (not in possession of all one's mental faculties) and had a diagnosis of dementia (a chronic condition that causes a decline in cognitive function, such as thinking, learning, and remembering, to the point that it interferes with daily life). During a record review of the admission record (Face sheet) indicated the Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), hypertension (elevated blood pressure), and conversion disorder with seizures (also known as functional neurological system disorder, is a psychiatric condition that can cause seizures [a sudden, uncontrolled burst of electrical activity in the brain that can cause changes in behavior, movements, feelings, and levels of consciousness] as a physical symptom of a mental health issue). (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 - Actual harm Residents Affected - Few	During a review of Resident ' s 1 care plan initiated on 9/4/2024, with a focus on Resident with behavior of crawling out bed, indicated the following interventions: Be attentive and responsive to resident's behavior and provide constant supervision that clothing and footwear is clean and appropriate. During a review of Resident ' s 1 Nursing Notes with an effective date of 9/4/2024 at 8:30 pm which was documented on 9/5/2024 at 4:18 pm, indicated LVN 2 was notified about the newly admitted resident (Resident 1) and was in the room at 8 pm. The same note indicated Resident 1 went to the nursing station with unsteady gait (a walking pattern that is abnormal, uncoordinated, or lacks balance) at 9 pm and that the CNA 1 assisted Resident 1 back to the room. During a review of Resident ' s 1 Nursing Notes with an effective date of 9/4/2024 at 10:40 pm which was documented on 9/5/2024 at 3:56 pm by the RNS 2 indicated, Resident 1 was received to the facility at 6:40 pm and re-oriented to his room. Frequent visual checks are needed due to Resident 1 getting up unassisted. The same note indicated all nursing care was rendered and to continue with the same plan of care. During an interview with LVN 2 on 9/16/2024 at 3:10 pm, LVN 2 stated that she was assigned with Resident 1 for the 11 pm to 7 am shift between 9/4/2024 and 9/5/2024. LVN 2 stated that during shift change, the off going LVN stated that Resident 1 likes to get on the floor in the hallway. LVN 2 stated she found Resident 1 sitting on the floor in the hallway and that Resident 1 was helped up and taken back to his room. During an interview with CNA 1 on 9/16/2024 at 2:48 pm, CNA 1 stated that Resident 1 was mostly sitting on the floor and appeared confused. CNA 1 stated that Resident 1 consistently stared at the ceiling and did not make eye contact when asked questions and instead would only mumble incoherently. CNA 1 stated that at 2:30 am while doing rounds, found Resident 1 unresponsive. CNA 1 stated that she immediately called an LVN to the room to assess further. During a concurrent record review of the facility ' s surveillance video footage on 9/19/2024 at 11:09 am with the Administrator, the Administrator stated that both himself and the Director of Nursing (DON) were both newly hired in the facility (four days ago). The video footage indicated that on (time stamp): 1. 9/4/2024 at 10 pm observed Resident 1 ' s hands are seen in the door frame (floor level) of his room. 2. 9/4/2024 between 10:00:10 pm to 10:04 pm, Resident 1 came out of the room crawling, and lying on the floor of the hallway. 3. 9/4/2024 at 10:05 pm, Resident 1 came in video frame outside the hallway sleeping on the floor, belly down with his face on the floor. Resident 1 had a gown which was hanging and dragging on the floor. Gown tied on the neck area. Resident 1 had his upper body exposed and had an incontinence brief that was around his knees and had his private parts exposed in the back. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	4. 9/4/2024 at 10:06 pm, Resident 1 turned to his left side (still on the floor) while a female (CNA 2) and male (LVN 3) were observed at nurses ' station talking to each other. Female nurse in navy blue scrubs (CNA2) noted walking from station to other side of the hall wall, within eyesight of Resident 1. 5. 9/4/2024 at 10:07 pm Resident 1 lying on his back with arms stretched out in the hallway floor close to nurses ' station (within eyesight of Resident 1). 6. 9/4/2024 at 10:08 pm Resident 1 tries to get up but then lands on left side of his body. Attempts to get up then gets into fetal position. Another male resident dressed in black (unidentified - Resident 88) with roll aider (walker) observed walking towards resident and (at 10:09 pm) hops over resident (still lying on the floor) while lifting his walker while CNA 2, Staff 11, Staff 12, and Staff 13 were present (within eyesight of Resident 1) and not paying attention to the Resident 1. 7. 9/4/2024 at 10:09 pm LVN in burgundy scrubs (Staff 10) seen working on the medicine cart (a movable piece of equipment used in healthcare settings to transport, store, and dispense medical supplies and medications) [within eyesight of Resident 1] with resident still lying on the floor. 8. 9/4/2024 Between 10:09 pm and 10:14 pm Resident 1 still lying down in the hallway. 9. 9/4/2024 at 10:14 pm LVN in burgundy scrubs (Staff 10) walks away from cart then returns. Moved to the nursing station placing Resident 1 in view of her sight. 10. 9/4/2024 at 10:14 pm, Resident 1 seen crawling back in his room with legs still in hallway and then turns to go back to the hallway in crawling. 11. 9/4/2024 at 10:15 pm, female nurse [CNA] in navy blue scrubs (CNA2) walks over with linen looks at resident then continues to the other side of the hallway. Nurse [CNA] in white scrub (CNA 9) walks over, looks at resident, then continues to other side of the hallway. 12. 9/4/2024 at 10:16 pm, nurse [CNA] in blue scrubs walks (CNA2) in hallway [within eyesight of Resident 1] and ignores Resident 1. Resident 1 lying on the floor. 13. 9/4/2024 at 10:17 pm to 10:19 pm, Resident 1 still lying down in the middle of the hallway with exposed back. 14. 9/4/2024 at 10:20 pm, a female resident (unidentified, Resident 89) who had walked up to the nursing station and was observed saying something to (CNA2) in blue scrubs and pointing at Resident 1 who was turning restlessly on the floor. The (CNA 2) then turned to look at Resident 1 then looked back ahead towards nursing station. 16 seconds later, (CNA2) turns back to look at resident over the shoulder then looks back ahead. Resident still lying on floor in hallway. The same (CNA 2) looks over shoulder again to look at Resident 1. 15. 9/4/2024 at 10:22:35 Resident 1 seen crawling further towards nurse station in hallway then falls to his left side. (CNA2) in blue scrubs (CNA2) turns to look at Resident 1 at 10:22:41 pm, then walks away. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	16. 9/4/2024 at 10:23 pm. (CNA2) in blue scrubs comes back in frame and ignores Resident1 who is still lying on the floor with CNA 2 ' s eyesight. 17. 9/4/2024 at 10:23:20 pm, Resident 1 seen crawling towards nursing station and gets within approximately 4 feet of CNA 2 in blue scrubs. Just then the nurse in white scrubs (CNA9) appears in frame and looks at Resident 1. Female nurse in blue scrubs (CNA2) turns towards Resident 1 who was now almost at her feet, then stands on other side of the medication cart, placing resident to her right side, now about 5-6 feet away. Resident 1 continues to wiggle and crawl on the floor. 18. 9/4/2024 at 10:23 pm, female nurse in blue scrubs (CNA2) starts chatting with another staff in blue scrubs with a mask sitting in the nurse ' s station (Staff 11). Resident 1 lying on the floor and looking at the two nurses in the station. 19. 9/4/2024 at 10:24 pm, Resident sits up facing the two staff (CNA2 and Staff 11) at the station who were observed speaking with each other and not paying attention to the Resident 1. 20. 9/4/2024 at 10:24:33 pm, Resident 1 lies down while facing the LVNs and CNA2 looks at resident then continues to chart. Resident 1 at this point sits up against the wall on the floor. 21. 9/4/2024 10:25 pm, nurse in white scrubs (CNA9) and female nurse in peach scrubs (Staff 12) walks in the hallway in full view of Resident 1 struggling on the floor. The two staff look at Resident 1 and left. 22. 9/4/2024 at 10:26 pm, a nurse in blue scrubs (CNA2) looks at Resident 1 again (lying down on the floor), turns to her coworker (Another female nurse in burgundy scrubs, Staff 13) and starts to walk away (Resident 1 was within eyesight). 23. 9/4/2024 at 10:26:36 male nurse in blue scrubs (LVN 3) comes to join the two staff (CNA 2 and Staff 11) in the station. Resident 1 still lying on the floor. 24. 9/4/2024 at 10:27:15 pm, the female nurse in blue (CNA2) and the one in white (CNA9) walk past approximately 2 feet from resident. Female resident dressed in white dress with green palm trees (Unidentified, Resident 90) struggles to walk between Resident 1 and medicine cart while pushing her wheelchair. 25. 9/4/2024 at 10:28 pm, Resident 1 attempted to sit up, lean against the wall, then slips back to the ground mostly starting with his head as though it was heavy. Female nurse in burgundy (Staff 13) observed going to room close to resident. Still no help offered. 26. 9/4/2024 at 10:32:10 pm, Resident 1 crawls back in room, female nurse (CNA 9) in burgundy (Staff 13) observed coming in frame at the medication cart in station 2. CNA9 in white scrubs observed walking past the resident ' s room, pause, then go into the next room. 27. 9/4/2024 at 10:33 to 10:51 pm, Resident 1 continues to be restlessly turning back and forth and crawling on the floor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	28. 9/4/2024 at 10:51 pm, Resident 1 comes back in hallway and the male nurse in blue scrubs (LVN3) as well as the female in burgundy (Staff 10) assist resident up back to room. 29. 9/4/2024 at 10:58:40 pm, Resident 1 came out of the room and laid on his belly down. 30. 9/4/2024 at 11:01 pm, female nurse in gray pants and black top scrubs (Staff 14) walks past Resident 1 with no offer for assistance. 31. 9/4/2024 at 11:03:52 pm, male nurse in burgundy (Registered Nurse Supervisor, RNS2) looks directly at Resident 1, while Resident 1 points at him. RNS 2 looks away with no offer for help. Several nurses (LVNs, RNS, and CNA) walked past Resident 1. 32. 9/4/2024 at 11:05:18 pm, Resident 1 pulls off his gown completely with his diaper still around his knees. Female nurse (Staff 14) that appeared to have been starting her shift gazed at resident with hand under her chin. 33. 9/4/2024 at 11:06:38 pm, male nurse in burgundy (RNS2) speak with Resident 1, then walks away leaving him on the floor. Resident 1 crawled next to medicine cart at nurse ' s station. Female nurse in light blue scrubs (Staff 14) speaks with him for a while then walks away. 34. 9/4/2024 at 11:06:38 pm was the last entry footage seen then skips to 9/5/2024 at 12 midnight. 35. 9/5/2024 at 12 midnight. Resident 1 was no longer seen in the hallway. During a review of the facility ' s surveillance video footage on 9/4/2024 at 11:15 am with the Administrator, the Administrator stated, it is always the same two nurses not helping the resident. During a concurrent interview and record review of the video surveillance with CNA 2 on 9/19/2024 at 3:32 pm, CNA 2 verified that she was one of the nurses who was dressed in blue scrubs and talking to another nurse while the Resident was lying down on the floor close to the nurses ' station. She stated that she was not assigned with Resident 1 but had observed Resident 1 come out in the hallway on several occasions lying down on the floor. She stated that she had helped the assigned nurses bring the resident to his room on one occasion. CNA 2 stated that Resident 1 appeared to be uncomfortable and possibly looking for attention when he crawled to the nurse ' s station. She stated that the residents ' dignity was not preserved. The potential of not helping could result in injury to the resident as well as embarrassment from being exposed. During a concurrent interview and record review of the video footage with CNA 3 on 9/19/2024 at 3:49 pm, CNA 3 stated that she was assigned with Resident 1 and admitted that Resident 1 consistently came out of his room crawling and lying in the hallway. CNA 3 started crying when she saw the footage and stated that she felt bad for Resident 1. She stated that she could have helped him more but was assigned to several other residents and it was impossible to assist him every time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the administrator on 9/19/2024 at 5:09 pm, the Administrator admitted that the nurses did see Resident 1 on lying on the floor and crawling while he was exposed multiple times and did not help him. He stated that the nurses should have helped him off the floor. The Administrator stated that his (Resident 1) dignity was not preserved. The Administrator stated that Resident 1 may have benefited from having a 1:1 sitter (a patient care intervention where a staff member is always present with a resident) as a potential intervention he kept coming back out. During a concurrent interview and record review on 9/19/2024 at 5:22 pm, with the Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled Abuse and Neglect - Clinical Protocol, dated 8/15/2024 was reviewed. The P&P indicated under treatment/management that the facility management and staff will institute measures to address the needs of the residents in order to reduce the possibility of abuse and neglect. The same P&P indicated, The physician and staff will address appropriately causes of problematic resident behavior where possible, such as mania (a mental and behavioral disorder that involves a period of abnormally elevated energy, arousal, and affect) psychosis (a severe form of mania that can involve a break from reality), and medication side effects. The same P&P indicated the Medical Director will advise facility management and staff to safeguard the basic needs functionally, medically, and psychosocial (looks at individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function) are met thereby preventing or treating conditions that affect function and quality of life are addressed appropriately. The DON stated that the staff in the facility did not know if lying and crawling in the hallway while exposed was Resident 1 ' s baseline behavior (normal behavior for Resident 1). A copy of the facility ' s surveillance video footages for 9/4/2024 and 9/520/24 was requested on 9/19/2024 but was not provided. On 9/20/2024 the facility Administrator informed the Department that the facility ' s surveillance video footages for 9/4/2024 and 9/5/2024 requested was mistakenly deleted and can no longer provide the footages to the Department. During a review of the facility ' s P&P titled Dignity, reviewed 8/15/2024, the P & P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The same P&P indicated: Staff are expected to treat cognitively impaired residents with dignity and sensitivity, for example: a. addressing the underlying motives or root causes for behavior; and b. not challenging or contradicting the resident's beliefs or statements.