| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056206 | A. Building<br>B. Wing | 11/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| University Park Healthcare Center | 230 E Adams Blvd<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50391<br><br>Based on interview and record review, the facility failed to protect the resident's right to be free from abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1), who had a diagnosis of Schizophrenia (a mental illness that is characterized by disturbances in thought) and mood disorder (a mental health condition that affects a person's emotional state, causing long periods of sadness, depression, mania, or elation). Resident 1 approached and physically became aggressive to Resident 2, while Resident 2 rested in bed and was awaken to see Resident 1 standing over him. As a result, on 11/9/2024, Resident 2 sustained a skin tear on the left ear.<br><br>Findings:<br><br>A review of Resident 1's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including anxiety (feeling of fear, dread and uneasiness that can be a normal reaction to stress) and depressive episodes (a period of time when someone experiences a depressed mood and other symptoms for at least two weeks).<br><br>A review of Resident 1's Potential to Demonstrate Abusive behavior care plan revised 12/21/2023 indicated the resident had ineffective coping skills and poor impulse control.<br><br>A review of Resident 1's History and Physical (H&P) dated 5/9/2024, indicated the resident had the capacity to understand and make decisions.<br><br>A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/27/2024, indicated the resident had no cognitive impairments (no problems with a person's ability to think, remember, use judgement, and make decisions).<br><br>A review of Resident 1's Change in Condition form (COC) dated 11/10/2024 at 12:55 AM indicated Resident 1 had a patient-to-patient altercation on 11/9/2024 in the afternoon. The COC indicated Certified Nursing Assistant (CNA) 1 reported to the charge nurse that residents were arguing inside the room. Resident 2 was lying in his bed when Resident 1 approached him, staff intervened and separated the residents. The COC indicated Resident 1 was assessed and placed on visual monitoring to ensure safety.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident 2's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including schizophrenia, mood disorders, and depressive episodes.<br><br>A review of Resident 2's MDS dated [DATE], indicated the resident had no cognitive impairment, no symptoms of feeling down, and no symptoms of little interest or pleasure in doing things, no hallucination or delusions and no physical/verbal behavior directed towards others.<br><br>A review of Resident 2's COC dated 11/9/2024 at 11:09 PM, indicated Resident 2 had a patient-to-patient altercation on 11/9/2024 in the afternoon. The COC indicated the Resident 2 was lying in bed and was awaken to see Resident 1 standing over him. Staff intervened and separated the residents. The COC indicated a body assessment was completed and scratches by the left ear and left shin were noted.<br><br>A review of Resident 2's Interdisciplinary Team (IDT, a team of health care professionals, which include the facility's medical director, Director of Nursing (DON), social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents) Note dated 11/11/2024 indicated on 11/9/24, Resident 2 was involved in an altercation with another resident (Resident 1). The IDT note indicated a situation escalated when Resident 1 approached Resident 2 while lying in bed. The IDT note indicated that Resident 1 approached and physically became aggressive to Resident 2. The IDT Note indicated Resident 2 had no known history of physically aggressive or inappropriate behaviors.<br><br>During an interview with CNA 1 on 11/21/24 at 11 AM, CNA 1 stated he was familiar with both residents and have worked with both residents. CNA 1 stated Resident 1 gets aggravated regarding volume control on the TVs. Residents tend to leave them loud and fall asleep, which triggers Resident 1.<br><br>During an interview on 11/21/24 at 1:30 PM, Licensed Vocational Nurse (LVN) 1 stated that Resident 1 did indeed have a issue with aggression when things were not done how he liked. LVN 1 explained that there have been several occasions when Resident 1 would become aggressive with staff if his directions were not followed. Resident 1 became aggressive when others did not follow the bathing schedule. LVN 1 stated the charge nurse was notified of this occurrence several times before.<br><br>During an interview on 11/21/24 at 1:45 PM, the Administrator (ADM) stated Resident 1 had a history of wanting to run the show. Resident 1 tends to get upset when he felt people were not listening to him, or he could not do something he wanted to do. The facility was aware that Resident 1 had many triggers and liked to control the flow of traffic.<br><br>During an interview on 11/21/24 at 2 PM, Registered Nurse (RN) 1 stated Resident 2 was a very nice man, who gets along with everyone. Resident 1 felt that he should control how things work in the room. If the slightest occurrence happened and Resident 1 felt provoked, he became aggressive. The RN 1 stated she was aware of Resident 1's certain triggers that possibly may lead to an altercation.<br><br>During an interview on 11/21/24 at 3 PM, the Director of Nursing stated, I am aware of the triggers and issues that surround Resident 1's behavior. I truly believe that we do not possess the level of care that Resident 1 needs. We are actively trying to transfer him to a location that is better suited for his needs.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's policy and procedure titled, Abuse and Neglect - Clinical Protocol, revised 3/2018, indicated abuse was defined as the willful infliction of injury, intimidation, or punishment with resulting harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. |