

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44253</p> <p>Based on interview and record review, the facility failed to protect one of three sampled residents' (Resident 1), right to be free from physical abuse by Resident 2. Resident 2, had a history of attempting to strike other residents and staff.</p> <p>As a result, on 11/1/2024, Resident 2 hit Resident 1 several times on the left side of his the face/chin which resulted in bleeding. Resident 1's left chin was treated by staff for 13 days. Resident 2 was transferred to a general acute care hospital (GACH) on 11/1/2024 by non-emergency transportation for evaluation and treatment.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), atrial fibrillation (an irregular heartbeat that can lead to blood clots and increases the risk of stroke and other heart complications) and stroke.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/22/2024, the MDS indicated the resident's cognition (ability to think, understand, and reason) was severely impaired. The MDS also indicated Resident 1 was dependent upon staff to go from lying to sitting, to stand, oral and toileting hygiene.</p> <p>During a review of Resident 1's Progress Note, dated 11/1/2024, the progress note indicated Resident 1 reported Resident 2 scratched Resident 1's chin, slapped his Resident 1's left cheek and kicked Resident 1's left leg. The progress note indicated Resident 1 was bleeding from the head and that Resident 1's roommate [Resident 2] allegedly hit Resident 1. The progress note indicated Resident 1 had a one centimeter (cm-unit of measurement) scratch on the chin. The progress note also indicated Resident 2 was transferred to another room.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's situation, background, assessment, recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) form dated 11/1/2024, indicated staff applied a cold pack (a medical device that reduces swelling and pain to various body parts) to Resident 1's left cheek. The SBAR indicated Resident 1's roommate [Resident 2] was moved to another room and that Resident 1 refused to be transferred out a GACH for further evaluation. The SBAR indicated a physician ordered a treatment (not specified) for Resident 1's skin scratch.</p> <p>During a review of Resident 1's care plan titled Risk for Emotional Distress initiated on 11/1/2024 (after the alleged abuse), indicated Resident 1 was subject to physical and verbal aggression from his roommate [Resident 2]. The care plan interventions included to assess Resident 1's pain and skin and to encourage the resident to verbalize fears, anxieties, and anger.</p> <p>During a review of Resident 1's care plan titled, Skin Scratch, initiated on 11/1/2024 (after the incident), indicated Resident 1 had a scratch on the chin. The care plan interventions included to keep skin (chin) clean and dry, monitor the site (scratch) for signs and symptoms of infection, and to notify the physician of any abnormal findings.</p> <p>During a review of Resident 1's Treatment Administration Record (TAR - a report detailing skin care provided to a resident) for 11/2024, the TAR indicated for Resident 1, to cleanse the site with normal saline, pat dry, apply triple antibiotic ointment then leave open to air daily, to the left chin with scratch daily from 11/1/2024 to 11/13/2024.</p> <p>Resident 1 several times on the left side of the face admitted to the facility on [DATE], with the diagnoses including dementia (a progressive state of decline in mental abilities), anxiety disorder (restlessness and worry) and unspecified psychosis (a mental disorder characterized by a disconnection from reality).</p> <p>During a review of Resident 2's Change in Condition (COC - a form that is a documentation of a complete assessment in response to a change in condition) Evaluation, dated 9/8/2024, the COC indicated the resident was verbally aggressive (cursing, screaming, .) and was trying to strike others in the hallway.</p> <p>During a review of Resident 2's care plan titled Behavior Problem initiated on 9/8/2024, indicated Resident 2 had an aggressive behavior. The care plan further indicated that on 10/21/2024, Resident 2 was aggressive towards Resident 2's roommate. A further review of the care plan indicated the goal was for Resident 2 to have fewer episodes of aggressive behavior. The care plan interventions included to monitor the resident's behavior episodes and attempt to determine underlying cause, administer Seroquel a medication used to stabilize mood), Depakote (a medication used to stabilize mood) and, and Ativan (medication to anxiety) was ordered and to assist the resident to develop more appropriate methods of coping and interacting.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. The MDS indicated Resident 2 did not have any physical (e.g. hitting, kicking, pushing) or verbal (e.g. threatening or screaming at others) behaviors. The MDS also indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with dressing, oral hygiene, toileting hygiene and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Physician Order dated 9/12//2024, indicated, Resident 2 was Behavior monitoring . per shift of target behavior anxiety manifested by (M/B) aggressive behavior .</p> <p>During a review of Resident 2's Psychiatry (Psych - medical specialty that focuses on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) Progress Note, dated 10/20/2024, the psych progress note indicated that for the month of 9/2024, Resident 2 had seven episodes of mood disorder manifested by anger outburst without trigger. The psych progress note also indicated the plan was to continue Resident 2 on Seroquel (an antipsychotic medication) 50 milligrams (mg-unit of measurement) orally at bedtime for delusional (believing something strong that is not true) disorder manifested by someone trying to harm in and to continue Depakote 250 mg orally every evening for mood disorder manifested by anger outburst without any triggers.</p> <p>During a review of Resident 2's COC, dated 10/21/2024 timed at 9:48 PM, the COC indicated Resident 2 attempted to strike his roommate.</p> <p>During a review of Resident 2's MDS, dated [DATE] (after the abuse), the MDS indicated Resident 2 exhibited physical behavioral symptoms directed towards others (e.g. hitting, kick, pushing, scratching, grabbing) in the past one to three days.</p> <p>During a review of Resident 2's SBAR Communication Form, dated 11/1/2024, the SBAR form indicated Resident 2 was physically and verbally aggressive towards his roommate [Resident 1]. The SBAR form also indicated Resident 2's roommate sustained a scratch on the chin. The SBAR form further indicated Resident 2 was placed on one to one monitoring and the resident's room was changed. The SBAR indicated the physician ordered Resident 2 transferred to a psychiatric unit for further evaluation and treatment.</p> <p>During a review of Resident 2's care plan titled Behavior problem related to (R/T) Physical and verbal aggression towards others initiated on 11/1/2024, the goal indicated Resident 2 will have no evidence of behavior problems, physical aggression towards others. The care plan interventions included to anticipate and meet the resident's needs.</p> <p>During a review of Resident 2's Physician's Order dated 11/1/2024, the physician order indicated the facility transferred Resident 2 to a general acute care hospital (GACH) emergency room (ER) to be evaluated due to severe agitation and physical and verbal aggression.</p> <p>During an interview on 11/15/2024 at 9:39 AM, Resident 1 stated on Halloween (10/31/2024) night Resident 2 approached Resident 1, who was in bed, and hit Resident 1 several times on the left side of the face and Resident 1 started bleeding.</p> <p>During an interview on 11/15/2024 at 9:54 AM, Resident 3 stated Resident 2 was previously his roommate. Resident 3 stated that Resident 2 had tried to hit him 2 or 3 times in the past. Resident 3 stated in 9/2024, Resident 2 tried to hit him but did not because the facility staff stopped Resident 2 from hitting him. Resident 3 stated Resident 2 was moved to another room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/15/2024 at 10:22, Resident 1's SBAR was reviewed with Licensed Vocational Nurse 2 (LVN 2). LVN 2 stated that on 11/1/2024 at 1:55 AM, Resident 1 reported that Resident 2 had scratched, slapped, and kicked Resident 1. LVN 2 further stated Resident 1 sustained a 1 cm scratch to the chin following an altercation (quarrel) and that Resident 1 received treatment for the scratch on the chin.</p> <p>During a concurrent interview and record review on 11/15/2024 at 10:28 AM, Resident 2's electronic medical record (EMR) was reviewed with LVN 2. After reviewing Resident 2's EMR, LVN 2 stated, it appears [Resident 2] has a history of being aggressive. LVN 2 stated per Resident 2's SBAR form, dated 9/8/2024, indicated Resident 2 had verbally aggressive behaviors and tried to strike others (not specified) in the hallway. LVN 2 also stated per the SBAR form, dated 10/21/2024, Resident 2 attempted to hit his roommate and Resident 2's room was changed. LVN 2 further stated Resident 2's aggressive behaviors were care planned and the resident was taking Depakote and Ativan.</p> <p>During an interview on 11/15/2024 at 12:09 PM, the Director of Nursing (DON) stated Resident 2 attempted to hit his roommate [Resident 3] in 10/2024 and was then moved to Resident 1's room. The DON further stated at first Resident 2 was okay in the new room [with Resident 1], but then Resident 2 physically threatened Resident 1.</p> <p>During an interview on 11/15/2024 at 12:22 PM, the Administrator stated he investigated the abuse allegation between Resident 1 and Resident 2. The Administrator stated after investigating the incident, he had determined that Resident 2 hit Resident 1.</p> <p>During a review of the facility's policy and procedures (P&amp;P) titled, Abuse Prevention and Prohibition Program, revised 8/1/2023, the P&amp;P indicated, each resident has the right to be free from abuse and neglect. The P&amp;P also indicated the facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, family members and visitors.</p>		