STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056377	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center on Pico	3233 W. Pico Boulevard Los Angeles, CA 90019

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 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** 49571 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 four sampled residents (Resident 1), who had diagnoses of mood affective disorder (a condition that affects a persons emotions) and unspecified psychosis (a condition that makes people lose contact with reality, seeing and hearing things that other people cannot, and believing things that are not true). The facility failed to: -Ensure a complete and adequate comprehensive assessment on 5/29/2024 and 7/24/2024, including cognitive patterns, mood, behaviors, and active diagnoses. -Review and reassess the Mood Impairment care plan interventions quarterly and on a regular basis, per the Abuse Prevention, Agitated or Combative Residents policy. -Develop a comprehensive person-centered care plan for the medical diagnosis psychosis (a mental disorder condition characterized by a disconnection from reality, seeing and hearing things that other people cannot, and believing things that are not true). -Supervise or monitor Resident 2, per the Depression care plan and the facility policy titled, Abuse Prevention, when on 8/25/2024 around 10 PM, Resident 2 was verbally abusive to staff, exhibiting a decline in mood and coping skills. As a result, on 8/25/2024 at around 11:15 PM, a charge nurse yelled for help as Resident 2 pulled the curtain back when the nurse provided care to Resident 2's roommate (Resident 1). Resident 2 continued to scream and yell inappropriately to the charge nurse and Resident 1, then threw a cup of juice which hit Resident 1. Resident 1 stated he was fearful and felt unprotected by being attacked by Resident 2. On 8/26/2024, Resident 2 was transferred to the General Acute Care Hospital (GACH) due to physical and verbal aggression, manifested by abusive behavior, inappropriate behavior, throwing objects, and for psychiatric evaluation. Findings: (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	A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including generalized muscle weakness, unspecified depression (a disease that causes low mood or loss of interest in activities, disrupts sleep patterns, and irritability), mood affective disorder (a condition that affects a persons emotions), and unspecified psychosis (a condition that makes people lose contact with reality, seeing and hearing things that other people cannot, and believing things that are not true). A review of the Psychology Assessment (an evaluation by a mental health professional who studies behavior, knowledge, and mind), dated 4/16/2024 indicated, Resident 2 spoke about his former roommate and an incident that caused him frustration. The assessment goal was to provide a space for Resident 2 to process emotion in order for him to feel calmer. A review of the At Risk for Mood Impairment care plan dated 4/18/2024, indicated Resident 2 was short tempered, easily annoyed, screamed and cursed at others. The goal indicted for Resident 2 not to exhibit a decline in mood and demonstrate coping skills. The care plan interventions indicated a psychological referral and treatment as indicated and to observe for and note decline or improvement since previous mood assessment. Further review indicated this care plan was not reviewed or revised quarterly, last update was 8/29/2024 (after the incident). According to a review of the Progress Note dated 4/21/2024, Resident 2 was being monitored due to an episode of verbal aggression towards his roommate indicating a decline in mood, per the Mood Impairment care plan. The Progress Note dated 4/24/2024 indicated Resident 2 was transferred to the GACH for evaluation of verbally aggressive behavior. A review of Resident 2's Psychiatric Intake Note dated 4/30/2024 indicated Resident 2 was very irritable, increasingly agitated, and dismissive. The note indicated the resident refused for the interview and conversations to continue, and refused taking the prescribed medication Zoloft (a medication that treats depression, anxiety). A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/29/2024 indicated Resident 2's cognitive skills for daily decision making were not assessed and remained blank. The MDS indicated Resident 2 had no symptoms of feeling down and no symptoms of little interest or pleasure in doing things, no hallucinations or delusions and no physical / verbal behaviors directed towards others. The MDS indicated Resident 2 did not reject evaluation of care, which was a discrepancy compared to the Psychiatric Intake Noted dated 4/30/2024. Further review of the MDS indicated the resident's active diagnoses remained blank, and did not have a psychotic disorder. The MDS indicated Resident 2 did not experience social isolation and never felt lonely or isolated from those around him. A review of the History of Depression care plan revised on 6/2/2024 indicated Resident 2 was not on any pharmacological intervention. The care plan interventions indicated to monitor / document / report anxiety, verbalizing negative statements, risk for harming others, increased anger, agitation, feels threatened by others or thoughts of harming someone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the Psychiatrist Progress Note dated 6/10/2024 indicated to refer Resident 2 to psychotherapy, encourage group participation and no psychotropic medications at this time. A review of the Psychiatrist Progress Noted dated 7/19/2024 indicated to refer Resident 2 to psychotherapy, encourage group participation and resident refused any psychotropic medication. Further review of the medical record indicated there was no referral completed for Resident 2 to receive psychotherapy after 6/10/2024. According to a review of the MDS dated [DATE], Resident 2's cognitive patterns had no acute change in mental status from the resident's baseline, no symptoms of feeling down and no symptoms of little interest or pleasure in doing things. The MDS indicated Resident 2 did not feel lonely or isolated and that the resident's cognitive skills for daily decision making were not assessed (remained blank). A review of Resident 1's admission record indicated the resident was admitted to the facility on [DATE] with diagnosis including quadriplegia (injury or disease affecting the spinal cord and brain that causes loss of feeling and function of limbs), muscle weakness, and unspecified disorder of muscle. The medical record indicated Resident 1's cognition was intact (ability to think, remember, use judgement, and make decisions). A review of the Progress Note dated 8/25/2024 indicated at around 10 PM, the charge nurse reported that Resident 2 (bed A) was verbally aggressive to staff. The Registered Nurse checked on Resident 2 and requested the resident calm down, but Resident 2 continued to be verbally aggressive to staff and the doctor was informed. The Progress Note indicated at around 11:15 PM, a charge nurse yelled for help as Resident 2 pulled the curtain back when the nurse provided care to Resident 2's roommate (Resident 1). Resident 2 continued to scream and yell inappropriately to charge nurse and Resident 1, then threw a cup of juice which hit Resident 1. A review of the Progress Note dated 8/26/2024 indicated Resident 2 was transferred to the GACH due to physical and verbal aggression, manifested by abusive behavior, inappropriate behavior, throwing objects, and for psychiatric evaluation. During an interview on 9/4/2024 at 9:43 AM, Resident 1 stated his roommate (Resident 2) was verbally and physically abusive towards him (on 8/25/2024). Resident 1 stated Resident 2 threw items at him hitting him on his arm and right side of his head. Resident 1 stated he was fearful and felt unprotected, as this incident with Resident 2 triggered a prior abuse experience from a different facility. During an interview on 9/4/2024 at 11:17 AM, the facility administrator (ADM) stated Resident 2 was verbally abusive towards staff throughout his stay in the facility. The ADM stated Resident 2 was referred for psychological and psychiatric evaluations with no significant outcomes that showed changes in Resident 2's behavior. During an interview on 9/4/2024 at 12:11 PM, Certified Nursing Assistant (CNA) 2 stated, that on 8/25/2024 around 11 AM, I was assisting a resident in the next room, and I heard Resident 2 screaming. I went to Resident 2's room to check. Resident 2 was verbally abusive cursing at Resident 1, and started throwing things. CNA 2 stated she remained with Resident 1, called for help, and Resident 2 continued being verbally abusive towards staff and Resident 1, throwing cups of juice and pillows hitting Resident 1. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/4/2024 at 12:29 PM, during a telephone interview, Licensed Vocational Nurse (LVN) 1 stated that on 8/25/2024 at around 11:15 AM, I witnessed Resident 2 throwing juice containers and pillows at Resident 1 and LVN 1. Resident 2 was verbally abusive and throwing things while LVN 1 was assisting Resident 1. Resident 1 had to be removed from room to ensure Resident 1's safety. During an interview on 9/5/2024 at 2:15 PM, the Director of Nursing (DON) stated Resident 2 had been refusing medications since April 2024, was verbally aggressive, dismissive, and uncooperative with care planning. The DON stated since Resident 2 did not exhibit any behaviors of psychosis that at psychosis care plan was not required. During an interview on 9/5/2024 at 2:31 PM, the MDS Coordinator stated she could not explain Resident 2's inadequate MDS assessment, including the resident's daily decision making and active diagnoses remaining blank. The MDS Coordinator stated the importance of a complete and accurate MDS assessment was to obtain the baseline assessment, prevent decline, and improve outcomes. The MDS Coordinator stated she would review and update the MDS for Resident 2. The MDS Coordinator stated the care plan for Psychosis was supposed to be developed and the importance of having the care plan was to get a resident's baseline, prevent decline, improve outcome of behavior and psychosocial wellbeing for the resident and other residents. A review of the facility's Policy and Procedure titled, Behavioral Health Services, dated March 2023, indicated the facility provides behavioral health care and services which include necessary care and services for person-centered care and reflects the resident's goals for care while maximizing the resident's dignity, autonomy, socialization, independence, choice, and safety. The interdisciplinary team including the resident, their family, or the resident representative ensures residents individualized behavioral health needs are met, through the Resident Assessment Instrument (RAI) process. A review of the facility's Policy and Procedure titled, Abuse Prevention Agitated or Combative Residents, dated March 2023, indicated each resident had the right to be free from mistreatment, neglect, and misappropriation of property. This included the facility's identification of residents' whose personal histories render them at risk for abusing other residents that would trigger abusive behavior, and reassessment of the interventions on a regular basis. The policy indicated the facility takes reasonable precautions, including providing adequate supervision, when the risk of resident-to-resident altercation was identified. A review of the facility's policy and procedure titled, Develop-Implement Comprehensive Care Plans, reviewed 3/2023 indicated the facility developed person-centered comprehensive care plans that were culturally competent and trauma-informed, developed and implemented to meet the resident's preferences and goals, and address the resident's medical, physical, and mental and psychosocial needs. The policy indicated care plans shall include the discipline providing care or services, measurable, objectives and timeframes in order to evaluate the resident's progress towards his/her goals(s). The policy did not indicate the federal requirement to review, revise or update the care plan on a quarterly basis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49571 Based on interview and record review, the facility failed to develop a comprehensive person-centered care planning for a medical diagnosis psychosis (a mental disorder condition characterized by a disconnection from reality, seeing and hearing things that other people cannot, and believing things that are not true) for one of four sampled residents (Resident 2). This deficient practice had the potential to negatively affect the delivery of provision of care necessary during events of psychotic episodes for Resident 2. Findings: A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including generalized muscle weakness, unspecified depression (a disease that causes low mood or loss of interest in activities, disrupts sleep patterns, and irritability), mood affective disorder (a condition that affects a person's emotions), and unspecified psychosis (a mental disorder condition characterized by a disconnection from reality, seeing and hearing things that other people cannot, and believing things that are not true). A review of the Psychology Assessment (an evaluation by a mental health professional who studies behavior, knowledge, and mind), dated 4/16/2024 indicated Resident 2 spoke about his former roommate and an incident that caused him frustration. The assessment indicated the goal was to provide a space for Resident 2 to process emotion in order for him to feel calmer. A review of Resident 2's Psychiatric intake note dated 4/30/2024 indicated Resident 2 was very irritable, increasingly agitated, and dismissive. The note indicated Resident 2 refused for the interview and conversations to continue, and refused to continue taking Zoloft (a medication that treats depression, anxiety) a medication he was prescribed on 2/23/2024. According to a review of the Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/29/2024, Resident 2 had no symptoms of hallucinations and delusions. Resident 2's MDS dated [DATE] indicated the resident's cognitive patterns indicated no acute change in mental status, and Section E for behavior was not assessed and remained blank (incomplete). During a telephone interview on 9/4/2024 at 12:29 PM, Licensed Vocational Nurse (LVN) 1 stated that on 8/25/2024 at around 11:15 AM, I witnessed Resident 2 throwing juice containers and pillows at Resident 1 and LVN 1. Resident 2 has been verbally abusive and throwing things while LVN 1 was assisting Resident 1. Resident 1 had to be removed from the room to ensure his safety. During an interview on 9/5/2024 at 2:15 PM, the Director of Nursing (DON) stated Resident 2 has been refusing medications since April 2024, has been verbally aggressive, dismissive, and uncooperative with care planning. The DON stated since Resident 2 did not exhibit any behaviors of psychosis that at psychosis care plan was not required. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/2024 at 2:31 PM, the MDS Coordinator stated the care plan for Psychosis was supposed to be developed and the importance of having the care plan was to get a resident's baseline, prevent decline, improve outcome of behavior and psychosocial wellbeing for the resident and other residents. A review of the facility's policy and procedure titled, Develop-Implement Comprehensive Care Plans, reviewed 3/2023 indicated the facility developed person-centered comprehensive care plans that were culturally competent and trauma-informed, developed and implemented to meet the resident's preferences and goals, and address the resident's medical, physical, and mental and psychosocial needs. The policy indicated care plans shall include the discipline providing care or services, measurable, objectives and timeframes in order to evaluate the resident's progress towards his/her goals(s).