| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056433 | A. Building<br>B. Wing | 04/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vermont Healthcare Center | 22035 S. Vermont Avenue<br>Torrance, CA 90502 |

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<br>(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** 45981<br><br>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. Facility failed to:<br><br>1. Separate Resident 1 and Resident 2 when CNA 1 witnessed Resident 2 hit Resident 1 on the face on 4/13/2024.<br><br>2. Separate Resident 1 and Resident 2 when Resident Representative ([RR] for Resident 1 (resident ' s legal guardian acting on behalf of the resident with the written consent of the resident, or a surrogate) reported the allegation of physical abuse to Registered Nurse (RN) 1 on 4/15/2024.<br><br>These deficient practices placed Resident 1 at risk for further abuse and had the potential to cause feelings of intimidation, neglect and not feeling safe in the facility which was considered their home.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), transient ischemic attack ([TIA] a short period of symptoms similar to those of a stroke), and heart failure ( a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs).<br><br>During a review of Resident 1 ' s History and Physical (H&P), dated 12/13/2023, the H&P indicated, Resident 1 had decision making capacity.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS], a comprehensive assessment and care screening tool]) dated 3/19/2024, The MDS indicated, Resident 1 required partial/moderate (helper does less than half the effort) assist with chair/bed-to-chair transfer, toilet transfer and had utilized a wheelchair as a mobility device.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056433 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/30/2024 |
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| NAME OF PROVIDER OR SUPPLIER Vermont Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 22035 S. Vermont Avenue Torrance, CA 90502 | |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 2 ' s Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities) and uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional).<br><br>During a review of Resident 2 ' s MDS dated [DATE], The MDS indicated, Resident 2 required dependent (helper does all of the effort) for chair/bed-to-chair transfer, showering, toileting, and had utilized a wheelchair and walker as a mobility device.<br><br>During an interview on 4/30/2024 at 8:31 a.m. with Resident 1, Resident 1 became agitated when asked about the incident. Resident 1 stated she does not want to discuss incident of Resident 2 hitting her. Resident 1 stated the incident happened a long time ago and does not want to discuss it. Resident 1 stated it was Resident 2 who hit her and does not remember exactly when the incident occurred. Resident 1 stated Resident 3 (roommate) witnessed the incident.<br><br>During an interview on 4/30/2024 at 8:35 a.m. with Resident 3 Resident 3 stated she witnessed Resident 2 hit Resident 1 on the face. Resident 3 stated she does not want to discuss the incident any further because it makes Resident 1 upset.<br><br>During a phone interview on 4/30/2024 at 8:47 a.m. RR for Resident 1, RR stated Resident 1 informed her on 4/14/2024 that when she was coming out of the restroom with assistance from CNA 1 Resident 2 allegedly slapped her in the face. RR stated Resident 1 told her CNA 1 witnessed the incident. RR stated CNA 1 was in Resident 1 ' s room at the time that she was speaking the resident. RR stated asked if she could speak to CNA 1. RR stated she spoke to the CNA 1 on Resident 1 ' s cell phone and asked CNA 1 if she witnessed the incident between Resident 1 and Resident 2. RR, CNA 1 stated yes. RR stated CNA 1 stated that she would report the incident to the charge nurse. RR stated she called the facility on 4/15/2024 to report the incident and spoke to the Social Service Director (SSD). RR stated she was informed by SSD that the facility will initiate an investigation regarding the alleged incident.<br><br>During a review of Employee/Resident Statement dated 4/16/2024, the Employee/Resident Statement indicated, Resident 1 stated she wants Resident 2 out of her room.<br><br>During an interview on 4/30/2024 at 9:52 a.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated that the incident occurred a few weeks ago but could not recall the exact date. CNA 1 stated she was assisting Resident 1 out of the restroom, and she noticed Resident 2 aggressively moving the privacy curtain (helping to maintain the dignity and privacy of residents). CNA 1 stated that she was assisting Resident 1 into her wheelchair. CNA 1 stated she noticed Resident 2 ' s voice being aggressive tone (speaking loudly) and appeared extremely agitated, however she could not understand Resident 2 because she was speaking in different language other than English. CNA 1 stated Resident 1 was sitting in her wheelchair in between Resident 1 ' s and Resident 2 ' s bed. CNA 1 stated she witnessed Resident 2 hit Resident 1 on her right arm. CNA 1 stated Resident 2 was swinging her arms aggressively, so she blocked Resident 2 from hitting Resident 1 again by moving Resident 1 back into the restroom. CNA 1 stated after the incident she informed LVN 1 of the incident. CNA 1 stated she informed LVN 1 that Resident 2 was behaving aggressively and refusing to be showered. CNA 1 stated LVN 1 went to speak to Resident 2 but was not present during the conversation. CNA 1 stated the residents were not separated after the incident on 4/13/2024 and remained in the same room.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Vermont Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 22035 S. Vermont Avenue Torrance, CA 90502 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/30/2024 at 10:00 a.m. with Social Service Director (SSD), the SSD stated that he was informed of the alleged incident on 4/16/2024 by the administrator. SSD stated he was informed that Resident 1 was hit by Resident 2. SSD stated he conducted an assessment for both residents and interviewed Resident 1, and she stated Resident 2 hit her on the cheek. SSD stated Resident 1 told him she was being assisted by CNA 1 out of the restroom and seen Resident 1 pulling at the privacy curtain and she attempted to stop Resident 2 from pulling the privacy curtain and then that was when Resident 2 hit her on her cheek. SSD stated Resident 1 first stated Resident 2 hit her on one cheek and then stated she was hit on both cheeks. SSD stated he reported the incident to the ombudsman on 4/16/2024. SSD stated both residents should be separated immediately to avoid further harm to Resident 1 and ensure safety. SSD stated Resident 2 ' s room was changed on 4/16/2024 due to Resident 1 claiming she was hit by Resident 2.<br><br>During an interview on 4/30/2024 at 10:26 a.m. with License Vocational Nurse (LVN 1), LVN 1 stated the alleged incident occurred over the weekend but does not remember the exact date. LVN 1 stated CNA 1 reported to her Resident 2 was being aggressive and refusing to shower but did not report Resident 2 hit Resident 1 at that time. LVN 1 stated she did not report to the RN or Resident 2 ' s physician that CNA 1 informed her Resident 2 was exhibiting aggressive behavior. LVN 1 stated a change in condition (a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) would be considered when residents (in general) are exhibiting aggressive behavior, and refusal of care. LVN 1 stated the Registered Nurse (RN), and the doctor should be informed immediately when there was a change of condition because the doctor could further assess the resident (in general) and implement interventions if necessary. LVN 1 stated a change of condition should also be documented in the nurse progress notes. LVN 1 stated Resident 2 had not exhibited aggressive behavior in the past towards other residents or staff. LVN 1 stated the report by CNA 1 that Resident 2 exhibited aggressive behavior would be considered a change in condition and should have been reported to the RN and Resident 2 ' s physician at that time. LVN 1 stated Resident 1 and Resident 2 should be separated immediately when there was allegation of physical abuse to protect the residents from further abuse. LVN 1 stated residents (in general) could feel afraid, and fearful if the resident (in general) are still in the presence of a resident who just hit them.<br><br>During a review of Resident 2 ' s Care Plan, titled Episode of being resistive to care as evidenced attempting to strike out during care and medication administration dated 4/2024 indicated interventions including to monitor resident behavior for any changes or improvements and to notify medical doctor of refusal of care.<br><br>(continued on next page) |

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| Vermont Healthcare Center | 22035 S. Vermont Avenue Torrance, CA 90502 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/30/2024 at 10:50 a.m. with the Registered Nurse (RN 1), RN 1 stated the incident occurred on 4/13/2024. RN 1 stated she was made aware of the incident the next day during hand off on 4/16/224 from RN 2. RN 1 stated she was informed Resident 1 stated Resident 2 slapped her in the face. RN stated she notified the administrator, and the investigation was started on 4/16/2024. RN 1 stated she did not move Resident 2 immediately because she was asleep, and she did not feel that residents were unsafe, so she made that judgement call to leave Resident 2 in the same room. RN 1 stated residents should be separated immediately to avoid the incident from reoccurring and keep the residents (in general) safe. RN 1 stated by Resident 2 being left in the room could have made Resident 1 felt afraid and threaten. RN 1 stated Resident 2 was moved to another room on 4/16/2024 (3 days after the incident on 4/13/2024) due to the report of Resident 2 hitting Resident 1 and to ensure Resident 1 ' s safety. RN 1 stated residents (in general) should be separated immediately after an altercation in order to protect the residents (in general) from further abuse. RN 1 stated Resident 1 has the right to feel safe in her room and should be free from any type of abuse. Resident 2 ' s nurses progress notes were reviewed, RN 1 stated Resident 2 room change did not occur until 4/16/2024.<br><br>During a concurrent interview and record review on 4/30/2024 at 11:30 a.m. with Director of Staff Development (DSD), DSD stated residents (in general) should be separated immediately after a report of abuse whether it is actual or allegedly because you don ' t want the abuse to continue and to ensure the residents (in general) safety.<br><br>During a concurrent interview and record review on 4/30/2024 at 12:27 p.m. with the Director of Nursing (DON), the DON stated that she was made aware of the alleged incident on 4/15/2024 by RN 2. DON stated RN 2 informed her that Resident 1 ' s daughter informed her that on 4/13/2024 Resident 2 hit Resident 1 in the face. DON stated she informed RN 2 to perform a physical assessment (a series of services that are provided to evaluate an individual's medical history and present physical condition), and pain assessment (designed to measure pain) for Resident 1 and begin an investigation. DON stated when abuse was reported staff should separate both residents immediately because it potentially places residents at risk for further harm. DON stated the incident with Resident 1 and Resident 2 should have been reported immediately and the residents should have been separated to avoid the potential for the abuse to occur again. DON stated that the delay in room change placed Resident 1 at risk for further harm.<br><br>During an interview on 4/30/2024 at 1:02 p.m. with Administrator (Admin), Admin stated that she was informed of the incident by RN 2 during the night on 04/15/2024. Admin stated RN 2 informed her that Resident 1 ' s daughter reported Resident 2 hit Resident 1 in the face. Admin stated Resident 1 ' s daughter informed RN 2 that she thought CNA 1 reported the incident to LVN 1. Admin stated, when she was informed about the incident she was told by RN 2 that Resident 1 and Resident 2 were sleeping at that time. Admin stated she instructed RN 2 to continue to let Resident 1 and Resident 2 sleep and move Resident 2 the next day 4/16/2024. Admins stated Resident 1 and Resident 2 should be separated immediately after abuse allegation occurs for safety reasons. Admin stated by Resident 2 not being moved immediately that could have made Resident 1feel fearful that the abuse could occur again.<br><br>During a review of the facility ' s Employee/Resident Statement dated 4/16/2024, the Employee/Resident Statement indicated, Resident 3 stated that Resident 2 has behavior of kicking staff.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Vermont Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 22035 S. Vermont Avenue Torrance, CA 90502 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2023, the P&P indicated, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determine what actions (if any) are needed for the protection of residents.<br><br>During a review of the facility ' s Charge Nurse/LVN Job Description, [undated] the Charge Nurse/LVN Job Description indicated, Report and investigate all allegations of resident abuse and/or misappropriation of resident property.<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Care of Dementia Resident, [undated] the P&P indicated, The staff will monitor the individual with dementia for change in condition and decline in function and report those findings to the MD. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981<br><br>Based on interview and record review, the facility failed to ensure an allegation of abuse were reported to the state agency (Department of Public Health (DPH) or the police department within two hours of the occurrence of incident and no later than 24 hours for one of three sampled residents (Resident 1).<br><br>This deficient practice had the potential to result in unidentified abuse in the facility and had the potential for Resident 1 to experience further abuse from Resident 2.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), transient ischemic attack ([TIA] a short period of symptoms similar to those of a stroke), and heart failure ( a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs).<br><br>During a review of Resident 1 ' s History and Physical (H&P), dated 12/13/2023, the H&P indicated, Resident 1 had decision making capacity.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS], a comprehensive assessment and care screening tool]) dated 3/19/2024, The MDS indicated, Resident 1 required partial/moderate (helper does less than half the effort) assist with chair/bed-to-chair transfer, toilet transfer and had utilized a wheelchair as a mobility device.<br><br>During a review of Resident 2 ' s Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities) and uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional).<br><br>During a review of Resident 2 ' s MDS dated [DATE], The MDS indicated, Resident 2 required dependent (helper does all the effort) for chair/bed-to-chair transfer, showering, toileting, and had utilized a wheelchair and walker as a mobility device.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 4/30/2024 at 8:47 a.m. with Resident Representative ([RR] (resident's legal guardian, an individual acting on behalf of the resident with the written consent of the resident, or a surrogate) for Resident 1, RR stated Resident 1 informed her on 4/14/2024 that when she was coming out of the restroom with assistance from CNA 1 Resident 2 allegedly slapped her in the face. RR stated Resident 1 told her CNA 1 witnessed the incident. RR stated CNA 1 was in Resident 1 ' s room at the time that she was speaking the resident. RR stated asked if she could speak to CNA 1. RR stated she spoke to the CNA 1 on Resident 1 ' s cell phone and asked CNA 1 if she witnessed the incident between Resident 1 and Resident 2. RR, CNA 1 stated yes. RR stated CNA 1 stated that she would report the incident to the charge nurse. RR stated she called the facility on 4/15/2024 to report the incident and spoke to the Social Service Director (SSD). RR stated she was informed by SSD that the facility will initiate an investigation regarding the alleged incident.<br><br>During an interview on 4/30/2024 at 9:52 a.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated that the incident occurred a few weeks ago but could not recall the exact date. CNA 1 stated she was assisting Resident 1 out of the restroom, and she noticed Resident 2 aggressively moving the privacy curtain (helping to maintain the dignity and privacy of residents). CNA 1 stated that she was assisting Resident 1 into her wheelchair. CNA 1 stated she noticed Resident 2 ' s voice being aggressive tone (speaking loudly) and appeared extremely agitated, however she could not understand Resident 2 because she was speaking in different language other than English. CNA 1 stated Resident 1 was sitting in her wheelchair in between Resident 1 ' s and Resident 2 ' s bed. CNA 1 stated she witnessed Resident 2 hit Resident 1 on her right arm. CNA 1 stated Resident 2 was swinging her arms aggressively, so she blocked Resident 2 from hitting Resident 1 again by moving Resident 1 back into the restroom. CNA 1 stated after the incident she informed LVN 1 of the incident. CNA 1 stated she informed LVN 1 that Resident 2 was behaving aggressively and refusing to be showered. CNA 1 stated LVN 1 went to speak to Resident 2 but was not present during the conversation. CNA 1 stated the residents were not separated after the incident on 4/13/2024 and remained in the same room. CNA 1 stated abuse should be reported right away to the charge nurse or the administrator.<br><br>During an interview on 4/30/2024 at 10:00 a.m. with Social Service Director (SSD), the SSD stated that he was informed of the alleged incident on 4/16/2024 by the administrator. SSD stated he was informed that Resident 1 was hit by Resident 2. SSD stated he conducted an assessment for both residents and interviewed Resident 1, and she stated Resident 2 hit her on the cheek. SSD stated Resident 1 told him she was being assisted by CNA 1 out of the restroom and seen Resident 1 pulling at the privacy curtain and she attempted to stop Resident 2 from pulling the privacy curtain and then that was when Resident 2 hit her on her cheek. SSD stated Resident 1 first stated Resident 2 hit her on one cheek and then stated she was hit on both cheeks. SSD stated he reported the incident to the ombudsman on 4/16/2024 (3 days after the incident on 4/13/2024). SSD stated abuse should be reported immediately upon knowledge of the allegation. SSD stated abuse should be reported to the administrator immediately and the residents should be separated immediately avoid further harm to the resident (in general) and ensure the residents safety.<br><br>During a concurrent interview and record review on 4/30/2024 at 10:50 a.m. with the Registered Nurse (RN 1), RN 1 stated the incident occurred on 4/13/2024. RN 1 stated she was made aware of the incident the next day during hand off on 4/16/224 from RN 2. RN 1 stated she was informed Resident 1 stated Resident 2 slapped her in the face. RN 1 stated abuse should be reported immediately to the administrator when it happened or when alleged abuse was reported. RN stated she notified the administrator, and the investigation was started on 4/16/2024.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/30/2024 at 11:30 a.m. with Director of Staff Development (DSD), the DSD stated abuse with an injury should be reported within 2 hours and without injury should be reported within 24 hours to the abuse coordinator, California Department of Public Health (CDPH), police, and ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities).<br><br>During a concurrent interview and record review on 4/302024 at 12:27 p.m. with Director of Nursing (DON), the DON stated that she was made aware of the alleged incident on 4/15/2024 by RN 2. DON stated RN 2 informed her that Resident 1 ' s daughter informed her that on 4/13/2024 Resident 2 hit Resident 1 in the face. DON stated when abuse was reported staff should separate residents (in general) immediately because it potentially places residents (in general) and staff at risk for further harm. The DON stated the abuse coordinator, CDPH, ombudsman, police, physician, and resident representative should be notified immediately. The DON stated CDPH should be notified within 24 hours if there was no injury. DON stated the incident with Resident 1 and Resident 2 should have been reported immediately and the residents should have been separated to avoid the potential for the abuse to occur again.<br><br>During an interview on 4/30/2024 at 1:02 p.m. with Administrator (Admin), the Admin stated that she was the facility ' s abuse coordinator and responsible for investigating abuse incidences. Admin stated that she was informed of the incident by RN 2 during the night of 4/15/2024. Admin stated RN 2 informed her that Resident 1 ' s daughter reported that Resident 2 hit Resident 1 in the face. Admin stated Resident 1 ' s daughter informed RN 2 that she thought CNA 1 reported the incident to LVN 1. Admin stated, when she was informed about the incident, she was told by RN 2 that Resident 1 and Resident 2 were sleeping at that time. Admin stated she instructed RN 2 to continue to let Resident 1 and Resident 2 sleep and move Resident 2 the next day on 4/16/2024. Admin stated abuse should be reported immediately to the administrator. Admin stated abuse should also be reported to CDPH, ombudsman, and police, doctor, and the resident ' s representative. Admin stated she reported the incident on 4/16/2024 to CDPH (3 days after the incident on 4/13/2024).<br><br>During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 2023, the P&P indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.<br><br>CROSS REFERENCE F600. |

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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 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45981<br><br>Based on interview and record review the facility failed to ensure Licensed Vocational Nurse (LVN) 1 had training on preventing all forms of abuse, and procedures for reporting incidents of abuse.<br><br>This deficient practice had a potential to place the residents at risk for elder abuse, neglect and exploitation or misappropriation of resident property and inappropriate dementia management.<br><br>Findings:<br><br>During a review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), transient ischemic attack ([TIA] a short period of symptoms similar to those of a stroke), and heart failure ( a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs).<br><br>During a review of Resident 1 ' s History and Physical (H&P), dated 12/13/2023, the H&P indicated, Resident 1 had decision making capacity.<br><br>During a review of Resident 1 ' s Minimum Data Set ([MDS], a comprehensive assessment and care screening tool]) dated 3/19/2024, The MDS indicated, Resident 1 required partial/moderate (helper does less than half the effort) with chair/bed-to-chair transfer, toilet transfer and had utilized a wheelchair as a mobility device.<br><br>During a review of Resident 2 ' s Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities) and uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional).<br><br>During a review of Resident 2 ' s MDS dated [DATE], The MDS indicated, Resident 2 required dependent (helper does all the effort) for chair/bed-to-chair transfer, showering, toileting, and had utilized a wheelchair and walker as a mobility device.<br><br>During an interview on 4/30/2024 at 10:26 a.m. with LVN 1, the LVN 1 stated the alleged incident occurred over the weekend but does not remember the exact date. LVN 1 stated CNA 1 reported to her that Resident 2 was being aggressive and refusing to shower but did not report Resident 2 hit Resident 1 at that time. LVN 1 stated she did not report to the RN or the doctor that CNA 1 informed her that Resident 2 was exhibiting aggressive behavior. LVN 1 stated a change in condition (a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains) would be considered when Resident 2was exhibiting aggressive behavior, and refusal of care.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056433 | A. Building<br>B. Wing | 04/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vermont Healthcare Center | 22035 S. Vermont Avenue<br>Torrance, CA 90502 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/30/2024 at 11:30 a.m. with Director of Staff Development (DSD), DSD stated all CNAs are required to have 2 days of orientation with the which entails reviewing the facility ' s policies and procedures (P&P ' s), abuse training, and dementia training. DSD stated abuse training was required for all staff. DSD stated abuse training should be done upon hire, every 6 months and as needed. DSD stated registry staff receives abuse training from their registry and was verified by the facility. DSD stated abuse training was important to ensure residents (in general) and staff are not exposed to being abused. DSD stated abuse training was also important to ensure that the staff will know what to do when abuse occurs because residents (in general) are supposed to remain free of any type of abuse. LVN 1 employee file was reviewed, DSD stated LVN 1 did not have abuse training.<br><br>During a concurrent interview and record review on 4/302024 at 12:27 p.m. with Director of Nursing (DON), stated abuse training was done upon hire, yearly, and as needed. DON stated abuse training was done by the DSD for all staff. DON stated, all staff should have abuse training in their employee file. DON stated abuse trainings were important for all staff to ensure that staff have knowledge on the types of abuse, when to report it, and to whom to report it to. DON stated if the staff were not trained on abuse, they will not know what to report, how to report it, and potentially places residents and staff at risk for harm. DON stated the incident with Resident 1 and Resident 2 should have been reported immediately and the residents should have been separated to avoid the potential for the abuse to occur again. LVN 1 ' s employee file [undated] was reviewed, the employee file indicated, LVN 1 did not have abuse training. DON validated LVN 1 did not have abuse training in her file. DON stated all staff are required to have abuse training.<br><br>During a concurrent interview and record review on 4/30/2024 at 1:05 p.m. With DSD, the facility ' s In-Service Attendance Log dated 1/13/2024, 1/24/2024 and 4/2/2024 were reviewed. The In-Service Attendance log indicated, LVN 1 had not attended in-services. DSD stated LVN 1 had not attended in-services since 10/2023. DSD stated staff are required to attend in-services upon hire, annually, and as needed.<br><br>During an interview on 4/30/2024 at 1:02 p.m. with Administrator (Admin), stated all staff are required to receive abuse training upon hire, yearly and as needed. Admin stated when abuse occurs all staff should receive in-services. Admin stated abuse training was important to keep the residents safe and all staff are mandated reporters.<br><br>During a review of the facility ' s Charge Nurse/LVN Job Description, [undated] the Charge Nurse/LVN Job Description indicated, Report and investigate all allegations of resident abuse and/or misappropriation of resident property.<br><br>CROSS REFERENCE TO F600 |