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 05/15/2024
NAME OF PROVIDER OR SUPPLIER: Vermont Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 22035 S. Vermont Avenue 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for 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** 45777 Based on interview and record review, the facility failed to ensure free from abuse by facility staff, for one of three sampled residents (Resident 1), as evidenced by: 1.Certified Nursing Assistant (CNA) slapped Resident 1's left forearm. 2. Registered Nurse Supervisor (RNS) did not separate Resident 1 from CNA 3 after the incident. These deficient practices had the potential to subject Resident 1 for further abuse and had the potential to cause feelings of intimidation, neglect and not feeling safe in the facility. Findings: During a review of Resident 1's Face Sheet (Admission record), the Face Sheet indicated Resident 1was originally admitted to the facility on [DATE] with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities) , unspecified severity, without behavioral disturbance (a persistent and repetitive pattern of behavior that can create distress in others at risk), mood disturbance (a condition that causes extreme happiness or sadness for a long periods of time) (unsteady gait (walking), and anxiety (a feeling o worry, nervousness , unease, typically about an imminent event or something with an uncertain outcome. During a review of Resident 1's Minimum Data Set (MDS), a standardize assessment tool dated 2/22/2024 , indicated Resident 1 has severe cognitively impairment (when someone has difficulty learning, remembering, concentrating, making decisions, or understanding the meaning of something) and required substantial /maximum assistance (helper does more than half the effort . Helper lifts or holds trunk or limbs and provides more than half the effort with Personal hygiene , lower body dressing (the ability to dress and undress below the waist, including fasteners; does not include footwear), personal hygiene (cleansing the body) and putting on/taking off footwear (the ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners , if applicable (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 - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's change of condition (COC - a sudden change from the Resident's baseline) note dated 5/7/2024, the COC indicated CNA 2 reported to the RNS that someone is hitting Resident 1. The COC indicated the RNS entered the room and found Resident 1 agitated and screaming as she was receiving a bed bath from CNA 3. The COC indicated the RNS witnessed CNA 3 slap the left forearm of Resident 1. During a review of the Interdisciplinary Notes (IDT) (brings together knowledge from different health care disciplines to help people receive the care they need), the IDT meeting was held on 5/8/2024, it indicated CNA 3 was removed immediately to resident care. During an interview on 5/15/2024 at 1:30 p.m. with Resident 1, through an interpreter the interpreter stated the Resident 1 would not answer any questions. During an interview on 5/15/2024 at 1:45 p.m., with CNA 1, CNA 1 stated he arrived in Resident 1's room to help CNA 3 and observed Resident 1 was agitated and upset pointing at CNA 3, Resident 1 then looked at me and pointed to her right cheek. CNA1 stated CNA 3 seems to be in upset while changing Resident 1. During an interview on 5/15/2024 at 3:35 p.m., with CNA 2, CNA 2 stated as she was passing by Resident 1's room CNA 2 peaked in and heard a slapping motion behind the curtains of Resident 1. CNA 2 stated she immediately looked for RNS to report what she heard. CNA 2 and the RNS went to Resident 1's room and saw CNA 3 was working with Resident 1. CNA 2 stated she heard RNS to ask for another nurse to help assist CNA 3 to complete the care. CNA 2 stated I do not know what RNS saw but heard RNS yell to CNA 3, stop it. CNA 2 then heard CNA 3 replied that Resident 1 hit her first. During an interview on 5/15/2024 at 4:35 p.m., with CNA 3, CNA 3 stated Resident 1 was heavily soiled with excrement (solid waste that is passed out of a person's body) and vomit (matter from the stomach) . CNA 3 stated she then collected her supplies (towels gown) then proceeded to clean Resident 1. CNA 3 stated Resident 1 was upset and flaring her arms and stating who are you. CNA 3 stated when I turned Resident 1 towards me Resident 1 slapped me, CNA 3 stated I told Resident 1 to stop hitting me. CNA 3 stated the Registered Nurse Supervisor (RNS) then entered the room and witnessed Resident 1 agitated and screaming while I was trying to clean the resident. CNA 3 stated RNS witnessed me slapping Resident 1's left forearm. CNA 3 stated I then apologized to Resident 1 and the RNS. The RNS then ask for another CNA to help me finish cleaning Resident 1. CNA 3 stated she was able to finish caring for two more Residents before she left the facility. CNA 3 stated she tried to take care of the situation, but realized it was the wrong thing to do . During an interview on 5/15/24 at 5:45 p.m., with the Administrator (ADM), the ADM stated when there is a suspected abuse reported we separate the CNA from the Resident immediately or as soon as we know that they are hurting residents, to prevent further harm. She stated the abuse is then reported within 2 hours, everyone is a mandated reporter. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/16/2024 at 11:19 a.m., with the RNS, RNS stated when she arrived in Resident 1' s room the Resident was agitated. RNS stated she observed CNA 3 cleaning Resident 1and observed CNA 3 tap Resident 1's left forearm . RNS 1 then stated to CNA 3 you are not supposed to do that . RNS stated she then called another CNA to help complete the care of Resident 1 while she observed the task. RNS stated she then knew that was the wrong thing to do she stated I should have stopped the care and removed the CNA from Resident 1 immediately. RNS stated by not removing the nurse from Resident 1 this could allow her to continue with hitting Resident 1 and put her in more harm. During an interview on 5/16/2024 at 5:45 p.m. with the Director of Nursing (DON) , the DON stated the RNS should have separated the CNA from the Resident this is critical thinking and she missed it. DON stated the Residents safety comes first. During a review of the facility's policy and procedure (P&P) titled, Abuse & Neglect Prohibition, dated 2017, the P&P indicated Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. During a review of the facility's policy and procedure (P&P) titled, Abuse & Neglect Prohibition dated January 2017 the P&P indicated , The facility will protect residents from harm during the investigation. During a review of the facility's policy and procedure titled RN Supervisor, [undated] the RN Supervisor Job Description indicated, monitor nursing care to ensure that all residents are treated fairly, with kindness, dignity, and respect.

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45777 Based on interview and record review, the facility failed to document, for one of three sampled resident's (Resident 1), records accurately and completely when Resident 1 had a change of condition. This failure has the potential to result in an inaccurate depiction of care and services rendered for Resident 1. Findings: During a review of Resident 1's Face Sheet (Admission record), the Face Sheet indicated Resident 1 original admitted was 2/15/2024 with diagnoses that included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities), mood disturbance (a condition that causes extreme happiness or sadness for a long period of time), and anxiety (a pervasive feeling of worry that affects daily life). During a review of Resident 1's Minimum Data Set (MDS), a standardize assessment tool, dated 2/22/2024, the MDS indicated Resident 1 has severe cognitively impairment (when someone has difficulty learning, remembering, concentrating, making decisions, or understanding the meaning of something) and required substantial /maximum assistance (helper does more than half the effort) with personal hygiene, and lower body dressing. During a record review of Resident 1' progress notes dated 5/7/2024 at 10:07 p.m. Registered Nurse Supervisor (RNS) documented upon arrival to Residents room she saw Resident 1 was agitated. During a record review of Resident 1's Medication Administration Record (MAR), for 5/2024, the MAR indicated Resident 1 was being monitored for the number of times Resident 1 resisted care and attempting to strike out during care. The MAR indicated Resident 1 had no episodes of the agitated behavior on 5/7/2024. During a telephone interview with the RNS on 5/16/2024 at 11:19 a.m. RNS stated Resident 1 was agitated on 5/7/2024. During a concurrent record review of Resident 1's records and a telephone interview with the Director of Nursing (DON) on 5/16/2024 at 2:20 p.m., Resident 1's MAR for 5/2024 and progress notes for 5/7/2024 was reviewed. The DON confirmed Resident 1 was agitated on 5/7/2024 and the agitation was not documented in the MAR. The DON stated she was not aware the RNS did not correctly chart the episodes of agitation with a hashmark in the MAR. The DON stated the reason for keeping track of Resident 1' episodes so the psychiatrist (physician specializes in mental health) will be correctly informed and can prescribe medication correctly. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation Revised July 2017 the P&P indicated , all services provided to the resident, progress to the care plan goals, or any changes in the resident's medical physical , functional, or psychosocial condition shall be documented in the resident's medical record. The medical record shall facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.