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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review the facility failed to ensure medical records were complete, legible, organized, and were readily available for one of three sampled residents (Resident 1) according to the facility ' s policy and procedure (P&P) titled Health Information Record Manual - Chapter III Legal Health Record. This deficient practice had the potential to cause miscommunication and confusion amongst the health care team due to illegible and/or missing documentation of Resident 1 ' s records which could result in Resident 1 to incur medication errors, a delay in care, and inability for Resident 1 to live at her highest practicable level. Findings: During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was readmitted to the facility on [DATE] with diagnoses including pressure-induced deep tissue damage (deep layers of muscle and connective tissues), epilepsy (seizures), hemiplegia (loss of strength) and hemiparesis (paralysis) following a cerebral infarction (brain tissue death due to lack of blood flow). During a review of Resident 2 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/8/2024, the MDS indicated Resident 2 ' s cognition was moderately impaired and was dependent for all Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During a review of Resident 2 ' s Order Summary Report (Physician ' s Orders) dated 6/19/2024, the Order Summary report indicated to monitor Resident 2 ' s respirations every day shift. During a review of Resident 2 ' s Order Summary Report dated 7/24/2024, the Order Summary Report indicated Metoprolol (a blood pressure medication) 25 milligrams ([mg] a unit of measurement) tablet was to be given twice daily for high blood pressure, but to not give if systolic (relating to the phase of the heartbeat when the muscle contracts and pumps blood from the chambers into the arteries) blood pressure was below 110 or heart rate below 60. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Medication Administration Record (MAR) dated 9/2024, the MAR indicated to monitor for respirations (breaths per minute) every day shift. The MAR indicated, on 9/5/2024, the documentation of respirations was illegible. During a review of Resident 2 ' s MAR dated 10/2024, the MAR indicated to administer Metoprolol 25 mg tablet twice daily for high blood pressure but to not give if systolic blood pressure was below 110 or heart rate was below 60. The MAR indicated for the 9 a.m. dose on 10/2/2024, the documentation of blood pressure and heart rate were illegible. During a concurrent interview and record review on 10/16/2024 at 1:50 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s MAR dated 10/2/2024 was reviewed. The MAR indicated to administer Metoprolol 25 mg tablet twice daily for high blood pressure, but to not give if systolic blood pressure was below 110 or heart rate was below 60. The MAR indicated an illegible heart rate of unknown quantity. LVN 1 stated he was not sure what the heart rate number was because he did not write it himself, and it was illegible. LVN 1 stated the LVNs are the ones who take vital signs prior to medication administration and the only place it was recorded was in the handwritten MAR. During a concurrent interview and record review on 10/16/2024 at 2:46 p.m., with RN 1, Resident 2 ' s MAR dated 10/2/2024 was reviewed. The MAR indicated to administer Metoprolol 25 mg tablet twice daily for high blood pressure, but to not give if systolic blood pressure was below 110 or heart rate was below 60 but had a blood pressure reading that was illegible and of unknown quantity documented on 10/2/2024. RN 1 stated she was unable to clearly read the numbers for Resident 2 ' s blood pressure written down on 10/2/2024. RN 2 stated vital signs should be clearly documented because the nurse administering medications have parameters for blood pressure medications and cannot always give them depending on the blood pressure or heart rate. During an interview on 10/16/2024 at 3:01 p.m. with RN 1, RN 1 stated she did not see any of Resident 2 ' s wound care notes in the electronic medical record or the physical chart. RN 1 stated she believed there might be another place the facility keeps wound care records and skin assessments, but she was unsure where to find them. During an interview on 10/16/2024 at 4:10 p.m. with the Director of Nursing (DON), the DON stated written records should be legible and organized so that the facility can make a proper plan of care for residents. The DON stated illegible vital sign documentation could cause confusion and a medication error. During a review of facility ' s policy and procedure (P&P) titled Health Information Record Manual - Chapter III Legal Health Record dated 3/9/2021, the P&P indicated documentation in manual records must be legible, where initials are used must confirm to a valid signature in the record that can be readily traced to that document. The P&P indicated the professional designation or status of the person writing/signing in the record must be clearly shown.