STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555380	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encino Hospital Medical Center D/P Snf	16237 Ventura Blvd Encino, CA 91436

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48367 Based on interview and record review, the facility failed to report an alleged incident of physical abuse involving one of one sampled resident (Resident 1) to the long-term care ombudsman (a person who investigates, reports on, and helps settle complaints) office, the local law enforcement agency, and the Department of Health Services in accordance with State law and the facility ' s policy and procedures, within but not later than two hours of the alleged involved incident. This deficient practice resulted in the California Department of Public Health (CDPH) being unaware of this alleged abuse incident and potential injury to Resident 1, which could then had the potential for a delay in CDPH ' s investigation and other abuse allegations to go unreported at the same facility. Findings: During a review of Resident 1 ' s Admission Record (known as Face Sheet) dated 01/01/2024, the face sheet indicated that Resident 1 was admitted to the facility on [DATE] with a diagnose of respiratory failure (a serious medical condition that makes it difficult to breath on your own). The admission records also indicated that Resident 1 is receiving services in the sub-acute unit in room [ROOM NUMBER]/A. During a review of Resident 1 ' s Minimum Data Set [(MDS), a standardized assessment and screening tool], dated 6/17/2024, the MDS indicated under the Brief Interview for Mental Status (BIMS, is a short cognitive screening tool used to assess a person ' s cognitive functioning), Resident 1 had BIMS of 4 (equal to a decline in cognitive performance). During a review of Resident 1 ' s clinical records Nursing Progress Notes, dated 10/14/2024 at 9:10 p.m., the nursing note indicated that Resident 1 stated that she was bending down while in the wheelchair reaching for a bag when the Certified Nurse Assistant 1 (CNA) pulled the wheelchair from behind causing her to slide off and fall on her buttocks. Resident 1 stated that she hit her back on the front of the wheelchair. During a review of Resident 1 ' s clinical records document titled wound assessment, dated 10/15/2024, the document indicated left buttock bluish discoloration skin color is purple. This wound assessment document has a picture of the area described in the document. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the SW note dated 10/21/2024 at 3:00 p.m., the SW note indicated that on 10/21/2024 during the meeting between the family member and the Manager of the Sub-Acute Unit (MSAU), the MSAU directed the SW that there was no need to file for an ombudsman report as this situation was addressed and both parties understood. During an interview on 12/19/2024 at 2:00 p.m. with SW 1 , SW 1 stated that on 10/17/2024 when the SW learned about Resident 1 ' s fall; SW stated she was instructed not to report this incident by the MSAU; however, SW went ahead and documented this in the Resident 1 ' s records about the directives received. SW stated that it is important to document this type of events. SW also added that there are several forms of abuse and physical abuse being one of those as well as financial, or sexual, or verbal abuse. SW stated that she understands the importance of reporting in a timely manner and to the proper agencies. During an interview on 12/19/2024 at 2:25 p.m., in the SW ' s office (room [ROOM NUMBER]) the MSAU stated she was notified of the incident that occurred with the Resident 1 in room [ROOM NUMBER]A. The MSAU stated the facility did not report nor investigate the incident because neither she nor the Administrator at the facility considered the incident related to abuse. The MSAU stated it is a facility policy to report any allegations of abuse. The MSAU stated the facility should have reported the incident due to the circumstances and especially because Resident 1 did not feel safe around CNA 1 and that Resident 1, had a bruise, and complained of pain after the incident. The MSAU stated failing to report the incident is a violation of Resident 1 ' s rights, facility policy and state and federal regulations. The MSAU stated failing to report allegations of abuse places Resident 1 and other residents potentially at risk for undetected incidents of abuse. During a review of the facility's policy and procedure (P/P) titled, Abuse, Elder & Dependent Adult, dated 04/2024, the P&P indicated that all staff members are responsible for the reporting of any reasonable suspicion or of any witnessed or alleged abuse. By law, a supervisor or administrator cannot prevent a staff member from reporting elder or dependent adult abuse. Furthermore, the P&P indicated that all health practitioners and all employees in a long-term health care facility are mandated reporters.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48367 Based on interview and record review, the facility failed to conduct a timely and thorough investigation for one of one sampled residents (Resident 1) when a Certified Nurse Assistant 1 (CNA) allegedly pulled Resident 1 ' s wheelchair from Resident 1 therefore causing Resident 1 ' s to suffer a fall from the wheelchair on 10/14/2024 at 9:00 p.m. On 10/15/2024, Resident 1 was noted to have a purple bruise on her left buttock and Resident 1 reported body pain 3/10. This deficient practice had the potential to result in unidentified abuse affecting Resident 1 and therefore, the facility failure to conduct a thoroughly investigation of the alleged violation. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), dated 01/01/2024, the face sheet indicated that Resident 1 was admitted to the facility on [DATE] with a diagnose of respiratory failure (a serious medical condition that makes it difficult to breath on your own). The admission records also indicated that Resident 1 is receiving services in the sub-acute unit in room [ROOM NUMBER]/A. During a review of Resident 1 ' s Minimum Data Set [(MDS), a standardized assessment and screening tool], dated 6/17/2024, the MDS indicated under the Brief Interview for Mental Status (BIMS, is a short cognitive screening tool used to assess a person ' s cognitive functioning), Resident 1 had BIMS of 4 (equal to a decline in cognitive performance). During a review of Resident 1 ' s clinical records Social Services Note , dated 10/17/2024 at 1:55 p.m., the social services note indicated that the Social Worker (SW) was informed that the Resident 1 experienced a fall on 10/14/2024 at night 9:00 p.m. Some bruising on Resident 1 ' s arms but no fractures or major injuries. This note indicated that SW was instructed there was no need to file an Ombudsman (a person who investigates, reports on, and helps settle complaint) report by the Manager of the Sub-Acute Unit (MSAU). During a review of the SW note dated 10/21/2024 at 3:00 p.m., the SW note indicated that on 10/21/2024 during the meeting between the family member and the Manager of the Sub-Acute Unit (MSAU), that Resident 1 ' s family member was upset because no one called her to inform her about her mother ' s fall, Resident 1 ' s family member said that whether or not the fall was critical she should have been informed in order for her to be able to arrange for transportation. The Resident 1 ' s family member stated that she believed her mother (Resident 1) because this has been the second incident with that CNA 1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 2:25 p.m., in room [ROOM NUMBER] with the MSAU, the MSAU stated she was notified of the incident that occurred with the Resident 1 in room [ROOM NUMBER]A. The MSAU stated the facility did not report nor investigate the incident because neither she nor the Administrator at the facility considered the incident related to abuse. The MSAU stated it is a facility policy to report any allegations of abuse. The MSAU stated the facility should have reported the incident due to the circumstances and especially because Resident 1 did not feel safe around CNA 1 and complained of pain after the incident. The MSAU stated failing to report the incident is a violation of resident ' s rights, facility policy and state and federal regulations. The MSAU stated failing to report allegations of abuse places Resident 1 and other residents potentially at risk for undetected incidents of abuse within the facility. Furthermore, the MSAU stated the individual (CNA 1) should ' ve been suspended pending the outcome of the investigation. During a review of the facility's policy and procedure (P&P) titled, Abuse, Elder & Dependent Adult, dated 04/2024, the P&P indicated that all staff members are responsible for the reporting of any reasonable suspicion or of any witnessed or alleged abuse. By law, a supervisor or administrator cannot prevent a staff member from reporting elder or dependent adult abuse. Furthermore, the P&P indicated that all health practitioners and all employees in a long-term health care facility are mandated reporters and fill out an incident report, Suspected Dependent Adult/Elder Abuse Form (SOC 341), and other designated forms by the facility. During a review of the facility's policy and procedure (P/P) titled, Abuse, Elder & Dependent Adult, dated 04/2024, the P&P indicated that for instance that involve abuse all results in serious bodily injury, call the local law enforcement agency, long term care ombudsman, end the Department of Health services license and certification immediately but not later than two hours after the alleged incidents and within 24 hours for all other cases. Furthermore the policy and procedure indicated that if a staff member had been alleged to be involved in the act of abuse, that person will be suspended pending the investigation. The results of all the investigation must be reported to officials in accordance with state law (including to the state survey and certification agency) within five (5) working days of the incident and if the alleged violation is verified appropriate corrective action must be taken.