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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555726 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/28/2025 |
| NAME OF PROVIDER OR SUPPLIER Mar Vista Country Villa Healthcare & Wellness | | STREET ADDRESS, CITY, STATE, ZIP CODE 3966 Marcasel Ave Los Angeles, CA 90066 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026</p> <p>Based on observation, interview, and record review, the facility failed to protect one of the three sampled residents (Resident 4) from verbal abuse by Resident 3 by failing to manage repeated aggressive behaviors by Resident 3.</p> <p>This deficient practice placed Resident 4 and all residents at risk for further abuse.</p> <p>Findings:</p> <p>A review of Resident 4's face sheet (admission record - a document containing demographic and diagnostic information) indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including: metabolic encephalopathy (a general term that describes a brain disease, damage or malfunction; brain function is disturbed), unspecified mood affective disorder (a group of mental health conditions characterized by significant and persistent changes in mood), and Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>A review of Resident 4's Preadmission Screening and Resident Review I (PASRR Level I -a screening that involves completion of an evaluation to determine if an individual has or is suspected of having a serious mental illness [SMI] or intellectual disability [ID]) dated 10/21/2024, indicated, Resident 4 did not require Level II (necessary to confirm the indicated diagnoses noted in the Level I screening, and to determine whether placement or continued stay in a nursing facility is appropriate) mental health evaluation.</p> <p>A review of Resident 4's [NAME] Data Set (MDS-resident assessment tool) dated 10/24/2024, indicated, Resident 4 had the capacity to make decisions on his activities of daily living.</p> <p>A review of Resident 4's History and physical (H&P - a physician's complete patient examination) dated 10/29/2024, indicated, Resident 4 could participate in own plan of care.</p> <p>A review of Resident 3's face sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including: type 2 DM, unspecified psychosis (not enough information to make a diagnosis of a specific psychotic disorder), cognitive communication deficit (trouble participating in conversations), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs).</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of Resident 3's PASRR -Level II (necessary to confirm the indicated diagnoses noted in the Level I screening, and to determine whether placement or continued stay in a nursing facility is appropriate) dated 11/21/2024, indicated, PASRR II recommended behavior monitors for verbal aggression for Resident 3</p> <p>A review of Resident 3's Informed Consent Documentation signed and dated by Resident 3 on 12/03/2024, indicated, Resident 3 refused to take Risperdal (risperidone - use to treat symptoms of schizophrenia) and Depakote (divalproex - treats various types of seizure disorders) medications.</p> <p>A review of Resident 3's Psychiatric Notes dated 12/04/2024, indicated Resident 3 refused adjustment on psychotropic medications.</p> <p>A review of Resident 3's MDS dated [DATE], indicated, Resident 3 had the mental ability to make decisions on activities of daily living.</p> <p>A review of Resident 3's Mental Health Initial Assessment (a healthcare professional gathering information about a patient's mental health, symptoms, and needs) dated 12/10/24, indicated, Resident 3's mental status during assessment were agitated, fidgety, anxious, depressed, and sad. The assessment also indicated Resident 3's thought content included ideas of reference (false beliefs that neutral or insignificant events in the environment are specifically directed at or related to oneself), and paranoia (one is overly suspicious and thinking others are out to harm them). The Mental Health Initial Assessment indicated Resident 3 had mood swings (range from the lows of depression to elevated periods of emotional highs), agitation (a state of restlessness, unease, quick to frustration and anger), poor coping skills (a person is easily embarrassed, offended, intimidated, quick to respond emotionally), poor social skills (a person having difficulty connecting with others), and had low volition (a person's inability to start or continue purposeful activities).</p> <p>A review of Resident 3's Order Summary Report (a list of all types of physician orders), with an order and start date of 12/11/2024, indicated to monitor Resident 3 of verbal aggression towards staff every shift.</p> <p>A review of Resident 3's Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a licensed healthcare professional at a facility) for 01/2025, MAR indicated Resident 3 did not take Xanax (alprazolam - produces a calming effect on the brain which helps to reduce anxiety and promote relaxation) medication as a prn (as needed) order on 01/13, 01/14, and 01/15, 2025. The MAR did not indicate Xanax was offered to Resident 3 nor did the MAR indicate Resident 3 refused to take Xanax when offered.</p> <p>A review of Resident 3's Care Plan (CP), dated 1/06/2025, indicated, Resident 3 had episodes of verbal aggression, including profanity and demeaning language directed at staff members. The CP had goals of reducing episodes of verbal aggression by 50% over the next four weeks and to promote positive interactions between the resident and staff with a target date of 3/06/2025. The CP had the following interventions: encourage staff to avoid taking aggression personally and to stay calm, firm, and empathetic, reinforce calm and respectful behavior with praise or small rewards, use clear, simple, and respectful language when speaking with Resident 3, and when verbal aggression occurs, calmly redirect the resident's attention to a neutral or pleasant topic.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of Resident 3's Order Summary Report with an order and start date of 1/07/2025, indicated to monitor Resident 3 for provocative behavior toward staff and resident every shift.</p> <p>A review of Resident 3's Psychosocial Note (a document that records a patient's mental health treatment, observations, and progress), dated 1/07/2025, indicated the goal was to enhance [Resident 3's] understanding of the role of social services . and to foster a more realistic perspective about [Resident 3's] current living situation and future housing options. The Psychosocial Note indicated, Resident 3 maintained a negative and irritable mood, which further exacerbated by [Resident 3's] dramatic and repetitive speech patterns. The plan was to focus on addressing [Resident 3's] grandiose delusions (false beliefs about one's own importance) and unrealistic expectations related to [Resident 3's] living situation. The Note also indicated ultimate goal of improving [Resident 3's] interpersonal relationships and quality of life within the skilled nursing home.</p> <p>A review of Resident 3's Internal Medicine Attending Note (medical documentation detailing a patient's clinical presentation, assessment, and treatment) dated 1/12/2025, indicated, Resident 3 refused to take risperidone (Risperdal) for [Resident 3's] bipolar disorder.</p> <p>A review of Resident 3's Behavior Note dated 1/13/2025, indicated, Resident 3 was observed by a nurse engaged in a verbal altercation using verbally aggressive language with both staff and other residents.</p> <p>A review of Social Service Director's (SSD - manages and coordinates social service programs [ex. housing, mental health, healthcare] and organizations that provide assistance to people in need) notes dated 1/13/2025, indicated, Resident 3 expressed feeling upset and distressed by the incident when asked how [Resident 3] felt about the Resident 4 allegedly throwing ice at Resident 3.</p> <p>A review of Resident 3's Situation, Background, Assessment, Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/13/2025, indicated, Resident 3 displayed physical aggression, verbally aggressive toward staff and other residents, was disrespectful towards staff, attempted to provoke other residents into conflicts without cause. The SBAR indicated a physician was notified and ordered a psychological/psychiatric consult.</p> <p>A review of Resident 3's IDT Progress Notes-Behavior Management dated 1/13/2025, indicated, Resident 3 provoked Resident 4 with persistent, unwanted verbal interactions. Resident 4 stated Resident 3's actions led to [Resident 4's] frustration, culminating in throwing ice at Resident 3. IDT recommended continued monitoring, reinforcement of behavioral interventions, and ongoing psychosocial support to minimize the likelihood of future incidents.</p> <p>A review of Resident 3's CP dated, 1/13/2025, indicated, Resident 3 had the tendency to get physically and verbally aggressive towards the staff. The CP had a goal of no unacceptable behaviors until next review date of 3/21/2025. The CP had the following interventions: point out Resident 3's unacceptable behavior, redirect attention to reduce behavior and escalation by monitoring Resident 3's whereabouts frequently, give Resident 3 boundaries with what is acceptable behavior, psychiatrist and psychologist consults, remind Resident 3 of expectations of behaviors, and offer alternatives to reduce behavior.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of Resident 3's CP, dated 1/13/2025, indicated, Resident 3 fabricating and confabulating stories, provoking other residents into arguments and fights. The CP had the following interventions: include the social worker in developing and implementing plans to address the Resident 3's needs and long-term care goals, work with the interdisciplinary team (IDT - a group of different healthcare professionals working together towards a common goal for a resident) to evaluate the Resident 3's suitability for a lower level of care or alternative placement based on progress and behavioral stability, ensure the resident attends all scheduled psychiatric evaluations and follow-up appointments), implement precautions to ensure the safety of staff and other residents, and separate the resident from others when their behavior becomes disruptive or aggressive.</p> <p>A review of Resident 3's IDT Progress Notes-Behavior Management dated 1/13/2025, indicated, Resident 3 provoked Resident 4 with persistent, unwanted verbal interactions. Resident 4 stated Resident 3's actions led to [Resident 4's] frustration, culminating in throwing ice at Resident 3. IDT recommended continued monitoring, reinforcement of behavioral interventions, and ongoing psychosocial support to minimize the likelihood of future incidents.</p> <p>A review of Resident 4's CP dated, 1/13/2025, indicated, Resident 4 had aggressive behavior with conflict resolution and impulse control. The CP had the following goals: resident will demonstrate improved control over aggressive behaviors, will use appropriate communication techniques to express frustration, and will engage in therapeutic activities designed to enhance emotional regulation and social interactions. The CP had the following interventions: offer resident a quiet space or calming activity to help reduce emotional arousal, resident will closely monitor for signs of agitation and frustration particularly during interaction with others, ensure the environment promotes calmness and structure, minimizing overstimulation and for resident to get a psychiatric evaluation to assess any underlying emotional or psychological conditions.</p> <p>A review of Resident 4's Nursing Progress Notes-Long Term Care Evaluation dated 1/13/2025, indicated, Resident 4's mood and behavior evaluated as being agitated.</p> <p>A review of Resident 4's Social Service Director's (SSD) notes dated 1/13/2025, indicated, Resident 4 reported to SSD that Resident 3 taunted him which triggered [Resident 3's] anger. The SSD report also indicated Resident 4 stated Resident 3 made an offensive comment towards Resident 4 further agitating Resident 4 which led to a verbal exchange between Residents 3 and 4. Resident 4 admitted to throwing ice at Resident 3 during their verbal exchange.</p> <p>A review of Resident 4's SBAR dated 1/13/2025, indicated, Resident 4 threw ice at Resident 3 during a verbal altercation. The SBAR indicated a physician was notified and ordered a psychological or psychiatric consult to assess resident's emotional state and behavioral triggers.</p> <p>A review of Resident 4's IDT Progress Notes-Behavior Management dated 1/13/2025 at 4:03 PM, indicated, Resident 3 was observed by staff provoking Resident 4 which led to physical aggression. IDT Progress Notes indicated Resident 4 threw ice at Resident 3 due to frustration.</p> <p>A review of Resident 3's Nursing Progress Notes, dated 1/14/2025, indicated Resident 3 continued to be rude to staff during 3-11 shift. Being very rude, demanding, and complaining of changes in medications .</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of Resident 3's Psychosocial Note (a document that records a patient's mental health treatment, observations, and progress), dated, 1/14/2025, indicated the goal of the consult was to develop effective coping strategies to manage Resident 3's bipolar and schizophrenia (a mental illness that is characterized by disturbances in thought) disorder symptoms, particularly during interpersonal conflicts. The Psychosocial Note indicated Resident 3 expressed dissatisfaction with [Resident 3] current living situation, reinforcing belief that Resident 3 is better than everybody else in the facility. The plan was to continue sessions focusing on incorporating stress management techniques and coping strategies to help [Resident 3] handle anxiety and irritability more effectively.</p> <p>A review of Resident 4's Psychosocial Notes dated 1/14/2025, indicated, Resident 4's primary goal was to enhance [Resident 4's] emotional regulation skills to manage anger and frustration effectively. During Resident 4's psychological consultation, Resident 4 actively participation in the session, openly admitting to throwing ice at Resident 3 due to feelings of irritation and being triggered. The plan was for Resident 4 to continue working on emotional regulation strategies with a focused on anger management and social interaction skills.</p> <p>A review of Resident 4's Physician/PA/NP Progress Notes dated 1/14/2025, indicated, Resident 4 requested to be discharged to home from the facility on 1/15/2025.</p> <p>A review of Resident 4's Psychosocial Notes dated 1/14/2025, indicated, Resident 4's primary goal was to enhance [Resident 4's] emotional regulation skills to manage anger and frustration effectively. During Resident 4's psychological consultation, Resident 4 actively participation in the session, openly admitting to throwing ice at Resident 3 due to feelings of irritation and being triggered. The plan was for Resident 4 to continue working on emotional regulation strategies with a focused on anger management and social interaction skills.</p> <p>A review of Resident 3's CP, dated 1/17/2025, indicated, Resident 3 exhibited provocative behavior towards both staff and other residents. The CP had the following goals: decrease instances of provocative behavior towards staff and residents, ensure a safe and respectful environmental for both the residents and others, improve communication and emotional regulation skills for the resident, and promote cooperation with staff and adherence to care protocols. The CP had the following interventions: staff will closely observe and document instances of provocative behavior, use calm, clear, and respectful communication to de-escalate situations, offer emotional support and reassurance, acknowledging the resident's concerns while encouraging cooperation with CPs, ensure Resident 3's environment is conducive to relaxation and comfort, reducing potential triggers for negative behavior, and IDT will meet regularly to assess the effectiveness of the interventions and make adjustments as needed.</p> <p>A review of Resident 3's Psychosocial Note dated, 1/22/2025, indicated the goal of the consult was to address Resident 3's mood and emotional states, particularly Resident 3's adjustment to living in a skilled nursing facility (SNF - provides nursing care and rehabilitative services to individuals recovering from an illness, injury, or surgery). The Psychosocial Note indicated Resident 3 appeared to have a depressed and angry affect during the session with a negative, agitated, anxious, and irritable mood. The Psychosocial Note also indicated Resident 3 had a lack of awareness about [Resident 3's] interpersonal interactions but recognized [Resident 3's] stress and the factors contributing to it, showing some willingness to discuss these issues further in future sessions. The plan was to continue sessions focusing on techniques to improve insight into how [Resident 3's] actions affect his relationships with the staff and other residents, and coordination with nursing staff will be maintained to ensure a supportive environment that aligns with the therapeutic objectives.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a phone interview with Resident 4 on 1/23/2025 at 10:13 AM, Resident 4 stated Resident 3 verbally attacked him repeatedly since Resident 3 was admitted to the facility. Resident 4 stated Resident 3 said to Resident 4 your football team is a loser just like you, and don't move that ashtray when they were in the smoking patio. Resident 4 stated when Resident 4 was on the phone talking to someone, Resident 3 would interrupt his telephone conversations. Resident 4 stated Resident 3 said you are not going to do anything to me and I am gonna get you kicked out of here. Resident 4 admitted to throwing ice at Resident 3 I got fed up so I threw a cup of ice on [Resident 3's] face. The ice didn't hit [Resident 3].</p> <p>During an interview with Resident 3 on 1/23/2025 at 10:50 AM, Resident 3 stated this [Resident 4] claimed an original gang-banger . I don't believe he was. I think [Resident 4] was straight out of [NAME]. [Resident 4] is filthy and disgusting. I spit on people like [Resident 4] every day because they don't do anything to make this country better .they are parasites. [Resident 4] is a grown [person] with a mind of a 6-year-old. Resident 3 stated on 1/13/2025 when [Resident 3] returned to the facility, Resident 4 was standing a few doors down from [Resident 3's] room when Resident 4 pointed at Resident 3 then said this white mother f****r over here. Resident 3 stated I said to [Resident 4] I am not a mother f****r, you are a piece of garbage when Resident 4 picked up a cup with ice in it and threw it at me. Resident 3 was observed smiling after stating the ice didn't hit me, but I acted like it did.</p> <p>During an interview with Resident 3 on 1/23/2025 at 10:50 AM, Resident 3 stated the facility nurses are nothing but a bunch of lowlifes, they don't do anything for me, I don't care about them.</p> <p>During an interview with the Certified Nurse's Aide (CNA 1) on 1/23/2025 at 11:26 AM, CNA 1 stated Resident 3 and Resident 4 had many verbal arguments before the alleged incident happen on 1/13/2025. CNA 1 stated Resident 4 was a nice man, friendly to the staff and residents; says hello to the staff. CNA 1 stated when CNA 1 asked Resident 3 if there was anything [Resident 3] needed, Resident 3 said not from you, you're just a CNA.</p> <p>During an interview with the Licensed Vocational Nurse 3 (LVN 3) on 1/23/2025 at 12:15 PM, LVN 3 stated these two (Residents 3 and 4) have been having issues for a while now. They are both verbally aggressive towards each other. [Resident 3] is more an aggressor. [Resident 3] is relentless .doesn't stop taunting [Resident 4]. They just don't like each other. LVN 3 also stated [Resident 3] is verbally abusive towards the staff F*****g a*****e, you are good for nothing, many F words. LVN 3 stated when Resident 3 didn't want to wait for [Resident 3's] turn getting medications, [Resident 3] got mad and called me names I cannot repeat.</p> <p>During an interview with the Registered Nurse Supervisor 2 (RNS 2) on 1/23/2025 at 1:20 PM, RNS 2 stated Resident 3 was very rude towards staff, called the staff bad names. RNS 2 was asked when Resident 3 exhibited expressions or indications of distress such as anxiety, and being verbally abusive towards staff and other residents, how did RNS 2 address these indications of distress, RNS 2 stated doing a 1:1 with the resident, notifying the doctor about the resident's behavior to get a consultation with a psychologist or a psychiatrist. When RNS 2 was asked how Resident 3's CP's effectiveness was monitored, RNS 2 stated when there were less or no behavioral issues indicated. RNS 2 also stated when the CP was not effective, CP revision must be done. RNS 2 stated Resident 3 does not adhere to the facility policy or orders from the doctor.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview with the Director of Nursing (DON) on 1/23/2025 at 3:07 PM, DON stated on the day before the alleged incident happened on 1/13/2025, Resident 4's football team was playing and the team lost the game. Resident 3 stated to Resident 4 you are a loser bastard like your team. DON stated Resident 3 can be argumentative, [Resident 3] lies, likes to argue, also calm while arguing with someone. Resident 3 is non-compliant, does not take meds that was prescribed, but that is [Resident 3's] right.</p> <p>During an interview with the DON on 1/24/2025 at 10:12 AM, DON was asked how the DON addressed Resident 3's anxiety and being verbally abusive to residents and staff, DON stated by having a 1:1 meeting with the resident to provide Resident 3 with the space and time needed to alleviate (improve) feelings of anxiety and to help Resident 3 calm down when verbally abusive to residents and/or staff. DON was asked how DON knew Resident 3's CP was effective, DON stated when Resident 3 showed calmness, not argumentative, not verbally abusive towards other residents and staff. DON also stated when CP interventions do not work, revisions to the CP must be done to meet the needs of Resident 3.</p> <p>During an interview with RNS 2 on 1/24/2025 at 2:31 PM, RNS 2 was asked to review Resident 3's Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a licensed healthcare professional at a facility) with surveyor for any antipsychotic (medications work by altering brain chemistry to help reduce psychotic symptoms such as hallucinations, delusions and disordered thinking [disturbance in how thoughts are organized and expressed]) medications, RNS 2 stated Resident 3 had Xanax (alprazolam - produces a calming effect on the brain which helps to reduce anxiety and promote relaxation) medication as a prn (as needed) order. When RNS 2 was asked to describe Resident 3's signs and symptoms of behavioral instability, RNS 2 stated verbal aggression .does not talk to anyone politely, physically Resident 3 would fidget (making small movements with the body), and skin turns red. RNS 2 stated Resident 3 did not take Xanax on 01/13, 01/14, and 01/15, 2025. RNS 2 stated RNS 2 would have offered Xanax to Resident 3 on the day of the alleged incident happened on 1/13/2025. RNS 2 was asked when the appropriate time to offer Xanax to Resident 3, RNS 2 stated at the time [Resident 3] displays behavioral instability. When asked to show documentation Resident 3 was offered but refused Xanax, RNS 2 reviewed the MAR and nursing progress notes then stated MAR would not show Xanax was offered to Resident 3 because there is no code for that. RNS 2 also stated no nursing documentation in the nursing progress notes were found indicating Resident 3 was offered but refused Xanax. When RNS 2 was asked if Resident 3's unstable behavior may have led to Resident 3 being aggressive with Resident 4, RNS 2 stated it may have . RNS 2 stated MD should be notified when Resident 3 showed signs and symptoms of behavioral instability. No nursing progress documentation indicating MD was notified each time Resident 3 had shown behavioral instability.</p> <p>During an interview with LVN 2 on 1/24/2025 at 3:05 PM, LVN 2 was asked if Xanax LVN 2 would have offered Xanax to Resident 3 after Resident 3 displayed outbursts and verbal aggression towards another resident, LVN 2 stated yes, because he displayed the signs and symptoms of anxiety . LVN 2 added MD would have been notified right away when Resident 3 showed signs and symptoms of behavioral instability but refused to accept the offer of Xanax. LVN 2 stated there were no nursing documentation indicating MD was notified about Resident 3's behavioral issues. When LVN 2 was asked if Resident 3's aggression towards Resident 4 may have led to the 1/13/2025 alleged incident of abuse, LVN 2 stated yes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview with LVN 1 on 1/28/2025 at 2:57 PM, LVN 1 stated LVN 1 witnessed Resident 3 speaks down to the staff, example he's a VIP and the staff are here to serve him; everything is as what he says regardless of what the MD orders. LVN 1 stated when Resident 3 showed signs and symptoms of behavioral issues especially towards staff or other residents, LVN 1 documented Resident 3's behavior to support the staff observation and have a history of Resident 3's behaviors. LVN 1 was asked to show LVN 1's nursing documentation notifying MD about Resident 3's behavioral instability, LVN 1 was not able to show nursing documentation from the electronic health record. When LVN 1 was asked when MD should be notified of Resident 3's behavioral instability, LVN 1 stated every incident .so MD is aware of [Resident 3's] behavioral issues and could properly manage [Resident 3's] behaviors. LVN 1 was asked if Resident 3's behavioral instability may have led to the alleged abusive incident with Resident 4 on 1/13/2025, LVN 1 stated yes.</p> <p>During an interview with the DON on 1/28/2025 at 4:08 PM, DON stated all licensed nurses need to document when Resident 3 was showing signs and symptoms of behavioral instability. When asked what happened if Resident 3's behavioral instability was not documented, DON stated we won't be able to monitor how often [Resident 3] shows aggression and other behavioral issues .we cannot tell the doctor an accurate documentation of [Resident 3's] behaviors. DON stated MD should be notified of Resident 3's behavioral issues when there is one situation that is above and beyond of what we are monitoring.</p> <p>A review of the facility's In-Service Education on Dealing with Resident Behaviors dated 12/24/2024, indicated, facility staff were educated on how to assess resident triggers and to reduce resident combativeness.</p> <p>A review of the facility's P&P titled Behavior Management dated 3/2018, indicated, the facility will identify the root cause of the behavior when a behavioral problem was recognized through the nursing assessment.</p> <p>A review of the facility's Policy & Procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Abuse - Prevention, Screening, and Training Program, dated 07/2018, indicated, staff are trained during orientation and annually how to understand resident behavioral symptoms that may increase the risk of abuse .and how to respond.</p> | | |