| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056417 | A. Building<br>B. Wing | 08/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| View Heights Conv Hosp | 12619 S. Avalon Blvd<br>Los Angeles, CA 90061 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>47858<br><br>Based on interview and record review, the facility failed to notify the physician when a resident exhibited an episode of touching himself inappropriately in the hallway for one out of six sampled residents (Resident 1).<br><br>This deficient practice led to a delay in medical evaluation and interventions for Resident 1's hypersexual behaviors. Cross-reference F656 and F600.<br><br>Findings:<br><br>During a concurrent interview and record review on, 8/6/2024, at 3:16 p.m., with Registered Nurse (RN) 2, Resident 1's Behavior Plan, dated 2/17/2024, and Resident 1's Change of Condition (COC) Notes, dated 2/2024, were reviewed. The Behavior Plan indicated it was reported that Resident 1 masturbated (to pleasure oneself in a sexual way) in the doorway of his room, in a public setting on 2/17/2024. The COC notes indicated there was no change of condition notification made to the physician, psychiatrist, nor the psychologist for Resident 1's display of inappropriate sexual behavior on 2/17/2024. RN 2 stated for every change of condition, the normal process was to complete a change of condition note, and notify the physician, and conservator or responsible party. RN 2 stated a change of condition note should have been completed on 2/17/2024 so that the physician and the appropriate doctors could place proper orders and interventions for Resident 1. RN 2 stated there was a possibility Resident 1's condition worsened or continued over time if the doctors were not made aware of his behaviors.<br><br>During an interview, on 8/6/2024, at 3:50 p.m., with the Director of Nursing (DON), the DON stated a change of condition note should have been made for Resident 1's display of inappropriate sexual behavior on 2/17/2024. The DON stated that the social services designee (SSD) did not relay this information to the licensed nursing staff so that the licensed nurses could complete the change of condition note and notify the physician. The DON stated it was expectation of the SSD to communicate any medical or behavioral changes to the nursing staff, and because of this, there was a delay in care for the medical treatment and interventions for Resident 1's hypersexual behaviors. The DON stated that if the doctor were not made aware of changes of condition, then it would be considered negligence .<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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| F 0580<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, Change of Condition (undated), the P&P indicated the facility shall promptly notify the resident, his or her attending physician, and Conservator (individual who handles the financial or daily life affairs of a conservatee) Los Angeles Public Guardian of changes in the resident's medical/mental condition.<br><br>During a review of the facility's Social Services Designee Job Description (undated), the job description indicated the SSD was to ensure that all charted progress notes are completed accurately, informative, descriptive, and timely of the services provided and of the resident's response to the service. The job description indicated the SSD was to communicate with the medical staff, nursing service, and other department directors. |

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| 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** 47858<br><br>Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 2) were free from sexual abuse from Resident 1, who had a known history of hypersexual behaviors (an intense focus on sexual fantasies, urges, or behaviors that can't be controlled), by failing to:<br><br>1. Immediately intervene and provide a safe distance between Resident 1 and Resident 2 when Resident 1 began masturbating (to pleasure onself sexually) in public.<br><br>2. Ensure the social services designee (SSD) notified and communicated with the licensed nurses when Resident 1 first exhibited hypersexual behaviors on 2/17/2024.<br><br>These deficient practices resulted in Resident 1 masturbating while standing in close proximity to Resident 2 in the hallway on 7/20/2024. These failures also resulted in Resident 2 exhibiting feelings of anger as evidenced by a furrowed brow and fast breathing when speaking of the incident.<br><br>Cross reference F656.<br><br>Findings:<br><br>1. During a concurrent observation and interview, on 8/5/2024, at 2:14 p.m., with the Director of Nursing (DON), the camera footage, dated 7/20/2024, timed at approximately 8:00 a.m. to 9:00 a.m., was reviewed. The camera footage showed that Resident 1 stood less than an arm's distance away from Resident 2, for approximately ten to fifteen minutes, while Resident 2 talked on the phone in the hallway. Two nurses (Registered Nurse [RN] 1 and Certified Nursing Assistant [CNA] 1) walked past the two residents. RN 1, stopped, and exchanged words with Resident 1, and proceeded to walk away from the two residents. CNA 1 appeared to look in the direction of the two residents and proceeded to walk past the two residents. Resident 1 proceeded to lower his shorts and insert his left hand and arm into his shorts, and Resident 1's left arm moved in a back-and-forth motion. The DON stated Resident 1 stood less than an arm's distance away from Resident 2, which was an inappropriate and unsafe distance. The DON stated she would have expected the facility staff to immediately, physically separate the residents to ensure safety for both residents. The DON stated that because staff did not intervene to maintain a safe distance between the two residents, there was an increased potential for Resident 1 to exhibit inappropriate sexual behavior in a public setting, in front of Resident 2. The DON stated any display of inappropriate touching, or sexual behavior directed at a specific individual, in a public setting, was classified as sexual abuse.<br><br>During a review of the facility's Incident Follow-Up Report, dated 7/25/2024, the report indicated Resident 2 reported (on 7/22/2024) the resident sat by the phone in the hallway when Resident 1 approached her and touched her on the back. The report indicated Resident 1 saw Resident 2's left hand inside his shorts when she turned around.<br><br>(continued on next page) |

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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 Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 1 was admitted with diagnoses that included schizophrenia (a serious mental health condition that affects how people think, feel and behave) and chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems).<br><br>During a review of Resident 1's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 6/14/2024, the MDS indicated Resident 1's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 1 was independent with activities of daily living (ADLs, daily self-care activities such as grooming, dressing, toileting, and personal hygiene).<br><br>During a review of Resident 1's care plan titled, Physical Aggression, dated 3/27/2023, the care plan indicated Resident 1 was to be placed on one-to-one monitoring for safety if necessary.<br><br>During a review of Resident 1's care plan titled Hypersexual Behavior, dated, 2/17/2024, the care plan indicated the staff's interventions indicated to encourage Resident 1 to attend healthy relationship, symptom management, and impulse control group, and staff were to model and role play appropriate behaviors for Resident 1. The care plan indicated staff were to notify Resident 1's Medical Doctor, Psychiatrist (a doctor who specializes in mental health), Psychologist (a person who specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders), and Therapist for additional support and interventions.<br><br>During a review of Resident 1's Behavior plan dated 2/17/2024, the behavior plan indicated Resident 1 masturbated (to pleasure oneself sexually) in the doorway of his room on 2/17/2024. The behavior plan indicated the plan was placed into effect so that Resident 1 would not have another similar incident while in the facility. The plan indicated staff would intervene immediately and reassess interventions at that time if Resident 1 were to deviate from the plan.<br><br>2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (mental health problem where you experience psychosis as well as mood symptoms) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration).<br><br>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 was independent with ADLs.<br><br>During a concurrent observation and interview, on 8/5/2024, at 9:50 a.m., with Resident 2, Resident 2 stated Resident 1 touched himself inappropriately in front of her while she used the phone on 7/19/2024 . Resident 2 stated that it happened again on 7/20/2024, and staff had knowledge of the incident. Resident 2 stated she was told to just ignore the resident. Resident 2 stated that made her feel mad and upset. Resident 2 was observed with a furrowed brow and fast breathing as she stated the incident made her feel uncomfortable for the duration that she was in the same unit as Resident 1. Resident 2 stated she felt angry when staff did not do anything to prevent Resident 1 from inappropriately touching himself. Resident 2 stated she had known Resident 1 to touch himself inappropriately in the past (in public) and stated that staff had knowledge of his inappropriate sexual behaviors.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (mental health problem where you experience psychosis as well as mood symptoms).<br><br>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 was independent with ADLs.<br><br>During an interview, on 8/5/2024, at 10:14 a.m., with Resident 3, Resident 3 stated she witnessed Resident 1 stand by Resident 2 and jack off (the stimulation of private body parts for sexual pleasure) in front of Resident 2 while she used the phone. Resident 3 stated that she tried to get Resident 2 to stop what he was doing but he did not listen. Resident 3 stated staff had knowledge of the incident but did not do anything to stop or prevent Resident 1's actions. Resident 3 stated Resident 1 was known to have similar incidents and display inappropriate sexual behavior in public, but could not identify the names of staff who knew or recall what dates these events transpired.<br><br>During a concurrent observation and interview, on 8/6/2024, at 1:00 p.m., with the Program Manager (PM), the camera footage, dated 7/20/2024, timed at approximately 8:00 a.m. to 9:00 a.m., was reviewed. The PM stated he would have separated the two residents immediately. The PM stated that staff (based on the camera footage) did not intervene immediately to ensure Resident 2's safety, and due to the lack of intervention and supervision, this led Resident 2 to be subject to Resident 1's inappropriate sexual behavior. The PM stated that staff did not perform everything to keep Resident 2 safe and free from Resident 1's inappropriate sexual behavior.<br><br>During an interview on 8/6/2024, at 2:59 p.m., with Registered Nurse (RN) 1, RN 1 stated on 7/20/2024 she recalled that Resident 1 stood at an unsafe distance form Resident 2. RN 1 stated that she should have delegated another staff member to supervise the two residents before she proceeded to walk away. RN 1 stated anything could have happened during the times that both residents were left unattended because the two residents were unsupervised and less than six feet from each other.<br><br>During a concurrent interview and record review on 8/6/2024, at 3:16 p.m., with RN 2, Resident 1's Behavior Plan, dated 2/17/2024, and Resident 1's Change of Condition Notes, dated 2/2024, were reviewed. The Behavior Plan indicated it was reported that Resident 1 masturbated in the doorway of his room, in a public setting on 2/17/2024. The Change of Condition notes indicated there was no change of condition notification made to the physician, psychiatrist, nor the psychologist for Resident 1's display of inappropriate sexual behavior on 2/17/2024. RN 2 stated, for every change of condition, the normal process was to complete a change of condition note, and notify the physician, and conservator or responsible party. RN 2 stated a change of condition note should have been completed on 2/17/2024 so that the physician and the appropriate doctors could place proper orders and interventions for Resident 1. RN 2 stated there was a possibility Resident 1's condition worsened or continued over time if the doctors were not made aware of his behaviors.<br><br>(continued on next page) |

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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 8/6/2024, at 3:50 p.m., with the Director of Nursing (DON), the DON stated a change of condition note should have been made for Resident 1's display of inappropriate sexual behavior on 2/17/2024. The DON stated the SSD did not relay that information to the licensed nursing staff so that the licensed nurses could complete the change of condition note and notify the physician. The DON stated it was expectation of the SSD to communicate any medical or behavioral changes to the nursing staff, and because of this, there was a delay in care for the medical treatment and interventions for Resident 1's hypersexual behaviors. The DON stated that if the doctor were not made aware of changes of condition, then it would be considered negligence .<br><br>During a review of the facility's Social Services Designee Job Description (undated), the job description indicated the SSD was to ensure that all charted progress notes are completed accurately, informative, descriptive, and timely of the services provided and of the resident's response to the service. The job description indicated the SSD was to communicate with the medical staff, nursing service, and other department directors.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Abuse , dated 2023, the P&P indicated every resident had the right to be free from abuse, the basic responsibility of every employee was to ensure the safety and well-being of the resident, and staff shall promote dignity and assist residents as needed.<br><br>During a review of the facility's P&P titled, Preventing Resident Abuse , dated 2023, the P&P indicated the facility was to assess residents with signs and symptoms of behavior problems and implementing care plans to address behavioral issues. The P&P indicated the facility was to identify areas within the facility that may make abuse and neglect more likely to occur and monitoring these areas regularly.<br><br>During a review of the facility's policy and procedure (P&P)titled, High Risk Safety Monitoring , dated 2020, the P&P indicated the following:<br><br>1. The facility closely monitored the status of residents who are at risk for unsafe behavior, to observe for a significant change in their behavior or their physical or mental condition.<br><br>2. Direct care staff were assigned common areas [throughout the facility] in order to observe resident behavior.<br><br>3. Staff was to respond and intervene as necessary to any resident who verbally and non-verbally communicates feeling unsafe or agitated, or is behaving in an unsafe manner.<br><br>4. Direct must have been in full view of the resident's rooms or other designated areas in order to observe the residents for safety.<br><br>5. The staff member may not leave his/her post until another staff member is present for relief.<br><br>6. When there was a significant change noted in the resident's mental status, or the resident is behaving in an unsafe manner, a Licensed Nurse is to be notified immediately.<br><br>(continued on next page) |

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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 P&P titled, Resident Rights , dated 2020, the P&P indicated the residents' rights were to be maintained and utilized to enhance the comfort and well-being of each patient. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858<br><br>Based on observation, interview, and record review, the facility failed to effectively implement care plan interventions to address a resident's hypersexual (an intense focus on sexual fantasies, urges or behaviors that can't be controlled) behaviors for one out of six sampled residents (Resident 1) when the facility failed to:<br><br>1. Document and encourage Resident 1 to attend therapeutic group meetings for healthy relationships, symptom management, and impulse control.<br><br>2. Model and role play appropriate behaviors for Resident 1.<br><br>3. Notify and communicate with licensed nurses and the physician when Resident 1 exhibited his first episode of publicly and inappropriately touching himself in the hallway on 2/17/2024.<br><br>These deficient practices resulted in Resident 1 sexually touching himself inappropriately as he stood in close proximity to Resident 2, as she spoke on the telephone, in the hallway (on 7/20/2024). These failures also resulted in Resident 2 exhibiting feelings of anger as evidenced by a furrowed brow and fast breathing.<br><br>Cross-reference F600.<br><br>Findings:<br><br>1. During an observation on 8/5/2024, at 2:14 p.m., of the facility's camera surveillance footage, dated 7/20/2024, timed at approximately 8:00 a.m. to 9:00 a.m., in the presence of the Administrator and Director of Nursing (DON), the camera footage showed that Resident 1 stood less than an arm's distance away from Resident 2, for approximately ten to fifteen minutes, while Resident 2 talked on the phone in the hallway. Two nurses (Registered Nurse [RN] 1 and Certified Nursing Assistant [CNA] 1) walked past the two residents. RN 1, stopped, and exchanged words with Resident 1, and proceeded to walk away from the two residents. CNA 1 appeared to look in the direction of the two residents and proceeded to walk past the two residents. Resident 1 proceeded to lower his shorts and insert his left hand and arm into his shorts, and Resident 1's left arm moved in a back-and-forth motion.<br><br>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 1 was admitted with diagnoses that included schizophrenia (a serious mental health condition that affects how people think, feel and behave) and chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems).<br><br>During a review of Resident 1's Minimum Data Set ([MDS]- a comprehensive resident assessment and care-screening tool), dated 6/14/2024, the MDS indicated Resident 1's cognition (ability to think and reason) was moderately impaired, and Resident 1 was independent with activities of daily living (ADLs, activities performed daily such as dressing, grooming, toileting, and personal hygiene).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Behavior Plan, dated 2/17/2024, the plan indicated Resident 1 masturbated (to stimulate one's own genitals for sexual pleasure) in the doorway of his room, in a public setting on 2/17/2024.<br><br>During a review of Resident 1's Hypersexual Behavior Care Plan, dated, 2/17/2024, the care plan indicated the staff's interventions included to encourage Resident 1 to attend the healthy relationship, symptom management, and impulse control group. The care plan indicated staff were to model and role play appropriate behaviors for Resident 1, and notify Resident 1's Medical Doctor (MD), Psychiatrist (a doctor who specializes in mental health), Psychologist (a person who specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders), and Therapist for additional support and interventions.<br><br>2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (mental health problem where you experience psychosis as well as mood symptoms) and bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration).<br><br>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact, and Resident 2 was independent with ADLs.<br><br>During a concurrent observation and interview, on 8/5/2024, at 9:50 a.m., with Resident 2, Resident 2 stated Resident 1 touched himself inappropriately in front of her while she used the phone on 7/19/2024. Resident 2 stated that it happened again on 7/20/2024, and staff had knowledge of the incident. Resident 2 stated she was told to just ignore [Resident 1] , which made her feel mad and upset, as evidenced by Resident 2's furrowed brow and fast breathing during the interview. Resident 2 stated it made her feel uncomfortable for the duration of the time that she was in the same unit as Resident 1. Resident 2 stated that it made it her feel angry when staff did not do anything to prevent Resident 1 from inappropriately touching himself. Resident 2 stated she had known Resident 1 to touch himself inappropriately in the past (in public) and stated that staff had knowledge of his inappropriate sexual behaviors.<br><br>3. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (mental health problem where you experience psychosis as well as mood symptoms).<br><br>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact, and Resident 3 was independent with ADLs.<br><br>During an interview, on 8/5/2024, at 10:14 a.m., with Resident 3, Resident 3 stated she witnessed Resident 1 stand by Resident 2 and jack off (the stimulation of private body parts for sexual pleasure) in front of Resident 2 while she used the phone (on 7/20/2024). Resident 3 stated that she tried to get Resident 2 to stop what he was doing, but he did not listen. Resident 3 stated staff had knowledge of the incident but did not do anything to stop or prevent his actions. Resident 3 stated Resident 2 was known to have similar incidents and display inappropriate sexual behavior in public, but could not identify the names of staff who knew or recall what dates these events transpired.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<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 8/5/2024, at 11:47 a.m., with Social Services Director (SSD) 1, Resident 1's Psychosocial notes, dated 2/2024 to 8/2024, were reviewed. The notes indicated Resident 1 was encouraged on one occasion (2/17/2024) to attend a healthy relationships group session. The notes did not indicate that Resident 1 was encouraged to attend symptom management and impulse control group sessions. SSD 1 stated that healthy relationship groups were held on a weekly basis. SSD 1 stated there was a lack of documentation that indicated Resident 1 was encouraged to attend all three different types of group meetings. SSD 1 stated Resident 1's care plan was not effectively implemented if Resident 1 was not encouraged to attend these meetings. SSD 1 stated it was important for him to attend these meetings so that Resident 1 could better himself and work on his impulses. SSD 1 stated that it was important to implement care plans because it was important for the overall safety of the resident and so that no other residents would be subject to re-traumatization.<br><br>During an interview, on 8/5/2024, at 12:17 p.m., with the DON, the DON stated it was important for residents to attend group sessions to gain skills to be better and [develop] proper social skills . The DON stated it was important to implement care plans because it served as the facility's plan on how to address resident-specific concerns. The DON stated the lack of documentation to prove that Resident 1 was encouraged to attend symptom management and impulse control group sessions could have potentially led to Resident 1's display of inappropriate sexual behavior.<br><br>During a concurrent observation and interview, on 8/6/2024, at 1:00 p.m., with the facility's Program Manager (PM), the camera surveillance footage, dated 7/20/2024, timed at approximately 8:00 a.m. to 9:00 a.m., was reviewed. The PM stated the nursing staff did not take the opportunity to model appropriate behavior for Resident 1 as he stood near Resident 2. The PM stated Resident 1's care plan was not effectively followed.<br><br>During a concurrent interview and record review on, 8/6/2024, at 3:16 p.m., with Registered Nurse (RN) 2, Resident 1's Behavior Plan, dated 2/17/2024, and Resident 1's Change of Condition (COC) Notes, dated 2/2024, were reviewed. The Behavior Plan indicated it was reported that Resident 1 masturbated in the doorway of his room, in a public setting on 2/17/2024. The COC notes indicated there was no change of condition notification made to the physician, psychiatrist, nor the psychologist for Resident 1's display of inappropriate sexual behavior on 2/17/2024. RN 2 stated for every change of condition, the normal process was to complete a change of condition note, and notify the physician, and conservator or responsible party. RN 2 stated a change of condition note should have been completed on 2/17/2024 so that the physician and the appropriate doctors could place proper orders and interventions for Resident 1. RN 2 stated there was a possibility Resident 1's condition worsened or continued over time if the doctors were not made aware of his behaviors.<br><br>During an interview, on 8/6/2024, at 3:50 p.m., with the DON, the DON stated a change of condition note should have been made for Resident 1's display of inappropriate sexual behavior on 2/17/2024. The DON stated that the social worker did not relay this information to the licensed nursing staff so that the licensed nurses could complete the change of condition note and notify the physician. The DON stated it was expectation of the social worker to communicate any medical or behavioral changes to the nursing staff, and because of this, there was a delay in care for the medical treatment and interventions for Resident 1's hypersexual behaviors. The DON stated that if the doctor were not made aware of changes of condition, then it would be considered negligence .<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 |
|---|---|---|---|
| | 056417 | A. Building<br>B. Wing | 08/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| View Heights Conv Hosp | 12619 S. Avalon Blvd<br>Los Angeles, CA 90061 |

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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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's Social Services Designee Job Description (undated), the job description indicated the SSD was to ensure that all charted progress notes are completed accurately, informative, descriptive, and timely of the services provided and of the resident's response to the service. The job description indicated the SSD was to communicate with the medical staff, nursing service, and other department directors.<br><br>During a review of the facility's policy and procedure (P&P) titled, Care Plans , dated 2020, the P&P indicated the facility was to develop and maintain a comprehensive care plan for each resident that identifies the high level of functioning the resident may be expected to attain.<br><br>During a review of the facility's P&P titled, High Risk Safety Monitoring , dated 2020, the P&P indicated the following:<br><br>1. The facility closely monitored the status of residents who are at risk for unsafe behavior, to observe for a significant change in their behavior or their physical or mental condition.<br><br>2. Direct care staff were assigned common areas [throughout the facility] in order to observe resident behavior.<br><br>3. Staff was to respond and intervene as necessary, to any resident who verbally and non-verbally communicates feeling unsafe or agitated, or is behaving in an unsafe manner.<br><br>4. Direct must have been in full view of the resident's rooms or other designated areas in order to observe the residents for safety.<br><br>5. The staff member may not leave his/her post until another staff member is present for relief.<br><br>6. When there was a significant change noted in the resident's mental status, or the resident is behaving in an unsafe manner, a Licensed Nurse is to be notified immediately.<br><br>During a review of the facility's P&P titled, Activities and Social Services Monthly, Quarterly, and Annual Documentation Format (undated), the P&P indicated staff should reference the care plan and describe the approaches the counselor is doing to encourage and involve the resident with the Special Treatment Program.<br><br>During a review of the facility's P&P titled, Resident Rights , dated 2020, the P&P indicated the residents' rights were to be maintained and utilized to enhance the comfort and well-being of each patient. |