Accepted 1/17/23
, 44253

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY HILLS REHABILITATION CENTRE	580 S SAN VICENTE BLVD. LOS ANGELES, CA 90048

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI). Facility Reported Incident Number: CA00809685 Representing the Department: Health Facilities Evaluator Nurse: 44253 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for Facility Reported Incident number CA00809685 at F600.	F 000	Submission of this Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly sited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents or other individuals who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. DG Initial	01/08/23
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600	F 600 Free From Abuse and Neglect a) How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. • No other resident has been affected by the deficient practice. • CNA 1 was suspended on 10/30/22 and is no longer working with us effective 11/4/22. • Resident 1 was visited by Social Services Director on 10/31/22, 11/1/22, and 11/2/22; he stated that he feels safe at the facility and has no problems or concerns. • Resident 1 was seen by the psychologist on 11/13/22 and has ongoing psychotherapy sessions on 11/25/22, 12/16/22, 12/23/22, 01/04/23, and 01/06/23. Per psychologist's notes, the resident demonstrated a full emotional and cognitive preoccupation with racial inequality, which looked like delusional ideations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Director Of Nursing	01/08/23

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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F 600	Continued From page 1 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by Certified Nursing Assistant 1 for one of two sampled residents (Resident 1). On 10/30/2022, Certified Nurse Assistant (CNA) 1 hit Resident 1 in the head and groin. As a result, Resident 1, who was incontinent of bowel and bladder (no control over urination or defecation) had continued pain and was tearful when remembering the incident. Findings: A review of Resident 1's admission record indicated the facility admitted Resident 1 on 5/25/2022 with diagnoses including difficulty in walking, muscle weakness, diabetes (high blood sugar) and bed sores. A review of the alteration in bowel and bladder care plan, initiated 5/28/2022, indicated Resident 1 was incontinent of bowel and bladder function due to limited mobility. A review of the History and Physical, dated 6/16/2022, indicated Resident 1 had the capacity to understand and make decisions. A review of the Minimum Data Set (MDS- a comprehensive assessment and care screening tool), dated 8/26/2022, indicated Resident 1 required extensive assistance with one-person physical assist with bed mobility, dressing, toileting, and personal hygiene. The MDS indicated Resident 1 was not steady and only able to stabilize with staff when moving from seated to standing position, moving on and off the toilet, and surface-to-surface transfer (transfer between bed and chair or wheelchair).	F 600	• Resident 1 was seen by the psychiatrist on 12/6/22 and 01/06/23. • The Director of Nursing conducted in-service education to facility staff on 01/03/23, 01/04/23, and 01/05/23 regarding: 1. Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy and procedure. 2. When residents resist and complain during care, stop and get assistance from other nurses and report immediately to the supervisor. b) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. • All in-house resident has the potential to be affected. • The Department Heads randomly interviewed residents on 01/04/23 and 01/05/23 to see if the staff was treating them well and if they felt safe and comfortable in the facility. No residents were found to be affected by the deficient practice. • The Director of Nursing conducted in-service education to facility staff on 01/03/23, 01/04/23, and 01/05/23 regarding: 1. Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy and procedure. 2. When residents resist and complain during care, stop and get assistance from other nurses and report immediately to the supervisor. c) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.	01/08/23

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F 600	Continued From page 2 According to a review of the Coaching/Counseling note, dated 9/21/2022, a resident's family member accused CNA 1 of being rude when speaking to her. A review of the Detail Time Report dated 10/30/2022, indicated CNA 1 worked a double shift from 3 PM to 7 AM. A review of Resident 1's nursing progress note, dated 10/30/2022, indicated Resident 1's Family Member called the facility and reported that a CNA hit Resident 1 in the groin and head with a closed fist. A review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR - a technique that can be used to facilitate prompt and appropriate communication between the different disciplines caring for the resident), dated 10/30/2022 indicated Resident 1 stated that the nurse who changed his incontinence brief, hit his face and pubic area. According to a review of Resident 1's nursing progress note, dated 10/30/2022, law enforcement came to the facility and spoke to Resident 1. A review of Resident 1's potential for injuries, pain, and emotional distress care plan, initiated on 10/30/2022 (after the abuse), indicated the interventions included to monitor for possible injuries and signs of pain, monitor mood and behavior for 72 hours and to encourage the resident to verbalize his feelings. A review of the Medication Administration Record	F 600	• The Department Heads will conduct daily (Monday to Friday) assigned room rounds and interview residents to ensure the staff is treating them well. They feel safe and comfortable in the facility. Any findings will be reported to the Administrator for further investigation. • The Director of Staff Development or designee will continue to provide in-service education to the facility staff regarding: 1. Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy and procedure. 2. When residents resist and complain during care, stop and get assistance from other nurses and report immediately to the supervisor. d) How the facility plans to monitor its performance to make sure that solutions are sustained. • The Administrator or designee will provide a recapitulation of findings at the Monthly QAA meeting for further evaluation and recommendations. If it is determined that we have accomplished the objectives in the POC above and the results are successful, then the facility will consider the matter resolved. The QA & A committee will continue to review until the deficiency has been proven resolved for two consecutive months and/or advised by the QA & A Committee.	01/08/23

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(MAR) indicated Resident 1 received Tylenol 650 milligrams (mg, a unit of measurement) for pain on 10/31/2022, 11/4, 11/5, 11/9, 11/12, 11/13, 11/16, 11/18, 11/22, 11/23 and 11/30/2022 (twelve times).

A review of Resident 1's interdisciplinary team (IDT, - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) note, dated 11/3/2022 indicated Resident 1 stated that CNA 1 hit his right eye and genitals.

According to a review of CNA 1's Separation Notice dated 11/4/2022, the facility terminated CNA 1 for failure to perform job duties and the last day of work was 10/31/2022.

A review of the Initial Psychology Consult note dated 11/13/2022, indicated Resident 1 was feeling hopeless and helpless, and felt that one of the staff was rough with him. The Psychology Consult note indicated Resident 1 was a "good candidate for psychotherapy and will be seen as medically necessary."

During an interview on 11/14/2022 at 1:26 PM, Resident 1 stated that while CNA 1 was changing his incontinence brief, she was treating him roughly. Resident 1 stated CNA 1 closed the door and "Next thing I know she hit me on my head and she hit me in my private parts, and it still hurts." Resident 1 became tearful. Resident 1 stated that after the incident he called his Family Member and the Family Member called the facility to report the abuse.

During an interview on 11/14/2022 at 2:01 PM,

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Resident 2 (Resident 1's roommate at the time of the incident) stated he heard CNA 1 scream an obscenity at Resident 1 and heard what sounded like Resident 1 being hit on the back. Resident 2 further stated CNA 1 then closed the door and hit Resident 1 again. Resident 2 stated that Resident 1 can be loud, "but he did not deserve to be hit."

A review of Resident 2's admission record indicated the facility admitted Resident 2 on 9/19/2022 with diagnoses including muscle weakness and high blood pressure.
A review of the MDS, dated 9/25/2022, indicated Resident 2 had the ability to hear adequately, was able to express ideas and wants, and was able to understand others.

During an interview on 11/14/2022 at 2:24 PM, the Director of Staff Development (DSD) stated CNA 1 had previously been counseled for a complaint of being rough with a different resident. The DSD stated after the facility conducted the investigation of Resident 1's abuse allegation, the facility fired CNA 1. The DSD stated CNA 1's last day working at the facility was 10/31/2022.

During a phone interview on 11/18/2022 at 12:47 PM, CNA 1 stated that she did not hit Resident 1 and that she "only cleaned him."

During an interview on 12/1/2022 at 1:35 PM, Licensed Vocational Nurse (LVN) 2 stated Resident 1 continued to complain of pain in his pubic area since the abuse allegation happened and has taken Tylenol several times for pain. LVN 2 stated that since the incident, Resident 1 has become "anxious or afraid that someone will hurt him again." LVN 2 further stated, "Yesterday, when we tried to close the door, the resident

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F 600	Continued From page 5 (Resident 1) stated he was a little afraid of the door being closed." A review of the facility's policy and procedure titled, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," revised 4/2021, indicated residents have a right to be free from abuse. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, or physical abuse. The policy indicated it was the facility's objective to protect residents from abuse by anyone including facility staff and to ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates. and to implement measures to address factors that may lead to abusive situations for example, adequately prepare staff for caregiving responsibilities.	F 600		