STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055247	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Oaks Care Center	215 W Pearl St Pomona, CA 91768

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** 46687 Based on interview and record review, the facility failed to report an allegation of resident-to-resident physical abuse (intentional bodily injury that includes slapping, pinching, choking, kicking, shoving, grabbing, and punching) to officials including, the State Survey Agency (SSA), law enforcement, and adult protective services, immediately but not later than two hours for one of four sampled residents (Resident 2) from the time the incident occurred, by failing to: Ensure the Administrator (ADM), who is the abuse coordinator, reported an allegation of abuse on 4/22/2024 when Resident 4 approached Resident 2 and grabbed Resident 2's right upper arm. The ADM reported the allegation of resident-to-resident abuse to the Department of Public Health on 5/7/2024 (15 days after Resident 2's allegation of abuse was made to the ADM). This failure had the potential to result in compromised safety and the reoccurrence of abuse to Resident 2 and the potential for incidents of abuse to occur throughout the facility. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities) and type II diabetes mellitus (DM2- a condition that happens because of a problem in the way the body regulates and uses sugar as fuel) During a review of Resident 4's untitled care plan, initiated 2/5/2024, the care plan indicated Resident 4 had the potential to be physically aggressive due to dementia as evidence by attempting to bite nurses and throw the remote control towards staff. The care plan's interventions indicated to monitor/document/report, as needed, any signs or symptoms of Resident 4 posing danger to self or others. The care plan indicated to intervene before Resident 4's agitation escalated. During a review of Resident 4's Change of Condition Notification (COC- a change in the resident's health or functioning that requires further assessment and intervention), dated 4/22/2024 timed at 6:47 pm, the COC indicated certified nurse assistant (CNA, unidentified) reported to Licensed Vocational Nurse (LVN) 3 Resident 4 grabbed Resident 4's roommate (Resident 2) by the arm when the roommate was entering the room. (continued on next page)

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 Resident 2's AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included Huntington's disease (causes the nerve cells in the brain to decay over time and affects a person's movements, thinking ability, and mental health) and difficulty walking (problems with joints, bones, circulation, or pain making it difficult to walk properly). During a review of Resident 2's COC, dated 4/22/2024, timed at 7:09 pm, the COC indicated a CNA (unidentified) reported to LVN 3 Resident 2 was grabbed by Resident 2's roommate (Resident 4). The COC indicated the unidentified CNA separated both residents. The COC indicated Resident 2 had redness on the right upper arm, but no complaints of pain. During an interview on 5/7/2024 at 12:53 pm, with the ADM, the ADM stated Resident 4 had a history of hoarding behavior (ongoing difficulty throwing away or parting with possessions because they are believed to need saving). The ADM stated on 4/22/2024, Resident 4 thought Resident 2's wheelchair belonged to Resident 4. The ADM stated Resident 4 reached for Resident 2 and grabbed Resident's arm. The ADM stated the ADM did not report the incident to Department of Public Health because the ADM, Did not feel the incident was abuse. The ADM stated a room change was initiated. During an interview on 5/7/2024 at 1 pm, with Resident 2, Resident 2 stated on 4/22/2024, Resident 4 grabbed Resident 2's arm from behind twice while Resident 2 was in the wheelchair. Resident 2 stated Resident 4 accused Resident 2 of taking Resident 4's wheelchair. Resident 2 stated Resident 4 did this [grabbing of the arm] to Resident 2 every day and, Really bugged, Resident 2. Resident 2 stated Resident 2 was glad facility staff moved Resident 4 to a different room because, It was a nightmare, having Resident 4 always trying to take Resident 2's belongings. During an interview on 5/7/2024 at 3:07 pm, with LVN 3, LVN 3 stated on 4/22/2024 at approximately 6:30 pm, 1:1 Sitter (TNA) 2 reported Resident 4 grabbed Resident 2 as Resident 2 entered the room. LVN 3 stated Resident 4 had the tendency to grab things or try and take things that did not belong to Resident 4. LVN 3 stated LVN 3 told Registered Nurse Supervisor (RNS) 1 what happened and RNS 1 called the ADM and the Director of Nursing (DON). LVN 3 stated grabbing another resident was a form of resident-to-resident physical abuse. LVN 3 stated allegations of abuse had to be reported in order to prevent the abuse from happening again. LVN 3 stated if abuse was not reported, the abuse could continue and cause more injury. During an interview on 5/7/2024 at 3:39 pm, with the DON, the DON stated if there was an allegation of a resident-to-resident altercation, the altercation was supposed to be reported to the appropriate agencies. The DON stated reporting the incident within two hours of learning of the abuse allegation protected the health and well-being of residents. The DON stated the DON was a mandated reporter, which meant any allegation of abuse needed to be reported to the Department of Public Health, law enforcement, and the Ombudsman. During an interview on 5/7/2024 at 3:45 pm, with the ADM, the ADM stated the ADM was the facility's abuse coordinator, which meant the ADM was supposed to facilitate the reporting of abuse allegations to the appropriate agencies. The ADM stated if a resident grabbed another resident, that could be considered resident-to-resident abuse. The ADM stated abuse allegations had to be reported within two hours of becoming aware of the allegations for the protection and safety of residents and everyone else at the facility. The ADM stated if an abuse allegation was not reported, further abuse could potentially occur. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, and Exploitation, revised 12/19/2022, the P&P indicated it was the policy of the facility to provide protections for the health, welfare, and rights of residents by developing and implementing written P&P that prohibited and prevented abuse, neglect, exploitation, and misappropriation of property. The P&P indicated reporting of all alleged violations to the ADM, SSA, adult protective services and to all other required agencies within specified timeframes immediately, but not later than two hours after the allegation was made .