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	06/11/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36288 Based on interview and record review, the facility failed to prevent physical abuse (willful infliction of injury, deliberate aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1). On 6/5/2024, Resident 2 hit Resident 1 on the right upper arm. This failure had the potential to cause a decline in Resident 1's physical and/or psychosocial well-being. Findings: a. During a review of Resident 2's Admission Record (AR), the AR indicated the facility initially admitted Resident 2 on 3/15/2024. During a review of Resident 2's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 3/22/2024, the MDS indicated Resident 2 had no impairment in cognition (ability to acquire knowledge and understand information). The MDS indicated Resident 2 required partial to moderate assistance with most self-care activities and mobility (ability to move). During a review of Resident 2's Initial Psychiatric Evaluation (IPE), dated 6/5/2024, the IPE indicated Resident 2 hit Resident 1 because Resident 1 called Resident 2 stupid idiot. The IPE indicated Resident 2 manifested paranoid delusions (psychosis symptom that causes irrational and frightening false beliefs of being threatened or mistreated) by stating, Everybody tries to kill me with water. The IPE indicated Resident 2 did not provide a coherent response when asked if she was having any hallucinations (false perception of objects or events involving the senses). The IPE recommended starting Depakote (medication that controls behavior or treat thought disorders) for poor impulse. During a review of Resident 2's Order Summary Report (OSR), dated active as of 6/11/2024, the OSR indicated the following: 1. Resident 2 had multiple diagnoses that included cerebral palsy (abnormal development of the brain that control movement) and psychosis (symptoms that affect the mind and cause an individual to lose contact with reality). (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2024 at 11:02 AM, the RTS stated the RTS was getting supplies when the RTS witnessed Resident 2 yelling at Resident 1, No, you're the idiot! the RTS stated Resident 2 did not like what Resident 2 heard, leaned over Resident 2's chair, and punched Resident 1 on the arm. The RTS stated the RTS did not hear Resident 1 talking to Resident 2. The RTS stated the RTS immediately separated Residents 1 & 2 to prevent further abuse. During an interview on 6/11/2024 at 4:21 PM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 2 was noted to have more disagreements with other residents recently and was getting more agitated. LVN 2 stated Resident 1 said Resident 1 did not say anything to Resident 2, but Resident 2 said something and hit Resident 1. During a review of the facility's policy and procedures (P&P), titled Abuse, Neglect, and Exploitation, dated 12/19/2022, the P&P indicated the following: 1. The facility must provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. 2. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff-to-resident abuse and certain resident-to-resident altercations. 3. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 4. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. 5. The facility must implement P&P to prevent and prohibit all types of abuse that achieves: a. Identifying, correcting, and intervening in situations in which abuse is more likely to occur with the deployment of trained and qualified staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. b. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which may lead to conflict or neglect, and c. Addressing features of the physical environment that may make abuse more likely to occur.