STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055256	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lompoc Valley Medical Ctr Comp Care Ctr D/P Snf	216 N Third Street Lompoc, CA 93436

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft.

35399

Based on interview and record review the facility failed to implement abuse prevention policy when two residents (Resident 1 and 2) had an alleged abuse incident on 7/17/24 for which no interventions were implemented for two days after the alleged physical abuse incident occured.

The facility's failure had the potential for the physical abuse incident to reoccur within those two days.

Findings:

A review of the facility's policy and procedure titled Prevention of Abuse , dated 3/24, indicated 1. It is the policy of this facility to take every proactive measure to prevent the occurrence of alleged abuse of any resident. 2. Residents must not be subject to abuse by anyone, including . other residents. 10. If suspected perpetrator is another resident: Separate the residents so that they do not interact with each other until the circumstances of the reported incident can be determined. 11. All incidents of witnessed, suspected, or alleged abuse are investigated . Facility shall report all incidents of alleged abuse/neglect or suspected abuse/neglect to CDPH within 24 hours and the results of the investigation are reported to CDPH within 5 working days of the incident .12. 1) Abuse: the willful infliction of injury . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 2) Abuse by one resident to another: Abuse by one resident to another can be a serious situation. This incidents are reported immediately to the nursing team leader and supervisor and immediate steps are taken. This steps may include: Temporarily separating the Residents from each other. Determine the cause for the abuse and intervene as appropriate. Notify the physicians and responsible parties. Closely monitor the residents. Care plan the interventions . Physical Abuse: Hitting, slapping, pushing, shoving, twisting, squeezing, pinching, and kicking.

The California Department of public health (CDPH) received a facility reported incident (FRI) on 7/19/24 reporting that 7/19/24 at 1:15 p.m., Resident 2 reported Resident 1 grabbed and squeezed her arm 7/17/24 around 4:00 p.m., in the activities room.

Resident 1's medical record was reviewed on 8/1/24. Record indicated resident's BIMS score was 14. A score of 13 to 15 suggests the resident is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment. Diagnosis included stroke (brain damage) with expressive aphasia (difficulties verbally expressing needs), right side of body impaired and uses wheelchair for mobility.

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Lompoc Valley Medical Ctr Comp Care Ctr D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 216 N Third Street Lompoc, CA 93436	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1 on 8/1/24 at 2:52 p.m., resident stated She (Resident 2) ranned me over with her wheelchair. She did it intentionally, on purpose. I thought the way to handle matters was to grab her by the arm. Resident 1 was asked if he was temporary separated from Resident 2 after the incident. Resident 1 stated No, I see her (Resident 2) during breakfast, at activities, I see her (Resident 2) all the time . Resident 2's medical record was reviewed on 8/1/24. Record indicated resident's BIMS score was 15. Diagnosis included left side of upper body impaired due to a brain stroke and psychoactive substance abuse. During an interview with Resident 2 on 8/1/24 at 3:03 p.m., resident stated He (Resident 1) grabbed my arm so hard that I was saying aww, aww. During an interview with activities leader (AL) on 8/1/24 at 12:42 p.m., AL confirmed witnessing the alleged abuse incident between the two residents (Resident 1 and 2) on 7/17/24 around 4: 00 p.m., AL stated [Resident 1's name] was on the pathway when [Resident 2's name] was going towards the door to the patio, to go smoke. [Resident 2's name] intentionally charged and ran into [Resident 1's name] wheelchair, running over his feet. It was like [Resident 2's name] said you're in my way so I'm going to run over you . She (Resident 2) did this intentionally. [Resident 1's name] then grabbed her (Resident 2) arm and squeezed it. [Resident 2's name] was saying ouch ouch. I intervened and separated them. I called and reported this to the supervisor [Supervisor's name], she said she will follow up later. Later, I checked on [Resident 1's name] , he said She (Resident 2) ran into me on purpose. During a concurrent review of Resident 2's document titled Activity Dining Room Code of Conduct and interview with the activities director (AD) on 8/1/24 at 12:52 p.m., the AD reported that on 7/12/24 the Code of Conduct rules were reviewed with Resident 2 because resident had been loud, use foul language and disturbing others, in the past. However, on 7/12/24, the resident was out of control, especially, with the use of foul language that necessitated for the AD to review and remind the resident of the rules listed on the Code of Conduct document. During an interview with the nursing supervisor (NS) on 8/1/24 at 2:10 p.m., NS confirmed being notified by activities leader (AL) regarding Resident 1 and Resident 2 alleged abuse incident (altercation) on 7/17/24. NS reported, later, checking on Resident 1. Resident 1 was upset with Resident 2 but with his expressive aphasia it was difficult to understand him and was getting frustrated. Later, NS checked on Resident 2 who was up on the front of the facility, at the time. According to NS, Resident 2 denied being hurt. Therefore, NS did not think this was a resident -to-resident abuse and nothing was done about this. On 7/19/24, Resident 2 reported to nursing staff that on 7/17/24 Resident 1 had grabbed her arm and hurt her. An investigation was initiated on 7/19/24 where details were discovered that on 7/17/24 Resident 2 intentionally ran into Resident 1's wheelchair, running over his feet. Then, Resident 1 grabbed Resident 2's arm and squeezed it. Resident 2 was saying ouch, ouch . NS was asked if on 7/17/24 when she checked on Resident 1 and 2, did she asked residents if there was any physical contact between them or did she asked the details of the incident. NS stated No, I did not . NS was asked if she performed an assessment of both residents on 7/17/24 and documented the assessment in the medical record. NS stated No I did not. I did not document any assessment or incident details etc. I did not write any notes in the residents record. I didn't think I needed to since they were both fine. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Lompoc Valley Medical Ctr Comp Care Ctr D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE: 216 N Third Street Lompoc, CA 93436	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of the facility policy titled Prevention of Abuse and interview with the facility manager (FM) on 8/1/24 at 3:45 p.m., the FM acknowledged and confirmed for two days, from 7/17/24 to 7/19/24, the facility did not implemented their policy and procedure related to abuse by one resident to another. FM confirmed on 7/17/24, date of the alleged abuse incident, the facility did not 1. Temporarily separated the residents so they do not interact with each other until investiagtion was completed. 2. Determine the cause for the abuse. 3. Notify the physicians and responsible parties. 4. Closely monitor the residents. 5. Initiate care plan with interventions. 6. Physical assessment of residents involved was not completed with findings documented in the record. Facility did not report alleged abuse incident to CDPH within 24 hours of incident. Furthermore, FM agreed the facility cannot account for Resident 1 and Resident 2 whereabouts and interactions between the two of them from 7/17/24 to 7/19/24, two days from the alleged abuse incident.