

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/15/2024
NAME OF PROVIDER OR SUPPLIER  Laurel Park Behavioral Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1425 Laurel Avenue 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38108</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from physical and verbal abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) according to the facility's policies and procedure (P&amp;P), when Resident 1 hit the back of Resident 2's head.</p> <p>This deficient practice resulted in Resident 1 experiencing verbal and physical abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the Admission record indicated Resident 1 was admitted to facility on 7/24/23 with multiple diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and psychoactive substance dependence (a strong desire or sense of compulsion to take the substance).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care-screening tool) dated 2/2/24, the MDS indicated Resident 1 was cognitively intact (ability to make daily decisions) and was independent (no help or staff oversight at any time) of staff for transfers, dressing, and toilet use.</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was readmitted to the facility on [DATE] with multiple diagnoses that included unspecified schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and diabetes (elevated blood sugar).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was cognitively intact (ability to make daily decisions) and was independent (no help or staff oversight at any time) of staff for transfers, dressing, and toilet use.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview with Resident 2, on 4/15/24 at 10:51 am, Resident 2 stated I threw water at Resident 1 and hit (open hand slap) her at the back of her head. I meant to hit her. Resident 2 stated I wanted to hit her. I planned in my head to hit her. I thought she was stepping up (being aggressive) and I didn't want to look weak. Resident 2 denied hearing voices and stated the resident intended to hit Resident 1 because she was tired of Resident 1 calling her names. Resident 2 stated it was wrong to hit others and next time will respect and keep her hands to herself.</p> <p>During an interview with Primary Counselor 1 (PC 1), on 4/15/24 at 11:06 am, the PC stated Resident 1 and Resident 2 had verbal altercations in the past. The PC stated Resident 1 and Resident 2 were asked to stay at designated areas in the facility to prevent any possible altercations between them.</p> <p>During an observation and concurrent interview with Resident 1, on 4/15/24 at 11:16 am, the area of Resident 1's back of the head was intact. There was no discoloration or swelling noted. Resident 1 stated Resident 2 threw water and hit the back of Resident 1's head and called her a Bitch. Resident 1 stated PC 1 instructed Resident 1 to keep away from Resident 2 to avoid any fights.</p> <p>During an interview with Licensed Vocational Nurse 1 (LVN 1), on 4/15/24 at 12:28 pm, LVN 1 stated LVN 1 was informed (could not remember by who) to keep Resident 1 and Resident 2 away from each other and to ask them to stay at separate areas of the facility to avoid any altercation between the residents.</p> <p>During an interview with the Administrator/Abuse Coordinator (ADM/AC), on 4/15/24 at 12:50 pm, the ADM/AC stated the facility was aware of tension between Resident 1 and Resident 2 and were catty (deliberately hurtful in one's remarks; spiteful) with each other. The ADM/AC stated ADM/AC instructed her staff to keep an eye on Resident 1 and Resident 2 to avoid any altercations.</p> <p>During an interview with the Director of Nursing (DON), on 4/15/24 at 1:21 pm, the DON stated if there is known tension between residents, the DON would separate the residents for fear of any possible altercations between the two. The DON stated additional staff would be implemented to monitor the residents for safety and protection.</p> <p>During a telephone interview with Certified Nurse Assistant 2 (CNA 2), on 4/15/24 at 1:44 pm, CNA 2 stated CNA 2 was aware of the tension between Resident 1 and Resident 2, and both were catty towards each other. CNA 2 stated on 4/10/24 around 7:15 pm, Resident 2 informed CNA 2 that Resident 2 threw a cup of water and hit the back of Resident 1's head. CNA 2 stated Resident 2 reported that Resident 2 wanted to hit Resident 1 and did not know why.</p> <p>During a review of Resident 1's Progress Notes (PN), dated 2/24/24, the PN indicated Resident 1 called another resident a [NAME] while pointing at her. Resident 1 stated she had a previous issue with the resident and that her face made her angry which is why Resident 1 called her a [NAME].</p> <p>During a review of Resident 2's PN, dated 2/24/24, the PN indicated another resident called Resident 2 a [NAME] in front of her face while pointing at her. Resident 2 stated that she had pervious issues with the resident and did not want to cause trouble and fight back.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Note (PN), dated 4/10/24, the PN indicated on 4/10/24 at approximately 7:20 pm, Resident 1 reported to staff that a female peer tossed water on her and hit her on the back of the head.</p> <p>During a review of Resident 1's Change in Condition Evaluation (COC), dated 4/10/24, the COC indicated, on 4/10/24, Resident 1 had a potential injury related to an unwitnessed hit to the back of head by female peer.</p> <p>During a review of Resident 2's PN, dated 4/10/24, indicated at appropriately 7:20 pm, Resident 2 reported to staff that resident tossed water and hit another resident on the head. Resident 2 admitted to throwing water at her hitting a peer.</p> <p>During a review of Resident 2's COC, dated 4/10/24, the COC indicated Resident 2 reported that Resident 2 approached a peer unprovoked and threw water on her peer and hit the peer in the back of her head, unwitnessed.</p> <p>During an interview with the ADM on 4/10/24 at 12:50 pm, the ADM stated abuse should not happen at the facility because this is the resident's home, and it is our (facility's) responsibility to provide them (residents) an environment that was non-violent and abuse free. Residents had rights they were entitled to being in an environment that was abuse free.</p> <p>During a review of the facility's P&amp;P titled, Abuse Prohibition, dated 2/23/21, the P&amp;P indicated, HealthCare Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. The P&amp;P indicated, The Center will implement an abuse prohibition program through the following: . Prevention of occurrences. The P&amp;P indicated, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Verbal abuse is any use of oral, written, or gesture language that willfully includes disparaging and derogatory terms to patients . Physical Abuse included hitting and slapping .</p> <p>During a review of the facility P&amp;P titled, Resident Rights, dated 12/2021, the P&amp;P indicated Federal and state laws guarantee certain basic right to all residents of this facility. These rights include the resident's right to: be free from abuse, neglect, misappropriation of property and exploitation.</p>		