STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Park Behavioral Health Center	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)
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** 42307 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 1), was free from sexual (non-consensual sexual contact of any type with a resident) abuse in accordance with the facility's policies and procedures (P&P). Resident 2 placed Resident 1's hand on Resident 2's crotch (the part of the body that includes the groin and genitals [the sexual organs located on the outside of the body]) without Resident 1's consent (permission for something to happen or agreement to do something). This deficient practice violated Resident 1's right and resulted in Resident 1 feeling bad and unsafe in the facility around Resident 2. Findings: a. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including schizophrenia (a serious mental health condition that affects how people think, feel and behave), hypothyroidism (the thyroid gland can't make enough thyroid hormone [controls metabolism, growth and other bodily functions] to keep the body running normally), unspecified and obesity (a disorder that involves having too much body fat, overweight), unspecified. During a review of Resident 1's History and Physical (H&P), dated 7/8/24, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screening tool), dated 7/17/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was intact. The MDS indicated, Resident 1 had behavior of hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated Resident 1 was independent (resident completes the activity by themselves with no assistance from a helper) of activities of daily living (ADL). (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

Printed: 12/04/2024
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NAME OF PROVIDER OR SUPPLIER Laurel Park Behavioral Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1425 Laurel Avenue Pomona, CA 91768	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's undated SBAR [Situation, Background, Appearance, Review and Notify] Communication Form (SBAR), the SBAR indicated, Resident 1 reported nonconsensual (not agreed to by one or more of the people involved) acts upon by peer on 9/10/24. The SBAR indicated, Resident 1 had reported that Resident 1 did not feel safe because one of her male peers had gone to her room last night and propositioned to her. The SBAR indicated, Resident 1 refused but male peer continued to do nonconsensual acts to which the male peer stated, I guided her hand to my pants. During a review of Resident 1's Progress Notes (PN), dated 9/10/24, timed at 12:54 p.m., the PN indicated, Resident 1 came into the program room and reported that a male peer kept asking Resident 1 to go into his room. Resident 1 stated I don ' t want to. Resident 1 stated, male peer took Resident 1's hand and put her hand to his penis. The PN indicated, Resident 1 stated, Resident 1 did not feel safe and really thought that male peer was going to hurt her because Resident 1 would not have sex with him. During a review of the facility's Witness Interview Record (WIR), dated 9/10/24 timed at 1:10 p.m., the WIR indicated, Resident 1 reported to staff (unnamed) on 9/10/24 at 12:56 p.m. that Resident 2 had grabbed Resident 1's hand and placed it (hand) on Resident 2's groin. The WIR indicated, Resident 2 proceeded to kiss Resident 1 and Resident 1 said no. The WIR indicated, Resident 1 stated, the incident happened on 9/9/24 after dinner in Resident 1's doorway. b. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including paranoid (unreasonably or obsessively anxious, suspecious, or mistrustful) schizophrenia, essential (primary) hypertension (high blood pressure) and hypothyroidism, uspecified. During a review of Resident 2's H&P, dated 5/31/24, timed at 10:09 a.m., the H&P indicated, Resident 2 was alert and oriented. During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's BIMS Summary Score for cognitive status was intact. The MDS indicated, Resident 2 had a behavior of hallucinations and delusions and was independent of ADL. During a review of Resident 2's undated SBAR, the SBAR indicated, nonconsensual acts upon peer on 9/10/24. The SBAR indicated, a female resident reported that Resident 2 propositioned to her to be his girlfriend last night but she refused. Resident 2 then followed female resident to the doorway and grabbed her hands and placed them onto her private parts and then started to kiss her. The SBAR indicated, Resident 2 stated, it (incident) happened on 9/9/24 after dinner time. During a review of Resident 2's PN dated 9/10/24, timed at 1:49 p.m., the PN indicated, (on 9/10/24) at approximately 12:53 p.m. a female peer reported that Resident 2 was standing in her doorway last night when he (Resident 2) kept asking her to go to his room. The PN indicated, the female peer stated Resident 2 took her hand and placed her hand on his penis. During a review of the facility's WIR dated 9/10/24 timed at 1:15 p.m., the WIR indicated, Resident 2 stated that before dinner on 9/9/24, Resident 1 came to his room two to three times and asked if she could give him a foot massage or engage in sexual acitivity. Resident 2 stated no. Resident 2 saw Resident 1 in the patio next to Resident 1's doorway after dinner and Resident 2 gently grabbed Resident 1's hand and placed it (hand) on his groin. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/24 at 11:21 a.m. with Resident 1, Resident 1 stated, the incident involved Resident 2 and happened in the doorway of Resident 1's room the other night. Resident 1 started to complaint of pain in her chest during the interview stating, I get this sometimes and had to be taken to the nursing station by Behavioral Specialist (BST). During an interview on 9/11/24 at 11:53 a.m. with Resident 2, Resident 2 stated, prior to the incident, Resident 1 was in Resident 2's room and had asked Resident 2 two to three times if Resident 1 could massage Resident 2's feet and give oral sex if Resident 2 would let Resident 1 use Resident 2's vapor pen (a type of smokeless cigarette). Resident 2 stated, Resident 2 kept saying no. Resident 2 stated, Resident 2 was outside of Resident 1's room doorway the day before yesterday, it was night time between 8:30 p.m. and 9:00 p.m. and asked Resident 1 if Resident 1 still wanted to go to Resident 2's room. Resident 2 stated, Resident 1 said maybe later on. Resident 2 stated, Resident 1 and Resident 2 were holding hands at first, and Resident 2 put Resident 1's hand on Resident 2's crotch, we were just being friendly. Resident 2 stated, Resident 1 did not resist or pull her hand away and kissed Resident 2 on the cheek. During an interview on 9/11/24 at 1:35 p.m. with Resident 1, Resident 1 stated, Resident 2 asked Resident 1 to be Resident 2's girlfriend and Resident 1 stated no, I can't, you have a girlfriend and Resident 2 answered who cares, I don't have a girlfriend, then grabbed Resident 1's hand and put my hand on his penis, outside of his clothes. Resident 1 stated, Resident 1 could not resist or pull her hand away since Resident 2 was holding her hand. Resident 1 stated, Resident 1 felt bad and did not feel safe at the facility and around Resident 2 and Resident 1 felt nervous Resident 2 might [NAME] me, hurt me, hit. During an interview on 9/11/2024 at 3:59 p.m. with Resident 2, Resident 2 stated, Resident 2 felt fine and was in his right mind during the incident. Resident 2 stated, Resident 2 did not ask Resident 1's permission if Resident 2 could put Resident 1's hand on Resident 2's crotch cuz she was leading me on. During an interview on 9/11/24 at 4:18 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, the incident between Resident 1 and Resident 2 was a type of sexual abuse. The ADON stated, residents should be free from abuse including sexual abuse because residents don't deserve, they're supposed to live comfortable and safe here. During an interview on 9/11/24 at 4:25 p.m. with the Administrator (ADM), the ADM stated, the incident between Resident 1 and Resident 2 was sexual abuse because it (incident) was not consensual. During a review of the facility's P&P titled, Abuse Prohibition Policy and Procedure, effective date 2/23/21, the P&P indicated, the facility was to provide a safe and secure environment. The P&P indicated, HealthCare Centers (facilities) prohibited abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. The P&P indicated, instances of abuse of all patients, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. During a review of the facility's P&P titled, Resident Rights, revised date December 2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights included the resident ' s rights to be free from abuse, neglect, misappropriation of property, and exploitation.