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	12/05/2024

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 - Some	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 two of two sampled residents (Resident 1 and Resident 2), were free from physical abuse (willful infliction of injury, deliberately aggressive or violent behavior with the intention to cause harm) in accordance with the facility's policy and procedure (P&P) titled Abuse Prohibition Policy and Procedure when on 11/19/24 Resident 1 pushed Resident 2 and Resident 2 reacted by hitting Resident 1 back. This deficient practice resulted in physical abuse, pain, and a bloody nose to Resident 1. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), unspecified, autistic disorder (a developmental brain disorder that affects how people interact with others, communicate, learn, and behave) and essential (primary) hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 10/22/24, the H&P indicated, Resident 1 could not make own decisions but could make needs known. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/19/24, the SBAR indicated, Resident 1 had an altercation where Resident 1 elbowed Resident 2 and Resident 2 hit back. The SBAR indicated, Resident 1 had a new pain rated 5 out of 10 (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt) in Resident 1's nose and Resident 1 had a small amount of blood on Resident 1's right nostril/face. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screening tool), dated 11/21/24, the MDS indicated, Resident 3's cognitive (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 1 had behaviors of hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to 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 - Some	During a review of Resident 1's Interdisciplinary Care Conference, (IDT [Interdisciplinary Team], a team of health care professions who work together to establish plans of care for residents), dated 11/21/24, timed at 11:20 a.m., the IDT indicated, Resident 1 elbowed Resident 2's back and Resident 1 was then struck twice by Resident 2 two times. 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, suspicious, or mistrustful) schizophrenia, hyperlipidemia (high cholesterol, a condition in which there are high levels of lipids or fats in your blood), unspecified and myopia (nearsighted), unspecified eye. During a review of Resident 2's H&P, dated 6/10/24, the H&P indicated, Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's SBAR, dated 11/19/24, the SBAR indicated, at approximately 8:30 p.m., a staff (unidentified on the record) witnessed Resident 1 elbowed Resident 2 on the back once and Resident 2 turned around and hit Resident 1's body twice with Resident 2's closed fist. The SBAR indicated, Resident 2 was evaluated, and Resident 2 had no pain, issues or injuries noted. During a review of Resident 2's IDT, dated 11/21/24, timed at 11:26 a.m., the IDT indicated, Resident 2 was elbowed in Resident 2's back by Resident 1 and then Resident 2 struck Resident 1 twice on 11/19/24. During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's cognitive status was intact. During an interview on 12/5/24 at 12:57 p.m. with Resident 1, Resident 1 stated, Resident 1 elbowed Resident 2 in the hallway (corridor) because Resident 2 tapped Resident 1's top of head. Resident 1 could not remember the exact date of incident September 6? Resident 1 got up and walked away from the interview before the interview could be completed. During an interview on 12/5/24 at 1:16 p.m. with the Primary Counselor (PC), the PC stated, from what the PC heard and understood from Certified Nursing Assistant (CNA) 1, Resident 1 and Resident 2, Resident 1 admitted hitting Resident 2's back and Resident 2 reacted and hit Resident 1 in the face. The PC stated, the incident happened at around 8:00 to 8:10 p.m. the week before Thanksgiving. The PC stated, the PC was at the facility the night of the incident and did not witness the incident but saw Resident 1 go to the Nursing Station because Resident 1 had a bloody nose. The PC stated, Resident 1 tended to strike (sudden violent blow at someone) out at staff and other residents (in general) when Resident 1 was frustrated. The PC stated, Resident 1 would cycle where Resident 1 did well and went several months without problems and suddenly violated rules, was disrespected to staff, hit staff or residents, and rummaged through the trash. The PC stated, staff tried to give Resident 1 safe distance when Resident 1 had such cycles [of behavior]. The PC stated, Resident 2 just reacted and Resident 2 understood that Resident 2 had done something wrong. During an interview on 12/5/24 at 2:32 p.m. with Resident 2, Resident 2 stated, Resident 2 hit Resident 1 because Resident 1 hit Resident 2 in the back in the corridor last week, so I hit him back. Resident 2 stated, Resident 2 had never hit Resident 1's top of the head. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 3:12 p.m. with CNA 1, CNA 1 stated the day of the incident (11/19/24), CNA 1 and CNA 2 were sorting the clean laundry in the corridor outside of the dining room and Resident 2 was helping CNA 1 and CNA 2. CNA 1 stated, Resident 1 must have come from the Nursing Station and pushed Resident 2 to get out of Resident 1's way because Resident 2 was backing up and did not see Resident 1 approaching. CNA 1 stated, the incident happened in the corridor around 8:15 p.m. after snack distribution. CNA 1 stated, CNA 1 told hey [Resident 1], don't do that when CNA 1 saw Resident 1 pushed Resident 2. CNA 1 stated, Resident 2 reacted fast, turned around and punched Resident 1. CNA 1 stated, Resident 1 had been cycling that day and had been agitated. CNA 1 stated, CNA 1 did not separate Resident 1 and Resident 2 immediately after Resident 1 pushed Resident 2 because the incident happened so fast and as long as we prompt them, they're pretty good at following. CNA 1 stated, CNA 1 and CNA 2 should have told Resident 1 and Resident 2 to go their separate ways and separated Resident 1 and Resident 2 immediately to prevent Resident 2 from fighting back and prevent the incident from escalating and stop the [physical] abuse. CNA 1 stated, CNA 1 and CNA 2 pulled Resident 1 and Resident 2 apart after Resident 2 hit Resident 1. During a review of the facility's Witness Interview Record (WIR), dated, 11/19/24, timed at 8:10 p.m. with CNA 1, the WIR indicated, Resident 1 walked behind Resident 2 and Resident 1 elbowed Resident 2 on the back and Resident 2 right away reacted and went after Resident 1 and threw punches. During a review of the facility's WIR, dated, 11/19/24, timed at 8:10 p.m. with CNA 2, the WIR indicated, Resident 2 was hit on the lower back by Resident 1 while Resident 1 was walking by Resident 2. Resident 2 then retaliated by striking Resident 1 a few times on the side of Resident 1's head. During a concurrent interview and record review on 12/5/24 at 4:20 p.m. with the Administrator (ADM), the facility's P&P titled, Abuse Prohibition Policy and Procedure, effective date 2/23/21, the P&P indicated, the purpose of the P&P was to ensure that staff were doing all that was within their control to prevent occurrences of abuse .for all patients. The P&P indicated, physical abuse included hitting, slapping, pinching, kicking etc. The ADM stated, staff must physically separate residents immediately upon witnessing an abuse for the security and safety of the residents. The ADM stated, if staff knew Resident 1 had been agitated that day prior to the incident, staff could have redirected Resident 1 away from Resident 2 and sent Resident 1 and Resident 2 their separate ways.