

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 06/17/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 1) was free from physical abuse when on 6/14/2025 Resident 2 shoved Resident 1.</p> <p>This failure resulted in physical abuse to Resident 1 and had the potential to result in psychosocial harm and injury to Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/7/2024 with a diagnosis that included paranoid schizophrenia (a mental illness characterized by hallucinations [false perception of objects or events involving the senses] and delusions, leading to a distorted perception of reality).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 1 was independent (the resident completes the activity by themselves with no assistance from a helper) with self-care (activities including eating, hygiene, and dressing) and mobility (walking, lying, and standing).</p> <p>During a review of Resident 1's Interdisciplinary Care Conference Note, dated 6/17/2025, the note indicated Resident 1 reported to staff Resident 1 was shoved by a male peer [Resident 2] in the hallway on 6/14/2025. The note indicated there was a history of boundary issues between Resident 1 and Resident 2.</p> <p>During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 4/6/2023 with diagnosis including schizophrenia (a mental illness characterized by disturbances in thought) and generalized anxiety disorder (a mental illness characterized by excessive, persistent, and irrational worry or fear that can interfere with daily life).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were intact. The MDS indicated Resident 2 was independent with self-care and mobility.</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 review of Resident 2's Care Plan (CP), the CP indicated Resident 2 exhibited inappropriate physical boundaries with male peer [Resident 1] engaging in play fighting, dated 6/14/2025, the CP indicated, Staff will support resident with identifying and implementing appropriate physical boundaries with peers .</p> <p>During an interview on 6/17/2025 at 12:20 pm with Behavioral Health Counselor (BHC) 1, BHC 1 stated, on 6/14/2025 in the morning (no time recall), Resident 1 approached BHC 1 and made the BHC 1 aware Resident 2 pushed Resident 1 in the hallway. BHC 1 stated BHC 1 approached Resident 2 and asked Resident 2 about the incident. BHC 1 stated Resident 2 told BHC 1 Resident 1 made inappropriate comments and entered Resident 2's room without permission. BHC 1 stated Resident 1 and Resident 2 had a history of giving each other a hard time. BHC 1 stated it was the policy of the facility to report this type of [physical] abuse immediately.</p> <p>During an interview on 6/17/2025 at 12:56 pm with Resident 1, Resident 1 stated the morning of 6/14/2025 Resident 1 and Resident 2 were talking about arcade games in the hallway when Resident 2 shoved Resident 1. Resident 1 stated Resident 2 placed Resident 2's palms on Resident 1's chest and shoved Resident 1. Resident 1 stated, He almost knocked me to the ground, but I didn't fall. Resident 1 stated Resident 1 didn't know why Resident 2 pushed Resident 1 but Resident 1 was upset after being shoved by Resident 2.</p> <p>During an interview on 6/17/2025 at 1:15 pm with Resident 2, Resident 2 stated during the morning of 6/14/2025 Resident 2 and Resident 1 were horseplaying (play that is physically rough) in the hallway. Resident 2 stated Resident 2 shoved Resident 1 in the chest after Resident 2 became upset with Resident 1 because Resident 1 didn't know how to play well.</p> <p>During an interview on 6/17/2025 at 1:30 pm, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 6/14/2025, BHC 1 told LVN 1 Resident 2 shoved Resident 1. LVN 1 stated Resident 2 admitted to shoving Resident 1 on the chest. LVN 1 stated physical abuse could result in bodily harm or may cause Resident 1 to become withdrawn (a condition where an individual tends to distance themselves from social interactions, both physically and emotionally).</p> <p>During an interview on 6/17/2025 at 2:45 pm with the Administration (ADM), the ADM stated the ADM is the abuse coordinator for the facility. The ADM stated it is the policy of the facility to prevent physical abuse [to residents]. The ADM stated that when a resident shoved another resident it was physical abuse.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prohibition, dated 2/23/2021, the P&P indicated, Healthcare Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents .Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish .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 . Physical abuse includes hitting, slapping, pinching, kicking, etc</p>		