STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555135	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Springs Care Center	1441 Michigan Avenue Beaumont, CA 92223

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 - 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** 37536 Based on interview and record review, the facility failed to ensure the residents involved in multiple altercations (physical fight) (Residents 1 and 2) were separated and distanced away from each other as indicated in the care plan. This failure resulted in Resident 1 being grabbed and pulled out from a chair which led to a closed clavicle fracture (broken collarbone). Findings: On October 2, 2024 at 8:30 a.m., an unannounced visit to the facility was conducted to investigate an allegation of physical abuse (the intentional use of physical force to cause injury or harm to another person). On October 2, 2024, Resident 2's admission record was reviewed. Resident 2 was admitted to facility on February 9, 2024, with diagnoses which included schizophrenia (a severe mental disorder affecting a person's emotions and perception of reality). A review of Resident 2's History and Physical, dated September 20, 2024, indicated Resident 2 does not have the capacity to understand and make decisions. A review of Resident 2's COC(Change of Condition)/Interact Assessment Form, indicated the following: - On September 13, 2024 at 6:34 p.m., indicated, .At 1834 (6:34 p.m.) outside .Staff heard a commotion between two residents .Resident (Resident 2) pushed another resident (Resident 1) on his right side of his head .; and - On September 14, 2024 at 2:00 p.m., indicated, .Resident on 1:1 (one on one) monitoring for aggressive behavior .Around 10:45 a.m .One resident (Resident 1) passed by his room and resident (Resident 2) suddenly attacked and hit the other resident (Resident 1) . A review of Resident 2's Care Plan, dated September 13-14, 2024, indicated .Focus: Resident to resident interaction on 9/13/2024 and 9/14/2024 .Resident is the aggressor .Interventions: Keep the 2 (two) involved residents apart from each other .Provide redirection when needed . (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 - Actual harm Residents Affected - Few	A review of Resident 2's Progress Notes, dated September 30, 2024 at 11:01 a.m., indicated, .Resident was observed pulling another resident (Resident 1) out of their chair at approximately 10am unprovoked .Incident observed by staff (IP and DM) and staff unable to redirect resident (Resident 2) prior to him pulling the other resident (Resident 1) out of his chair . On October 2, 2024, Resident 1's admission record was reviewed. Resident 1 was admitted to facility on February 9, 2024 with diagnoses which included Bipolar Disorder (a mental illness that causes extreme mood swings). A review of Resident 1's History and Physical, dated February 9, 2024, indicated Resident 1 can make needs know but cannot make medical decisions. A review of Resident 1's Minimum Data set (MDS - an assessment tool), dated August 12, 2024, indicated Resident 1 had a Brief Interview for Mental Status (tool used to assess a resident's cognitive function) score of 10 (moderate cognitive impairment). A review of Resident 1's COC/Interact Assessment Form, indicated the following: - On September 13, 2024 at 6:34 p.m., indicated, .At 1834 (6:34 p.m.) in the hallway, outside room [ROOM NUMBER] .Staff heard a commotion between two residents .Resident was pushed by another resident on his right side of his head .; and - On September 14, 2024 at 10:45 a.m., indicated, .At 10:45 outside room [ROOM NUMBER] .Staff heard a commotion between two residents .Resident was hit by another resident on his right side of his head . A review of Resident 1's Care Plan, dated September 13, 2024, indicated, .Focus: Resident is at risk for emotional/psychosocial distress related to being victim of a resident to resident (Residents 1 and 2) altercation on 9/13/2024 and 9/14/2024 .Interventions: Keep the 2 involved resident apart from each other . Redirect resident when needed . A review of Resident 1's Progress Notes, indicated the following: - On September 30, 2024 at 10:00 a.m., indicated, .Staff reported that resident was on the floor after being pulled out of his chair at approximately 1000 am .Upon assessment resident complained of pain to the left side of his head and left shoulder .Sent to (name of hospital) for further evaluation . - On September 30, 2024 at 5:12 p.m., indicated, .Received resident from (name of company) transportation @ (at) 1603 hours (4:03 p.m.) .Resident has new diagnosis of closed fracture of left clavicle .Uses sling to support left arm . A review of Resident 1's General Emergency Department Discharge Instructions, dated September 30, 2024, indicated the following: - Diagnosis: Closed fracture of left clavicle .Victim of assault. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- XR (X-Ray) Shoulder 2 or More Views-Left .Findings: Minimally displaced distal clavicular fracture with regional soft tissue swelling. On October 2, 2024 at 11:25 a.m., during an interview with the Infection Preventionist (IP), she stated on September 30, 2024 around 10:00 a.m. she was with Resident 2 at the front lobby reception window and saw Resident 1 on his wheelchair coming in the lobby front door. The IP stated she asked the Dietary Manager (DM) to bring Resident 1 to the activity room to divert away from Resident 2 due to previous altercations with each other. The IP stated while the DM was wheeling Resident 1 down the lobby hallway, Resident 1 yelled (vulgar word) to Resident 2. The IP further stated Resident 2 charged towards Resident 1, grabbed his shirt, pulled Resident 1 off his wheelchair, and dropped him on the floor which caused Resident 1 to fall on his left side. The IP stated the DM should have redirected Resident 1 out of the lobby to the alternate entrance at the side of the facility and she should have redirected Resident 2 away from the lobby to prevent interaction between residents. The IP stated Resident 1 and Resident 2 should have been redirected on opposite direction of each other which could have prevented the altercation incident on September 30, 2024. On October 2, 2024 at 12:02 p.m., during an interview with the DM, she stated she was aware Resident 1 and Resident 2 had previous altercation incidents with each other and needed to be apart and redirected away from each other at all times. The DM stated on September 30, 2024 around 10:00 a.m., the IP asked her to bring Resident 1 into the activity room while the IP was with Resident 2 at the front lobby reception window. The DM stated she wheeled Resident 1 down the lobby hallway towards Resident 2 and the IP when Resident 1 turned his head and yelled (vulgar word) to Resident 2. The DM stated Resident 2 ran towards Resident 1 grabbed and pulled his shirt which caused Resident 1 to fall from the chair. The DM stated she should have redirected Resident 1 into the entrance at the side of the facility away from Resident 2 to prevent interaction between the residents which could have avoided the altercation incident on September 30, 2024. On October 2, 2024 at 1:44 p.m., during an interview and review of Resident 1 and Resident 2 ' s progress notes and care plans with the Director of Nursing (DON), she stated Resident 1 and Resident 2 had two previous altercations with each other on September 13 and 14, 2024. The DON stated all facility staff is aware to keep both residents apart from each other at all times. The DON stated Resident 1 and Resident 2 had a third altercation incident on September 30, 2024 around 10:00 a.m. in the front lobby where Resident 2 grabbed and flipped Resident 1's wheelchair which caused Resident 1 to fall on the floor to his left side. The DON further stated Resident 1 was sent to the hospital and came back in the facility with left clavicle fracture related to the fall. The DON stated the DM and the IP should have redirected Resident 1 and Resident 2 in the opposite direction of each other to avoid further contact which could have prevented the altercation incident. A review of the facility policy and procedure titled, Abuse & Mistreatment of Residents, undated, indicated, . Purpose: To uphold a resident ' s right to be free from .abuse .Facility shall make reasonable efforts to protect residents from harm .If the suspected perpetrator is another resident, residents shall be separated to avoid any further contact