STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555353	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Health Care Center	8965 Magnolia Avenue Riverside, CA 92503

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47374 Based on interview and record review, the facility failed to ensure an alleged physical abuse was reported to the California Department of Public Health (CDPH) and other officials immediately, but not later than 2 hours after the allegation was made. The facility was made aware of the alleged physical abuse of a facility staff to a resident on August 26, 2024. This failure had the potential to cause a delay in investigation of the alleged abuse and to expose residents in the facility to further abuse. Findings: On August 28, 2024, at 07:05 a.m., an unannounced visit was conducted at the facility to investigate an abuse allegation. On August 28, 2024, Resident 1 ' s record was reviewed. Resident 1 was admitted to the facility on [DATE], with Huntington ' s Disease (a progress disease and results in progressive, involuntary movements, thinking and psychiatric symptoms) and muscular weakness. A review of Resident 1's Minimum Data Set (MDS - an assessment tool) dated July 13,2024, indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a cognitive screening tool) score of 05 (cognitively severely impaired). A review of Resident 1's progress notes dated August 26 and August 27, 2024, indicated no change in physical or behavioral well-being. A review of the progress notes and care plans did not indicate documentation and interventions related to the alleged physical abuse. On August 28, 2024, at 0730 a.m., during a concurrent observation and interview with Certified Nurse (CNA) 3, CNA 3 stated she has not witnessed any verbal or physical abuse of staff or residents in her four years working at the facility. CNA 3 further stated if she did witness any kind of abuse, she would make sure resident is safe and she would report the incident immediately to the licensed nurse. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 28, 2024, at 07:37 a.m., during a concurrent observation and interview with Resident 2, the roommate of the Resident 1, the resident stated the staff have not verbally or physically mistreated him or any of the roommates. Resident 2 further stated he would have reported immediately because that would be important to him. On August 28, 2024, at 7:50 a.m., during an interview with Resident 1 with a Spanish interpreter, Resident 1 denied being slapped or hit by anyone, by shaking his head. On August 28, 2024, at 8:00 a.m., during a concurrent observation and interview with the RN Supervisor, the RN Supervisor stated she attended several in-services on ABUSE reporting, documentation, and procedures to follow. She stated if there were incidents of a resident to resident or a staff and resident altercations, she would make sure both parties are separated and assessed. In addition, she stated she would immediately notify Administration, the Director of Nursing, physicians, family, the Ombudsman, CDPH and sheriff. The RN Supervisor stated she would document and then update the care plan. On August 28, 2024, at 8:00 a.m., during an interview and concurrent chart review with the Director of Nursing (DON) in the DON ' s office, the DON stated she had the two student nurses and the Director of the Training facility on August 26, 2024, at approximately 1:00 p.m. expressed concerns of a witnessed physical abuse on Resident 1, who was slapped on the leg by CNA 1, when Resident 1 was being transferred to a shower chair. The DON further stated she immediately began an investigation of the alleged abuse, removed the CNA from work and interviewed CNA 1 and CNA 2 (assisting with the resident ' s transfer the time of the incident). The DON stated both the CNAs denied doing or seeing Resident 1 being slapped. CNA 1 explained the method of gentle tapping or patting the extremity to calm the resident ' s chorea movements and when the resident focused on the gentle tapping, the movements lessen. The DON stated CNA 1 was suspended pending investigation. The DON stated that the initial meeting with the students and the staff were also attended by the Social Services Director (SSD) and the Director of Staff Developement (DSD). The DON stated after the investigation of the incident, it was determined that there was a misunderstanding of the calming methods used and CNA 1 was allowed to return to work the next shift, though not to care for Resident 1. The DON further stated the alleged incident was not reported as it was found to be unsubstantiated. On August 28, 2024, at 11:05 a.m., an interview with the SSD to review incident and the meetings that were attended. She stated the student expressed concern of abuse when CNA 1 slapped the leg of Resident 1, and the student explained that Resident 1 was trying to hit and kick the CNA. The SSD stated CNA 2 did not see any slapping and explained the resident has continuous movements because of his disease. The SSD stated CNA 2 further explained CNA 1 was tapping on the resident ' s leg, in a rhythmic way, which usually calms the movements allowing resident to be transferred without injury. The SSD stated the Interdisciplinary Team met after the investigation to review and the team agreed it was unsubstantiated. On August 28, 2024, at 1:15 p.m., an interview with the DON to review and clarify the incident and the outcome of the investigation, the DON stated incident was not sent to CDPH as an investigation was completed in house. The DON stated there was no slapping incident but it was the usual intervention to calm Resident 1, by softly patting or tapping. The DON stated acknowledged the incident should have been reported, even if it was a suspected abuse. The DON also acknowledged even without injury the facility should have reported to CDPH, in accordance with their facility policy, even a suspicion must be reported immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. Dated October 2023, indicated, allegations of abuse .are reported to local, state and federal agencies (as required by current regulations) .abuse, neglect .must be immediately reported . state licensing/certification agency .within two hours of any allegation involving abuse .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47374 Based on interview, and record review, the facility failed to review and revise the care plan for one of five residents reviewed (Residents 1) based on the changing needs of the resident who has involuntary twitching and jerking movement related to a disease process. This failure had the potential to result in increased discomfort and possibility of injury to the resident. Findings: On August 28, 2024, at 7:05 a.m., an unannounced visit was conducted at the facility to investigate an abuse allegation. On August 28, 2024, Resident 1 ' s record was reviewed. Resident 1 was admitted to the facility on [DATE], with Huntington ' s Disease (an incurable neurodegenerative disease that is mostly inherited) and muscular weakness. A review of the Minimum Data Set (MDS - an assessment tool) dated July 13, 2024, indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a cognitive screening tool) score of 05 (cognitively severely impaired). The care plan titled, The resident has an alteration in neurological status INVOLUNTARY TWITCHING/JERKING r/t disease process HUNTINGTON ' S CHOREA DZ(diagnosis) . dated 10/03/2022, was reviewed. The care plan goals and interventions were initiated on 10/03/2022. There was no documented evidence the care plan was periodically reviewed and updated to reflect the goals and objectives were met and interventions were effective addressing interventions to assist control resident ' s involuntary movements, related to Huntington ' s Chorea. On August 28, 2024, at 08:00 a.m., during an interview with Registered Nurse (RN) 1, RN 1 stated she was not aware of Resident 1's care plan being revised recently with new goals and interventions for Resident 1 ' s involuntary twitching and jerking related to Huntington ' s Chorea. On August 28, 2024, at 11:05 a.m., during an interview with the Social Services Director (SSD), the SSD stated CNA 1 had been caring for Resident 1 for long time and the method of rhythmic tapping on Resident 1 ' s extremity, seemed to cause movements to lessen. The SSD further stated CNA 2 explained CNA 1 was tapping on the resident ' s leg, in a rhythmic way which would usually calm the movements allowing resident to be transferred without injury. The SSD stated she was unaware if that intervention had been added to Resident 1 ' s care plan. On August 28, 2024, at 1:15 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON stated the tapping and gentle patting was not included in Resident 1 ' s care plan as each nurse has different methods. The DON acknowledged the importance of including effective, safe interventions in care plans to allow for person-centered care.