

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555711	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Community Care on Palm		STREET ADDRESS, CITY, STATE, ZIP CODE 4768 Palm Avenue Riverside, CA 92501	

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 - 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** 39920</p> <p>Based on observation, interview, and record review, the facility failed to protect the resident ' s right to be free from physical abuse for one out of six residents reviewed (Resident 2), when another resident (Resident 1) hit Resident 2 on the head with a cane.</p> <p>This failure resulted in Resident 2 sustaining four lacerations (deep cut/tear in skin) on his head and bruising to his hands and shoulder. Resident 2 was transferred to the acute hospital, where he received 18 staples (surgical staples - used to close large wounds or deep cuts) to treat his head wounds.</p> <p>Findings:</p> <p>On June 4, 2024, at 9:10 a.m., an unannounced visit was made to the facility to investigate a facility-reported resident-to-resident altercation between Resident 1 and Resident 2 on June 1, 2024.</p> <p>On June 4, 2024, at 9:30 a.m., Resident 1 was interviewed. Resident 1 was alert and oriented. Resident 1 stated he did hit his former roommate (Resident 2) in the head with a cane because he thought Resident 2 messed with his radio. Resident 1 stated the cane was not his and he did not remember how he got the cane.</p> <p>On June 4, 2024, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain dysfunction), schizoaffective disorder, bipolar type (schizophrenia - hallucinations, delusions, mixed with extreme mood swings), Alzheimer ' s disease (memory loss and confusion), and impulse disorder (difficulty controlling emotions and behaviors). Resident 1 ' s BIMS (Brief Interview for Mental Status - an assessment tool) score was 10, indicating moderate cognitive (thinking) impairment.</p> <p>Resident 1's care plan, dated December 20, 2023, was reviewed. The care plan indicated, .Episodes of physical and verbal aggression: [episodes of agitation .breaking windows, property destruction, removing signs from walls, taking iPad chargers, etc .Goal .Will demonstrate effective coping skills .</p> <p>Resident 1's care plan, dated January 24, 2024, was reviewed. The care plan indicated, .Impulse control disorder m/b (manifested by) mood swings .</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's psychiatry (physician who treats mental illness) note, dated May 16, 2024, was reviewed. The note indicated, .Psych consulted with resident (Resident 1) today. Pt (patient - Resident 1) continues to display behaviors that require medication to manage. Pt continues to display disruptive behaviors. Pt will pull objects off the walls such as hand sanitizer dispensers, artwork, or posters for no reason. Pt with positive symptoms of schizophrenia. Pt with positive auditory hallucinations .</p> <p>On June 4, 2024, at 10:40 a.m., a concurrent observation and interview was conducted with Resident 2, in his room. Resident 2 was alert and confused. Resident 2 was observed with multiple staples on the top of his head. Resident 2 stated he did not remember what happened, how he acquired the wounds.</p> <p>On June 4, 2024, Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included disorder of the brain, epilepsy (brain disease causing seizures), legal blindness, difficulty walking, dementia (memory loss and lack of judgement), schizoaffective disorder (combination of schizophrenia - hallucinations, delusions - and mood disorder). Resident 2 ' s BIMS score was 0, indicating severe cognitive impairment.</p> <p>Resident 2's skin observation tool notes (a nursing assessment), dated June 1, 2024, was reviewed. The notes indicated Resident 2 sustained four lacerations to the top of his head that required 18 staples, a left-hand laceration, and discoloration to both hands and left shoulder related to the resident-to-resident altercation on June 1, 2024.</p> <p>On June 4, 2024, at 10:16 a.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON stated Resident 1 had a history of schizophrenia, had episodes of hitting himself and was violent against property (broke a window a few months ago).</p> <p>On June 4, 2024, at 11:15 a.m., the Director of Nursing (DON) was interviewed. The DON stated Resident 1 had a history of property destruction, but no history of physical aggression. The DON stated Resident 1 ' s physical aggression towards Resident 2, on June 1, 2024, resulted in physical injuries to Resident 2 and it was the facility policy that no resident should be subjected to any kind of abuse.</p> <p>On June 4, 2024, at 11:38 a.m., a telephone interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 1 had a history of moments of aggression, hitting physical things and objects.</p> <p>On June 4, 2024, at 11:46 a.m., the Social Worker (SW) was interviewed. The SW stated she witnessed Resident 1 a few weeks ago yelling and cursing, stating I can do whatever I want and taking papers with other resident names off the wall.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On June 7, 2024, at 4:15 p.m., a telephone interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated he witnessed the incident involving Resident 1 and Resident 2 on June 1, 2024, shortly after midnight. CNA 1 stated Resident 1 hit Resident 2 three times in the head with a cane. CNA 1 witnessed Resident 2 sitting on the floor in his room, and Resident 1 was in his wheelchair, leaning forward when he hit Resident 2 with the cane. CNA 1 stated there was blood on Resident 2 ' s face and head. CNA 1 stated Resident 2 sustained a bloody head injury from being hit by Resident 1 with a cane. CNA 1 stated no abuse, including resident to resident abuse was allowed, per facility policy.</p> <p>The facility policy and procedure titled, Abuse Prevention Program, revised December 2016, was reviewed. The policy and procedure indicated, .Our residents have the right to be free from abuse .This includes but is not limited to .physical abuse .Protect our residents from abuse by anyone including .other residents .</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39920</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for one out of six residents reviewed for accidents, when Resident 1 had access to a cane which he used to hit Resident 2.</p> <p>This failure resulted in Resident 2 sustaining four lacerations (deep cut/tear in skin) on his head and bruising to his hands and shoulder. Resident 2 was transferred to the acute hospital, where he received 18 staples (surgical staples - used to close large wounds or deep cuts) to treat his head wounds.</p> <p>Findings:</p> <p>On June 4, 2024, at 9:10 a.m., an unannounced visit was made to the facility to investigate a facility-reported resident-to-resident altercation.</p> <p>On June 4, 2024, at 9:10 a.m., the Director of Nursing (DON) was interviewed. The DON stated Resident 1 had a history of property destruction. The DON stated Resident 1 hit Resident 2 with a cane on June 1, 2024. The DON stated Resident 1 did not use or have a cane. The DON stated the cane belonged to Resident 3, who often left it around the facility, such as outside the DON office or in the hallway, where other residents had access to it. The DON stated Resident 1 ' s physical aggression towards Resident 2 resulted in physical injuries to Resident 2.</p> <p>On June 4, 2024, at 9:30 a.m., Resident 1 was interviewed. Resident 1 was alert and able to answer questions. Resident 1 stated he did hit his former roommate (Resident 2) in the head with a cane, at night, a few days prior but did not remember the details. Resident 1 stated the cane was not his, he did not have a cane and he did not remember how he got the cane.</p> <p>On June 4, 2024, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain dysfunction), schizoaffective disorder, bipolar type (schizophrenia - hallucinations, delusions, mixed with extreme mood swings), Alzheimer ' s disease (memory loss and confusion), and impulse disorder (difficulty controlling emotions and behaviors). Resident 1 ' s BIMS (Brief Interview for Mental Status - an assessment tool) score was 10, indicating moderate cognitive (thinking) impairment.</p> <p>Resident 1's care plan, dated December 20, 2023, was reviewed. The care plan indicated, .Episodes of physical and verbal aggression: [episodes of agitation .breaking windows, property destruction, removing signs from walls, taking iPad chargers, etc .Goal .Will demonstrate effective coping skills .</p> <p>Resident 1's care plan, dated January 24, 2024, was reviewed. The care plan indicated, .Impulse control disorder m/b (manifested by) mood swings .</p> <p>On June 4, 2024, at 10:40 a.m., a concurrent observation and interview was conducted with Resident 2. Resident 2 was alert and confused. Resident 2 was observed with multiple staples on the top of his head. Resident 2 stated he did not remember what happened.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On June 4, 2024, Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included disorder of the brain, epilepsy (brain disease causing seizures), legal blindness, difficulty walking, dementia (memory loss and lack of judgement), schizoaffective disorder (combination of schizophrenia - hallucinations, delusions - and mood disorder). Resident 2 ' s BIMS score was 0, indicating severe cognitive impairment.</p> <p>On June 4, 2024, at 9:53 a.m., Licensed Vocational Nurse (LVN) 2 was interviewed. LVN 2 stated Resident 1 had a history of confusion, forgetfulness, delusions, and hitting himself. LVN 2 stated Resident 1 did not have a cane, and his roommate (Resident 2) did not have a cane either. LVN 2 stated she did not know how Resident 1 got the cane. LVN 2 stated it was not safe for the residents to leave a cane out, staff should put it out of reach of residents, because it could be used as a weapon.</p> <p>On June 4, 2024, at 10:28 a.m., Resident 3 was interviewed. Resident 3 was alert and able to answer questions. Resident 3 stated he did have a cane, but he did not know where his cane was. Resident 3 stated he has not used the cane in a couple of months and did not need it anymore.</p> <p>On June 4, 2024, Resident 3's medical record was reviewed. Resident 3 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder, bipolar type, and lack of coordination.</p> <p>On June 4, 2024, at 10:16 a.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON stated Resident 1 had a history of schizophrenia, had episodes of hitting himself and was violent against property (broke a window a few months ago).</p> <p>On June 4, 2024, at 11:38 a.m., a telephone interview was conducted with LVN 1. LVN 1 stated Resident 1 had a history of moments of aggression, hitting physical things and objects.</p> <p>On June 7, 2024, at 4:15 p.m., a telephone interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated he witnessed the incident involving Resident 1 and Resident 2. CNA 1 stated Resident 1 hit Resident 2 three times in the head with a cane. CNA 1 stated Resident 2 sustained bloody head injuries from being hit by Resident 1 with a cane. CNA 1 stated Resident 1 did not have a cane and he did not know how Resident 1 got the cane. CNA 1 stated the cane should not have been left unattended for residents ' safety.</p> <p>The facility policy and procedure titled, Safety and Supervision of Residents, revised July 2017, was reviewed. The policy and procedure indicated, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .</p>		