STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555887	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Special Care Center	11962 Woodside Avenue Lakeside, CA 92040

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 - 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** 49330 Based on observation, interview, and record review, the facility failed to ensure 1 of 6 residents (Resident 2) was free from physical abuse when Resident 1, who had a history of hearing voices and responding with physical aggression, was removed from 1:1 supervision (continuous supervision provided by an assigned staff member) and placed on q15 (every 15 minutes) location monitoring which the facility had determined was ineffective in managing the resident's aggressive behavior. As a result, Resident 1, while on q15 location monitoring, hit Resident 2 in the eye. Resident 2 sustained a bruise to the right eye and was sent to the hospital for evaluation. This had the potential for Resident 2 to experience pain, psychosocial distress, and trauma. Findings: A review of Resident 2's Admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental disorder characterized by abnormal though processes and an unstable mood), and impulse disorder (a condition that makes it difficult to control actions or reactions). A review of Resident 1's Psychiatry Progress notes, dated 6/19/23, indicated resident had auditory hallucinations (hearing things that are not there) and he continues to endorse voices, grandiose delusions [false beliefs], and violent impulses. A review of Resident 1's nursing progress notes indicated that the resident had altercations on the following dates: 5/14/23 at 5:35 P.M. - Resident 1 came into the dining room and hit the female resident with a full lotion container, hit the female resident in the L (left) side of the face . Resident 1 was heard swearing/posturing screaming/yelling and said ' how do you like it [expletive]? (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555887	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Special Care Center	11962 Woodside Avenue Lakeside, CA 92040

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 - Few	6/10/23 at 3:07 P.M. - Resident 1 threw water at two different CNA (certified nurse assistant) staff and half cup of water at LN (licensed nurse). Resident (Resident 1) stated he is hearing voices .Resident (Resident 1) then later went into the hallway and attempted to throw a bottle of lotion at peer, but hit CNA thigh. 6/12/23 at 10:47 P.M. - Resident 1 was on monitoring q15 due to aggressive behavior towards peers. A review of Resident 1's Behavior note, dated 6/12/23 at 12:29 P.M., indicated Resident 1 threw water at a peer and picked up a chair and hit peer with the chair. 12/29/23 at 1:30 P.M. - Resident 1 stuck [sic] peer in the hallway in face . 1/6/24 at 8:17 A.M. - Resident 1 was involved in an incident in which he struck a peer. 1/17/24 at 8:41 P.M. - the resident continued expressing thoughts of harming others, stating ' the voices in my head are telling me to hurt you. They want me to rape.' 2/17/24 at 2:23 P.M. - writer heard a disturbance from down the hallway. [Resident 1] assaulted select peer x2 unprovoked .when conversating about why he did it he explained that the voices told him to do it. A review of Resident 1's interdisciplinary team (IDT- a group of healthcare professionals with various areas of expertise) note, dated 1/18/24 at 8:43 A.M., indicated Resident 1 became agitated while responding to internal stimulation, resulting in him assaulting a peer and as of recent [Resident 1] has been involved in multiple instances in which [Resident 1] has acted in an aggressive manner, making assaultive physical contact with peers. All the noted incidents are related to his hallucinations, voices instructing him to harm others. The note further indicated, the team has implemented various approaches; IE Q-15 checks [location monitoring] .None of the above have been successful in altering assaultive behavior. Resident 1 was sent to an acute psychiatric hospital for further evaluation per the IDT note. A review of Resident 1's IDT note dated, 1/29/24, indicated that Resident 1 returned to the facility from a psychiatric hospital. Per the IDT note, the resident was calm upon returning from the psychiatric hospital, however despite [Resident 1's] current disposition the potential for combative/assaultive behavior remain. 1:1 monitoring was implemented as a new approach ensure the safety of the residents. A review of Resident 1's IDT note, dated 2/14/2024 at 12 P.M., indicated that Resident 1's 1:1 supervision was discontinued, due to appropriately seeking out nursing staff to verbalize feelings. According to the note, Resident 1 was placed on q15 minute safety checks (location monitoring). On 2/22/24 at 12 P.M., an interview was conducted with the Program Counselor (PC). The PC stated that 1:1 monitoring worked well for Resident 1. The PC stated that 1:1 monitoring allowed Resident 1 to have a staff member present to talk to him during episodes of hearing voices/hallucinating. The PC further stated 1:1 monitoring kept others safe from Resident 1 and Resident 1 may not always self-report hearing voices if he is only on q15 monitoring. The PC stated that Resident 1 is not 100% fine, he is fine until the voices get to him. He responds well when someone is right there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555887	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Special Care Center	11962 Woodside Avenue Lakeside, CA 92040

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 - Few	On 3/6/24 at 9:15A.M., an interview with Resident 2 was conducted. Resident 2 stated while walking down the hall in Cottage 2, Resident 1 told him to eff off and hit Resident 2 on the outer corner of his right eye. Resident 2 stated he fell to his knees and had pain in his right eye. On 3/6/24 at 12:55P.M., an interview with CNA 1 was conducted. CNA 1 stated a q15 monitoring meant to see what residents are doing and where they are and that they are only documenting the resident's location. CNA 1 stated that during a 1:1 monitoring, Resident 1 was constantly reassured and reminded to report hearing voices. CNA 1 stated asking [the resident] if they are ok would help more than just looking to see where they are. On 3/7/24 at 1:50 P.M., an interview was conducted with LN 1 and LN 2. LN 1 stated that Resident 1 had no incidences of physical aggression while on 1:1 monitoring. LN 1 stated that while on 1:1 monitoring, the CNA would bring Resident 1 to the licensed nurse and talk him down. LN 1 and LN 2 both stated that 1:1 monitoring worked well for Resident 1 and Resident 1 should have stayed on 1:1 monitoring to prevent physical aggression towards others. On 3/6/24 at 12:15 P.M., a joint record review and interview was conducted with the facility's Assistant Director of Nursing (ADON). A record review indicated Resident 1 did not have any incidences of physical or verbal aggression while on 1:1 monitoring. The ADON stated that Resident 1 was placed on 1:1 safety monitoring on 1/29/24 to not put people at risk. The ADON indicated that q15 safety checks meant putting eyes on a resident and noting their location on the unit and demeanor. The ADON stated that Resident 1 should not have been downgraded to q15 safety checks from 1:1 monitoring. The ADON stated physical abuse occurred with Resident 2. On 3/6/2024 at 12:50 P.M., an interview was conducted with the administrator (ADM) who stated Resident 2 was not free from physical abuse. The ADM further stated, that's why we reported it. A review of the facility's policy titled Abuse Prevention Program effective 7/1/20 indicated Our residents have the right to be free from abuse .As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to .other residents .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555887	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Special Care Center	11962 Woodside Avenue Lakeside, CA 92040

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on interviews and record review, the facility failed to develop an individualized care plan for one of seven residents (Resident 1) when Resident 1's care plan did not address the resident's behavior of responding to auditory hallucinations by hitting others. This failure had the potential for Resident 1 to not receive the care he needed and could potentially result in Resident 1 injuring himself or others. Findings: A review of Resident 1's undated Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental disorder characterized by abnormal though processes and an unstable mood), impulse behavior (a condition that makes it difficult to control actions or reactions). A review of Resident 1's Nursing Progress Note, dated 1/29/24, indicated the resident returned to the facility from an acute psychiatric hospital. The progress note further indicated that the recent acute stay was in relation to [Resident 1]'s increase in internal stim [sic] with commands to harm others. The progress note indicated Resident 1 was placed on 1:1 supervision (continuous supervision for the resident by an assigned staff member). A review of Resident 1's Nursing Progress Note, dated 2/14/24, indicated Resident 1 was appropriately seeking out nursing staff to verbalize feelings and 1:1 supervision discontinued per IDT (define) review . [Resident 1] placed on q15 min (every 15 minutes) safety checks (monitoring the resident's location and activity every 15 minutes). A review of Resident 1's Nursing Progress Note, dated 2/19/24, indicated Resident 1 struck another resident, Resident 2, on the side of the face. During an interview with Certified Nurse Assistant (CNA) 1 on 2/22/24 at 11:40 A.M., CNA1 stated q15 monitoring consisted of tracking and logging Resident 1's whereabouts and activity (ie. standing, sitting in bed, etc). CNA 1 stated 1:1 monitoring was effective for Resident 1 because Resident 1 would not always let staff know when he was hearing voices. CNA 1 stated that when a resident was placed on 1:1, there was always someone there to talk to. During an interview with the Program Counselor (PC), the PC stated that 1:1 monitoring kept others safe from Resident 1. The PC stated that Resident 1 did not always self-report voices and did not always tell staff how he was feeling. With 1:1 monitoring, a staff member was always present to redirect Resident 1 and [Resident 1] responded well when someone is right there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555887	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Special Care Center	11962 Woodside Avenue Lakeside, CA 92040

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Nurse (LN) 1 on 3/6/24 at 1:40 P.M., LN 1 stated Resident 1 had no incidents of aggression during 1:1 monitoring. LN 1 stated during 1:1 monitoring, Resident 1 told the assigned staff member when he was hearing voices. LN 1 stated the assigned staff member would bring Resident 1 to a licensed nurse for a PRN (as needed) medication before Resident 1 had an opportunity to become physically aggressive due to hearing voices. During an interview with LN 2 on 3/7/24 at 11:00 A.M., LN 2 stated the purpose of a care plan was to direct staff on what care should be provided to a resident. LN 2 stated care plan interventions should be individualized based on a resident's specific needs. LN 2 stated developing an individualized care plan provides the best possible care for a resident. On 3/7/24 at 12:15 P.M., a concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON). A review of an IDT (Interdisciplinary Team) note from 1/18/24 listed various approaches implemented to address Resident 1's aggressive behavior. One of the approaches was q15 monitoring. The IDT note indicated, None of the above [approaches] have been successful in altering assaultive behavior. The ADON stated that Resident 1 should not have been downgraded to q15 safety checks from 1:1 monitoring. Per ADON, Resident 1 did not regularly self-report episodes of auditory hallucinations. The ADON stated 1:1 monitoring would have been more effective to monitor Resident 1's mood/distressed behaviors. The ADON stated individualizing the care plan for Resident 1 might have worked better for him instead of just checking his location. A review of the facility's Policy and Procedure entitled Abuse-Resident to Resident Altercation indicated, The interdisciplinary team completes a resident assessment and develops a care plan to address resident's distressed behaviors.