STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. BUILDING _____ B. WING _____	**06/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK AVENUE HEALTHCARE & WELLNESS CENTER	**1550 NORTH PARK 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)
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interviews and record reviews, the facility failed to have a policy and procedure that include to immediately report of all alleged abuse to the state agency and not later than two hours after the allegation is made. This deficient practice has the potential to delay the investigation by the state agency and expose the residents in an environment of abuse and mistreatment. Findings: On 5/16/18 at 2 p.m., an unannounced visit was made to the facility to investigate a facility reported incident about an alleged resident-to-resident abuse. During a telephone interview on 5/16/18 at 3:25 p.m., the facility's activity assistant (AA 1) stated that on 4/29/18, Resident 1 was on his wheelchair in the dining room since 9 a.m. At around 9:40 a.m., Resident 2 came to the dining room to attend an activity. During the activity, Resident 1 and 2 had an altercation with each other that led to Resident 2 hitting Resident 1 on his face. AA 1 stated that she reported the incident immediately to the facility's Manager of the Day (MOD) since she was the only staff who witnessed the event. During a telephone interview on 5/16/18 at 4:10 p.m., the MOD stated that AA 1 promptly reported the 4/29/18 incident to him. After being aware of the event, he faxed an SOC to the state agency, ombudsman, and to the police department. The MOD stated that the facility is required to notify the state agency and to other officials within 24 hours an abuse incident that did not result to a serious bodily injury. He stated that he was not aware that the facility was required to report an allegation of an abuse incident within 2 hours, regardless if the incident resulted to a serious bodily injury or not. A review of the facility's transmission log report, dated 4/29/18, indicated that the facility notified the state agency, Ombudsman, and the police department at 5:11 p.m. via facsimile. A review of the facility's policy and procedure titled, Abuse - Reporting & Investigations, version 2.0, revised in September 2017, indicated that the administrator or designated representative would notify the police department, ombudsman, and CDPH Licensing and Certification by telephone followed by a written report within 24 hours of a report of an alleged physical abuse. The facility's policy and procedure had not been updated in accordance with the federal requirement.
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** Based on interviews and record reviews, the facility failed to report an alleged abuse incident to the state agency and to other officials within two hours after two of four sampled residents (Resident 1 and 2) had a physical altercation. This deficient practice resulted in the delay of the investigation by the state agency and has the potential to expose the residents in an environment of abuse and mistreatment. Findings: A review of Resident 1's face sheet (admission record) indicated that the facility admitted Resident 1 on 9/28/09 and readmitted the resident on 8/25/16. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's minimum data set (MDS), a resident assessment and care-screening tool, dated 2/19/18, indicated that Resident 1's cognition was moderately impaired. The MDS indicated that Resident 1 required limited assistance to total dependence from at least one person to perform activities of daily living (ADLs) such as dressing, eating, toilet use, and personal hygiene. The MDS indicated that Resident 1 uses a wheelchair for mobility. A review of Resident 2's face sheet indicated that the facility admitted Resident 2 on 10/30/17 and readmitted the resident on 5/9/18. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's MDS, dated [DATE], indicated that Resident 2's cognition was severely impaired. The MDS indicated that Resident 2 required extensive assistance to total dependence from a person to perform activities of daily living (ADLs) such as dressing, eating, toilet use, personal hygiene and walking in the room and corridors. On 5/16/18 at 2 p.m., an unannounced visit was made to the facility to investigate a facility reported incident about an alleged resident-to-resident abuse. During a telephone interview on 5/16/18 at 3:25 p.m., the facility's activity assistant (AA 1) stated that on 4/29/18, Resident 1 was on his wheelchair in the dining room since 9 a.m. At around 9:40 a.m., Resident 2 came to the dining room to attend an activity. During the activity, Resident 1 and 2 had an altercation with each other that led to Resident 2 hitting Resident 1 on his face. AA 1 stated that she reported the incident immediately to the facility's Manager of the Day (MOD) since she was the only staff who witnessed the event. During a telephone interview on 5/16/18 at 4:10 p.m., the MOD stated that AA 1 promptly reported the 4/29/18 incident to him. After being aware of the event, he faxed an SOC to the state agency, ombudsman, and to the police department. The MOD stated that the facility is required to notify the state agency and to other officials within 24 hours an abuse incident that did not result to a serious bodily injury. He stated that he was not aware that the facility was required to report an allegation of an abuse incident within 2 hours, regardless if the incident resulted to a serious bodily injury or not. A review of the facility's transmission log report, dated 4/29/18, indicated that the facility notified the state agency, ombudsman, and the police department at 5:11 p.m. via facsimile. A review of the facility's policy and procedure titled, Abuse - Reporting & Investigations, version 2.0, revised in September 2017, indicated that the administrator or designated representative would notify the police department, ombudsman, and CDPH Licensing and Certification by telephone followed by a written report within 24 hours of a report of an alleged physical abuse. The facility has not revised its abuse reporting policy in according with the new federal requirement.

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

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.