STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555487	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION DE LA CASA NURSING & REHABILITATION CENTER	**2501 ALVIN AVENUE SAN JOSE, CA 95121**

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 interview and record review, the facility failed to implement their abuse policy for two of four sampled residents (Residents 1 and 2) when: 1. Staff did not immediately separate the residents after Resident 1 was bitten by Resident 2; and 2. The licensed nurse did not follow abuse reporting requirements after she was made aware of the incident. These failures had the potential to compromise the residents' safety and to delay investigation of the incident. Findings: Review of Resident 1's Change of Condition note dated 2/25/2020, indicated that while giving the resident a shower, staff noted a purplish discoloration on his right hand down to wrist area. When asked what happened to his hand, Resident 1 stated Resident 2 bit his hand the previous day ([DATE]20). Review of Resident 1's Progress Note, dated 2/25/2020, indicated staff suspected Resident 1 was involved in physical abuse with Resident 2. The note indicated Resident 1 verbalized that Resident 2 bit him the previous day. During an interview with unit manager A (UM A) on 3/4/2020 at 1:40 p.m., she explained that on [DATE]20, Resident 1 and restorative nursing assistant B (RNA B) were in Resident 2's room trying to encourage her to get out of bed. Resident 2 became agitated and bit Resident 1's hand. UM A stated that when she questioned RNA B about the incident on a later date, RNA B indicated she notified Resident 1's nurse about the incident when it occurred. UM A added that she was working on [DATE]20 and did not get any report about the incident on that day. UM A stated that if Resident 1's nurse was aware of the incident, she should have reported it right away. During an interview with Resident 1 on 3/4/2020 at 2:50 p.m., he explained that on the day of the incident, he was trying to help staff encourage Resident 2 to get out of bed when she became agitated and bit his hand. Resident 1 stated after the biting incident, Resident 2 calmed down and they spent the rest of the day together afterward. Resident 1 stated the staff saw Resident 2 bite his hand. During an interview with the director of staff development (DSD) on 3/4/2020 at 3:05 p.m., she confirmed that biting was considered a form of physical abuse. The DSD stated staff should have separated Residents 1 and 2 immediately. She further stated the nurse who was aware of the incident was a mandated reporter and should have reported it to her immediate supervisor, the director of nursing (DON), the social services director (SSD) and the administrator (ADM). During an interview with RNA B on 3/5/2020 at 9:00 a.m., she confirmed on [DATE]20, she saw Resident 2 bite Resident 1 and she reported the incident to licensed nurse C (LN C). RNA B confirmed staff did not separate the residents immediately after the incident. RNA B stated LN C did not give any instruction to separate the residents. During an interview with LN C on 3/6/2020 at 3:20 p.m., she confirmed she was informed about the incident between Residents 1 and 2 at the time it occurred. LN C stated she was aware that she was supposed to notify her supervisors about what happened, but she did not do so. LN C confirmed that staff did not separate the residents after the incident and stated she did not recall that she was supposed to do so. Review of the facility's policy, Abuse Prevention and Prohibition Program, revised 1/30/2020, indicated If the allegation is regarding a resident-resident altercation, the residents will be separated immediately, pending the investigation. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and the California Elder Abuse and Dependent Adult Civil Protection Act to report known or suspected instances of elder or dependent adults. Facility Staff will report known or suspected instances of abuse to the Administrator, or his/her designee.

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.