

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555852	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2020
NAME OF PROVIDER OF SUPPLIER PARK AVENUE HEALTHCARE & WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 0609 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on the interview and record review the facility failed to report an abuse allegation to the [ST] Department of Public Health (CDPH) and to other officials within two hours for one of three sampled residents (Resident 1) in accordance with the mandated Federal and State regulatory guidelines and the facility's policy and procedures. This deficient practice had the potential for the facility to under report allegations of abuse, which could lead to failure to investigate abuse in a timely manner. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility, on [DATE], with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care planning tool) dated 11/25/20, indicated Resident 1 was communicative and was cognitively intact. Resident 1 required extensive assistance (needing staff support) with activities of daily living and was wheelchair bound. During an interview, on 2/28/20 at 3:15 p.m., the Director of Nursing (DON) stated Resident 1 had made a false abuse allegation in the past. The DON stated a Licensed Vocational Nurse (LVN) was interviewed regarding Resident 1's abuse allegation. The DON said the Ombudsman had brought Resident 1's abuse allegation to his attention (no date provided). The DON stated there was no one in the facility, past or present that goes by the name of the abuser given by Resident 1. A record review of Resident 1's Behavioral/[MEDICAL CONDITION] Medication Care Plan, dated [DATE], indicated problem included feeling anxious and make false allegations. A record review of Resident 1's Social Work Progress Notes, dated 11/18/19, indicate Resident 1 was going to report of being abused. During an interview, on [DATE] at 9:30 a.m., the DON stated the Ombudsman had reported Resident 1's abuse allegation to the Administrator (no date provided) and would ask the Administrator for any documentation about the investigation of the abuse allegation. During an interview, on [DATE] at 11:15 a.m., the Director of Social Services (DSS) stated she was aware of Resident 1 voicing concerns of abuse to the Ombudsman. DSS stated she was unable to find any record that Resident 1's abuse allegation was reported to the Ombudsman. During an interview, on [DATE] at 11:37a.m., the Administrator stated the Ombudsman did tell him of the Resident 1's abuse allegation. The Administrator stated Resident 1's abuse allegation was not reported due to the facility did not have any staff members by the name of the abuser given by Resident 1. The Administrator stated the facility had determined the abuse allegation did not occur. A review of the facility's policy and procedures titled, Abuse-Reporting & Investigations, revised 3/2018, indicated the facility would promptly reports and thoroughly investigates allegations of resident abuse, mistreatment, neglect. The facility was to notification of outside agencies of allegations of abuse. The Administrator or designated representative will notify within two (2) hours by telephone, CDPH, the Ombudsman, and Law Enforcement. The Administrator or designated representative would send a written SOC 341 report to the Ombudsman, CDPH, and Law Enforcement within two (2) hours. The policy and procedure indicated that should the investigation reveal a false report was made/filed, the investigation will cease. Residents, family members, Long Term Care (LTC) Ombudsman, state agencies, etc., will be notified of the findings.</p>		
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.