STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INLAND VALLEY CARE AND REHABILITATION CENTER	**250 W. ARTESIA STREET 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 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** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) remained free from verbal abuse. Resident 2 told Resident 1 were roommates and Resident 2 had a history of [REDACTED]. Resident 2 was sent out to General Acute Care Hospital (GACH) and was readmitted to the facility and placed in the same room as Resident 1. This deficient practice resulted in Resident 1 fearing for her life and the potential for further verbal abuse. Findings: A review of the Admission Record (face sheet) indicated Resident 1 was admitted to the facility 4/24/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 5/1/19, indicated that Resident 1's cognition (ability to understand and make decisions) was intact. A review of the Admission Record (face sheet) indicated Resident 2 was admitted to the facility 11/21/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 11/27/19 indicated that Resident 2's cognition was moderately intact. A review of the Behavior care plan dated 12/3/19 indicated Resident 2 needed behavior management due to a tendency to be loud, use foul and offensive language. The care plan's goal was to be able to redirect the behavior and no altercation with her roommate (Resident 1). A review of the Departmental Notes dated 12/30/19 indicated Resident 1 was reporting that Resident 2 was pushing her with the wheelchair, flipping her off, and using foul language. A review of Departmental Notes (Registered Nurse 1, RN 1) dated 1/12/20 indicated at 6:30 pm, Resident 2 was acting aggressive toward Resident 1 and Resident 2 stated that Resident 1 was a witch. Resident 1 was crying because she feared Resident 2. Resident 1 stated that she felt threatened to be harmed by Resident 2 and was afraid to go back to her room. At 9:30 pm., Resident 2 was sent out to GACH for evaluation. A review of Departmental Notes (Licensed Vocational Nurse 1, LVN 1), dated 1/13/20, indicated that Resident 1 was readmitted to the facility at 5:40 am. Resident 2 was offered a different room and she refused. Resident 2 was placed back in the same room as Resident 1. A review of the Room Change Notification dated 1/13/20 indicated Resident 1 was given another room (located across the hallway from Resident 2) during the 3:00 - 11:00 pm. shift. On 1/27/20 at 9:50 am., a facility visit was made to investigate a complaint allegation regarding abuse. On 1/27/20 at 9:51 am., during an interview, Administrator stated that prior to 1/13/20 (incident date between Resident 1 and Resident 2), the facility was aware the Resident 1 did not want to be around Resident 2 because she did not feel safe. On 1/27/20 at 11:22 am., during an interview, Resident 1 stated that Resident 2 had boxed her up (blocking her path with the wheelchair) in the past and on 1/13/20, Resident 2 told her I'm going to kill you. Resident 1 stated that she was frightened and felt like Resident 2 meant business. Resident 1 stated that prior to the incident, she had made Administrator aware that she was afraid of Resident 2 and did not want to be around her. On 1/27/20 at 1:18 pm., during an interview, Social Service Director (SSD) stated that Resident 2 was readmitted by night shift staff and I don't know why they put them (Resident 1 and Resident 2) together. On 1/27/20 at 3:52 pm., during an interview, Certified Nursing Assistant 1 (CNA 1) stated that on 1/12/20, Resident 2 was combative with the staff and Resident 1. Resident 2 was screaming at Resident 1 get away from me, I'm going to kill you. On 1/27/20 at 4:03 pm., during an interview, RN 1 stated that on 1/12/20, Resident 1 was crying and scared to go back to her room because Resident 2 was threatening her and calling her a witch. RN 1 assessed Resident 2 and she was very angry. RN 1 stated that based on the assessment, she determined Resident 2 was a threat to Resident 1 because Resident 2 truly believed that Resident 1 was a witch and could walk a couple of steps. On 1/27/20 at 4:26 pm., during an interview, LVN 1 stated that RN 2 determined that Resident 2 was refusing to be placed in a different room upon readmission and it was ok to put her back in her old room with Resident 1. On 1/27/20 at 4:41 pm., during an interview, Director of Nursing (DON) stated that when residents feel threatened, the facility should separate them. DON stated that it the facility's responsibility to protect and keep all residents safe. A review of the Reporting Abuse to Facility Management policy and procedure revised December 2013 indicated the facility did not condone resident abuse by anyone. A review of the Abuse Prevention Program revised August 2006 indicated the residents have the right to be free from abuse and the facility was committed to protecting the residents from other residents.

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