STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. BUILDING _____ B. WING _____	**06/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA GLEN CARE CENTER	**638 E COLORADO AVENUE GLENDORA, CA 91740**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have a policy and procedure that include to report to the state agency within two hours, an alleged abuse incident for one of three sampled residents (Resident 1), who reported to the facility's staff that someone raped her. This deficient practice resulted in the delay of the investigation by the Department and had the potential to expose the residents in the unsafe environment. Findings: On 7/13/18 at 3 p.m., an unannounced visit was made to the facility to investigate a facility reported incident regarding sexual abuse. A review of Resident 1's face sheet (admission record) indicated that the facility admitted Resident 1 on 7/9/18. Resident 1's [DIAGNOSES REDACTED]. activities). A review of Resident 1's history and physical dated 7/12/18, indicated that Resident 1 does not have the capacity to understand and make decisions due to [DIAGNOSES REDACTED]. A review of the facility's facsimile transaction report dated, 7/12/18, indicated that the DSS faxed a copy of the abuse allegation notification to the ombudsman and to the state agency on 7/12/18 at 1:11 p.m. and 1:15 p.m. accordingly. During an interview on 7/17/18 at 1:40 p.m., the Director of Social Services Director (DSS) stated that on 7/12/18 at around 8:40 a.m., Resident 1 informed her that someone raped her yesterday at night (7/11/18) when she was smoking a cigarette outside the facility. The DSS stated that she reported the allegation to the Administrator (ADM) at around 9:30 a.m. and notified the ombudsman and the state agency thru fax at 1:15 p.m. The DSS stated that she was not sure how soon she had to report an abuse allegation to the state agency and to other officials, although the Director of Staff Development (DSD) gave an in-service on abuse reporting sometime in March 2018. During an interview on 7/17/18 at 2:40 p.m., the DSD stated that one of her main duties and responsibilities is to provide education to the staff. The DSD stated that she provided an in-service on abuse in March 2018 using the facility's policy titled, Abuse Prevention, revised in November 2017. The DSD stated that according to the policy, the facility should report an abuse allegation to the state agency and to other officials within 24 hours if the allegation did not result to a serious bodily injury. During an interview on 7/13/18 at 3:15 p.m., Resident 1 stated a nurse by the name of M (unable to provide the last name) wheeled her out of the facility into the neighborhood at around 6:30 p.m. M lit a cigarette and started a conversation with her. He told her that he wanted to get a woman or a man and wanted her to show him how. She replied, You better figure that out yourself. Resident 1 stated that M kept on asking her to teach him how to find a woman and started touching her arms and legs. She stated that M made her feel uncomfortable and asked him to take her back to the facility because he was emotionally raping her. When they returned to the facility, she immediately reported the incident to a male nurse (unable to identify) but the nurse refused to believe her and asked her to go to bed. When asked if someone raped her, she replied, No, I was not raped but I do not feel safe in the facility because the staff are holding me hostage. A review of the facility's policy and procedure titled, Abuse Prevention, revised in November 2017 indicated that the facility should report a reasonable suspicion of a crime against a resident to the law enforcement and to the Department of Public Health no later than two hours, only if the event results in serious bodily injury. Otherwise, the facility should report the incident no later than 24 hours. There was no revision of this policy to reflect the new federal guidelines which requiring the facility to report alleged violations involving abuse no later than two hours.
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 to the Department within two hours, an alleged abuse incident for one of three sampled residents (Resident 1), who reported to the facility's staff that someone raped her. This deficient practice resulted in the delay of the investigation by the Department and had the potential to expose the residents in the unsafe environment. Findings: On 7/13/18 at 3 p.m., an unannounced visit was made to the facility to investigate a facility reported incident regarding sexual abuse. A review of Resident 1's face sheet (admission record) indicated that the facility admitted Resident 1 on 7/9/18. Resident 1's [DIAGNOSES REDACTED]. activities). A review of Resident 1's history and physical dated 7/12/18, indicated that Resident 1 does not have the capacity to understand and make decisions due to [DIAGNOSES REDACTED]. A review of the facility's facsimile transaction report dated, 7/12/18, indicated that the DSS faxed a copy of the abuse allegation notification to the ombudsman and to the state agency on 7/12/18 at 1:11 p.m. and 1:15 p.m. accordingly. During an interview on 7/17/18 at 1:40 p.m., the Director of Social Services Director (DSS) stated that on 7/12/18 at around 8:40 a.m., Resident 1 informed her that someone raped her yesterday at night (7/11/18) when she was smoking a cigarette outside the facility. The DSS stated that she reported the allegation to the Administrator (ADM) at around 9:30 a.m. and notified the ombudsman and the state agency thru fax at 1:15 p.m. The DSS stated that she was not sure how soon she had to report an abuse allegation to the state agency and to other officials, although the Director of Staff Development (DSD) gave an in-service on abuse reporting sometime in March 2018. During an interview on 7/17/18 at 2:40 p.m., the DSD stated that one of her main duties and responsibilities is to provide education to the staff. The DSD stated that she provided an in-service on abuse in March 2018 using the facility's policy titled, Abuse Prevention, revised in November 2017. The DSD stated that according to the policy, the facility should report an abuse allegation to the state agency and to other officials within 24 hours if the allegation did not result to a serious bodily injury. During an interview on 7/13/18 at 3:15 p.m., Resident 1 stated a nurse by the name of M (unable to provide the last name) wheeled her out of the facility into the neighborhood at around 6:30 p.m. M lit a cigarette and started a conversation with her. He told her that he wanted to get a woman or a man and wanted her to show him how. She replied, You better figure that out yourself. Resident 1 stated that M kept on asking her to teach him how to find a woman and started touching her arms and legs. She stated that M made her feel uncomfortable and asked him to take her back to the facility because he was emotionally raping her. When they returned to the facility, she immediately reported the incident to a male nurse (unable to identify) but the nurse refused to believe her and asked her to go to bed. When asked if someone raped her, she replied, No, I was not raped but I do not feel safe in the facility because the staff are holding me hostage. A review of the facility's policy and procedure titled, Abuse Prevention, revised in November 2017 indicated that the facility should report a reasonable suspicion of a crime against a resident to the law enforcement and to the Department of Public Health no later than two hours, only if the event results in serious bodily injury. Otherwise, the facility should report the incident no later than 24 hours. There was no revision of this policy to reflect the new federal guidelines which requiring the facility to report alleged violations involving abuse no later than two hours.

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.