| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **056117** | A. BUILDING _____ B. WING _____ | **04/07/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **THE ROWLAND** | **330 W. ROWLAND STREET COVINA, CA 91723** |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to report an allegation of abuse to the Department and other officials immediately, but not later than two hours for one of two sampled residents (Resident 1) in accordance with the mandated Federal and State regulatory guidelines. This deficient practice had the potential for the facility to under report allegations of abuse, which could lead to failure to investigate alleged abuse in a timely manner. Findings: A review of Resident 1's Admission Record, indicated the facility admitted the resident on 7/11/17, with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 1/22/2020, indicated Resident 1 usually understood others and usually made herself understood, had short and long term memory problem and severe impairment in cognition (mental process involved in knowing, learning, and understanding things). Resident 1 required limited assistance with bed mobility and transfer, extensive assistance with locomotion on and off unit, dressing and personal hygiene, and total assistance with toilet use and bathing. During an interview on [DATE] at 8:45 a.m., the Administrator stated he received an electronic mail (e-mail) from Family Member 2 (FM 2) claiming that a facility staff rough handled Resident 1. During an interview and concurrent record review on [DATE] at 9 a.m., the Administrator provided a copy of the e-mail from FM 2 dated [DATE]20. The Administrator stated FM 2 was requesting for the name and state certification number of a male certified nursing assistant (CNA 1). The Administrator stated FM 2 spoke to him sometime in 2/2020, and claimed CNA 1 rough handled Resident 1's. The Administrator stated he provided FM 2 with CNA 1's name on 2/12/2020. The Administrator indicated on his e-mail response to FM 2, that there were no complaints about CNA 1. During an observation on [DATE] at 9:40 a.m., Resident 1 was observed awake in bed. Resident 1 stated she liked being in the facility because everyone was nice to her. Resident 1 stated no one has mistreated her or handled her roughly. During an interview on [DATE] at 11:15 a.m., the Administrator stated some time on the first week of February, FM 2 visited Resident 1 and claimed that a male CNA brought in Resident 1's dinner tray and pulled Resident 1's arm roughly to get the resident out of bed. The Administrator stated he did not investigate the allegation at that time because he was just having a conversation with FM 2 and did not take it as a complaint. The Administrator stated he did not report the allegation to the Department of Public Health because there was nothing to report. A review of the facility's undated policy and procedures titled Abuse Policy and Procedures indicated the facility will investigate all allegations or suspicions of any type of abuse. The Administrator or Director of Nurses will notify the Department of Health Services of all abuse allegations, as well as results of the investigation. A review of the facility's undated policy and procedures titled Mandated Reporter Reporting Under the Elder Abuse and Dependent Adult Civil Protection Act indicated if suspected abuse does not result in serious bodily injury, the mandated reporter must do the following: report the incident by telephone within 24 hours to local law enforcement agency and provide a written report to the local Ombudsman, the Licensing & Certification (L&C) program and the local law enforcement agency within 24 hours. Cross Reference F610 |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to thoroughly investigate an allegation of staff to resident abuse involving Certified Nursing Assistant (CNA 1) and failed to prevent further potential abuse when investigating abuse allegation for one of two sampled residents (Resident 1) in accordance with the facility's policy and procedures. This deficient practice placed Resident 1 and other residents at risk for harm. Findings: A review of Resident 1's Admission Record, indicated the facility admitted the resident on 7/11/17, with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 1/22/2020, indicated Resident 1 usually understood others and usually made herself understood, had short and long-term memory problem, and severe impairment in cognition (mental process involved in knowing, learning, and understanding things). Resident 1 required limited assistance with bed mobility and transfer, extensive assistance with locomotion on and off unit, dressing and personal hygiene, and total assistance with toilet use and bathing. During an interview on [DATE] at 8:45 a.m., the Administrator stated he received an electronic mail (e-mail) from Family Member 2 (FM 2) claiming that a facility staff rough handled Resident 1. During an interview and concurrent record review on [DATE] at 9 a.m., the Administrator provided a copy of the e-mail from FM 2 dated [DATE]20. The Administrator stated FM 2 was requesting for the name and state certification number of a male certified nursing assistant (CNA 1). The Administrator stated he spoke about with FM 2 who claimed Resident 1 was rough handled by CNA 1. The Administrator stated he provided FM 2 with CNA 1's name on 2/12/2020. The Administrator indicated on his e-mail response that there were no complaints about CNA 1. During an observation on [DATE] at 9:40 a.m., Resident 1 was observed awake in bed. Resident 1 stated she liked being in the facility because everyone was nice to her. Resident 1 stated no one has mistreated or rough handled her. During an interview on [DATE] at 11:15 a.m., the Administrator stated some time on the first week of February, FM 2 visited Resident 1 and claimed that a male CNA brought in Resident 1's dinner tray and pulled Resident 1's arm roughly to get her out of bed. The Administrator stated he did not investigate the allegation at that time because he was just having a conversation with FM 2 and did not take it as a complaint. The Administrator stated after he received FM 2's e-mail, he asked the Director of Social Services (DSS) to investigate the rough handling allegation. During an interview on [DATE] at 11:45 a.m., the DSS stated the Administrator informed her of FM 2's concern about CNA 1 being rough with Resident 1. The DSS stated, she interviewed Resident 1 and the resident's friend who visited the facility daily, and both had no issue with any of the staff. The DSS stated she did not interview CNA 1 or any other residents receiving care from CNA 1. During an interview on 2/20/2020 at 3:20 p.m., the Director of Staff Development (DSD) stated CNA 1 was not suspended from his CNA duties during the investigation, and that CNA 1 worked from 2/9/2020 to 2/12/2020, on the 3 p.m. to 11 p.m. shift. A review of the facility's undated policy and procedures titled Abuse Policy and Procedures indicated the facility will investigate all allegations or suspicions of any type of abuse. All allegations are reported to the Administrator and Director of Nurses for investigation. Investigation process includes: (1) Physical and Psychosocial Assessment of resident to identify abuse/neglect and resident's cognitive status/reliability, (2) resident or responsible party interview, (3) staff interview and/or review of staffing patterns, (4) witness interview, if applicable, (5) medical record review. The policy and procedures indicated the following measures will be taken to ensure that residents remain safe during and thereafter, an investigation: (1) suspected staff members will be suspended from their duties until the investigation is completed, (2) suspected staff members will not be permitted to enter the facility for any reason, except by appointment. Cross Reference F609 |

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.