STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555135	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLAND SPRINGS CARE CENTER	**1441 MICHIGAN AVENUE BEAUMONT, CA 92223**

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 interview and record review, the facility failed to ensure their policy and procedure regarding reporting allegations of abuse was updated to reflect the current regulation when a resident to resident physical altercation that resulted in injury was not reported to CDPH (California Department of Public Health) immediately, or within two hours. This failure resulted in the delayed reporting of an allegation of abuse which could place the residents at risk for further abuse. Findings: On August 7, 2020, at 9:10 a.m., an unannounced visit was made to the facility to investigate a facility reported resident to resident physical altercation involving Resident 1 and Resident 2 which resulted in Resident 1's transfer to the acute care hospital for evaluation and treatment of [REDACTED]. The LICENSED PROGRESS NOTES, dated June 30, 2020, indicated Resident 1 was kicked in the face by another resident (Resident 2) at 9 p.m. The California Department of Public Health received the report of the incident on July 1, 2020, at 8:32 a.m., more than 11 hours after the incident occurred. The undated facility policy and procedure titled, Abuse Allegation Reporting, was reviewed. The facility's policy did not reflect the current regulation of the timely reporting of allegations of abuse to be reported to CDPH immediately, but not later than two hours after the allegation was made. On August 10, 2020, at 1 p.m., the Administrator was interviewed. The Administrator confirmed the facility's policy and procedure titled, Abuse Allegation Reporting, was not updated.
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 interview and record review, the facility failed to ensure a resident to resident physical altercation which resulted in injury, was reported to CDPH (California Department of Public Health) immediately, or within two hours. This failure had the potential to result in a delay of investigation and reporting of further allegations of abuse. Findings: On August 7, 2020, a.m., at 9:10 a.m., an unannounced visit was made to the facility to investigate a facility reported resident to resident physical altercation involving Resident 1 and Resident 2 which resulted in Resident 1's transfer to the acute care hospital for evaluation and treatment of [REDACTED]. The LICENSED PROGRESS NOTES, dated June 30, 2020, indicated Resident 1 was kicked in the face by another resident (Resident 2) at 9 p.m. During an interview with the Director of Nursing (DON) on August 7, 2020, at 11 a.m., the DON stated the alleged incident occurred on June 30, 2020, at around 9 p.m. The DON stated all allegations of abuse should be reported to CDPH within two hours. The California Department of Public Health received the report of the incident on July 1, 2020, at 8:32 a.m., more than 11 hours after the incident occurred. The undated facility policy and procedure titled, Abuse Allegation Reporting, was reviewed. The facility's policy did not reflect the current regulation of the timely reporting of allegations of abuse to be reported to CDPH immediately, but not later than two hours after the allegation was made.

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.