STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555823	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTERCOMMUNITY CARE CENTER	**2626 GRAND AVENUE LONG BEACH, CA 90815**

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's administrative staff failed to investigate allegations of abuse made by two of two randomly sampled resident (Resident B and C). This deficient practice placed the resident's at risk for continued abuse and the inability to prevent it from recurring. Findings: a. A review of Resident B's Admission Records indicated Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 12/17/18 at 11:05 a.m., during an interview, Resident B stated he was sitting in his wheelchair when Resident A got off the elevator and hit him in the top of his head. b. A review of Resident C's Admission Records indicated Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to Licensed Personnel Weekly Progress Notes, dated 11/28/27 at 10 a.m., Resident C reported that he got into an altercation with another resident (Resident A). A review of a Confidential Report of Suspected Dependent Adult/Elder Abuse, dated 11/28/18, indicated a patient (Resident A) became aggressive with a patient (Resident C) and hit him (Resident C) with a chair. On 12/17/18 at 11 a.m., during an interview, through an interceptor, Resident C stated he did not remember anything. On 1/17/18 at 9:15 a.m., during an interview and a subsequent interview the same day at 10:15 a.m., the Director of Nursing (DON) stated he had not investigated allegations of abuse made by Residents B and C against Resident A and he did not know what an investigation entailed. The DON stated he called the Administrator to verify if the administrator had investigated the allegations of abuse, the Administrator said he had not. A review of an undated facility policy and procedure, titled Abuse Prevention and Investigation indicated under Investigation: to Investigate different types of incidents and to identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. Note: The facility policy did not speak in full detail on investigation of abuse
F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's nursing staff failed to permit one randomly selected resident (Resident A) readmission to the facility following his transfer to a general acute care hospital (GACH) for evaluation of escalating behavior. This deficient practice resulted in Resident A not being readmitted to the facility. Findings: According to a GACH history and physical, dated 6/[DATE]8, Resident A had a history of [REDACTED]. A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) Assessment, dated 10/8/18, indicated Resident A's cognitive skills for daily decision-making were severely impaired with behaviors of being easily distractible and disorganized thinking. A review of Licensed Personnel Weekly Progress Notes, dated 11/28/18 at 9:30 a.m., indicated Resident A has been increasingly agitated, verbally and physically abusive towards other residents and staff and was more difficult to redirect. A physician's orders [REDACTED]. On 12/13/18 at 5:40 p.m., during an interview, the Administrator stated four hours after Resident A was transferred to the GACH for evaluation of uncontrollable and aggressive behavior the GACH called and wanted to transfer the resident back to the facility. The Administrator stated he told the GACH he would not readmit Resident A because Resident A could not have been stabilized that quickly. The Administrator stated Resident A was aggressive, sexually inappropriate and the residents' and staff were afraid of him.

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.