STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A137	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL PARK BEHAVIORAL HEALTH CENTER	**1425 LAUREL AVENUE POMONA, CA 91767**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision (interventions and means of mitigating risk based on the individual residents' assessed needs) to prevent an altercation between 2 of 2 sampled residents (Residents 1 and 2). For Residents 1 and 2, who had serious mental illnesses and were unable to provide for their own needs for shelter, food or clothing, the facility staff failed to provide adequate supervision. This resulted in resident to resident physical abuse, leaving one resident injured. The failure to provide adequate supervision resulted in one resident (Resident 2) receiving abrasions (skin tears) to the left forehead and cheek, swelling to the left ear area, and swelling to right knee. Findings: a. During a review of Resident 1's Face Sheet (which contained admission information) indicated, admission to the facility on [DATE], with [DIAGNOSES REDACTED].) A review of a Behavioral Care Plan initiated 02/24/19, indicated Resident 1 exhibited physical behavior related to swinging at peers and a history of physical behaviors toward peers. b. During a review of the clinical record for Resident 2, the Face Sheet indicated, the resident was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. and what's not real) about people conspiring (plotting) against him, and threatening staff and others. c. A review of documentation provided by the Administrator dated 09/06/19, indicated: At around 14:55 on 09/01/19, the resident (Resident 1) brought the orange water container to the front yard area and was putting it on the table for the residents to drink. The resident (Resident 1) offered 3 female peers some water. While the resident (Resident 1) was helping the female peers get the water, another resident (Resident 2) stood behind him (Resident 1). The other resident (Resident 2) reached over Resident 1 to serve himself some water. Resident 1 asked Resident 2 if he could move, but the resident (Resident 2) did not move, and continued to try to reach over Resident 1 for the second time. Resident 1 again asked Resident 2 to move, and attempted to move Resident 2's arm. Resident 2 said, What?, and swung his fist, striking Resident 1's hand. Resident 1 then punched the left side of Resident 2's face, which caused Resident 2 to fall down on his left side. One of the female peers, Resident 3 notified the staff in the program trailer what had occurred and the staff came out to the yard area. Resident 2 was assessed and found to have a small superficial cut on his face and his right knee and swelling on the left side of his face by his ear. The physician was notified, orders including x-rays were received and carried out. Investigation and interviews determined when Resident 1 was assisting the female peers to get water, Resident 2 stood behind Resident 1 and tried to reach over him to get himself some water. Resident 1 asked Resident 2 if he could move, but Resident 2 did not move and continued to try to reach over Resident 1 to get a drink. Resident 1 asked him to move again and attempted to move Resident 2's arm. At that point, Resident 2 said What?, and swung his fist, striking Resident 1's right hand. Resident 1 then punched Resident 2 in the left side of his face, which caused Resident 2 to fall on his left side. Staff to continue monitoring (Resident 1) for aggression toward others (Resident has a history of such behaviors). A review of a Witness Interview Record dated 09/01/19, with Resident 3 (female peer present during the incident) indicated the incident occurred in the front yard, by the patio table with the umbrella. Resident 3 stated it was about 3 p.m. Resident 1 was putting the water container on the table and offered a drink to her and the others at the table. She stated Resident 2 stood behind Resident 1 and was reaching over Resident 1 to try to get a drink of water. Resident 1 asked him for space and if he could move, but Resident 2 would not move and kept reaching over Resident 1. Resident 1 asked him again to move and then tried to move Resident 2's arm away. Resident 2 said, What? and punched Resident 1's hand. Resident 1 swung back, punching Resident 2 in the left side of his face, causing Resident 2 to fall on his left side. A review of a Witness Interview Record dated 09/01/19, with Resident 1 indicated, he was getting water, and told Resident 2 to back off. He wouldn't and he held Resident 2's arm for him to stop. He stated Resident 2 swung for his face, but missed, and he hit Resident 2 on the head, causing him to fall down. Resident 1 stated he felt concerned that maybe he slept him, so he used his cup of water and poured it on him and splashed him. He stated he didn't want Resident 2 to die or pass out. A review of a Witness Interview Record dated 09/01/19, with Resident 2 indicated, Resident 2 stated while trying to get water from the cooler, he fell while interacting with another resident (Resident 1). A review of a Witness Interview Record dated 09/04/19, with Certified Nurses Aide 3 (CNA 3), he was monitoring the yard area on Sunday (09/01/19). He stated he saw there was a program staff person sitting by the trailer door, and he had to use the restroom. He (CNA 3) left really quick to use the bathroom. During those few minutes while he (CNA 3) was gone, the incident occurred. During an interview on 12/27/19, at 10:15 a.m. with the Cook, she stated I had brought the water cooler out to the yard and when I arrived, the resident (Resident 1) insisted on helping me. I allowed him (Resident 1)to place the water cooler on the table. I left the yard after about 5 minutes and there was no problem with the residents. I did not notice any staff on the yard while I was there. During an interview on 12/27/19, at 12:30 p.m. with Nurse 1, she stated, I did not think there was a staff witness of the incident in question. During an interview on 12/27/19, at 12:47 p.m. with Resident 3, she stated, The altercation happened as reported above. The staff were at the program trailer and not on the yard when the incident happened. I went to the program trailer to get help. During an interview on 02/20/20 at 2:30 p.m. with the Director of Nursing (DON), she stated, The CNA (CNA 3) was assigned to supervise the yard on the day of the incident. The CNA (CNA 3) was at the bathroom when the incident occurred. Whoever is supervising the yard area is supposed to inform the Charge nurse if they need to leave the yard area. The CNA (CNA 3) no longer works at the facility. During an interview on 02/21/20 at 7 a.m., with Licensed Vocational Nurse 1 (LVN 1), she stated, I was working the day of the incident in question, but did not witness it. The staff monitoring the yard needed to go to the bathroom, they are suppose to find staff to relieve them. If they are unable to find someone to relieve them, the Charge nurse would be called. As far as I know, when the staff monitoring the yard goes on lunch break they are responsible to find someone to cover for them. During an interview on 02/21/20 at 8:15 a.m., with CNA 2, she stated, Staff monitoring the yard are not responsible for finding someone to relieve them for lunch and breaks. It is the responsibility of the Charge Nurse. During an interview with the Administrator on 02/24/20, at 3:35 p.m., the Administrator stated, When a staff is monitoring the yard, they are not to leave unless they have a replacement. During an interview the Administrator on 06/05/20, at 9 a.m., the Administrator stated, The CNA (CNA 3) should not have left the residents unsupervised on the yard. He should have waited till some one could be found to relieve him. It was a lack of communication. When asked if there was a policy regarding coverage for staff while monitoring the yard, the Administrator stated, The facility has no policy and procedure to address monitoring the yard area. Review of the facility's policy and procedure (P&P) titled Abuse Prohibition revised 07/01/19, indicated, If suspected abuse is resident to resident, the Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The Center will provide adequate supervision when the risk of resident to resident altercation is suspected.

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.

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