STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055213	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIALTO POST ACUTE CENTER	1471 S RIVERSIDE AVE RIALTO, CA 92376

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect residents from physical abuse when a Certified Nursing Assistant (CNA 1) was observed to provide excessively rough care when: 1. The CNA 1 placed an excessive amount of food onto the fork and forcefully entering into a resident's (Resident 1) mouth. 2. The CNA 1 pushed Resident 1 into bed, and 3. The CNA 1, while pushing a resident (Resident 2), in the Geri-chair, hit Resident 2's head against the handrail along the wall. This failure had the potential to jeopardize the health, safety and psychosocial well-being of Resident 1 and Resident 2. Findings: A review of the facility document titled, :Admission Record - (name of facility commonly known as the 'facesheet') showed Resident 1 was admitted to the facility on [DATE], with the [DIAGNOSES REDACTED]. 1. During an interview with the Licensed Vocational Nurse Student 1 (LVNS 1), conducted on [DATE], at 2:05 PM, LVNS 1 stated on [DATE], at 12:30, LVNS 1 walked into Resident 1's room, and heard the Certified Nurse Assistant (CNA 1) state She needs to eat and at the same time LVNS 1 observed the CNA 1 shoving a lot of mechanically soft meat into Resident 1's mouth. LVNS 1 stated Resident 1 has no teeth. During an interview with LVNS 3, conducted on [DATE], at 2:12 PM, LVNS 3 stated the CNA 1 was shoving food into Resident 1's mouth so we took over. During an interview with the Licensed Vocational Nurse Charge Nurse, (LVNCN) conducted on [DATE], at 2:39 PM, the LVNCN stated the LVN student nurse reported the CNA 1 was being rough with Resident 1. The LVNCN stated the student nurse reported the CNA 1 was shoving food into Resident 1's mouth. Concurrently, the student nurse stated she CNA 1 Resident 1 could choke. CNA 1 responded it was okay because Resident 1 knows how to swallow. Concurrently, the LVNCN stated he is not sure if it is safe for CNA 1 to be working with the residents, adding he would not feel safe with the CNA 1 feeding residents by herself. A review of the facility document titled, (name of facility) Progress Notes, dated [DATE], at 2:09 PM, the Quality Assurance Nurse (QAN) documented the following: .Resident experienced alleged abuse. Upon investigation the (name of school) Students/Instructor reported a staff member was being to rough with resident. There were three students who witnessed staff member put too much food in resident's mouth . A review of the facility document titled VCSL-SBAR/COC (RevXXX 4) dated [DATE], at 3:30 PM, under section .AA. SBAR Charting Notes reflects the following: It was reported to the DSD by (name of school) students/instructor that they witnessed a staff member being rough with resident during meal as Resident was being feed, CNA was putting too much food in resident's mouth . A review of the document authored by LVNS 1, dated [DATE], no time indicated, the document revealed on [DATE], LVNS 1 walked into Resident 1's room and observed CNA 1 feeding Resident 1 with an excessive amount of food on the fork, shoving it into Resident 1's mouth. LVNS 1 indicates she spoke to CNA 1 asking her to not feed Resident 1 so much, it could make the resident choke. CNA 1 responded It's okay, you and another student could do Cardio-Pulmonary Resuscitation (CPR). A review of the document authored by LVNS 3, undated, revealed on [DATE], in (room number), D bed, LVNS 3 indicated walking into the room to assist with changing Resident 1. LVNS 3 observed CNA 1 shove food into Resident 1's mouth, aggressively, without letting Resident 1 finish the food she had just begun eating. The document reflects CNA 1 jokingly saying LVNS 3 can give Cardio-Pulmonary Resuscitation (CPR) if anything happens. A review of the document authored by the Licensed Vocational Nurse Student Instructor (LVNSI), dated [DATE], revealed on [DATE], at lunch time CNA 1 appeared to be feeding large amounts of food to Resident 1 and not allowing Resident 1 adequate time to swallow before pushing another bite of food into Resident 1's mouth. A review of the facility document titled, Assistance with Meals, dated 2001 MED-PASS, INC. (Revised [DATE]), found the following: Policy Statement - Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation - Dining Room Resident: .3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity . 2. During an interview, with LVNS 1, conducted on [DATE], at 2:07 PM, LVNS 1 stated on [DATE], after lunch, Resident 1 asked to be taken back to bed. LVNS 2 stated CNA 1 told Resident 1 once she puts her back to bed she will leave her (Resident 1) in bed. LVNS 1 heard CNA 1 tell Resident 1 to Shut up. During an interview with the Licensed Vocational Nurse Student 2 (LVNS 2), conducted on [DATE], at 2:07 PM, LVNS 2 stated CNA 1 was asked by LVNS 1 and LVNS 2 to assist putting Resident 1 back to bed. LVNS 2 stated during putting Resident 1 back to bed, CNA 1 stated to Resident 1 she needs to stay in bed because she (Resident 1) is So big. LVNS 2 stated CNA 1 pushed Resident 1 on the abdomen. Resident 1 stating, Don't push me. LVNS 2 stated Resident 1 stated CNA 1 makes her anxious and nervous, and she talks with a loud angry voice to the residents. During an interview with the Licensed Vocational 3 (LVNS 3) conducted on [DATE], at 2:12 PM, LVNS 3 stated while assisting Resident 1 back to bed with the help of LVNS 2, LVNS 1, and with CNA 1, Resident 1 continually asked CNA 1 to stop pushing her. During an interview conducted on [DATE], the LVNCN stated the student nurse reported when they were assisting putting Resident 1 back to bed CNA 1 was pushing Resident 1 down in the bed with Resident 1 stating Please don't push me. LVNCN stated an assessment of Resident 1's body was conducted with bruising found. LVNCN stated based upon the allegations brought by the students, LVNCN is not sure it is safe for CNA 1 to be working with the residents. During an interview with Certified Nursing Assistant 2 (CNA 2), conducted on [DATE], at 3:08 PM, CNA 2 stated CNA 1 is a little rough, pushing to strong, when turning patients, she needs to be more gentle. During an interview with Resident 1, conducted on [DATE], at 4:02 PM, Resident 1 was tearful, with no verbal response, when asked if CNA 1 was verbally or physically abusive to her. A review of the facility document titled VCSL-SBAR/COC (RevXXX 4) dated [DATE], at 3:30 PM, under section .AA. SBAR Charting Notes reflects the following: It was reported to DSD by (name of school) students/instructor that they witnessed a staff member being rough with resident .when resident wanted to go to bed CNA was rough putting resident into bed. A review of the document authored by LVNS 1, dated [DATE], revealed LVNS 1 was walking in the hallway when Resident 1, sitting in her wheelchair, asked LVNS 1 if she could put her back to bed. LVNS 1 asked fell ow students LVNS 2 and LVNS 3 to assist her with putting Resident 1 back to bed, knowing CNA 1 was already in the room. LVNS 1 continues that CNA 1 told Resident 1 When I put you to bed you are staying there all day, don't ask to get back up. LVNS 1 continued in the document, the four of them (the three students and CNA 1) lifted Resident 1 into the bed. Once in bed, LVNS 1 documented, CNA 1 pushed Resident 1 down onto the bed, and threw Resident 1's legs onto the bed, with Resident 1 responding Don't push me and CNA 1 responded Oh, shut up. A review of the document authored by LVNS 2, dated [DATE], revealed LVNS 2 was asked by LVNS 1 to assist putting Resident 1 back to bed. LVNS 2's documents that after the CNA's actions, Resident 1 started crying and stated. Please stop and don't push me. A review of the document authored by LVNS 3, undated, revealed LVNS 3 was present in Resident 1's room when he observed CNA 1 pushing Resident 1 into the bed, aggressively, and heard Resident 1 request Please stop pushing me. A review of the document authored by the LVNSI, dated [DATE], revealed LVNSI documented on [DATE], at 10:45 AM, Resident 1 was waiting to be placed back in bed. The Student asked CNA 1 if they (Students) could assist in the transfer back to bed. The LVNSI conveys the Student reported to her CNA 1 refused and starting yelling at Resident 1, telling her the students were not allowed to put her back to bed. The document continues, the students checked with the Charge Nurse, confirming it would be

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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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) okay for the LVN students to place Resident 1 back to bed. When assisting CNA 1 to place Resident 1 back to bed, the students reported to the LVNS I they observed CNA 1 to be very rough with Resident 1. The LVN students reported Resident 1 was asking CNA 1 to stop pushing her because it was hurting. A review of the facility document titled (name of facility) - Progress Notes dated [DATE], at 2:09 PM, the QAN documented the following: .Resident experienced alleged abuse. Upon investigation (name of school) students/instructor reported a staff member was being too rough with resident .the same staff member pushed resident into bed during transfer, in which resident asked staff member not to push her . A review of the facility document titled, Abuse Prevention Program, dated 2001 MED-PASS, Inc. (Revised [DATE]) Nursing Services Policy and Procedure Manual for Long-Term Care, found the following: Policy Statement - Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical, and physical or chemical restraint not required to treat the resident's symptoms, Policy Interpretation and Implementation - As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual . A review of the facility document titled Admission Record (name of facility) dated [DATE], at 3:46 PM, found Resident 2 was admitted to the facility on [DATE], with the [DIAGNOSES REDACTED]. 3. During an interview conducted on [DATE], at 2:05 PM, with the Licensed Vocational Nurse Student 1(LVN'S 1) the LVN stated on [DATE], at 8:09 AM, she observed the Certified Nursing Assistant 1 (CNA 1) pushing Resident 2 in the Geri-chair (a medical reclining chair designed to allow someone to get out of the confines of their bed and be able to sit comfortably in a variety of positions while being fully supported) in the hallway when CNA 1 pushed the chair into the wall, hurting Resident 2's head. During an interview with the Licensed Vocational Nurse Charge Nurse (LVNCN) conducted on [DATE], at 2:39 PM, the LVNCN stated he was told by the Student Nurse she observed CNA 1 pushing Resident 2 against the wall hitting her head against the hand bars residents use while walking. The LVNCN stated Resident 2 complained of pain to the left side of her head. A review of the facility document titled (name of facility) Progress Notes dated [DATE], the Interdisciplinary Team (IDT) Progress Note dated [DATE], at 2:50 PM, reflected Resident 2 complained of pain and was provided pain medication as ordered. A review of the facility document titles VCSL-SBAR/COC (RevXXX 4) in Section AA. SBAR Charting Notes .Resident was sitting in the Geri-chair in hallway and CNA pushed chair to move resident and resident bumped the left side of her head against hallway railing. Resident complained of pain ,[DATE] to left side of head; (Trade name) Extra Strength tablet 500 MG given . A review of the document authored by LVNCN, dated [DATE], LVNS 1 documented she observed CNA 1 pushing Resident 2, while sitting in the Geri-chair, hit the wall, resulting in Resident 2 hitting her head against the railing connected to the wall. A review of the document authored by the Licensed Vocational Nurse Student Instructor (LVNSI) the LVNSI documented the Student observed CNA 1 push Resident 2, who was sitting in the Geri-chair, into the wall, which resulted in Resident 2 striking her head against the wall or railing. Resident 2 confirmed she had hit her head against the wall. Policy Statement - Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical, and physical or chemical restraint not required to treat the resident's symptoms, Policy Interpretation and Implementation - As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual .