STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056053	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA HACIENDA HEALTHCARE CENTER	**1311 EAST DATE STREET SAN BERNARDINO, CA 92404**

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 **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 report an instance of alleged resident to resident sexual abuse which occurred on October 6, 2019, for two of three sampled residents (Residents 1 and 2) when a Certified Nursing Assistant (CNA 1) witnessed Resident 2 kissing another resident (Resident 1) and touching the resident in the vaginal and breast area. Neither resident had the capacity to consent. The facility did not report the incident to the state agency, ombudsman, or law enforcement until October 8, 2019. This failure resulted in the facility to not report an allegation of abuse within the regulatory guidelines which had the potential to delay the investigation of abuse by outside agencies. Findings: During an interview on October 9, 2019, at 10:30 AM, with the Director of Nursing (DON), the DON stated a Certified Nursing Assistant (CNA) saw a resident (Resident 2) with one hand inside another residents' diaper (Resident 1) and the other hand on the residents' breast over her shirt. The DON further stated Resident 2 was kissing Resident 1. During an interview on January 17, 2019, at 1:07 PM, with Social Services Director (SSD), SSD stated staff is supposed to report to the abuse coordinator (an individual who oversees the abuse prevention program and ensures that all suspected abuse is reported to authorities) any instances of witnessed or suspected abuse. SSD further stated if abuse occurs within the facility, the police department, California Department of Public Health (CDPH), and the Ombudsman (an individual who acts as an advocate for residents of nursing homes, board and care homes and assisted living facilities) should be notified within 24 hours if there were no injuries sustained. The SSD stated the administrator (oversees the daily operations of the nursing home) is the abuse coordinator of the facility. During an interview on January 17, 2020, at 2:25 PM, with the DON, the DON stated the incident (witnessed abuse between Resident 1 and Resident 2), was not reported to the California Department of Public Health (CDPH) until a few days later because there was confusion about reporting requirements since both residents had dementia. The DON further stated, the incident should have been reported to CDPH right away but wasn't. During an interview on January 17, 2020, at 2:45 PM, with RN SUP 1, RN SUP 1 stated she was made aware of the incident between Resident 2 and Resident 1. RN SUP 1 then stated she informed the DON and administrator immediately when she found out (on October 6, 2019), and remembered the DON stating she (DON) would follow up regarding the incident because both residents had dementia. During an interview on January 22, 2020, at 5:30 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she witnessed Resident 2 in the room of Resident 1, and Resident 2 was kissing Resident 1 and had one hand on her breast and one hand on her vagina. CNA 1 stated she reported the incident to the AM nurse on shift (Licensed Vocational Nurse 1- LVN 1) and the Registered Nurse Supervisor 1 (RN SUP 1). During a follow up interview on January 23, 2020, at 9:30 AM, with the DON, the DON stated staff did not immediately report all the information that was witnessed by CNA 1 and there was confusion on if the incident needed to be reported since both residents had dementia. The DON further stated she initially was informed on October 6, 2019, at 6 PM that resident 2 was found in Resident 1's room and that's all. The DON stated after they interviewed staff and discovered Resident 2 had his hands on Resident 1's private parts, they consulted with the facility team regarding consent and dementia and decided it needed to be reported and that's why there was a delay in the incident being reported. During a review of Resident 1's clinical record, the Face Sheet (contains demographic and medical information), indicated Resident 1 was a female who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a review of Resident 1's History and Physical (H&P), dated May 20, 2019, the H&P indicated Capacity: This resident does not have the capacity to understand and make decisions. During a review of Resident 2's clinical record, the Face Sheet indicated Resident 2 was a male who was admitted to the facility on [DATE], and readmitted on (NAME)21, 2019, with [DIAGNOSES REDACTED]. During a review of Resident 2's H&P, dated (NAME)23, 2019, the H&P indicated Capacity: This resident does not have the capacity to understand and make decisions. During a review of Resident 2's Nursing progress note, dated October 6, 2019, the progress noted indicated Resident noted to have entered another resident's bedroom and reportedly initiated inappropriate behavior kissing + touching the other resident. CNA alerted writer at approx. 5 PM (5:00 PM) of incident which took place at approx. 330 (3:30 PM) reportedly. Writer informed MD (Medical Director), DON, and responsible party . During a review of the facility's policy and procedure (P&P) titled, Abuse - Reporting and Investigations, revised (NAME)2018, the P&P indicated, Purpose: To protect the health, safety, and welfare of facility residents by ensuring that all reports of resident abuse, mistreatment, neglect, exploitation or injuries of unknown source and suspicion of crimes are promptly reported and thoroughly investigated. Policy: The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies .Procedure: A. Allegations of abuse, neglect, mistreatment, exploitation or reasonable suspicion of a crime to be reported to the administrator or designated representative immediately .Immediate Action .Immediately notify law enforcement .B. The administrator or designated representative conducting the investigation will interview individuals who may have information relevant to the allegation or suspected crime .IV. Notification of outside Agencies of Allegations of Abuse Caused by a Resident with Dementia diagnosed by a Physician - A. After a Licensed Nurse drawing on his/her training and experience determines there is no serious bodily injury: i. The administrator or designated representative will notify within two (2) hours notify, by telephone, CDPH, the Ombudsman and law enforcement. Ii. The administrator or designated representative will send a written SOC 341 report (a document used to report information regarding alleged abuse) to the Ombudsman and law enforcement and CDPH Licensing and Certification within 2 hours .

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.