STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055541	A. BUILDING _____ B. WING _____	05/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL TERRACE HEALTHCARE	1340 HIGHLAND AVE. DUARTE, CA 91010

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** - Minimal harm or potential for 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 interviews and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from physical abuse. Admission Director (AD) witnessed Certified Nursing Assistant 1 (CNA 1) tapping/patting/hitting on the top of Resident 1's head causing Resident 1 to say Ow Ow. The facility also failed to suspend CNA 1 immediately after the incident was noted by the AD. This deficient practice had the potential to result in Resident 1's further physical and psychosocial decline. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility 2/12/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 2/19/19 indicated Resident 1's cognition was severely impaired. A review of the Situation Background Assessment and Recommendation (change of condition) form dated 2/27/19 indicated, a staff member (AD) came to the charge nurse (LVN 1) and reported that CNA 1 was patting Resident 1 on the top of the resident's head. A review of the facility's investigation dated 2/28/19, completed by AD indicated that on 2/27/19 at 3:25 p.m., CNA 1 was wheeling Resident 1 back into the lobby toward the hall. The record indicated Resident 1 was moving crazy when CNA 1 hit him on top of his head, the resident responded by rubbing his head and saying Ow Ow Ow. AD informed the Director of Staff Development (DSD) and the Administrator. A review of the facility's payroll records indicated that on 2/27/19, CNA 1 clocked in at 3:17 pm. and clocked out at 11:01 pm. CNA 1 was not suspended immediately after the abuse incident. A review of the CNA's assignment sheet dated 2/27/19 evening shift, indicated CNA 1 taking care of Resident 1. On 3/8/19 at 10:51 am., during an interview, AD stated that on 2/27/19 at 3:30 pm., she witnessed CNA 1 tapping Resident 1's on top of the head hard while pushing his wheelchair. AD stated that Resident 1 rubbed the top of his head and said Ow Ow. On 3/8/19 at 11:01 am., during an interview, DSD stated that on 2/27/19, soon after CNA 1 was wheeling Resident 1, AD approached her and said, did you see your CNA tap the patient's head? DSD stated that CNA 1 worked the evening shift and when the incident happened. DSD stated that CNA 1 continued to work the entire shift on 2/27/19 and was not suspended until 2/28/19 per Administrator's instruction. On 3/8/19 at 11:34 am., during an interview, the Payroll Coordinator (PC) stated that on 2/27/19 when CNA 1 was wheeling Resident 1 in the lobby, she saw Resident 1 holding the top of his head. On 3/8/19 at 12:46 pm., during an interview, the Director of Nursing 1 (DON 1) stated that she did not find out about the abuse allegation toward Resident 1 until 2/28/19 around 9:30 a.m. DON 1 stated that the facility should have suspended CNA 1 as soon as the abuse allegation was made. A review of the facility's policy and procedure, titled Abuse Prevention Program revised December 2016 indicated that the residents at the facility have the right to be free from physical abuse. The administration would protect the residents from abuse by anyone including: facility staff and the facility would protect residents during abuse investigations. A review of the facility's Abuse Investigation and Reporting policy and procedure revised July 2017 indicated that the administrator is to suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation, and the administrator is to ensure that any further potential abuse was prevented.
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 interviews and record review, the facility failed to report an abuse allegation within two hours to the Department for one of four sampled residents (Resident 1). On 2/27/19 at around 3 p.m., Resident 1 was observed by the facility's staff (AD) that the certified nursing assistant (CNA1) was tapping/patting/hitting on top of the resident's head causing the resident to say Ow Ow. This allegation of physical abuse was received by the Department on 2/28/19 at 1:57 p.m. via facsimile. This deficient practice resulted in delay of investigation by the Department. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility 2/12/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 2/19/19 indicated Resident 1's cognition was severely impaired. A review of the Situation Background Assessment and Recommendation (change of condition) form dated 2/27/19 regarding an alleged abuse by CNA 1 toward Resident 1, indicated A staff member (Admission Director, AD) came to the charge nurse (LVN 1) and reported that a CNA (CNA 1) was patting (Resident 1) on the top of his head. This form indicated that the Administrator was notified of the incident. On 3/8/19 at 10:51 am., during an interview, AD stated that on 2/27/19 at 3:30 pm., she witnessed CNA 1 tapping Resident 1's on top of the head hard while pushing his wheelchair. AD stated that Resident 1 rubbed the top of his head and said Ow Ow. AD immediately reported the incident to Director of Staff Development (DSD). AD stated that soon after the incident, the Administrator held a meeting and stated we're not going to report it, is everyone on the same page? On 3/8/19 at 11:01 am., during an interview, DSD stated that on 2/27/19, soon after CNA 1 was wheeling Resident 1, AD approached her and said, did you see your CNA tap the patient's head? DSD immediately reported the incident to Administrator. On 3/8/19 at 11:34 am., during an interview, Payroll Coordinator (PC) stated that on 2/27/19 Administrator told staff members we're not going to report this, is everyone on the same page? On 3/8/19 at 12:08 pm., during an interview, Social Service Director (SSD) stated that on 2/27/19, after the abuse allegation involving Resident 1, Administrator held a meeting and told everyone not to report the event. On 3/8/19 at 12:22 pm., during an interview, Dietary Supervisor (DS) stated that on 2/27/19 after the abuse allegation, Administrator held a meeting and told everyone not to mention the incident to Director of Nursing 1 (DON 1). On 3/8/19 at 12:46 pm., during an interview, DON 1 stated that she did not find out about the abuse allegation involving Resident 1 until 2/28/19 around 9:30 am., DON 1 spoke with Administrator and made him aware that the incident had to be reported immediately. DON 1 stated that the facility had to report abuse allegations within two hours to The Department. A review of the facsimile report received by the Department on 2/28/19 at 1:57 p.m. indicated the facility's DON reporting that on 2/27/19 at around 3:29 p.m., a staff member claimed that she saw the hand of a CNA came into contact withe the top of the head of Resident 1. The CNA has been placed on suspension until further investigation. A review of the facility's policy and procedure titled, Abuse Investigation and Reporting revised in July 2017, indicated all reports of abuse shall be promptly reported to local, state and federal agencies. The role of the administrator included: if an incident or suspected incident of resident abuse was reported, the administrator is to assign the investigation to an appropriate individual. Any alleged violations of abuse would be reported immediately but no later than two hours if the alleged violation involved abuse and verbal/written notices to agencies may be submitted via fax, e-mail, or by telephone.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan in a timely manner for one of four sampled residents (Resident 1). On 2/27/19, Admission Director (AD) witnessed Certified Nursing Assistant 1 (CNA 1) tapping Resident 1 on top of the head, and the facility did not develop a care plan to address this concern until 3/1/19. This deficient practice had a potential for the facility's staff not being able to provide services to meet the resident's physical and mental well-being. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility 2/12/19 with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 2/19/19 indicated Resident 1's cognition was severely impaired. A review of the Situation Background Assessment and Recommendation (change of condition) form dated 2/27/19 indicated an alleged abuse by CNA 1 toward Resident 1, A staff member (AD) came to the charge nurse (LVN 1) and reported that a CNA (CNA 1) was patting (Resident 1) on the top of his head. A review of Resident 1's care plan developed/initiated on 3/1/19 identified focus regarding patting resident on the head by CNA with no pain and apparent injury noted. The care plan goal indicated the resident will have no pain or injury. On 12/19/19 at 1:21 pm., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated that the incident occurred toward the end of his shift (morning shift from 7 am. to 3:00 pm.) and he endorsed to the following shift (evening shift from 3:00 pm. to 11:00 pm) to develop a care plan. LVN 1 stated that it was facility's practice to develop care plans within the same day of the incident. On 12/19/19 at 1:54 pm., during an interview, Director of Nursing (DON) stated that it was facility's practice for care plans to be developed with in the same day, this would ensure appropriate interventions and goals for the residents. A review of the facility's policy and procedure, titled Care Plans-Comprehensive revised in September 2010 indicated that an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was to be developed for each resident. The care plan was designed to incorporate identified problem areas.