STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055992	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST COVINA HEALTHCARE CENTER	**850 S. SUNKIST AVE. WEST COVINA, CA 91790**

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 interviews and record reviews, the facility failed to report an abuse allegation to the State Survey Agency in a timely manner when one of four sampled residents (Resident 2) tried to hit another resident (Resident 1) during a verbal altercation. This deficient practice has the potential to expose the residents of the facility in an environment of abuse and mistreatment. Findings: On 5/18/18 at 12 p.m., an unannounced visit was made at the facility to investigate a facility-reported incident regarding resident abuse. A review of Resident 1's face sheet (admission record) indicated that the facility admitted Resident 1 on 9/14/15. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's minimum data set (MDS), a resident assessment and care-screening tool, dated 3/9/18, indicated that Resident 1's cognition (ability to think and process information) was intact. The MDS indicated that Resident 1 required supervision to perform his activities of daily living (ADLs) such as walking in corridors, eating, toileting, and performing personal hygiene. The MDS indicated that Resident 1 uses a walker or a wheelchair for mobility. A review of Resident 2's face sheet indicated that the facility admitted Resident 2 on 12/20/12 and last readmitted the resident on 8/12/16. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's MDS, dated [DATE], indicated that Resident 2's cognition was intact. The MDS indicated that Resident 2 required extensive assistance to perform activities of daily living (ADLs) such as dressing, toileting, performing personal hygiene, and walking in corridors. The MDS indicated that Resident 2 uses a walker or a wheelchair for mobility. During an interview on 5/18/18 at 2:05 p.m., Resident 1 stated that on 4/15/18, Resident 2 was blocking his way while he was trying to maneuver his wheelchair out of his room to meet his brother at the lobby. He asked Resident 2 to move out of the way but the resident became upset and tried to hit him. He stated that Resident 3 witnessed the incident and went to the front desk to ask for assistance since there was no staff in the hallway. During an interview on 5/18/18 at 2:40 p.m., Resident 3 stated that on 4/15/18, Resident 2 tried to hit Resident 1 a couple of times in the hallway but missed. Resident 3 stated he had to go to the front desk to ask for help since there was no staff in the hallway when the incident happened. During an interview on 6/15/18 at 2:15 p.m., Licensed Vocational Nurse 1 (LVN 1) stated that she worked on 4/14/18 when the incident happened and she was the first to know about the alleged altercation. LNV 1 stated that she did not witness the incident but reported it immediately to her supervisor. A review of Resident 1's medical record titled, Progress Notes dated, 4/14/18 at 5:30 p.m., LVN 1 documented that she saw Resident 1 sitting in his wheelchair, at the back hallway yelling at his roommate (Resident 2). The notes indicated Resident 2 was saying something in Spanish in a low voice. The charge nurse separated them immediately by wheeling Resident 2 to the hallway in front of the nursing station. Around 10 to 15 minutes later, Resident 1 came to the nursing station and told LVN 1 that He was trying to hit my face 3 times and if he touches me, I'll call the police. During an interview on 6/15/18 at 2:45 p.m., Registered Nurse 1 (RN 1) stated that LVN 1 reported to her on 4/14/18 at around 5:30 p.m. that Resident 1 and 2 had a verbal altercation in the hallway but had no physical contact. She stated that she reported the incident to the Director of Nursing (DON) 15 minutes later after she received that information. However, she could not recall if she notified the Administrator (ADM). During an interview on 6/15/18 at 3:30 p.m., the DON stated that RN 1 reported to her on 4/14/18 that Resident 1 and 2 had an exchange of words in the hallway but had no physical contact. She stated that she immediately notified the ADM after she received that information. During an interview on 6/15/18 at 3:45 p.m., the ADM stated that the DON notified him on 4/14/18 that Resident 1 and 2 had an exchange of words in the hallway but had no physical contact. A review of the letter sent from the facility to the State Agency indicated that the facility notified the State Agency about the abuse allegation (involved Residents 1 and 2) through fax on 4/16/18 at 1:14 p.m. A review of the facility's policy titled, Abuse Investigation and Reporting revised in December 2016, indicated that the facility's policy does not conform to the federal's regulatory requirement in reporting abuse allegations. The facility's policy indicated that abuse allegations will be reported within two hours, only if the alleged event resulted in serious bodily injury.

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.