STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM GROVE HEALTH CARE	**1665 EAST EIGHTH STREET BEAUMONT, CA 92223**

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.** Based on interview and record review, the facility failed to ensure the two residents (Residents A and B) involved in a physical altercation, were separated from each other in accordance to the care plan. This failure resulted in another physical altercation between the two residents (Residents A and B). Findings: On June 12, 2020, at 11:10 a.m., an unannounced visit was conducted at the facility to investigate an incident of a resident to resident altercation. On June 12, 2020, at 2:45 p.m., the Registered Nurse Supervisor (RNS) was interviewed. The RNS stated at around 8:10 p.m., on June 10, 2020, she saw Resident A standing over Resident B inside the residents' room. She stated the resident's (Resident B) head was bleeding, and the resident told her, He (Resident A) hit me with the TV. A review of Resident A's undated, Care Plan, indicated, Focus- Altercation with Resident (Room number of Resident B); Goal- will have no further altercation within the next 90 days with proper tx (treatment) and nursing intervention; Interventions- Monitor residents whereabouts .Separate each resident to each other . On July 1, 2020, at 1:40 p.m., Licensed Vocational Nurse (LVN) 1, was interviewed. LVN 1 stated she was the charge nurse when the two residents (Residents A and B) had an altercation the second time. LVN 1 stated the two residents (Residents A and B) should have been separated as indicated in their care plan. On July 1, 2020, at 3:41 p.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated the Activity Assistant (AA 1) escorted Resident A to the dining room the day of the incident (second altercation). CNA 1 stated, she was not able to help AA 1 in watching Resident A since she had to assist another resident. CNA 1 stated she forgot to endorse Resident A to the activity assistant (AA 1). On July 2, 2020, at 12:35 p.m., AA 1 was interviewed. AA 1 stated that on June 11, 2020, she escorted Resident A to the dining room, and was watching on Resident A until the time she needed to take a 10-minute- break. She stated she asked permission to take a break from a charge nurse who was at the desk doing paperwork. On July 2, 2020, at 1 p.m., AA 2 was interviewed. AA 2 verified she was in the dining room when an altercation involving Residents A and B happened. AA 2 verified nobody told her that the two residents had an altercation the night before, and Residents A and B needed to be separated. On July 2, 2020, at 3 p.m., the Activity Director Designee (ADD) was interviewed. The ADD verified she was in the dining room when the altercation involving Residents A and B happened. The ADD stated nobody told her that the two residents had an altercation the night before and they needed to be separated. She further stated if she knew that the two residents had to be separated, she could have watched the two residents closely. The ADD stated when one resident come closer to the other she could go in the middle of the two residents to avoid confrontation. Resident A's facility document titled, SBAR Communication Form and progress note, dated June 11, 2020, was reviewed. The document indicated, resident was struck on his back twice with a foot rest, CN (Charge Nurse) noted 4 abrasions, and redness on his back including his neck, 911 was called .resident requested to be transported to Loma(NAME)VA for further evaluation . On July 2, 2020, at 3:05 p.m., the Director of Nursing (DON) was interviewed. The DON stated the LVN (LVN 1) assigned two staff to watch on Resident A. When the AA 1 asked for a break she should have assigned another staff to watched Resident A. The undated facility policy and procedure titled, Resident Abuse, Neglect, or Mistreatment, was reviewed. The policy indicated, .If the accused is a resident or resident's roommate, the individual should be placed in a supervised temporary separation in order to ensure that the rights of the residents-at-large will be protected .

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.