STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056466	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Care Center	14318 Ohio Street Baldwin Park, CA 91706

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** 40913 Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for one of one sampled resident (Resident 1). Resident 1 was hit by Family Member 1 (FM1- Resident 1's brother) during visitation on 5/21/24. This deficient practice resulted in discoloration of Resident 1's right lower lip and left temporal (side) area of the face. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted the resident on 2/22/24 and readmitted on [DATE] with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and bipolar disorder (mental disorder with periods of depression [persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities] and periods of elevated mood.) During a review of Resident 1's Progress Notes dated 5/21/24 at 3:20 pm, the Progress Notes indicated Resident was on 1:1 monitoring (providing continuous observation for a period of time) due to agitation and aggressiveness. The Progress Notes indicated a staff (unidentified) left Resident 1 because Resident 1's FM1 came to visit him. The Progress Notes indicated according to the staff, both Resident 1 and FM1 were calm and after 5-10 minutes later, Resident 1 was heard yelling loud saying Nurse, Nurse. Resident 1 was sitting on his wheelchair, pointed at FM1, and stated He (FM1) hit me. During a review of Resident 1's Progress Notes dated 5/21/24 at 4:02 pm, the Progress Notes indicated assessment was done on Resident 1, neurocheck (examination of the brain, nerve, and spinal cord functioning) was started and Resident 1 was given Tylenol (medication for pain) for complaint of 6/10 pain (0= no pain and 10=worst pain based on pain scale) on the left temporal area. During a review of Resident 1's Progress Notes dated 5/21/24 at 10:37 pm, the Progress Notes indicated Resident 1 arrived back to the facility from General Acute Care Hospital 1 (GACH 1) with discoloration on his right lower lip and left temporal area of the face related to an incident prior to his transfer to GACH 1. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056466	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Care Center	14318 Ohio Street Baldwin Park, CA 91706

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	During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 5/22/24, the MDS indicated Resident 1 had severely impaired cognition (ability to understand). The MDS indicated Resident 1 was using a manual wheelchair for ambulation. The MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with chair/bed-to-chair transfers. During an interview on 6/3/24 at 1:45 pm with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 was verbally aggressive but not physically aggressive towards staff. During an interview on 6/3/24 at 2:28 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated during the two days she was assigned to Resident 1 (5/20/24 and 5/21/24), Resident 1 was easily agitated and he would yell . LVN 1 stated the SSD was sitting with Resident 1 on 5/21/24 at around 9 am to 9:30 am and Resident 1 calmed down. LVN 1 stated the SSD was sitting with Resident 1 before FM1 came to the facility on [DATE] at 2:38 pm. During an interview on 6/3/24 at 2:39 pm, CNA 2 stated it was around 3 pm on 5/21/24 when she heard a resident yelling Nurse, Nurse and CNA 2 saw FM1 came out of Resident 1's room. CNA 2 stated when she checked Resident 1, Resident 1 had a scratch on the side of the left eye and CNA 2 went out to get an ice pack and applied the ice pack to the side near Resident 1's left eye. During an interview on 6/3/24 at 3:05 pm, Resident 1's roommate who was alert and coherent, stated on 5/21/24, he could see both Resident 1 and FM1 talking by the doorway inside the room Resident 1's roommate stated FM1 told Resident 1 not to cause a ruckus and to quiet down and FM1 reassured Resident 1 that the family supports him. Resident 1's roomate stated Resident 1 started cursing and said to FM1 I'm not going to change, I'll do what I want. Resident 1's roommate stated FM1 hit Resident 1 after hearing Resident 1's statement. During an interview on 6/3/24 at 3:47 pm with the Social Services Director (SSD), the SSD stated she stayed with Resident 1 on 5/21/24 from 9 am to 3 pm when FM1 came. SSD stated she left Resident 1's room to go to the bathroom after observing Resident 1 was welcoming of FM1. The SSD stated she later heard Resident 1 screaming he (FM1) hit me. The SSD stated when she interviewed FM1, FM1 stated FM1 hit Resident 1 because Resident 1 was verbally aggressive. During a phone interview with Resident 1's FM2 on 6/3/24 at 5:20 pm, FM2 stated FM1 had intact cognition and was not confused. During a review of the facility's Policy and Procedure (P&P) titled Abuse, Neglect and Exploitation revised 12/19/22, the P&P indicated abuse means the willful infliction of injury .with resulting physical harm, pain, or mental anguish.