CITATION NUMBER: 250011724

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00414983, CA00414090

Licensee Name: Riverside Sanitarium, LLC
Address: 6300 Wilshire Blvd., Suite #1800 LOS ANGELES, CA 90048
License Number: 250000119
Type of Ownership: Limited Liability Company

Facility Name: RIVERSIDE BEHAVIORAL HEALTHCARE CENTER
Address: 4580 Palm Ave Riverside, CA 92501
Telephone:
Facility Type: Skilled Nursing Facility
Capacity: 120
Facility ID: 250000021

SECTIONS VIOLATED | CLASS AND NATURE OF VIOLATIONS | PENALTY ASSESSMENT | DEADLINE FOR COMPLIANCE
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CLASS: B | CITATION: Abuse/Facility Not Self Reported | $2,000.00 | 9/30/2015

483.13(c)(2) CLASS B CITATION -- Abuse/Facility Not Self Reported

483.13(c)(2) Reporting alleged violations and the results of investigations to the State survey agency...as soon as possible, but ought not exceed 24 hours after discovery of the incident.

The facility failure to ensure the charge nurse immediately reported an allegation of suspected sexual abuse by Certified Nurses Assistant (CNA 1) to Patient 1 to the Administrator and/or the Director of Nursing. The facility failed to report the allegation of sexual abuse by Certified Nurse Assistant 1 to Patient 1 within 24 hours to the ombudsman, local law enforcement, resident's responsible party, or to the California Department of Public Health (CDPH).

The facility is licensed as a Skilled Nursing Facility with a Special Treatment Program for psychiatric residents.

On September 23, 2014 at 2:45 p.m., an unannounced visit was made to the facility to investigate a complaint of alleged sexual abuse of one patient, Patient 2 by Certified Nurse Assistant 1. Upon entrance to the facility, an interview was conducted with the Director of Nursing (DON). The DON stated that only one of two incidents of alleged sexual abuse by Certified Nurse Assistant 1 to two different patients had been reported to the California Department of Public Health. The incident involving Patient 2 was reported to the California Department of Public Health however the incident involving Patient 1 had not been reported to the California Department of Public Health. During this interview, the DON indicated that on September 13, 2014, Patient 3 reported to the Charge Licensed Vocational Nurse 1 (Charge LVN 1) that Patient 1 had confided to Patient 3 and told him that while he was naked in the shower, Certified Nurse Assistant 1 peeked his head.

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE
around the corner of the shower and asked him uncomfortable questions such as, "Are you gay?" and "Do you like guys?"

Patient 1 committed suicide on September 10, 2014, by hanging himself from a fire sprinkler with a bed sheet in his bathroom.

A concurrent review of the facility document titled, "Interdisciplinary Team Notes," dated September 13, 2014 at 1745, signed by Charge LVN 1, indicated, "When (Patient 1’s name) was taking a shower, this staff was asking (Patient 1’s name) uncomfortable questions such as are you gay, heterosexual ?, do you like guys? According to (Patient 3’s name), when he was talking to (CNA 2’s name), the description of this staff was tall, big, black and talks a lot. When the name (CNA 1’s name) was raised, (Patient 3’s name) agreed to the person."

On September 24, 2014 at 2:50 p.m., an interview was conducted with Patient 3. Patient 3 stated, "That prior to the suicide of my friend, he had confided in me that (CNA 1’s name) had peeked his head around the corner of the shower and asked (Patient 1’s name) questions about being gay. (Patient 1’s name) told (CNA 1’s name) that he was straight. (Patient 1’s name) said he didn't like it and I could tell by the way he was talking about it that he was uncomfortable with it. He just shrugged it off and didn’t tell anyone. I didn’t tell anyone because it really didn't matter to me. I told the staff about what (Patient 1’s name) told me to relieve my conscience after he (Patient 1) hung himself." Patient 3 could not recall a time frame for this conversation.

A review of facility time sheets indicated that on September 13, 2014, after Charge LVN 1 was made aware of the alleged sexual abuse by CNA 1 to Patient 1, CNA 1 continued to work in direct contact with residents. CNA 1 worked the remainder of his shift on September 13, 2014, his regular schedule shift on September 14, 2014, his regular schedule shift plus overtime on September 15, 2014, and his regular schedule shift on September 16, 2014.

On September 24, 2014, at 5:00 p.m., during an interview, the DON indicated CNA 1 continued working for three days after the alleged sexual abuse was reported to Charge LNV 1 and CNA 1 was not suspended until the end of his shift on the fourth day, September 16, 2014. The DON also stated, "I was not made aware of the incident until Monday, September 15, 2014. The 13th was a weekend. We were a bit consumed with the current suicide of our patient, (Patient 1’s name). That was the time the deceased patient's family was coming in. I have not yet reported it" The DON was not able to produce any documentation supporting the initial incident of alleged sexual abuse by CNA 1 to Patient 1 had been reported to nursing administration, the administrator (ADM), California Department of Public Health, the resident's responsible party, or any other agency.

On April 20, 2015 a review of the facility's undated policy and procedure on abuse reporting was reviewed. The facility's abuse policy and procedure indicated:

B. If the suspected perpetrator is an employee:
   2. Suspend employee during the investigation.
2. If the reportable event results in bodily injury or sexual abuse, the staff member shall report the suspicion immediately to local law enforcement and within two hours a written report to ...licensing agency...
C. First responder or first staff member informed will be responsible for informing immediate supervisor and initiating incident report.
D. the ADM ... and DON must be notified immediately after the incident is reported."

The facility failed to ensure that an allegation of sexual abuse was reported. The facility failed to report the allegation of sexual abuse by CNA 1 to Patient 1 to the California Department of Public Health within 24 hours. These failures had the potential to subject all facility residents to sexual harm by CNA 1.
The above violations either jointly, separately or in any combination had a direct or immediate relation to patient health, safety, or security.

Name Of Evaluator:
Kacy Floyd
HFEN

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:______________________________________
Evaluator

Name:_______________________________________
Title:_________________________________________

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