DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555673	A. BUILDING _____ B. WING _____	C 05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PARK NURSING & REHABILITATION CENTER	2257 FAIR OAKS BLVD. SACRAMENTO, CA 95825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of facility reported incident #CA00706136. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 38834 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	See attached.	BOC/EOC Accepted 6/9/21 RVB
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the call light for three of 4 sampled residents (Resident 1, Resident 3, and Resident 4) was accessible and within their reach at all times. This failure resulted in Resident 1 being unable to call for help when he was hit by his roommate and had the potential for Resident 1, Resident 3, and Resident 4 not to receive help timely in the event of an emergency, which could jeopardize their health and safety. Findings:	F 558		BTC 6/26/21 RVB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel Rivkin, MHA | TITLE: Administrator | (X6) DATE: 6/4/2021

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 558	Continued From page 1 According to the Admission Record, Resident 1 was admitted to the facility 15 years ago with diagnoses which included quadriplegia (complete paralysis of both the arms and legs from neck down), depression, and anxiety disorder. During a review of Resident 1's Minimal Data Set (MDS, resident care assessment tool), dated 9/10/20, indicated resident scored 15 out of 15 during the assessment which indicated he was cognitively intact. The same assessment under the Section G, Functional Status, indicated Resident 1 was totally dependent for staff's assistance for bed mobility, transfer, dressing, eating, and personal hygiene. During an observation on 10/6/20, at 11:40 a.m., Resident 1 was in his bed watching TV. Resident 1 stated he was not able to use his hands, but was able to control the remote control for his TV and make phone calls to his family by touching his phone with a stylus attached to his headband. Resident 1 stated he was able to push the call light (soft touch pad) with his chin when he needed to call for staff's assistance. When Resident 1 was asked to demonstrate how he used his call light, he slightly lowered the chin in an attempt to activate the call light. Resident 1 made a few attempts to locate a call light, but the call light was not there. Resident 1 stated the call light had a white cord and asked the Department to look for it in his bed. Upon further observation, it was noted that Resident 1's EZ touch call light was clipped to the white sheet draped over the bedside table which was standing parallel to the head of bed. The table with pinned call light was about two feet away and far from resident's reach. Resident 1 stated, "Sometimes they [staff]	F 558		

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F 558	Continued From page 2 forget to put it under my chin and I have no means to call them." During a concurrent interview on 10/6/20, at 11:40 a.m., Resident 1 explained that a few weeks ago he had an argument with one of his roommates over his roommate's TV being very loud. Resident 1 stated on that day when he asked his roommate (Resident 2) "to turn down his TV, the roommate became really aggressive, rolled up in his wheel chair to my bed ...grabbed a hanger, and hit me on my feet." Resident 1 added, "It hurt some, not bad ...I had a blanket over my feet ...but the most important I was afraid that he will get close to my head and hurt me ...see I can't move my arms and legs and have this fear ...I won't be able to defend myself." Resident 1 stated he was not able to call staff for assistance because the call light was not under his chin so he started yelling and called his wife on the phone who summoned facility's staff to resident's room. During a follow up observation and a concurrent interview with Licensed Nurse (LN 1) on 10/6/20, at 12 p.m., in resident's room, LN 1 stated staff usually checked on Resident 1 every 2 hours unless his call light was on. LN 1 explained that Resident 1 was able to activate the call light, but it should always be under resident's chin. LN 1 observed the call light was not by Resident 1's chin and looked around in resident's bed, but was not able to locate the call light anywhere. When LN found the call light pinned to a cover on the bedside drawer away from resident's reach, she stated, "...shouldn't be there, I don't know why it's not under his chin." A phone interview with a Social Services Assistant (SSA) was conducted on 10/9/20, at	F 558		

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F 558	Continued From page 3 1:20 p.m. The SSA stated on the day of the altercation between Resident 1 and Resident 2, she received a call from Resident 1's wife who stated that her "husband was attacked by his roommate." The SSA stated she immediately ran into Resident 1's room and removed Resident 2 from the room. The SSA stated she did not remember if Resident 1's call light was on or was accessible to him. The SSA did not provide any answer when asked if it was possible that Resident 1 did not have his call light by his chin to call for assistance and called his wife instead. A review of Resident 1's physician notes dated 9/23/20, at 6:09 p.m., indicated, "Patient states that about 1 week ago his roommate "attacked him" with a clothes hanger ...Apparently when he was being struck, he was unable to access his call light and this made him anxious and panic, he was able to call his wife who then subsequently called nursing staff to assist." A clinical record review indicated Resident 1 had a care plan initiated on 4/30/20 and titled, "The resident has EZ call light due to quadriplegia." The care plan's interventions were to "Encourage resident to use EZ call light when necessary," and "Staff will ensure that EZ is properly place (sic) at all times." During an observation and interview on 10/6/20, at 12:35 p.m., with Director of Staff Development (DSD) in Resident 1's room, which he shared with Resident 3 and Resident 4, the DSD stated that each resident should have his call light within reach. Upon entering the room, Resident 3 was observed assisted with feeding by a Certified Nursing Assistant (CNA 1). Resident 3's call light was hanging coiled on the wall above resident's	F 558		

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F 558	Continued From page 4 head, far from resident's reach. When DSD asked CNA 1 if she forgot to place the call light within resident's reach, CNA 1 replied, "he can't use it anyway." Resident 4 was sleeping in his bed and his call light was observed laying on the floor under his bed. CNA 1 stated that Resident 4 was not able to use the call light as well. The CNA 1 did not provide any answer when asked about residents' rights and facility's policies regarding the call lights. In an interview with a Director of Nursing (DON) on 10/6/20, at 12:55 p.m., the DON stated, "Each resident should have his/hers call light and it should be within their reach at all times. It doesn't matter if resident can use it or can't - it's the basic resident's right." In an interview with a facility's Administrator (ADM) and DON on 10/6/20 at 2:30 p.m., Resident 1's issues with accessibility to the call light were discussed. The ADM confirmed Resident 1 was very vulnerable and had lots of anxiety that somebody would hurt him and he would not be able to defend himself. The ADM stated all staff was aware of Resident 1's needs and his expectation was that before leaving resident's room, "staff double checks ...if his [Resident 1's] call light properly secured by his chin". Review of the document provided by the facility and titled, "Nursing Services Policy and Procedure Manual. Answering the Call Light," dated September 2003, indicated, "The purpose of this procedure is to respond to the resident's requests and needs. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Some residents	F 558		

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F 558	Continued From page 5 may not be able to use their call light. Be sure you check these residents frequently."	F 558		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their abuse policies and procedures to ensure one of 4 sampled residents (Resident 1) was free from abuse when he was hit by Resident 2. This failure resulted in vulnerable Resident 1 experiencing fear and anxiety for not being able to protect himself when another Resident hit his legs Findings: According to the Admission Record, Resident 1 was admitted to the facility 15 years ago with diagnoses which included quadriplegia (complete paralysis of both the arms and legs from neck	F 600		

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F 600	Continued From page 6 down), depression, and anxiety disorder. During a review of Resident 1's Minimal Data Set (MDS, resident care assessment tool), dated 9/10/20, indicated resident scored 15 out of 15 during the assessment which indicated he was cognitively intact. The same assessment indicated Resident 1 was totally dependent for staff's assistance for bed mobility, transfer, dressing, eating, and personal hygiene. Resident 2 was admitted to the facility in the spring of 2020 with multiple diagnoses which included dementia (memory impairment) and traumatic brain injury. During a review of the most recent MDS, dated 9/4/20 indicated Resident 2 scored 9 out of 15 during the assessment, indicating he had mild cognitive impairment. During an observation and a concurrent interview on 10/6/20, at 11:40 a.m., Resident 1 was in his bed watching TV. Resident 1 stated he was not able to use his hands, but was able to control the remote control for his TV and make phone calls to his family by touching his phone with a stylus attached to his headband. Resident 1 stated he was able to push the call light (soft touch pad) with his chin when he needed to call for staff's assistance. When Resident 1 was asked to demonstrate how he used his call light, he slightly lowered the chin in an attempt to activate the call light. Resident 1 made a few attempts to locate a call light, but the call light was not there. Upon further observation, it was noted that Resident 1's EZ touch call light was clipped to the white sheet draped over the bedside table. The table with pinned call light was about two feet away and	F 600		

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F 600	Continued From page 7 away from resident's reach. Resident 1 stated, "Sometimes they [staff] forget to put it under my chin and I have no means to call them." During an interview on 10/6/20, at 11:40 a.m., Resident 1 stated, "I can't move my arms and legs and I have this fear that somebody will come and attack me." Resident 1 continued, "Had an incident several years back and still afraid that I won't be able to defend myself." Resident 1 explained because of this fear, he requested the facility's administration that his roommates were non-ambulatory and the facility agreed to that arrangement. Resident 1 stated when he was in a different room, his roommates were not able to come over to his bed and hurt him, but then he was moved to this room. According to Resident 1, one of his roommates (Resident 2) was very loud constantly and "his TV was loud 24/7". Resident 1 stated when he asked his roommate to turn down his TV, he would start "name calling ...swearing all the time ...I couldn't sleep at night, had constant headache." During further conversation, Resident 1 stated one day when he asked his roommate (Resident 2) "to turn down his TV, the roommate became really aggressive, rolled up in his wheel chair to my bed ...grabbed a hanger, and hit me on my feet." Resident 1 added, "It hurt some, not bad ...I had a blanket over my feet ...but the most important I was afraid that he will get close to my head and hurt me." Resident 1 stated he was not able to call staff for assistance because the call light was not under his chin so he started yelling and called his wife on the phone who summoned facility's staff to resident's room. During a review of Social Services Note for	F 600		

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F 600	Continued From page 8 Resident 1, dated 9/21/20 at 1:32 p.m., indicated, "Notified by resident spouse via phone that resident is being attacked by roommate ...Immediately went into resident's room and observed resident lying in bed ...resident [Resident 2] in his wheelchair with a plastic hanger in his hand at the foot of the bed of the resident [Resident 1] ...When asked ...what happened resident [Resident 1] stated "the guy keeps the TV on 24 hours a day ...I have a headache. Resident stated the guy [Resident 2] began to say [expletives] words and other bad words towards me, he unplugged his TV and brought the plastic hanger at my legs and hit me ...I called my wife..." A review of Resident 1's physician notes dated 9/23/20, at 6:09 p.m., (visit was 3 days after the incident), indicated, "Depression/Anxiety/Panic attacks: recently exacerbated ...states that more recently he has been feeling more depressed and anxious ...Patient states that about 1 week ago his roommate "attacked him" with a clothes hanger ...Apparently when he was being struck, he was unable to access his call light and this made him anxious and panic." During an interview with Licensed Nurse (LN 1) on 10/6/20, at 12 p.m., LN 1 stated Resident 1 was alert and oriented, was unable to move his arms and legs, and entirely depended on staff's assistance. During an interview with LN 2 on 10/6/20, at 1:15 p.m., LN 2 stated Resident 2 was alert with forgetfulness and was impulsive. According to LN 2, when things were not his way, Resident 2 had tendency to argue with staff and/or residents.	F 600		

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F 600	Continued From page 9 In an interview with a Certified Nursing Assistant (CNA 2) on 10/6/20, at 1:26 p.m., CNA 2 stated Resident 2 was short-tempered. CNA 2 stated she witnessed Resident 2 yell at other residents in the past and she had to re-direct him to avoid altercation. A review of the facility's policy and procedure titled, "Abuse Prevention Program," dated 1/2019, indicated, "Our residents have the right to be free from abuse ...Our facility is committed to protecting our residents from abuse by anyone including ...other residents." In an interview with a facility's Administrator (ADM) and DON on 10/6/20 at 2:30 p.m., the ADM stated he was very familiar with Resident 1's needs and requests. The ADM confirmed Resident 1 was very vulnerable and had a lot of anxiety that "some confused and disoriented resident will hurt him and he would not be able to defend himself." The ADM stated he agreed to Resident 1's request to have bed bound roommates and explained that in the past Resident 1's roommates were non-ambulatory. The ADM stated that moving Resident 1 to a room with Resident 2 who was impulsive and short-tempered was not the best option.	F 600		

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NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Park Nursing & Rehabilitation Center	2257 Fair Oaks Blvd Sacramento, CA 95825

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F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)		" Preparation and/or execition of this plan of correction does not constitue admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on this Statement of Deficiencies. This plan of correction id prepared and/or executed soley bevause it is required by provisions of Health and Safety Code Section 1280 and CFR 483 Et seq. 1. Resident 1 is alert and able to make needs known.. Resident dependent on staff for all ADLs. He is able to tolerate sitting up in his motorized chair and can maneuver it on his own. Upon investigation staff reported always making sure resident 1's EZ touch call light be under his chin. On 10/06/20 call light cord was immediately placed under resident's 1 chin. 2. All other resident's call lights have been verified and are in reach. In-Servicing of the staff has been conducted on 10/26/2020, & 05/26/2021. 3. Department Managers will continue to conduct daily rounds to ensure compliance. 4. Changes will be reviewd by the QA&A	10/06/2020 10/06/2020 10/28/2020, 05/26/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Doug Hawkins, NHA	Administrator	6/4/2021

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F 600 SS=D	Free from abuse and neglect CFR(s): 483.12(a)(1)		1. Resident 1 is alert able to make needs known.. Resident 1 is dependent on staff for all ADLs, Resident 2 is alert and able to make needs known.. Resident 2 is indepedent with ADLs, admited with dementia(memory impairment) and trumatic brain injury, and mild cognitive impairment. At the time of incident sosial services immediately went into resident's room and observed resident 1 lying in bed, and resident 2 in his wheelchair with a plastic hanger in his hand at the foot of the bed of the resident 1, Social services immediately removed resident 2 from the room. Resident 2 had room change immediately from 49C to 9B, Social services discussed racial equality and gave support to both residents. Social service department visited residents 1&2, 3 continuous working days, then 2 days x 1 week to monitor for any emotional distress. 2. Skin assessment done on Resident 1, no scratches,no bruise,no marks,no injury noted, on Q shift charting for any changes on skin, also on monitoring for any emotional distress for 3 days. Resident 2 was on monitoring for room change X3 days from 49C to 9B. No change in behavior or anxiety noted. orientation given about the room , bathroom and introduced with the room mates. resident stated felt comfortable in the room. Resident 2 was on monitoring for any further changes on behavior. 3. In-Servicing of the staff has been conducted. 4. Changes reviewd by the QA&A.	09/21/2020 09/21/2020 09/21/2020 04/02/2021

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 reverse for further 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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Doug Hawkins NHA	Administrator	6/4/2021