PRINTED: 09/30/20
FORM APPROVED
OMB NO. 0938-03

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
	055956	A. BUILDING _____ B. WING _____	C 09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

10/6/20 Accepted.

(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 #CA00647949. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 38970 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		
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 protect one of three sampled residents (Resident 1) from physical abuse when another resident (Resident 2) hit Resident 1 on the arm.	F 600	**F-600 Free From Abuse & Neglect** **Corrective action initiated for Resident/s:** Resident 1 and 2 were separated. Resident 1 was assess for pain or any other injury and none noted. Resident 2 seen by Social Service Director regarding his behavior and no other behavior noted. Resident 1 and 2's primary physician was notified of the event.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/6/20

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.

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

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OMB NO. 0938-0391

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	050956	A. BUILDING _____ B. WING _____	C 09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

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F 600	Continued From page 1 This failure resulted in Resident 1 experiencing pain and had the potential to negatively affect her long term emotional well-being. Findings: Resident 2 was admitted to the facility in 2015 with diagnoses which included schizophrenia (a thought disorder). Resident 1 was admitted to the facility in 2018 with diagnoses which included dementia (a loss of memory, judgment, language, complex motor skills, and other intellectual function). Review of Resident 2's medical record revealed a care plan for inappropriate behavior, dated 6/19/19, which indicated Resident 2 was physically abusive toward others. Review of Resident 2's medical record revealed a nurse's note, dated 7/28/19, which indicated Resident 2 hit Resident 1 in the dining room, and told the staff it was because Resident 1 was trying to steal his food. Review of Resident 1's medical record revealed a nurse's note, dated 7/28/19, which indicated Resident 1 was hit by Resident 2 in the dining room. During an interview with the Director of Nursing (DON) on 8/2/19 at 11:40 a.m., the DON stated Resident 1 had intrusive behaviors, she was attracted to sweet food and would often try to steal other residents' dessert items. The DON stated staff were constantly redirecting Resident 1. The DON stated Resident 2 was, for the most part, quiet until you got into his space, and he	F 600	**How Potential Other Residents Were Identified and Corrective Action Taken** Director of Nursing and Director of Staff Developer check on other resident who have the potential to be aggressive. No other issue noted. **Measures/Systemic Changes Initiated to Prevent Future Recurrence** Director of Staff Development gave In-Service to staff, monitor resident closely while in the dining room and other area with emphasis on resident with potential to be aggressive and to monitor space between the residents. **Monitoring Plans to Ensure Solutions are Achieved and Integrated into QOI System.that will be** Director of Staff Developer will monitor resident sitting arrangement and space during each meal time. Weekly, Director of Staff Development and Activity Director will check dining room for residents seating assignment.	

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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
	055656	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 600	Continued From page 2 was then quick to correct you. DON stated she instructed staff to re-direct others away from Resident 2. During an interview with Certified Nurse Assistant 1 (CNA 1) on 8/2/19 at 4 p.m., CNA 1 stated she was in the dining room when the altercation occurred between Resident 1 and Resident 2. CNA 1 stated she had her back to Resident 1 when she heard a slapping sound and Resident 1 yelled "owee." CNA 1 stated she asked Resident 1 if she was hit and Resident 1 stated yes and pointed to Resident 2. CNA 1 stated Resident 2 admitted to hitting Resident 1 because she grabbed his spoon. Review of a facility policy and procedure titled "Abuse - Prevention Program" dated 11/16, indicated "The facility will prohibit all types of abuse...by identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behavior's which might lead to conflict..."	F 600	Administrator will provide a summary trend analysis of the findings to the facility's monthly CQI Steering Committee for further review, evaluation and recommendations, if any. Compliance Date: November 19, 2019	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607	F-607 Develop/Implement Abuse/Neglect Policies Corrective Action Initiated for Resident/s Director of Staff Developer gave training to staff in regards abuse prevention per facility Policy & Procedure.	

F 600 Amendment:

Director of Staff Development and other nursing staff members will monitor residents sitting arrangements and space during each meal. Weekly, Director of Staff Development and Activities Director will monitor dining room for residents seating assignments.

Date of Completion 11/17/19

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
	055858	A. BUILDING _____ B. WING _____	C 09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 607	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their abuse prevention policy and procedure when procedures were not implemented to prevent one of three sampled residents (Resident 1) from physical abuse by another resident (Resident 2). This failure resulted in Resident 1 experiencing pain and had the potential to negatively affect her long term emotional well-being. Findings: Resident 2 was admitted to the facility in 2015 with diagnoses which included schizophrenia (a thought disorder). Resident 1 was admitted to the facility in 2018 with diagnoses which included dementia (a loss of memory, judgment, language, complex motor skills, and other intellectual function) with behavioral disturbances. Review of Resident 2's medical record revealed a care plan for inappropriate behavior dated 3/11/19, indicated Resident 2 was physically abusive toward others. The care plan was last reviewed on 7/6/19. Review of Resident 1's medical record revealed physician orders for 7/19 contained no documented evidence of an order for staff to monitor and document Resident 1's behavioral disturbances. Review of Resident 2's physician orders for 7/19, revealed no documented evidence of an order for	F 607	**How Potential Other Residents Were Identified and Corrective Action Taken** Director of Nursing and Director of Staff Developer check on other staff in regards abuse Prevention training. No other issue noted. **Measures/Systemic Changes Initiated to Prevent Future Recurrence** Director of Staff Development completed schedule for abuse prevention training on different type of abuse. The Director of Staff Developer will reeducate the Staff regarding abuse prevention per facility Policy & Procedure as scheduled, from hire and as needed.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	055956	A. BUILDING _____ B. WING _____	C 09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	5901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 607	Continued From page 4 staff to monitor and document Resident 2's physically abusive behaviors. Review of Resident 1's medical record revealed no documented evidence of a care plan for Resident 1's dementia with behavioral disturbances. Review of Resident 1's medical record revealed a nurse's note, dated 7/28/19, which indicated Resident 1 was hit by Resident 2 in the dining room. Review of Resident 2's medical record revealed a nurse's note, dated 7/28/19, which indicated Resident 2 hit Resident 1 in the dining room, and told the staff it was because Resident 1 was trying to steal his food. During an interview with the Director of Nursing (DON) on 9/2/19 at 11:40 a.m., the DON stated Resident 1 had intrusive behaviors, she was attracted to sweet food and often tried to steal other residents' desert items. The DON stated staff were constantly redirecting Resident 1. The DON stated Resident 2 was, for the most part, quiet until you got into his space, and he was then quick to correct you. The DON stated she instructed staff to re-direct others away from Resident 2. During an interview with the DON on 9/2/19 at 2:30 p.m., the DON stated, when residents were involved in an altercation, the staff were expected to monitor the residents for 72 hours and develop a short term care plan related to the incident. The DON reviewed the medical records for Resident 1 and Resident 2, and confirmed neither resident had a short term care plan developed related to	F 607	**Monitoring Plans to Ensure Solutions are Achieved and integrated into QOI System that will be** Monitoring for timely completion of the abuse prevention per facility Policy & Procedure will be completed monthly by the Director of Staff Development. Administrator will conduct Monthly abuse prevention training per facility Policy & Procedure. The Administrator will provide a summary trend analysis of the findings to the facility's monthly CQI committee for further review and recommendations. **Compliance Date:** November 21, 2019	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055966	A. BUILDING _____ B. WING _____	C 09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	6901 LEMON HILL AVE SACRAMENTO, CA 95824

(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 607	Continued From page 6 their altercation. The DON also confirmed there was no documented evidence the staff monitored Resident 2's behavior for 72 hours following the incident. During an interview with Certified Nurse Assistant 1 (CNA 1) on 8/2/19 at 4 p.m., CNA 1 stated she was in the dining room when the altercation occurred between Resident 1 and Resident 2. CNA 1 stated Resident 1 was sitting at a separate table in close proximity to Resident 2. CNA 1 stated she had her back to Resident 1 when she heard a slapping sound and heard Resident 1 yell "owee." CNA 1 stated she asked Resident 1 if she was hit and Resident 1 stated yes and pointed to Resident 2. CNA 1 stated Resident 2 admitted to hitting Resident 1 because she grabbed his spoon. Review of a facility policy and procedure titled "Abuse - Prevention Program" dated 11/15, indicated "The facility will prohibit all types of abuse...by identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict..."	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610	**F-610 Investigate/Prevent/Correct/Alleged Violation** **Corrective Action Initiated for Resident/s** Previous administrator is no longer at Briarwood Post- Acute. Regional Operations Leader provided training to current Administrator in regards completion and submitting the results of an investigation allegation of abuse to CDPH with in five working days.	

F **607** Amendment:

Date of completion: 11/17/19

RTMENT OF HEALTH AND HUMAN SERVICES
ERS FOR MEDICARE & MEDICAID SERVICES

NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055958	A. BUILDING _____ B. WING _____	C 09/30/201

F PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD POST ACUTE	5001 LEMON HILL AVE SACRAMENTO, CA 95824

	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)	COMP DA
0	Continued From page 8 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report the results of an investigation of an allegation of abuse to the Department within five working days, per State law for one of three sampled residents (Resident 1). This failure placed Resident 1 at potential risk of further abuse. Findings: Resident 2 was admitted to the facility in 2016 with diagnoses which included schizophrenia (a thought disorder). Resident 1 was admitted to the facility in 2018 with diagnoses which included dementia (a loss of memory, judgment, language, complex motor skills, and other intellectual function). Review of Resident 1's medical record revealed a nurse's note, dated 7/26/19, which indicated Resident 1 was hit by Resident 2 in the dining room. The note indicated the writer reported the incident to the Nurse Practitioner, the Director of Nursing (DON), the Administrator, and the Department.	F 610	**How Potential Other Residents Were Identified and Corrective Action Taken** Regional Operations Leader reviewed results of investigation of allegation of abuse. No other issue noted. **Measures/Systemic Changes Initiated to Prevent Future Recurrence** Current Administrator and Director of Nurses will review reviewed results of investigation of allegation of abuse and will report to CDPH with five working days, per State Law. **Monitoring Plans to Ensure Solutions are Achieved and Integrated into CQI System that will be** Monitoring for timely completion of the reviewed results of investigation of allegation of abuse will be completed monthly by the Administrator will conduct Monthly abuse prevention training per facility Policy & Procedure. The Administrator will provide a summary trend analysis of the findings to the facility's monthly CQI	

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	055956	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD POST ACUTE	4901 LEMON HILL AVE SACRAMENTO, CA 95824

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F 610	Continued From page 7 Review of Resident 2's medical record revealed a nurse's note, dated 7/28/19, which indicated Resident 2 hit Resident 1 in the dining room, and told the staff it was because Resident 1 was trying to steal his food. During an interview with the DON on 8/18/19 at 11:06 a.m., the DON stated the Administrator had resigned and the Interim Administrator was the facility's abuse coordinator. During an interview with the Interim Administrator on 8/18/19 at 12:40 p.m., he stated the investigation was completed but he was not aware the results were not reported to the Department. The Interim Administrator stated he was aware of the five working day reporting timeframe to the Department. Review of a facility policy and procedure titled "Abuse - Reporting & Investigations" dated 11/16, indicated "The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to [The Department] and others that may be required by state or local laws, within five (5) working days of the reported allegation."	F 610	committee for further review and recommendations. Compliance Date: November 21, 2019	

F 610 Amendment:

Administrator will document each facility reported incident in a planner and in the planner the day that the five day summary is due will be noted. Facility reported incidents will be discussed during the next morning stand up meeting and staff will have access to the planner as well to check dates.

Date of Completion 11/17/19