STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555625	A. BUILDING _____ B. WING _____	C 10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA PARK REHABILITATION HOSPITAL	2850 SIERRA SUNRISE TERRACE CHICO, CA 95928

(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) COMPLETE DATE
F000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for a complaint. A COVID-19 focused survey for infection control was completed concurrently. Complaint Number: 699364 The inspection was limited to the specific facility reported incident or complaint investigated and does not represent the findings of a full inspection of the facility. Total Residents: 57 Representing the Department: 40091, Health Facilities Evaluator Nurse Deficiencies were issued for Complaint #699364 at F600 & F609.	F000		
F600 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	F600		

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

Electronically Signed NHA 10/27/2020

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one (Resident 1) of four sampled residents was free from abuse when Resident 2 was reported to slap the shoulder of Resident 1. This failure had the potential to negatively impact Resident 3's security, emotional and psychological well-being as well as placing other residents at risk for abuse by Resident 2. Findings: A review of facility policy titled, "Abuse, Prevention of," dated 11/24/17, indicated that "each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, exploitation, mistreatment and involuntary seclusion." "Facility staff is to identify, correct and intervene in situations in which abuse, neglect, exploitation and/or misappropriation of resident property are more likely to occur." "Resident to resident altercations are to be reviewed as a potential situation of abuse, even if one or both residents have a diagnosis of dementia." A review of Resident 1's clinical record indicated she was admitted to the facility on 9/21/17 with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people), muscle wasting and adult failure to thrive. The Minimum Data Set (MDS, a standardized assessment and care planning tool) indicated Resident 1 had	F600	**Plan of Correction F600:** 1. Resident 1 was interviewed on Aug. 3, 2020 and denied that event happened. Skin assessment was conducted on Aug. 5, 2020 with zero adverse effects. Facility Reported Incident conclusion submitted on Aug. 7, 2020 noted that Resident 1 was at baseline per nursing, social services, activity, and dietary assessments. Resident 2 also denied incident. Facility has reviewed care plans, sought interventions via Medical Director, IDT review, family consult and participation, room change, referral to Senior Bridges, pharmaceutical consult and as of Aug. 5, 2020; Resident was also at clinical baselines. 2 Facility has (and continues) to review the 24-hour resident care report to ensure that all behavioral interventions are appropriate and that residents are free from abuse. The Social Services designee has conducted intermittent resident safety interviews and the facility Resident Council has met monthly with zero safety issues forwarded to the IDT. The Facility has also relocated the Director of Staff Development (DSD) onto the Dementia Care Unit for enhanced supervisorial support to ensure optimal resident environment.	

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F600	Continued From page 2 moderate cognitive impairment and required one person assistance with activities of daily living. A review of "Interdisciplinary Team (IDT) Summary," dated 8/4/20 at 10:02 am in Resident 1's clinical record, indicated it was reported on 8/3/20 that Resident 2 slapped Resident 1 on the shoulder in their room on "7/30/20." Resident 1's skin was assessed on 8/3/20 and no discolorations noted. Resident 1's RP was notified of the alleged incident. A review of "Nursing Note," dated 8/3/20 at 5:41 pm in Resident 1's clinical record, indicated "On or about 7/30/2020 it was reported that there were allegations of abuse to patient. Patient does not have any marks, or brulsing to her upper chest, back or her shoulders. DON, Administrator, DSD (Director of Staff Development), MD (Medical Doctor) all aware. Will continue to monitor." A review of Resident 2's clinical record indicated she was admitted to the facility on 6/24/20 with diagnoses that included cognitive communication deficit, dementia and difficulty walking. The Minimum Data Set (MDS, a standardized assessment and care planning tool) indicated Resident 2 had severe cognitive impairment and required one person assistance with activities of daily living. A review of "Social Services Note," dated 7/29/20 at 2:43 pm in Resident 2's clinical record, indicated that Social Services Director (SSD) had spoken with Resident 2's family members updating them on the resident's "current behaviors over the last few days." A review of "Social Services Note," dated 7/30/20 at 4:04 pm in Resident 2's clinical	F600	**3.** Facility Administrator and (DSD) conducted prevention of abuse in-services on: Feb. 3, Aug. 3-7, 13, 20, 27, Sept. 1, 3, 11, and 23, 2020. The DSD and the Facility Dementia care consultant have also conducted dementia education and intervention training on Aug. 18, 25, 28, Sept. 16, and 17, 2020 to enhance the education and training of staff re: behavioral interventions and abuse prevention. 4. The facility shall monitor for freedom of abuse by reviewing: the 24-hour resident care report, the Resident Council minutes, the intermittent Resident interviews, admission, and the quarterly and change of condition care plans. Results of this review shall be forwarded to the Quality Assurance and Performance Improvement Committee, which meets as necessary and at least quarterly. The QAPI Committee shall review for implementation and effectiveness of the plan of correction. 5. Date of Completion: Oct. 26, 2020	

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F600	Continued From page 3 record, indicated "room move completed for resident." During an observation and concurrent interview on 8/3/20 at 2:09 pm with Nurse Assistant (NA) A, Resident 1 was observed in her room and did not have a roommate. NA stated the resident's roommate (Resident 2) had been moved to another about a week ago. She stated that Resident 2 had been moved for allegedly slapping and yelling at Resident 1. NA stated the altercation had been reported to the nurse and social services. During an interview on 8/3/20 at 2:19 pm with Resident 1 in her room, she stated she got along alright with her previous roommate (Resident 2). Resident 1 did not deny or confirm an altercation with Resident 2. During an observation an interview on 8/3/20 at 2:38 pm with Resident 2 in her room, Resident 2 confirmed she had been "moved for false pretenses" from another room. She stated she was accused of slapping her roommate and "would never hit her." During an interview on 8/4/20 at 11:40 am with Certified Nurse Assistant (CNA) D, he confirmed he was caring for Resident 2. CNA D stated that other CNAs had indicated that Resident 2 sometimes would get agitated with other residents and yell at them. During an interview on 8/4/20 at 12 pm with CNA H, she confirmed she was caring for Resident 1. CNA H stated she had heard that Resident 2 had hit Resident 1. CNA H indicated that CNA E was on duty at the time of the altercation and had reported it to the nurse on duty. CNA H stated that Resident 1 was	F600		

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F600	Continued From page 4 traumatized by the altercation. During an interview on 8/4/20 at 2:20 pm with Certified Nurse Assistant (CNA) E, she stated that on Tuesday or Wednesday the week before, she was standing across the hallway from the room of Residents 1 and 2. CNA E stated she heard an audible loud slap. When she entered the room to investigate, she observed Resident 1 holding her shoulder and heard Resident 1 state to Resident 2 "why would you do that." CNA E indicated that she immediately separated the residents by taking Resident 1 out of the room; CNA E stated she reported the incident to Licensed Nurse (LN) B. CNA E stated Resident 1 was moved to a different room three days later. CNA E indicated Resident 2 had a history of talking loudly over Resident 1 and saying "hurtful mean things" to her. During an interview on 9/23/20 at 2:44 pm with LN B, she stated she did not recall the specific date of the alleged altercation between Resident 2 and Resident 1 and did not witness it. LN B confirmed the altercation was reported to her by CNA E. She stated she assessed Resident 1 for injury and there were no marks or bruises present. LN A stated that both residents had denied any contact.	F600		
F609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident	F609	**Plan of Correction F609:** 1. Facility Administrator and (DSD) conducted reporting of abuse in-services on: Feb. 3, Aug. 3-7, 13, 20, 27, Sept. 1, 3, 11, and 23, 2020.	

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F609	Continued From page 5 property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 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 observation, interview and record review the facility failed to report alleged abuse by Resident 2, within 2 hours of discovery of an altercation with Resident 1, to the Administrator (ADM) and California Department of Public Health (CDPH). This failure had the potential to delay identification and implementation of appropriate corrective action and placed other facility residents at risk for potential abuse. Findings: A review of facility policy titled, "Abuse, Prevention of," dated 11/24/17, indicated that resident to resident altercations were to be reviewed as a potential situation of abuse and	F609	**2.** Facility has (and continues) to review the 24-hour resident care report to ensure that allegations of abuse incidents go unreported. The Social Services designee has conducted intermittent resident safety interviews and the facility Resident Council has met monthly with zero safety issues forwarded to the IDT. The Facility has also relocated the Director of Staff Development (DSD) onto the Dementia Care Unit for enhanced supervisorial support to ensure optimal resident environment. **3.** Facility Administrator and (DSD) conducted prevention of abuse in-services on: Feb. 3, Aug. 3-7, 13, 20, 27, Sept. 1, 3, 11, and 23, 2020. The DSD also conducts allegation of abuse prevention and reporting upon new hire orientation. 4. The facility shall monitor for reporting of allegations of abuse by reviewing: the 24-hour resident care report, the Resident Council minutes, the intermittent Resident interviews, admission, and the quarterly and change of condition care plans. Results of this review shall be forwarded to the Quality Assurance and Performance Improvement Committee, which meets as necessary and at least quarterly. The QAPI Committee shall review for implementation and effectiveness of the plan of correction.	

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F609	Continued From page 6 should be reported to the administrator immediately, but no later than two hours after receiving a report of actual, alleged or suspected abuse. The administrator, or mandated reporter in the absence of the administrator, were required by law to report the incident of actual, alleged or suspected abuse by written report by fax to CDPH and the local Ombudsman (an official who investigates and endeavors to resolve complaints made by, or on behalf of, individual residents in long-term care facilities) office. A review of the facility's reporting document to CDPH from ADM, dated 8/4/20, indicated the alleged abuse by Resident 2 towards Resident 1 occurred on 7/28/20 at 10:30 am and was reported to CDPH on 8/4/20 at 10:44 am. This was seven days after date of alleged altercation on 7/28/20. A review of "Interdisciplinary Team (IDT) Summary," dated 8/4/20 at 10:02 am in Resident 1's clinical record, indicated it was reported on 8/3/20 that Resident 2 slapped Resident 1 on the shoulder in their room on "7/30/20." Resident 1's skin was assessed on 8/3/20 and no discolorations noted. Resident 1's RP was notified of the alleged incident. A review of "Nursing Note," dated 8/3/20 at 5:41 pm in Resident 1's clinical record, indicated "On or about 7/30/2020 it was reported that there were allegations of abuse to patient. Patient does not have any marks, or bruising to her upper chest, back or her shoulders. DON (Director of Nursing), Administrator, DSD (Director of Staff Development), MD (Medical Doctor) all aware. Will continue to monitor." During an interview on 8/4/20 at 2:20 pm with	F609	5. Date of Completion: Oct. 26, 2020	

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F609	Continued From page 7 Certified Nurse Assistant (CNA) E, she stated that on Tuesday or Wednesday the week before, she was standing across the hallway from the room of Residents 1 and 2. CNA E stated she heard an audible loud slap. When she entered the room to investigate, she observed Resident 1 holding her shoulder and heard Resident 1 state to Resident 2 "why would you do that." CNA E indicated that she immediately separated the residents by taking Resident 1 out of the room. CNA E stated she reported the incident to Licensed Nurse (LN) B. During an interview on 9/23/20 at 2:44 pm with LN B, she stated she did not recall the specific date of the alleged altercation between Resident 2 and Resident 1 and did not witness it. LN B confirmed the altercation was reported to her by CNA E. She stated she assessed Resident 1 for injury and there were no marks or bruises present. LN A stated that both residents had denied any contact. She stated she did not report the incident or complete any forms/documents as she did not consider the situation as abuse. LN B stated that CNA E had reported the incident to "the State" about two days later. During an interview on 9/23/20 at 2:57 pm with Resident 1's Responsible Party (RP), he stated he had a vague memory of a CNA reporting to him that Resident 2 had hit Resident 1. RP stated that when he asked Resident 1 about the incident, she denied it. RP indicated it was not surprising that Resident 1 would deny the incident, as she was very nice and would never complain. RP stated the incident had occurred sometime in late July. During an interview on 9/24/20 at 8:38 am with SSD, she stated that Resident 2 was moved	F609		

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F609	Continued From page 8 from the room with Resident 1 to another room on 7/30/20, because Resident 2 was exhibiting behaviors. She stated she was not aware of the alleged altercation between the two residents until it was reported by CNA E on 8/4/20. DSS stated the altercation was then thoroughly investigated and both residents denied any altercation. DSD stated the incident should have been reported within two hours of the alleged occurrence. During an interview on 9/24/20 at 9:55 am with Director of Nursing (DON), she confirmed the alleged altercation between Resident 2 and Resident 1 occurred on or around 7/30/20. DON stated she was not aware of the incident until 8/3/20. She stated the alleged altercation should have been reported by staff immediately. DON confirmed the incident was reported to CDPH on 8/4/20. During an interview on 9/24/20 at 10:33 am with ADM, he stated he was not aware of the alleged altercation between Resident 2 and Resident 1, until the allegation of abuse complaint was being investigated by CDPH on 8/3/20. ADM stated staff should have reported the alleged altercation to him within two hours of the event, according to facility policy and regulation. He confirmed the incident was reported to CDPH via fax on 8/4/20 at 10:45 am, more than seven days after the alleged altercation.	F609		

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