

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/21/2025
NAME OF PROVIDER OR SUPPLIER  Yuba City Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1220 Plumas St Yuba City, CA 95991	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43031</b></p> <p>Based on Interview and Record Review the facility failed to report a crime or abuse incident for 1 of 3 residents (Resident 1) when Resident 2 's Family Member (FM) exposed himself to Resident 1 while in Resident 1 and Resident 2 's shared room.</p> <p>This failure to report to proper authorities placed all residents at risk for allegations of abuse to go unreported.</p> <p>Findings:</p> <p>During a review of the facility ' s policy and procedure titled, Abuse Investigation and Reporting, revised December 2018, the Abuse Investigation and Reporting policy indicated, All reports of resident abuse .(and) mistreatment .shall be promptly reported to local state and federal agencies .</p> <p>A review of Resident 1 ' s medical record indicated Resident 1 was admitted on [DATE] with diagnoses that included, Right Femur Fracture, R Femur Surgical Intervention, and History of Falls. The Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 1/8/25, indicated Resident 1 rated 15/15, which equates to being cognitively intact. Resident 1 is their own representative (RP) and make their own medical decisions.</p> <p>During an interview on 1/21/25 at 08:30 am, with Resident 1 over the phone, Resident 1 stated Resident 2 ' s Family Member (FM) came out of the shared bathroom and stood at the foot of the bed, made sounds of clearing the throat for attention, and exposed his genitals. I did not feel abused, just very uncomfortable.</p> <p>During an interview with Social Services Director (SSD), in SSD office, on 1/21/25 at 11:00 am, SSD indicated, SSD was aware of the incident, and interviewed both Resident 1 and FM. Resident 1 informed SSD there were no feelings of abuse, just felt very uncomfortable and requested a discharge from the facility. The facility did not file a report based on Resident 1 ' s response.</p> <p>During an interview with Administrator (Admin) in Admin ' s office, on 1/21/25 at 2:10 pm, Admin confirmed he is aware of the incident ' s occurrence, and the investigation was complete. Resident 1 did not wish to pursue reporting or feel the incident was abuse, thus, the facility did not file a report.</p> <p>(continued on next page)</p>

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
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