

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Willow Pass Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3318 Willow Pass Road Concord, CA 94519	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36593</p> <p>Based on observation, interview and record review, the facility failed to protect one (Resident 1) of three sampled residents' right to be free from verbal and physical abuse when, Resident 2 yelled and punched Resident 1 in the face. Resident 1 sustained skin tear with flap (a traumatic wound that is caused by direct contact between the skin and another object) during an altercation in the courtyard.</p> <p>This failure resulted in Resident 1's increased anger and fear for his safety at the facility from Resident 2.</p> <p>Findings:</p> <p>Review of Resident 1's Minimum Data Set (MDS- an assessment and care screening tool used to guide care), dated 3/26/24, indicated. Resident 1 had clear speech, able to express his ideas and wants, made self-understood and understood others. Resident 1 had no physical or verbal behavioral symptoms such as hitting, kicking, pushing, screaming, cursing, and threatening others. Resident 1 used wheelchair for mobility. Resident 1's diagnosis included depression and quadriplegia (a form of paralysis that affects all four limbs plus torso from neck down).</p> <p>During an interview on 4/11/24, at 11:15 a.m., Resident 1 stated he was outside in the courtyard patio when Resident 2 came to the patio and made a profanity statement about beating another resident. Resident 1 stated he told Resident 2 he will not beat anyone when Resident 1 was present. Resident 1 stated Resident 2 then punched him on the left side of his head eight times and scratched his face. Resident 1 stated there was no staff present during the altercation. Resident 1 stated he was angry and fearful for his safety at the facility from Resident 2.</p> <p>Review of Resident 2's Minimum Data Set, dated [DATE], indicated Resident 2 had clear speech, able to express his ideas and wants, and understood what others said to him. Resident 2 used wheelchair for mobility. Resident 2's diagnosis included schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly).</p> <p>During an interview on 4/11/24, at 11:25 a.m., Resident 2 stated Resident 1 called him a derogatory name. Resident 2 stated Resident 1 made him mad. Resident 2 said he hit Resident 1 in the face. Resident 2 said he tried to avoid Resident 1 every time he saw him.</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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's IDT (IDT - interdisciplinary team is a group of health care professionals with various areas of expertise who work together toward the goals of their clients) notes dated 3/13/24 indicated licensed nurse heard a loud verbal altercation from down the hall and noted Resident 1 and Resident 2 outside in the courtyard yelling at each other. Resident 2 stated Resident 1 hit him first. Resident 1 was noted with a small skin tear flap to the face. Resident 2 was noted with bleeding from two small skin tears in-between knuckles of the right hand. Incident was not witnessed by staff.</p> <p>During an observation of the courtyard, on 4/11/24, at 1:10 p.m., with Administrator (Admin) and Director of Nursing (DON), the courtyard had no visual oversight by the nursing staff. Admin stated there was no staff presence during the resident-to-resident altercation.</p> <p>Review of Resident 2's behavior care plan, initiated 5/31/23, indicated Resident 2 had behavior problems; easily get angry, yelling and cursing at other residents and staff. Resident 2 had the followings episodes of verbal and physical altercation:</p> <p>7/11/23 - encounter with another resident holding him on his wrist and calling him names;</p> <p>7/16/23 - Resident 2 had verbal altercation with another resident;</p> <p>11/11/23 - Resident 2 had alleged physical encounter with another resident both denied touching each other;</p> <p>11/18/23 - Resident 2 had alleged physical altercation with another resident;</p> <p>1/8/24 - Resident 2 had alleged physical altercation;</p> <p>3/12/24 - Resident 2 had resident to resident altercation;</p> <p>Resident 2's care plan intervention included anticipate and meet resident's needs.</p> <p>Review of Resident 1's psychosocial well-being care plan, initiated 7/16/23, indicated Resident 1 had potential for verbal altercation with another resident.</p> <p>During an interview on 4/11/24, at 2:35 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated she heard screaming from the courtyard patio and went to the area. LVN 1 said Resident 1 stated Resident 2 hit and punched him in the face. Resident 1 sustained skin tear to the face. LVN 1 stated there was no staff presence at the patio during the altercation. LVN 1 stated she did not remember if she updated Resident 1's care plan to address the altercation and injury sustained. LVN 1 stated she did not call the police but called the Administrator.</p> <p>During a concurrent interview with DON and clinical record review, on 4/11/24, at 12:15 p.m., DON stated Resident 1's care plan was not revised and updated to address verbal and physical altercation with Resident 2. DON said Resident 1's injury to face was not addressed on his care plan. DON stated she thought the focus was on Resident 2.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Abuse, Prevention, dated 9/1/2008, the P&P indicated, Each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals .		