STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055311	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Healthcare	315 Alameda Avenue Salinas, CA 93901

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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37686 Based on interview and record review, the facility failed to follow its abuse reporting policy for one of four sampled residents (Resident 1). This failure resulted in an incident of abuse not being investigated and had the potential to compromise the safety of the residents in the facility. Findings: Review of Resident 1's medical record indicated Resident 1 was admitted on [DATE] and had diagnoses including major depressive disorder (a mental condition characterized by long-term loss of interest or pleasure in life) and bipolar disorder (a mental health condition that causes extreme mood swings). Review of Resident 1's Progress Notes, dated 4/29/23, indicated licensed nurse A (LN A) witnessed Resident 1 yelling and cursing at another resident. The Progress Notes indicated Resident 1 then pushed the other resident's wheelchair with such force that the wheelchair rolled approximately 20 feet before coming to rest. Resident 1 then yelled, And don't come back! There was no documentation that indicated LN A reported this incident to anyone. During an interview and concurrent record review with LN B on 4/9/24 at 10:50 a.m., LN B reviewed Resident 1's 4/29/23 Progress Notes. LN B confirmed Resident 1's documented actions were considered abuse and should have been reported. LN B explained incidents of abuse should be reported to the facility's abuse coordinator. LN B stated the abuse coordinator would then report the incident to the Ombudsman (resident advocate), the California Department of Public Health (CDPH, State licensing and certification agency), and if necessary, the police. During a follow-up interview with LN B on 4/9/24 at 1:58 p.m., in the presence of administrative staff C (AS C), LN B confirmed there was no documentation that the incident involving Resident 1 on 4/29/23 was reported to the facility's abuse coordinator, the Ombudsman, CDPH, or the police. During a telephone interview with LN A on 4/9/24 at 2:11 p.m., LN A indicated she vaguely remembered the incident involving Resident 1 on 4/29/23. LN A stated she did not remember if she reported the incident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Abuse Investigation and Reporting, revised 7/2017 indicated, All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director.