

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Riverside Point Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Cohasset Rd Chico, CA 95926	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 49418</p> <p>Based on observation, interview, and record review, the facility failed to protect residents' rights to be free from physical, psychological (mental), or verbal sexual abuse for two of four sampled residents (Residents 1 and 3) when:</p> <ol style="list-style-type: none"> 1. Resident 2 made sexually explicit comments to Resident 3 and continued to harass her after staff and law enforcement asked him to stop. 2. Laundry Personnel 2 (LP2) touched Resident 1 on the shoulder and whispered into her ear, which made Resident 1 feel very uncomfortable. <p>These failures caused mental suffering and feelings of distress for Resident 3 and an increase in anxiety for Resident 1.</p> <p>Findings:</p> <p>During a review of facility Policy and Procedure (P&P) titled Unusual Occurrence Reporting, dated 8/1/12, the P&P indicated its purpose was to ensure timely reports are made to designated agencies as required by state and federal laws and regulations. The P&P further indicated the facility will report by phone and in writing to the appropriate State or Federal agencies allegations of abuse or neglect and other unusual occurrences that interfere with facility operations and affect the welfare, safety, and health of residents, employees, or visitors. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing. The facility conducts and documents timely and thorough investigations into all unusual occurrences and takes corrective action as appropriate. Reportable events will be documented on AP-12-Form B-Reportable Events Log.</p> <p>During a review of facility P&P titled AN07 Abuse-Reporting and Investigations, dated 1/3/24, the P&P indicated purpose: To protect the health, safety, and welfare of facility residents. The facility will (a) report all allegations of abuse and criminal activity as required by law and regulations to appropriate agencies and (b) will promptly report and thoroughly investigate allegations of resident abuse, mistreatment, neglect, exploitation, abuse facilitated or enabled using technology, misuse/theft of resident property, injuries of unknown source, and any suspicion of crimes.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. During a review of Resident 2's Interdisciplinary Team Note (IDT - a team of professionals from different disciplines who help plan residents' care), dated 4/30/24 at 1:37 pm, indicated Resident 2 was admitted [DATE], from a local hospital after hitting his head during a seizure. The record indicated current status of homelessness and methamphetamine abuse with cognitive deficits (impairment in mental processing) were noted, but no behavioral issues at that time.</p> <p>During a review of Resident 2's Order Summary Report: Active Orders as of 6/1/24, printed 7/18/24, the record indicated Resident 2 was capable of making his own healthcare decisions and had diagnoses of a stable fracture of the third thoracic vertebra (a bone in the low neck/upper back that protects the spine), difficulty walking, muscle weakness, and a history of transient ischemic attack (mini stroke) and cerebral infarction (death of brain tissue related to a blood clot).</p> <p>During a review of Resident 3's Order Summary Report: Active Orders as of 6/20/24, indicated Resident 3 had diagnoses of left-sided partial paralysis from a stroke, muscle weakness, abnormality of gait (walking) and mobility (ability to move), and anxiety disorder. The record indicated an active order was placed 5/27/24, indicating Resident 3 was not capable of making her own healthcare decisions related to her prior stroke, and 'Healthcare Decision Maker' role was assigned to Family Member 1 (FM1).</p> <p>During a review of a record titled Smoking Residents, interviews conducted on 6/20/24, indicated Resident 3 reported Resident 2 made sexual comments toward her the night of 6/19/24, had tried to cause a fight with Resident 4, and had used foul language about FM1.</p> <p>During a review of Resident 2's medical record titled Psychosocial Note, dated 6/20/24 at 11:54 am, indicated local law enforcement spoke with Resident 2 and informed him the female resident [Resident 3] did not like those comments and he was to stay away from resident if she was asking him to do so. The record indicated the Administrator (ADM), and charge nurse were notified.</p> <p>During a review of Resident 3's Psychosocial Note, dated 6/20/24 at 6:17 pm, indicated Resident 3 stated, I don't like it when he says I give him [Resident 2] a [NAME], and He asked me what hand I use to play with myself. Resident 3 reported Resident 2 made similar comments to a Certified Nurse Assistant (CNA) during a residents' smoke break. The record indicated Resident 2 was given a smoke break separate from Resident 3.</p> <p>During a review of Resident 3's Care Plan for admission indicated the Social Services Director (SSD) revised an active order on 6/20/24. The order indicated Resident 3 had a psychosocial (relating social conditions to mental health) wellbeing problem related to being harassed and receiving an inappropriate sexual statement from another resident on 6/20/24. Interventions ordered included allowing the resident time to answer questions and verbalize feelings, perceptions, and fears; consulting with pastoral care, Social Services, and/or psychology services as needed; and to encourage participation from resident who depends on others to make own decisions.</p> <p>During a review of Resident 3's Alert Note, dated 6/20/24 at 10:27 pm, indicated Resident 3 stated she still has feelings of distress related to the incident of being harassed and inappropriate sexual behavior by another resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Facility-Reported Incident Intake Information received by State Agency, dated 6/21/24 at 7 am, the record indicated alleged resident-to-resident abuse occurred when Resident 2 asked Resident 3 a series of sexually oriented questions. The record indicated Resident 3 suffered sexual and psychological/mental abuse resulting in mental suffering.</p> <p>During a review of Resident 3's Psychosocial Note, dated 6/21/24 at 6:13 pm, indicated Social Services visited Resident 3 to check on her wellbeing. The record indicated Resident 3 had spoken with the Ombudsman (OMB - an official who investigates individuals' complaints against administration) about the incident. The record indicated Resident 2 had been writing signs and notes, and Resident 3 stated she does not like that. Resident 3 stated she felt more comfortable going out to smoke now that Resident 2 had a separate smoke break time.</p> <p>During a review of Resident 2's Alert Note, dated 6/21/24 at 10:26 pm, Licensed Vocational Nurse 4 (LVN4) documented Resident 2 wheeled himself to room [ROOM NUMBER] (Resident 3's room) where he is not allowed to be near, and CNA attempted to redirect him when he started yelling and cussing. The record indicated LVN4 intervened and also asked him to leave, to which Resident 2 replied he had a right to be there and nobody has asked him before to stay away. The record indicated Resident 2 asked LVN4, Do you know what I can do? Do you know where I'm from? The record indicated Resident 2 left the area still cussing at staff.</p> <p>During a review of Resident 2's Alert Note, dated 6/24/24 at 11:40 am, indicated Resident 2 expressed a desire to leave against medical advice rather than transfer to a suitable room within the facility. The record indicated the physician arranged for Resident 2's medications to be provided on discharge, including a two-week supply of narcotics, subject to in-house availability of the medications. The record indicated Resident 2 replied, That's okay. I can medicate myself. I've already done so this morning.</p> <p>During a review of Resident 2's Social Services, dated 6/24/24 at 1:46 pm, the record indicated Resident 2 was discharged from the facility against medical advice. The record indicated transportation was arranged for Resident 2 to a nearby town but that he refused to provide the facility an exact address.</p> <p>During a review of record titled Smoking Residents, interviews conducted 6/26/24, the record indicated Resident 3 reported she feels safer and better now that Resident 2 is gone.</p> <p>During a review of record titled Smoking Residents, interviews conducted 6/27/24, the record indicated Resident 3 reported feeling safer. Resident 5 reported she was scared Resident 2 would come back to the facility at night, noting that Resident 2 is mad at her and others. Resident 5 stated she is afraid the doors will be left unattended and Resident 2 will come in. Resident 15 reported feeling uncertain of knowing what Resident 2 is capable of doing, concerned he could possibly be carrying a weapon. Resident 6 reported seeing Resident 2 behind a facility fence and was afraid of him hopping over the fence. Resident 6 reported feeling uneasy, anxious, and stated Resident 2 should be arrested. Resident 14 reported feeling ok but stated she did witness Resident 2 being aggressive to others and him needs to stay away. Resident 12 reported anxiety, afraid Resident 2 may come back with a weapon. Resident 12 reported seeing Resident 2 behind the facility, feeling unsafe that he keeps showing up at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Director of Nursing (DON) on 7/3/24 at 3:45 pm, DON stated we did our best with Resident 2 while he was at the facility. DON stated Resident 2 put inappropriate notes on his door, and facility residents complained that they were intimidated or frightened by the notes. DON stated Resident 2 once informed her he had been in prison for [AGE] years for murder; DON believed it was to let her know he was someone she should take seriously. DON stated Resident 2 had been homeless prior to admission. DON stated Resident 2 would have erratic behavior and often had strange visitors, noting his behavior would get worse after the visitors left. DON acknowledged concern for potential substance use while he was in the facility.</p> <p>During an interview with OMB on 7/5/24 at 8:48 am, OMB stated she was familiar with Resident 2 and noted, while she was not a medical professional, she was sure he had a major mental illness. OMB stated his thought process was tangential (adding irrelevant or excessive details to conversation) and he willfully tried to aggravate other residents by saying very crude things to them. OMB stated he was discharged against medical advice but was coming back trying to agitate people, at one point throwing bottles toward the building. OMB stated ADM reported Resident 2 had returned to the facility twice since discharge and police had been called. OMB stated he had not hit a resident with a bottle to her knowledge. OMB stated, I'm assuming [Resident 2] will get 5150'd (an involuntary 72-hour psychiatric hospitalization for adults in danger of harming themselves or others) at one point. OMB stated the facility attempted to get a 5150 for Resident 2, but police told ADM 'Cussing and words' didn't qualify as 5150. OMB stated Resident 2 was awful, noting he was going into a young woman's room saying very inappropriate things like, 'Suck my d*ck.' OMB stated staff did a lot of work because they were concerned with his safety and others'.</p> <p>During an interview with Licensed Vocational Nurse 1 (LVN1) on 7/10/24 at 2 pm, LVN1 stated staff had been directed to keep [Resident 2] out of [Resident 3's] room because he kept going in there incessantly.</p> <p>During an interview with LVN3 on 7/10/24 at 2:33 pm, LVN3 stated Resident 2's behavior was frequently disruptive. LVN3 stated Resident 2 made other staff and residents uncomfortable and stated other resident smokers didn't feel safe with him around. LVN3 stated Resident 2 followed Resident 3 around and made really bad comments. LVN3 stated she sat in Resident 3's room with her after the incident of 6/20/24. LVN3 stated when Resident 2 walked by the room, Resident 3 asked her, Why is he here? LVN3 stated department heads began sitting in the dining room during meals, and the facility started putting extra people outside to monitor smokers during smoke breaks, not just one CNA. LVN3 stated eventually Resident 2 was separated from others for smoke breaks.</p> <p>During an interview with Resident 3 on 7/18/24 at 12:21 pm, resident was observed in her room eating lunch with Restorative Nurse Assistant 1 (RNA1 - cares for residents who require assistance with functional abilities) seated nearby. Asked about the incident of 6/19/24, Resident 3 stated Resident 2 was disgusting and constantly harassing her verbally. Resident 3 stated Resident 2 came to her door once in the middle of the night but nurses intervened and told him to leave her alone. Resident 3 acknowledged she was afraid and anxious. Resident 3 stated before Resident 2 was discharged, I didn't go outside anymore. If I did, I went with [Family Member 1]. Resident 3 stated she felt safe for the most part now that Resident 2 had discharged but noted Resident 2 comes back to see me. Resident 3 stated, As long as he stays gone, I'm fine.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with ADM on 7/18/24 at 2:15 pm, ADM stated Resident 2 had returned to the facility after his discharge, and police had been notified. ADM stated he had called the police twice, and the facility was placed in lockdown (all doors and windows locked, staff and residents inside) at one point while law enforcement searched for Resident 2. ADM acknowledged that the lockdown should have been reported to State Agency but was not. ADM initially stated Resident 2 had not been inside the facility since his discharge but later stated, I take that back. He made it in once. ADM stated Resident 2 returned to visit a resident. ADM stated, I escorted him to the room with the receptionist, resident didn't want to see him, and we walked him out. Asked if he was aware staff and residents were reporting concern that Resident 2 kept returning, ADM stated, I have had no note of that from staff. ADM stated SSD interviewed all the residents who smoke for four weeks, and they stopped the interviews because their answers indicated all was well. ADM offered to provide copies of two police reports at a later time: one from the lockdown and one from an incident where drugs were removed by law enforcement from the property (source unknown). Police reports had not been received as of 7/24/24.</p> <p>2. During a review of record titled Minimum Data Set (MDS - a resident assessment and care screening tool), dated 4/24/24, the record indicated Resident 1 was an alert female with a score of 15 out of 15 (no mental impairment) on Brief Interview for Mental Status (BIMS - a resident assessment tool of mental function). The MDS indicated Resident 1 required substantial/maximal assistance to move in bed or transfer to chair or shower and used a wheelchair when out of bed. The MDS indicated Resident 1 had diagnoses of previous leg fracture, debility (weakness), respiratory failure, and history of anxiety and depression.</p> <p>During a review of Resident 1's medical record titled Psychosocial (relating social conditions to mental health) Note, dated 5/31/24 at 3:37 pm, the record indicated Social Services Director (SSD) was notified Resident 1 was making statements of being touched on the shoulder by a male and it made her uncomfortable. SSD visited Resident 1 and asked what had happened that made her feel uncomfortable. Resident stated she had her head back, trying to fall asleep, when the male from laundry came in with clothes, rubbed her shoulder, it made me feel uncomfortable, and I froze. Resident 1 stated she wanted to fill out a grievance form, and one was provided. Resident 1's room was made into a female only room.</p> <p>During a review of record titled Resident Grievance/Complaint Investigation Report, dated 5/30/24 [sic], the record indicated Resident 1, in a handwritten statement, reported an older man from laundry dept. came into her room, began putting clothes away, he started chit-chatting [sic] with me and getting closer. Before I knew it, he was up against my bed then he began. (handwriting stopped there). Immediate Corrective Action Taken: Room female only. No males allowed in room. Investigation Initiated: 5/31/24. Assigned Department's Response to Grievance: Laundry supervisor notified of complaint. Staff educated and in-serviced on going into female-/male-only rooms. Was the grievance confirmed? No. Resident will be monitored for psychosocial wellbeing, and room will be kept female only until needed. Follow-up Required? No.</p> <p>During a review of records titled Corrective Action Memo, dated 5/30/24 and 6/6/24, indicated verbal and written warnings were given to Laundry Personnel 2 (LP2) for violation of policy or procedure. The records indicated LP2 was not passing residents' personal clothing items on his shift and putting clean clothes back on the dirty side to be rewashed and done by the next shift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During review of record titled Interdisciplinary Team (IDT) Note, dated 6/19/24 at 4:37 pm, indicated team members present were SSD, Nursing Supervisor (LVN2), DON, Activities Director (AD), and Administrator (ADM). The record indicated Resident 1 was at risk for decline in psychosocial well-being due to an incident on 5/30/24 of feeling uncomfortable when a male staff member touched her shoulder. The record indicated a facility consultant and SSD deemed it appropriate to open an Adult Protective Services (APS) case, and a report was filed 6/19/24. The record indicated the Medical Director (MD) was notified.</p> <p>During a review of Facility-Reported Incident Intake Information received by State Agency, dated 6/20/24 at 7:56 am, the report indicated alleged physical and psychological/mental staff-to-resident abuse from unknown (male) to Resident 1 occurred on 5/30/24 resulting in no physical injury. The record indicated a male from the laundry came into Resident 1's room and touched her shoulder, which made her uncomfortable.</p> <p>During a review of Resident 1's Psychological Evaluation and Consultation, dated 6/3/24, written by Doctor of Psychology (PSYD), the record indicated date of service 5/31/24. Referring Physician: MD. Note: Resident 1 shared a recent situation that caused her to feel upset with mild anxiety symptoms. Compared to a previous assessment approximately three months ago, this indicates an increase in anxiety.</p> <p>During review of record titled In-Service/Meeting Sign-In Sheet, dated 6/5/24, indicated a lecture was given on 6/5/24 titled No going into room [ROOM NUMBER] (Resident 1's room). Staff in attendance included Laundry Personnel 1 (LP1 - instructor), LP2, Housekeeper 1 (HK1), and LP3.</p> <p>During a review of nine written resident interviews (Residents 5, 7, 8, 9, 10, 11, 12, 13, 14), untitled, dated 6/21/24, interview questions asked the following: (a) Have any male laundry workers made you feel uncomfortable? and (b) If so, who was it, and when did it happen? Resident 5's interview indicated an older white guy made her feel uncomfortable, she noticed him just watching, and he makes her nervous. Resident 7's interview indicated an older white gentleman with glasses made her feel uncomfortable (name unknown).</p> <p>During an interview with SSD and ADM on 7/3/24 at 3:55 pm, SSD stated the alleged abuse to Resident 1 occurred 5/30/24, and they had identified the unknown male employee as LP2. SSD stated she spoke with the OMB who informed the facility to report the alleged abuse incident to the State Agency. SSD stated she had interviewed several residents about LP2, and two other residents also complained about him. ADM left briefly and returned with the personnel file of LP2. ADM stated I would find in the file that LP2 had been terminated effective today (7/3/24), but it was related to poor job performance, not the abuse complaint.</p> <p>During a review of records titled Personnel Change Notice, dated 7/3/24, the record indicated LP2 was hired 4/23/24 and terminated effective 7/3/24 due to violation of policy or procedure.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with LP1 on 7/10/24 at 12:40 pm, LP1 stated she interviewed Resident 1 shortly after receiving notice of the alleged abuse by LP2 on 5/30/24. LP1 stated Resident 1 reported being half asleep, dozing, and saw LP2 enter the room and put clothes in the closet. Resident 1 reported LP2 leaned into her, caressed her shoulder, and whispered something, but Resident 1 couldn't remember what he said because she froze. LP1 stated she immediately reported her findings to ADM, probably a day or two after the incident. LP1 stated staff were notified that no male employees could enter Resident 1's room without a second party but that LP2 could not enter the room at all. LP1 stated LP2 denied any wrongdoing and repeatedly declined to write a statement telling his side of the story. LP1 stated LP2 was suspended after the abuse incident. LP1 stated LP2 returned from suspension and, when questioned, admitted going back into Resident 1's room despite being told not to do so, stating, No one was in the room. LP1 stated she spoke with a corporate consultant who advised suspending LP2 for going back into Resident 1's room despite in-service and warnings. LP1 stated she had written up LP2 for poor job performance four or five times during his employment for being insubordinate. LP1 stated she did not feel comfortable giving him verbal reprimands, however, without a male present, and she usually brought [Maintenance Supervisor]. LP1 stated in a discussion with ADM, ADM advised her to monitor him and keep reporting incidents to ADM. LP1 voiced concerns that LP2 had not returned a set of keys that open the back door of the facility and chemical rooms. LP1 stated he also knew the door codes to the laundry room, noting it was the same code for all employees and that the code opened the whole building.</p> <p>During an interview with Resident 1 on 7/10/24 at 1:40 pm, Resident 1 stated she remembered the incident with LP2 but could not remember the words LP2 said to her. Resident 1 stated she was drowsy and nodding off in her bed, eyes closed. Resident 1 stated it sounded like someone was putting away clothes in the closet and she came to find LP2 caressing her left shoulder and whispering in her ear. Resident 1 stated she froze because his actions made her very uncomfortable. Resident 1 stated she spoke to SSD on 5/31/24 and a grievance was filed. Asked about residual effects from the incident, Resident 1 stated, I'm okay since he's not here. Resident 1 stated she felt Administration did the right thing by firing him, adding, I think he stayed here too long.</p> <p>During concurrent interview with ADM on 7/18/24 at 2:15 pm and review of records titled [LP2] 4/15/2024 - 7/18/2024 (timecards showing days/hours worked), ADM stated, Within 24 to 48 hours of starting the investigation, we identified it was [LP2] as the perpetrator of abuse to Resident 1 on 5/30/24. During review of timecard time stamps, ADM acknowledged LP2 had been suspended with pay for three days while the abuse allegation was investigated (6/20, 6/21, and 6/22/24 - 20 days after the incident). The record indicated LP2 returned to work five more days (6/26 - 6/29/24 and 7/2/24) before his termination effective 7/3/24. When asked if LP2's behavior toward Resident 1 had been unacceptable, ADM stated LP2 did a gesture that's done 5000 times a day by CNAs to residents. ADM stated Resident 1's room had been made female only while they investigated without knowing LP2's identity because of Resident 1's being uncomfortable with the incident. ADM stated their investigation of the incident revealed LP2 was determined to not be a threat. ADM stated SSD interviewed other residents, and they let him come back.</p> <p>(continued on next page)</p>		

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<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>49418</p> <p>Based on observation, interview, and record review, the facility failed to report allegations of abuse within 24 hours for one of four residents (Resident 1).</p> <p>This failure had the potential for ongoing staff-to-resident abuse for all 89 residents within the facility.</p> <p>Findings:</p> <p>During a review of facility Policy and Procedure (P&P) titled Unusual Occurrence Reporting, dated 8/1/12, the P&P indicated its purpose was to ensure timely reports are made to designated agencies as required by state and federal laws and regulations. The P&P further indicated the facility will report by phone and in writing to the appropriate State or Federal agencies allegations of abuse or neglect and other unusual occurrences that interfere with facility operations and affect the welfare, safety, and health of residents, employees, or visitors. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing. The facility conducts and documents timely and thorough investigations into all unusual occurrences and takes corrective action as appropriate. Reportable events will be documented on AP-12-Form B-Reportable Events Log.</p> <p>During a review of record titled Minimum Data Set (MDS - a resident assessment and care screening tool), dated 4/24/24, the record indicated Resident 1 was an alert female with a score of 15 out of 15 (no mental impairment) on the Brief Interview for Mental Status (BIMS - a resident assessment tool of mental function). The MDS indicated Resident 1 required substantial/maximal assistance to move in bed or transfer to chair or shower and used a wheelchair when out of bed. The MDS indicated Resident 1 had diagnoses of previous leg fracture, debility (weakness), respiratory failure, and history of anxiety and depression.</p> <p>During a review of Resident 1's medical record titled Psychosocial (relating social conditions to mental health) Note, dated 5/31/24 at 3:37 pm, the record indicated Social Services Director (SSD) was notified Resident 1 was making statements of being touched on the shoulder by a male and it made her uncomfortable. SSD visited Resident 1 and asked what had happened that made her feel uncomfortable. Resident stated she had her head back, trying to fall asleep, when the male from laundry came in with clothes, rubbed her shoulder, it made me feel uncomfortable, and I froze. Resident 1 stated she wanted to fill out a grievance form, and one was provided. Resident 1's room was made into a female only room.</p> <p>During a review of record titled Resident Grievance/Complaint Investigation Report, dated 5/30/24, the record indicated a handwritten statement by Resident 1 reported an older man from laundry dept. came into her room, began putting clothes away, he started chit-chatting [sic] with me and getting closer. Before I knew it, he was up against my bed then he began. (handwriting stopped there). Immediate Corrective Action Taken: Room female only. No males allowed in room. Investigation Initiated: 5/31/24. Assigned Department's Response to Grievance: Laundry supervisor notified of complaint. Staff educated and in-serviced on going into female-/male-only rooms. Resident will be monitored for psychosocial wellbeing, and room will be kept female only until needed. Follow-up Required? No.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Riverside Point Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Cohasset Rd Chico, CA 95926	
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During review of record titled Interdisciplinary Team (IDT) Note, dated 6/19/24 at 4:37 pm, indicated team members present were SSD, Nursing Supervisor (NS), Director of Nursing (DON), Activities Director (AD), and Administrator (ADM). The record indicated Resident 1 was at risk for decline in psychosocial well-being due to an incident on 5/30/24 of feeling uncomfortable when a male staff member touched her shoulder. The record indicated a facility consultant and SSD deemed it appropriate to open an Adult Protective Services (APS) case, and a report was filed 6/19/24. The record indicated the MD was notified.</p> <p>During a review of Facility-Reported Incident Intake Information received at State Agency California Department of Public Health, dated 6/20/24 at 7:56 am, the report indicated alleged physical , and psychological/mental employee-to-resident abuse occurred on 5/30/24 when a male from the laundry came into Resident 1's room and touched her shoulder, which made her uncomfortable. The record indicated the alleged abuse resulted in no physical injury.</p> <p>During an interview with Laundry Personnel 1 (LP1) on 7/10/24 at 12:40 pm, LP1 stated she interviewed Resident 1 shortly after receiving notice of the alleged abuse by LP2 on 5/30/24. LP1 stated Resident 1 reported she had been half asleep, dozing, saw LP2 enter the room and put clothes in the closet. LP1 stated Resident 1 reported LP2 leaned into her, caressed her shoulder, whispered something, and Resident 1 couldn't remember what he said because she froze. LP1 stated she immediately reported her findings to ADM, probably a day or two after the incident.</p> <p>During an interview with Resident 1 on 7/10/24 at 1:40 pm, Resident 1 stated she remembered the incident with LP2 but could not remember the words LP2 said to her. Resident 1 stated she was drowsy and nodding off in her bed, eyes closed. Resident 1 stated it sounded like someone was putting away clothes in the closet and she came to to find LP2 caressing her left shoulder and whispering in her ear. Resident 1 stated she froze because his actions made her very uncomfortable. Resident 1 stated she spoke to SSD and a grievance was filed on 5/31/24.</p> <p>During concurrent interview with ADM on 7/18/24 at 2:15 pm and review of LP2s timecards, dated 4/15/24 to 7/18/24, ADM stated, Within 24 to 48 hours of starting the investigation, we identified it was [LP2] as the alleged abuser of Resident 1 on 5/30/24. During review of the timecards, ADM acknowledged LP2 had been suspended with pay for three days (6/20, 6/21, and 6/22/24) while the abuse allegation was investigated 20 days after it occurred.</p> <p>During an interview with SSD on 7/18/24 at 3 pm, SSD stated Licensed Vocational Nurse 2 (LVN2) was the first to hear report of LP2-to-Resident 1 alleged abuse. SSD stated, We [staff] are all mandated reporters. SSD stated the facility protocol is, Usually the first person to hear about the abuse reports it; however, SSD stated she does most of the reporting because she is often the first to hear about abuse.</p> <p>During an interview with LVN2 on 7/18/24 at 3:46 pm, LVN2 stated she was the first person to take Resident 1's account of the allegation of staff-to-resident abuse between LP2 and Resident 1. LVN2 stated, I heard it. [Resident 1] felt it was abuse. She was scared. LVN2 acknowledged she was a mandated reporter and should have notified appropriate agencies as the first person aware of the incident. LVN2 stated she assumed SSD would report it 5/31/24. LVN2 stated she freaked out when she learned the incident had not been reported right away.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident environments remained free from avoidable accidents and hazards when Resident 5 lived in her bedroom for three days with a ceiling leak from a malfunctioning rooftop air conditioning unit. This failure resulted in a negative psychosocial (relating social conditions to mental health) outcome when Resident 5 stated she felt frustrated and worried, and put her a risk for accidents and hazards.</p> <p>Findings:</p> <p>During a review of facility records titled Administrator (ADM) Job Description, undated, the record indicated ADM is responsible for directing and monitoring compliance with federal and state regulations and laws, coordinating compliance with established policies and procedures, hiring and training competent and committed staff, and positioning the facility to operate in a successful manner.</p> <p>During a review of facility Policy and Procedure (P&P) titled Maintenance Service: Operational Manual - Physical Environment, dated 1/1/12, the P&P indicated its purpose is to protect the health and safety of residents, visitors, and staff by maintaining all areas of the buildings, grounds, and equipment in a safe and operable manner at all times. The Maintenance Department is responsible for maintaining heating and cooling system, plumbing fixtures, wiring, etcetera, in good working order, and for establishing priorities in providing repair service.</p> <p>During a review of facility record titled Maintenance Log, dated 4/30/24 to 7/18/24, the record indicated on 7/8/24, specific Issue/Problem: Ceiling leaking from curtain track in room [ROOM NUMBER]A. Date Addressed: 7/9/24. Target date: Vendors called to find location of leak. Date Completed: 7/9/24.</p> <p>During a review of facility record titled Open Work Order #324, created 7/8/24 at 2:45 pm by Social Services Director (SSD), the record indicated Room/Area: room [ROOM NUMBER]A. Notes: Plumber inspected on 7/9/24 said it's not a plumbing issue or a fire sprinkler issue but an HVAC issue. [HVAC company name] was called. Scheduled to be out 7/11/24. Location: In room. Priority: Medium.</p> <p>During a review of Resident 5's Order Summary Report: Active Orders as of 7/1/24, indicated Resident 5 had diagnoses of chronic obstructive pulmonary disease (COPD - a condition causing constrictions of the airways and difficulty breathing), heart failure, chronic kidney disease, anxiety, and depression. The record revealed an active order, dated 3/14/22, indicating Resident 5 had the mental capacity to make her own healthcare decisions.</p> <p>During a review of Resident 5's No Type Specified (a nursing note), dated 7/8/24 at 2:13 pm, indicated Resident 5 had increased anger regarding a maintenance issue in her room (room [ROOM NUMBER]A).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 5's Psychosocial Note by SSD, dated 7/10/24 at 9:30 am, indicated Resident 5 visited SSD to ask about her room ceiling leak. SSD observed resident room and found the ceiling was dripping into a bucket. The note indicated Resident 5 was concerned and wanted to know when it would be fixed. SSD offered Resident 5 a room change until the leak was fixed, but she declined and stated she did not want to leave her belongings. The note indicated Admit [sic], Maintenance were notified of Resident 5's ceiling leak.</p> <p>During an interview with Resident 5 on 7/10/24 at 1:45 pm, Resident 5 stated, It's raining in my room. Resident 5 stated she informed staff Sunday, 7/7/24, that water was dripping from the ceiling near her television. Resident 5 stated staff put a big bucket under the leak. Resident 5 stated she was worried her television would get ruined and did not have the money to replace it. Resident 5, who was in a wheelchair, stated she was frustrated because she had difficulty getting around the bucket to the bathroom and on one occasion almost urinated in her chair.</p> <p>During observation of Resident 5's bedroom (room [ROOM NUMBER]A) on 7/10/24 at 3:04 pm, observed steady drips of clear liquid streaming from a metal curtain track in the ceiling. The liquid dripped into a 50-gallon garbage can directly below the leak, between Bed A and the doorway. Bed A (Resident 5's bed) was nearest the entryway.</p> <p>During a concurrent observation and interview with Maintenance Supervisor (MS) on 7/10/24 at 3:07 pm, MS stated he received a call from the facility late Sunday night (7/7/24) indicating a possible leak was present in room [ROOM NUMBER]A. MS stated he called a local heating, ventilation, and air conditioning (HVAC) company on 7/8/24. MS stated a local plumber inspected the leak on 7/9/24 who informed MS the issue was not plumbing-related. MS stated he called the HVAC company again and made an appointment for 7/11/24 to fix a leaking air conditioning unit. Observed MS's mobile work phone indicating an open work order for the leak in room [ROOM NUMBER]A and photos revealing moist areas present in the attic above room [ROOM NUMBER]A and -B.</p> <p>During an interview with Administrator (ADM) on 7/10/24 at 4:33 pm, ADM stated he was aware room [ROOM NUMBER]A had a leak since 7/7/24. ADM stated Resident 5 had been offered a room change several times but repeatedly declined stating she liked her room and did not want to leave. ADM stated MS informed him the leak was scheduled for repair tomorrow (7/11/24) at 11 am. ADM stated the plan at that time was to let Resident 5 stay in the room.</p> <p>During concurrent observation of room [ROOM NUMBER] and interview with Resident 5 on 7/10/24 at 4:35 pm, observed Resident 5 sitting in her wheelchair in the hallway. Observed Resident 5 looking into her room while speaking with unknown staff member about the leak. Observation of room [ROOM NUMBER] revealed a wet towel in the doorway and a large puddle surrounding the garbage can next to Bed A. Resident 5 stated the leak was getting worse and housekeeping had been called to mop the floor. Resident 5 stated she did not want to move rooms but would be okay moving to Bed B. ADM, SSD, and Director of Staff Development (DSD) arrived at the room at that time (approximately 4:40 pm). DSD stated to Resident 5 that she must move to another room for safety reasons until the leak was fixed.</p> <p>During an interview on 7/10/24 at 4:41 pm with ADM and SSD, ADM stated, [MS] didn't tell me it had gotten that bad. I looked at it this morning, and it was not dripping like that.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with MS on 7/18/24 at 10:59 am, MS stated he did not have invoices describing findings of damage and/or repairs performed by plumbing and HVAC companies from the week of 7/8/24. MS stated he requested copies from the vendors and would send them to State Agency via email. Invoices had not been received as of 7/24/24.</p> <p>During an interview with Activities Personnel 2 (ACT2) on 7/18/24 at 12:58 pm, ACT2 stated Resident 5 was upset about the leak in her room.</p> <p>During an interview with ADM on 7/18/24 at 2:15 pm, ADM stated the facility determined the leak was a result of the air conditioning pipes having a lot of condensation (water collects on a cold surface in the presence of humid air). ADM stated the pipes got plugged by debris from landscaping maintenance. ADM stated, The condensation mixes with the debris and makes mud and water can't pass through.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32797</p> <p>Based on interview, and record review, the facility's Administrator (ADM) failed to ensure effective oversight and necessary resources to ensure resident care services were met to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident when:</p> <ol style="list-style-type: none"> 1. ADM did not ensure the abuse policy was implemented to protect residents' rights to be free from physical, psychological (mental), or verbal sexual abuse, and allegations of abuse were identified/reported. Refer to F600 and F609. 2. ADM did not report an unusual occurrence of a facility lockdown. 3. ADM did not ensure the building equipment was operating and the environment was safe. Refer to F689 and F908. <p>This put all residents at risk for ongoing abuse and accidents and hazards.</p> <p>Findings:</p> <p>During a review of the facility undated document titled, Administrator Job Description, indicated the administrator (ADM) reports to Governing Body & President of Operation. The ADM's principal responsibilities and duties are serves as liaison between Governing Body and Facility Personnel, implementing performance improvement initiatives to ensure that residents are continuously improving. Directing and monitoring compliance with federal and state regulations and laws. Coordinating compliance with established policies and procedures. Allocating resources to effectively carry out facility programs. Recruiting, hiring, and training competent and committed staff. Fostering cooperative rapport with and between departments fostering the importance of each staff member's contributions to the facility. Positioning the facility to operate in a successful manner.</p> <p>During a review of facility P&P titled AN07 Abuse-Reporting and Investigations, dated 1/3/24, the P&P indicated the purpose: To protect the health, safety, and welfare of facility residents. The facility will (a) report all allegations of abuse and criminal activity as required by law and regulations to appropriate agencies and (b) will promptly report and thoroughly investigate allegations of resident abuse, mistreatment, neglect, exploitation, abuse facilitated or enabled using technology, misuse/stealing of resident property, injuries of unknown source, and any suspicion of crimes.</p> <p>During concurrent observation of facility bulletin board at the Unit 2 nurses' station and review of posted facility P&P titled Abuse - Prevention, Screening, & Training Program dated 7/2018, the P&P indicated the facility does not condone any form of resident abuse and develops facility policies, procedures, training programs, and screening and prevention systems to promote an environment free from abuse and mistreatment. The P&P indicated the Administer as abuse prevention coordinator is responsible for implementation (putting into effect) of the facility's abuse prevention, screening, and training program policies.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. a. During a review of record titled Resident Grievance/Complaint Investigation Report, dated 5/30/24 [sic], the record indicated Resident 1, in a handwritten statement, reported an older man from laundry dept. came into her room, began putting clothes away, he started chit-chatting [sic] with me and getting closer . Before I knew it, he was up against my bed then he began . (handwriting stopped there). Immediate Corrective Action Taken: Room female only. No males allowed in room. Investigation Initiated: 5/31/24. Assigned Department's Response to Grievance: Laundry supervisor notified of complaint. Staff educated and in-serviced on going into female-/male-only rooms. Was the grievance confirmed? No. Resident will be monitored for psychosocial wellbeing, and room will be kept female only until needed. Follow-up Required? No.</p> <p>During review of record titled Interdisciplinary Team (IDT) Note, dated 6/19/24 at 4:37 pm, the record indicated team members present were SSD, Nursing Supervisor (NS), Director of Nursing (DON), Activities Director (AD), and Administrator (ADM). The record indicated Resident 1 was at risk for decline in psychosocial well-being due to an incident on 5/30/24 of feeling uncomfortable when a male staff member touched her shoulder. The record indicated a facility consultant and SSD deemed it appropriate to open an Adult Protective Services (APS) case, and a report was filed 6/19/24.</p> <p>During a review of Facility-Reported Incident Intake Information received at State Agency California Department of Public Health, dated 6/20/24 at 7:56 am, the report indicated alleged physical , and psychological/mental employee-to-resident abuse occurred on 5/30/24 when a male from the laundry came into Resident 1's room and touched her shoulder, which made her uncomfortable. The record indicated the alleged abuse resulted in no physical injury.</p> <p>During an interview with Resident 1 on 7/10/24 at 1:40 pm, Resident 1 stated she remembered the incident with LP2 but could not remember the words LP2 said to her. Resident 1 stated she was drowsy and nodding off in her bed, eyes closed. Resident 1 stated it sounded like someone was putting away clothes in the closet and she came to to find LP2 caressing her left shoulder and whispering in her ear. Resident 1 stated she froze because his actions made her very uncomfortable. Resident 1 stated she spoke to SSD and a grievance was filed on 5/31/24.</p> <p>During an interview with SSD on 7/18/24 at 3 pm, SSD stated a corporate consultant was reviewing facility grievances and stated Resident 1's grievance dated 5/31/24 should have been reported to state. SSD stated she didn't recognize it as abuse at the time but now thinks it could be considered that. SSD stated the consultant verbally reeducated her with abuse training and could not provide a record of that. SSD stated Licensed Vocational Nurse 2 (LVN2) was the first to hear report of LP2-to-Resident 1 abuse. SSD stated, We [staff] are all mandated reporters. SSD stated the facility protocol is, Usually the first person to hear about the abuse reports it. However, SSD stated she does most of the reporting because she is often the first to hear about abuse.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During concurrent interview with ADM on 7/18/24 at 2:15 pm and review of records titled [LP2] 4/15/2024 - 7/18/2024 (timecards showing days/hours worked), ADM stated, Within 24 to 48 hours of starting the investigation, we identified it was [LP2] as the perpetrator of abuse to Resident 1 on 5/30/24. During review of timecard time stamps, ADM acknowledged LP2 had been suspended with pay for three days while the abuse allegation was investigated (6/20, 6/21, and 6/22/24 - 20 days after the incident). The record indicated LP2 returned to work five more days (6/26 - 6/29/24 and 7/2/24) before his termination effective 7/3/24. When asked if LP2's behavior toward Resident 1 had been unacceptable, ADM stated LP2 did a gesture that's done 5000 times a day by CNAs to residents. ADM stated Resident 1's room had been made female only while they investigated without knowing LP2's identity because of Resident 1's being uncomfortable with the incident. ADM stated their investigation of the incident revealed LP2 was determined to not be a threat. ADM stated SSD interviewed other residents, and they let him come back.</p> <p>1.b. During a review of Facility-Reported Incident Intake Information received by State Agency, dated 6/21/24 at 7 am, the record indicated alleged resident-to-resident abuse occurred when Resident 2 asked Resident 3 a series of sexually oriented questions. The record indicated Resident 3 suffered sexual and psychological/mental abuse resulting in mental suffering.</p> <p>During a review of Resident 3's Alert Note, dated 6/20/24 at 10:27 pm, indicated Resident 3 stated she still has feelings of distress related to the incident of being harassed and inappropriate sexual behavior by another resident.</p> <p>During a review of record titled Smoking Residents, interviews conducted 6/27/24, the record indicated Resident 3 reported feeling safer. Resident 5 reported she was scared Resident 2 would come back to the facility at night, noting that Resident 2 is mad at her and others. Resident 5 stated she is afraid the doors will be left unattended and Resident 2 will come in. Resident 15 reported feeling uncertain of knowing what Resident 2 is capable of doing, concerned he could possibly be carrying a weapon. Resident 6 reported seeing Resident 2 behind a facility fence and was afraid of him hopping over the fence. Resident 6 reported feeling uneasy, anxious, and stated Resident 2 should be arrested. Resident 14 reported feeling ok but stated she did witness Resident 2 being aggressive to others and him needs to stay away. Resident 12 reported anxiety, afraid Resident 2 may come back with a weapon. Resident 12 reported seeing Resident 2 behind the facility, feeling unsafe that he keeps showing up at the facility.</p> <p>During an interview with Director of Nursing (DON) on 7/3/24 at 3:45 pm, DON stated we did our best with Resident 2 while he was at the facility. DON stated Resident 2 put inappropriate notes on his door, and facility residents complained that they were intimidated or frightened by the notes. DON stated Resident 2 once informed her he had been in prison for [AGE] years for murder; DON believed it was to let her know he was someone she should take seriously. DON stated Resident 2 had been homeless prior to admission. DON stated Resident 2 would have erratic behavior and often had strange visitors, noting his behavior would get worse after the visitors left. DON acknowledged concern for potential substance use while he was in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with OMB on 7/5/24 at 8:48 am, OMB stated she was familiar with Resident 2 and noted, while she was not a medical professional, she was sure he had a major mental illness. OMB stated his thought process was tangential (adding irrelevant or excessive details to conversation) and he willfully tried to aggravate other residents by saying very crude things to them. OMB stated he was discharged against medical advice but was coming back trying to agitate people, at one point throwing bottles toward the building. OMB stated ADM reported Resident 2 had returned to the facility twice since discharge and police had been called. OMB stated he had not hit a resident with a bottle to her knowledge. OMB stated, I'm assuming [Resident 2] will get 5150'd (an involuntary 72-hour psychiatric hospitalization for adults in danger of harming themselves or others) at one point. OMB stated the facility attempted to get a 5150 for Resident 2, but police told ADM 'Cussing and words' didn't qualify as 5150. OMB stated Resident 2 was awful, noting he was going into a young woman's room saying very inappropriate things like, 'Suck my d*ck.' OMB stated staff did a lot of work because they were concerned with his safety and others'.</p> <p>2. During a review of facility Policy and Procedure (P&P) titled Unusual Occurrence Reporting, dated 8/1/12, the P&P indicated its purpose was to ensure timely reports are made to designated agencies as required by state and federal laws and regulations. The P&P further indicated the facility will report by phone and in writing to the appropriate State or Federal agencies allegations of abuse or neglect and other unusual occurrences that interfere with facility operations and affect the welfare, safety, and health of residents, employees, or visitors. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing. The facility conducts and documents timely and thorough investigations into all unusual occurrences and takes corrective action as appropriate.</p> <p>The Administrator (ADM) did not report placing the facility on lockdown (all doors and windows were locked, staff and residents remained inside) while local law enforcement searched the area for a former resident (Resident 2) who threw bottles at the building.</p> <p>During an interview with ADM on 7/18/24 at 2:15 pm, ADM stated Resident 2 had returned to the facility after his discharge, and police had been notified. ADM stated he had called the police twice, and the facility was placed in lockdown (all doors and windows locked, staff and residents inside) at one point while law enforcement searched for Resident 2. ADM acknowledged that the lockdown should have been reported to State Agency but was not. ADM initially stated Resident 2 had not been inside the facility since his discharge but later stated, I take that back. He made it in once. ADM stated Resident 2 returned to visit a resident. ADM stated, I escorted him to the room with the receptionist, resident didn't want to see him, and we walked him out. Asked if he was aware staff and residents were reporting concern that Resident 2 kept returning, ADM stated, I have had no note of that from staff. ADM stated SSD interviewed all the residents who smoke for four weeks, and they stopped the interviews because their answers indicated all was well. ADM offered to provide copies of two police reports at a later time: one from the lockdown and one from an incident where drugs were removed by law enforcement from the property (source unknown). Police reports had not been received as of 7/24/24.</p> <p>3. During a review of facility records titled Administrator (ADM) Job Description, undated, the record indicated ADM is responsible for directing and monitoring compliance with federal and state regulations and laws, coordinating compliance with established policies and procedures, hiring and training competent and committed staff, and positioning the facility to operate in a successful manner.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055656	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER Riverside Point Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 375 Cohasset Rd Chico, CA 95926	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 5 lived in her bedroom for three days with an unreported ceiling leak from a malfunctioning rooftop air conditioning unit.</p> <p>During an interview on 7/10/24 at 4:41 pm with ADM and SSD, ADM stated, [MS] didn't tell me it had gotten that bad. I looked at it this morning, and it was not dripping like that.</p> <p>During an interview with MS on 7/18/24 at 10:59 am, MS stated he did not have invoices describing findings of damage and/or repairs performed by plumbing and HVAC companies from the week of 7/8/24. MS stated he requested copies from the vendors and would send them to State Agency via email. Invoices had not been received as of 7/24/24.</p> <p>During an interview with Activities Personnel 2 (ACT2) on 7/18/24 at 12:58 pm, ACT2 stated Resident 5 was upset about the leak in her room.</p> <p>During an interview with ADM on 7/18/24 at 2:15 pm, ADM stated the facility determined the leak was a result of the air conditioning pipes having a lot of condensation (water collects on a cold surface in the presence of humid air). ADM stated the pipes got plugged by debris from landscaping maintenance. ADM stated, The condensation mixes with the debris and makes mud and water can't pass through.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418</p> <p>Based on observation, interview, and record review, the facility failed to maintain essential equipment in safe operating condition when:</p> <ol style="list-style-type: none"> 1. An air conditioning unit leaked for three days from the ceiling in room [ROOM NUMBER]A (Resident 5's bedroom). This failure resulted in Resident 5 stating she felt frustrated and worried and had the potential for avoidable life-threatening hazards such as ceiling collapse from water damage, electrocution, and infection from mold and bacterial growth. 2. Facility staff silenced a malfunctioning fire system alarm for five hours. Failure to maintain the fire system had the potential to place all 89 residents, staff, and visitors at risk of injury or death in the event of a fire. <p>Findings:</p> <p>During a review of facility Policy and Procedure (P&P) titled Maintenance Service: Operational Manual - Physical Environment, dated 1/1/12, the P&P indicated its purpose was to protect the health and safety of residents, visitors, and staff by maintaining all areas of the buildings, grounds, and equipment in a safe and operable manner at all times. The Maintenance Department is responsible for maintaining fire alarm system, heating and cooling system, plumbing fixtures, wiring, etcetera, in good working order. The Director of Maintenance is responsible for maintaining records/reports of building inspections, work order requests, and maintenance schedules. Maintenance staff follow established safety regulations to ensure the safety and well-being of all concerned.</p> <p>1. During a review of facility record titled Maintenance Log, dated 4/30/24 to 7/18/24, the record indicated on 7/8/24, specific Issue/Problem: Ceiling leaking from curtain track in room [ROOM NUMBER]A. Date Addressed: 7/9/24. Target date: Vendor called to find location of leak. Date Completed: 7/9/24.</p> <p>During an interview with Resident 5 on 7/10/24 at 1:45 pm, Resident 5 stated, It's raining in my room. Resident 5 stated she informed staff Sunday, 7/7/24, that water was dripping from the ceiling near her television. Resident 5 stated staff put a big bucket under the leak. Resident 5 stated she was worried her television would get ruined and did not have the money to replace it. Resident 5, who was in a wheelchair, stated she was frustrated because she had difficulty getting around the bucket to the bathroom and on one occasion almost urinated in her chair.</p> <p>During observation of room [ROOM NUMBER] on 7/10/24 at 3:04 pm, observed a steady drip of clear liquid from a metal curtain track in the ceiling. The liquid dripped into a 50-gallon garbage can that had been placed below the leak. The room had two beds; the garbage can was located beside the foot of Bed A (Resident 5's bed) between the bed and the doorway. Bed A was nearest the entryway; Bed B was on the far side of the room near the windows and bathroom. Bed B was not occupied.</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview with Maintenance Supervisor (MS) on 7/10/24 at 3:07 pm, MS stated he had received a call late Sunday night (7/7/24) about a possible leak in room [ROOM NUMBER]. MS stated he called a local heating, ventilation, and air conditioning (HVAC) company on 7/8/24. MS stated a local plumber inspected the leak on 7/9/24 who indicated the issue was not plumbing-related. MS stated he returned a call to the HVAC company and made an appointment for 7/11/24 to stop condensation leaking from air conditioning pipes. MS showed me his mobile work phone indicating (1) an open work order for the leak in room [ROOM NUMBER]A and (2) photos revealing moist areas in the attic above room [ROOM NUMBER].</p> <p>During a review of facility record titled Open Work Order #324, created 7/8/24 at 2:45 pm by Social Services Director (SSD), the record indicated Room/Area: room [ROOM NUMBER]A. Notes: Plumber inspected on 7/9/24 said it's not a plumbing issue or a fire sprinkler issue but an HVAC issue. [HVAC company name] was called. Scheduled to be out 7/11/24. Location: In room. Priority: Medium.</p> <p>During an interview with Administrator (ADM) on 7/10/24 at 4:33 pm, ADM stated he was aware room [ROOM NUMBER] had a leak since 7/7/24. ADM stated MS informed him the leak was scheduled for repair tomorrow (7/11/24) at 11 am with a plan to let Resident 5 stay in the room.</p> <p>During concurrent observation of room [ROOM NUMBER] and interview with Resident 5 on 7/10/24 at 4:35 pm, observed Resident 5 sitting in her wheelchair in the hallway, looking into her room while speaking with unknown staff member about the leak. Observation of room [ROOM NUMBER] revealed a wet towel in the doorway and a large puddle on the floor surrounding the garbage can. Resident 5 stated the leak was getting worse and housekeeping had been called to mop the floor. Resident 5 stated she did not want to move to another room but would be okay moving to the other (unoccupied) side of her room. ADM, SSD, and Director of Staff Development (DSD) arrived at the room at approximately 4:37 pm. DSD stated to Resident 5 that she must move to another room for safety reasons until the leak was fixed.</p> <p>During an interview on 7/10/24 at 4:40 pm with ADM and SSD, ADM stated he had observed the leak in room [ROOM NUMBER]A on the morning of 7/10/24, and it was not dripping like that. ADM stated MS had not informed him the leak had gotten that bad.</p> <p>During an interview with MS on 7/18/24 at 10:59 am, MS stated he did not have invoices describing findings of damage and/or repairs from plumbing and HVAC companies from 7/9/24 and 7/11/24, respectively. MS stated he had requested copies from the vendors and would send them to State Agency via email. Invoices have not been received.</p> <p>During an interview with ADM on 7/18/24 at 2:15 pm, ADM stated the facility determined the leak was a result of the air conditioning pipes having a lot of condensation (water collects on a cold surface in the presence of humid air). ADM stated the pipes get plugged by debris from landscaping maintenance. ADM stated, The condensation mixes with the debris and makes mud and water can't pass through.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of [Vendor Name] Service Request by Repair Person 1 (RP1), dated 7/9/24 at 1:21 pm, the record indicated Scope of Work/Problem Code: Large Leak. Work Performed/Resolution Code: RP1 called MS before leaving. MS stated there was a sprinkler/pipe leak at site and the Fire Alarm Control Panel (FACP) and alarms were activated. Arrived on site and customer stated there was no fire sprinkler-related leak. The FACP was in alarm. Checked and tested waterflow switch (a water flow detector), adjusted the setting, and checked tamper switch on Post Indicator Valve (PIV - opens/closes the facility water supply from outside the building). Advised customer the FACP is seriously outdated and new panel needs to be installed or this problem will consist of [sic].</p> <p>During a review of [Vendor Name] Service Request by RP2, dated 7/9/24 at 3 pm, the record indicated Scope of Work/Problem Code: Panel Trouble/Supervisory. Work Performed/Resolution Code: Fire alarm service for PIV. RP1 and RP2 adjusted and tested the switch.</p> <p>During an interview with MS on 7/10/24 at 3:07 pm, MS stated there had been a malfunction in the fire rise on 7/9/24 that set off the fire alarm early in the morning. MS stated he set one of the eight fire system zones (Zone 8) to silent until approximately 3 pm on 7/9/24 to stop the alarm.</p> <p>During concurrent observation of fire control panel behind Nurses' Station 1 and interview with MS on 7/18/24 at 9:58 am, MS stated a local vendor checked the system 7/9/24 because the fire riser (a pipe that connects pressurized water sources and supplies sprinkler system with water) indicated different pressures. MS stated that was the cause of the system alarm that morning. MS stated he switched Zone 8 from Alarm to Disable/Trouble and then pressed the Trouble Silence button, which he stated silenced the alarm for that zone only. MS stated Zone 8 was off from 10 or 11 am to 3 pm on 7/9/24.</p> <p>During an interview with ADM on 7/18/24 at 2:15 pm, ADM stated he was aware a fire alarm zone had been turned off for several hours on 7/9/24. ADM stated, The machine doesn't turn off. The rest of the building would still alarm. ADM stated a fire watch (continuous observation for fire activity) was not performed. ADM stated he was aware the fire vendor's invoices indicated the fire system was outdated. ADM stated he was awaiting a quote from [Vendor Name] to replace the fire system but would need two different quotes before corporate would fund it.</p>		