

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055677	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Pittsburg Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 School Street Pittsburg, CA 94565	

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 - 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>Based on observation, interview and record review, the facility failed to ensure one of one sampled resident, (Resident 1), was free from physical abuse when two Student Nurses (SN) witnessed Certified Nurse Assistant (CNA) 1 pushed Resident 1's face aggressively and forcefully back into Resident 1's wheelchair.</p> <p>This failure had the potential to result in physical and emotional harm on Resident 1.</p> <p>Findings:</p> <p>During a record review of Resident 1's admission Record (AR), printed on 5/8/25, the AR indicated Resident 1 was admitted to the facility in May 2023 with diagnoses of dementia (a loss of brain function that occurs with certain diseases, affecting one or more brain functions such as memory, thinking, language, judgment, or behavior) and post-traumatic stress disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event).</p> <p>During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan.), dated 5/25/24, the MDS assessment section C indicated Resident 1's Brief Interview of Mental Status (BIMS- an assessment for cognition status) score was 0 out of 15 which indicated severely impaired mental status.</p> <p>During an observation and interview on 6/3/25 at 10:21 a.m. with Resident 1, Resident 1 was awake in his bed and noted to have tremors on his hands. Resident 1 did not respond when asked how he was doing.</p> <p>During an interview on 6/3/25 at 10:22 a.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated Resident 1 was totally dependent on staff with Activities of Daily Living (ADLs, are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating). CNA 1 further stated Resident 1 was cognitively impaired and unable to verbalize his needs.</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 - Few</p>	<p>During a phone interview on 6/3/25 at 12:22 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was notified by two SNs and their clinical instructor that SN 1 and SN 2 witnessed a physical abuse on Resident 1 committed by CNA 1. LVN 1 stated Resident 1 had tremors and had behaviors of leaning forward when in the wheelchair. LVN 1 stated repositioning Resident 1 should have been done by two people using the proper technique such as placing the arms under Resident 1's armpits. LVN 1 stated CNA 1 should have never touched Resident 1's face to push him back into the wheelchair. LVN 1 stated Resident 1 could have had physical injury or mental harm.</p> <p>During an interview on 6/3/25 at 1:06 p.m. with the Administrator (ADM) who was also the Abuse Coordinator, ADM stated he was notified of the suspected abuse on 4/26/25. The ADM stated SN 1 and SN 2 did not notify the facility about the suspected abuse that occurred on 4/19/25 until a week after. The ADM stated SN 1 and SN 2 demonstrated to him how CNA 1 pushed Resident 1 into his wheelchair. The ADM stated he was told by SN 1 and SN 2 that they were bothered by the physical abuse they have witnessed, and they decided to report it to the facility. The ADM stated in January 2022, CNA 1 was also investigated for suspected physical abuse but at that time he could not prove the allegation. The ADM stated CNA 1 might have lost his patience and compassion for Resident 1 because Resident 1 kept leaning forward after CNA 1 repositioned Resident 1 several times.</p> <p>During an interview on 6/3/25 at 2:14 p.m. with the Director of Nursing (DON), the DON stated what SN 1 and SN 2 witnessed was a form of abuse on Resident 1. The DON stated she felt sorry for Resident 1 because CNA 1's action was so inappropriate and demeaning. The DON stated pushing Resident 1 on the face could have triggered Resident 1's PTSD since Resident 1 used to serve in the military.</p> <p>During a phone interview on 6/3/25 at 3:04 p.m. with SN 1, SN 1 stated on 4/19/25, SN 1 and SN 2 they were walking around the hallway to see who needed help. SN 1 stated initially Resident 1 was with another staff when CNA 1 came and took over Resident 1. SN 1 stated Resident 1 kept leaning forward and it looked like Resident 1 was going to fall over. SN 1 stated CNA 1 looked frustrated when he was repositioning Resident 1. SN 1 stated after attempting several times to reposition Resident 1, CNA 1 suddenly pushed Resident 1's face aggressively to put Resident 1 back again to the wheelchair. SN 1 stated CNA 1's used his whole hand to push Resident 1's face. SN 1 stated they were shocked with how the CNA 1 treated Resident 1. SN 1 stated after CNA 1 pushed Resident 1's face, they tried to offer their help, but CNA 1 refused. SN 1 stated CNA 1 brought Resident 1 back to the room and closed the curtain. SN 1 stated Resident 1 did not deserve to be pushed in the face by CNA 1.</p> <p>During a phone interview on 6/3/25 at 3:43 p.m. with SN 2, SN 2 stated on 4/19/25 approximately between 4:00 p.m. and 6:00 p.m., SN 2 and SN 1 saw Resident 1 was in the wheelchair by the nurse's station in the hallway. SN 2 stated they tried to help Resident 1 because Resident 1 kept leaning forward and they did not want Resident 1 to fall. SN 2 stated CNA 1 came and told them that he will take care of Resident 1. SN 2 stated when Resident 1 was leaning forward again, they witnessed CNA 1 pushed Resident 1's face aggressively using his hand that created a whiplash (rapid back-and-forth movement of the neck) motion on Resident 1. SN 2 stated CNA 1 used a lot of force to throw Resident back to the wheelchair. SN 2 stated CNA 1 did not have the right to put his hands on Resident 1. SN 2 stated what CNA 1 did was very disrespectful and abusive. SN 2 stated they did not report right away because they were scared of retaliation. SN 2 stated they decided to report it a week after because what they witnessed bothered them a lot.</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 - Few</p>	<p>During a record review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised in April 2021, the P&P indicated, Residents have the right to be free from abuse .This includes .physical abuse .1. Protect residents from abuse .by anyone including .a. facility staff .5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.</p>		