STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055855	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Park Post Acute	3400 Alta Arden Expressway Sacramento, CA 95825

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47197 Based on interview and record review, the facility failed to protect the five out of eight sampled residents' (Resident 1, Resident 3, Resident 4, Resident 5, and Resident 7) right to be free from mental and physical abuse by a resident (Resident 2) when: 1. The facility failed to reasonably investigate residents' complaints regarding Resident 2 to ensure their well-being and safety; and, 2. Resident 2 (with known history of wandering) went inside Resident 1 and Resident 4's room on 7/2/24, unsupervised, masturbated, and pooped on the floor. These failures resulted in Resident 1, Resident 3, Resident 5, and Resident 7 being scared, feeling unsafe, fearful, and experiencing emotional distress, and had the potential for Resident 1, Resident 3, Resident 4, Resident 5, and Resident 7 and all residents in the facility to experience physical and/or psychosocial harm. Findings: 1. A review of Resident 1's clinical record indicated Resident 1 was admitted November of 2018 and had diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), chronic pain, absence of left upper limb below elbow, and absence of right leg above knee. A review of Resident 1's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/19/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 1 had intact cognition. A review of Resident 1's MDS Mood status, dated 4/19/24, indicated Resident 1 had experienced feeling down, depressed, or hopeless nearly every day. A review of Resident 2's clinical record indicated Resident 2 was admitted October of 2023 and had diagnoses that included dementia (memory loss that interferes with daily functions) and brief psychotic disorder (a temporary loss of connection with reality, often caused by a significantly stressful circumstance or event). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2's MDS Cognitive Patterns, dated 5/2/24, indicated Resident 2 had short term and long-term memory problems and had severely impaired cognitive skills for daily decision making. A review of Resident 3's clinical record indicated Resident 3 was admitted to the facility December 2022 with multiple diagnoses which included legal blindless and muscle weakness. During a review of Resident 3's face sheet (a document containing patient information), the face sheet indicated Resident 3 was his own responsible party. A review of Resident 5's clinical record indicated Resident 5 was admitted to the facility May 2023 with multiple diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). A review of Resident 5's MDS, dated [DATE], indicated, Resident 5 had no memory problems. Resident 7 was admitted to the facility December 2022 with multiple diagnoses which included generalized anxiety and muscle weakness. A review of Resident 7's MDS, dated [DATE], indicated, Resident 7 had moderate cognition impairment. During an interview on 6/26/24, at 1:34 p.m., with Resident 1, Resident 1 stated that on 4/9/24, she was slapped on her arm by Resident 2 while walking in the hallway near the Nurse's Station. Resident 1 confirmed staff were present and aware of the incident. Resident 1 further stated nothing was done by facility staff and she was fearful of Resident 2 and what he may do. During an interview on 6/26/24, at 2:05 p.m., with Resident 3, Resident 3 stated Resident 2 had thrown a pillow at him and grabbed his leg. Resident 3 stated he was afraid of Resident 2, did not sleep well because of his fear and did not feel safe in his room. Resident 3 states he is blind but knows it was [sic] Resident 2 who grabbed his leg and threw the pillow because he recognized his voice, animal sounds. Resident 3 stated he thought he had told a CNA (Certified Nursing Assistant). During an interview on 6/26/24, at 2:15 p.m., with CNA 2, CNA 2 stated he was aware that Resident 1 was scared of Resident 2 and did not know why she was afraid. During a further interview on 6/26/24 at 3:12 p.m., with Resident 1, Resident 1 stated that she had told a night nurse a few nights ago that Resident 2 came into her room. She said she told the nurse that she felt unsafe and felt nothing was being done to protect her. Resident 1 further stated she told the Social Services Director yesterday 6/25/24 that she felt unsafe. Resident 1 stated that she feels, Scared, unprotected, anything can happen to me. During an interview on 6/26/24, at 3:25 p.m., with Resident 5, Resident 5 stated Resident 2 had walked into her room several times and had tried to touch her. Resident 5 stated, He [Resident 2] scares me .horrible feeling to fight someone off every day .makes me nervous .feels violated. Resident 5 stated she had not spoken to staff about her concerns because she didn't think anything would have been done. During an interview on 6/26/24, at 3:33 p.m., with Resident 7, Resident 7 stated Resident 2 had walked into her room and sat on her bed. Resident 7 stated she felt threatened by Resident 2 and felt scared and helpless. Resident 7 confirmed she had not spoken to staff about her fears or the past incident because she did not know how to report. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/24, at 4:35 p.m., with the Administrator (Admin), the Admin stated he was not aware of any allegations of Resident 1 being slapped in April 2024 and had not investigated or reported the incident to state agencies. During a review of Resident 1's care plan initiated on 6/26/24, indicated, Alleged emotional abuse: at risk for emotional distress after stating she had concerns with another resident going in her room . During an interview on 7/3/24, at 1:53 p.m., with the Assistant Director of Nursing (ADON), the ADON confirmed residents had the right to live at the facility without being in fear. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 09/2022, indicated, All reports of resident abuse .are thoroughly investigated by facility management. Findings of all investigations are documented and reported. 2. A review of Resident 2's progress notes, dated 7/2/24, indicated, .allegation of psychological abuse on resident [room number for Resident 1]. Resident states he masturbated and went to the bathroom on my floor . During an interview on 7/3/24 at 11:14 a.m. with the ADON, the ADON stated Resident 1 notified her on 7/2/24 that Resident 2 went inside her room unsupervised, masturbated, and pooped on the floor. The ADON further stated, He [Resident 2] was not on one-on-one supervision and frequent checks that time [prior to the incident on 7/2/24] .The staff just needs to watch him [Resident 2] and document if he goes in someone' s room .Nobody saw him [Resident 2] go to her [Resident 1] room. During an interview and video observation on 7/3/24 at 11:45 a.m. with Resident 1, in Resident 1's room, Resident 1 stated, .I saw him [Resident 2] come inside the room and stood next to the curtain, I yelled at him to get out .he [Resident 2] started masturbating first and then he pooped on the floor. Resident 1 showed a video of Resident 2 standing inside her room next to a clump of brownish material, beside the door area, with Resident 2's pants down and was touching his own genital area. The video recording had a date and time stamp of 7/2/24 at 2:47 p.m. Resident 1 further stated, I was so scared that time .I was shaking, and I got dizzy this morning, I got so stressed . During a concurrent interview and record review on 7/3/24 at 12:14 p.m. with the Director of Staff Development (DSD), the staffing schedule of the week was reviewed. The DSD stated Resident 2 was placed on one-on-one supervision after the incident on 7/2/24. The DSD further stated they had scheduled one-on-one supervision of Resident 2 on morning shifts and afternoon shifts but not on night shifts because Resident 2 does not wander in the halls at night and Resident 2 is usually asleep. During an interview on 7/3/24 at 12:25 p.m. with Licensed Nurse [LN] 2, LN 2 stated, .He's [Resident 2] a wanderer. We [staff] would orient him [Resident 2] back to his room .He's [Resident 2] confused .He [Resident 2] would sometimes go inside someone's room. LN 2 further stated, Before that [incident on 7/2/24], he [Resident 2] was not on one-on-one [supervision]. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4's clinical record indicated Resident 4 was admitted May of 2024 and was in the same room as Resident 1. Resident 4 had diagnoses that included multiple fractures (a break in the continuity of a bone) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A review of Resident 4's MDS Cognitive Patterns, dated 5/20/24, indicated Resident 4 had a BIMS score of 7 out of 15 which indicated Resident 4 had severely impaired cognition. During an interview on 7/3/24 at 12:30 p.m. with Resident 4, Resident 4 stated she saw Resident 2 go inside their room on 7/2/24 and stood in front of her bed. Resident 4 further stated, I saw him [Resident 2] come in . He [Resident 2] left his poop, I could smell it .I just pushed my [call light] button when he [Resident 2] came . During an interview on 7/3/24 at 12:35 p.m. with LN 3, LN 3 stated, I see him [Resident 2] wandering in the halls .We [staff] were keeping an eye on him [Resident 2] yesterday [7/2/24] . LN 3 further stated, No, it [monitoring] was not enough .He [Resident 2] needed a one-on-one supervision .When you're not looking after him [Resident 2], that's the time when incidents happen .He wanders .If he [Resident 2] was on one-on-one [supervision] before yesterday [incident], it [incident] could have been prevented since it's not the first time it happened .Everyone is aware of his [Resident 2] behavior. A review of Resident 2's care plan, dated 6/26/24, indicated, Resident [Resident 2] allegedly wandered into another resident's room on 6/24/24 . A review of Resident 2's care plan goal, initiated 6/26/24, indicated, Resident [Resident 2] will not wander into other resident ' s rooms. A review of Resident 2's care plan intervention, initiated 6/26/24, indicated, Monitor resident and redirect if episode occurs. A review of Resident 2's care plan intervention, dated 7/2/24, indicated, Frequent visual checks: Q [every] 15 min [minutes] x 8 hours; Q 30 minutes X 8 hours; Q 1 hour until 30 days completed. During an interview on 7/3/24 at 1:53 p.m. with the ADON, the ADON stated, there have been multiple occasions when Resident 2 has wandered into other resident's rooms. Resident 2 should have had more supervision to prevent the last incident (7/2/24) from happening. A review of the facility's P&P titled, Safety and Supervision of Residents, revised 07/2017, indicated, .2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs . A review of the facility's P&P titled, Resident Rights, revised 12/2016, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .c. be free from abuse .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46872 Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of abuse in accordance with section 1150B of the Act for one of eight sampled residents (Resident 1) when: 1. Resident 1 reported to nursing staff that she was slapped by Resident 2 on 4/9/24; and, 2. Resident 1 reported to the Assistant Director of Nursing (ADON) that Resident 2 (with known history of wandering) went inside Resident 1's room on 7/2/24, unsupervised, masturbated, and pooped on the floor. This failure had placed Resident 1 and other residents in the facility at risk for further abuse, and possible serious physical and/or psychosocial harm. Findings: 1. A review of Resident 1's clinical record indicated Resident 1 was admitted November of 2018 and had diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), chronic pain, absence of left upper limb below elbow, and absence of right leg above knee. A review of Resident 1's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/19/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 1 had an intact cognition. A review of Resident 1's MDS Mood status, dated 4/19/24, indicated Resident 1 had experienced feeling down, depressed, or hopeless nearly every day. A review of Resident 2's clinical record indicated Resident 2 was admitted October of 2023 and had diagnoses that included dementia (memory loss that interferes with daily functions) and brief psychotic disorder (a temporary loss of connection with reality, often caused by a significantly stressful circumstance or event). A review of Resident 2's MDS Cognitive Patterns, dated 5/2/24, indicated Resident 2 had short term and long-term memory problem and had severely impaired cognitive skills for daily decision making. During an interview on 6/26/24, at 1:34 p.m., with Resident 1, Resident 1 stated that on 4/9/2024 she was slapped on her arm by Resident 2 while walking in the hallway near the Nurse ' s Station. Resident 1 confirmed staff were present and aware of the incident. Resident 1 further stated nothing was done by facility staff and she was fearful of Resident 2 and what he may do. During an interview on 6/26/24, at 4:35 p.m., with the Administrator (Admin), the Admin stated he was not aware of any allegations of Resident 1 being slapped in April 2024 and had not investigated or reported the incident to state agencies. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s care plan initiated on 4/9/24, indicated, Claiming slapped her Left Arm by other res. [resident] unwitnessed & skin assessed . During a review of Resident 1 ' s Progress Note, dated 4/9/24, the PN indicated, .claiming that [Resident 2] slappedher [sic] arm & its unwitnessed incident, resident separated. During a review of Resident 1 ' s SBAR Communication Form (SBAR), dated 4/9/24, the SBAR indicated, Resident alert and oriented .Resident claiming that [Resident 2] slapped her Left arm & its unwitnessed incident, resident separated. 2. A review of Resident 2's progress notes, dated 7/2/24, indicated, .allegation of psychological abuse on resident 203B [Resident 1]. Resident states he masturbated and went to the bathroom on my floor . During an interview on 7/3/24 at 11:14 a.m. with the ADON, the ADON stated Resident 1 notified her on 7/2/24 at 3:30 p.m. that Resident 2 went inside her room unsupervised, masturbated, and pooped of the floor. The ADON also stated Resident 1 showed her the videos she took when Resident 2 went inside her room. The ADON further stated she reported the alleged incident to the state agency on 7/2/24 at around 4:30 p.m. The fax receipt of the sent report was requested, the ADON then explained that the fax receipt was in the Administrator's office, and she will provide it once her administrator is back on Monday the following week. During an interview on 7/3/24 at 11:45 a.m. with Resident 1, in Resident 1's room, Resident 1 stated, .I saw him [resident 2] come inside the room and stood next to the curtain, I yelled at him to get out .he [Resident 2] started masturbating first and then he pooped on the floor. Resident 1 showed a video of Resident 2 standing inside her room next to a clump of brownish material, beside the door area, with Resident 2's pants down and was touching his own genitals. The video recording had a date and time stamp of 7/2/24 at 2:47 p. m. Resident 1 further stated, I was so scared that time .I was shaking, and I got dizzy this morning, I got so stressed . The fax receipt of the abuse allegation report sent to the state agency on 7/2/24 was again requested on 7/8/24 at 10:20 a.m. via e-mail to the Medical Record Assistant (MRA). No fax receipt was provided. The fax receipt of the abuse allegation report sent to the state agency on 7/2/24 was requested for the third time on 7/15/24 at 3:25 p.m. via e-mail to the MRA. No fax receipt was provided. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 09/2022, indicated, All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; . e. Law enforcement officials; .within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46872 Based on interview and record review, the facility failed to implement its Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy for four of seven sampled residents (Resident 1, Resident 3, Resident 5, and Resident 7) when the facility failed to ensure one of Resident 1's allegation of abuse and mistreatment was timely and thoroughly investigated. This failure to protect, investigate, and provide a safe environment caused Resident 1, Resident 3, Resident 5 and Resident 7 to feel emotionally unsafe, violated, and helpless. Not investigating and interviewing these other residents allowed the perpetrator (Resident 2) to have access to Resident 1, Resident 3, Resident 5 and Resident 7 and other vulnerable residents and allowed further abuse. Findings: A review of Resident 1's clinical record indicated Resident 1 was admitted November of 2018 and had diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), chronic pain, absence of left upper limb below elbow, and absence of right leg above knee. A review of Resident 1's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 4/19/24, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 1 had an intact cognition. A review of Resident 1's MDS Mood status, dated 4/19/24, indicated Resident 1 had experienced feeling down, depressed, or hopeless nearly every day. A review of Resident 2's clinical record indicated Resident 2 was admitted October of 2023 and had diagnoses that included dementia (memory loss that interferes with daily functions) and brief psychotic disorder (a temporary loss of connection with reality, often caused by a significantly stressful circumstance or event). A review of Resident 2's MDS Cognitive Patterns, dated 5/2/24, indicated Resident 2 had short term and long-term memory problem and had severely impaired cognitive skills for daily decision making. A review of Resident 3's clinical record indicated Resident 3 was admitted to the facility December 2022 with multiple diagnoses which included legal blindless and muscle weakness. During a review of Resident 3's face sheet (a document containing patient information), the face sheet indicated Resident 3 was his own responsible party. A review of Resident 3's clinical record indicated Resident 3 was admitted to the facility December 2022 with multiple diagnoses which included legal blindless and muscle weakness. During a review of Resident 3's face sheet (a document containing patient information), the face sheet indicated Resident 3 was his own responsible party. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 5's clinical record indicated Resident 5 was admitted to the facility May 2023 with multiple diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). A review of Resident 5 ' s MDS dated [DATE], indicated, Resident 5 had no memory problems. Resident 7 was admitted to the facility December 2022 with multiple diagnoses which included generalized anxiety and muscle weakness. A review of Resident 7 ' s MDS dated [DATE], indicated, Resident 7 had moderate cognition impairment. During an interview on 6/26/24, at 1:34 p.m., with Resident 1, Resident 1 stated that on 4/9/2024 she was slapped on her arm by Resident 2 while walking in the hallway near the Nurse ' s Station. Resident 1 confirmed staff were present and aware of the incident. Resident 1 further stated nothing was done by facility staff and she was fearful of Resident 2 and what he may do. During an interview on 6/26/24, at 2:05 p.m., with Resident 3, Resident 3 stated Resident 2 had thrown a pillow at him and grabbed his leg. Resident 3 stated he was afraid of Resident 2, did not sleep well because of his fear and did not feel safe in his room. Resident 3 confirmed that he had not spoken to staff about his fear or about the prior incident. During an interview on 6/26/24, at 2:15 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated he was aware that Resident 1 was scared of Resident 2 and did not know why she was afraid. During a further interview on 6/26/24 at 3:12 p.m., with Resident 1, Resident 1 stated that she had told a night nurse a few nights ago that Resident 2 came into her room. She said she told the nurse that she felt unsafe and felt nothing was being done to protect her. Resident 1 further stated she told the Social Services Director yesterday 6/25/24 that she felt unsafe. Resident 1 stated that she feels, Scared, unprotected, anything can happen to me. During an interview on 6/26/24, at 3:25 p.m., with Resident 5, Resident 5 stated Resident 2 had walked into her room several times and had tried to touch her. Resident 5 stated, He [Resident 2] scares me .horrible feeling to fight someone off every day .makes me nervous .feels violated. Resident 5 stated she had not spoken to staff about her concerns because she didn ' t think anything would have been done. During an interview on 6/26/24, at 4:35 p.m., with the Admin, the Admin stated he was not aware of any allegations of Resident 1 being slapped in April 2024 and had not investigated or reported the incident to state agencies. During a review of Resident 1 ' s care plan initiated on 4/9/24, indicated, Claiming slapped her Left Arm by other res. [resident] unwitnessed & skin assessed . During a review of Resident 1 ' s Progress Note (PN), dated 4/9/24, the PN indicated, .claiming that [Resident 2] slappedher [sic] arm & its unwitnessed incident, resident separated. During a review of Resident 1 ' s SBAR Communication Form (SBAR), dated 4/9/24, the SBAR indicated, Resident alert and oriented .Resident claiming that [Resident 2] slapped her Left arm & its unwitnessed incident, resident separated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/22, the P&P indicated, All reports of resident abuse .are reported to local, state and federal agencies .All allegations are thoroughly investigated.