STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056069	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Clara Post Acute	991 Clyde Avenue Santa Clara, CA 95054

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 - Few	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** 44733 Based on observation, interview, and record review, the facility failed to ensure residents were free from physical abuse for one out of two residents (Resident 1) when Resident 2 hit Resident 1 in the face, causing injury to Resident 1's above the eyebrow area and first aid being administered. Resident 2's act of hitting Resident 1 in the face was a deliberate act to inflict harm or injury, not accidental; therefore, his action was deemed a willful act and considered abuse. This failure had the potential to cause both physical and emotional harm to all residents. Findings: On 3/08/24, the facility submitted a facsimile (FAX, a telephonic transmission of scanned printed material) to the California Department of Public Health (CDPH) about a physical altercation between residents. The FAX indicated residents were observed in a physical altercation, and first aid was rendered to victim (Resident 1)'s skin tear on the right eye. Review of Resident 1's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including dementia (changes to memory, thinking, and behavior, decline in thinking skills), paranoid personality disorder (a mental health condition marked by a pattern of distrust and suspicion of others without adequate reason), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear). Resident 1's Minimum Data Set (MDS, an assessment tool) dated 12/16/23 indicated a Brief Interview for Mental Status (BIMS) score of 11 (mild impaired cognition). Review of Resident 1's care plans indicated a plan to address an allegation of abuse, resident to resident altercation with injury: skin tear to the right lateral orbital area (the cavity of the skull in which the eyeballs are situated). The interventions included assessing the resident for injuries and rendering care promptly. Review of Resident 1's Interdisciplinary Team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents) note dated 3/11/24 indicated that on 3/08/24, at approximately 11:10 a.m., a CNA alerted the licensed nurse that residents had a disagreement. The licensed nurse went to the room, and when she entered the room, the licensed nurse saw Resident 2 standing on the right side of Resident 1's bed. Resident 1 claimed that Resident 2 hit him in the head twice. The licensed nurse noted a skin tear on the side of the right eye with a small amount of blood on Resident 1. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's physician's order dated 3/08/24 indicated cleanses the skin tear to the right lateral periorbital area with NS (normal saline), pat dry, then apply steri-strips for 1 day; monitor right lateral periorbital area skin tear for s/sx (signs/symptoms) of infection for 14 days. During an observation and interview on 4/04/24 at 11:30 a.m., Resident 1 was observed lying in bed, awake and alert, with some confusion. Resident 1 stated that he did not have any trouble with co-residents and could not remember someone hitting him. Review of Resident 2's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including mild cognitive impairment (problems with a person's ability to think, learn, and remember), depression (a mood disorder that causes a feeling of sadness and loss of interest), and alcohol dependence (a chronic disease characterized by uncontrolled drinking alcohol). Resident 2's MDS, dated [DATE], indicated a BIMS score of 14 (intact cognition). Review of Resident 2's care plans indicated a plan to address an allegation of abuse, perpetrator. The interventions included monitoring for episodes of hitting others and initiating room changes. Review of Resident 2's IDT note dated 3/08/24 indicated that on 3/08/24, at approximately 11:10 a.m., the licensed nurse saw Resident 2 standing on the right side of Resident 1's bed. Resident 2 reported that he was annoyed by Resident 1, Resident 1 told him that he was ugly, and then he got mad and slapped Resident 1 twice. Resident 2 was aware of what he did to his roommate. During an observation and interview on 4/04/24 at 11:50 a.m., Resident 2 was sitting up in his wheelchair in the big dining room, alert and calm. Resident 2 stated that he remembered having trouble with his ex-roommate but could not recall if he hit his ex-roommate. Review of the facility's 5 day follow up investigative summary dated 3/13/24 indicated that on 3/08/24 at 11:10 a.m., a licensed nurse (LN) responded to the residents' room after receiving the report from a Certified Nurse Assistant (CNA) that the residents were having a disagreement. When the LN came into the room, she saw Resident 2 standing on the side of the bed of Resident 1 who was lying on his bed. The licensed nurse did not witness the actual incident of the altercation. Resident 1 stated that he was hit on the right side of his face/eye by Resident 2 twice. Resident 2 admitted to hitting Resident 1, saying that he got annoyed by Resident 1 as Resident 1 was yelling at nursing staff. The summary further indicated, Conclusion: physical altercation between two male residents was verified based upon staff and resident interviews and injury sustained by the victim. During a telephone interview on 5/03/24 at 12:55 p.m. with Licensed Vocational Nurse A (LVN A), he stated that he heard loud voices from the hallway and went to the residents' room. He saw Resident 2 standing at the side of Resident 1's bed. Resident 1 claimed he got hit on the face twice by Resident 2. Resident 1 was observed with a skin tear above his eyebrow. Resident 2 stated he hit Resident 1 twice because he was annoyed by Resident 1. During an interview on 5/02/24 at 3:58 p.m. with the administrator (ADM), the ADM stated the facility considered the incident an altercation, not abuse, because Resident 2's act was not intentional to harm Resident 1. (continued on next page)

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F 0600 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 and Misappropriation Prevention Program, revised 4/2021, the P&P indicated, Residents have the right to be free from abuse . 1. Protect residents from abuse . by anyone including, b. other residents . During a review of the facility's Policy and Procedure (P&P) titled Abuse Prohibition Policy and Procedure, effective date 2/23/21, the P&P indicated, Healthcare centers prohibits abuse .Abuse is defined as the willful infliction of injury .Physical Abuse includes hitting, slapping .