

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/24/2024
NAME OF PROVIDER OR SUPPLIER  Sherwood Oaks Post Acute Care, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  130 Dana Street Fort Bragg, CA 95437	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27532</b></p> <p>Based on interview and record review, the facility failed to ensure a resident was free from abuse when Resident 1 hit with her fist Resident 2's thigh while they were seated close to each other. This failure caused pain and potential mental anguish to Resident 2.</p> <p>Findings:</p> <p>A review of Resident 1's medical records indicated the following:</p> <ul style="list-style-type: none"> <li>- The Quarterly Minimum Data Set (MDS - federally mandated clinical assessment) dated 9/23/24 indicated Resident 1 had severe memory issues.</li> <li>- The MDS further indicated Resident 1 had delusions (misconceptions or beliefs that are firmly held, contrary to reality) and exhibited verbal behavior symptoms directed towards others such as threatening, screaming, and cursing at others;</li> <li>- Resident 1's order summary report for 12/2024 indicated she was receiving Quetiapine Fumarate (an antipsychotic - medications used to treat several kinds of mental health conditions to regulate your mood, behaviors and thoughts) 50 milligram (mg, unit of measure) tablet in the afternoon and 25 mg in the morning for severe dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), with agitation.</li> <li>- Resident 1's care plan dated 8/1/24 indicated verbally abusive behaviors directed towards roommates, confused residents, and aggressive behaviors involving striking out at others, interfering with other resident's activities, etc.</li> <li>- Resident 1's care plan Interventions included: assist the resident from the confused resident's presence if the resident becomes abusive at the confused resident in a public environment or area; attempt to redirect the resident away from others if the resident is behaving aggressively or overly assertive manners or behaviors - be aware that the resident may not be easily redirected; do not locate or assist the resident to a location that enables the resident to be able to reach another resident by striking out when stimulated by the other resident.</li> </ul> <p>A review of Resident 2's medical records indicated the following:</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>- The Quarterly MDS dated [DATE] indicated Resident 2 had minimal hearing difficulty, cognition severely impaired, difficulty focusing attention, easily distracted, difficulty keeping track of what was said, exhibits disorganized thinking manifested by incoherent, rambling and unclear or illogical flow of ideas.</p> <p>- Resident 2's face sheet (one-page summary of important information about a patient, includes patient identification, allergies, insurance status, or other pertinent information like diagnosis on admission) indicated she was admitted with multiple diagnoses which included unspecified dementia without behavior disturbance.</p> <p>During an interview on 12/23/24, at 11:39 AM, Unlicensed Staff A stated, on the day of incident residents including Resident 1 and Resident 2 were out in the hallway seated in their wheelchairs near each other across the nurses' station. Unlicensed Staff A stated, Resident 1 said something to Resident 2, then Resident 1 said: what, are you not gonna answer me? Resident 1 then hit with her balled fist Resident 2 on the thigh area and Resident 2 said, Ouch! Unlicensed Staff A told Resident 1: you could not be hitting others, as she took her back to her room.</p> <p>A review of the facility's policy titled: Preventing resident abuse taken from the Operational policy and procedure manual for long-term care 2021 Med Pass, Inc., revised 12/2013, indicated, the facility's goal was to achieve and maintain an abuse-free environment and assess residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavior issues.</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>27532</p> <p>Based on interview and record review, the facility failed to report an alleged resident abuse immediately when Resident 1 allegedly hit Resident 2 who was sitting near and opposite her. This failure reduced the facility's potential to ensure resident safety.</p> <p>Findings:</p> <p>A review of facility Transmission Verification report sent 11/11/24 at 4:52 p.m. and received by the Department on 11/12/24 at 8:00 a.m., indicated an allegation of suspected dependent adult/elder abuse had been made related to a resident-to-resident altercation between Resident 1 and Resident 2.</p> <p>A review of the Report of Suspected Dependent Adult/Elder Abuse (documenting a report of abuse or neglect of an elder or dependent adult) between Resident 1 and Resident 2, indicated the incident happened on 11/10/24, at 4:18 p.m.</p> <p>During a review of record and concurrent interview on 12/23/24 at 11:45 a.m., the facility's abuse prevention policy did not indicate a timeframe for reporting suspected abuse incidents. The DON stated they follow the flowchart of Mandated Reporter (attached in facility documents) posted on his workstation. The DON was not familiar with the reporting requirement timeline for alleged abuse incident after he was informed by the Department that alleged incidents of abuse were reported not later than 2 hours after the allegation is made.</p> <p>A review of the facility's policy titled: Reporting abuse to State Agencies and other entities/individual, indicated, all suspected violations . of abuse will be immediately reported to appropriate state agencies . as maybe required by law.</p>