STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A371	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Wellness and Recovery Center	3062 Churn Creek Rd. Redding, CA 96002

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** 39942 Based on interview and record review, the facility failed to ensure that two of 20 sampled residents (Residents 3 and 82) were protected from physical abuse when: 1. On 6/12/24, Resident 84 struck Resident 82 in the face. 2. On 5/22/24, Resident 84 placed their hands around Resident 3's throat. This failure resulted in bleeding injuries to Resident 82, and had the potential to threaten the physical, emotional and psychological health and well-being of both residents. Findings: A facility policy, titled, Client (resident) Abuse Prevention, updated 4/5/22, was reviewed. The policy indicated clients should not have been subjected to verbal or physical abuse of any kind and clients should not have disciplined other clients. During pre-admission screening, all clients would have been assessed for history of poor impulse control, combativeness and assault to self and others. The interdisciplinary team (IDT-a group of professionals from different disciplines that met to discuss the residents' care) would have identified which clients, per history treatment plan or active treatment plan, needed treatment planning and would have followed up after any incidents to update interventions and decrease potential reoccurrence. A review of Resident 84's clinical record indicated they were admitted to the faciltiy on 2/26/24. Resident 84's diagnoses included paranoid schizophrenia (a severe mental disorder that resulted in hallucinations, delusions, and extremely disordered thinking and behavior), and unspecified psychosis (a mental disorder characterized by a disconnection from the ability to perceive what is real and what is not), and tachycardia (fast heart rate). The Minimum Data Set (MDS, tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function), dated 5/7/24, indicated Resident 84 rated 15/15, which equated to being cognitively intact. Resident 84 was legally conserved (a judge appointed an individual to make decisions to protect and manage a needy individual's life choices and personal needs). (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. A review of Resident 82's medical record indicated that Resident 82 was admitted on [DATE] with diagnoses that included, schizophrenia, cerebral palsy (neurological disorder, damage to the developing brain appearing in infancy affecting movement and muscle coordination), and chronic obstructive pulmonary disease (COPD, inflammatory lung diseases that block airflow and make it difficult to breathe). The MDS BIMS Section C assessing cognitive function, dated 5/7/24, indicated Resident 82 rated 15/15, which equated to being cognitively intact. Resident 82 was legally conserved. During an interview on 6/18/24 at 3:00 pm with Resident 82 in the resident's room, Resident 82 stated he had just returned to the room following a shower, went to the bathroom in the room, and was walking past Resident 84's bed which was closest to the door. Resident 84 made the statement that Resident 82 had spit on them. Resident 82 replied they were not close enough to spit on them and Resident 84 got up and punched Resident 82 in the nose and face four to five times causing Resident 82's nose to bleed heavily. Immediately following the injury, Resident 82 struck out at Resident 84 in order to escape from the attack and retreat to the nursing station for assistance. During an interview, on 6/18/24, at 3:30 pm, with the Administrator (ADMIN) in the conference room, ADMIN confirmed the incident did occur and was substantiated in the facility investigation. The facility staff did not expect any such incident as there had been no indication of aggression from Resident 84 towards the roommate Resident 82. Believes hallucinations were involved in the incident. Conveyed Resident 84's conservator was, at the time the incident took place, looking for a facility more suitable for the very impulsive, aggressive behaviors, and inappropriate interactions commonly demonstrated by Resident 84. 2. Review of Resident 3's clinical record indicated they were originally admitted to the facility on [DATE]. Resident 3's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by symptoms of schizophrenia and a mood disorder, such as mania and depression), and attention-deficit hyperactivity disorder (ADHD--an ongoing pattern of inattention and/or hyperactivity-impulsivity). Record review of a Nurses Note, dated 5/22/24 (21 days prior to the incident with Resident 82), at 2:34 AM, by Licensed Nurse (LN) A, showed a description of an incident. At approximately 2:15 AM staff was crossing through the day room and witnessed [Resident 84] standing over the top of [Resident 3], who was positioned reclined in a chair. [Resident 84] had his hands grasped around [Resident 3's] throat at the time and was bearing down on him. Staff immediately separated the clients from each other. The residents were both assessed for injuries and had none. Record review of an IDT Progress Note, dated 5/22/24, at 12:30 PM, by ADMIN, showed a note about a conversation with Resident 84. ADMIN wrote, Client [Resident 84] thought peer [Resident 3] was calling him names. Education provided regarding safety and nonviolent conflict resolution. [Resident 84] stated understanding related to not putting hands on peers. A Welfare Checks note, dated 5/22/24, at 3:41 PM, by the Service Coordinator (SC), was reviewed. The note indicated, [Resident 84] is on welfare checks Q15 (every 15 minutes) for aggressive behavior. SC spoke with [Resident 84] about the incident last night and he said he doesn't remember it and said, 'It's all hazy.' No further issues and will continue to monitor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Telepsychiatry (a clinical visit with a psychiatrist done remotely via computer) Progress Note, dated 5/23/24, at 11:32 AM, by a Psychiatric Nurse Practitioner (NP), showed a summary of the visit with Resident 84. NP wrote, Denies any violence except hitting a cop before his last hospitalization , and Resident 84 stated, I'm ok except that I got mad at some [NAME] the other day and I ended up choking him because of the way that he was talking to me. NP also wrote, 'When asked what made him feel the need to choke the other patient, he stated, 'it doesn't matter while, it was stupid. I understand that I shouldn't have done that and I am not going to do it again.' Throughout the entire conversation, patient was smiling and laughing. Patient does not appear to have any insight to his wrongdoing/inappropriate behavior and is a safety risk for the environment in which he is currently in. During a concurrent observation and interview, on 6/17/24, at 10:41 AM, Resident 3 was calm and answered questions while sitting in his room. Resident 3 stated he got along with others, once in a while got in fights. Said he practiced [NAME] arts. Seemed to [NAME] off into other topics and was not able to speak specifically about the incident on 5/22/24. During an interview, on 6/19/24, at 8:40 AM, LN A described the incident from 5/22/24. LN A stated that Certified Nursing Assistant (CNA) B discovered the incident in the day room and called a Code Three (emergency situation alert). Then LN A and another nurse responded. LN A could only see the back of Resident 84 standing over Resident 3. Resident 3 was in a recliner chair and didn't appear to be in distress, but CNA B had separated the two. LN A said clients are up at all hours [NAME] around. LN A stated that Resident 84's behavior was sporadic and unpredictable and there was no warning beforehand. During an interview, on 6/20/24, at 7:15 AM, CNA B they were going through the day room on 5/22/24 at 2 AM, and saw Resident 84 choking Resident 3. CNA B stated they pulled Resident 84's hands off Resident 3's neck. Then Resident 84 backed off. Resident 3 was in a recliner chair. Both residents answered that they were OK. CNA B stated Resident 84 was kind of in a daze, not angry or anything else. CNA B stated there were other residents in the day room at the time who started yelling, then other staff came in to help. 43031

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43031 Based on observation, interview, and record review the facility failed to store food in accordance with professional standards when they failed to label and date food containers/ product bags of frozen breaded fish, frozen fried eggs, frozen hashbrowns, frozen frenchtoast, pepperoni, and peeled garlic cloves with open dates after the packages were open and the products being used for meals. This failure had the potential to allow food products to sit an inappropriate amount of time after the packaging was open with no dating label adehered leading to bacterial or fungal growth causing food borne illnesses amongst residents if the product was served for meals and not used by an appropriate date following guidelines. Findings: During a review of the facility's policy and procedure titled, Labeling and Dating of Foods, dated 2020, indicated, Newly opened food items will need to be closed and labeled with an open date and used by the date that follows guidelines . During a concurrent observation and interview on 6/17/24 at 11:18 am with [NAME] in the kitchen, multiple packages were observed in the freezer unit open and unlabeled, including frozen breaded fish, frozen frenchtoast, frozen hashbrowns, and frozen fried eggs. [NAME] stated, I just opened and used some of those, I forgot to label them. During a concurrent observation and interview on 6/17/24 at 11:18 am with Food Service Supervisor (FSS) in the walk-in refrigerator, a package of fresh pepperoni and a bag of peeled garlic cloves were observed open and unlabeled. FSS confirmed the bags were previously opened with no label applied nor present. During an interview on 6/19/24 at 10:45 am with FSS in the kitchen by the back sink, FSS confirmed once product packaging is open for use the products are to be labeled with an open date.