STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555158	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Centro Post-Acute Care	1700 S. Imperial Ave El Centro, CA 92243

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 - 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** 40610 Based on observation, interviews and record reviews, the facility failed to protect the resident ' s (Resident 1) rights to be free from sexual abuse when Resident 2 ' s wandering behavior was not assessed, and he was found in Resident 1 ' s bed engaging in sexual act. As a result, Resident 1 and Resident 2 engaged in sexual encounter which was not consensual and Resident 1 required hospitalization for evaluation of sexual assault. Findings: On 6/9/22 at 2:24 P.M., an unannounced onsite at the facility was conducted related to a facility reported resident abuse. On 6/9/22, a review of Resident 1 and Resident 2 ' s record was conducted. 1. Resident 1 was admitted to the facility on [DATE], from an acute care hospital (ACH) for skilled nursing (a patient's need for care or treatment that can only be performed by licensed nurse), with diagnoses which included stroke (a loss of blood flow to part of the brain, which damages brain tissue) and generalized muscle weakness, per the facility ' s Admission Record. Resident 1 ' s History and Physical (H&P), dated 3/14/22, the H & P indicated the attending physician (AP 1) documented Resident 1 did not have the capacity to understand and make decisions. Resident 1 ' s Minimum Data Set (MDS - an assessment tool), dated 3/16/22, the MDS indicated Resident 1's brief interview for mental status (BIMS, ability to recall) score was 5, which meant Resident 1's cognition was severely impaired. The MDS section G for activities of daily living (ADLs- activities related to personal care .include .getting in and out of bed .) indicated, Resident 1 needed limited assistance and required a one-person physical assist during bed mobility. Resident 1 ' s Change in Condition (CIC) notes, dated 6/9/22 at 3:09 A.M., completed by a Licensed Nurse (LN) 1, indicated Resident 1 was heard shouting from her room, Certified Nursing Assistant (CNA) 3 checked Resident 1, found Resident 2 in Resident 1 ' s bed without underwear, and his hips propped against Resident 1 ' s lower region. Per the nurses ' notes, Resident 2 was in this position until CNA 3 showed up to witness, then Resident 2 released Resident 1 and pulled up his underwear. (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 - Actual harm Residents Affected - Few	Resident 1 ' s acute care hospital (ACH) record, dated 6/9/22 at 2:06 P.M., the Emergency Department Attending Physician (EDAP 1) documented Resident 1 presented to the emergency room for evaluation after sexual assault. Per EDAP 1 notes on 6/9/22 at 8:08 P.M., Resident 1 underwent diagnostic test. While hospitalized , Resident 1 received medications including antibiotics. The same EDAP 1 notes indicated, It was unclear if there was actual penetration or not. Resident 1 ' s discharge instructions from the ACH dated 6/10/22 at 3:28 P.M., the discharge instructions indicated, .Final diagnosis: Sexual Assault . The discharge instructions from ACH indicated Resident 1 had to continue antibiotics at home. 2. Resident 2 was admitted to the facility on [DATE], from a skilled nursing facility (nursing home), with diagnoses which included dementia (the loss of cognitive functioning like thinking, remembering, and reasoning), per the facility ' s Admission Record. Resident 2 ' s H&P, dated 2/7/22, indicated, the attending physician (AP 1) documented Resident 2 did not have the capacity to understand and make decisions. Resident 2 ' s MDS dated [DATE], indicated, Resident 2's BIMS score was 6, which meant Resident 2's cognition was severely impaired. The Behavior section of the MDS dated [DATE] and 5/13/22, indicated Resident 2 did not have a wandering behavior. On 6/9/22 at 2:24 P.M., an observation was conducted. Resident 1's room was located adjacent to Resident 2 ' s room at the end of the hallway in Station 2. Resident 1 resided in a two-bedroom by herself with her bed located by the window. Resident 2 resided in the adjacent two-bedroom room by himself. On 6/9/22 at 3:26 P.M., an observation and an interview of Resident 2 was conducted. Resident 2 was sitting in a chair, holding a cane, and was watching a television show in his room. Resident 2 stated he used to go out of his room and did not know why he now had restrictions. Resident 2 stated he did not recall if he had gone to another residents ' room. Resident 2 stated, Maybe I have to start looking for a girlfriend. I want to hold hands with somebody, it was important to me because I always have a girl in my hand/arms. I used to have somebody with me always. On 6/9/22 at 4 P.M., a follow up observation of Resident 2 in his room was conducted. Resident 2 tried to go out of his room, but the CNA stopped him because he was on a 1:1 monitoring at the time of visit. On 6/9/22 at 3:46 P.M., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated Resident 1 was confused and was totally dependent to staff. CNA 1 stated Resident 1 was admitted to the hospital after the assault. On 6/9/22 at 3:46 P.M., an interview with CNA 1 was conducted. CNA 1 stated Resident 2 had memory impairment when he forgot things like his name and his room. CNA 1 stated Resident 2 tended to go to another resident ' s room but was easily redirected. CNA 1 stated Resident 2 had wandering behaviors and were reported to the licensed nurses. CNA 1 further stated he witnessed Resident 2 entering other residents ' rooms, and CNA 1 redirected Resident 2 out of the room. (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 - Actual harm Residents Affected - Few	On 6/9/22 at 4:09 P.M., an interview with CNA 2 was conducted. CNA 2 stated she provided care to Resident 1 and Resident 2. CNA 2 stated Resident 1 was confused, required two persons assist, got nervous when staff moved her. CNA 2 stated Resident 2 was alert, oriented and could hold a conversation. CNA 2 stated Resident 2 would always ask for his room number. CNA 2 stated the staff had to look for him because he would push wheelchair bound, confused female residents from station 2 hallways to the lobby. CNA 2 stated Resident 2 would get mad when staff separated Resident 2 from the female residents, he became violent and swung his cane up the air. CNA 2 stated other CNAs were aware Resident 2 would go to other residents ' rooms. CNA 2 stated his wandering behaviors were reported to the licensed nurses. CNA 2 stated Resident 2 was not on monitoring during the time of incident. On 7/11/22 at 3:16 P.M., a telephone interview with CNA 3 was conducted. CNA 3 stated she provided care to Resident 1 and Resident 2 during the night shift on 6/8/22. CNA 3 stated Resident 1 was nonverbal, yelled when she was being cleaned or changed. CNA 3 stated Resident 2 was independent, wandered around the station and was usually awake during the night shift. CNA 3 stated Resident 2 was aggressive towards staff and cursed everybody out. CNA 3 stated Resident 2 would sometimes walk naked in the hallway, and the licensed nurses would redirect him. CNA 3 stated on 6/9/22, after midnight, she heard Resident 1 yelling. CNA 3 stated she went into Resident 1 ' s room and found Resident 1 lying on her left side, her pull ups (incontinence brief) was on the floor, her legs were around Resident 2 ' s waist, while Resident 2, whose pull ups were to his knees, was on top of Resident 1 and was thrusting. CNA 3 stated, It was hard to see with their position that his penis was in her vagina. CNA 3 stated she told Resident 2 to get out but Resident 2 refused. CNA 3 stated it took them 10 minutes until Resident 2 went out of Resident 1 ' s room. CNA 3 stated Resident 2 was aggressive and said to CNA 3, She gave me consents and I can do anything to her. CNA 3 stated there was feces on Resident 2 ' s shirt and the police officer took the shirt. On 6/9/22 at 4:27 P.M., an interview and facility record review with LN 2 was conducted. LN 2 stated Resident 1 required staff assistance, she was nonverbal and would scream when staff changed her. LN 2 stated Resident 2 was alert, oriented, would walk up and down the hallway and asked for his room number. LN 2 stated she did not witness Resident 2 going into other residents ' room nor received a report from the CNAs that Resident 2 went into other resident ' s room. LN 2 stated Resident 2 would stop in each resident ' s door and wandered around to find his room by walking up and down the hall. LN 2 stated there was no wandering assessment or care plan in Resident 2 ' s record. LN 2 stated the staff did not consider Resident 2 as wanderer because he did not have an exit seeking behavior (wander or try to leave the facility without companion). LN 2 stated, We could have prevented the incident if we had a sitter and redirected him. On 7/11/22 at 1:16 P.M., a telephone interview with LN 3 was conducted. LN 3 stated Resident 1 was confused, required staff assistance with ADLs. LN 3 stated Resident 2 had an aggressive behavior at times, was rude and yelled at staff. LN 3 stated Resident 2 wandered around, walked down the hallway, would come to the nurse ' s station, asked for his room number, would go back to his room then will come out again. LN 3 stated Resident 2 would do the behavior three to four times during her shift. LN 3 stated she did not do any assessment or care plan related to Resident 2 ' s wandering behavior. LN 3 stated she was not in the facility on the day of the incident. LN 3 stated the incident could have been prevented if staff paid more attention to Resident 2 ' s behavior. On 10/24/22 at 5:12 P.M., a telephone call was placed to the police officer, but no answer to phone call and did not return call. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/18/23 at 3:34 P.M., a telephone call was placed to Resident 1 ' s daughter, but no answer to phone call, and a voicemail was left. On 12/26/23 at 11:37 A.M., a telephone interview with the Assistant Director of Nursing (ADON) was conducted. The ADON acknowledged that Resident 1 and every resident should have been free from any form abuse. A review of the facility ' s policy titled, Resident Rights, revised December 2016, the policy indicated, .1. 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 . A review of the facility ' s policy, titled, Wandering ., revised March 2019. The policy indicated, The facility will identify residents who are at risk for unsafe wandering and strive to prevent harm .1. If identified as at risk for wandering .or other safety issues, the resident ' s care plan will include strategies and interventions to maintain the resident ' s safety . A review of the facility ' s policy, titled, Safety and Supervision of Residents, revised July 2017, the policy indicated, .Resident safety and supervision .to prevent accidents are facility-wide priorities .Systems Approach to Safety .2. Resident supervision is a core component of the systems approach to safety .

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40610 Based on observation, interview and record review, the facility failed to assess a resident ' s (Resident 2) wandering behavior and develop a baseline care plan (detailed plan with information about a patient's treatment, goal, and interventions) of Resident 2's wandering behavior. As a result, the lack of a resident centered care plan with specific interventions to reduce wandering behavior had the potential for Resident 2 to enter the rooms of other residents without permission. In addition, Resident 2 was found in another resident's room engaging in a sexual act. Findings: On 6/9/22 at 2:24 P.M., an unannounced onsite at the facility was conducted. 1. Resident 2 was admitted to the facility on [DATE], from a skilled nursing facility (nursing home), with diagnoses which included dementia (the loss of cognitive function like thinking, remembering, and reasoning), per the facility ' s Admission Record. Resident 2 ' s history and physical (H&P), dated 2/7/22, indicated, the attending physician (AP 1) documented Resident 2 did not have the capacity to understand and make decisions. Resident 2 ' s minimum data set (MDS, an assessment tool) dated 2/10/22, indicated Resident 2's brief interview for mental status (BIMS, ability to recall) score was 6, which meant Resident 2's cognition was severely impaired. The Behavior section of the MDS dated [DATE] and 5/13/22 indicated, Resident 2 did not have a wandering behavior. 2. Resident 1 was admitted to the facility on [DATE], from an acute care hospital (ACH) for skilled nursing (a patient's need for care or treatment that can only be performed by licensed nurse), with diagnoses which included stroke and generalized muscle weakness, per the facility ' s Admission Record. Resident 1 ' s H&P, dated 3/14/22, indicated the attending physician documented Resident 1 did not have the capacity to understand and make decisions. 3. Resident 3 was readmitted to the facility on [DATE], from an acute care hospital with diagnoses which included chronic kidney disease and generalized muscle weakness, per the facility ' s Admission Record. Resident 3 ' s H&P, dated 10/17/22, indicated the AP 1 documented Resident 3 had the capacity to understand and make decisions. Resident 3 ' s MDS, dated [DATE], indicated Resident 3's brief interview for mental status (BIMS, ability to recall) score was 8, which meant Resident 3's cognition was moderately impaired. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/22 at 3:26 P.M., an observation and an interview of Resident 2 was conducted. Resident 2 was sitting in a chair, holding a cane, and was watching a television show in his room. Resident 2 stated he used to go out of his room and did not know why he now had restrictions. Resident 2 stated he did not recall if he had gone to another residents ' room. Resident 2 stated, Maybe I have to start looking for a girlfriend. I want to hold hands with somebody, it was important to me because I always have a girl in my hand/arms. I used to have somebody with me always. On 6/9/22 at 4 P.M., a follow up observation of Resident 2 in his room was conducted. Resident 2 tried to go out of his room. On 6/9/22 at 3:46 P.M., an interview with certified nursing assistant (CNA) 1 was conducted. CNA 1 stated Resident 2 had memory impairment when he forgot things like his name and his room. CNA 1 stated Resident 2 tended to go to another resident ' s room but was easily redirected. CNA 1 stated Resident 2 had wandering behaviors and were reported to the licensed nurses. CNA 1 further stated he witnessed Resident 2 entering Resident 3 ' s room and that Resident 3 yelled at Resident 2 to leave. CNA 1 stated alert residents got upset when Resident 2 went into their rooms. On 6/9/22 at 4:09 P.M., an interview with CNA 2 was conducted. CNA 2 stated she provided care to Resident 1 and Resident 2. CNA 2 stated Resident 1 was confused, required two persons assist, got nervous when staff moved her. CNA 2 stated Resident 2 was alert, oriented and could hold a conversation. CNA 2 stated Resident 2 would always ask for his room number. CNA 2 stated the staff had to look for him because he would push wheelchair bound, confused female residents from station 2 hallways to the lobby. CNA 2 stated Resident 2 would get mad when staff separated Resident 2 from the female residents, he became violent and swung his cane up the air. CNA 2 stated other CNAs were aware Resident 2 would go to other residents ' rooms. CNA 2 stated his wandering behaviors were reported to the licensed nurses. CNA 2 further stated Resident 2 was not on 1:1 monitoring during the time of incident. On 7/11/22 at 3:16 P.M., a telephone interview with CNA 3 was conducted. CNA 3 stated Resident 2 was independent, wandered around the station and was usually awake during the night shift. CNA 3 stated Resident 2 was aggressive towards staff and cursed everybody out. CNA 3 stated Resident 2 would sometimes walk naked in the hallway, and the licensed nurses would redirect him. CNA 3 stated on 6/9/22 after midnight, she heard Resident 1 yelling, went into Resident 1 ' s room and found Resident 2 in Resident 1 ' s bed engaging in a sexual act. On 6/9/22 at 4:27 P.M., an interview and facility record review with Licensed Nurse (LN) 2 was conducted. LN 2 stated Resident 1 required staff assistance, she was nonverbal and would scream when staff changed her. LN 2 stated Resident 2 was alert, oriented, would walk up and down the hallway and asked for his room number. LN 2 stated she did not witness Resident 2 going into other residents ' room nor got a report that Resident 2 went into other resident ' s room. LN 2 stated Resident 2 would stop in each resident ' s door and wandered around to find his room by walking up and down the hall. LN 2 stated there was no wandering assessment or care plan in Resident 2 ' s record. LN 2 stated the staff did not consider Resident 2 as wanderer because he did not have an exit seeking (wander or try to leave the facility without companion) behavior. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/22 at 1:16 P.M., a telephone interview with LN 3 was conducted. LN 3 stated Resident 2 had an aggressive behavior at times, was rude and yelled at staff. LN 3 stated Resident 2 wandered around, walked down the hallway, would come to the nurse ' s station, asked for his room number, would go back to his room then will come out again. LN 3 stated Resident 2 would do the behavior three to four times her shift. LN 3 stated she did not do any assessment or care plan related to Resident 2 ' s wandering behavior. A review of the facility ' s policy, titled, Care plans, Baseline, revised March 2022, the policy indicated, .1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident .3. A comprehensive care plan may be used in place of the baseline care plan .is developed within 48 hours of the resident ' s admission and meets the requirements of a comprehensive assessment . A review of the facility ' s policy, titled, Wandering ., revised March 2019. The policy indicated, The facility will identify residents who are at risk for unsafe wandering and strive to prevent harm .1. If identified as at risk for wandering .or other safety issues, the resident ' s care plan will include strategies and interventions to maintain the resident ' s safety .