STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Almond View Care Center	1224 E Street Williams, CA 95987

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** 49934 Based on observation and interview the facility failed to ensure one of three residents (Resident 1) was free from abuse when another resident (Resident 2) pushed him down. This failure resulted in a rib fracture of Resident 1. Findings: During a review of the facility ' s policy and procedure, Resident-To-Resident Altercations, revised 11/16, indicated that the facility acts promptly and conscientiously to prevent and address altercations between residents. The purpose of this policy is to protect the health and safety of residents by ensuring that altercations between residents are promptly reported, investigated, and addressed by the facility. During a review of the facility ' s policy, Resident [NAME] of Rights, California Code of Regulations Title 22, Section 72527, Skilled Nursing Facilities, no date noted, indicated that patients have the rights detailed in these sections and the facility will safeguard that these rights are not violated. Paragraph (10) states, patients shall have the right to be free from mental and physical abuse. A review of a facility reported incident to the California Department of Public Health, dated 06/03/24 at 8:09 am, indicated Resident 2 pushed Resident 1 when Resident 1 entered Resident 2 ' s room and began to flip the light switch on and off. The actions of Resident 2 resulted in Resident 1 acquiring a broken rib. During a review of Resident 1 ' s records, initial admitted was 10/26/2023, with diagnoses of Alzheimer ' s Disease, dementia- moderate with other behavioral disturbances, and insomnia. During a review of Minimum Data Sets (MDS- a standardized assessment and care screening tool for residents), on 06/19/24, at 1:09 pm, indicated that the Brief Interview for Mental Status (BIMS- test of mental capacity) score of Resident 1 on 05/02/24, was scored a 3, which is severe cognitive impairment. During a review of Resident 2 ' s records, his initial admitted was 12/02/2023, with diagnoses of dementia-unspecified severity with other behavioral disturbances, paranoid schizophrenia, and anxiety disorder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of MDS on 06/19/24, at 1:09 pm, indicated the BIMS for Resident 2 on 03/07/24, was scored at a 7, which is severe cognitive impairment, and on 06/10/24, his BIMS was scored at a 12, which is moderate cognitive impairment. During a review of Resident 2 ' s Care Plan (CP) about Mood and Behavior, initiated on 12/07/23, indicated that Resident 2 had a history of kicking in doors and a history of resident-to-resident abuse. Resident to Resident Altercation #1: During a review of Interdisciplinary Team Note (IDT- a meeting that includes several departments to discuss care of residents), dated 12/26/23, at 12:1 pm, indicated on 12/25/23, around 4:00 pm, a loud noise was heard in the hallway. A Licensed Vocational Nurse (LVN) found a resident (Resident 4) on the floor, on his right side. Resident 4 stated that Resident 2 hit him. Resident 2 opened his door and stated Resident 4 hit him first on the lip. Resident 2 stated that Resident 4 had gained access to his room by way of a shared bathroom. When Resident 2 found Resident 4 in his room, he told him that that he was in the wrong room. Then resident 4 proceeded to hit Resident 2, and then Resident 2 pushed resident 4 out of his room, with Resident 4 being found on the floor. Resident to Resident Altercation #2: During a review of IDT Note, dated 01/03/24, at 11:37 am, indicated on 01/02/24, around 11:15 am, a Certified Nursing Assistant (CNA) heard a housekeeper say, No!. The CNA noticed that another resident (Resident 3) was backing out of Resident 2 ' s room, and both residents were throwing punches at each other. When asked about what had occurred, Resident 2 stated that Resident 3 was grabbing his belongings. Resident 2 stated he proceeded to grab Resident 3 by the back of the head and slammed his face into the door. Resident to Resident Altercation #3: During a review of IDT Note, dated 02/26/24, at 11:23 am, indicated on 02/24/24, around 5:00 am, Resident 2 came out of his room and stated his roommate was in his bed. Resident 2 stated that if they did not go in and take care of it, he was going to beat him the F up. The roommate was assisted out of the bed, and he went out to the nurses ' station. Resident 2 came out of his room a couple more times stating this was all BS. Just before 6:00AM, Resident 2 came out of his room, with his backpack on, and stated something about the FBI. Resident 2 proceeded down the hallway, with a CNA following him. Staff heard two loud bangs and Resident 2 had kicked the side door open. Resident to Resident Altercation #4: During an interview with Resident 2 on 06/19/24, at 11:28 am, he indicated that Resident 1 was in his closet. I was in bed and Resident 1 was turning my light on and off and was rummaging through my closet. I grabbed him by the t-shirt and pushed him through the door and he tripped over his feet. That didn ' t seem to do much to him at all. They claim he may have cracked a rib. I am up to my ears with this situation. I don ' t want people in my room; it upsets me. (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 - Few	During an interview with Certified Nursing Assistant (CNA 1) on 06/19/24, at 11:22 am, who was doing 1:1 (provides direct supervision of resident) with Resident 1 and stated that he was curious about everything. CNA 1 stated Resident 1 will wander around the halls, confused, and tends to go into rooms; he was a busy man. During an interview with the Administrator (Admin) on 06/19/24, at 12:13 pm, Admin stated that Resident 1 was sent to the hospital after Resident 2 pushed him, which resulted in a fall. The facility was given a verbal report that Resident 1 had two broken ribs. The discharge papers from the hospital did not contain a record of rib x-rays, so the facility ordered in-house (performed in the facility) x-rays. These showed a new fracture at a rib and an old fracture at a rib. A review of the in-house x-ray findings report, dated 06/10/24, indicated a fracture of the sixth rib and an old fracture of the right ninth rib of Resident 1. During an interview with the Admin on 06/19/24, at 1:28 pm, she indicated that Resident 1 goes where he goes, and it can be into rooms. During an interview with Licensed Vocational Nurse (LVN A) on 06/19/24, at 1:40 pm, she indicated that Resident 1 wanders into rooms. During an interview with the Infection Preventionist (IP) on 06/19/24, at 1:43 pm, she indicated that Resident 1 tries to get into rooms, but we re-direct him. During an interview with the Director of Nursing (DON) on 06/19/24, at 1:50 pm, she indicated that Resident 1 wanders everywhere, including into rooms and he will open doors. During an interview on 06/19/24, at 2:00 pm, with CNA 2, stated she observed Resident 1 at Resident 2 ' s door and Resident 1 was closing the door. Resident 2 came to his door as Resident 1 was closing it and started yelling at Resident 1. Then Resident 2 pushed Resident 1 into the corner and Resident 1 fell . Resident 1 sustained a right broken rib. CNA 2 stated that Resident 2 gets upset easily. CNA 2 also stated that Resident 1 wanders up and down the hallways, and he loved to open doors and sometimes will go in the room once he opens the door. During an interview with CNA 3 on 06/19/24, at 2:25 pm, via a phone call, she stated that CNA 2 was keeping an eye on Resident 1. CNA 3 stated she only saw Resident 1 hit the wall and fall after Resident 2 pushed him; she heard Resident 2 cussing at Resident 1. CNA 3 stated that Resident 2 was an angry person. CNA 3 also stated the Resident 1 wanders the halls. He will go into peoples ' rooms, and that is the main thing he likes to do. During an interview on 06/26/24, at 4:43 pm, with Licensed Vocation Nurse (LVN B) stated that Resident 2 was territorial of his room. She states you never know when he is going to go off. CNA 3 stated that Resident 2 doesn ' t like loud noises. During an interview with LVN C on 06/26/24, at 4:54 pm, she stated that Resident 2 does not like anyone going into his room. She stated that Resident 2 knows how to follow the rules and he gets upset when other don ' t follow the rules; he will yell. (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 - Few	During an interview with the Assistant Director of Nursing (ADON) on 06/26/24, at 5:03 pm, she stated that Resident 2 fights the demons in his head and doesn ' t always win and that he can be an angry person. During an observation on 06/26/24, at 5:15 pm, Resident 1 entered the room twice, where the ADON was being interviewed, and both the CNA and ADON redirected him each time. During an interview with CNA 4 on 06/26/24, at 5:29 pm, she stated that Resident 2 gets irritated with other residents and that he is territorial, and he yells a lot. During an observation on 06/26/24, at 5:45 pm, Resident 1 attempted to get into Resident 2 ' s room three times within 45 seconds, with two CNAs and the ADON attempting to redirect each time. Resident 1 was determined, grabbing the handle firmly, with one and then two hands, and trying to turn the handle to open the door each time. Resident 2 ' s door was shut, and a stop sign across the threshold. Resident 2 remained in his room. Resident 1 was on a 1:1 at the time. During a phone call on 07/09/24, at 12:20 pm, a family member of Resident 2 stated that Resident 2 is living 20 to [AGE] years ago, when his parents passed. When the family member was asked what Resident 2 ' s disposition was like prior to his mental decline, the family member stated that Resident 2 was, always confrontational and combative, always. He gave the example of their neighbor ' s dogs that would bark. Resident 2 would get into physical and verbal fights with the neighbors over their dogs barking and would threaten the neighbors. The family member also stated that Resident 2 got into no more than the normal amount of fights during high school.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49934 Based on observation, interview, and record review, the facility failed to develop and implement a care plan for one of three residents (Resident 2) that would prevent altercations with other residents, thus hindering the delivery of individualized dementia care needs. These failures have resulted in multiple resident to resident altercations with injuries and places this resident at high risk of further harm to others and self. Findings: During a review of the facility ' s policy, Care Plans, Comprehensive Person-Centered, revised 03/2022, indicated that the IDT team develops and implements a comprehensive, person-centered care plan, and the interventions come from thorough analysis of information gathered as part of the comprehensive assessment of the resident. These interventions are chosen with consideration of the relationship between the resident ' s problem areas and the causes, in alignment with clinical decision making. During a review of the facility ' s policy, Resident [NAME] of Rights, Title 22, Chapter IV, Part 483- Requirements For States And Long Term Care Facilities, Subpart B-Requirements for Long Term Care Facilities, Section 483.10- Resident Rights, paragraph (e) Privacy and Confidentiality, no date noted, Paragraph (1) indicated that personal privacy includes accommodations. During a review of Resident 2 ' s records, his initial admitted was 12/02/2023, with diagnoses of dementia-unspecified severity with other behavioral disturbances, paranoid schizophrenia, and anxiety disorder. During a review of the Minimum Data Sets (MDS- a standardized assessment and care screening tool for residents), it indicated the BIMS for Resident 2 on 03/07/24, was scored at a 7, which is severe cognitive impairment, and on 06/10/24, his BIMS was scored at a 12, which is moderate cognitive impairment. During a review of Resident 2 ' s Care Plan (CP) about Mood and Behavior, initiated on 12/07/23, indicated that Resident 2 had a history of kicking in doors and a history of resident-to-resident abuse. Resident to Resident Altercation #1: During a review of Interdisciplinary Team Note (IDT- a meeting that includes several departments to discuss care of residents), dated 12/26/23, at 12:1 pm, indicated on 12/25/23, around 4:00 pm, a loud noise was heard in the hallway. A Licensed Vocational Nurse (LVN) found a resident (Resident 4) on the floor, on his right side. Resident 4 stated that Resident 2 hit him. Resident 2 opened his door and stated Resident 4 hit him first on the lip. Resident 2 stated that Resident 4 had gained access to his room by way of a shared bathroom. When Resident 2 found Resident 4 in his room, he told him that that he was in the wrong room. Then resident 4 proceeded to hit Resident 2, and then Resident 2 pushed resident 4 out of his room, with Resident 4 being found on the floor. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of Interdisciplinary Team Notes (IDT, team of various staff to evaluate and develop resident plan of care) Notes, dated 12/26/23 at 12:13 pm, indicated Resident 2 was to be moved into a new room, nursing was to do alert charting (charting during all shifts that keeps track- mentally, physically, emotionally- of a resident after an incident), and a follow up with a psychologist for medication management. Nurses Note dated 12/26/23 at 1:30 pm, indicated that Resident 2 was on alert charting for the incident and was adjusting well to his new room, and a Nurses Note dated 12/28/23 at 9:22 am, indicated that the Medical Doctor (MD) reviewed the psychiatrist notes and no new orders given. Resident to Resident Altercation #2: During a review of IDT Note, dated 01/03/24, at 11:37 am, indicated on 01/02/24, around 11:15 am, a Certified Nursing Assistant (CNA) heard a housekeeper say, No!. The CNA noticed that another resident (Resident 3) was backing out of Resident 2 ' s room, and both residents were throwing punches at each other. When asked about what had occurred, Resident 2 stated that Resident 3 was grabbing his belongings. Resident 2 stated he proceeded to grab Resident 3 by the back of the head and slammed his face into the door. During review of IDT Notes, dated 01/03/24 at 11:37 am, indicated that staff was to attempt to keep these residents apart while in the common area, STOP sign on the door of Resident 2 to attempt to keep other resident out of his room, and a follow up with a psychologist. Nurses Note, dated 01/01/24 at 1:15, indicated the nursing staff received orders to increase a behavior modification medication for Resident 2. On 01/02/24 at 4:01 pm, a Nurses Note indicated that Resident 2 was given orders for as needed anxiety medication. Resident to Resident Altercation #3: During a review of IDT Note, dated 02/26/24, at 11:23 am, indicated on 02/24/24, around 5:00 am, Resident 2 came out of his room and stated his roommate was in his bed. Resident 2 stated that if they did not go in and take care of it, he was going to beat him the F up. The roommate was assisted out of the bed, and he went out to the nurses ' station. Resident 2 came out of his room a couple more times stating this was all BS. Just before 6:00AM, Resident 2 came out of his room, with his backpack on, and stated something about the FBI. Resident 2 proceeded down the hallway, with a CNA following him. Staff heard two loud bangs and Resident 2 had kicked the side door open. During review of IDT Notes, dated 02/26/24 at 11:23 am, indicated Resident 2 was moved into a new room with a new roommate, was referred to a psychologist, Responsible Party (RP) inquired about an inpatient behavioral health program, use of distraction (model airplane, model car, sketchpad, pencils, paper), attempt to redirect, and attempt to prevent triggers via room change and evaluation from psychologist. Nurses Note, dated 02/27/24 at 12:56, indicated resident was moved into a new private room and at 5:46 pm, nursing staff received orders to increase the behavior modification medication, with a blood draw and an analysis of urine. Nurses Note, dated 03/07/24 at 7:30, indicated that Resident 2 left for an inpatient stay at a behavioral health program. Resident to Resident Altercation #4: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 2 on 06/19/24, at 11:28 am, he indicated that Resident 1 was in his closet. I was in bed and Resident 1 was turning my light on and off and was rummaging through my closet. I grabbed him by the t-shirt and pushed him through the door and he tripped over his feet. That didn ' t seem to do much to him at all. They claim he may have cracked a rib. I am up to my ears with this situation. I don ' t want people in my room; it upsets me. During a review of Resident 2 ' s Care Plan regarding mood and behavior problems, indicated that most interventions, except for one, were not recently updated: Administer medications as ordered. Initiated 12/07/23. Hall monitor to deter other resident from entering room. Revised 02/07/24. If/when having aggressive outbursts: provide redirection, monitor pain, toilet, offer snack/drink, Outdoor patio, tv. Resident enjoys doing projects in his room. Offer drawing supplies, model airplanes to put together, puzzles, etc. Revised 02/14/24. If/when having anxious statements of feeling trapped: offer outdoor patio, offer a snack, offer music. Revised 04/04/24. If/when having auditory hallucinations: approach in a calm, reassuring manner, provide orientation to reality, offer distraction techniques, diversional activities for distraction. Date initiated 01/17/24. If/when resident removes stop sign from door educate resident on the reasoning for the need of the stop sign and encourage to leave it on the door. Initiated 06/19/24. Keep resident comfortable and pain management controlled. Initiated 03/08/24.There was no documentation found in the IDT notes or care plans that address the issues Resident 1 and direct care staff have communicated that he does not like others in his room. During an interview on 06/19/24, at 2:00 pm, with CNA 2, stated she observed Resident 1 at Resident 2 ' s door and Resident 1 was closing the door. Resident 2 came to his door as Resident 1 was closing it and started yelling at Resident 1. Then Resident 2 pushed Resident 1 into the corner and Resident 1 fell . Resident 1 sustained a right broken rib. CNA 2 stated that Resident 2 gets upset easily. CNA 2 also stated that Resident 1 wanders up and down the hallways, and he loved to open doors and sometimes will go in the room once he opens the door. During an interview with CNA 3 on 06/19/24, at 2:25 pm, via a phone call, she stated that CNA 2 was keeping an eye on Resident 1. CNA 3 stated she only saw Resident 1 hit the wall and fall after Resident 2 pushed him; she heard Resident 2 cussing at Resident 1. CNA 3 stated that Resident 2 was an angry person. CNA 3 also stated the Resident 1 wanders the halls. He will go into peoples ' rooms, and that is the main thing he likes to do. During an interview on 06/26/24, at 4:43 pm, with Licensed Vocation Nurse (LVN B) stated that Resident 2 was territorial of his room. She states you never know when he is going to go off. CNA 3 stated that Resident 2 doesn ' t like loud noises. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN C on 06/26/24, at 4:54 pm, she stated that Resident 2 does not like anyone going into his room. She stated that Resident 2 knows how to follow the rules and he gets upset when other don ' t follow the rules; he will yell. During an interview with the Assistant Director of Nursing (ADON) on 06/26/24, at 5:03 pm, she stated that Resident 2 fights the demons in his head and doesn ' t always win and that he can be an angry person. During an observation on 06/26/24, at 5:15 pm, Resident 1 entered the room twice, where the ADON was being interviewed, and both the CNA and ADON redirected him each time. During an interview with CNA 4 on 06/26/24, at 5:29 pm, she stated that Resident 2 gets irritated with other residents and that he is territorial, and he yells a lot. During an observation on 06/26/24, at 5:45 pm, Resident 1 attempted to get into Resident 2 ' s room three times within 45 seconds, with two CNAs and the ADON attempting to redirect each time. Resident 1 was determined, grabbing the handle firmly, with one and then two hands, and trying to turn the handle to open the door each time. Resident 2 ' s door was shut, and a stop sign across the threshold. Resident 2 remained in his room. Resident 1 was on a 1:1 at the time. During a phone call on 07/09/24, at 12:20 pm, a family member of Resident 2 stated that Resident 2 is living 20 to [AGE] years ago, when his parents passed. When the family member was asked what Resident 2 ' s disposition was like prior to his mental decline, the family member stated that Resident 2 was, always confrontational and combative, always. He gave the example of their neighbor ' s dogs that would bark. Resident 2 would get into physical and verbal fights with the neighbors over their dogs barking and would threaten the neighbors. The family member also stated that Resident 2 got into no more than the normal amount of fights during high school. During an interview with the Admin on 07/26/24, at 11:47 am, stated that before the inpatient stay at a behavioral health facility, resident was involved in several altercations, but since the inpatient program he has had fewer altercations. A new intervention is implemented each time an incident happens. We have considered moving the resident off the unit, but we are concerned about him going out of the facility and not being able to get him back in. During an interview with the DON on 07/26/24, at 12:10 pm, stated, like the Admin stated, before the inpatient stay, the resident had lots of issues but since the stay he has had one incident. The care plans seem to be doing well, and we have had to add interventions as needed.