STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oroville Hospital Post-Acute Center	1000 Executive Parkway Oroville, CA 95966

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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 - Immediate jeopardy to resident health or safety 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** 51253 Based on interview and record review the facility failed to ensure one of 12 sampled residents (Resident 1) was free from mistreatment, misappropriation of property, and mental abuse when he was abducted (removed by force) from the facility by a restricted visitor (not authorized to visit or call). This resulted in Resident 1 to be taken out of the facility for 90 minutes with a restricted visitor who would attempt to financially abuse him. An Immediate Jeopardy (IJ) situation was identified on 7/19/24 at 3:45 pm, in the presence of the Executive Director (ED) and Director of Staff Development (DSD), due to not implementing a restricted visitor screening system that ensured residents were protected from any type of abuse from unauthorized visitors. An immediate jeopardy removal plan was requested from the ED and DSD. An IJ removal plan was provided by the ED and accepted on 7/19/24 at 4 pm. The IJ removal plan included all facility staff training on the new policy titled Visitation which included checking identification for all visitors coming to visit a resident on the Visitor and Phone Call Precaution list (restricted visitors). The Visitor ' s log will now include reason for visit and pictures of restricted visitors. The nursing staff should be aware of all visitors and any concerns regarding visitors should be reported to immediately supervisor or security/maintenance. The IJ removal plan was verified that it was fully implemented by an onsite visit. The IJ was removed on 7/23/24 at 4:10 pm. Findings: A review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property Prohibition revised on 7/15/2021, indicated that each resident has the right to be free from mistreatment, neglect, misappropriation of property. The 'Center' implements policies and processes so the residents are not subjected to abuse by individuals who may have unsupervised access to residents. Abuse is defined as Misappropriation of Residential Property, which is a deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident ' s belongings or money without the resident ' s consent. This document also indicated that Mental Abuse through either verbal or nonverbal conduct which has caused or has potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Visitation Policy, undated, that was in existence prior to incident, there were no procedures to address any visitors' precautions or restrictions. A review of a facility reported incident dated 7/17/2024 at 7:00 am, the facility notified California Department of Public Health (CDPH) that a Restricted Visitor (RSV 1) entered the facility at 9:44 am on 7/16/2024 and abducted (take someone away by force) Resident 1. RSV 1 took Resident 1 to a local check cashing business with a check belonging to Resident 1 in the amount of $7,836.03. Local Police Department returned Resident 1 to facility at 12:20 pm. A review of Resident 1's admission record indicated he was admitted into the facility on [DATE], with diagnoses which included dementia, anxiety disorder, and generalized muscle weakness. Resident 1 was unable to make his own healthcare decisions and the facility Interdisciplinary Team (ID, a group of multiple disciplines who develop plan of care for residents) was his decision maker until he was conserved (judge appoints another person to act or make decisions for a resident) by the county. A review of the Minimum Data Set (MDS, a resident health assessment) dated 6/18/2024, indicated the Brief Interview for Mental Status (BIMS) was a score of 3 (severe cognitive impairment). Resident 1 can walk 10 to 50 feet with supervision and/or touching assistance. Resident 1 was unable to walk 150 feet due to his medical condition or safety concerns and had a walker (an assistive device to walk), no wheelchair. A review of the Social Services Progress Note dated 11/16/2023 at 9:46 am, the Social Services Director (SSD) documented upon admission that she spoke with Ombudsman (resident advocate) about Resident 1. The Ombudsman stated there was suspected elder financial abuse with the previous caregiver (RSV 1 and RSV 2). SSD also spoke with Adult Protective Services (APS, agency to help elder adults who are victims of abuse, neglect, or exploitation). APS asked SSD to put in place a do not contact order put in for the safety of the Resident 1 while the investigation is still on going. SSD notified front desk and email was sent to all facility managers. A review of the Social Service Progress note dated 12/12/2023 at 4:16 pm, indicated Social Services Assistant (SSA) received a call from RSV 1 wanting to talk to Resident 1 and requested information regarding his care. A review of the Social Service Progress note dated 5/24/24 at 11:50 am, SSD documented that RSV 2 came to the facility in person attempting to visit Resident 1. RSV 1 and RSV 2 was NOT to have any contact per APS. A record review of an Order Summary Report, a Physician Order dated 6/12/2024 indicated, Resident 1 may leave the facility with responsible party with medications. A review of the Visitor Log dated 7/16/2024 at 9:44 am, RSV 1 came to the facility and signed in with a fictitious (false) name and wrote room [ROOM NUMBER]B (Resident 1 ' s room). A review of the Visitor and Phone Call Precautions list dated 7/16/2024, indicated that the fictitious name given by RSV 1 was not on the precaution visitor list. The list indicated RSV 1 and RSV 2 were not allowed to visit or call Resident 1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on 7/19/2024 at 11:10 am, Receptionist (REC A) stated her process for when a visitor enters the facility lobby. REC A greets the visitor and asks the visitor their name and the room they are visiting. The visitor fills out the Visitor Log. On the day of the abduction on 7/16/24, REC A explained RSV 1, and two gentlemen came in, she asked them to sign the Visitors Log, only RSV 1 signed the log with a false name, and she did not offer a reason for visiting Resident 1. REC A explained she was not completely trained on the expectations of handling facility visitors. REC A stated, I trained myself the rest. She does check the Visitor and Phone Call Precautions list posted at the desk which lists the resident's names and the names of visitors that are not allowed. REC A confirmed Visitors Log included date, time in, visitors name, resident room number and time out, and did not include a space for the reason for the visit. REC A does not ask for precautionary visitor identification and REC A there were not any pictures of restricted visitors. REC A stated the receptionists get busy sometimes and people can get by them. REC A stated it would have been better if we had descriptions of restricted visitors and better to include on log reason for visiting resident. A record review of the Facility's In-Service Education Summary dated 7/17/2024, indicated that only the six facility receptionists received this training and it lasted 30 minutes. The Reception Meeting Agenda included the changes implemented by the facility after the incident: -Visitors wear name badges -Visitors sign in and sign out on log -Check visitor identification if they are on the restrictive list -Add picture of restrictive visitor to elopement binder at front desk in lobby -Page for help During an interview on 7/19/2024 at 11:25 am, Executive Director (ED) reviewed her investigation of the event on 7/16/24. ED confirmed no other facility staff had been trained after the abduction event just the six receptionists. Asked ED that if the facility was asking for identification for only the names on the Visitor and Phone Call Precautions list, would that have stopped the recent abduction? ED confirmed just checking for the names of the visitors on the list would not stop a restricted visitor who gave a false name. ED agreed that it would be better to ask for all visitor's identification for the residents listed on the Visitor and Phone Call Precautions list. ED confirmed all facility staff are responsible for identifying visitors, not just the receptionists. ED confirmed they made no changes to facility policies, and the visitor badges was an older practice in place and ED brought it back. No face-to-face in-services were conducted with facility staff except receptionists. ED explained she had a Security alert in the Electronic Medical Record (EMR) system in the Facility Bulletin section leaving instructions for staff on how to handle visitors in the facility. During an interview on 7/19/2024 at 1 pm, Family Visitor (Visitor A) was interviewed when seen pushing his wife in a wheelchair in the hallway. Visitor A stated the visitor badge/sticker just started again this week. Visitor A stated it is not consistent at the front desk whether he was greeted or asked to wear a badge/sticker. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent observation and interview on 7/19/2024 at 1:10 pm, Resident 1 was laying in his bed watching television upon entering room. Resident 1 did not remember anything about the abduction event. When asked how far he can walk, Resident 1 explained from his bed to the door. Resident 1 stated he needs a walker and assistance to walk. During an interview on 7/19/2024 at 1:20 pm, Activity Assistant (Activity A) explained the visitor pass sticker was just started this week due to what happened, otherwise Activity A would not know who a visitor was. Activity A had no visitor training this week and did not see the security message. During an interview on 7/19/2024 at 1:25 pm, Registered Nurse (RN) A at north nurse's station was able to show that they had a paper titled Visitor and Phone Call Precaution list to reference. RN A stated the visitor sticker badges started two days ago. RN A was unaware that the special instructions on the resident profile in EMR had information about restricted visitors. RN A had no recent training and was not sure if they care plan restricted visitors in the EMR. During a concurrent interview and record review on 7/19/2024 at 1:30 pm, Certified Nurse's Assistant (CNA) A had not heard about any resident leaving the facility with a restricted visitor recently. CNA A stated she did not know about the restricted list, about the resident dashboard special instructions in EMR, nor was she aware of the security message on the facility bulletin page that notified all staff of the abduction on 7/16/24. During a review of Resident 1 ' s records, CNA A confirmed there was no visitor abuse care plan found in Resident 1 ' s record. CNA A explained she had no training in orientation about visitors and how to deal with them. During an interview on 7/19/2024 at 2 pm spoke with Director of Staff Development (DSD). DSD was asked if any training for new direct staff included how to deal with visitors and restricted visitors. DSD stated he just reviews residents rights and talks to direct care staff in orientation during their first week. DSD stated he has not given any in-services to direct care staff about the changes made after the abduction event. DSD stated he has been working on some training. DSD stated the restricted visitors are identified initially upon admission with IDT team. DSD stated all employees are responsible for ensuring residents are safe with visitors, not just the front desk receptionists. During a concurrent interview and record review on 7/23/2024 at 1 pm, REC B stated she received new training about dealing with visitors. REC B stated now all visitors receive a sticker/badge with their name and room number of the resident. REC B stated the badge was now enforced and was not prior to the abduction event. The receptionists have a new binder called elopement/visitor precautions that has a lot more information in it on each resident and visitor including pictures. REC B showed the binder page for Resident 1, and it had a picture of two individuals who were not allowed (RSV 1 and 2). REC B stated the binder was more readily available. REC B stated they will be asking for identification for all visitors who visit a resident listed on the Visitor and Phone Call Precaution list. A review of a new policy title Visitation, undated, indicated the restricted visitor list has to be posted, reception desk, all nursing stations, and provided to all managers. Facility staff will request of all patient's visitors that are on the restricted visitor list. Facility staff are to contact the supervisor or ED immediately if a restricted visitor attempts to enter the facility. The Visitor Log now includes the request that the visitor writes, Reason for Visit. Staff are to page Security overhead when a restricted visitor attempts to come into the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/23/2024 at 1:35 pm, LVN C stated on 7/16/2024, the day of the abduction, a woman came up to the East nursing station and asked if she could have a wheelchair for her Dad. LVN C stated she went to check with Physical Therapy (PT) to see about a wheelchair. PT referred her to maintenance department since they did not have any wheelchairs available. LVN C stated it was time for lunch, so she clocked out at 10:18 am and clocked back in at 10:48 am. LVN C stated I remembered after returning from lunch that Resident 1 does not have family or visitors just an APS worker. She explained Resident 1 used a walker and could walk short distances with Restorative Nursing Assistance. Resident 1 did not have a wheelchair, only a walker. LVN C stated there was really no reason for a need for a wheelchair. LVN C stated she came back from lunch and asked CNA B to ask the visitor her name, since LVN C remembered he did not have family. LVN C stated she could have asked more questions of the visitor, like her name. LVN C stated communication will be better now that all visitors will have a badge to identify them and who they are visiting. LVN C was asked if nursing staff were made aware of residents discharging daily? LVN C stated, Yes, it is on their EMR main page dashboard, and the social worker puts the information in the dashboard as to who is discharging that day. LVN C stated she did not check the restricted visitor list and did not check on the PCC dashboard under special instructions on the day of the abduction of Resident 1. During an interview on 7/23/2024 at 2 pm, LVN D confirmed she was assigned to Resident 1 that day he was abducted. LVN D explained RSV 1 wanted to take her Dad home. LVN D informed RSV 1 that she would need to talk to Social Services about that. LVN D stated that RSV 1 requested a wheelchair and nursing asked PT/Maintenance for a chair. At around 10:55 am, Resident 1 was in a wheelchair, then LVN D pointed RSV 1 in the direction of the Social Services office; but did not follow them or check to see if they went to the Social Services Office. LVN D stated she trusted that they went there. Twenty minutes later, CNA B came to her and explained that Resident 1 never had visitors and was not in his room. LVN D realized Resident 1 had restricted visitors. LVN D stated the facility staff checked the entire facility, notified Social Services, and paged for missing Resident 1 overhead throughout the facility. Resident 1 was nowhere to be found. LVN D stated the wheelchair was located outside and the SSD initiated 911. LVN D explained Resident 1 could only walk short distances and would get short of breath. LVN D explained it is okay to ask questions of visitors, just do not assume who they are, and if you do not know, ask. LVN D agreed care planning would have been another good place to indicate restricted visitors in addition to special instructions. LVN D confirmed the physician order that Resident 1 can go out with RP was confusing since he did not have one. LVN D stated she did not check to see if Resident 1 was discharging that day. During an interview on 7/23/2024 at 2:15 pm, CNA B who was not assigned to Resident 1 that day but keeps on eye on the entire hallway and stated, All residents are my patients and I keep an eye on everyone. CNA B stated she observed RSV 1 on 7/16/24, and she was acting suspicious. CNA B stated RSV 1 was moving her head back and forth in the hallway in front of Resident 1 ' s room. CNA B thought to herself, Is this his daughter? And went to check with the charge nurse, and they were not sure. CNA B was instructed to go back and ask her name and RSV 1 was gone. CNA B stated she should have stopped everything when RSV 1 was acting suspicious and not left Resident 1 alone with her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/23/2024 at 2:30 pm, SSD gave the account of the day of the abduction. SSD stated LVN C came down looking for Resident 1 and his Daughter. LVN C stated RSV 1 wanted to talk about discharge planning, SSD was puzzled because Resident 1 does not have a daughter. SSD thought of RSV 1, a restricted visitor and remembered she was reported by APS upon admission last year. SSD stated RSV 1 was his In-Home Support Services (IHSS, county program for people who need help to stay in their home) worker and charged with neglect and financial abuse. SSD stated RSV 1 was restricted, then began to search for Resident 1, went to front desk and reviewed the visitor log. SSD noticed RSV 1 used fictitious name. SSD stated out of all the residents on the restricted visitor list, Resident 1 was the most vulnerable due to his BIMS of 3 and easy-going nature. SSD called 911 after searching the building. SSD stated they now have a binder which will include detailed information about the residents and their visitors. SSD stated she will keep it updated for all staff. SSD explained the binder identified restricted visitors upon admission, at resident care conferences and speaking with the residents. SSD stated every facility staff member was responsible for questioning and identifying visitors in the facility. SSD stated Resident 1 thought he was in trouble because the local police returned him after 90 minutes of being gone. SSD stated she had to reassure Resident 1. During an interview on 7/23/2024 at 2:45 pm, Maintenance Director (MaintD) stated he was not security before the incident, and now after the abduction, he has been asked to step in like security until the hospital ' s actual security team can arrive from across the parking lot. MaintD stated the maintenance team has been trained on deescalating visitors. MaintD stated now all facility visitors will wear stickers to identify them.