STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanford Court Skilled Nursing & Rehab Center	8778 Cuyamaca Street Santee, CA 92071

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46235 Based on observation, interview, and record review, the facility failed to ensure staff reported in a timely manner an allegation of abuse to the facility's administration including the California Department of Public Health (CDPH- the State Survey and Certification Agency) for one resident (Resident 1) This deficient practice had the potential for a repeat abuse allegation for Resident 1, and for all other residents to be unprotected from abuse. Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood) according to the facility's Admission Record. The Admission MDS (a clinical assessment tool) dated 5/16/24, listed a cognitive score of 7, indicating Resident 1 was severely impaired. During an observation and interview with Resident 1 on 7/11/24, at 12:14 P.M., Resident 1 was observed lying in bed. Resident 1 stated there were four females who pulled her around on the back of her shirt and started beating on her. Resident 1 stated she did not remember what the females looked like. The Director of Nurses (DON) was interviewed on 7/11/24 at 12:50 P.M. The DON stated on 6/27/24 she received report from licensed nurse (LN) 2 regarding certified nurse assistant (CNA) 3 who witnessed an abuse. The DON stated CNA 3 witnessed CNA 4 pulled and punched Resident 1 on the left side of her face three times on 6/25/24. The DON stated on 6/26/24 CNA 3 witnessed CNA 4 squeeze Resident 1's face and pushed Resident 1 back to her bed while squeezing Resident 1's face. The DON stated she was not aware of the first incident on 6/25/24 and CNA 3 should have reported the incident immediately according to the facility's policy. The DON further stated if abuse allegations were not reported, the resident could suffer because the perpetrator should be pulled out of schedule to protect the resident. (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: 555290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Stanford Court Skilled Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8778 Cuyamaca Street Santee, CA 92071	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview on 7/12/24 at 7:36 A.M. was conducted with CNA 3. CNA 3 stated she worked with CNA 4 on 6/25/24, night shift. CNA 3 stated Resident 1 was on one-on-one monitoring (providing one to one observation of resident for a period of time). On 6/25/24 CNA 3 stated CNA 4 responded to an alarm from Resident 1's room. CNA 3 stated she also went to Resident 1's room and while at the doorway, CNA 3 stated she saw Resident 1 sitting in the wheelchair in front of the sink and CNA 4 slapped Resident 1 three times on the left face. CNA 3 stated there was blood in the soap dispenser, bed rail and the floor. CNA 3 stated Resident 1 had a cut on the right hand and Resident 1 continued to be restless. CNA 3 stated Resident 1 was screaming she was being harassed and punched. CNA 3 stated CNA 4 was cursing in Spanish and called Resident 1, Crazy. CNA 3 further stated her, Body was in shock, and did not know who to report because she did not want others to gossip about her. CNA 3 continued to talk about CNA 4 during the interview on 7/12/24 at 7:36 A.M. CNA 3 stated on 6/26/24 CNA 4 responded to an alarm from Resident 1's room and Resident 1 was already walking close to the bathroom door. CNA 3 stated Resident 1 preferred privacy and requested for staff to wait outside the bathroom. CNA 3 stated when Resident 1 came out of the bathroom, Resident 1 wanted to keep walking but CNA 4 pushed Resident 1 towards the wheelchair and fell in the wheelchair. CNA 3 stated Resident 1 was fighting back, and CNA 4 started choking Resident 1. CNA 3 stated CNA 4 released Resident 1 when Resident 1 made a choking sound. CNA 3 stated she told CNA 4 that she will take over Resident 1. On the same night 6/26/24 at approximately 3:32 A.M., CNA 3 stated Resident 1 came out of the bathroom. CNA 3 stated she instructed Resident 1 to wash her hands and Resident 1 jokingly placed her hand on CNA 3's face. CNA 3 stated Resident 1 attempted to do the same on CNA 4's face, but CNA 4 placed her hand on Resident 1's face instead and pushed Resident 1 back to Resident 1's bed while CNA 4's hand was on Resident 1's face. CNA 3 stated she was stressed and again did not report the incidents to the charge nurse. CNA 3 further stated she reported the incident to the charge nurse, LN 2 the following day on 6/27/24. A phone interview on 7/12/24 at 8:45 A.M. was conducted with LN 2. LN 2 stated CNA 3 reported abuse allegations to her around 3 A.M. on 6/27/24. LN 2 stated she texted the DON and asked Resident 1 what happened to her hand with a skin tear. LN 2 stated Resident 1 did not remember what happened to her hand. LN 2 stated she expected CNAs to report abuse right away. LN 2 stated if abuse was not reported, the resident could be abused repeatedly. LN 2 further stated abuse allegations involving residents who were confused, should be reported because these residents could not speak for themselves. During a phone interview on 7/15/24 at 1:14 P.M. with the director of staff development (DSD- a licensed nurse certified for staff training), the DSD stated abuse training was conducted twice a year and after an abuse allegation. The DSD stated he taught staff to report abuse immediately. The DSD stated immediately meant right away. The DSD stated he expected CNAs to report abuse allegations right away because if it was not reported, the resident would feel neglected. The DSD further stated reporting abuse allegations immediately will prevent re-occurrence. A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation of Misappropriation-Reporting and Investigating, revised September 2022 was conducted. The P&P indicated, . Reporting Allegations to the Administrator and Authorities .3. [Immediately] is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury .