

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Springfield Drive Chico, CA 95928	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48129</p> <p>Based on observation, interview and records review, the facility failed to provide a safe environment which was free from abuse for 1 of 5 samples residents (Resident 8, 10, 16, 27, and 38), when Certified Nursing Assistant 2 (CNA 2) verbally abused Resident 10 on 3/2/24.</p> <p>This failure caused Resident 10 to have feelings of fear and emotional distress, and affected their psychological well-being. This failure also had to potential for other Residents to be abused, when CNA 2 was allowed to continue working.</p> <p>Findings:</p> <p>During a review of Resident 10 ' s Admission Record, it showed Resident 10 was admitted on [DATE], with diagnoses including Hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness following a stroke), Type 2 Diabetes Mellitus (a disease where the pancreas doesn ' t work properly, causing high blood sugar), and Chronic Obstructive Pulmonary Disease (A disease that causes lung problems and trouble breathing).</p> <p>During an interview with Resident 10 on 3/7/24, they stated that over the previous weekend, CNA 2 had verbally abused them. Resident 10 stated that CNA 1 and CNA 2 had entered their room to assist with a bedding change, and that CNA 2 had yelled at me, and had made hurtful comments about Resident 10 ' s weight, health status, and personal hygiene. Resident 10 stated this made them feel very upset, hurt, and that they had cried. Resident 10 reported that CNA 1 had been present and witnessed the events, and had consoled Resident 10 afterwards. Resident 10 told CNA 2 to leave their room, stop yelling, and leave them alone. Resident 10 stated that CNA 2 returned to Resident 10 ' s room later, alone, and told Resident 10 they need to figure this out, this will get me fired. Resident 10 told CNA 2 to leave again, which they did.</p> <p>(continued on next page)</p>

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: 555304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Springfield Drive Chico, CA 95928	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Registered Nurse (RN) 1 on 3/26/24, RN 1 stated that on 3/2/24, they were working as Charge RN, on day shift. RN 1 stated they were working on the floor, and could hear raised voices coming from room of Resident 10. RN 1 stated they didn't hear exactly what was said, just the raised voices. RN 1 went to the room, both CNA 1 and CNA 2 had left the room by then. RN 1 stated Resident 10 told them that CNA 2 had yelled at them, and said mean things to them. RN 1 spent several minutes listening to Resident 10, therapeutically offering sympathy, support, and reassured Resident 10 that CNA 2 should not have done that, and would not return into Resident 10's room. This happened around 10:45 am. RN 1 stated that after consoling Resident 10, RN 1 verbally told CNA 2 not to enter or speak to resident again that shift. RN 1 also stated that CNA 2 continued to work the rest of the shift, stating Yes, they worked the whole shift. RN 1 also stated that CNA 2 did not follow their instruction to avoid Resident 10. RN 1 stated they found out later in the day that CNA 2 had re-entered Resident 10's room to speak with Resident 10, despite being told not to. RN 1 stated they had called the on-call administrator for that weekend, the Director of Staff Development (DSD) to report the incident. The DSD told RN 1 to follow up about incident on Sunday 3/4/24. RN 1 stated they did not call other administrators that day.</p> <p>During an interview with CNA 1 on 3/27/24, CNA 1 stated they had been in Resident 10's room and witnessed the events. CNA 1 stated they had been the assigned primary CNA for Resident 10, and had asked CNA 2 for assistance turning and changing Resident 10. CNA 1 stated that CNA 2 had been huffy, verbally and physically, and had seemed unwilling to do the extra work. CNA 1 stated that CNA 2 had made comments to Resident 10 about candy, then it had escalated to remarks about Resident 10's weight and their health, and that CNA 2 had raised their voice and was yelling at Resident 10. CNA 1 stated that after the verbal altercation, Resident 10 had been very upset, and crying. CNA 1 remained in the room, and provided therapeutic listening. Resident 10 informed CNA 1 that's why I don't like [CNA 2] they're mean to me. CNA 1 stated that when they left the room, RN 1 was coming down the hall to investigate, and CNA 1 reported to RN 1 that CNA 2 had verbally abused Resident 10. RN 1 and CNA 1 talked at the nursing station, and RN 1 informed CNA 1 how to fill out the abuse witness form to make a statement. CNA 1 made their written statement that day, 3/2/24.</p> <p>During an interview with the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) on 3/7/24, the ADON stated they had handled this investigation case. ADON stated that this event did happen about 10:45 am on Saturday 3/2/24. ADON stated that RN 1 had heard the CNA 2 and Resident 10 yelling, from their nursing desk, and had walked over to investigate. RN 1 verbally told CNA 2 to stop yelling, and to not return to Resident 10's room, and then went into room to console Resident 10, who was visibly upset and crying. ADON stated that CNA 2 did not listen to RN 1's instructions, and had re-entered Resident 10's room later, alone, and had spoken harshly to Resident 10 again, telling Resident 10 this will get me fired. ADON stated this was a pretty clear case of verbal abuse, which isn't tolerated at this facility. ADON also stated that CNA 2 had been a CNA for many years, and had previous complaints about CNA 2's attitude and care on their file. ADON stated that CNA 2 had been suspended from working on 3/4/24, when DON and ADON arrived at the facility that morning.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Arbor Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Springfield Drive Chico, CA 95928	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with DON and ADON on 3/26/24, DON stated that they had not been notified or called about this event over the weekend. DON stated they had been informed first thing Monday morning, on 3/4/24. DON stated they had called CNA 2 and suspended them from working on Monday 3/4/24. ADON reviewed employee clocking records, and stated that CNA 2 had worked a 12-hour shift on Saturday 3/2/24, the day of the event, from 10 am to 10:30pm. ADON also stated that CNA 2 had worked Sunday 3/3/24, from 10:30 am to 11 pm. DON stated that yes, the abuse policy was not followed, in regard to reporting and suspension pending investigation. DON stated the CNA 2 was suspended from working on 3/4/24, and terminated from employment on 3/6/24.</p> <p>During a review of facility policies titled Abuse Investigating and Reporting, the policy shows The Administrator will suspend immediately any employee who has been accused of Resident abuse, pending the outcome of the investigation.</p> <p>During a review of records titled, Care Plan for Resident 10, the Care Plan shows Psychosocial Well Being-Resident 10 at risk for psychosocial well-being concerns related to recent alleged Verbal Abuse from staff on 3/2/24. Date Initiated: 03/05/2024. Revision on: 03/05/2024. This record shows appropriate interventions are also listed.</p> <p>During a review of records titled, Inservice Education Summary, dated 12/19/23, the records show that CNA 2 had signed in and attended the staff Inservice called Focusing on Resident-to-Resident Abuse and Antecedent Behaviors, Intentions and Redirections on 12/19/23.</p> <p>During a review of records titled, Elder Abuse DOJ Training Video, dated 7/5/23, the records show that CNA 2 had received training, watched an informative video about elder abuse, had passed a quiz about elder abuse, and had signed the attestation form that documented completion of Elder Abuse training from the facility.</p> <p>During a review of records titled, Employee Disciplinary Action Form, dated 11/28/23, the records show that CNA 2 was written up for failure to perform walking rounds, resulting in falls. This record shows signature of written disciplinary action from the Director of Staff Development (DSD). This record shows that CNA 2 did not sign the form acknowledging the written action.</p>		