

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  11/21/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46527</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that one of two sampled residents was communicated with in a language that she could understand (Resident 1), when Resident 1 only spoke Spanish and the facility failed to provide an interpreter.</p> <p>This failure resulted in Resident 1 not understanding why she was moved to a new room and negatively impacted her emotional and psychosocial well-being, and had the potential to affect all residents who ' s primary language was not English.</p> <p>Findings:</p> <p>A review of a facility policy titled, Translation and/or Interpretation of Facility Services, with a revision date of November 2020, indicated, Competent oral translation of vital information that is not available in written translation . A staff member who is trained and competent in the skill of interpreting; a staff interpreter who is trained and competent in the skill of interpreting; contracted interpreter service; voluntary community interpreters who are trained and competent in the skill of interpreting; and telephone interpretation service. Interpreters and translators must be appropriately trained in medical terminology . and ethical issues that may arise in communicating health-related information .</p> <p>A review of the facility ' s records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included difficulty in walking, multiple fractures (break or crack in a bone) of ribs and sacrum (a bone at the base of the spine that connects the spine to the pelvis). This resident only spoke the Spanish language.</p> <p>During a concurrent observation and interview on 10/24/24 at 2:45 PM, with Resident 1, she stated that she did not fully understand why she had been moved from her previous room on Station 4 to her current room on Station 3. Resident 1 stated it was explained to her that she was moved due to resident ' s having COVID-19 on nurse ' s station 4, which confused her as to why she couldn ' t stay at nurse ' s station 4 because there were several residents with COVID-19 on nurse ' s station 3. She stated that the situation was not cleared up with her. Resident 1 was moved not long after the discussion was had and was not given a one day written notice - as the policy indicated.</p> <p>During an interview on 11/4/24 at 3:45 PM, with resident advocate (OB) 1, stated that she believed Business Marketer (BM) 1, 100%, took advantage of the fact that the resident did not speak English when it came to the room change.</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
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/5/24 at 4 PM, with BM 1, he stated that two separate Spanish-speaking Certified Nursing Assistants (CNA) translated between staff and Resident 1 to explain the room change for Resident 1 from Station 4 to Station 3.</p> <p>During an interview on 11/5/24 at 4:25 PM, with the Administrator, she stated that CNA 2 did translate Spanish between staff and Resident 1 at the time of the room change from Station 4 to Station 3 during CNA 2 ' s shift.</p> <p>During an interview on 11/7/24 at 12:40 PM, with CNA 2, stated that she had translated Spanish between staff and Resident 1. CNA 2 stated that Resident 1 was also upset about being moved to Station 3 due to having further difficulty communicating with any staff, as she stated there were more Spanish speaking staff on Station 4.</p> <p>During an interview on 11/19/24 at 10 AM, with Social Services Director (SD) 1, stated that the interpreter she had used to speak with Resident 1 about her being upset with the room change was a nurse to interpret Spanish between staff and Resident 1. SD 1 stated language interpreter lines (a phone service to speak with a professional interpreter to facilitate communication between people who speak different languages) can be used, but the facility had some Spanish-speaking nurses.</p> <p>During an interview on 11/21/24 at 8:55 AM, with Administrator, she stated that the facility has staff translate who are fluent in the Spanish language; however, do not have any certification proving that staff is competent or trained. Administrator stated that a language line interpreter service is not often used for Spanish-speaking residents because there are many staff members that speak Spanish. Administrator stated she would hope that staff would express if they did not feel comfortable enough to translate to a resident.</p> <p>During an interview on 11/21/24 at 4:45 PM, with Administrator, she stated that historically at other facilities she has worked at she did not feel it was necessary to use the language line if there were staff members available that could fluently speak Spanish to her Spanish-speaking residents. Administrator stated, Majority of the time, there are staff that could speak Spanish to the Spanish-speaking residents, but she stated she was unable to confirm and unsure if Spanish-speaking staff was available every single day and every single shift without looking through the staffing logs. She stated she was not sure if adequate training had been done for the staff with the language line translator since she had begun as an administrator at this facility.</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46527</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents was notified of a room/roommate change with a written notice that included the reason before the facility had the resident ' s room changed (Resident 1).</p> <p>This failure resulted in negatively impacting Resident 1 ' s emotional and psychosocial well-being due to being upset and without proper notification and/or understanding of the room change.</p> <p>Findings:</p> <p>A review of a facility policy titled, Room Change/Roommate Assignment, with a revised date of March 2021, indicated, Prior to changing a room or roommate assignment all parties involved in the change/assignment . are given at least a day advance written notice of such change. Advance written notice of a roommate change includes why the change is being made and any information that will assist the roommate in becoming acquainted with his or her new roommate.</p> <p>A review of a facility policy titled, Room Change/Roommate Notification, with a revised date of March 2021, indicated, Unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended.</p> <p>A review of the facility ' s records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included difficulty in walking, multiple fractures (break or crack in a bone) of ribs and sacrum (a bone at the base of the spine that connects the spine to the pelvis).</p> <p>During a concurrent observation and interview on 10/24/24 at 2:45 PM, with Resident 1, she stated that she did not fully understand why she had been moved from her previous room on Station 4 to her current room on nurse ' s station 3. Resident 1 stated it was explained to her that she was moved due to resident ' s having COVID-19 on nurse ' s station 4, which confused her as to why she couldn ' t stay at nurse ' s station 4 because there were several residents with COVID-19 on nurse ' s station 3. She stated that the situation was not cleared up with her. Resident 1 was moved not long after the discussion was had and was not given a one day written notice, as the policy indicated.</p> <p>During an interview on 10/24/24 at 3 PM, with Certified Nursing Assistant (CNA) 1, she stated that she had observed Resident 1 crying and upset after she was moved from a room on Station 4 to a room on Station 3.</p> <p>During an interview on 11/5/24 at 4 PM, with Business Marketer (BM) 1 , stated that Resident 1 asked when the room change would occur, in the afternoon or tomorrow and BM 1 explained it would happen within the hour. BM 1 stated that Resident 1 was moved to Station 3. Resident 1 was given approximately a one-hour notice, and not a one day written notice as the policy indicated.</p> <p>During an interview on 11/7/24 at 12:40 PM, with CNA 2, she stated that Resident 1 was crying her whole shift after Resident 1 moved to her new room on Station 3.</p> <p>(continued on next page)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/24 at 10 AM, with Social Services Director (SD) 1, stated written notices for room changes were given in the past to residents, but since residents seemed to not like to sign the notices the facility had stopped giving them out. SD 1 acknowledged that the facility could start the process of written notices for room changes, as indicated by the facility policy.</p>

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46527</p> <p>Based on interview and record review, the facility failed to ensure that one of three residents sampled (Resident 1), had reasonable access to the use of a telephone in the facility without their calls being overheard.</p> <p>This failure resulted in the resident not having enough privacy to speak to the Ombudsman (an individual that assists residents with their concerns), on her own and voicing her concerns properly without facility staff being present.</p> <p>Findings:</p> <p>A review of a facility policy titled, Grievances/Complaints, Filing, with a revised date of April 2017, indicated, Residents and their representatives have the right to file grievances . to the agency designated to hear grievances (e.g., the State Ombudsman).</p> <p>A review of a facility policy titled, Telephones, Resident Use of, with a revised date of February 2021, indicated, Designated telephones are available to residents to make and receive private telephone calls. Telephones will be in areas that offer privacy . A private telephone line or cellular phone may be available or installed in the resident ' s room.</p> <p>A review of the facility ' s records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included difficulty in walking, multiple fractures (break or crack in a bone) of ribs and sacrum (a bone at the base of the spine that connects the spine to the pelvis).</p> <p>During an interview on 11/5/24 at 4 PM, with Business Marketer (BM) 1, he stated he heard from the hallway that Resident 1 was on the phone with the Ombudsman and he had walked into Resident 1 ' s room and explained over the phone to the Ombudsman why Resident 1 was being moved from Station 4 to Station 3.</p> <p>During an interview on 11/7/24 at 12:40 PM, with Certified Nursing Assistant (CNA) 2, stated she observed Resident 1 and BM 1 in the room together. She observed BM 1 was holding the phone and was speaking to the Ombudsman in Resident 1 ' s room, instead of Resident 1. CNA 2 stated she felt that this was unfair because Resident 1 was unable to speak to the Ombudsman in private about her room change concerns (which involved BM 1) comfortably with BM 1 there. CNA 2 stated BM 1 was a little overpowering when speaking to the Ombudsman in regards to his tone of voice.</p> <p>During an interview on 11/19/24 at 10 AM, with Social Services Director (SD) 1, stated Resident 1 explained that she was very upset about the room change and called the Ombudsman and had Licensed Nurse (LN) 1 translate to the Ombudsman then LN 1 left Resident 1 ' s room for privacy purposes. Then BM 1 came into the room and grabbed the phone from Resident 1 and began speaking with the Ombudsman, as witnessed by CNA 2. SD 1 stated that this was absolutely a lack of privacy for Resident 1. SD 1 stated that it is the resident ' s right to speak with the Ombudsman in private and if a staff member were to walk by the room, they do not have a right to go in the resident ' s room and take the phone and speak to the Ombudsman.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/24 at 4:45 PM, with Administrator, stated that Resident 1 was on speaker phone with the Ombudsman in her room and BM 1 overheard from the hallway and entered the room and began to speak with the Ombudsman.</p>