

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2025
NAME OF PROVIDER OR SUPPLIER Blythe Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 285 West Chanslor Way Blythe, CA 92225	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on interview and record review, the facility failed for one of three sampled residents (Resident 1) to conduct a thorough investigation into Resident 1's allegation of abuse involving Certified Nursing Assistant (CNA 1) before allowing the alleged perpetrator to return to work.</p> <p>This failure had the potential to expose Resident 1 to further abuse and compromised the integrity of the abuse investigation process.</p> <p>Findings:</p> <p>On March 28, 2025, at 10:50 a.m., an unannounced visit was made to the facility to investigate an allegation of abuse.</p> <p>On March 28, 2025, at 11:10 a.m., an interview was conducted with Resident 1, who stated, CNA 1 was rough while changing her brief, pushing her against the bed railing and causing pain and a bump on her left wrist on March 15, 2025. Resident 1 stated It upset me at the time.</p> <p>A Review of Resident 1's medical record, title, Resident Information, dated, March 18, 2025, at 11:50 a.m., indicated, resident was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis (One-sided {Left} paralysis or weakness) following a stroke.</p> <p>A review of Resident 1's, Brief Interview for Mental Status (a cognitive assessment), indicated a score of 15 (cognitively intact).</p> <p>A review of Resident 1's, Change of Condition, (A deviation from baseline condition) note, dated, March 15, 2025, at 8:00 p.m., by Licensed Vocational Nurse (LVN) 1, indicated, . (Resident 1 . accusing {CNA 1} being rough while changing (resident), (Resident 1) complained of a bump (on) left wrist . (LVN 1 assessed Resident 1's left wrist) bone, no noted (injuries) skin intact, no discolorations . (CNA 1) stated she was not rough with (resident) and had . (CNA 2) with her, while changing Resident 1 . (LVN 1) . notified . Director of Nursing (DON) and Administrator ({Admin}-Abuse Coordinator) . DON informed all staff to take a second person at all times caring for (Resident 1) . Police officer arrived and spoke to (LVN 1) . (Resident 1) and (Admin). (Admin) called (the facility) and tried to speak to (Resident 1) twice and (resident) said No I'm not talking to (Admin) .</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On March 28, 2025, at 1:18 p.m., an interview was conducted with CNA 1, who stated, she worked double shift on March 15, 2025, and cared for Resident 1 in the morning without incident. CNA 1 stated she was informed on March 15, 2025, at 9:23 p.m. (one hour after the allegation was reported), that she could return to work the next morning, March 16, 2025 at 6:30 a.m.</p> <p>On March 28, 2025, at 1:37 p.m., an interview was conducted with the DON, who stated, she was informed of the allegation and spoke with Resident 1 by phone, then reported the incident to the Administrator. The DON stated, she did not participate further in the investigation, as she was off duty.</p> <p>On March 28, 2025, at 2:23 p.m., an interview was conducted with the Administrator (Abuse Coordinator), who stated, he was responsible for abuse investigations. The Administrator stated, he received the report from LVN 1, spoke with the police, and attempted to interview Resident 1, who declined. The Administrator stated, he interviewed staff who assisted with Resident 1's care but did not interview Resident 1 or any other residents assigned to CNA 1 prior to allowing the CNA to return to work. The Administrator stated, he believed he had enough information and permitted CNA 1 to return to her shift on March 16, 2025, even though the investigation was not complete.</p> <p>On April 1, 2025, at 10:29 a.m., an interview was conducted with LVN 1, who stated, Resident 1 reported the incident around 7:50 p.m. on March 15, 2025. LVN 1 stated she assessed the resident, notified the DON and Administrator. LVN 1 stated, the police arrived shortly afterward to interview Resident 1. LVN 1 stated CNA 1 was sent home around 8:45 p.m. that evening.</p> <p>On April 1, 2025, at 4:45 p.m., an interview was conducted with the Administrator, who stated, on March 17, 2025 (a day after the reported allegation of abuse), he presented to the facility to interview other residents who had received care from CNA 1 and conducted a follow-up with Resident 1, who decline to discuss the incident further. The Administrator stated, he allowed CNA 1 to return to work on March 16, 2025.</p> <p>A review of the facility Policy and Procedure, titled, Abuse Investigation and Reporting, revised, July 2017, indicated, . Policy Statement: All reports of resident abuse . shall be promptly . and thoroughly investigated by facility management. Policy Interpretation and Implementation: Role of the Administrator . 4. The administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented . Role of the investigator: 1. The individual conducting the investigation will, as a minimum: c. Interview the person(s) reporting the incident; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident . 2. The following guidelines will be used when conducting interviews: a. Each interview will be conducted separately and in a private location . d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it .</p>