| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555442 | A. Building<br>B. Wing | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Capital Post Acute | 6821 24th Street<br>Sacramento, CA 95822 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>48445<br><br>Based on observation, interview, and record review, the facility failed to report an incident of allegation of abuse for one of four sampled residents (Resident 1) as required by the regulations.<br><br>This failure resulted in a delay in the abuse investigation process and decreased the facility's potential to protect residents from physical and psychosocial harm.<br><br>Findings:<br><br>A review of Resident 1's Admission Record, dated 4/4/24 indicated, Resident 1 was admitted to the facility over two years ago with multiple diagnoses which included hemiplegia ( paralysis of half of the body) following cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it). The admission record also indicated Resident 1 was non-English speaking. The Minimum Data Set (MDS, an assessment tool) dated 3/14/24, indicated the resident had severe cognitive impairment.<br><br>During a review of Resident 1's change in condition (CIC) notes, dated 3/16/24, the notes indicated, On 3/16/2024 at around 8:00 AM, resident reported to RNA [Restorative Nursing Assistant] that he was hit on the chest twice by his CNA [Certified Nursing Assistant] the day before. Nurse reported the incident to Administrator and DON [Director of Nursing] .<br><br>A review of Resident 1's nursing progress notes, dated 3/16/24, indicated, @[at]0700 RNA reported to charge nurse that [Resident 1] called her over to his bed and stated that the evening CNA the day before on 3/15/24 struck him twice in the chest .[Resident 1] was very adamant about being struck and kept repeating it over and over again. Administrator and DON notified.<br><br>During a review of a facility provided document titled Report of Suspected Dependent Adult/Elder Abuse, dated 3/16/24, the document indicated, On 3/16 between 0645-0700 am resident reported to CNA that the PM [afternoon] shift CNA hit him 2x [twice] in his chest. Report made to supervisor. Supervisor informed abuse coordinator and DON. The document also had a line struck across it and had a written note that stated, DID NOT SEND *Based on information.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the Interdisciplinary Team (IDT) notes, dated 3/18/24, the notes indicated, LATE ENTRY . Root Cause: Resident stated he was hit by a CNA twice to the chest area with his hand .Interventions: Incident reported to Administrator, DON and MD (Medical Doctor). Closely monitor for behavior changes, thought process, skin issue/discoloration or pain/discomfort to the chest area, internal/facility investigation initiated as per facility protocol.<br><br>A review of Resident 1's CIC notes dated 3/29/24 indicated, .On 3/29/2024 at around 4:00 PM, resident reported that he was hit on the chest twice by his CNA 2 weeks ago .<br><br>During a review of the IDT notes dated, 3/29/24, notes indicated, Root cause: Resident stated he was hit by a CNA twice to the chest area with his fist 2 weeks ago .Interventions: Incident reported to Administrator, DON, MD and RP Responsible Party] .internal/facility investigation initiated as per facility protocol. Incident reported to the following agencies within time frame: Ombudsman, CDPH and local Law Enforcement.<br><br>A review of a document titled Intake Information, dated 4/2/24 indicated the report was received by the Department on 4/2/24. The report indicated Resident 1 had reported on 3/29/24 on an incident that happened two weeks ago when a CNA allegedly hit him twice on his chest.<br><br>During an interview on 4/4/24 at 10:40 a.m. with CNA 1, she stated an RNA came out that day in the morning, and asked if she can come and translate to make sure what Resident 1 was saying was understood. CNA 1 stated, I went with him and asked what happened, he said - he hit me - and I said who hit you and he said that guy and he said that the CNA from yesterday and I said why did he hit you. CNA 1 stated Resident 1 didn't answer but responded by an action that indicated he did not know. CNA 1 stated, He said I don't want him anymore, I'm scared. CNA 1 stated she informed the nurse and the nurse made a report on 3/16/24.<br><br>During a concurrent observation and interview on 4/4/24 at 11:10 a.m. with Resident 1 in his room, Resident 1 was observed sitting on wheelchair, alert, calm, and responded to questions using short English words. When asked about the incident, Resident 1 stated, two time punch, hurt a little, and demonstrated with a ball of fist and punched on the chest. Resident 1 stated he felt scared, and he reported to the nurse.<br><br>During an interview on 4/4/24 at 11:18 a.m. with the DON, the DON confirmed the incident was reported to her and the administrator on 3/16/24. The DON stated, As per that situation, the event that happened 2 weeks ago, we made this an isolated incident, that's why the [report] was not sent out. Then after two weeks, the Ombudsman was notified .and then when that still it came up, that's when we were like let's do another investigation and then that's when we decided let's just proceed with the whole thing. The DON confirmed the report was filled out on 3/16/24, and stated, The administrator as the abuse coordinator decided that it's not reportable. DON stated they considered it as non-reportable at that point on that event on the 3/16/24 but after two weeks decided it's reportable. The DON confirmed the incident was reported to the department on 3/29/24.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 4/4/24 at 11:34 p.m. with the Administrator (ADM), the ADM stated, The stories were changing, and I told them let us start writing everything out because it happened on weekend .we held on to it because the story was changing, left and right, and nothing really made sense. So I had them fill it all out, I held on to it and then when I talked to everybody when I got back, I wrote it on there that we're not sending this because nothing makes sense on this. When asked about the process on reporting allegations of abuse, the ADM stated, It depends on capacity of the resident .I decided to just hold off because nothing added up to what he was saying.<br><br>A review of the facility ' s policy and procedure (P&P) titled, Reporting Allegations of Abuse/Neglect/Exploitation, dated 1/1/24, the P&P indicated, 8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required . Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: When suspicion of abuse/neglect/exploitation of reports of abuse/neglect/exploitation occur, the following procedure will be initiated. 1. The facility will: .h. Notify the appropriate agencies immediately: as soon as practically possible, no later than two hours after observing, obtaining knowledge of, or suspecting the alleged abuse or neglect. i. Submit a written report to the long-term care ombudsman; Local law enforcement; and the California Department of Public Health (CDPH) within 24 hours. |