STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555542	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer House	415 P Street Sacramento, CA 95814

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38834 Based on interview and record review, the facility failed to protect two sampled residents (Resident 3 and Resident 2) from abuse, when, Resident 3 was verbally threatened and punched by Resident 1 in the face and neck and Resident 2 experienced multiple episodes of sexual inappropriateness from Resident 1, who had a known history of verbal aggression and sexual inappropriateness. These failures resulted in Resident 3's physical injury and emotional distress and feeling dirty for Resident 2. Findings: A review of the facility's policy titled, Abuse, Neglect, Exploitation, and Misappropriation Program, revised 4/2021, indicated, Residents have the right to be free from abuse .This includes . freedom from . verbal, mental, sexual or physical abuse. According to the admission record, the facility admitted Resident 1 in the fall of 2024 with diagnoses which included multiple fractures of left leg. A review of Resident 1's Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), dated 10/3/24 indicated the resident scored 15 out of 15 on the assessment and was cognitively intact. A review of Resident 1's Order Summary Report' contained two physician's orders dated 9/27/24 and 11/12/24 for psychiatric evaluation. A review of Resident 1's care plan dated 10/31/24 and revised 12/11/24 indicated, The resident is/has potential to be sexually inappropriate to staff .to other residents r/t [related to poor impulse control .The resident will verbalize .need to control behavior. The interventions included, monitoring behaviors, documenting observed behaviors and attempted interventions, monitoring resident's whereabouts every 30 minutes, and arrange for psychiatrist consult. A review of Resident 1's care plan dated 11/15/24 indicated, The resident is reported to be verbally aggressive and threatened peer .The resident will not harm self or others. The interventions directed staff to monitor for irritability . monitor/document any s/sx [signs and symptoms] of resident posing dangers to others . intervene before agitation escalates . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the nursing progress notes (NPN) indicated Resident 1 had been having history of multiple episodes of verbal and physical aggression and sexually inappropriate behaviors. There was no documented evidence that the resident had been referred or had been evaluated by a psychiatrist as was ordered by the resident's physician on 9/27/24 and 11/12/24 and as indicated in Resident 1's care plan. A review of the NPN dated 10/31/24, at 11:15 a.m., indicated Resident 1 made inappropriate sexual comments toward a female staff. A review of the NPN dated 11/8/24, at 3:42 p.m., indicated that Resident 1 was noted with increased behaviors . continues to make false, accusatory, and paranoid/delusional statements . The NPN indicated the physician was notified and the psychiatric consult was requested. A review of the social services note dated 11/15/24, at 11:56 a.m., indicated that Resident 1 has had verbal altercation with another resident from across his room and continued to go back to his room and is threatening the other resident, all verbal only. A review of the NPN dated 12/9/24, at 7:22 p.m., indicated that Resident 1 was witnessed by staff entering Resident 3's room. Per NPN, Resident 1 started yelling at Resident 3, and then was noted . charging toward [Resident 3], hitting him [Resident 3] in the head. A review of Resident 1's 'Change in Condition Evaluation' dated 12/10/24 at 3:29 p.m., indicated, Resident [1] made unwanted sexual advances multiple times towards another resident. A review of the admission record indicated the facility admitted Resident 3 earlier this year with multiple diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk of the left side of the body). A review of Resident 3's quarterly BIMS assessment dated [DATE] indicated that Resident 3 scored 15 out of 15 and was cognitively intact. A review of the NPN note dated 12/9/24, at 7:09 p.m., indicated Resident 3 was verbally threatened and then was hit in the head by Resident 1. The nurse documented that Resident 3 was assessed after the incident and complained of severe headache. Per NPN, Resident 3 rated the pain as an 8 on a scale from 1 to 10, where 8 indicated a severe pain. A review of Resident 3's care plan dated 12/9/24 indicated, Peer to Peer - Resident received episode of physical aggression by another resident. A review of the admission record indicated the facility admitted Resident 2 earlier this year with multiple diagnoses which included left-sided hemiplegia and above the knee amputation (AKA- surgical removal of the portion of right leg above the knee). A review of Resident 2's BIMS dated 9/22/24 indicated that Resident 2 scored 13 out of 15 and was cognitively intact (had sufficient judgement). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2's care plan dated 10/6/24 indicated the resident used anti-anxiety medication related to anxiety disorder. One of the interventions directed staff to monitor the resident for safety. A review of Resident 2's 'Change in Condition' document dated 12/10/24, at 4:04 p.m., indicated, Resident verbalized to charge nurse .about 6-8 days ago [Resident 1] came to me again and made sexual advances towards me. He said, 'I want you to come lay in my bed so I can .you and you can suck my .Lately nothing has happened but 3-4 more advances .I didn't want to do it .I didn't tell anyone because I was uncomfortable. A review of Resident 2's 'PSYCHO-SOCIAL/WELL BEING' care plan dated 12/10/24 indicated, [Resident 2] recently experienced unwanted sexual advances. At risk for altered wellbeing [and] reduced sense of well-being . The interventions included, Daily psychosocial visit from Social Services for next 3 days & [and] as needed . Determine if mood endangers the resident and intervene if necessary .Identify relationships that the resident could draw on. The care plan did not contain any interventions to show how the facility will ensure Resident 2's safety. During an interview on 12/19/24, at 1:20 p.m., Restorative Nursing Assistant (RNA 1) stated she and another staff assisted Resident 3's roommate with care when they overheard Resident 1 in the hall screaming and yelling loudly calling Resident 3's name. RNA 1 stated both staff attempted to unsuccessfully calm down Resident 1 before he quickly barged into room and hit Resident 3 in the head. RNA 1 stated Resident 3 did not argue or talk back during all this time and it all happened so fast, the staff was not able to stop Resident 1 from hitting Resident 3. During a continued interview with RNA 1 on 12/19/24, at 1:20 p.m., RNA 1 stated that she was aware of Resident 1's inappropriate sexual advances towards Resident 2. RNA 1 described Resident 2 as alert and oriented. RNA 1 stated that a few days after Resident 2 reported the alleged incident, the resident approached RNA 1 and talked about the incident with Resident 1. RNA 1 stated that Resident 2 verbalized to her that she was weary of [Resident 1's] behaviors. During an observation and interview on 12/19/24, at 1:35 p.m., Resident 3 was observed lying in his bed. Resident 3 stated he was eating dinner when he heard Resident 1 yelling loudly. Resident 3 continued, I don't remember what he was saying, it was very quick. He came here and hit me in the face and my neck with his fist . It hurt bad. Resident 3 demonstrated the area on his face and neck where he was hit and continued, That guy is always mean and angry. We were in the same room before, across the hall and he always yelled at me. He even threatened to kill me, said he is going to smash my head with a fan. Resident 3 added that he complained about Resident 1 and the facility moved him to a different room. Resident 3 stated, Every time I hear his voice I cringe because I'm still scared of him. I cannot walk and cannot defend myself. I am safe when he's not around. During an interview with CNA 1 on 12/19/24, at 1:50 p.m., CNA 1 stated Resident 1 had lots of behaviors and described him as very short tempered and irritable. CNA 1 stated Resident 1 had frequent arguments with Resident 3 in the past when they were roommates. CNA 1 stated that Resident 1 had history of saying sexual things and making sexual advances towards female staff and the staff was aware of it. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/19/24, at 2:10 p.m., the Assistant of Director of Nursing (ADON) validated that on 12/9/24 Resident 1 yelled at Resident 3 and then physically assaulted him in the face. The ADON stated she was aware that Resident 1 and Resident 3 were not getting along when they were roommates. The ADON stated was not aware of Resident 1's threats to Resident 3 and not aware if they had physical altercations prior. The ADON stated she was not sure what happened .and what triggered to move [Resident 3] to a different room. During a continued interview on 12/19/24, at 2:10 p.m., the ADON stated she was present when Resident 2 reported the sexual allegation incident with Resident 1 on 12/10/24. The ADON stated that Resident 2 did not report alleged encounter with Resident 1 right away and reported the incident 6 - 8 days after the incident happened. The ADON stated that Resident 2 reported that Resident 1 made 3 or 4 more advances after the first incident and put his arm around Resident 1 and that she [Resident 2] was uncomfortable with that. The ADON added, I asked . if she was scary of him and if she felt safe. She said she was okay. During an interview on 12/19/24, at 2:20 p.m., Resident 2 stated that Resident 1 had been having inappropriate conversations and sexual suggestions on many occasions when they were in the hall, dining room or outside. Resident 2 stated, [Resident 1] would put his arm around me and even tried to put his hand into my pants . I've told him to stop, but he did not listen .I did not like what he was doing . I didn't want to talk to anyone about it because it was so gross, and I felt dirty. Resident 2 stated she decided to report Resident 1 when the incidents became more frequent. Resident 2 continued, They moved him away from me, but he continues talking to me and even yelled at me when I was outside . I'm okay if other people around but not comfortable to be alone with him. Resident 2 stated she did not report to anyone that Resident 1 continues talking to her inappropriately when they are outside after she reported it first on 12/10/24. A joint interview with Resident 2, Social Services Director (SSD), and Administrator (ADM), was conducted on 12/19/24, at 2:40 p.m. SSD stated that Resident 1 was moved to a different hall and had been on frequent monitoring every 30 minutes since the incident was reported. The SSD and ADM assured that the staff did not observe any further incidents of Resident 1 being inappropriate. During the interview, Resident 2 explained that Resident 1 continues talking inappropriately when they are outside and when there are no other residents around and added that she did not talk to anyone about this. During an interview on 12/19/24, at 2:55 p.m., Resident 1 was asked about the incident of physical aggression toward Resident 3. Resident 1 stated, We were not getting along when we were living in the same room; he always called me words and racial slurs . That day I was in the hall talking on the phone . He overheard me and started calling me . word again .I lost it . went to his room and slapped him. During a continued interview on 12/19/24, at 2:55 p.m., Resident 1 was asked regarding alleged incident with Resident 2. The resident denied the allegations and stated, it's false, it's all lie. I have never said or done anything like that. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint interview with Director of Nursing (DON) and ADM on 12/19/24, at 3:25 p.m., the DON validated that Resident 1 had history of verbal altercations with another resident prior to the incident with Resident 3. The DON acknowledged that Resident 1 had a known episodes of sexually inappropriate behaviors toward the staff, but no incidents towards the residents prior to Resident 2's report. The ADM stated the facility will implement additional steps to ensure Resident 2's safety and the ADM added, It is our goal for everyone to feel safe here. We are responsible for protecting our residents. A review of the facility's policy titled, Safety and Supervision of Residents, with the revision date of 7/2017, indicated, Resident safety and supervision . are facility-wide priorities . Resident supervision is a core component of the systems approach to safety.