STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555588	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Hospital of Northern California D/P Snf	2801 Eureka Way Redding, CA 96001

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on interview and record review, the facility failed to ensure that a thorough investigation of an allegation of staff to resident abuse was conducted in accordance with the facility's Abuse Policy, for one of three sampled residents (Resident 1). This had the potential to put all residents of the facility at risk for staff to resident abuse. Findings: Review of a facility's policy titled, Abuse Prevention and Management: TCU dated 6/24 indicated, .each resident shall be free from verbal, sexual, physical and mental abuse . , Residents must not be subjected to abuse by anyone, including .staff of other agencies serving the resident , and The Administrator will: 4) Begin the interviewing process of all involved residents, employees and witnesses , and 7) Start a confidential file including: 1) Resident Statement, 2) Employee Statements 3) Witness Statements . Review of admission records for Resident 1, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including high blood pressure with heart failure (heart is unable to pump blood to meet the body's need), chronic kidney disease (the kidneys are damaged and can't filter blood the way they should), atrial fibrillation (an irregular and often very fast heart beat that can cause poor blood flow), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and overactive bladder (a problem with bladder function that causes the sudden uncontrollable urge to urinate). Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) of 13 out of 15, which indicated she was cognitively intact. Review of a Registered Nurse Note dated 1/27/25 at 10:18 AM, indicated that Resident 1 reported the alleged abuse to the Director of Staff Development (DSD), and stated to the DSD that around 1000 (10:00 PM) last night my CNA [Certified Nursing Assistant] got me back into bed after using the bathroom and hit me with my call light. The DSD indicated that Resident 1 showed him a bruise to her left hand. The DSD indicated that, although Resident 1 did not know the name of her CNA, that CNA E had been determined to be Resident 1's CNA. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Vibra Hospital of Northern California D/P Snf	2801 Eureka Way Redding, CA 96001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 11:09 AM, with the DSD, the DSD stated Resident 1 pointed out a visible bruise on her left hand and indicated that CNA E hit her on the hand with the call light. The DSD stated that Resident 1 reported that she felt CNA E hit her on purpose. The DSD indicated that he could not recall who had been interviewed regarding this allegation, and confirmed there was no supporting documentation. The DSD was not able to describe CNA E, as he had never seen her. Review of a Case Manager note dated 1/29/25 at 2:00 PM, reflected Resident 1 didn't remember the allegation that CNA E had hit her with the call light and wasn't sure what the Case Manager was talking about. During a phone interview on 2/5/25 at 1:11 PM, with Resident 1, Resident 1 stated that on 1/26/25 around 10 PM, she was in bed and CNA E came in and was being a smart [NAME] with her and conked her on the hand with the call light and left a bruise. Resident 1 stated that she could not remember CNA E's name. Resident 1 stated that she slept the rest of the night and confirmed that she had not reported this to anyone until the next morning, on 1/27/25, she told, the big boss. During a phone interview on 2/5/25 at 1:54 PM, CNA E stated that around 3:00 AM on 1/27/25, she went into Resident 1's room and found that her call light was wedged in between her mattress and the bed rail. CNA E indicated that she untangled the call light and placed it within Resident 1's reach. CNA E stated, There was no indication that the call light had hit her [Resident 1] hand. She [Resident 1] never said anything. CNA E added if the call light had hit Resident 1's hand on accident, I would have reported it. During an interview and conncurrent Abuse Policy record review on 2/5/25 at 12:59 PM, the Director of Nursing (DON) and Chief Nursing Officer (CNO), confirmed the facility's investigation had not included the interviewing process of all involved other residents who had been under the care of CNA E, employees and witnesses, and there was no confidential file that included a resident statement, employee statements, or witness statements, as their Abuse policy directed. CNO stated Resident 1 should have been shown a picture of CNA E, to positively confirm that she was the person alleged to have hit her.