STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555698	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Hospital D/P Snf	2170 South Avenue South Lake Tahoe, CA 96150

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 - Few	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** Based on observation, interview, and record review, the facility failed to protect two residents (Resident 1 and Resident 2) from abuse, when the staff witnessed Resident 1 hitting Resident 2 in the head and Resident 2 grabbing Resident 1's forearm. In addition, the facility failed to assess and document Resident 1's skin injury and the treatment that was provided. This failure resulted in Resident 2 being hit on the head and Resident 1 receiving skin tears to right forearm and had the potential to result in emotional distress for Resident 1 and Resident 2. Findings: A review of the admission record indicated the facility admitted Resident 1 in 2021 with multiple diagnoses, which included dementia (a progressive state of decline in mental abilities) and depression. A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/8/25, indicated the resident scored 10 out of 15 for Brief Interview for Mental Status (BIMS, an assessment tool used to screen and identify memory, orientation, and judgement status of the resident), which indicated moderate impaired cognition. A review of Resident 1's interdisciplinary care plan dated 5/20/25 indicated, RESIDENT TO RESIDENT ALTERCATION, Resident displayed inappropriate treatment of another resident; Resident received inappropriate treatment from another resident. The nursing interventions directed staff to ensure safe environment and perform body check for injuries. A review of the admission record for Resident 2 indicated the facility admitted the resident in 2015 with multiple diagnoses which included dementia and anxiety. A review of Resident 2's MDS dated [DATE] indicated the resident BIMS of 10, which indicated moderate impaired cognitive status. A review of Resident 2's interdisciplinary care plan, dated 5/20/25 indicated, RESIDENT TO RESIDENT ALTERCATION, Resident displayed inappropriate treatment of another resident; Resident received inappropriate treatment from another resident. (continued on next page)

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 - Few	A review of the nursing alert notes for Resident 1, dated 5/20/25, at 5:02 p.m., indicated, Residents were gathered in dining room with activity staff present. This resident . walked down .and tapped another resident [Resident 2] . in the head with an open hand. The note further indicated that Resident 2 grabbed Resident 1's arm and dug in his nails leaving several deep scratches. The note indicated that first aid to Resident 1 was administered. A review of Resident 1's clinical record, including skin and wound assessments failed to reveal the facility staff assessed and documented the resident's skin injury obtained during the altercation with Resident 2. There was no documented evidence that nursing staff documented the location, measurements, description of the injuries, and treatment that was provided. During an interview on 6/3/25, at 9:30 a.m., the Director of Nursing (DON) validated that there was a witnessed altercation between Resident 1 and Resident 2 on 5/20/25. The DON stated the facility had difficulty to determine who was the victim and added, [Resident 1] was the one that initially tapped [Resident 2] on his head, but he ended up being injured. During an observation and interview on 6/3/25, at 10:05 a.m., Resident 1 was observed laying in his bed. Resident 1 responded appropriately to questions asked. Resident 1 was observed having a few scattered bruises and three scabs on his right forearm. Resident 1 explained, This guy [Resident 2's name] grabbed my arm and my skin got ripped. You see, my skin is so thin .was bleeding . lots of blood. My arm was sore. Resident 1 added, He [Resident 2] took offence on something I had said. I don't remember what I said. During an observation and interview with Resident 2 on 6/3/25, at 10:15 a.m., Resident 2 was observed in his bed. When Resident 2 was asked about the altercation with Resident 1, the resident stated, My memory is gone completely . I can't recall if I hurt him and I don't remember if he hurt me. If I did, I can't recall. During an interview with facility staff (FS) on 6/3/25, at 11:04 a.m., the FS stated that the altercation between Resident 1 and Resident 2 happened on 5/20/25, around 5 p.m. The FS stated Resident 1 was standing in front of Resident 2 and both were swinging their arms like attempting to punch each other and then [Resident 2] suddenly grabbed [Resident 1's arm. The FS stated the incident happened very quickly after which Resident 1's forearm started bleeding and the resident's nurse was notified of the skin injuries. During an interview with Licensed Nurse (LN 1) on 6/3/25, at 11:30 a.m., LN 1 stated she was notified by FS that [Resident 1] hit [Resident 2] in the head after which [Resident 2] grabbed [Resident 1's] forearm and squeezed hard. LN 1 stated Resident 1 had three skin tears and they were bleeding. LN 1 stated the photo of skin tears was taken on 5/20/25 and the description of the injuries to Resident 1's forearm should be found under skin and wound assessment in the resident's clinical record. Upon reviewing the record, LN 1 was not able to locate the assessment, description of skin tears or picture of Resident 1's injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview and record review with DON on 6/3/25, at 12 p.m., the DON provided a document titled, [Name of the facility] skilled nursing new skin condition and explained that this checklist was used every time the nurses observed resident having a new skin issue. The DON stated that per LN 1's documentation, Resident 1's skin and wound assessment and a progress note about the wound were completed and signed on 5/20/25 and validated that the resident's clinical record did not reflect any wound/skin assessment documentation dated 5/20/25. The DON stated the expectation was that nurses followed the facility protocol and documented skin tears assessment in Resident 1's clinical record. A review of the facility's 'Abuse Policy,' with the revision date of 8/24, indicated, It is the policy of the Skilled Facility to promote an environment free from any type of abuse for all of its residents .After identification of any type of abuse, a full head to toe assessment must be done on the resident/s and documented in the medical record . Any bruising .skin tear .will be documented .Any visible injuries should be photographed.