

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555877	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2024
NAME OF PROVIDER OR SUPPLIER  Ridgecrest Regional Transitional Care and Rehabili		STREET ADDRESS, CITY, STATE, ZIP CODE  1081 North China Lake Boulevard Ridgecrest, CA 93555	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48901</p> <p>Based on observation, interview, and record review, the facility failed to protect one of two sampled residents from abuse (Resident 1) when Resident 2, who had a history of inappropriate behavior, was not adequately supervised. This failure resulted in abuse when Resident 2 touched Resident 1's breasts and perineal area.</p> <p>Findings:</p> <p>During a review of Resident 1's clinical record the Record of Admission (ROA), indicated Resident 1 was admitted on [DATE]. The SOAP [Subjective, Objective, Assessment and Plan - method of documentation used by healthcare workers] Note dated 3/14/22 at 11:09 a.m., indicated, Major neurocognitive disorder [decreased mental function and loss of ability to do daily tasks] due to dementia [a group of symptoms affecting memory, thinking and social abilities], R/O [rule out] Alzheimer's disease [a progressive disease that destroys memory and other important mental functions]. The Minimum Data Set (MDS) assessment dated [DATE] indicated, Resident 1's Brief Interview for Mental Status (BIMS-screening tool to identify the cognitive condition of a resident with a scoring of 0 to 15, 15 being cognitively intact) assessment score was 4 which indicated Resident 1 has severe impaired cognitive ability. The MDS assessment dated [DATE] indicated Resident 1 is in a wheelchair and is not ambulatory.</p> <p>During a review of Resident 1's Plan of Care dated 3/30/24, the Plan of Care indicated, Victim: Resident [1] was inappropriately touched by another resident [Resident 2]. The interventions included: perform a body check, provide one-on-one reassurance, monitor for changes in mood, behavior, socialization, sleep, or appetite, and Social Services Director to provide supportive one-to-one visits.</p> <p>During a review of Resident 1's Physician Progress Note (PPN), dated 4/8/24 at 12:57 p.m., the PPN indicated, LATE ENTRY FOR 04/01/2024 08:30 [8:30 a.m.]: Patient [Resident 1] was involved in an incident with another resident [Resident 2] recently [3/30/24] but does not recall any of the details. She [Resident 1] continues to demonstrate cognitive [mental] decline/dementia. She continues to be unable to make her own medical decisions. She does have varying degrees of clarity and can carry on conversations and express her needs. Overall has poor safety awareness. When asked about these incidents she does not seem to recall any details of specifics.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Initial and Final Report (IFR), dated 4/1/24, the IFR indicated, On 3/30/2024 at about 0900 [9 a.m.] hours [Resident 1] was found by the C.N.A. [Certified Nursing Assistant- CNA 2] lying on her bed with her adult brief down and [Resident 2] was standing on the right side of her bed.</p> <p>During a review of Resident 2's ROA, the ROA indicated Resident 2 was admitted on [DATE].</p> <p>The MDS assessment dated [DATE] indicated Resident 2's BIMS score was 13 which indicates the resident is cognitively intact. Resident 2 is independent with mobility and can walk 150 feet independently.</p> <p>During a review of the Behavior Management Note (BMN), dated 2/22/24 at 6:50 p.m., the BMN indicated, Resident [Resident 2] provided comfort by touching resident [Resident 6] arm. Resident [6] later explained to writer that she does not prefer to be touched on the shoulder or arm when resident [Resident 1] comes to visit her.</p> <p>During a review of Resident 2's Nurses Notes (NN), dated 2/26/24 at 4:20 p.m., the NN indicated, Informed SS [Social Services] to work on setting healthy boundaries with him [Resident 2], in regards to friendship with another resident [Resident 1] telling her to move to Trona with him.</p> <p>During a review Resident 2's Behavioral Management Note, Alert Charting Note (BMNACN - when staff monitor and document a resident's change in condition every shift for 72 hours), dated 2/26/24 at 11:21 p.m., the BMNACN indicated, Resident [2] is on alert charting for behaviors relating to [Resident 1] and inappropriate sexual comments towards staff. Resident [2] was heard stating to CNA [Certified Nursing Assistant - unidentified] ' I would like to see more of your chest tattoo that is covered' and ' are there any tattoos you have tattoos are covered that I could see if you were naked' [sic]. Resident [2] also said to another CNA [unidentified] 'Your freckles look good all over your body'. CNA [unidentified] staff has reported many inappropriate comments from resident [2] today.</p> <p>During a review of Resident 2's Plan of Care dated 2/27/24, the Plan of Care indicated, Conflict: Resident [2] has been identified as having a high potential for conflict with staff/other residents/family. Resident [2] is at risk for conflict due to crossing professional boundaries with staff AEB [As evidence by]: asking to see staff tattoos and freckles under clothing. Potential for crossing platonic boundaries with other residents AEB: discussing moving with another resident. The interventions include: if resident is assigned one-on-one staff assignments will be rotated regularly to avoid burnout, staff will regularly document notes on behavior and refer to social services, Social Services will review resident chart documentation 1x monthly to identify any trends/issues.</p> <p>During a review of Resident 2's Plan of Care dated 3/30/24, the Plan of Care indicated, SEXUAL-BEHAVIORAL SYMPTOMS: PUBLIC SEXUAL ACTS: Resident [2] has engaged in sexual behaviors [with Resident 1] such as: Needs continual reminders of acceptable public behavior and of resident's rights. May be unable to comprehend or remember appropriate behavior related to a diagnosis of dementia The interventions include to schedule and coordinate a care conference with resident and family, provide secured privacy, explain acceptable behavior and expressions of sexuality based on cognitive evaluation, evaluate resident's cognitive status for memory and social reasoning, remind resident in a private setting of the need to observe specific limits, protect other residents by close monitoring, educate staff on behavior approaches designed to effectively manage unacceptable sexual advances, and psychiatric evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Plan of Care dated 3/30/24, the Plan of Care indicated, SEXUAL-BEHAVIORAL SYMPTOMS: PUBLIC SEXUAL ACTS : Resident has engaged in sexual behaviors such as .touches/fondles other resident, Makes verbally explicit comments and suggestions Needs continual reminders of acceptable public behavior and of resident's rights.03/30/24: Resident [2] found in a female resident's room with door closed.Resident [2] initially reports he did not touch female resident [1]. Resident [2] later reported to staff that he touched female resident's [1's] breasts and he reported to state surveyor tht [that] he ' tickeld [tickled]" the same female resident's [1's] vagina. The goals include Resident [2] will not engage in sexual behavior in public by re-evaluation date [6/28/24], resident will not squeeze/slap/touch/fondle staff, resident will not make sexual advances to other non-consenting residents, and resident will respond to redirection and staff monitoring. The interventions include to protect other residents by close monitoring - every 15-minute checks x 3 days, every 30 minutes checks x 3 days and hourly checks x 14 days and re-evaluate for continued monitoring need, checks to include monitoring for activity and location and change room to near nursing station.</p> <p>During an interview on 4/8/24 at 11:24 a.m. with Resident 2, Resident 2 stated, I did pull her [Resident 1] clothes down. I wanted to see what she looked like. I wanted to tickle her. I did tickle her down there [in her private area]. I find her to be attractive and I was interested.</p> <p>During an observation and interview on 4/8/24 at 11:46 a.m. with Resident 1, in Resident 1's room, Resident 1 was sitting in her wheelchair. Resident 1 stated, I do not remember that this [sexual abuse] happened. What did he [Resident 2] do to me? I do not know who this resident [2] is. Resident 1 was unable to recall the 3/30/24 incident where Resident 2 admitted to touching Resident 1's breasts and perineal area.</p> <p>During an interview on 4/8/24 at 12:06 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 touched staff members in their private parts. LVN 1 stated Resident 1 has been displaying these behaviors for almost a month. LVN 1 stated he would inform Resident 1 the behavior was not appropriate but LVN 1 did not report the behavior to anyone.</p> <p>During an interview on 4/8/24 at 12:16 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2 was in Resident 1's room prior to the incident on 3/30/24. CNA 1 stated she keeps an eye on Resident 2 because she has noticed Resident 2 watches staff to see when they are busy and not at the nurses' station. CNA 1 stated Resident 2 is alert and oriented, and Resident 1 is confused. CNA 1 stated Resident 1 and Resident 2 would sit in the dining room holding hands. CNA 1 stated he seemed more interested in her [Resident 1] two weeks prior to the incident.</p> <p>During an interview on 4/8/24 at 2:15 p.m. with Director of Nursing (DON), DON stated she is aware Resident 2 has said inappropriate words to staff but was not aware of any other inappropriate behavior with other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/8/24 at 2:47 p.m., with Social Services Director (SSD) Resident 2's Plan of Care dated 3/30/24 the Plan of Care was reviewed. The Plan of Care indicated, SEXUAL-BEHAVIORAL SYMPTOMS: PUBLIC SEXUAL ACTS: Resident [2] has engaged in sexual behaviors such as touches/fondles other resident, Makes verbally explicit comments and suggestions Needs continual reminders of acceptable public behavior and of resident's rights.03/30/24: Resident [2] found in a female resident's room with door closed.Resident [2] initially reports he did not touch female resident [1]. Resident [2] later reported to staff that he touched female resident's [1's] breasts and he reported to state surveyor tht [that] he ' tickeld [tickled]' the same female resident's [1's] vagina. The goals include Resident will not engage in sexual behavior in public by re-evaluation date [6/28/24], resident will not squeeze/slap/touch/fondle staff, resident will not make sexual advances to other non-consenting residents, and resident will respond to redirection and staff monitoring. The interventions include to protect other residents by close monitoring - every 15-minute checks x 3 days, every 30 minutes checks x 3 days and hourly checks x 14 days and re-evaluate for continued monitoring need, checks to include monitoring for activity and location and change room to near nursing station (not added until 4/9/24). SSD stated close monitoring means just checking on him [Resident 2] when we are on the floor. I am not sure if it is specific enough. SSD stated to make sure close monitoring is occurring for Resident 2, he would review alert chartings (when staff monitor and document a resident's change in condition every shift for 72 hours). During a subsequent interview on 4/29/24 at 8:30 a.m., with SSD, SSD stated looking back now at the prior alert charting for Resident 2, shows the interventions were not effective.</p> <p>During an interview on 4/11/23 at 3:06 p.m. with CNA 2, CNA 2 stated Resident 1's room door was always open. On 3/30/24 after coming out of another resident's room, she noticed Resident 1's room door was closed and when she went in, she noticed Resident 2 was standing on Resident 1's right side and Resident 1's brief was all the way down to her ankles. CNA 2 stated Resident 1 and Resident 2 looked surprised. CNA 2 stated the time of the incident was right after breakfast during morning rounds approximately 9:30 a.m. CNA 2 stated this was the first time she noticed Resident 1 had her brief all the way down. CNA 2 stated she heard when the police [during the sexual assault incident that occurred on 3/30/24] asked Resident 1 if Resident 2 touched her breast, Resident 1 said yes.</p> <p>During an interview on 4/11/23 at 3:24 p.m. with LVN 3, LVN 3 stated she was notified of what CNA 2 witnessed [Resident 2 on the right side of Resident 1's bed and Resident 1 having her briefs down to her ankle] during med pass on 3/30/24. LVN 3 stated Resident 1 does not have the capacity to understand. LVN 3 stated she heard Resident 1 tell the police that Resident 2 touched her breast.</p> <p>During an interview on 4/29/24 at 9:46 a.m. with LVN 3, LVN 3 stated a few months ago Resident 2 had gone into Resident 1's room. LVN 3 stated Resident 2 had gone into Resident 1's room multiple times. LVN 3 stated during those incidents, she was made aware, and she informed staff to keep any eye on them [Resident 1 and Resident 2].</p> <p>During a review of the Policy and Procedure (P&amp;P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, the P&amp;P indicated, Residents have the right to be free from abuse. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse by anyone including, but not necessarily limited to: b. other residents. 8. Identify and investigate all possible incidents of abuse. 10. Protect residents from any further harm during investigations.</p>		