STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056300	A. BUILDING _____ B. WING _____	**03/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANADA REHABILITATION & WELLNESS CENTER, LP	**2885 HARRIS STREET EUREKA, CA 95503**

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.** Based on observation, interview and record review, the facility failed to prevent staff abuse of one Resident (Resident 1), when a Certified Nursing Assistant (CNA-B) spanked Resident 1 on the right buttock while changing Resident 1's briefs and used Resident 1's gown to restrict movement. This failure resulted in physical abuse, restraint, and potentially resulted in increased psychosocial distress to Resident 1. Findings: Review of a California Department of Health, Intake Information Form, dated 2/12/20, indicated a facility staff, CNA-A, reported CNA-B tied up Resident 1 and spanked Resident 1's bottom during personal care on 2/11/20, at 9:30 p.m. An interview with the facility's Administrator, 2/13/20 at 11:14 a.m., indicated Resident 1 was hard-of-hearing, had poor vision, and a startle reflex. Administrator stated Resident 1 had no bruising on either buttock, and bruising on one hand had existed prior to the reported incident. Administrator stated Resident 1 had dementia and had no recall of the incident. During an observation on 2/13/20, at 11:58 a.m., Resident 1 sat in a wheelchair at a dining table prepared for lunch. When approached from behind, Resident 1 fisted his right hand and brought it up in a startle reflex. Resident 1 was hard-of-hearing and required eye contact, careful enunciation and a loud voice. Once Resident 1 identified his visitor, he smiled and cooperated with a concurrent interview, in which he denied recalling the 'spanking' incident on 2/12/20, or having any associated pain. Review of Resident 1's, Face Sheet, admission 10/4/19, and Resident 1's comprehensive care plan, indicated Resident 1 had impaired cognition, memory, and communication. The face sheet indicated Resident 1 had dementia without behavioral disturbance. Neither document indicated a previous history of aggression, combativeness during care, startle reflex, or whether Resident 1's hardness of hearing and poor vision contributed to Resident 1's reaction to care. During an interview on 2/13/20, at 12:12 p.m., Restorative Nursing Assistant, RNA-C, stated Resident 1 had put him in a headlock in the past and if staff did not announce themselves, or startled Resident 1 by placing a hand on the resident's shoulder, Resident 1 responded with a defensive pose. RNA-C stated Resident 1 was not aggressive towards other residents, but required preparation during care (5-10 minutes). During an interview on 2/13/20, at 2:17 p.m., CNA-B stated she had been assigned to Resident 1 and he frequently was combative. When asked how she had been trained to work with combative or dementia residents, CNA-B stated Resident 1 was always combative and You just have to continue in the work no one has told me how to do things better. CNA-B stated the facility had a book that listed instructions on Resident 1's daily living needs, like toileting and floating heels, but nothing on Resident 1's behaviors. When asked to describe what happened on 2/12/20, CNA-B stated that, with the help of CNA-A, she had woken Resident 1 up at about 10 p.m. to change his brief. CNA-B stated she used Resident 1's gown to wrap his hands in to prevent him from hitting her, saying another CNA had shown her the technique. CNA-B stated she slapped Resident 1's bare bottom before putting his briefs on and regretted it, saying she had just reacted, and it had not been premeditated. CNA-B denied slapping Resident 1 in anger. An interview on 2/13/20, at 4:38 p.m., with CNA-A, indicated CNA-B had asked for assistance in Resident 1's care on the evening of 2/12/20. CNA-A stated Resident 1 was positioned on his left side when she entered Resident 1's room and when he tried to turn over, CNA-B wrapped Resident 1's hand in his gown and slapped Resident 1's right buttock hard before putting on Resident 1's brief. During an interview on 3/23/20, at 2:09 p.m., Director of Staff Development (DSD) stated CNA-B had received training on abuse and had at least two days training on where to find resident nursing care plans and how to use them. DSD stated CNA-B's behavior towards Resident 1 had been inexcusable, and denied being aware of other CNAs using resident gowns to restrain resident movements. During an interview on 3/24/20, at 2:05 p.m., Director of Nursing (DON) stated Resident 1's care plan had not been as complete as it could have been, and did not refer to any history of combative behaviors. Review of the facility's Procedure for preventing abuse, Abuse - Prevention, Screening, & Training Program, Definitions, page one, defined abuse as deliberate and physical abuse included slapping or hitting. The definition for physical restraint included staff actions used for discipline or staff convenience and not the good of the resident. Page three, III. Screening Residents, indicated the facility initiated preventative measures that included .ongoing assessments (screening) and care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.