STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555304	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR POST ACUTE	**1200 SPRINGFIELD DRIVE CHICO, CA 95928**

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 interview and record review, the facility failed to protect Resident 1 from physical abuse when Resident 2 picked up a footrest and struck Resident 1 on the left side of the back of her head. This failure caused Resident 1 to have pain, confusion, lethargy, hospitalization and had the potential to cause emotional and psychological harm. Findings: A review of Resident 1's clinical record indicated she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 2's clinical record indicated, Resident 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 3's clinical record indicated, Resident 3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's clinical record indicted, Resident 4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During an interview with Resident 3 on 01/25/19, at 12:40 PM, Resident 3 stated in a past event, he was just trying to move a chair in the dining room when Resident 2 hauled off and punched him in the nose. During an observation on 01/25/19, at 12:44 PM, on Station 2 in the hallway, the 1 to 1 sitter was sitting outside of Resident 2's room. Other residents were socializing with the sitter. During an interview on 01/30/20, at 3:00 PM, with Certified Nurse Assistant (CNA A), CNA A stated, he witnessed Resident 2 wondering into room [ROOM NUMBER], he went into the room and saw Resident 2 take the footrest that was on a chair in the room and walk out and down the hallway. CNA A also stated, he then went out to his car. CNA A then heard a commotion at the end of the hall and witnessed Resident 2 with the footrest, standing and turning, then heard the footrest hitting Resident 1 in the head and saw her recoil. During a review of Resident 1's Nurses Notes (NN), no date, the NN indicated, on January 20th Resident 2 was shouting at the sitter in his room. Resident 2 was very agitated and confused. Resident 2 walked quickly over to Station 3 and entered room [ROOM NUMBER]. The 1 to 1 CNA was shielding the Resident in 314 B while Licensed Nurse (LN) B attempted to redirect him. Resident 1 attempted to cross the curtain toward Bed B and LN B stood in his way. The nurse reported Resident 2 started yelling at me to get out of here and then picked up a footrest from the wheelchair that was next to the bed and began swinging it. Resident 2 then left the room and went down hall and entered room [ROOM NUMBER]. As the one on one CNA and LN B tried to enter the room Resident 2 attempted to close the door with the wheelchair footrest still in hand. Resident 2 kept turning around to see how close we were to him. As Resident 2 turned his body to yell at us, the footrest in his right hand struck Resident 1 in the back of her head. LN B heard the metallic sound it made and saw Resident 1's head recoil from the contact. During a record review of Resident1's investigative report (IR) no date, the IR indicated, while CNA C was relieving the one on one CNA for Resident 2, Resident 2 walked out of his room and towards station 3. While doing so Resident 2 picked up a wheelchair foot rest and continued down the hall to room [ROOM NUMBER]. Resident 2 walked over to Resident 1 waking her up. Resident 1 sat up on the side of her bed and Resident 2 turned around to face the door, while doing this he hit Resident 1 in the head. During this altercation Resident 2 was very upset, agitated, confused and attempted to hurt others during the time of him being restrained after the incident. During a review of Resident 1's Progress Notes (PG), dated 01/21/19, the PG indicated, Resident 2 was witnessed entering room by Person assigned to one on one for him additional CNA and Nurses stepped up and removed Resident 2 from Resident 1's room. Later witness stated Resident 1 was struck on head by Resident 2. Resident was sent to the hospital for evaluation. During a review of Resident 1's PG dated 01/24/19, at 8:52 AM, the PG indicated, neuro checks were started due to acute change of condition with further decline. During a review of Resident 1's PG dated 01/24/19, at 11:41 AM, the PG indicated Resident 1 complained of pain to the back of her head. Medical Doctor notified and Resident 1 was sent to the emergency room for a head scan and evaluation. During a review of Resident 2's Emergency Department Provider Note (PN) dated 01/08/19, the PN indicated, Resident 2 presents to the hospital with worsening agitation with no provoking factors. During a review of Resident 2's PN dated 01/09/19, the PN indicated, Resident 2 was placed on a 51/50 by law enforcement and determined he was a danger to himself and others and cannot be safely released from the hospital. During a review of Resident 4's IR dated July 2018, indicated Resident 2 grabbed hold of Resident 4's wheelchair and pushed it up against the wall violently calling Resident 4 a rat.

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.