STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY WEST POST ACUTE	**1224 E STREET WILLIAMS, CA 95987**

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** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** Based on interview and record review the facility failed to ensure nursing staff did not use electronic devices (cell phones) in a resident room when filming a video of inappropriate staff behaviors. This had the potential to expose residents to inappropriate behaviors and mental anguish. Findings: A review of a facility policy titled Abuse Prevention and the Reporting of Alleged Abuse and Suspicion of Crime revised 11/2016, indicated the purpose was to ensure that residents' rights are protected by providing a method for the prevention of any type of resident abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Also, verbal, sexual, physical and mental abuse including abuse facilitated or enabled through use of technology. Each resident has to right to be free from abuse. An untitled and undated facility policy was provided and indicated under Electronic Devices Policy that in order to provide our residents with the best care in the safest manner, the use of cell phones or any electronic device with audio or video capabilities is prohibited during working time. Employees should not take pictures, or make audio video recordings in private areas such as changing room locker rooms and restroom or share such pictures via social media or any other means. Due to the confidential nature of our business and to protect privacy of our residents electronic devices able to take pictures, video or audio shall not be used in patient care areas or other workrooms. The facility policy titled Abuse Prevention and the Reporting of Alleged Abuse and Suspicion of Crime revised 11/2016, was reviewed. Under Prevention, it indicated Administrative staff, nursing supervisors, charge nurses are responsible for directing, supervising and evaluating all resident care activities. Facility will identify, correct and intervene in situations in which abuse and neglect are more likely to occur such as deployment of staff in sufficient numbers to meet the needs of the residents, supervision of staff to identify inappropriate behaviors and monitoring of residents with needs and behaviors which might lead to conflict or neglect. A facility reported incident dated 2/26/18 at 7:57 am, indicated one Nursing Assistants (NA, not certified) B and a Certified Nursing Assistants (CNA) D and E were reported as filming in a resident room of staff pole dancing (erotic dancing on a pole) in November 2017. During a interview on 3/12/18 at 10:50 am, the Administrator stated NA B and CNA D no longer employed at facility and CNA E was suspended due to prior cell phone violations. During an interview on 3/12/18 at 11:40 am, Licensed Nurse (LN) A stated around November 2017, she walked into an all male resident room with four beds when she saw NA B and CNA D dancing on a resident transfer pole (residents use for support when standing up). CNA D was video taping on cell phone of NA B dancing on the pole. LN A stated NA B and CNA D were planning on sending it to CNA E. LN A stated only one resident was in the room Resident 2. LN A had them delete the video and gave them a verbal warning for violation of cell phone policy. LN A confirmed she did not report this as abuse due to being worried due to NA B was the Administrator's child. LN A stated the Administrator determined what was abuse and what was reportable.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and record review the facility failed to ensure facility staff reported all allegations abuse using electronic devices when an inappropriate video was recorded in a room that had four residents. This failure had the potential to expose all residents' to abuse. Findings: The facility policy titled Abuse Prevention and the Reporting of Alleged Abuse and Suspicion of Crime revised 11/2016, was reviewed. Under Reporting, it indicated all mandated reporters are required by law to report incidents of known or suspected abuse by telephone or written report within two days to California Department Public Health (CDPH). First responder or first staff member informed shall by responsible for informing immediate supervisor and initiating incident report. The Licensed Nurse shall document objective data in medical record and initiate care plan to prevent further occurrence. A facility reported incident dated 2/26/18 at 7:57 am, indicated one Nursing Assistants (NA, not certified) B and a Certified Nursing Assistants (CNA) D and E were reported as filming in a resident room of staff pole dancing (erotic dancing on a pole) in Nonmember of 2017. During an interview on 3/12/18 at 11:40 am, Licensed Nurse (LN) A stated around November 2017, she walked into an all male resident room with four beds when she saw NA B and CNA D dancing on a resident transfer pole (residents use for support when standing up). CNA D was video taping on cell phone of NA B dancing on the pole. LN A stated NA B and CNA D were planning on sending it to CNA E. LN A stated only one resident was in the room Resident 2. LN A had them delete the video and gave them a verbal warning for violation of cell phone policy. LN A confirmed she did not report this as abuse to anyone due to being worried due to NA B was the Administrator's child. LN A stated the Administrator determined what was abuse and what was reportable.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Keep all essential equipment working safely.** Based on interview and record review the facility failed to ensure their back up generator was functional during a power outage for an hour and did not call for service to determine the cause timely. This failure had the potential for all residents to at risk during a power outage without generator back up to provide quality of care. Findings: During an interview on 4/12/18 at 1:30 pm, the Dietary Services Supervisor (DSS) stated last week on Friday 4/6/2018, the generator did not come on during a power outage that lasted about an hour. During a concurrent observation and interview on 4/12/18 at 1:30 pm, the Maintenance Supervisor (MS) started within 5 seconds and stated there were no issues with the generator last Friday 4/6/18. During a concurrent interview and record review on 4/12/18 at 3:10 pm, the Maintenance Assistant (MA) stated there were not issues with the generator last Friday, 4/6/2018, when there was not power for about an hour. A review of the emergency generator visual log indicated the generator was run for 30 minutes with no issues. During an interview on 4/12/18 at 3:30 pm, MS when questioned again about the generator during the power outage last week, he stated I was not here, MA jump started the generator battery with a car battery. MS confirmed no service request was made to check the generator and no new battery had been ordered. During an interview on 4/12/18 at 3:45 pm, the Director of Clinical Services stated she was unaware of the generator battery issue and would get a new battery. A review of a document dated 12/20/16, indicated the battery for the generator was replaced back in 12/2016.

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.