STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555281	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OROVILLE HOSPITAL POST-ACUTE CENTER	**1000 EXECUTIVE PARKWAY OROVILLE, CA 95966**

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 ensure one of two sampled resudents (Resident 1) was free from intimidation and physical abuse when Resident 2 hit Resident 1 in the face on 2/17/20. This had the potential to cause physical injuries that could negatively impact Resident 1's emotional and psychological well-being. Findings: A review of the facility's policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property Prohibition, undated, defined physical abuse as the infliction of injury including hitting or slapping resulting in physical harm, pain or mental anguish. The policy statement indicated that each resident has the right to be free from any abuse such as physical and be free from mistreatment. On 2/18/20, the California Department of Public Health (CDPH) received a report that on 2/17/20 at 6 pm a Licensed Nurse (LN) A heard screaming, and when he entered Resident 1 and 2's room, Resident 1 claimed Resident 2 had hit him in the face. A review of Resident 1's record indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 1 was his own responsible party (RP) and had the capacity to understand and make his own health care decisions. A review of the most recent Minimum Data Set (MDS, an assessment tool) dated 12/27/19, indicated Resident 1 had intact cognition (able to think and reason) and not having any signs of [MEDICAL CONDITION] (restlessness, disorganized thoughts that can include hallucinations) and required extensive assistance from staff for bed mobility, transfers and toilet use. A review of Resident 2's record indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A MDS, dated [DATE], indicated Resident 2 had cognitive deficits (mentally impaired) and required limited assistance from staff for bed mobility and transfers. A review of nursing progress notes from 12/8/19 to 2/20/20 indicated Resident 2 was alert, oriented and with period of confusion. During an interview with Resident 2 on 2/25/20 at 2:10 pm, he stated his old room mate was across the hall now and that he yelled all night long. He denied hitting or slapping Resident 2. On 2/25/20 at 2:30 pm Resident 1 was interviewed. Resident 1 was alert and was able to state the year and the name of the facility. He stated he recalled an incident that occurred this month with his old roommate across the hall. Resident 1 stated it happened in the evening just before he was going to go to bed. He stated Resident 2 walked over to his bed, poked his head through the curtain and punched him in the face. He stated it pissed him off, still thinks about it and does not feel safe here. Resident 1 stated he still gets upset and angry about the incident. On 2/25/20 at 3:30 pm, the Assistant Executive Director (AED) was interviewed. He stated he was on another hall when LN A came to him and informed him that Resident 1 and 2 were yelling at each other and that Resident 1 accused Resident 2 of hitting him. On 2/27/20 at 5 pm LN A was interviewed. He stated the incident happened on the pm shift and believed the curtain was drawn between the residents. He stated he heard Resident 1 yelling for help, and he stated verbatim .Help me. Help me. Resident 1 stated that Resident 2 had hit him. LN A stated when he ran into the room he observed Resident 2 walking towards his bed. He stated Resident 2 denied hitting Resident 1 and had no recollection of the incident. During an interview with the facility Social Worker (SW) on 3/4/20 at 2:15 pm, he stated he considered Resident 1 alert, oriented, abble to verbalize needs and that he was his own responsible party. During a concurrent interview and record review with the Director of Nurses (DON) on 3/4/20 at 3 pm, he stated Resident 1 was his own RP and did not have a [DIAGNOSES REDACTED].

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.