| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **555221** | A. BUILDING _____ B. WING _____ | **07/03/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **SURPRISE VALLEY COMMUNITY HOSPITAL D/P SNF** | **741 N. MAIN STREET CEDARVILLE, CA 96104** |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to keep one of one sampled residents (Resident 1) safe from verbal and physical abuse from Staff A, when she reacted to her touching food and supplies on the medication cart. This failure placed the resident at risk for injuries both physical and psychological, which could lead to negative clinical outcomes. Findings: In an interview, with Staff B on 6/2/20 at 8:25 am, she reported that on Sunday, 5/31/20, around 2:15 pm, she witnessed Resident 1 in her Merry Walker (an assistive device to promote independent walking) at the medication cart next to the nurse's station. Resident 1 has dementia and was noted to be using her fingers to eat uncovered applesauce that was sitting on top of the cart. Staff A stated loudly to Resident 1, You don't run the show just cause you used to be a nurse and you are older than dirt. Sometimes I just want to ram you with this cart! Staff B then stated that she saw Staff A take her arms and place them on Resident 1's shoulder and push her in her Merry Walker, which caused the resident to almost lose her balance. The resident was able to retain her balance by grabbing the handles of the Merry Walker. The resident then wandered away, apparently unaffected by the incident. During an interview, with Staff C on 6/2/20 at 10:50 am, she confirmed that she also observed this incident and stated that Staff A seemed extremely frustrated with Resident 1, and further stated that she should have handled this situation differently. Resident 1 was originally admitted to this facility on 11/2/15, with [DIAGNOSES REDACTED]. The facility's Minimum Data Set (an assessment tool), dated 6/2/20, indicated that Resident 1 was severely cognitively impaired. Resident 1 was observed on 6/2/20 at 9:55 am, in the activity room in her Merry Walker. Resident 1 was alert, but not oriented to date or time. Resident 1 did not remember the incident, and was unable to be interviewed. According to a written statement prepared by the facility's Director of Nursing (DON) dated 6/1/20, Staff A had resigned from her position following this incident indicating that she was old and worn out, and this job was difficult with the computer program, and all the interruptions. The facility's policy titled, Patient/Resident Abuse Report, dated 11/18, was reviewed and indicated that it the policy of this facility to provide a safe, secure environment for all clients who reside and/or who are provided health care services within this facility. All residents will be protected from abuse through an ongoing aggressive program of education and prevention. |
| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br><br>Based on interview, and policy review, the facility failed to fully implement it's abuse policy for the protection of one of one sampled residents (Resident 1) during an investigation of an alleged abuse. This failure placed the residents at risk for further and/or continued injuries both physical and psychological, which could lead to negative clinical outcomes. Findings: An onsite investigation was conducted on 6/2/2020, after the facility reported a suspected allegation of abuse occurring between Staff A and Resident 1 on 5/31/20. (See F 600) The facility's policy titled, Patient/Resident Abuse Reporting, dated 11/18, was reviewed and indicated that the facility will protect the resident from harm during an investigation. If a staff member is implicated in resident abuse, the staff member will be immediately removed from their assignment. During an interview, with the Administrator (Admin) on 6/2/20 at 9:10 am, he reported that he was notified of this incident by the Director of Nursing (DON) at about 3 pm on 5/31/20. The Admin stated, Since the nursing supervisor had reported that Resident 1 was ok, and that Staff A's shift ended at 6:30 pm, I decided to just let Staff A finish her shift. |

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.