STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555798	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODSIDE HEALTHCARE CENTER	**2240 NORTHROP AVE SACRAMENTO, CA 95825**

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 -** 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 observation, interview, and record review, the facility failed to ensure residents were free from sexual assault when 1 male resident (Resident 3) touched the private parts of 2 male residents (Resident 1 and Resident 2) in a 58-bed facility. The facility failed to move Resident 3 to a single room or provide 1:1 supervision as directed by the care plan. This failure resulted in Resident 1 feeling uncomfortable living in the facility, Resident 2 having emotional distress, and potential residual effects for Resident 4, Resident 5, and Resident 6. This failure increased the risk for non-consensual contact with other residents. Findings: Record review of Resident 1's face sheet indicated Resident 1 was legally blind and resided in the facility long term with [DIAGNOSES REDACTED]. During record review of the most recent Minimum Data Set (MDS, an assessment tool), dated 9/9/19, indicated Resident 1 scored 11/15 on the Brief Interview for Mental Status (BIMS) assessment. The score indicated Resident 1 had moderately impaired cognition. In a concurrent observation and interview on 10/17/19 at 10:45 a.m., Resident 1 was lying in his bed wearing black sunglasses. Resident 1 voiced that about a week ago at approximately 5 a.m., his former roommate, Resident 3, climbed into his bed and touched him inappropriately while he was sleeping. Resident 1 stated he yelled at Resident 3 to get the hell out and pushed his hands away. Resident 1 stated he was aware Resident 3 had a history of [REDACTED]. Resident 1 stated Resident 3 did not touch him inappropriately prior to the incident. Resident 1 indicated the facility relocated Resident 3 to a different room with another male resident. Resident 1 complained he was, Uncomfortable because he (Resident 3) is in the same building .still in the area. Resident 1 stated, I am sorry .He (Resident 3) is going to do it again. He's sick .He should have gone a long time ago. Record review of Resident 3's face sheet indicated Resident 3 was a long term resident in the facility with [DIAGNOSES REDACTED]. During record review of the MDS, dated [DATE], indicated Resident 3 had a BIMS score of 14/15 indicating he had intact cognition. During record review of Resident 3's clinical record, Progress Notes, dated 10/10/19 at 5:45 p.m., indicated, This morning at aprox 0500 (approximately 5 a.m.) this residents (sic) roommate was yelling for the nurse to come to his room. This residents (sic) roommate stated .this resident was attempting to climb into his bed and touched him on his thigh and butt. Residents (sic) roommate states he pushed this resident. In an interview on 10/17/19 at 11:11 a.m., Licensed Nurse 1 (LN 1) stated Resident 3 had a history of [REDACTED]. During record review of Resident 4, Resident 5, and Resident 6's clinical records, the face sheets and progress notes indicated Resident 3 was involved in sexually inappropriate behaviors multiple times as follows: Record review of Resident 4's face sheet indicated Resident 4 was a short term resident at the facility for rehabilitation therapy after a [MEDICAL CONDITION]. During record review of Resident 4's clinical record, Progress Notes, dated 4/11/19 at 2 a.m., indicated, .CNA (Certified Nurse Assistant) reported .a male Resident (Resident 3) was found in room (Resident 4's room number) .Resident (Resident 4) was crying, with a report that another male Resident in (Resident 3's room number), wandered into her room, kissed her on the right cheek, opened her brief and touched her private part. During record review of the clinical record, the face sheet indicated Resident 5 was a long term resident in the facility with [DIAGNOSES REDACTED]. During record review of Resident 5's clinical record, Progress Notes, dated 4/11/19 at 8 p.m., indicated, .on 4/10/19 aprox 9:45 (approximately at 9:45 p.m.) .observing a male resident (Resident 3) coming out of her room (Resident 5). Nursing states they went in room and noticed that resident was in bed, with her gown pushed up .She (Resident 5) has [DIAGNOSES REDACTED]. Record review of Resident 6's face sheet indicated Resident 6 was a short term resident at the facility with [DIAGNOSES REDACTED].was sleeping in bed, felt her sheets move on her R (right) side, and thought she was dreaming of her dog snuggling as he does at home. When sheets were completely removed pt woke to a outline of man crouching at R bedside .Pt states the male then reached out, and began to grab her brief, attempting to pull it off .she attempted to refuse advances, when that didn't work .she began screaming. Pt states this spooked male into abruptly standing and hurriedly he left the room .she got up and saw pt (patient, Resident 3) walking quickly into room (Resident 3's room number) .(Resident 6) .move to . other side of building due to pt (patient, Resident 6) vocalization of not feeling safe. Record review of Resident 3's clinical record included care plans related to sexually inappropriate behaviors as follows: A care plan, dated 1/25/19, for behavior problems related to sexual inappropriateness with the goal to have fewer episodes of (SPECIFY: sexual inappropriateness .by review date. The care plan was updated on 4/11/19 with a new intervention of monitoring the resident every 15 minutes 24 hours a day/7 days a week (24/7). The care plan was revised on 7/20/19 to continue monitoring the resident every 15 minutes 24/7. A care plan, initiated 7/20/19, for recurrent wandering into other patient's room and inappropriately touching female residents. The goals for the care plan included, Resident will not have inappropriate behavior towards other residents. The interventions included to check the resident every 15 minutes 24 hours a day 7 days a week. A care plan, initiated 7/20/19, for Pt (Resident 3) to have one-on-one sitter during NOC (night) shift. The intervention included having CNAs on NOC shift rotate through one-on-one sitter duties. The care plan was revised on 9/23/19 with the target date of [DATE] which indicated the care plan was in effect. In an interview on 10/17/19 at 11:22 a.m., the Director of Nursing (DON), in the presence of the Administrator, stated Resident 3 had a long history of touching female residents inappropriately but had not advanced to male residents prior to the incident with Resident 1. The DON stated the facility relocated Resident 3 immediately to a different location and was roomed with another male resident (Resident 2) due to a single room not being available since the incident on 10/10/19. In an interview on 10/17/19 at 11:50 a.m., the DON verified Resident 3 was not on 1:1 monitoring as directed by the care plan but continued to be on 15-minute checks in the new location by staff for his whereabouts. However, the DON acknowledged the 15-minute check was ineffective to prevent inappropriate sexual behaviors since repeated sexual behaviors had occurred while Resident 3 was on 15-minute monitoring. Record review of Resident 2's face sheet indicated Resident 2 was a long term resident in the facility with [DIAGNOSES REDACTED]. In an interview on 10/30/19 at 10:40 a.m., Resident 2 voiced his former roommate (Resident 3) climbed into his bed, lied next to him and touched his penis. While speaking, Resident 2 pointed to his private part to explain what happened. Resident 2 stated he pushed Resident 3 and yelled, Get out of here but Resident 3 continued touching him. Resident 2 then hit Resident 3's arm and Resident 3 fell out of the bed. Resident 2 stated, I didn't like it .I was shocked .angry, mad. Resident 2 appeared to be shocked and frustrated, and stated, (It) never happened before. Resident 2 stated Resident 3 was still visible in the facility and he was able to see Resident 2 in bed from the hallway and stated, .I don't want to see him .I want he's (sic) out of the facility. Resident 2 indicated he did not want to talk about the incident any further. In an interview on 10/30/19 at 11 a.m., the Administrator stated Resident 2 indicated he did not remember the alleged sexual assault on 10/25/19, the day following the incident, when the Administrator interviewed him. In an interview on 10/30/19 at 11:20 a.m., CNA 1 stated Resident 3 had a history of [REDACTED]. CNA 1 stated once, date unknown, Resident 3 attempted to touch her. In an interview on 10/30/19 at 11:33 a.m., CNA 2 stated Resident 3 had a long history of inappropriate sexual behaviors towards other residents in the facility. CNA 2

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.

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) stated a female resident reported to CNA 2 that Resident 3 approached her and tried to remove her underwear. In a concurrent interview and documentation review on 10/30/19 starting at 11:40 a.m., the Social Service Director (SSD) indicated Resident 2 stated, I don't know .I don't remember when she interviewed and assessed the resident's psychological status about the sexual assault from his roommate. The SSD stated she could not tell whether Resident 2 refused to discuss it or was not able to remember the incident then. The facility census and the room occupancy reports, Resident Roster, for the period 10/11/19 to 10/25/19, were reviewed with the SSD. During the period, 10/11/19 to 10/25/19, there were 8 days when a single room was available for Resident 3 to be relocated as indicated in the care plan in an attempt to prevent the potential sexual assault to Resident 2. A single room was available on 10/14/19, 10/16/19, 10/17/19, 10/18/19, 10/19/19, 10/20/19, 10/22/19, and 10/23/19 prior to 10/25/19 when Resident 3 was found on the floor next to Resident 2's bed. The SSD verified the vacancies. The SSD acknowledged if Resident 3 been relocated to a single room, the sexual assault on 10/25/19 to Resident 2 could have been prevented. In a telephone interview on 10/30/19 at 2:50 p.m., CNA 3, who witnessed Resident 3 on the floor next to Resident 2's bed on 10/25/19, stated Resident 2 was upset and crying when she asked what had happened. CNA 3 stated Resident 2 reported Resident 3 touched his private part. CNA 3 recounted that she went to the residents' room to check when Resident 3's bed alarm went off. CNA 3 recollected the door was closed when she went to the room which she thought was unusual. CNA 3 stated most of the time the door to the room was left open and staff was able to check the residents from the hallways. Review of the facility's policy and procedure, Abuse Prevention Program, revised 5/1/19, stipulated, Our residents have the right to be free from abuse, neglect .Our facility is committed to protecting our residents from abuse by anyone including .other residents The implementation of changes to prevent future occurrences of abuse. Record review of Resident 3's clinical record included a care plan, revised 10/17/19, for 10/10/19-wandering into roommate/male resident bed, touching resident, indicated the goals included, .resident will not have inappropriate behavior towards other residents. The new implementations to achieve the goals included, .relocate resident in room without roommate when available. In an interview on 10/30/19 at 1:40 p.m., the Administrator verified the 10/17/19 care plan intervention to relocate Resident 3 to a single room without a roommate to prevent further inappropriate behavior. The Administrator verified the vacancy of the rooms available for the period between 10/10/19, a sexual assault to his roommate, Resident 1, and 10/25/19, another sexual assault to his roommate, Resident 2. The Administrator acknowledged the care plan intervention to relocate Resident 3 to a single room should have been implemented to prevent the incident to Resident 2 since Resident 3 would not have had a roommate in the single room.