STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056259	A. BUILDING _____ B. WING _____	**05/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHVINE POSTACUTE CARE	**446 ARROWOOD DR SANTA ROSA, CA 95407**

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 prevent one resident (Resident 1) from physically abusing another resident (Resident 2), when the facility did not provide individualized, care planned interventions to ensure Resident 1, who had a history of [REDACTED]. This failure resulted in Resident 1 knocking Resident 2 to the ground and Resident 2 suffering a [MEDICAL CONDITION] (a deep cut) that required four medical staples (designed to close incisions and lacerations). Findings: Review of a California Department of Public Health Intake Information report, dated 9/26/19, indicated the facility reported a resident to resident abuse, when facility staff heard a scream and found Resident 1 standing over Resident 2 who was on the floor. The report indicated the facility reported blood on the floor, and Resident 1 told staff she knocked out Resident 2 because Resident 2 .was giving her (Resident 1) smart talk. During an initial observation on 10/1/19 at 2:15 p.m., Resident 1 and Resident 2 had shared a 4-person bedroom with a bathroom and there were 4 small closets on one side of the room. Resident 1 was walking with a steady gait, from the dining room to her bedroom. Resident 1's room assignment was changed after the incident on 9/25/19, placing her on a different hall. Resident 2 was ambulatory and talking with another resident. During a concurrent interview, Resident 2 stated she had been talking to a friend and Resident 1 had been standing by the bedroom door. Resident 2 stated, I went to close the door, she (Resident 1) was talking but I don't know what, she hit me in the face and hit me again. I fell and hit my head and I have four staples. A review of Resident 2's Nurse Progress Notes, dated 9/25/19, at 11:05 a.m., indicated Licensed Nurse A documented that on 9/24/19 at approximately 4:30 p.m. she heard screaming and yelling coming from the vicinity of hallway. The nursing note indicated Licensed Nurse A saw Resident 2 lying on the floor bleeding profusely from a scalp wound. When questioned Resident 2 told Licensed Nurse A that Resident 1 had .hit her a few times and pushed her hard so that she fell . and hit her head. The progress note indicated when Licensed Nurse A questioned Resident 1, Resident 1 told the nurse that Resident 2 had been talking smart to her. During an interview on 10/1/19, at 1:45 p.m., Social Worker (SW) stated Resident 2 had reported an incident earlier in the month between Resident 1 and herself, but they were not able to discern if it had actually happened. Review of Resident 2's Social Service Progress Notes, dated 9/10/19, at 12:09 p.m., indicated Resident 2 reported to the Social Worker (SW) that while getting ready for a shower on 9/9/19, at approximately 5:50 P.M., her roommate, Resident 1, confronted her. The progress note documented that Resident 1 said to Resident 2, .What are you doing in my closet? (Resident 2's) response was 'it's everybody's closet.' The progress note indicated Resident 2 told SW that Resident 1 then grabbed her (Resident 2) by her upper arm, punched her in the left side of her face and (slapped) her right cheek. During an interview, on 10/1/19, at 4 p.m., Licensed Nurse B sated, Resident 1 had a history of [REDACTED]. Review of Resident 1's Nursing Care Plan, revised 9/17/19, indicated Resident 1 had been observed to be .physically and verbally aggressive towards other residents. Will curse, belittle, and make fun of other residents .roommate in past has reported (Resident 1 named) to be verbally and physically abusive. The care plan did not indicate what interventions staff should do for signs of aggressive behavior towards others or abuse prevention. During an interview on 10/1/19, at 2 p.m., Director of Nursing stated she was aware of Resident 1's anger and that staff should re-direct Resident 1 when needed. Review of the facility's policy, Resident to Resident Altercations, dated 1/2018, instructed: Facility staff will monitor residents for aggressive/inappropriate behavior towards other resident .Review the events with the Nursing Supervisor and Director of Nursing and possible measures to try to prevent additional incidents: Make any necessary changes in the care plan approaches to any or all of the involved individual, and Document in the resident's clinical record all interventions and their effectiveness.

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.