STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055499	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCKY POINT CARE CENTER	**625 16TH STREET LAKEPORT, CA 95453**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 **Level of harm -** Immediate jeopardy **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 two residents (Residents 34 and 32) were free from abuse, when facility staff did not: 1) Ensure Resident 34's safety from a known risk of verbal and physical abuse posed by Resident 3. Due to the facility's failure to ensure Resident 34's safety from abuse, the Administrator and Director of Nursing were verbally notified of an Immediate Jeopardy situation on 1/7/20, at 4:15 p.m. The Administrator and Director of Nursing were informed of the observations, interviews with staff, and record reviews, which evidenced a gap in care exposing Resident 34 to harm. On 1/7/19, at 7:06 p.m., the facility presented and implemented a corrective Plan of Action, including, but not limited to: Use of one-to-one assignments for managing resident behaviors to mitigate safety risks, competency training for all staff assigned to one-to-one assignments, and development of individualized care plans to guide clinical management for residents at risk for abuse or receiving one-to-one supervision. Removal of the Immediate Jeopardy occurred in the presence of the Administrator, Director of Staff Development (DSD), Licensed Staff I, Corporate Area President, Corporate Staff GG, Corporate Staff HH, and Corporate Staff II on 1/10/20, at 2:52 p.m., after observations, interviews and record reviews confirmed staff members tasked with a one-to-one assignment had been trained consistently and implemented one-to-one assignments consistently, and the facility developed the necessary care plans; and, 2) Ensure Resident 32's safety from being the victim of abuse, a risk of which the facility was aware. These failures did not ensure a safe environment and exposed Residents 34 and 32 to the abusive behavior of other residents. Findings: 1) Resident 3's Minimum Data Set (MDS, an assessment tool), dated 10/30/19, indicated Resident 3 was admitted to the facility from an, acute hospital on [DATE]. The MDS indicated Resident 3 received a, summary score of 03(/15) during a cognitive assessment, indicating he had severely impaired cognition. The MDS indicated Resident 3 exhibited no adverse behaviors or moods affecting his psychosocial well-being. The MDS indicated Resident 3 had no, neurological or psychiatric/mood disorder, diagnoses, but was diagnosed with [REDACTED]. Resident 34's Minimum Data Set (MDS, an assessment tool), dated 11/5/19, indicated Resident 34 was admitted to the facility from an, acute hospital on [DATE]. The MDS indicated Resident 34 received a, summary score of 07(/15) during a cognitive assessment, indicating she had severely impaired cognition. The MDS indicated Resident 34 exhibited no adverse behaviors or moods affecting her psychosocial well-being. The MDS indicated Resident 34 had no, neurological or psychiatric/mood disorder, diagnoses. During an observation on 12/20/19, at 10 a.m., a female staff member sat in an office adjacent to the facility's front door. A, STOP sign, secured across the office's doorway, precluded ingress and egress to the office. An unidentified female resident sat in a wheelchair staring out of the front door toward the driveway. During a concurrent interview and record review on 1/6/20, at 10:45 a.m., Administrator A stated she was the Abuse Coordinator at the facility. Administrator A stated she was accountable for investigating allegations of abuse in the facility, and she, the Social Services Director (SSD), and Director of Nursing (DON) facilitated abuse investigations at the facility. Administrator A stated the facility recently, separated residents who were, husband and wife, due to behaviors between the two residents. Administrator A stated Resident 3 required a, one-to-one assignment, in the evening. During a concurrent observation and interview on 1/6/20, at 12:45 p.m., Resident 20 called out in a loud volume audible from an adjacent room: Get out! This is not your room! On entering her room, Resident 20 was lying in bed. No staff were inside Resident 20's room or in the hallway. When asked about her concern, Resident 20 pointed in the direction of her bathroom. Resident 3, a male resident, sat in a wheelchair inside Resident 20's bathroom. Resident 3 stated he was, just trying to find . , but did not finish his sentence. Resident 3 exited Resident 20's bathroom and then the room. Resident 20 stated she had, hit the call light, but no staff had responded. Resident 20 stated this was the, first time she observed Resident 3 inside her room. Resident 20 stated she knew of Resident 3: His wife is here. They sleep in separate rooms. Resident 20 stated Resident 3, pursues me more since his wife moved rooms. During an observation on 1/6/20, at 12:50 p.m., a, STOP sign was placed across Resident 20's doorway. During an interview on 1/6/20, at 12:50 p.m., Resident 3 stated he entered Resident 20's bathroom because he was, waiting for a car to pick me up. Resident 3 stated there was, nothing in Resident 20's room, that I need. During an interview on 1/6/20, at 12:56 p.m., Unlicensed Staff EE stated he was a Certified Nurse Assistant (CNA) familiar with Resident 3's care needs. Unlicensed Staff EE stated Resident 3 was, normally independent, but required one-person assistance with toileting. Unlicensed Staff EE stated Resident 3 exhibited, verbal aggression. Unlicensed Staff EE stated Resident 3 was, mentally abusive to Resident 34. Unlicensed Staff EE also stated Resident 3 threatened to, hit other residents and staff, and actually did, hit his wife (Resident 34) on an earlier occasion. Unlicensed Staff EE stated, (Resident 3's) brother, was available to, come in and help (Resident 3) participate in care, if Resident 3 behaved unreasonably toward staff. In regard to the facility's plan to monitor Resident 3's behavior, Unlicensed Staff EE stated Resident 3, can do what he wants, and go where he wants. Unlicensed Staff EE stated the facility did not impose a, one-to-one, staff assignment for Resident 3. Unlicensed Staff EE stated the facility, cannot provide 24-hour observations, of Resident 3. Unlicensed Staff EE stated the facility kept other residents safe from Resident 3 by, guid(ing) other residents, past Resident 3 upon encountering him in a common area. Unlicensed Staff EE stated the facility used, stop signs, too, to prevent Resident 3 from entering other resident rooms. Unlicensed Staff EE stated, additionally, facility staff, keep an eye on, Resident 3. When asked how frequently staff kept an eye on Resident 3, Unlicensed Staff EE stated, as best as we can. During an observation on 1/6/20, at 1:05 p.m., Resident 3 was seated in his wheelchair near the front lobby door to the facility. Resident 3 faced Resident 34, who was also seated in a wheelchair. At most, one-to-two-feet of space separated Residents 3 and 34. Resident 3 and Resident 34 were engaged in conversation and appeared to be arguing. Then, Resident 3 lifted his leg from the wheelchair's foot rest and a made a kicking motion toward Resident 34. Resident 3 did not make contact with Resident 34. Two staff observed the interaction between Resident 3 and Resident 34. Neither staff placed themselves between Residents 3 and 34, or vocalized the clinical inappropriateness of Resident 3's action. A female staff stated, I think (Resident 34) has to use the restroom, and wheeled Resident 34 way from Resident 3. During an interview on 1/6/20, at 1:45 p.m., Licensed Staff H stated she was Resident 3's nurse and familiar with the interactions between Residents 3 and 34. Licensed Staff H stated, between Thanksgiving and Christmas of 2019, Resident 3, cornered (Resident 34), while both resided in the same room. Licensed Staff H stated, we are all trying, to keep Resident 34, at a safe distance, from Resident 3. Licensed Staff H described the safe distance as using a, different hallway, than Resident 3, to assist Resident 34 through the facility. Licensed Staff H stated Resident 3 exhibited, seeking behavior, toward Resident 34, and, staff have to keep an eye on him. Licensed Staff H stated Residents 3 and 34, need to be in separate locations, of the facility. During a concurrent observation and interview on 1/7/20, at 10:08 a.m., Resident 3 was lying down in his room. Resident 3 stated he, feels safe, at the facility, but, I do not feel safe now. Resident 3 stated another man, stole his wife, (Resident 34), and some

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) way or another he's had help from the city and it worked. Resident 3 stated he woke up and his, wife's gone. Resident 3 stated he did not know the name of the man who stole his wife. Resident 3 stated he would use a, pistol on (the man who stole his wife) . but I don't want to go to jail. During an interview on 1/7/20, at 11:18 a.m., Administrative Staff FF stated she was the facility's receptionist. Administrative Staff FF stated she was present when Residents 3 and 34 interacted in the facility lobby area after lunch on 1/6/20. Administrative Staff FF stated she did not remember what the residents said to each other. Administrative Staff FF stated Resident 34 said something, but Resident 3, misheard it. Administrative Staff FF stated she saw Resident 3 try to kick Resident 34, out of the corner of her eye. Administrative Staff FF stated she did not step-in before Resident 3's kick, because they were just talking. Administrative Staff FF stated she was in the lobby that day due to her role as facility receptionist. Administrative Staff FF stated the facility did not task her with resident supervision in the reception area. Yet, Administrative Staff FF stated she, keeps an eye out for all residents, generally. During an interview on 1/7/20, at 11:38 a.m., Unlicensed Staff T stated he was present in the lobby area when Residents 3 and 34 interacted after lunch on 1/6/20. Unlicensed Staff T stated he, saw (Resident 3) kick at (Resident 34). Unlicensed Staff T stated he and the receptionist were present at the time. Unlicensed Staff T stated, no nurses were in the area. Unlicensed Staff T stated, I've been told to step-in for (Resident 3) if (Resident 3) gets physical. Unlicensed Staff T stated he would step-in, when I'm in the hallways and if nursing is not around. Unlicensed Staff T stated he was not formally trained on how to manage Resident 3's or Resident 34's behaviors. During an interview on 1/7/20, at 1:40 p.m., the Director of Staff Development (DSD) stated she trained staff on abuse and dementia, annually, on orientation, and, as needed. The DSD stated she trained staff on the duties of a, one-to-one assignment on 12/20/19, for about, 20 minutes. The DSD stated she trained staff individually, face-to-face, because staff prefer(red), that method of training. The DSD stated, all staff were trained on, potential abusive situations. During an interview on 1/7/20, at 2 p.m., Unlicensed Staff T verified he received face-to-face training on identifying abuse. Unlicensed Staff T stated the training was, general, and not specific to any one resident. During an interview on 1/7/20, at 2:10 p.m., the Director of Nursing (DON) stated licensed nurses, nursing administration, therapy, and the activities or Social Services Director, may initiate a resident care plan, or modify an existing resident care plan. The DON stated a care plan, applicable to nursing, would indicate, nursing staff on the care plan. The DON stated if a care plan indicated, all staff, then it applied to all staff in the facility. The DON stated the facility used a, template to create its resident care plans. The DON stated, staff are meant to modify the template, in order to make an individualized care plan. Regarding Resident 3's plan of care, the DON stated Resident 3 exhibited, paranoid behavior and had, held (Resident 34) hostage, when the two were admitted to the same room, and did not let staff in. The DON stated Resident 3 had a history of [REDACTED]. During a concurrent interview and record review on 1/7/20, at 3:40 p.m., the DON reviewed all open care plans for Resident 34, and stated the facility currently had, no care plan, to protect Resident 34 from Resident 3's pursuits and abusive behaviors. During a review of Resident 3's clinical record, the Care Plan, revised 10/24/19, at 11:14 a.m., indicated the facility planned to care for Resident 3's psychosocial needs and well-being related to, depression, mental illness, and other, care needs, which required placement at the facility. According to this care plan, the facility did not plan to manage Resident 3's psychosocial needs and well-being arising from Resident 3's relationship with Resident 34. During a review of Resident 3's clinical record, the Care Plan for Activities, revised 1/7/20, at 9:58 a.m., indicated Resident 3, spends most of his day worried about his wife and what she is doing and where she is located. . (Resident 3) at times confuses other residents for his wife and can become upset when redirected and reassured . and believes we are lying to him. During a review of Resident 3's clinical record, the Care Plan, revised 1/8/20, at 12:03 p.m., indicated the facility planned to care for Resident 3's, combative behaviors. The care plan indicated Resident 3, aggressively seeks (Resident 34) out, mistakes other women for being (Resident 34) . and will follow them . The care plan indicated Resident 3's combative behaviors increased if unable to locate his wife (Resident 34). The care plan indicated Resident 3 had attempted, to hold (Resident 34) hostage in rooms. During a review of Resident 3's clinical record, the Behavior Monitoring Administration History, dated 1/2020, indicated, every shift staff must, monitor (Resident 3's) episodes of dementia (with [MEDICAL CONDITION], as evidenced by) striking out (with) delusions. The monitoring record indicated the facility did not record the episode of behavior observed in the lobby between Residents 3 and 34, and observed by Administrative Staff FF and Unlicensed Staff T on 1/6/20, during the, AM shift. During a review of Resident 3's clinical record, the Resident Progress Notes, dated 12/9/19, at 4:51 a.m., indicated Resident 3's wife (Resident 34) was his, roommate. The note indicated the two had, no issues noted. During a review of Resident 3's clinical record, the Resident Progress Notes, dated 12/13/19, at 6:28 a.m., indicated the facility spoke with Resident 3's, (responsible party), who stated the facility should not admit Residents 3 and 34 to, the same room for (Resident 34's) safety. During a review of Resident 3's clinical record, the Resident Progress Notes, dated 12/17/19, at 9:52 a.m., indicated Resident 3's abusive vocalizations and actions toward staff, and his pursuits of Resident 34: Resident responded: 'Don't you worry about my hand. I'll slap you with it. Get out of the road ya hear(?),' as he raised his (hand) up in a motion(,) like he was going to strike me with the back of his hand . 'Don't think I won't either.' . Resident continued to sit in front of the fire door thinking that every woman at the end of the hall is (Resident 34). During a review of Resident 3's clinical record, the Resident Progress Notes, dated 12/17/19, at 10:10 a.m., indicated Resident 3 ambulated with a front-wheeled walker into a room occupied by two female residents. The note indicated its author, ran down to the room to intervene. The note indicated Resident 3 was, yelling and slamming, his walker on the ground. The note indicated Resident 3 yelled: Wake up (Resident 34's name), Wake up! The note indicated Resident 34 did not occupy the room. The note indicated Resident 3, attempted to slam his (walker) down on (a) resident and I was able to grab it before, it reached the resident. The noted indicated Resident 3, then grabbed his (walker) and attempted to hit me with it. . I reported this incident to Administrator, DON, and SSD. During a review of Resident 3's clinical record, the Resident Progress Notes, dated 12/28/19, at 8:58 a.m., indicated Resident 3 yelled, at (Resident 34) to get her, 'g**d*** a** over here, you don't need a smoke and (you're) a stupid b**** if you go outside.' (Resident 3) then came to the dining room and ate (breakfast). During a review of Resident 3's clinical record, the Resident Progress Notes, dated 1/9/20, at 3:48 p.m., indicated the facility's Interdisciplinary Team (IDT) reviewed Resident 3's recent history of behaviors. The note indicated, as of 12/29/19, Resident 3's, verbal and physical behaviors toward staff and (Resident 34) continue. An altercation with (Resident 34) occurred with a resulting skin tear to (Resident 34's) arm. During a review of Resident 3's clinical record, the Resident Progress Notes, dated 12/22/19, at 2 a.m., indicated the facility, removed Resident 34 from Resident 3's room, for safety reasons. The note indicated Resident 3 received a psychiatric evaluation two days prior and the facility now had the medication in house for administration. The noted indicated Resident 3, has been combative with staff and resistant to care. During a review of Resident 34's clinical record, the Resident Progress Notes, dated 12/15/19, indicated the facility initiated a, room change. The note did not indicate the reason for changing rooms. During a review of Resident 34's clinical record, the SOAP Note from Resident 34's physician, dated 12/19/19, indicated the facility had, separated Resident 34, from her husband (Resident 3) because Resident 3 exhibited, behaviors toward Resident 34. During a review of Resident 34's clinical record, the Resident Progress Notes, dated 12/20/19, indicated Resident 34 was inside Resident 3's room. The note indicated Resident 3 was Resident 34's, abusive spouse. The note indicated the two were, arguing and using foul language. The note indicated Resident 3, punched the nurse who tried to separate the two residents. During a review of Resident 34's clinical record, the Resident Progress Notes, dated 12/29/19, indicated Resident 34 received a physical injury, a skin tear on her left hand. The note indicated Resident 34 had been, a victim of a (resident-to-resident) incident with Resident 3. The noted indicated the injury occurred when Resident 3 followed Resident 34 down a hallway and, attempted to restrain Resident 34's movement. The note indicated facility staff cleaned Resident 34's wound, at which time Resident 34, grimace(d) in pain. During a review of Resident 34's clinical record, the Care Plan, revised 10/30/19, indicated facility planned to care for Resident 34's psychosocial needs and well-being related to dementia, mental illness, and other, care needs, which required placement at the facility. The facility did not plan to manage Resident 3's psychosocial needs and well-being arising from Resident 34's relationship with Resident 3. During a review of Resident 34's clinical record on 1/7/20, at 3:40 p.m., the facility maintained no care plan to protect Resident 34 from Resident 3's pursuits and abusive behaviors. During a review of the facility business record, the SOC 341 form for, Report of Suspected Dependent Adult/Elder Abuse, completed 12/29/19, indicated Resident 34 had been the, victim of Resident 3's abuse. The form indicated Resident 3, was seen striking victim with hand (on) her left arm. (Resident 3) proceeded to hit staff with closed fists after that. The form indicated Resident 34 suffered, no physical injury, from the abuse. The facility policy and procedure titled, Abuse Prevention Program, dated 8/2006, indicated the facility's residents, have the right to be free from abuse . and involuntary seclusion. The facility policy and procedure titled, Preventing Resident

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Abuse, dated 12/2006, indicated the facility's abuse prevention/intervention program included, but was not necessarily limited to, the following: . j. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect(.) The facility policy and procedure titled, Abuse and Neglect - Clinical Protocol, dated 10/2010, indicated the facility's, Treatment/Management, portion of the protocol tasked, facility management and staff, as responsible to, institute measures to address the needs of residents and minimize the possibility of abuse . The facility document titled, Final Investigation Report, dated 1/3/20, indicated Resident 3 and Resident 34 had exhibited behaviors, requiring staff redirection, since the incident on 12/29/19. The report indicated the facility plan included, monitoring both (Resident 3 and Resident 34) closely, involving all staff in efforts to redirect when needed. The report did not indicate any reason why the incident occurred, or whether (and why) it could have been prevented. 2) Resident 32's Minimum Data Set (MDS, an assessment tool), dated 11/5/19, indicated Resident 32 was admitted to the facility from, another nursing home or swing bed on 1/18/13. The MDS indicated Resident 32 received a, summary score of 01(/15), during a cognitive assessment, indicating a severely impaired cognition. The MDS indicated Resident 32 exhibited infrequent, physical behavior symptoms directed toward others, which occurred between, one and three days, during the assessment look-back window. The MDS indicated Resident 32 did not exhibit rejection of care or wandering and exhibited no moods affecting psychosocial well-being. The MDS indicated Resident 32 had no, neurological or psychiatric/mood disorder, diagnoses. The MDS indicated Resident 32 suffered from, Non-Alzheimer's Dementia, and also had, additional active diagnoses, including Dementia with Lewy bodies, [MEDICAL CONDITION] with late onset, and other symptoms and signs involving cognitive functions following cerebral infarction, (e.g., stroke). During an interview on 12/18/19, at 11:16 a.m., Unlicensed Staff X stated Resident 32 had unpredictable behavior and a propensity for being combative. Unlicensed Staff X stated Resident 32 had a tendency to squeeze arms very tight, and tried to strike staff members who assisted him with his Activities of Daily Living. During an interview on 12/18/19 at 12:05 p.m., Unlicensed Staff Z stated Resident 32 would flip someone off or swear at them, usually male residents, for no apparent reason while ambulating the hallway. During an observation and interview on 12/20/19, at 10:48 a.m., Resident 32 was lying down on his bed. Resident 32's head of bed was elevated. A new brief rested on Resident 32's feet. A device was wrapped around his ankle, like an anklet. When asked whether he felt safe, Resident 32 was quick to dismiss the question by replying loudly and aggressively, stating, It's ***t! It's just ***t! It doesn't matter! When re-educated that safety did matter, Resident 32 replied: Yea--everything's fine. During an observation on 12/20/19, at 11:30 a.m., Resident 32 remained lying down in bed. Resident 32's head of bed was reclined to flat. During an interview on 12/20/19, at 11:40 a.m., Unlicensed Staff X stated she was Resident 32's Certified Nurse Aide (CNA). Unlicensed Staff X stated she switched to Resident 32's hallway about one month prior. Unlicensed Staff X stated she encouraged Resident 32 to get out of bed. Unlicensed Staff X stated Resident 32 did get up and socialized in the dining room and group activities. Unlicensed Staff X stated she did not know Resident 32's preferred activities and did not recall learning anything about his preferred activities from the licensed nurses or activity staff. Unlicensed Staff X stated, I'm not sure what (Resident 32's) care plan says for activities. Unlicensed Staff X stated Resident 32 used vulgar language in the facility around men and when, male staff provided care. Unlicensed Staff X stated the facility trained her to manage Resident 32's verbal outburst by, redirect(ing the) situation, and informing him, We can't talk like that. Unlicensed Staff X stated, other times, she just moved (the) person (he was) yelling at. Unlicensed Staff X stated she had not witnessed Resident 32 having a physical outburst. Unlicensed Staff X stated she heard, only stories, of physical outbursts. During an observation on 12/20/19, at 12 p.m., Resident 32 was lying down in bed. Upon entering the doorway to inquire about his condition, he yelled, Get out! and showed the middle finger of his hand, stated A**h***! Resident 32's aggression, language and posturing precluded the opportunity for an interview. During a concurrent interview and record review on 1/6/20, at 10:45 a.m., Administrator A stated she was the Abuse Coordinator at the facility, and stated she was accountable for investigating allegations of abuse in the facility, and she, the Social Services Director (SSD), and Director of Nursing (DON) contributed to the facility's abuse investigations. Administrator A stated the facility's care process and medical record system, for victims of abuse, did not require an Interdisciplinary Team (IDT) review: The way the system is setup, an aggressor and the victim require different forms, and the victim form does not have an IDT section to complete. Administrator A stated the facility conducted an IDT meeting every morning after, stand-up. Administrator A stated the IDT decided whether a resident's behavioral health needs required, one-to-one, to more closely supervise the resident. Administrator A stated she was familiar with Resident 32's behaviors: I was just in (Resident 32's room) because he was not happy with the CNA. He didn't take a like to the CNA. Administrator A stated, (Resident 32) takes a dislike to certain people, at certain times, and Resident 32's mood and behaviors were, not predictable. Administrator A added the facility used, telepsych, from a psychiatric nurse practitioner and an, LCSW, or licensed clinical social worker, to manage Resident 32's behavioral health needs. Administrator A also stated the facility used a, third psychologist, if needed. There's not much out there, referencing the behavioral health services available in the facility's county and greater region. During an observation on 1/6/20, at 11:25 a.m., Resident 32 was lying in bed. The head of Resident 32's bed was elevated about 15 degrees, and his eyes were closed. During an interview on 1/6/20, at 11:27 a.m., Unlicensed Staff DD stated she was a CNA and familiar with Resident 32's behaviors. Unlicensed Staff DD stated Resident 32's behaviors showed, no improvement, over the last eight months. Unlicensed Staff DD stated Resident 32 had hit her before, and stated she observed Resident 32 hit other staff. Unlicensed Staff DD stated Resident 32, throws weight, around and used his, elbow and fists to hit staff on their backs, near the kidneys. Unlicensed Staff DD stated she experienced this physical abuse at least once every shift. Unlicensed Staff DD stated Resident 32 refused care and services: Sometimes he won't let us change him and that makes me sad. During an interview on 1/6/20, at 11:40 a.m., Responsible Party 22 stated she began her role as, Conservator, for Resident 32 eight months prior, in 5/2019. Responsible Party 22 stated the facility informed her of Resident 32's incidents with other residents. Responsible Party 22 stated facility staff, haven't made them sound too bad. Responsible Party 22 stated she attended a care conference each, quarter, and most of the time, in person. Responsible Party 22 stated she knew Resident 32 was, still combative, and did not recall having discussed talk therapy or telepsychiatry as a means to manage Resident 32's thoughts and behaviors while in the facility. During an interview on 1/7/20 at 12;12 p.m., Licensed Staff H stated Resident 32 exhibited very aggressive and unpredictable behaviors. Licensed Staff H stated Resident 32's behaviors made it difficult to watch out for him and for the safety of other residents who gather in the hallway to sit and pass time. During an interview on 3/10/20, at 8:50 a.m., Administrator A stated Residents 32 and 18 had a past history of resident-to-resident incidents. Administrator A stated Resident 18 had reported an unwitnessed incident, in 11/2019, when Resident 32 instigated physical contact. Administrator A stated Residents 32 and 18 engaged in another incident, one month later in 12/2019, and witnessed when Resident 18 swore and kicked at Resident 32. Administrator A stated the facility's investigation into the 12/9/19, incident between Residents 32 and 18, indicated the incident was, a chance encounter even though they had a prior history. Administrator A stated the facility's investigation into the 12/9/19, incident indicated the facility could not have prevented the residents' altercation, because facility staff were not expecting anything to happen between Residents 32 and 18, in the dining room. During a review of Resident 32's clinical record, the Resident Progress Notes, between 10/17/19 and 1/9/20, indicated 14 incidents involving Resident 32, arising out of physical or verbal aggression toward staff and other residents. On 10/17/19, at 2:45 p.m., the record indicated Resident 32 attempted to throw hot coffee on a Certified Nursing Assistant (CNA). On 10/21/19, at 4:33 a.m., the record indicated Resident 32 attempted to strike and kick staff while receiving personal care. On 10/25/19, at 2 p.m., the record indicated Resident 32 was observed hitting Resident 7, with his hand. On 10/27/19, at 7:30 p.m., the record indicated Resident 32 and Resident 13, collided in their wheelchairs, causing Resident 13 to strike Resident 32, and Resident 32 to strike Resident 13, thereafter. On 10/29/19, at 3 p.m., the record indicated Resident 32 squeezed Resident 28's arm, which caused bruising. On 11/2/19, at 4 p.m., the record indicated Resident 32 made contact with another resident's wrist. On 11/6/19, at 2:47 p.m., the record indicated Resident 32 was combative with staff while receiving routine personal care. On 11/11/19, at 3:45 p.m., the record indicated Residents 28 and 18, alleged Resident 32 hit each of them while Resident 32 ambulated in a wheelchair through the hallway. On 11/20/19 at 3:52 p.m., staff documented Resident 32 was combative while receiving care. On 11/22/19 at 5:55 a.m., the record indicated Resident 32 was agitated and combative when receiving care to clean his incontinence. On 12/6/19, at 4:58 a.m., the record indicated Resident 32 was yelling and attempting to strike staff. On 12/9/19, at 12 p.m., the record indicated Resident 32 was the victim of an incident in which Resident 18 yelled profanities at Resident 32 and then kicked Resident 32 in the leg with staff nearby. On 12/16/19, at 10:30 a.m., the record indicated Resident 32 shouted profanities at, and attempted to punch, a staff member. On 1/1/20, at 6:37 a.m., the record indicated Resident 32 attempted to punch staff while receiving

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	055499	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCKY POINT CARE CENTER	625 16TH STREET LAKEPORT, CA 95453

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) incontinence care. During a review of Resident 32's clinical record, the Resident Progress Notes, dated 10/27/19, at 7:30 p.m., indicated Residents 32 and Resident 13, collided in their wheelchairs. The record indicated the collision caused Resident 13 to strike Resident 32, which caused Resident 32 to strike Resident 13, in response. During the review of Resident 32's clinical record, the Resident Progress Notes, dated 11/11/19, at 5:45 p.m., indicated Resident 18 verbalized unwanted physical contact by Resident 32, while Resident 18 sat in the hallway. The record indicated Resident 32, passed by (Resident 18) . gave him the middle finger and then, with a closed hand, struck (Resident 18) in the abdomen. The record indicated Resident 18 verbalized no complaint of pain or discomfort. During a review of Resident 32's clinical record, the Care Plan, revised 11/15/19, indicated the facility identified Resident 32 as both, victim and aggressor, of abuse. The care plan indicated its, goal for planning Resident 32's care, sought to ensure Resident 32 did not, harm (himself) or others secondary to inappropriate/disruptive behaviors. The facility did not plan to protect Residen
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy for reporting on abuse investigations, when it did not supply the California Department of Public Health (CDPH) with a copy of its final investigation report for an incident between two residents (Residents 32 and 18), within five working days and without sufficient detail about the facility's investigation. This failure did not ensure timely notification to a state agency to ensure compliance with federal regulations and facility practices for its abuse prevention program. Findings: During an interview on 3/10/20, at 8:50 a.m., Administrator A stated Residents 32 and 18 were involved in a verbal and physical altercation on 12/9/19. Administrator A stated the facility did not submit its final investigation report for the 12/9/19, incident to CDPH within five working days, because, I forgot to send the final report. Administrator A stated the facility's investigation into the 12/9/19, incident between Residents 32 and 18 indicated the incident was, a chance encounter even though they had a prior history. Administrator A stated the facility's investigation into the 12/9/19, incident indicated the facility could not have prevented the residents' altercation, because facility staff were not expecting anything to happen between Residents 32 and 18 in the dining room. During a review of Resident 32's clinical record, the Resident Progress Notes, dated 12/9/19, at 12 p.m., indicated a resident-to-resident incident involving Residents 18 and 32. The record indicated staff brought Resident 32 into a common area, nearby Resident 18. The record indicated Resident 18, said to Resident 32: I'm going to kill you m*****f*****, I hate you, a******. The record indicated Resident 18 then kicked at Resident 32, connecting with Resident 32's right lower extremity. During a review of facility documents, the, Report of Suspected Dependent Adult/Elder Abuse, dated 12/9/19, indicated the facility notified, CDPH on 12/9/19, that Residents 32 and 18 were, in (the) dining room, and Resident 18, said some words (harsh) to (Resident 32) as he was passing by, and Resident 18, kicked his left foot toward (Resident 32), making physical contact with (Resident 32's) right lower leg allegedly. During a review of the facility documents, the Final investigation report for: (Residents 32 and 18) on 12-9-19, dated 12/18/19 (received 12/19/19), indicated Administrator A, forgot to send a final investigation report, on the 16 th. The document indicated no description of the facility's investigation into the events leading up to the incident on 12/9/19. The facility policy and procedure titled, Abuse Prevention Program, dated 8/2006, indicated the facility's Abuse Prevention Program was comprised of, comprehensive policies and procedures . to aid our facility in preventing abuse, neglect, or mistreatment of [REDACTED]. f. Timely and thorough investigations of all reports and allegations of abuse; g. The reporting and filing of accurate documents relative to incidents of abuse(.) The facility policy and procedure titled, Reporting Abuse to State Agencies and Other Entities/Individuals, dated 12/2009, indicated, The Administrator, or his/her designee, will provide the appropriate agencies . with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. The facility policy and procedure titled, Abuse Investigation and Reporting, dated 7/2017, indicated, The Administrator, or his/her designee, will provide the appropriate agencies . with a written report of the findings of the investigations within five (5) working days of the occurrence of the incident.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe living environment, free of physical altercations by not providing appropriate supervision for six out of 10 sampled residents (Resident 1, 7, 11, 18, 28, and 32), who had a combined total of 19 episodes of aggression over a two-month time period, dating from 10/17/19 to 1/1/20). On 1/7/20 at 4:15 p.m., due to the facility's failure to provide appropriate supervision, Administrative Staff A and the Director of Nursing (DON) were verbally notified of the Immediate Jeopardy. The Health Facilties Evaluator Nurse informed Administrative Staff A and the DON of the multiple episodes of aggression which were associated with lack of appropriate supervision. Immediate Jeopardy is a situation in which a provider's noncompliance with one or more requirements of participation has caused or is like to cause serious injury, harm, impairment or death to a resident (Standard Operations Manual, Appendix Q). On 1/10/20, at 2:25 p.m., the facility presented a correction plan of action, including one-to-one supervision for Residents (7 and 32) amongst others. On 1/10/20 at 2:25 p.m., the abatement (lifted) of Immediate Jeopardy occurred in the presence of Administrative Staff A and the Director of Staff Development (DSD) after interviews and observations confirmed the facility implemented the corrective plan of action to provide appropriate supervision. On 1/10/20 at 2:25 p.m., Administrative Staff A and the DSD were notified of Substandard Quality of Care identified and the facility was on an Extended Survey. Substandard quality of care means one or more deficiencies related to participation requirements under Quality of Care 483.25 (d) (2), which constituted Immediate Jeopardy to resident health and safety (level J, K, or L) (Standard Operation Manual, Appendix P) These failures resulted in emotional and physical harm (Resident 1, 7, 18, 28, and 32) to the affected residents and the creation of an unsafe (Resident 11) and fearful living (Resident 28) environment for the residents residing at the facility. Findings: 1. During a review of, Resident Face Sheet, (undated), Resident 7, a [AGE] year-old female, was admitted to the facility on [DATE], with a history of [MEDICAL CONDITION] (a group of lung diseases that block airflow and make it difficult to breathe), muscle weakness from [MEDICAL CONDITION] (blood vessels in the brain break, causing bleeding inside of the brain), [DIAGNOSES REDACTED] (a group of brain disorders that affect the personality, behavior and language of the brain), [MEDICAL CONDITION] disorder (mental health condition including mood disorder symptoms). During a review of Resident 7's quarterly, Minimum Data Set (MDS -- a clinical assessment process providing a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 11/13/19, indicated Resident 7's cognitive skills (core skills your brain uses to think, read, learn, remember, reason and pay attention) were severely impaired (never/rarely made decisions). During a review of a, Care Plan for Resident 7, dated 8/18/18, indicated she had a problem with behavioral symptoms by episodes of inappropriate, disruptive and combative behaviors, along with altered behaviors including a potential for screaming, cursing, threatening, kicking, shoving, scratches, grabbing, throwing items and rummaging through other people's belongings. The approach or interventions to be used in keeping Resident 7's behavior appropriate was for 1:1 supervision, as needed, to calm her if distress occurred, allow a safe distance between Resident 7 and staff, to prevent her from striking or becoming increasingly agitated, monitor behaviors that could endanger herself or others, monitor her wandering behaviors that may become unsafe, remove her from group activities when her behavior had been unacceptable and seat Resident 7 where constant or near constant observation would be possible, all dated, 8/18/18. Resident 7's plan of care was updated on 3/14/19, to include a problem of Resident 7 ambulating around the facility until she was exhausted, while walking into things like doors, equipment and other residents. The approach or interventions suggested included monitoring Resident 7 while ambulating to ensure she used her front-wheel walker. Resident 7's, Plan of Care was updated on 1/2/20, to include a problem with making physical contact with a female resident in the dining room. The approach or interventions suggested to keep Resident 7 from harming other residents, including redirecting her from heavily populated areas if she appeared to be in an unpredictable mood or if angry, offering diversion activities if her mood appeared to be angry until she returned to a calmer state, allowing a safe distance between Resident 7, with peers and staff, and monitoring her behavior as it related to endangering herself with other residents or staff, and intervening as necessary. During a review of, Nursing

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) Progress notes for Resident 7, dated 10/28/19 at 10:03 a.m., she was observed yelling at the housekeeper who was in an office emptying the trash. Resident 7 then repeatedly slapped the housekeeper who was attempting to assist her out of the office area due to safety concerns around equipment and cords, which might create a fall risk. The medical record did not indicate how or why Resident 7 was able to enter an office not designated for resident use. During a review of Resident 7's Nursing Progress Notes, dated 11/1/19 at 8:25 p.m., indicated she was observed to have her hand on Resident 11's door while attempting to talk to her. Resident 11 then shut the door abruptly, injuring Resident 7, as she stated, ouch. On 11/2/19 at 4:53 p.m., Nursing Progress Notes indicated Resident 7 subsequently developed a hematoma (blood or bleeding under the skin due to trauma of any kind) as result of the door being shut in her face. During a review of Nursing Progress Notes dated 12/3/19 at 12:15 p.m., Resident 7 was observed in the dining area attempting to take belongings from Resident 28, who was sitting at a table. Resident 28 stated to Resident 7, You can't take my stuff, and, at that point, Resident 7 made contact with her open hand to Resident 28's left cheek. During an interview on 12/18/19 at 11:43 a.m., Resident 28 stated Resident 7 slapped her in the face, thought to be due from something she (Resident 28) said. Resident 28 stated she had to be careful around Resident 7 because, in the past, Resident 7 grabbed her knee, causing pain. Resident 28 stated Resident 7 was someone who just walked everywhere and did not know what she was doing and behaved unpredictably as you just did not know what she would do. During a review of, Nursing Progress notes dated 12/8/19 at 11:29 a.m., Resident 7 was indicated to be exhibiting aggressive behaviors by striking a nurse in the face, cursing at staff and was placed on a 1:1 supervision. During a review of, Nursing Progress notes dated 12/18/19 at 11:45 a.m., Resident 7 was indicated to continue to be on 1:1 supervision, while trying to prevent her from striking other residents and throwing plastic bins, while ambulating around the facility, calling anyone in the hallways curse words and throwing plastic bins at staff. The medical record did not indicate the interventions identified from the, Plan of Care, used to keep Resident 7 or the other residents safe from the aggressive behaviors, or how the 1:1 supervision was effective in eliminating the aggressive behaviors. During an observation on 12/18/19 at 11:08 a.m., Administrative Staff A was escorting the surveyor down the hallway, and Resident 7 was ambulating with her front-wheeled walker in the hallway. Administrator Staff A called out to her (Resident 7), but she did not respond and continued to ambulate at a consistent pace. Administrator Staff A indicated Resident 7 would not respond unless there was tactile stimulation or face-to-face contact. When greeted, while making eye contact, Resident 7 smiled, stated she was fine and then bent her head down and proceeded to ambulate with her front wheel-walker. In an interview on 12/18/19 at 11:16 a.m., Unlicensed Staff X indicated Resident 7 continued to roam or walk throughout the facility, consistently, from the time she got up until the time she went to sleep. Unlicensed Staff X stated Resident 7 would sit for a few minutes to eat, but then returned to roaming the hallways. Unlicensed Staff X indicated Resident 7 would wander into other residents' rooms, and if they would yell at her to get out, that would trigger her to yell back or to strike out. Unlicensed Staff X stated, Resident 7 roamed the hallways, at times crowded with other residents in their wheelchairs, prompting some residents to yell at Resident 7 to watch out and be careful (not to bump into them). Those described incidents would provoke Resident 7 to cuss or strike out at the person yelling at her. During an interview on 12/18/19 at 12:05 p.m., Unlicensed Staff Z indicated Resident 7 would wander throughout the facility presenting problems by wandering through the dining room for instance, consistently touching other peoples' stuff. The residents would yell at Resident 7, even though she might have just picked something up to look at and then put it down and again, this would trigger aggressive behaviors, like yelling profanity or striking out physically. During a review of the, Investigation Notes, dated 1/2/20 at 12:30 p.m., Resident 7 was in the dining room and made contact, with an open hand, to Resident 1's forehead, resulting in a bruise. During a review of the, Social Services Progress Note dated 1/3/20 at 4:30 p.m., Resident 1 stated she had no memory of the event. During a review of the, Interdisciplinary Team Note dated 1/7/20 at 12:31 p.m., indicated Resident 7 may appropriately verbalize her needs at times, but often times she would make unintelligible statements. Resident 7 was indicated to be often times confused and wandering throughout the facility aimlessly, requiring redirection. Resident 7 was encouraged to be redirected from heavily populated areas if she appeared to be in an unpredictable mood or angry. During an interview on 1/7/20 at 11:53 a.m., Unlicensed Staff W stated Resident 7 tended to bump into things (equipment/furniture), staff and other residents. Unlicensed Staff W stated, when she took care of Resident 7, she and all of the staff, watched out for her and what she was doing. Unlicensed Staff W stated she could get busy with providing care for other residents and agreed, while Resident 7 roamed the hallways, sometimes there were no staff members in the hallways to watch out for her behaviors. During an interview on 1/7/20 at 12:12 p.m., with Licensed Staff H, she stated everyone watched out for Resident 7, and agreed there were times during the course of the shift there were no staff members in the hallways to watch out for her. Licensed Staff H indicated the safety concern for Resident 7 was not her being aggressive with other residents, but more of the other aggressive residents striking out if she (Resident 7) were to bump into them or get too close to them, while unsupervised. During an interview on 1/7/20 at 12:31 p.m., Unlicensed Staff S stated Resident 7 would not make eye contact, even if you were right in front her, and indicated there were no other staff members identified to watch the hallways or certain residents. Unlicensed Staff S restated, if she were to call out to Resident 7 not to go into another resident's room, for example; Resident 7 would not be able to redirect herself, thus creating the potential for a resident-to-resident altercation. During an interview on 1/7/20 at 1:02 p.m., Administrative Staff CC stated Resident 7 fell a few times because she did not stay with her walker and left it behind. Administrative Staff CC stated Resident 7 would leave her walker behind and then start using the back of a chair or the hand rails, along the side of the hallway, for assistance in getting around. Administrative Staff CC agreed Resident 7 was unable to remember to consistently use her walker and had little-to-no safety awareness. Administrative Staff CC indicated Resident 7 would no longer continue with physical therapy for gait balance because she could not follow the instructions, due to her lack of cognition. During an interview on 1/7/20 at 2:12 p.m., with the DON, she reviewed Resident 7's plan of care and stated the following explanations, regarding the approaches or interventions indicated on the plan of care: 1) allowing a safe distance would be determined by an arm's reach, but the DON agreed not all of the facility staff would have that same understanding for determining a safe distance. The DON agreed a safe distance would be difficult or impossible when the hallways would become crowded with multiple residents in wheelchairs, which happened every day. The DON could not state Resident 7's specific behaviors, as indicated on the, Plan of Care, which would require monitoring, or who specifically would monitor Resident 7's wandering behaviors if all staff were busy providing resident care. The DON agreed, if Resident 7's behavior were inappropriate during an activity, she would then be removed, but this would occur after-the-fact, as the behavior had already occurred. The activity person would not be able to prevent the inappropriate behavior from occurring since they would be conducting the activity and could not focus completely on Resident 7's behavior. The DON could not explain how Resident 7's behavior would be monitored, with regard to keeping a safe distance away from known aggressive residents and how to keep Resident 7 safe from being the victim of resident-to-resident altercations. Two separate observations were made on 1/7/20: 1) at 1:50 p.m., Resident 7 was walking without her front-wheel walker at the front of the building, with multiple staff members walking past her and not acknowledging she was not using her front-wheel walker, but rather using the hand rail or any other piece of equipment to navigate the hallway; and, 2) at 3:30 p.m., Resident 7 was navigating down a different hallway without her front-wheel walker, instead using the hand rails and wall to steady her gait, while multiple staff members passed her, and only one staff member verbally called out for her to get her walker. Resident 7 did not acknowledge the request and did not stop her wandering behavior to retrieve her walker. Resident 7's walker was not in sight of the hallway, and it was unclear exactly where the walker was located. During a concurrent observation and interview on 1/10/20 at 11:25 a.m., Unlicensed Staff Z she was sitting next to Resident 7, who was coloring in the dining room. Unlicensed Staff Z stated Resident 7 would sit for an activity if someone was with her, sitting next to her, and then she could stay focused on an activity, versus attending a group activity. Resident 7 would not stay focused very long for a group activity, maybe a minute or two and would then go back to walking the hallways. Unlicensed Staff Z stated Resident 7 would roam through the dining room throughout the day, but rarely stopped to participate in an activity. During an interview on 1/10/20 at 11:52 a.m., Unlicensed Staff Q stated Resident 7 liked to go outside where the smoke breaks occurred and often times would leave her walker in random places and needed lots of encouragement to use her walker. During an interview on 1/10/20 at 4:37 p.m., Licensed Staff L indicated Resident 7 would be in a certain mood in the morning and this would set the tone for the day, meaning; staff would know if she was in a bad mood and would have to watch out for her and how she reacted with other residents. Licensed Staff L stated Resident 7 generally walked the hallways all day, had a tendency to leave her walker behind, and then would use the wall for support. Licensed Staff L stated everyone (all staff) watched out for her, but agreed that many times there would be no staff present in the hallways to watch her, as they would be providing care to other residents, and then no one would be watching

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F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 5) her. 2. During a review of Resident 32's face sheet, (undated), Resident 32, an [AGE] year-old male, was admitted to the facility on [DATE], with a history of [DIAGNOSES REDACTED] (a disease associated with abnormal protein deposits, which affects a person's thinking, movement and behavior), Alzheimer's (a progressive disorder causing brain cells to waste away and die, resulting in a decline of thinking, behavioral and social skills, which disrupted a person's ability to function), and high blood pressure. During a review of Resident 32's quarterly, Minimum Data Set (MDS -- a clinical assessment process providing a comprehensive assessment of the resident's functional capabilities and helps staff identify health problems), dated 11/5/19, indicated Resident 32's cognitive skills (core skills your brain uses to think, read, learn, remember, reason and pay attention) were severely impaired (never/rarely made decisions). During a review of Resident 32's, Care Plan dated 3/27/19, indicated he had a problems with refusing personal care after being incontinent, whereby he would become combative toward staff, by yelling, kicking or hitting. The approach or interventions suggested to allow staff to assist in personal care, thereby preventing him from staying in his urine and feces, were: Allowing him to pick out his clothes and let him wipe himself down, explain the importance of personal care, and if Resident 32 denied care being provided, then have another staff member make an attempt to provide care. During a review of a, Care Plan, for Resident 32 dated, 10/25/19, indicated he had a problem with behavioral symptoms by being the aggressor in resident-to-resident altercations. The approach or interventions suggested to prevent him from harming himself or others, were: Monitor for changes in behaviors, monitor whereabouts when propelling through the building and allowing a safe distance between resident and staff. During a review of a, Care Plan, for Resident 32 dated, 11/2/19, indicated he had a problem with episodes of inappropriate, disruptive behaviors with/and/or combative features. The approach or interventions suggested to prevent him from harming himself or others, were identified as: Offering to take Resident 32 for a stroll in his wheelchair, allow a safe distance between resident and staff, to prevent him from striking staff, and to promote activities such as painting, reading and watching television. During a review of the, Nursing Progress Notes, dated from 10/17/9 to 1/9/20, Resident 32 had 14 separate physical and/or verbal altercations with either residents or staff, from 10/17/19 to 1/1/20. On 10/17/19 at 2:45 p.m., Resident 32 attempted to throw hot coffee on a Certified Nursing Assistant (CNA). On 10/21/19 at 4:33 a.m., he attempted to strike and kick staff, while staff were trying to provide personal care. On 10/25/19 at 2 p.m., Resident 32 was observed hitting Resident 7 in the lower back area with his hand. On 10/27/19 at 7:30 p.m., Resident 32 and Resident 13, were involved in a wheelchair collision, whereby Resident 13 struck Resident 32, who then hit Resident 13. On 10/29/19 at 3 p.m., Resident 32 squeezed Resident 28's arm, resulting in pain and bruises. On 11/2/19 at 4 p.m., Resident 32 put his right hand on another resident's wrist (unclear if it was Resident 13). On 11/6/19 at 2:47 p.m., Resident 32 was combative with staff attempting to provide routine personal care. On 11/11/19 at 3:45 p.m., Resident 32 struck Resident 28 and Resident 18. On 11/20/19 at 3:52 p.m., Resident 32 was combative with staff while they were attempting to providing personal care. On 11/22/19 at 5:55 a.m., Resident 32 was agitated and combative when staff were attempting to provide incontinent care. On 12/6/19 at 4:58 a.m., Resident 32 was combative with care, as indicated by yelling and attempting to strike staff. On 12/9/19 at 12 p.m., Resident 32 was involved in a resident-to-resident altercation, where Resident 18 yelled profanities, and then Resident 7 kicked him in the leg. On 12/16/19 at 10:30 a.m., Resident 32 was observed to shout profanities and attempted to punch a staff member. On 1/1/20 at 6:37 a.m., Resident 32 was observed to attempt to punch staff while trying to provide incontinent care. During an interview on 12/18/19 at 11:16 a.m., Unlicensed Staff X stated Resident 32 was the only resident which scared her, as he had a certain look and a sort of grimace. Unlicensed Staff X stated she would ask for help when providing care for Resident 32, due to his unpredictable behavior and propensity for being combative. Unlicensed Staff X stated she would try and get him out of bed in the morning, but if he did not answer in a happy tone then she would know it would be a bad day. Unlicensed Staff X stated she would attempt to change his clothes if they were dirty, and during the process of providing care, he might squeeze her arm very tight and then might try and strike at her; either way it would hurt if he squeezed her arm really tight. Unlicensed Staff X stated she never observed Resident 32 reading a book, painting or watching television. Unlicensed Staff X indicated Resident 32 injured her during the course of providing care. During an interview on 12/18/19 at 12:05 p.m., Unlicensed Staff Z stated Resident 32 might be walking down (resident used a wheelchair) the hallway, he might just flip someone off and or start swearing at them, usually at male residents and for no apparent reason. She stated the approach to deal with Resident 32 was try and distract him, and agreed that it would be difficult or impossible if staff were in resident rooms providing care, and he was unsupervised. During an interview on 1/7/20 at 12:12 p.m., Licensed Staff H stated she was concerned regarding Resident 32 and his unpredictable combative behavior. Licensed Staff H stated Resident 32 could be very aggressive and unpredictable, making it difficult to watch out for him and the safety of other residents, who liked to gather in the hallways and sit. Licensed Staff H indicated the hallways became crowded with residents, who liked to be out of their rooms sitting in the hallways daily. During a review of the facility's job description, titled, Job Description For Sitter (not dated), indicated, The sitter is to protect and promote the residents rights and assist the resident to maintain independence and control to the greatest extent possible Have the ability to interact effectively with individuals who are cognitively and/or physically impaired Have the ability to respond to changes productively and to handle additional task/projects as assigned.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify competency of nursing skills, when staff were allowed to self-assess their own competency in nursing skills, and there was no process to determine competency in nursing skills. This failure had the potential for staff performing nursing skills who were not competent, resulting in resident harm or death. Findings: During an interview and concurrent review on 1/7/20 at 2:12 p.m., with Director of Nursing (DON), she stated an example of training for staff, would be after each resident-to-resident altercation. The DON indicated after each resident-to-resident altercation, training for the nursing staff would help the nurses understand what factors contributed to the incident and how to further prevent or diminish resident-to-resident altercations. A review of, Nursing Progress, notes for Resident 7, indicated she had three resident-to-resident altercations in the last three months. A review of the Plan of Care indicated an approach, dated 8/18/18, suggested to keep Resident 7 at a safe distance between her and other residents. The DON indicated her definition of a safe distance would be an arm length (measurement), but also stated the other licensed staff might not use the same definition. The DON agreed the facility did not teach what a safe distance meant and how to carry out that approach. The DON agreed Resident 7 had not always been the aggressor in the resident altercations, but since she had no safety awareness and would bump into other residents, those actions would create a potential for further resident-to-resident altercations. The DON agreed the approach on Resident 7's, Care Plan, did not keep her free from risk of personal injury or injuring other residents. During an interview on 1/7/20 at 12:12 p.m., Licensed Staff H stated the term, safe distance from the, Care Plan, for Resident 7 did not have a specific meaning, but would be interpreted to her that everyone would watch out for Resident 7. During an interview on 1/7/20 at 2:15 p.m., the DON stated training would be provided after each resident-to-resident altercation and gave an example: A review of the(NAME)Point Care Center Nurse Meeting Agenda, dated 1/8/20, which indicated: 1) what to do if feeling overwhelmed; 2) seeing a situation escalating; 3) high risk resident requiring 1:1; and, 4) safeguarding all residents from potential behaviors. The DON stated the agenda items listed above were discussed to ensure staff were able to keep residents safe, especially with regard to not hurting each other. The DON stated all nursing staff attended the nursing meetings. During an interview on 1/15/20 at 11:40 a.m., Licensed Staff G stated staff meetings were not mandatory, and there had not been a mandatory one in a long time. Licensed Staff G stated staff meetings were conducted standing up, where the nurses would read and sign the agenda items as they were read aloud, but not discussed. Licensed Staff G stated staff were expected to go back to work right away, and there was no time for discussion. During an interview on 1/10/20 at 4:15 p.m., Licensed Staff J stated she attended the staff meeting on 1/10/20, stated the staff meeting was quick, there was no discussion regarding the agenda items, and the expectation was to go back to work. Licensed Staff J stated no one asked questions regarding any of the 20 listed items on the agenda, and many of the agenda items listed on the 1/8/20, meeting agenda had been repeated on many previous staff meeting minutes, so staff were used to seeing these items. During concurrent interview and record review on 1/16/20 at 3:14 p.m., with the DON, the, Licensed Nurses [DIAGNOSES REDACTED]. The staff member would then rate their own performance on a scale from, 1 (little or no experience) to 4 (competent, experienced able to assess

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055499	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCKY POINT CARE CENTER	**625 16TH STREET LAKEPORT, CA 95453**

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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) competency and teach others). The DON stated each nurse would rate their own competency and not done by the DON or Director of Staff Development (DSD). A review of, Licensed Nurses [DIAGNOSES REDACTED]. The DON stated any number less than, 3 would require further follow-up to ensure the staff member was competent to perform the task. The DON could not explain why the, Licensed Nurses [DIAGNOSES REDACTED]. The DON could not demonstrate Licensed Staff L was competent to perform the tasks listed. During an interview and record review on 2/7/20 at 2:12 p.m., with the DON, the Competency Skills Checklist, dated 10/3/18, indicated Licensed Staff G completed the check list, but had identified areas requiring further training: Tube Feeding, checking for placement (nursing skill to ensure a tube used for passing food or formula through the nose to the stomach; if entered the stomach, rather than the lungs, could cause choking, pneumonia or death) was assessed as a, 2 --meaning the nurse had some experience but may require supervision or assistance. The DON stated the nurse who assessed their own competency at a level below a, 3 would require further training as follow-up to ensure the nurse was competent to perform the necessary skill. The DON stated she could not explain why Licensed Staff G had not had further follow-up, as there was no documentation to indicate follow-up had taken place. The DON could not demonstrate Licensed Staff G was competent to perform tube feeding placement and stated it must have slipped her mind. The DON stated there was no policy regarding nursing competency assessments.