SECTION 1424 NOTICE

CITATION NUMBER: 11-2923-0012936-S

Date: 03/14/2017 Time: __________

Type of Visit :

Incident/Complaint No.(s) : No complaints found

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Licensee Name: Eureka Rehabilitation & Wellness Center, LP

Address: 2353 23rd Street Eureka, CA 95501

License Number: 010000054 Type of Ownership: Partnership

Facility Name: Eureka Rehab & Wellness Center, LP

Address: 2353 23rd St Eureka, CA 95501

Telephone:

Facility Type: Skilled Nursing Facility Capacity: 99

Facility ID: 010000078

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $2,000.00	DEADLINE FOR COMPLIANCE 3/24/17 12:00 a.m.

1418.91(ab)

CLASS B **CITATION -- ABUSE/FACILITY NOT SELF REPORTED**

Health & Safety Code 1418.91(a) and 1418.91(b)

(a) A long-term health care facility shall report all incidents of alleged abuse or suspected abuse of a resident of the facility to the department immediately, or within 24 hours.
(b) A failure to comply with the requirements of this section shall be a class "B" violation.

The facility failed to report an incident of resident-to-resident abuse to the Department of Public Health within 24 hours when Licensed Staff J did not report a witnessed event involving one Sampled Resident (Resident 7) and three Unsampled Residents (Resident 28, 33, and 34). This resulted in lack of a facility investigation and the Department's ability to ensure a complete investigation was initiated timely and ensure interventions were initiated to protect other residents, as well as those residents involved, preventing a reoccurrence of abusive behaviors.

During concurrent record review and interview on 12/7/16 at 8:40 a.m., the "24 Hour Report" flow sheet, dated 9/2/16, relevant to the residents on C Wing and the "Nurse's Notes," indicated Resident 7 was abusive, both verbally and physically on 9/2/16 at 12:00 a.m. Resident 7 was sitting in her wheelchair and blocking the entrance of her room, refusing to allow her roommates (Resident 28, 33, and 34) out of their room. Resident 7 started yelling at Resident 28, 33, 34 and staff, "I am going to kill you fucken

Name of Evaluator:
Katherine Myrum
HFEN

Evaluator Signature : ____________________

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : ____________________

Name : ____________________

Title : ____________________

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

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SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	bitch," and then Resident 7 threw a trash can down. Resident 7's abusive behavior caused Resident 28 and 33 to be fearful of Resident 7. The Director of Nursing (DON) was asked if Resident 7's abusive behavior should have been reported to: 1. her and/or the administrator; and 2. the State licensing/certification agency, police, and ombudsman. The DON stated Resident 7's aggressive behavior was documented on the, "24 Hour Report" flow sheet, which was filled out by the nurse each shift documenting relevant resident information, and the information was then passed on to the nurse on the following shift. The DON stated the, "24 Hour Report" went to the facility's daily Stand-Up Meeting, which included all department heads. The DON stated she did not see the incident on the, "24 Hour Report" due to she had been working nights and had not attended the Stand-Up Meeting on 9/2/16. The DON stated Resident 7's abusive behavior should have been reported to her and to the administrator in order for the resident-to-resident altercation to have been investigated and reported to the appropriate authorities. During an interview on 12/8/16 at 5:32 a.m., when Licensed Staff J was asked why she did not report Resident 7's abusive behavior to the DON and/or administrator, which took place during her shift (9/2/16 at 12 a.m.), Licensed Staff J stated she did not feel it was at the level of abuse to report the incident even though Resident 7 was: 1) sitting in her wheelchair and blocking the entrance of her room, refusing to allow her roommates (Resident 28, 33, and 34) out of their room, and 2) throwing hair brushes at staff. Licensed Staff J stated she documented Resident 7's abusive behavior on the, "24 Hour Report," which should have gone to the Stand-Up Meeting, which the DON attended; The DON would have been aware of Resident 7's abusive behavior by way of the, "24 Hour Report." Review of the facility policy and procedure titled, "Abuse - Reporting & Investigation," revised date 11/18/15, indicated the facility needed to report the suspected incident of resident abuse to the administrator or designee in order for he or she to have: 1. Started an investigation; 2. Provided a safe environment for the residents involved; and 3. Reported the allegation of resident-to-resident abuse to law enforcement by telephone, and a written report (SOC 341) needed to be sent to the Ombudsman and to the California Department of Public Health Licensing and Certification within 24 hours of the alleged abuse. Therefore, the facility failed to notify the Department within 24 hours of an alleged incident of abuse, resulting in an automatic B violation.

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