CITATION NUMBER: 020012796

Date: 12/8/2016 12:00:00 AM

Type Of Visit: Complaint Investig.

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

Incident/Complaint No.(s) : CA00506332

Licensee Name: Alameda Healthcare & Wellness Center LLC

Address: 430 Willow Street Alameda, CA 94501

License Number: 020000268 Type of Ownership: Limited Liability Company

Facility Name: Alameda Healthcare & Wellness Center

Address: 430 Willow Street Alameda, CA 94501

Telephone :

Facility Type: Skilled Nursing Facility Capacity: 166

Facility ID: 020000043

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: B CITATION: Other	$2,000.00	12/22/2016

F226

CLASS B **CITATION --** Other

483.13(c) (1) (i) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
The facility violated the aforementioned regulation by failing to implement their abuse policies and procedures to: 1. Immediately remove from the care of the resident and suspend a staff member accused of physical abuse. 2. Immediately notify the Director of Nursing and the Administrator In a review of the clinical record on 10/17/16 showed Resident 1 was an elderly resident admitted on xxxxxxx with diagnoses that included cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body).
Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/16, showed Resident 1 required extensive assistance from the facility in bed mobility and transfers. The MDS also showed Resident 1 was cognitively intact (had the ability to think, reason, or remember clearly). During an observation and concurrent interview on 10/17/16 at 10:40 a.m., Resident 1 said on 10/6/16 at 4:45 a.m., she was in her bed and felt pain in her back. She wanted to get up and into her wheel chair where she felt she would be more comfortable. Resident 1 pushed her call light and CNA 1 entered her room. Resident 1 said she was sitting up in bed and CNA 1, "pushed," her down and then left the room. Resident 1 said she speaks a little English but was able to point at, and say the word, "wheel chair," to CNA 1. Resident 1 said she rang her call light a second time. Resident 1 said CNA 1 returned to her room and "hit" Resident 1 in the head. Resident 1 demonstrated how CNA 1 assisted her to the wheelchair. Resident 1 showed that CNA 1 grabbed her shirt sleeve in a rough manner to get her into the wheel chair. Resident 1 said CNA 1 did not take her hand or lift my arm to assist like they (CNAs) usually do. Resident 1 continued and said after CNA 1 hit her (Resident 1) she was "scared" and her "heart

was racing." Resident 1 also said she was so scared she could not scream for help, so she banged her back scratcher on the bedside table in order to get the attention of other staff. Resident 1 said she wanted to tell other staff that this person (CNA 1) hurt her. Resident 1 further said when the charge nurse (LVN 1) entered the room and talked to her, she (Resident 1) could not understand what LVN 1 said. Resident 1 said she felt unable to verbally tell LVN 1 that CNA 1 hit her. Resident 1 said she tried to show LVN 1 that CNA 1 hit her by pointing to CNA 1 and then moving her (Resident 1's) fist against her forehead. In a telephone interview on 10/17/16 at 1:05 p.m., LVN 1 said on 10/6/16 between 4:30 and 5:00 a.m., Resident 1 told her CNA 1 had hit her in the head. LVN 1 stated she did not investigate, report the incident to the administrator or the director of nursing, call an interpreter, or send CNA 1 home at that time. In an interview on 10/17/16 at 10:00 a.m., LVN 2 said on 10/6/16, as she began her day shift, the night nurse (LVN 1) reported to her that CNA 1 hit Resident 1. LVN 2 said she went to check on Resident 1 and discovered a purplish discoloration on Resident 1's forehead. Resident 1 complained of pain, pointed to her forehead, and indicated that a staff member hit her. In an interview at 11:30 a.m., the Activities Assistant (AA) said she spoke to Resident 1 in her native language on 10/6/16 at approximately 8:30 a.m. The AA said Resident 1 had tears in her eyes when Resident 1 told her what happened (with CNA 1). The AA said Resident 1 told her that on 10/6/16 between 4:30-5:00 a.m., Resident 1 pushed her call light to call for CNA 1 to help her get up. The AA said Resident 1 also told her the first time CNA 1 went into the room, CNA 1 "slammed" Resident 1 back onto the bed "very hard" and told Resident 1 it was too early to get up. The AA said Resident 1 said she pushed her call light a second time and CNA 1 came into her room and punched her on the left side of her forehead and then left the room. The AA continued and said Resident 1 banged her backscratcher on the side table in order to get the staffs' attention. The AA said ever since the incident on 10/6/16, whenever Resident 1 sees her (AA) she (Resident 1) holds her hands and Resident 1 "Won't let me go." The AA said Resident 1 shakes and asks her to stay with her. In an interview on 10/17/16 at 12:00 p.m., the Administrator (ADM) said she was not notified that CNA 1 hit Resident 1 until 10:00 a.m. on 10/6/16. The ADM said CNA 1 worked with residents in the facility and finished her shift because she (the ADM) had not been told what had happened until 10:00 a.m. The ADM stated CNA 1 was suspended and then resigned from her position at the facility. In an interview at 12:30 p.m., the Director of Nursing, (DON) said when a resident communicates to staff that another staff person hit them, staff was to first assess the resident and notify the administrator. The DON stated Resident 1 was alert and oriented. The DON stated staff should have called for an interpreter and sent CNA 1 home right away. Review of the facility's policy and procedure titled, "Abuse-Reporting and Investigations", dated 11/18/15, showed the administrator or designee "will provide for a safe environment for the resident as indicated by the situation ...If the suspected perpetrator is an employee, remove the employee immediately from the care of the resident and immediately suspend the employee pending the outcome of the investigation in accordance with facilities (sic) policy." Review of the facility's policy and procedure titled, Alleged Abuse Investigation Checklist, dated 11/13/15, showed staff are expected to take the following steps when investigating alleged abuse: "Initiate investigation, suspend accused staff immediately, perform physical, psycho-social and mental assessment, notify attending physician, notify responsible party, notify administrator, notify the Director of Nursing, and initiate incident/accident reports." Therefore, facility failed to implement their abuse policies and procedures to: 1. Immediately remove from the care of the resident and suspend a staff member accused of physical abuse. 2. Immediately notify the Director of Nursing and the Administrator These violations had a direct relationship to the health, safety, or security of residents.

Name Of Evaluator:
FELICIA BARBATO
HFEN

Evaluator Signature:_____

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

Signature:_____

Name:_____

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

Title:_____

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