DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED survey for COMPLAINT No: CA00603377 and ENTITY REPORTED INCIDENT (ERI) No: CA00604221. Inspection was limited to the specific complaint and ERI investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 33453, HFEN. FOR COMPLAINT NO. CA00603377: THE DEPARTMENT WAS UNABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATIONS. FOR ERI NO. CA00604221: THE DEPARTMENT WAS UNABLE TO SUBSTANTIATE THE ERI. HOWEVER, DURING THE INVESTIGATION, THE DEPARTMENT FOUND A VIOLATION OF THE REGULATIONS RELATED TO THE ERI. FINDINGS WERE CITED AT F610 FOR RESIDENT 2. GLOSSARY OF ABBREVIATIONS: cm - centimeter(s) CNA - Certified Nursing Assistant DON - Director of Nursing SSD - Social Services Director	F 000	By submitting this POC, Laguna Hills Health and Rehabilitation Center does not admit or concede the facts and contents cited, or the existence or scope or severity of the deficiencies and conditions cited in the CA00603377 and CA00604221.. The POC is submitted to comply with federal and state law. Laguna Hills Health and Rehabilitation Center respects the allegations made in the 2567 have acted and will continue to act to implement this POC.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		

2018 OCT 31 AM 9:1

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.

accepted 11/2/18 # 33453

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 1 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility document review, the facility failed to thoroughly investigate an allegation of abuse for one of two sampled residents (Resident 2). Resident 2 alleged being "punched in the chest and the hand while changing my brief" on 9/11/18. Resident 2's right hand had a bruise. The facility failed to complete a thorough investigation of the right hand injury. Not completing a thorough investigation put vulnerable residents at risk for potential abuse. Findings: Medical record review was initiated for Resident 2 on 9/18/18. Resident 2 was admitted to the facility on 7/4/18. Review of Resident 2's Initial History and Physical Examination dated 8/2/18, showed Resident 2 had fluctuating capacity to understand and make	F 610	**F610** **Corrective action for resident found to have been affected by this deficiency:** Resident #2 was discharged on 09/15/18. The Director of Staff Development interviewed the Activity Staff on 09/12/18 and 09/13/18 regarding Resident #2's right hand discolorations. Activity staff did not notice any right hand bruise on 09/11/18. **Identification of other residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** The Director of Nursing and Director of Staff Development and designee conducted an audit of discoloration incidents from October 1, 2018 through October 24, 2018. There were no incidents as of 10/24/18 deficient of this practice. Four discolorations incidents were investigated thoroughly with staff interviews prior to incident to ensure residents are not at risk for potential abuse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 2 decisions. Review of the facility's investigation initiated on 9/11/18, showed Resident 2 reported to LVN 2 of being punched in the stomach, chest, and top of the hand. Review of Resident 2's Shower Skin Assessment Report dated 9/11/18 at 1856 hours, showed Resident 2 had a bluish discoloration on the right hand which measured 4.5 cm (length) x 3.5 cm (width). Review of the facility's investigation which included an Interview Record completed by the SSD dated 9/12/18, showed Resident 2 alleged a female staff member "punched me in the chest/arm." The record showed Resident 2 was not able to give a name and stated the alleged staff member had taken care of her before. The record showed Resident 2 described the staff member as Caucasian, heavy set, wore glasses, and wore make up. On 9/18/18 at 1345 hours, an interview was conducted with CNA 2. CNA 2 stated she was assigned to Resident 2 on 9/11/18, and it was the first time she had cared for the resident. CNA 2 stated she had provided morning care to Resident 2, which included bathing, toileting, dressing, and transferring the resident to the wheelchair. CNA 2 stated after Resident 2 ate breakfast, Resident 2 was assisted to the activity room. CNA 2 stated an Activity staff member brought Resident 2 back to the resident's room. CNA 2 stated the Activity staff member informed her Resident 2 needed oxygen. CNA 2 stated the oxygen was provided to Resident 2 and then the resident had gestured she wanted to stay in her	F 610	**Measures / Corrective action that will be put into place to ensure that this deficiency does not re-occur:** On 10/22/18, the Director of Nursing, Director of Staff Development and designee initiated in service on October 22, 2018. In service will be completed by October 29, 2018 regarding thorough investigation and staff interviews prior to incident of injury to prevent residents at risk for potential abuse. **Measures that will be Implemented to ensure that solutions are sustained:** When there is an abuse incident, the assigned charge nurse, or nurse supervisor, will do a head to toe assessment the same day. If injury is noted, the charge nurse will initiate an incident report, followed up by a separate thorough investigation and interviews by the IDT. The IDT will review findings during the daily COC meeting. Findings will be corrected and documented by the Director of Nursing and/or designee within 72 hours.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 3 room. CNA 2 stated Resident 2 was cooperative with care rendered. CNA 2 stated she did not remember seeing any bruises or marks on Resident 2. CNA 2 further stated, "if I did see any bruises or marks on Resident 2, I would have reported it." On 10/16/18 at 1508 hours, a telephone interview was conducted with the DON. The DON stated she reviewed Resident 2's medical record and was unable to find documentation of Resident 2 having any discoloration to the right hand prior to the allegation of abuse on 9/11/18. Review of the facility's conclusion of the investigation showed Resident 2 gave a description of a female who did not resemble any staff member and the resident's discoloration on the right hand could possibly have (occurred if the resident) hit it anywhere during movement. However, review of the facility's investigation showed the staff and residents were interviewed regarding how CNA 2's behavior was and the care she had provided to the residents. There was no documented evidence the staff members were asked regarding the resident's discoloration on the right hand or the resident's behavior (agitated, restless or striking out) prior to 9/11/18, when they noted the discoloration. The facility could not show any documentation the injury to Resident 2's right hand was thoroughly investigated.	F 610	Results will be documented on the Continuous Quality Improvement Audit Tool. Forwarded to QAA for further monitoring, which occurs monthly, and action planning as indicated, or until QAA Committee determines compliance. Completion Date: 10/29/18	