POC Accepted 11/7/23 HFEN, 46787

PRINTED: 10/17/2023
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
	055206	A. BUILDING _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA ANA HEALTHCARE & WELLNESS CENTRE, LP	1209 HEMLOCK WAY SANTA ANA, CA 92707

(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 FACILITY REPORTED INCIDENT (FRI) & COMPLAINT No: CA00863816 and COMPLAINT No. CA00864329. Inspection was limited to the specific complaint and FRI investigated and did not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 46787, HFEN. FOR FRI & COMPLAINT NO. CA00863816: THE DEPARTMENT WAS ABLE TO PARTIALLY SUBSTANTIATE THE COMPLAINT ALLEGATION(S). FINDINGS WERE CITED AT F600 FOR RESIDENT 1. FOR COMPLAINT NO. CA00864329: THE DEPARTMENT WAS UNABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATION(S) THAT DID NOT CONSTITUATE A VIOLATION OF THE REGULATIONS. GLOSSARY OF ABBREVIATIONS: DON - Director of Nursing H&P - History and Physical LVN - Licensed Vocational Nurse MDS - Minimum Data Set (a standardized assessment)	F 000	Preparation, submission, and/or execution of this plan of correction does not constitute admissions or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of correction is prepared submitted and /or executeedsolely because it is required by the provision of federal and state law.	10-23-23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cherie Harper	Administrator 10-27-23	

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 000	Continued From page 1 P&P - policy and procedure RN - Registered Nurse	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to protect one of five sampled resident's (Resident 1) rights to be free from the physical abuse by Resident 2. This had the potential for Resident 1 to be injured and have psychological harm. Findings: Review of the facility's P&P titled Resident to Resident Altercations showed the facility will make any necessary changes in the care plan for any and or all of the involved residents as necessary.	F 600	IMMEDIATE CORRECTIVE ACTION TAKEN: IDT meeting conducted and as 10-9-2023 resident's 2 care plan's have been updated to reflect wandering and aggressive behaviors. OTHER RESIDENT'S POTENTIALLY AFFECTED BY THIS DEFICIENT PRACTICE: Other residents could have been affected by this deficient practice. ADON and Medical Records Director conducted an audit of residents to residents altercations in the last 60 days and found no other residents were affected. On 10-9-23, 10-10-23, and 10-11-23 the ADON and DSD provided in-service training to all licensed nurse's on Care Planning and documenting all behaviors.	10-23-23 10-23-23

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F 600	Continued From page 2 Review of the SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 10/3/23, showed Resident 1 was hit on his face by Resident 2. a. Medical record review for Resident 2 was initiated on 10/5/23. Resident 2 was admitted to the facility on 1/19/23. Review of Resident 2's H&P examination dated 1/26/23, showed Resident 2 did not have the mental capacity to make informed decisions. Review of Resident 2's MDS dated 7/20/23, showed Resident 2 had severe cognitive impairment. Review of Resident 2's progress notes dated 10/3/23, showed Resident 2 had an episode of aggression toward another resident. Resident 2 was in Resident 1's room looking in the closet. Resident 1 confronted Resident 2, then Resident 2 put his hands on Resident 1. On 10/5/23 at 1130 hours, an interview was conducted with the Nursing Manager. The Nursing Manager stated Resident 2 had a history of wandering and going into other residents' rooms. On 10/5/23 at 1230 hours, an interview was conducted with LVNs 1 and 2. LVNs 1 and 2 stated Resident 2 had a history of wandering and going into other residents' rooms. b. Medical record review for Resident 1 was initiated on 10/5/23. Resident 1 was admitted to the facility on 7/17/23, and discharged to the acute care hospital on 10/3/23.	F 600	WHAT MEASURES OR SYSTEMATIC MEASURES WILL BE PUT INTO PLACE TO ASSURE THAT THIS DEFICIENT PRACTICE DOES NOT RECUR On 10-9-23 the Administrator re-inserviced all Licensed Nurse's and CNA's on the Facilities monitoring of all resident's every q 1 hour and writing the location of all residents in the building. All incidents need to be reported to RN Supervisor who will investigate and follow up with Charge Nurse for appropriate documentation and careplanning. PLAN TO MONITOR AND EVALUATE PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE MAINTAINED AND EFFECTIVE: The DON/ADON and Medical Records Director shall monitor weekly all incidents and audit Care Plan's and documentation for completion for the next 30 days until compliance is met and report any findings ot the QA/QI Committee monthly for further review, for a period not to exceed three months or until compliance is achieved. PERSON RESPONSIBLE FOR THIS PLAN: DON/ADON/ AND ADMINISTRATOR.	10-23-23 10-23-23

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F 600	Continued From page 3 Review of Resident 1's H&P examination dated 7/18/23, showed Resident 1 did not have the mental capacity to make informed decisions. Review of Resident 1's MDS dated 10/3/23, showed Resident 1 had severe cognitive impairment. Review of Resident 1's Progress Notes dated 10/3/23 at 1545 hours, showed a change in Resident 1's condition when the registered nurse went into Resident 1's room where Resident 1 was found sitting in his wheelchair with a bloody nose and redness on the face. Resident 2 was observed grabbing Resident 1's shirt with his right hand in a closed fist. Both residents were immediately separated. Resident 1 received first aid treatment for his injuries. On 10/5/23 at 1330 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified there was no care plan for Resident 2's behaviors of wandering and going into other residents' rooms. The DON stated it should have been put on the care plan and these behaviors should have been monitored by the staff.	F 600		