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

PRINTED: 07/09/2015
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
	555751	A. BUILDING _____ B. WING _____	C 07/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT SUBACUTE HEALTHCARE CENTER	2570 NEWPORT BLVD COSTA MESA, CA 92627

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED SURVEY for an Entity Reported Incident No: CA00444912. Inspection was limited to the specific Entity Reported Incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 29767, HFEN. GLOSSARY OF ABBREVIATIONS AND BRIEF DEFINITIONS: CNA - Certified Nursing Assistant Craniotomy - (a surgical opening into the skull) DSD - Director of Staff Development Dysphagia - (difficulty or inability to swallow) Expressive aphasia - (loss of the ability to produce language) GT - Gastrostomy Tube (a tube placed through the abdominal wall into the stomach used for feeding and/or administering medication) Hand mitten - (mittens applied to a hand(s) to prevent pulling on tubes or medical devices) LVN - Licensed Vocational Nurse P&P - Policy and Procedure	F 000	**"Preparation and/or execution of this plan of correction, does not constitute admission or agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq".** **This Plan of Correction constitutes the facility's credible allegation of compliance.**	
F 226 SS=D	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.	F 226	**How Corrective Action will be accomplished for residents affected:** Resident 1 is no longer a Resident at Facility at this time.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 7/17/15

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 7/21/15

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F 226	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, the facility failed to thoroughly investigate an injury of unknown origin for one of two sampled residents (Resident 1). Resident 1 sustained a fracture to his right wrist. The facility failed to follow their Abuse P&P and thoroughly investigate an injury of unknown origin to rule out abuse. Failure to thoroughly investigate an injury of unknown origin had the potential for placing residents at risk for neglect or mistreatment. Findings: Review of the facility's P&P titled Abuse Investigation revised 2006, showed "All reports of ... injuries of unknown source shall be promptly and thoroughly investigated...The individual conducting the investigation will, as a minimum...interview staff members (on all shifts) who have had contact with the resident during the period of the ...incident; interview the residents roommate, family members..." On 6/3/15 at 1450 hours, Resident 1 was observed lying in bed with a right hand/wrist splint applied. The resident's left hand was in a hand mitten. The resident was calm but not able to be interviewed. Clinical record review for Resident 1 was initiated on 6/3/15. Resident 1 was admitted to the facility on 4/9/15, with diagnoses including expressive aphasia, severe cognitive impairment and received nutrition via GT. Review of the physician's orders dated 4/10/15,	F 226	Administrator spoke with family of Resident 1 on 7/16/15, and interviewed regarding incident which occurred on 5/16/15. Family stated she does not know what happened. Family stated that if she would have a concern of potential abuse, that she felt comfortable to share it with Facility staff and management without fear of retaliation. Family felt safe during the duration of Resident's stay. Resident 1's roommates during 5/16/15 were unable to be interviewed, due to impaired cognitive status. IDT met on 7/15/15 to further reviewed incident, with no additional findings or recommendations.	07/16/15

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F 226	Continued From page 2 showed an order to apply hand mittens to both hands to prevent the resident from pulling out of medical devices (GT), release the hand mittens every two hours, and check circulation to the resident's hands every shift. Review of the progress note dated 5/16/15 at 1226 hours, showed Resident 1's family member was visiting and had removed the resident's hand mittens. The resident's right hand "appears swollen and slightly red on the wrist area." The licensed nurse and CNA were called to assist in keeping the resident's right upper extremity immobilized and keep the resident on his back as "he tends be restless at times." Review of the physician's orders dated 5/16/15, showed an order for an x-ray of the Resident 1's right hand, wrist, arm, and shoulder due to swelling and redness. The x-ray report dated 5/16/15, showed a fracture of the right wrist. Review of the facility's investigation of Resident 1's fractured right wrist showed the interviews were conducted with the CNA who had been assigned to care for Resident 1 on the night shift of 5/15/15, and the Occupational Therapy Assistant who was assigned to care for Resident 1 on the day shift of 5/16/15. Review of the documentation for these two staff interviews did not show the investigator had asked the staff members to describe the condition of Resident 1's right arm or wrist during their care or their observations of Resident 1's right arm or wrist. In addition, the investigation did not include documented evidence the resident's family and/or roommate were interviewed. There was no documentation to show the interviews were conducted with the staff regarding the release of	F 226	**Identification of Residents with the Potential to be Affected:** No other residents were affected. **Measures to Prevent Recurrence:** Facility Abuse Policies and Procedures, as wells as P&P for incidents of unknown origin, were reviewed with DSD on 7/14/15, to ensure further investigations are complete with thorough documentation, including interviews of all potentially involved parties. Administrator/Designee initiated in-services on 7/1/15 to all staff on Abuse Policies and Procedures, with emphasis on investigation of incidents of unknown origin. **Monitoring Corrective Action and Responsibility:** Administrator will review all further investigations, to ensure complete and thorough documentation, including	

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F 226	Continued From page 3 the resident's hand mittens and if the resident's circulation was checked every two hours on 5/15 and 5/16/15 as ordered to see if anyone had noticed anything unusual. During an interview on 6/3/15 at 1510 hours, the DSD confirmed there was no further documentation available to show additional interviews were conducted other than what was listed above. On 6/4/15 at 1345 hours, an interview with Resident 1's family member. The family member stated she usually visited Resident 1 every day. The family member stated she would remove the hand mittens while she was visiting with Resident 1 and at the end of her visit, either she or a facility staff member would reapply the hand mittens. The family member was asked what happened the day the x-ray showed Resident 1's right wrist was fractured. The family member stated as soon as she removed the resident's right hand mitten, she noticed the right wrist was red and swollen. The family member stated she told the charge nurse right away and an x-ray was done. The family member stated the resident's right wrist was not swollen or red the previous evening (5/15/15) when she visited him.	F 226	interviews of all potentially involved parties. Any finding will be reported to the QA Committee for further recommendations **Date of compliance:** 8/6/15	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**How Corrective Action will be accomplished for residents affected:** Physician Order for Resident 1 was reviewed and corrected. Medical Record reflects release and assessment for CMS.	

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to follow the physician's orders to release bilateral hand mittens every two hours, to check the hand circulation and to leave the hand mittens off for 15 minutes for one of two sampled residents (Resident 1). Failure to follow the physician's orders had the potential for a delay in detection and treatment of a fractured wrist. Findings: Clinical record review for Resident 1 was initiated on 6/3/15. Resident 1 was admitted to the facility on 4/9/15, with diagnoses including status post craniotomy for a subdural hematoma, expressive aphasia and received nutritional via GT. Review of the physician's order dated 4/10/15, showed an order to apply hand mittens to Resident 1' hands to prevent the resident from pulling out of medical devices (GT). The order included to release the hand mittens every two hours, as needed and check the his hand circulation every shift. Review of the x-ray dated 5/16/15, showed Resident 1 was found with a right wrist fracture. Review of the physician's order dated 5/16/15, showed to apply a right hand wrist and forearm splint and monitor Resident 1's right hand for circulation (including color, motion, and sensation) due to the use of the hand splint every shift.	F 309	CNA's for Resident 1 were provided counseling on 5/19/15. **Identification of Residents with the Potential to be Affected:** Residents with orders for hand mittens have the potential to be affected. Other Residents with orders for hand mittens were identified, and orders were clarified for tracking of application, release, and assessment for CMS. **Measures to Prevent Recurrence:** DON/Designee in-serviced 3 shifts of LVN's and CNA's on following physicians orders, with emphasis on procedures for Residents with hand mittens, including that medical record reflects release and assessment every 2 hours.	

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F 309	Continued From page 5 Review of Resident 1's plan of care showed a care plan problem initiated 4/30/15, for the use of bilateral hand mittens due to pulling out medical devices (GT and tracheostomy tube). One of the interventions showed the resident was to have "restraint-free time and physical activity daily" and release the bilateral hand mittens every two hours and as needed. There was no intervention updated to include assessing the resident's hand circulation as ordered by the physician. The physician's order dated 5/18/15, showed to apply a left hand mitten at all times to prevent pulling out of medical devices and may release every two hours on every shift for 15 minutes for circulation check. On 6/3/15 at 1500 hours, an interview and concurrent clinical record review was conducted with LVN 1. LVN 1 was asked how she documented the release of Resident 1's left hand mitten every two hours and checking the resident's circulation as ordered by the physician on 4/10 and 5/18/15. LVN 1 reviewed Resident 1's electronic clinical record which showed a restraint check done every shift (every 8 hours). LVN 1 stated at the end of the shift she placed a check mark into the box to identify the restraint was checked. When LVN 1 was asked if there was additional documentation to show Resident 1's hand mitten checks were done every two hours and included the time of the checks, and his circulation was assessed and/or the time the mitten was removed for at least 15 minutes. LVN 1 stated these parameters were not documented. On 6/3/15 at 1510 hours, an interview with the DSD was conducted. The DSD confirmed the only documentation to show the physician's	F 309	**Monitoring Corrective Action and Responsibility:** DON/Designee to monitor through random observation rounds to ensure continued complianee. Medical Records will conduct random audits weekly x 3 weeks to ensure Medical Administration Record is completed according to parameters of order. Any finding will be reported to the QA Committee for further recommendations **Date of compliance**: 8/6/15	08/06/15

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F 309	Continued From page 6 orders dated 4/10 and 5/18/15, for the removal of Resident 1's mitten(s) every two hours, the application and on/off times of the mittens and the circulation checks were done, was a check mark at the end of each shift. When the DSD was asked if the fracture of Resident 1's wrist could have been present for hours before being identified by the resident's family member on the afternoon of 5/16/15, since there was no documentation to show the last time the wrist was checked. The DSD agreed. On 6/4/15 at 1345 hours, an interview with Resident 1's family member. The family member stated she would remove Resident 1's hand mittens as she always did every day. She stated as soon as she removed the resident's right hand mitten (on 5/16/15), she noticed the right wrist was red and swollen. The family member stated she told the charge nurse right away and an x-ray was done. The family member stated the resident's right wrist was not swollen or red the previous evening (5/15/15) when she visited him.	F 309		08/01/15