STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FLAGSHIP HEALTHCARE CENTER	**466 FLAGSHIP ROAD NEWPORT BEACH, CA 92663**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to implement the facility's grievance/concern P&P for one of three sampled residents (Resident 1). * Resident 1's family member (Family Member A) contacted the facility's Administrator (Grievance Official) regarding concerns with the care Resident 1 received at the facility. Family Member A stated she informed the Administrator Resident 1 utilized his call light to request for staff assistance. The CNAs who spoke a foreign language responded to Resident 1's request for assistance, however, only assisted Resident 1's roommates who spoke the same language as those CNAs. Family Member A stated the staff failed to assist Resident 1 with brushing his hair, brushing his teeth, and changing Resident 1's incontinence briefs. * The facility's Grievance Official failed to implement the facility's P&P for grievances/concerns as evidenced by failure to document Family Member A's grievance/concern to conduct an investigation into the grievance/concern and follow up with Family Member A to ensure the grievance/concern was addressed to Family Member A's satisfaction. These failures posed the risk for resident grievances not being addressed and resolved at a facility with a highly vulnerable resident population. Findings: Review of the facility's P&P titled Truly Listening to Our Customers (TLC) Program revised May 2017 showed the facility actively resolves the concerns submitted by the residents, resident representatives or another interested person. The Administrator acts as the facility's Grievance Official and is responsible for overseeing the grievance/concern process, receiving and tracking all concerns through to conclusion, and leading or delegating any necessary investigations by the facility. A staff member should encourage and assist the person acting on the resident's behalf to file a written concern. If the facility received the concern orally, staff should then document the concern. If the concern may be resolved immediately, the staff, under the guidance of the Grievance Official, will resolve the concern and document the solution of the facility's Concern Form. Concerns are to be investigated and resolved within 72 hours from the receipt of the concern. The staff member investigating the concern/grievance will have 2 days to complete the investigation and document the conclusions using the Concern Form. The Grievance Official is to inform the individual filing the concern of the resolution as soon as possible but not longer than 72 hours after receipt of the concern. Medical record review for Resident 1 was initiated on 4/22/20. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 was cognitively intact. Resident 1 required extensive assistance from two staff members with dressing, toilet use, and personal hygiene. On 4/22/20 at 1350 hours, an interview was conducted with Family Member A. Family Member A stated she reported concerns regarding Resident 1 to the facility's Administrator. Family Member A stated the Administrator told her he would conduct an investigation into the concerns she reported to him, however, the facility failed to follow up with her regarding the concerns she reported. Family Member A stated she informed the Administrator Resident 1 utilized his call light to request for staff assistance, and several CNAs who spoke a foreign language than Resident 1 responded to Resident 1's request for assistance but only assisted Resident 1's roommates who spoke the same language as those CNAs. Family Member A stated staff failed to assist Resident 1 with brushing his hair, brushing his teeth, and changing his incontinence briefs. On 4/22/20 at 1420 hours, an interview was conducted with Resident 1. Resident 1 was asked if he had any concerns with the care he received at the facility. Resident 1 stated last Friday he utilized his call light in order to request for assistance from staff. Resident 1 stated CNA 2 responded to his room, and kept telling him she was going to change him, however, he was not changed for several hours. Resident 1 was asked how this made him feel, to which he replied, I felt bad, I felt like they did not care. Resident 1 stated he needed assistance with brushing his teeth and combing his hair in the morning. Resident 1 stated over the previous six months, approximately twice per week staff failed to assist him with brushing his teeth and combing his hair in the morning. Resident 1 stated when he utilized his call light for assistance, the CNAs who spoke a foreign language often failed to assist him, and instead, the CNAs attended to his roommates who spoke the same foreign language as those CNAs. Resident 1 stated he told Family Member A about these concerns and Family Member A then contacted the facility's Administrator. Resident 1 stated the facility failed to contact him regarding these concerns. On 4/22/20 at 1536 hours, an interview and concurrent facility P&P review was conducted with the Administrator. The Administrator verified he was the facility's Grievance Official, who was in charge of the facility's grievance process. The Administrator verified the process in addressing grievances and concerns per the facility's P&P titled Truly Listening to Our Customers (TLC) Program. The Administrator stated Family Member A contacted him and told him the following: the CNAs were speaking in their native language to each other and to Resident 1's roommates. Resident 1 did not speak nor understand the CNAs' language and felt his roommates were receiving preferential treatment. The Administrator stated the facility had not documented or conducted any investigations into any grievances/concerns for Resident 1. The Administrator verified the facility's grievance process was not initiated. The Administrator stated the facility's grievance process should have been followed. The Administrator was asked if he spoke with Resident 1 regarding this concern. The Administrator stated he had not addressed this concern with Resident 1. The Administrator was asked if Family Member A informed him of any additional concerns, to which he replied, he did not recall.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 2) was free from abuse. * LVN 3 threw a cup of coffee at Resident 2. This failure had the potential to cause serious injuries and physical and/or psychosocial harm to the resident. Findings: Review of the facility's P&P titled Abuse and Neglect Prohibition revised July 2018 showed each resident has the right to be free from abuse. Review of the Report of Suspected Dependent Adult/Elder Abuse (SOC 341) form dated 4/20/2020, showed the facility reported an allegation of physical abuse against Resident 2. LVN 3 threw coffee at Resident 2. On 4/22/2020 at 1433 hours, an interview was conducted with the DON and Administrator. The DON stated LVN 1 had reported an unwitnessed allegation of abuse on 4/20/2020, after learning of the incident from LVN 3. The DON stated she interviewed LVN 3 regarding the incident. The DON stated LVN 3 admitted she threw a cup of coffee (was not hot) at Resident 2 because Resident 2 threw a water pitcher at her. The Administrator stated he substantiated the allegation of abuse against Resident 2. The Administrator stated the facility did not tolerate any kind of abuse against a resident. On 4/22/2020 at 1450 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed awake and sitting in his

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.

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) wheelchair by the front lobby. Resident 2 was observed moving his left arm independently. Resident 2 did not have any observable injuries on his arms, neck, and face. Resident 2 was asked how he was doing, he responded with yes. Resident 2 was asked if he remembered the incident from 4/19/2020. Resident 2 responded with obscenities. Resident 2 was asked if he wanted to talk about the incident in a more private setting. Resident 2 responded with obscenities. Resident 2 was asked if he wanted to talk about the incident. Resident 2 again responded with obscenities but did not answer the question. Medical record review for Resident 2 was initiated on 4/22/2020. Resident 2 was admitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. Review of Resident 2's MDS dated [DATE], showed Resident 2 had severely impaired cognition. Resident 2 required extensive one person assistance for bed mobility and had limitation in range of motion to one side of his upper extremities. Review of Resident 2's Progress Notes dated 4/20/2020, showed LVN 3 acknowledged an incident had occurred between her and Resident 2 around 2000 hours on 4/19/2020. The documentation showed LVN 3 was trying to administer Resident 2's medication and check his blood glucose level when Resident 2 became agitated. LVN 3 stayed with the resident while trying to find out why he was upset. The documentation showed Resident 2 became more agitated and threw a water pitcher at LVN 3. LVN 3 then picked up a cup of coffee from Resident 2's dinner tray and threw it at Resident 2. Documentation showed an investigation of the alleged abuse was initiated and a skin assessment did not show any injuries to Resident 2. On 4/22/2020 at 1516 hours, an interview was conducted with LVN 1. LVN 1 stated she was familiar with Resident 2 and was one of the few staff who usually understood what the resident needed. LVN 1 stated Resident 2 spoke limited words and often used obscenities to communicate. LVN 1 was asked about the above alleged abuse against Resident 2. LVN 1 stated she was receiving end of shift report from LVN 3 when LVN 3 reported Resident 2 had thrown a water pitcher at her and she (LVN 3) then threw a cup of coffee back at Resident 2. LVN 1 stated she immediately reported the alleged abuse to a supervisor. On 4/22/2020 at 1635 hours, an interview was conducted with Resident C (Resident 2's roommate). Resident C was asked regarding the events that took place on 4/19/2020, surrounding Resident 2. Resident C stated he heard LVN 3 and Resident 2 yelling at each other. Resident C stated after dinner time, Resident 2 was yelling out, out, out and obscenities at LVN 3. Resident C stated he heard something fall on the floor and assumed Resident 2 threw something at LVN 3. Resident C stated she overheard LVN 3 saying . don't play me like that and left the room. Resident C was asked if he saw LVN 3 throw anything at Resident 2. Resident C stated no, he did not see anything because the curtains were drawn. On 4/24/2020 at 1736 hours, a telephone interview was conducted with CNA 4. CNA 4 verified she was assigned to take care of Resident 2 on 4/19/2020. CNA 4 was asked to describe the events that took place surrounding Resident 2. CNA 4 stated she was attending to another resident near Resident 2's room. CNA 4 stated she overheard Resident 2 yelling obscenities while LVN 3 was explaining to Resident 2 why he needed to take his medications. CNA 4 stated at around 2000 hours, she went to Resident 2's room and saw water and fruit on the floor, and spilled coffee on the table and coffee stains on Resident 2's bed sheets and gown. CNA 4 stated Resident 2 was calm and allowed her to change his sheets. CNA denied witnessing any incident between Resident 2 and LVN 3. On 4/28/2020 at 1449 hours, a telephone interview was conducted with LVN 3. LVN 3 verified she was assigned to take care of Resident 2 on 4/19/2020. LVN 3 was asked to describe the events that took place surrounding Resident 2 on 4/19/2020. LVN 3 stated the incident occurred between 2000 and 2100 hours when Resident 2 became upset and refused to take his medications or have his blood sugar level checked. LVN 3 stated she stayed in the room to find out why Resident 2 was upset and explained to him why he needed to take his medications. LVN 3 stated Resident 2 was increasingly getting agitated and was yelling . out, out, out. LVN 3 stated Resident 2 got up from his bed and threw ice water at her. LVN 3 stated Resident 2 started to walk towards her and attempted to punch her on the chest, so she poured coffee on the resident's gown. LVN 3 stated Resident 2's neck and gown got wet with coffee. LVN 3 stated she did not throw the cup at Resident 2, only the cool liquid that was inside the cup. LVN 3 stated she knew the coffee was not hot because it had been there since dinner (several a few hours earlier) and it had spilled onto her hand. LVN 3 was asked what she should have done when Resident 2 threw water at her. LVN 3 stated she should have walked away and stayed out of his room. When asked if she had reported the incident, LVN 3 stated she told the supervisor Resident 2 had thrown water at her, but she did not tell her supervisor she had poured coffee at Resident 2.