STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555751	A. BUILDING _____ B. WING _____	**09/25/2020**

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

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, and facility document review, the facility failed to thoroughly investigate an injury of unknown origin for one of two sampled residents (Resident 1). The facility failed to ensure a thorough investigation was conducted to rule out possible abuse. * Resident 1 was found with purple discoloration to the right side of his face/eye area. The facility interviewed the CNA who found the discoloration; however, there was no documented evidence the staff from other shifts or other potential witnesses were interviewed to determine the potential cause and rule out abuse. Findings: Review of the facility's P&P titled Abuse Prevention (undated), under Reporting and Abuse Prevention procedures, showed all alleged violations including injuries of unknown origin, such as skin tears, bruises, and abrasions on residents who cannot speak for themselves, or misappropriation of resident property is reported to the Administrator, or designated representative. Evidence that alleged violations are investigated and necessary correction taken is maintained in facility files. Notification of any incident of abuse will be reported to the State Department of Health, Licensing and Certification unit, within five calendar days of the incident. On 8/20/2020 at 1446 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated she received a call from the facility on 6/23/2020, by a nurse who informed her Resident 1 was found with a purple discoloration around the right eye. Family Member 1 stated she was informed by the DON .somebody probably got too rough, while using a facecloth with the resident. Medical record review for Resident 1 was initiated on 8/21/2020. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severely impaired cognition. Review of Resident 1's Progress Notes identified a nursing entry dated 6/18/2020, showed Resident 1 was being prepared for morning care at 0800 hours by a CNA when Resident 1 was noted with a new skin discoloration to the right side of their face. Review of the facility's Incident Report dated 6/18/2020, showed Resident 1 was noted with a dark purple skin discoloration to the right lower eye area, measuring 2.5 cm x 4.5 cm x UTD (unable to determine). Resident 1 was unable to answer yes or no questions or recount the events that had led to the discoloration. The incident investigation failed to show the interviews were conducted with the staff members on the other shifts who had contacted and/or provided care for Resident 1 prior to the discovery of the skin discoloration, and other staff who might have witnessed the alleged incident to rule out possible abuse. Review of the facility's Interview Record dated 6/18/2020, showed CNA 3 and LVN 3 were interviewed. However, there was no documentation to show any other interviews were conducted with other staff members who had taken care of Resident 1 to determine if they had noticed the discoloration or were aware of any potential cause of the injury. Review of the facility's Investigation of Incident/Accident/Injury of Unknown Origin dated 6/18/2020, showed CNA 3 and LVN 3 were interviewed. The conclusion showed the injury was unwitnessed, but it was possible the resident might have been cold during the previous night and could have injured himself while trying to pull up the blankets. Documentation failed to show the state agency was not notified of this injury of unknown origin. On 9/23/2020 at 1727 hours, an interview, concurrent facility document and medical record review for Resident 1 was conducted with LVN 3. LVN 3 stated CNA 3 informed her Resident 1 had a skin discoloration on the right side of his face. LVN 3 verified she completed the incident report and interviewed CNA 3. LVN 3 stated she asked the staff on her shift and previous shift who might have witnessed what happened. When asked about the documentation of her interviews, LVN 3 could not provide any documentation. LVN 3 stated RN 1 conducted the formal interviews. On 9/24/2020 at 1417 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the above findings. When asked for any interviews from the previous shift, the DON stated she interviewed a staff member from the previous shift but forgot to document in the interview record.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE