STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555249	A. BUILDING _____ B. WING _____	04/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA CLIFF HEALTHCARE CENTER	18811 FLORIDA ST HUNTINGTON BEACH, CA 92648

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 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 interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 1) was free from abuse. * The facility failed to ensure Resident 1 remained free from verbal abuse when CNA 1 made inappropriate comments regarding the resident's bowel movement. The facility also failed to ensure Resident 1 was free from neglect when CNA 1 left Resident 1 in bed sheet soiled with feces after not thoroughly changing the resident. These failures caused Resident 1 to feel bad and disrespected and had the potential to cause unintended consequences such as skin breakdown to Resident 1. Findings: According to the facility's P&P titled Abuse Prevention and Prohibition Against revised 11/28/17, the residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to neglect and verbal abuse. Review of the facility's abuse investigation completed on [DATE], showed the following: * Resident 1 verbalized CNA 1 was making unprofessional comments about her bowel movement when he was changing her on [DATE], and left her bed sheet soiled with feces. Resident 1 verbalized she did not want CNA 1 back to her room. Resident 1 stated CNA 1 was unprofessional and disrespectful. Resident 1 stated CNA 1 said eww poop, it stinks! as he changed Resident 1's incontinence pad. * Resident 1's roommate (Resident A) stated she heard CNA 1 complain about Resident 1's bowel movement, stating, I don't know what to do with you, poop ugghhh I'm gonna quit my job. * CNA 3 stated she helped change Resident 1's incontinence pad and bed sheets because the incontinence pad was not properly closed and there were feces stains on the bed sheets. * CNA 4 stated while providing care to Resident 1, CNA 1 walked into the room and Resident 1 yelled, I don't want you here, and CNA 1 responded, I don't want you either because you're too much and left the room. Review of the Administrator's investigative conclusion dated 3/8/2020, showed the facility substantiated Resident 1's allegations. Medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], showed Resident 1 had no cognitive impairment. Resident 1 required extensive assistance of one person for toileting and was totally dependent on staff for personal hygiene. On [DATE] at 1042 hours, a telephone interview was conducted with the ADON. The ADON stated on [DATE], Resident 1's roommate informed him CNA 1 was making inappropriate comments regarding Resident 1's bowel movement. The ADON stated during his investigation, two CNAs verified Resident 1's allegations (CNAs 3 and 4). On [DATE] at 1327 hours, an interview was conducted with Resident 1. Resident 1 stated she was dependent on the staff for incontinence care. Resident 1 stated on [DATE], CNA 1 walked into her room to change her incontinence pad. Resident 1 stated when CNA 1 started removing her incontinence pad, he stated, eww .yuck. I don't like this job. Resident 1 stated this made her feel bad and disrespected. Resident 1 stated she informed CNA 1 how this made her feel. Resident 1 stated CNA 1 did not put her incontinence pad correctly and did not clean up the sheets soiled with feces from her bed. Resident 1 stated the following day, when CNA 1 walked into her room, she told him she did not want him, and CNA 1 stated he did not want her either and walked out. On [DATE] at 1335 hours, an interview was conducted with Resident 1's roommate (Resident A). Resident A stated she was in the room when CNA 1 provided care to Resident 1 on [DATE]. Resident A stated she heard CNA 1 make the comment of Eww .yuck to Resident 1 as he was providing care. Resident A stated she also heard CNA 1 ask the Resident 1, Can't you move? and Resident 1 responded, No, I can't move my left hip is bad. Resident A stated CNA 3 walked into the room after CNA 1 left and helped Resident 1. Resident A stated Resident 1 was visibly upset and hurt by how CNA 1 had treated her. On 3/18/2020 at 1043 hours, a telephone interview was conducted with CNA 2. CNA 2 stated on [DATE], when she started her shift at 1500 hours, Resident 1 stated she was wet and needed to be changed. CNA 2 observed Resident 1's incontinence pad was soiled and the bed sheets were soaked all the way up her back. Resident 1 informed her CNA 1 had taken care of her and left her that way before his shift was over. On 3/18/2020 at 1346 hours, a telephone interview was conducted with CNA 3. CNA 3 stated in the morning of [DATE], a charge nurse asked her to help Resident 1. CNA 3 stated she did not remember who asked her to do this. CNA 3 noted Resident 1 appeared very angry when she walked into the room. CNA 3 stated she provided care to Resident 1 because CNA 1 did not finish the job. CNA 3 stated she changed Resident 1's incontinence pad and the soiled bed sheets. CNA 3 stated Resident 1's incontinence pad was not properly applied and the bed sheets were soiled with feces. On 3/18/2020 at 1403 hours, a telephone interview was conducted with CNA 4. CNA 4 stated she worked the 0700 to 1500 hours shift on [DATE], and was assigned to provide care Resident 1. CNA 4 stated Resident 1 informed of an incident that occurred the day before. Resident 1 reported CNA 1 made inappropriate comments about her bowel movement smelling so bad and how CNA 1 ignored Resident 1 when she spoke to him. CNA 4 stated while she was in the room with Resident 1, CNA 1 walked into the room. CNA 4 stated Resident 1 told CNA 1 she did not want him taking care of her, to which CNA 1 responded he did not want Resident 1 either because she was too much and then left the room. Cross reference to F610.
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, and facility P&P review, the facility failed to report an incident of an allegation of staff to resident abuse in a timely manner for one of two sampled residents (Resident 1). * Resident 1 reported an allegation of verbal abuse and neglect against CNA 1. The incident was not immediately reported by three staff members to the facility's Abuse Coordinator. Failure to report and investigate Resident 1's allegation of abuse placed other vulnerable residents at an increased risk for abuse. Findings: According to the facility's P&P titled Abuse Prevention and Prohibition Against revised 11/28/17, all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator (Abuse Coordinator). Review of the SOC 341 (facility's report of suspected dependent adult/elder abuse) dated [DATE], showed Resident 1's roommate (Resident A) reported CNA 1 made inappropriate comments about Resident 1's bowel movement and did not clean Resident 1 appropriately. Medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], showed Resident 1 had no cognitive impairment. On [DATE] at 1042 hours, a telephone interview was conducted with the ADON. The ADON stated he first learned of Resident 1's abuse allegation from a licensed nurse on [DATE]. The ADON stated he spoke to Resident 1's roommate and was informed about CNA 1 making inappropriate comments regarding Resident 1's bowel movement. The ADON stated during his investigation, two CNAs had verified Resident 1's allegations. On [DATE] at 1327 hours, an interview was conducted with Resident 1. Resident 1 stated she was dependent on the staff for incontinence care. Resident 1 stated on [DATE], CNA 1 provided incontinence care. When CNA 1 removed her incontinence pad, CNA 1 stated, eww .yuck. I don't like this job. Resident 1 stated this made her feel bad and disrespected. Resident 1 stated she informed CNA 1 how this made her feel. Resident 1 stated CNA 1 did not put her incontinence pad correctly and did not clean up the bed sheets soiled withn feces from her bed. Resident 1 stated the

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

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) following day, when CNA 1 came back to her room to provide care, she told him she did not want him taking care of her, to which CNA 1 responded he did not want her either and walked out. On [DATE] at 1335 hours, an interview was conducted with Resident 1's roommate, Resident A. Resident A stated she was in the room when CNA 1 provided care to Resident 1 on [DATE]. Resident A stated she heard CNA 1 made the comment of Eww .yuck to Resident 1. Resident A stated she also heard CNA 1 asking Resident 1, Can't you move? Resident 1 responded she can not move because her hip was bad. Resident A stated CNA 3 had to help change her sheets and incontinence pad. Resident A stated Resident 1 was visibly upset and hurt by how CNA 1 treated her. Resident A stated CNA 3 told her CNA 1 had left Resident 1 in the bed dirty with feces all over and the incontinence pad half on. Resident A stated later that night, she shared what happened with CNA 2. Resident A stated CNA 2 told her she needed to report this immediately. Resident A stated she informed LVN 1 about the incident on [DATE] after 1200 hours. On 3/18/2020 at 1028 hours, a telephone interview was conducted with LVN 1. LVN 1 stated on [DATE], during his morning shift, Resident A came up to him and informed him CNA 1 was rude and mistreating Resident 1. LVN 1 stated he immediately told the ADON about the incident. LVN 1 stated it was the facility's policy to immediately report the incident to the Administrator or the person in charge. LVN 1 stated it was important to immediately separate the resident and staff member if the abuse was suspected so they no longer took care of the resident. LVN 1 was asked what the expectation was for a CNA who was verbally reported of an abuse incident by a resident. LVN 1 stated the CNAs were to immediately report it to the Administrator or to their charge nurse. On 3/18/2020 at 1043 hours, a telephone interview was conducted with CNA 2. CNA 2 stated when she started her shift on [DATE] at 1500 hours, Resident 1's incontinence pad and bed sheet were soaking wet. Resident 1 informed her CNA 1 was making inappropriate comments during the incontinence care and left her that way before his shift was over. CNA 2 stated Resident 1 told her she did not want to see CNA 1 or have him take care of her again. CNA 2 was asked if she reported this to anybody, to which she stated no because it did not happen on her shift and she was informed by Resident 1's roommate they reported this already. On 3/18/2020 at 1346 hours, a telephone interview was conducted with CNA 3. CNA 3 stated on [DATE], at around 0900 hours, a charge nurse asked her to help Resident 1. CNA 3 stated she found Resident 1 with bed sheet soiled in feces and her incontinence pad was not secured properly. CNA 3 stated Resident 1 was very upset about this and stated CNA 1 did not know what he was doing. CNA 3 stated she did not report the incident because she thought this was not abuse. At 3/18/2020 at 1403 hours, a telephone interview was conducted with CNA 4. CNA 4 stated while she was providing care to Resident 1 on [DATE], Resident 1 informed her of an incident that occurred with CNA 1 the day before. CNA 1 had made inappropriate comments about her bowel movement smelling so bad and CNA 1 ignored Resident 1 when she spoke to him. CNA 4 stated while she was providing care to Resident 1, CNA 1 walked in the room. Resident 1 told CNA 1 she did not want him taking care of her, to which CNA responded he did not want her either because she was too much, and CNA 1 then left the room. CNA 4 stated she did not notify anybody regarding the incident because she did not think this was abuse. CNA 4 stated she also did not report what Resident 1 had told her because she did not know if Resident 1 was telling the truth. On [DATE]20 at 1420 hours, a telephone interview was conducted with the Administrator. The Administrator stated if there was an allegation of abuse, he expected the staff to report the allegation right away. The Administrator stated any allegation should be reported even if staff did not know if what the resident alleged was true. Review of the Administrator's investigative conclusion dated 3/8/2020, showed the facility substantiated Resident 1's allegations. Cross reference to F600.