STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055237	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORIA HEALTHCARE AND REHABILITATION CENTER	340 VICTORIA STREET 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 document review, and facility P&P review, the facility failed to remove two alleged abuse perpetrators immediately from the care of the resident after a resident's allegation of abuse was reported. This failure had the potential to result in Resident 1 and other residents experiencing abuse from staff. Findings: Review of the facility's P&P titled Nursing Administration, Resident rights, Abuse Prevention revised [DATE]7/17, showed the residents must not be subjected to abuse by anyone including facility staff. The facility will take the following steps to prevent further potential abuse while the investigation is in progress. If the suspected perpetrator is an employee, remove the employee immediately from the care of any resident and suspend the employee during the investigation. Review of the Report of Suspected Dependent Adult/Elder Abuse (SOC 341 form) dated 4/26/2020, showed the licensed nurse noted a skin tear to Resident 1's anterior thigh. Resident 1 reported he was .physically held down by two CNAs during care. Medical record review for Resident 1 was initiated on 4/29/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 was alert and had no cognitive impairment. Review of the LN - Skin Ulcer Non-Pressure Weekly form dated 4/26/2020, showed Resident 1 sustained an 8 cm (length) x 8 cm (width) skin tear to his right anterior thigh. On 4/29/2020 at 0936 hours, an interview was conducted with Resident 1. Resident 1 stated he had been held down by CNAs 1 and 2 during incontinence care. Resident 1 stated this resulted in a skin tear to his right anterior thigh. Review of the staff assignment for Nursing Stations 1 and 2 for for the night shift (2300 to 0700 hours) dated 4/25/2020, showed CNA 1 was assigned to care for Resident 1. CNA 2 was assigned to work on the same nursing station. Review of the staffing sheet did not show any documentation CNAs 1 or 2 had been replaced by another staff member after Resident 1 had reported the allegation of abuse against CNAs 1 and 2. On 4/29/2020 at 1239 hours, an interview was conducted with the DON. The DON stated CNAs 1 and 2 were suspended during the investigation. However, the DON stated both CNAs 1 and 2 had completed their shifts after Resident 1 made the allegation of abuse against them. The DON stated she did not know if they had been relieved their duties of caring for their assigned residents. Review of CNA 1's time card for 4/25/2020, showed she had completed her shift and clocked out at 0708 hours on 4/26/2020. Review of CNA 2's time card for 4/25/2020, showed he had completed his shift and clocked out at 0712 hours on 4/26/2020. On 5/1/2020 at 0825 hours, a telephone interview was conducted with CNA 2. CNA 2 stated the incident with Resident 1 occurred on 4/26/2020 at 0500 hours, when he was helping CNA 1. CNA 2 stated he was not removed from care of his assigned residents after the alleged abuse incident. CNA 2 stated no other staff members relieved him from his assigned duty. CNA 2 stated he was instructed by his supervisor, LVN 1, to continue working with the residents in his assigned rooms until the end of his shift. CNA 2 verified he completed his run and clocked out at the end of his scheduled shift. On 5/1/2020 at 1015 hours, a telephone interview was conducted with LVN 1. LVN 1 stated she was the nurse in charge of Station 1 on the night shift of 4/25/2020. LVN 1 stated she was the nurse supervisor for both CNAs 1 and 2. LVN 1 verified both CNAs had reported the incident regarding Resident 1 to her on 4/26/2020 at 0515 hours, approximately two hours before the end of their shift. LVN 1 stated she went to Resident 1's room to provide care to Resident 1's skin tear and to interview Resident 1 regarding his allegation of abuse against CNAs 1 and 2. LVN 1 stated she instructed CNA 2 to continue working with his assigned residents until the end of his shift (at 0700 hours). LVN 1 stated she instructed CNA 1 to not provide care to Resident 1, but to continue working with the other residents in her assigned rooms until the end of her shift. LVN 1 verified no other staff member relieved CNA 1 or CNA 2 from their assigned resident duties. On 5/1/2020 at 1407 hours, a telephone interview was conducted with the DSD. The DSD stated she was responsible for providing abuse training to facility staff was her responsibility. The DSD stated the expectation was for the staff, including the charge nurses and nurse supervisors to know and implement all aspects of the facility's abuse policy when an allegation of abuse was received. The DSD verified the policy identified the staff members who had been accused of abuse were to be removed immediately from any resident care. The DSD verified the above findings. On 5/4/2020 at 0845 hours, a telephone interview was conducted with CNA 1. CNA 1 stated she was assigned to provide care for Resident 1 on the night shift of 4/25/2020. CNA 1 stated she asked CNA 2 for assistance with turning and providing incontinence care to Resident 1. CNA 1 stated CNA 2 was with her when the incident with Resident 1 occurred. CNA 1 stated she was not removed from care of her assigned residents after the alleged abuse incident. CNA 1 stated no other staff member relieved her from her assignment and was instructed by LVN 1, to stay out of Resident 1's room. CNA 1 stated LVN 1 instructed her to continue providing care to her assigned residents until the end of her shift (at 0700 hours). CNA 1 verified she completed the care to her assigned residents and clocked out at the end of her scheduled shift.

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.