| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555259 | A. BUILDING _____ B. WING _____ | 08/07/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MAINPLACE POST ACUTE** | **1835 WEST LA VETA AVENUE ORANGE, CA 92868** |

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

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| F 0553<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Allow resident to participate in the development and implementation of his or her person-centered plan of care.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and medical record review, the facility failed to ensure a care plan conference was conducted in a timely manner for one of three sampled residents (Resident 2). This had the potential for Resident 2 to not be able to participate in choosing their treatment options and make decisions about the planning of their care. Findings: Medical record review for Resident 2 was initiated on 7/1/20. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE], showed Resident 2 had severe cognitive impairment. On 7/6/20 at 0901 hours, a telephone interview was conducted with Family Member A. Family Member A stated she was involved in Resident 2's care and she was the power of attorney for Resident 2. Family Member A stated she wanted to know the plan of care was for Resident 2. Family Member A stated she asked the facility multiple times to have the care plan conference since the resident's admission. Family Member A was told the social worker would arrange the care plan conference, but the conference was not held until 5/7/2, three months later, and this was very frustrating. Review of Resident 2's IDT-Care Plan Review dated 5/7/20, showed the type of review was documented as Initial Review. On 7/10/20 at 1549 hours, a telephone interview was conducted with the SSD. The SSD was asked if she arranged the initial care conference for a newly admitted residents. The SSD stated yes, but when she started working at the facility in May 2020, and the MDS Coordinator had arranged for the new admission's care conferences. On 7/14/20 at 1150 hours, a telephone interview was conducted with the MDS Coordinator Assistant. The MDS Coordinator Assistant stated the initial care plan meeting/conference should be held within 14 days of admission. The MDS Coordinator Assistant was asked if she knew why Resident 2's initial care plan conference was held three months after their admission. The MDS Coordinator Assistant stated she started arranging the care plan conferences after the former SSD left the facility. When Resident 2 was admitted to the facility in February 2020, the previous SSD was responsible in scheduling and arranging the initial care plan conference. Review of the Social Service Progress Notes for the month of February 2020 failed to show documentation the SSD had attempted to conduct the initial care plan conference nor communicated with Resident 2's responsible party regarding the care plan conference. On 7/17/20 at 1559 hours, a telephone interview was conducted with the DON. The DON verified the above findings. The DON was asked if there was any reason why Resident 2's initial care plan conference was conducted three months after admission. The DON stated the initial care plan conference should have been conducted within 14 days of admission and she was not sure why it was delayed for three months. |
| F 0582<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and medical record review, the facility failed to provide one of three sampled residents (Resident 2) with the Notice of Medicare Non-Coverage (NOMNC). The NOMNC is used to inform residents of their potential financial liability and appeal rights and protections should they wish to receive care and services that may not be covered by Medicare. This had the potential of not allowing Resident 2 to make an informed decision regarding their Medicare services. Findings: Medical record review for Resident 2 was initiated on 7/1/20. Resident 2 was admitted to the facility on [DATE]. Review of the Order Summary Report for July 2020 showed an order dated 2/24/20, identifying Resident 2's last covered day was 2/29/20, and he was to transition to custodial care on 3/1/20. Review of the Case Manager Progress Notes from February to March 2020 failed to show any documentation Resident 2 and/or his responsible party was informed Resident 2's last date of Medicare coverage and Resident 2's transition to custodial care. On 7/1/20 at 1251 hours, an interview and concurrent medical record review was conducted with the Case Manager. The Case Manager was asked about the process of issuing a NOMNC. The Case Manager stated she notified residents or their responsible party at least two days prior to residents' last date of Medicare coverage and issued the NOMNC. The Case Manager failed to provide any documentation to show a NOMNC was issued to Resident 2 or his responsible party two days before his last Medicare covered day. The Case Manager stated the NOMNC should have been issued between 2/24 and 2/27/20. The Case Manager verified the above findings. On 7/6/20 at 0901 hours, a telephone interview was conducted with Family Member A. Family Member A stated she was involved with Resident 2's care and she was the power of attorney for Resident 2. Family Member A was asked if she was informed about Resident 2's medicare last covered day or Resident 2 becoming custodial care. Family Member A stated she was not informed Resident 2's status had changed to custodial care; she was not informed about NOMNC and was not given an opportunity to appeal. Family Member A stated she found out about all these when she received an unexpected bill from the facility. The Family Member A stated she wished she had been informed, so that she could have taken action to potentially appeal |
| F 0585<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to promptly and thoroughly investigate a grievance of staff being rude to Resident 2. This failure had the potential to impact Resident 2's psychosocial well-being. Findings: Review of the facility's P&P titled Grievances revised 11/2007 showed when a concern is voiced to a facility employee, the resident, family, guest or fell ow employee is directed to the appropriate department supervisor to evaluate and resolve the issue. The Administrator evaluates and investigates the concerns and takes the appropriate action to resolve the concerns and prevent further occurrences. On 7/6/20 at 0901 hours, a telephone interview was conducted with Family member A. Family Member A stated Resident 2 reported to her a CNA was not treating him right and he wanted to go back home. Family Member A stated she reported this to the SSD but never heard back from anyone on this. On 7/10/20 at 1549 hours, a telephone interview was conducted with the SSD. The SSD was asked about Family Member A's concern regarding staff not treating Resident 2 right. The SSD stated she was informed one of the staff was rude to Resident 2 and she documented this in the Grievance Resolution Form. The SSD stated when she informed the scheduler not to assign the alleged CNA to Resident 2, the SSD was told the CNA was no longer working at the facility because other residents had reported similar concerns involving this CNA. The SSD was asked if she knew what had happened between the CNA and Resident 2. The SSD stated no, she was not sure but it might have been documented in the Grievance Resolution Form. When asked about the CNA's name, the SSD stated she did not remember, but she probably wrote the name down on the Grievance Resolution Form. Review of Grievance Resolution Form dated 6/19/20, under the section for the summary of concern (to include time, place and |

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 0585<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>names of those involved )showed family stated that CNA was being rude to resident was written. Under the section for the resolution (to include how the concern will be resolved and those responsible) showed SSD spoke with staffing coordinator and the staffing coordinator stated that CNA was let go 1-2 weeks ago. There was no documentation of what had happened and who the CNA was in the Grievance Resolution Form. On 7/16/20 at 1559 hours, a telephone interview was conducted with the DON. The DON was asked if she received the report about a complaint or grievance regarding a CNA being rude to Resident 2. The DON stated she was not aware of any. The DON was asked if any CNA was terminated in May or June 2020 due to mistreatment to the residents. The DON stated no. Review of the Employee Termination Report dated 5/13/20, showed a CNA was terminated for insubordination of nursing leadership and demonstrating an inability to work along side of his peers. On 7/17/20 at 1059 hours, a telephone interview was conducted with the Administrator. The Administrator was asked the process of resolving grievances. The Administrator stated when the SSD receives a grievances, the SSD discusses the concerns with the particular department and would report this the Administrator. When asked about Resident 2's grievance on 6/19/20, the Administrator stated when the complaint was reported by the family member, the CNA was no longer working at the facility; therefore, there was no further action taken. When the Administrator was asked if he knew what had happened and who the CNA was. The Administrator stated he did not remember. The Administrator acknowledged the investigation and evaluation of the grievance was not conducted per the facility's P&P. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for one of three sampled residents (Resident 3). * The facility did not attempt to interview Resident 3's roommate and the other two residents who shared Resident 3's bathroom as potential witnesses to the allegation. This had the potential for the circumstances related to the allegation to remain undisclosed. * The facility failed to interview the other residents assigned to CNA 2 and LVN 2 to identify other potential victims of abuse. This posed the risk for other potential victims of abuse to remain unidentified and go unprotected.<br>Findings: Review of the facility's P&P titled Abuse Investigation (undated) showed it is the policy of the facility that reports of abuse are promptly and thoroughly investigated. The investigation will consist of at least the following .interviews with any witnesses to the incident and interviews with the resident's roommate, family members, and visitors, if indicated. Review of the Report of Suspected Dependent Adult/Elder Abuse SOC 341 form, completed and signed by the facility's Administrator dated 4/14/2020, showed Resident 3 reported to the Administrator that a CNA and LVN (later identified as CNA 2 and LVN 2) assisted Resident 3 out of the bathroom before she was done by grabbing her arm. Resident 3 also reported CNA 2 and LVN 2 threatened to cut her hair and laughed at her when she stated she was going to report the incident to the Administrator. Medical record review for Resident 3 was initiated on 7/1/2020. Resident 3 was admitted to the facility on [DATE]. On 7/1/2020 at 1122 hours, an observation of Resident 3's room and concurrent interview was conducted with CNA 3. CNA 3 stated Resident 3 shared the bathroom with her roommate and the two residents in the adjoining room. Review of the facility's census dated 4/14/2020, showed Resident 3 had one roommate and the adjoining room sharing Resident 3's bathroom was occupied by two other residents. On 7/1/2020 at 1315 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator stated he conducted the abuse investigation along with LVN 3. The Administrator stated, it was reported that Resident 3 was in the bathroom for too long when another resident sharing the bathroom needed to use it. The Administrator stated Resident 3 reported that CNA 2 and LVN 2 grabbed her forearm to rush her out of the bathroom and threatened to cut her hair. Review of the abuse investigation showed documented interviews relating to the abuse allegation with CNA 2, LVN 2, and the Dining Service Director. No other interviews were documented, including of Resident 3's roommate, of the other residents sharing the same bathroom, nor of other residents assigned to CNA 2 and LVN 2. The Administrator verified this. The Administrator was asked the purpose of interviewing Resident 3's roommate and the other residents assigned to CNA 2 and LVN 2. The Administrator stated to identify potential witnesses and identify other potential abuse by CNA 2 and LVN 2. On 7/1/2020 at 1325 hours, an interview and concurrent facility document review was conducted with LVN 3. LVN 3 verified she assisted the Administrator to conduct the abuse investigation related to Resident 3's allegations. LVN 3 verified she only interviewed Resident 3, CNA 2, and LVN 2. LVN 3 stated she spoke to Resident 3's roommate, who was alert and oriented, but verified there was no documentation to show Resident 3's roommate was interviewed. LVN 3 was asked if other residents assigned to CNA 2 and LVN 2 were interviewed. LVN 3 stated she should have interviewed other residents assigned to CNA 2 and LVN 2, but did not because she did not previously receive complaints about CNA 2 and LVN 2 from other residents. On 7/15/2020 at 1539 hours, a telephone interview was conducted with CNA 2. CNA 2 stated the resident in the adjoining room was upset because Resident 3 was taking too long in the bathroom. CNA 2 denied the allegations and stated she was able to convince Resident 3 to leave the bathroom so the other resident could use the bathroom. When asked, CNA 2 stated she recalled Resident 3's roommate was in the room at the time of the incident. |
| F 0687<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate foot care.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to provide proper toenail and foot care to one of three sampled residents (Resident 2). This failure had the potential to affect resident's health, contribute to skin or toe nail injury and/or infections. Findings: Medical record review for Resident 2 was initiated on 7/1/20. Resident 2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Family Member A stated she asked the facility multiple times for Resident's toe nails to be cut since the resident's admission. Family Member A stated Resident 2 had an ingrown toe nail and it had been hurting him. However, Resident's 2 toe nails were not cut until approximately three months after his admission. Review of the physician's orders [REDACTED]. - An order dated 2/17/20, showed podiatry consultation. - An order dated 4/9/20, showed podiatry consultation for toe nail debridement. - An order dated 5/2/20, showed podiatry consultation as need for [DIAGNOSES REDACTED]. Review of Resident 2's Nursing Progress Notes showed an entry dated 2/17/20 at 1116 hours, showing Resident 2 was seen and examined by the Nurse Practitioner with new orders noted and carried out: podiatrist consultation. Review of the Podiatric Evaluation and Treatment dated on 5/21/20, showed an assessment identified Resident 2 had a diabetes and he had mycotic nails (nails that become infected with a fungus). Documentation identified Resident 2 was at risk and required foot care and nail debridement. On 7/10/20 at 1549 hours, telephone interview was conducted with the SSD. The SSD was asked if she was in charge of podiatrist referrals for residents. The SSD stated yes. The SSD was asked if there was a timeline to arrange the podiatrist consultation. The SSD stated she usually did it right away within a day. The SSD was asked the reason why Resident 2's podiatry consultation was completed more than three month after it was first ordered. The SSD stated she was not sure. Review of the Social Service Progress Notes showed an entry by the SSD dated 5/13/20 at 2300 hours, showed Resident 2's family member had requested the resident have podiatrist consultation. There was no documentation regarding Resident 2's podiatrist consultation prior to 5/13/20. Review of Resident 2's plan of care showed a care plan problem dated 2/18/20, to address Resident 2's diabetes mellitus management. The interventions included to refer to podiatrist or foot care nurse to monitor/document foot care needs and to cut long nails. On 7/14/20 at 1131 hours, telephone interview was conducted with LVN 4. When LVN 4 was asked who cut the resident's toe nails, he stated the podiatrist cut the toe nails for residents with diabetes mellitus. LVN 4 was asked when he took care of Resident 2, if he looked at Resident 2's toe nails and documented his findings. LVN 4 stated if Resident did not complain of any pain at the time, then no assessment and documentation was needed. LVN 4 stated he did not assess or document anything about Resident 2's toe nails. On 7/21/20 at 1502 hours, a telephone interview was conducted with CNA 4. CNA 4 provided care for Resident 2 in May 2020. When CNA 4 was asked if Resident 2's toe nail was long, CNA 4 stated yes. CNA 4 was asked if Resident 2 complained of any pain or discomfort about his toe nails. CNA 4 stated yes but she did not remember exactly when but recalled reporting this to the licensed nurse who was on duty. Review of the Nursing Progress Notes from Resident 2's admission on 2/6/20 through to 5/20/20, failed to find any documentation showing Resident 2's toe nails were assessed or cut. On 7/21/20 at 1600 hours, a telephone interview was conducted with the DON. The DON was informed about above findings and the DON verified the findings. |