STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555915	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS HEALTH AND REHABILITATION CENTER	**25924 JACKSON AVE MURRIETA, CA 92563**

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident's needs and preferences were met, for one of three residents reviewed (Resident A). This failure resulted in Resident A experiencing emotional distress and had the potential for Resident A to have a decline in her overall health condition. Findings: On July 28, 2020, at 9:25 a.m., an unannounced visit was conducted to the facility to investigate a facility reported incident of an allegation of abuse. On July 28, 2020, at 11 a.m., the Administrator (ADM) and the Director of Nursing (DON) were interviewed. The ADM stated she received a call from the DON on July 20, 2020, at around 7 a.m., regarding an allegation from Resident A that Certified Nurse Assistant (CNA) 1 was rough when she made a gesture towards her. The DON stated Resident A was very particular with her belongings and CNA 1 did not place her belongings where she usually preferred them to be. She stated CNA 1 was not familiar of Resident A's preferences and had a hard time understanding Resident A as she was speaking in Spanish. She stated CNA 1 should have used the communication board or could have used Google Translate (a website device to translate English to different languages) to communicate with a resident who did not understand or speak the English language. On July 28, 2020, at 11:53 a.m., the Register Nurse Supervisor (RNS) was interviewed. She stated she went to assess Resident A after Licensed Vocational Nurse (LVN) 1 reported to her Resident A did not like CNA 1. She stated while she was talking to Resident A to ask what happened, Resident A called her family member (FM) who talked to her. She stated Resident A's FM told her Resident A was hysterical and crying, as CNA 1 did not put her belongings within her reach. She stated the FM told her the chair located beside Resident A's bed, which contained some of Resident A's belongings, was covered with with the provacy curtain and the overbed table was far from her. On July 28, 2020, at 3:41 p.m., Resident A was observed in bed in a semi-sitting position. An overbed table was observed located at the left side of Resident A's bed. The overbed table was observed to have a water pitcher and Vaseline cream, among other things on top of it. A box of Resident A's belongings was observed on a chair at the right side of Resident A's bed. In a concurrent interview with Resident A, she stated there was one night when her overbed table was moved away from her. She stated she preferred the overbed table to be close to her bed. She stated the CNA did not place her belongings where she preferred them to be. She stated the CNA told her to turn and to speak English, in a rude manner. She stated she was very upset about the incident and felt her blood pressure shoot up. On July 29, 2002, at 9:27 a.m., LVN 1 was interviewed. She stated Resident A's FM called the facility to inform her the CNA was rough on Resident A and her things at bedside were taken away from her. She stated she checked Resident A's blood pressure and it was high. She stated she gave Resident A medication for her elevated blood pressure. On July 29, 2020, Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Progress Notes, completed by Resident A's physician, dated June 4, 2020, indicated Resident A had the capacity to make decisions. An untitled document included a plan of care, dated June 8, 2020, indicating, .The resident has a communication problem r/t (related to) Language barrier; Spanish Speaking only .Goal .The resident will be able to make basic needs known .Interventions .Anticipate and meet needs .Encourage resident to continue stating thoughts even if resident is having difficulty .Monitor effectiveness of communication strategies and assistive devices . The Progress Notes, dated July 20, 2020, at 6:05 a.m., indicated, .Writer was called to the resident's room because Charge Nurse said that resident was talking to the (FM) on the phone and was crying .Resident appears upset when she was talking to this writer.She reported that she was sleeping good and staff tap her on the arm and asked if she peepee started pushing her stuff and bedside table away from her.Resident started dialing the (FM's) number (name of FM) and hand (sic) me over the phone. (FM) (name of FM) was upset about the incident.Resident reported it to her that after the staff was done changing her,staff left her bed high,bedside table pushed away and the chair with all her stuff on it covered with curtain. When she asked the staff to bring her stuff closed (sic) to her,staff waved her hand in a rough manner. When the staff went back to the room,resident reported to the (FM) that the staff brought her stuff closer to her and put her bed down in a rough manner and was being rude to her telling her to speak English . The facility's final report, received by facsimile (a telephonic transmission) on July 24, 2020, indicated Resident A reported to the FM the CNA was 'rough with her gestures and care' and had told her to speak English. The report indicated Resident A was upset the CNA moved her stuff away from her and did not put them back within her reach. On July 30, 2020, at 10:39 a.m., CNA 1 was interviewed. She stated she went to Resident A and explained what she will be doing to her. She stated Resident A started to speak in Spanish and she had a hard time understanding what resident wanted such as where Resident A preferred her belongings to be placed. She stated Resident A wanted her belongings placed in a certain way and she moved Resident A's things around, as much as she understood. She stated she went to Resident A's room again to check her vital signs but Resident A told her Not you. I don't want you here. On August 4, 2020, at 2:06 p.m, a follow up interview was conducted with CNA 1. She stated she asked CNA 2 to help her to understand Resident A but CNA 2 told her he did not speak or understand Spanish. She stated she did not ask the licensed nurse's help to understand Resident A. She stated she was not aware of resources she could have used to communicate with Resident A. She stated she did not receive information about resources to communicate to a non-English speaking resident such as the communication board during her orientation. She stated she did not ask other staff to help her with Resident A. On August 4, 2020, at 2:16 p.m., the DON was interviewed. She stated CNA 1 should have asked the licensed nurses where she could get additional resources to be able to communicate with Resident A when she had difficulty communicating with Resident A to prevent the resident from getting upset. On August 6, 2020, at 10:30 a.m., a follow up interview was conducted with the DON. She stated Resident A had specific preference on where she wanted her belongings placed in her room. She stated Resident A's preference where her belongings were to be placed was not accomodated as the CNA was not able to understand her well. She stated Resident A's preference should have been accomodated to be able to provide her a home-like environment. The facility policy and procedure titled, Resident Rights - Accomodation of Needs, dated July 1, 2015, was reviewed. The policy indicated, .To ensure that the facility provides an environment and services that meet residents' individual needs .The Facility's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being .Residents' individual needs and preferences are accommodated to the extent possible .In order to accommodate residents' individual needs and preferences, Facility staff attitude and behavior are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible according to residents' wishes .Facility Staff interacts with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains each resident's dignity .Facility Staff arranges toiletries and personal items so that they are within easy reach of the resident . The facility policy and procedure titled, Translation or Interpretation Services, dated August 1, 2017, was reviewed. The policy indicated, .To ensure that residents with Limited English Proficiency (LEP) .have the same access to Facility services as other residents .The Facility aids residents with LEP .through translation and interpretation services .Providing meaningful access to services provided by the Facility requires that the LEP resident's needs and questions are accurately communicated to Facility Staff .In addition to the use of interpreters and translators, the Facility may use

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 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) electronic devices, written materials and communication boards to address language barriers .