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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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** 48332 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to protect Resident 1's rights to be free from the physical abuse by Resident 2. This failure had the potential to result in the serious injury and/or psychosocial harm to Resident 1. Findings: Review of the facility's P&P titled P-AN01 Abuse Prevention and management, Operation Manual Abuse & Neglect revised 5/30/24, showed abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, and physical or chemical restraint not required to treat symptoms, and/or imposed for the purposes of discipline or convenience, intimidation, exploitation, misappropriation of resident property, mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. Abuse includes the neglect and deprivation of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse also includes verbal abuse, sexual abuse, physical abuse, mental abuse, or abuse facilitated or enabled by the use of technology that causes physical harm, pain, or mental anguish. Thephysical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. Review of the facility's SOC 341 dated 6/5/24, showed Resident 1 was making moaning sounds that was irritating to Resident 2. Resident 2 became upset and physically aggressive when Resident 1 did not stop moaning when asked. Resident 1 sustained a superficial skin tear on his hand. 1. Medical record review was initiated for Resident 1 on 6/13/24. Resident 1 was admitted to the facility on [DATE], with the diagnoses including unspecified psychosis not due to substance abuse and Alzheimer's dementia. Review of Resident 1's History and Physical examination dated 2/3/24, showed Resident 1 did not have capacity to understand and make decisions. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severe cognitive impairment with a BIMS score recorded as 99 (unable to complete interview). (continued on next page)

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.

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

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(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	Review of Resident 1's SBAR Summary Progress Notes dated 6/5/24, showed Residents 1 and 2 got into a verbal and physical altercation. The note further showed Resident 1 stated he was hit by Resident 2 and was noted bleeding from his scalp and scattered skin tear to the right and left hands. Review of Resident 1's Progress Notes dated 6/5/24, showed the facility conducted an IDT meeting to discuss the event happened on 6/5/24 at 0210 hours, involving Residents 1 and 2. Resident 1 stated his roommate (Resident 2) hit him. 2. Medical Record review for Resident 2 was initiated on 6/13/24. Resident 2 was admitted to the facility on [DATE], with the diagnoses including schizoaffective disorder, depressive type, unspecified dementia, unspecified severity with psychotic disturbance. Resident 2 was discharged to the acute hospital on 6/5/24. Review of Resident 2's Admission Summary Progress Notes dated 6/4/24, showed Resident 2 was alert and oriented times three to four (person, place, time, and event) and able to make the needs known. Review of Resident 2's MDS assessment dated [DATE], under Sections A, S and Z, showed Resident 2 did not stay in the facility for 24 hours. Review of Resident 2's SBAR Summary Progress Note dated 6/5/24, showed the charge nurse heard screaming from the room. When the charge nurse entered the room, the charge nurse observed Resident 2 verbally aggressive with Resident 1. Resident 1 was observed bleeding from his scalp and having scattered skin tears to the right and left hands. Review of Resident 2's Plan of Care dated 6/5/24, showed a care plan problem to address Resident 2's altercation on 6/5/24,with another resident and being physically and verbally aggressive towards his roommate. On 6/13/24 at 0815 hours, an interview was conducted with theDON. TheDON was asked about the incident that took place on 6/5/24. The DON stated Residents 1 and 2 were in room [ROOM NUMBER]. Resident 2 became aggressive due to some reason and hit Resident 1 with a pitcher. As soon as the staff learned of the alleged incident, the two residents were separated. On 6/13/24 at 0955 hours, an interview was conducted with LVN 2. LVN 2 was asked aboutthe details of the incident on 6/5/24. LVN 2 stated around 0200 hours, Resident 2 stated Resident 1 made moaning sounds. Resident 2 got irritated and told Resident 1 to stop. LVN 2 stated Resident 1 threw water at Resident 2; and Resident 2 got mad, got thewater pitcher, and hit Resident 1. LVN 2 further stated this was based on Resident 2's statement. Review of the facility's Investigation Summary Report dated 6/7/24, showed Resident 1 stated Resident 2 wanted the bed by the window and Resident 2 hit Resident 1 after claiming Resident 1 was on his bed. The summary report further showed Resident 2 hit Resident 1 when Resident 1 would not be quiet.