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	07/10/2024

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** 45560 Based on interview, medical record review, observation, facility document review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse by another resident for one of seven sampled residents (Resident 7). * Resident 7 was hit by Resident 8 causing a laceration to her left outer eye and a skin tear to her right elbow. This failure had the potential to negatively impact the resident's well-being. Findings: 1. Review of facility's P&P titled Abuse Prevention and Management revised 5/30/24 and effective on 6/12/24, under the section for Definitions showed the following: - 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. - Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment which is physical punishment used to correct and/or control behavior. Review of the facility's SOC 341 dated 7/8/24, showed Resident 8 was observed screaming and yelling in the hallway and then approached and pushed Resident 7 down to the floor. a. Medical record review for Resident 7 was initiated on 7/9/24. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's MDS dated [DATE], showed Resident 7 had severe cognitive impairment and a medical history to include psychosis, non-Alzheimer's dementia, anxiety disorder, depression, and a psychotic disorder. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's Health Status note dated 7/8/24, showed Resident 7 was walking in the hallway when Resident 8 became aggressive and pushed her which caused her to fall and hit her head on the floor. Review of Resident 7's Heath Status note dated 7/8/24, showed Resident 7 received a first aid after the incident with Resident 8 for a laceration to her left outer eye and a skin tear to her right elbow. Review of the Psychosocial note dated 7/8/24, showed Resident 7 stated, I don't know what happened. Yes, I was hit by someone. I don't remember what happened or who hit me. b. Medical record review for Resident 8 was initiated on 7/9/24. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's MDS dated [DATE], showed Resident 8 was cognitively intact (one who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of their environment), and had a medical history to include schizoaffective disorder, anxiety disorder, schizophrenia, and autistic disorder. Review of the Behavior note dated 7/8/24, showed Resident 8 wandered out of his room into the hallway at 0050 hours, and suddenly began punching another resident in the hallway. Review of the Psychosocial note dated 7/8/24, showed Resident 8 stated, I started hitting someone yesterday. I thought everything will be ok for me if I hit someone, but it wasn't. I was really upset and mad at them. I don't know why I did not. I just got mad and started punching. On 7/9/24 at 0855 hours, an interview was conducted with Resident 8. Resident 8 stated he was in the hallway and another Resident made him very angry so he punched, punched, and punched her. On 7/9/24 at 0915 hours, a concurrent interview and observation was completed with Resident 7. Resident 7 was observed to have a laceration with sutures to the left temple, approximately 3 cm in length. When asked what happened, Resident 7 stated she was hit. On 7/9/24 at 1500 hours, a telephone interview was conducted with RN 2. RN 2 stated on 7/8/24 at around 0040 - 0050 hours, he heard Resident 8 screaming in the hallway; and when he went to check on the commotion, he observed Resident 8 pushedResident 7 to the ground where she hit her head on the ground. RN 2 stated after the incident, he observed Resident 7 with a laceration to her forehead. On 7/9/24 at 1555 hours, a telephone interview was conducted with LVN 2. LVN 2 stated after the incident, she observed Resident 7 bleeding from a laceration by her left eye, having a hematoma to her forehead, swelling to the back of her head, and a skin tear to her right elbow and left hand. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 1605 hours, a telephone interview was conducted with CNA 1. CNA 1 stated on the early morning of 7/8/24, she observed Resident 8 wandering the hallways and becoming increasingly agitated with each lap around the facility. CNA 1 stated she then heard what sounded like something was being hit, she then observed Resident 8 crouched over and repeatedly punching Resident 7 with closed fists. Resident 8 was on the ground with her back to the floor, CNA 1 stated Resident 7 was not attempting to protect her head or face during the incident. CNA 1 stated post incident, Resident 7 was full of blood and observed having a laceration by her left eye, a hematoma to her forehead and back of head, and skin tears to her left hand. On 7/10/24 at 1533 hours the Administrator and DON were notified of the above findings.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40617 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the implementation of their P&P for abuse prevention program for two of seven sampled residents (Residents 4 and 9) when CNA 4 received a report of physical abuse from Resident 9 regarding CNA 5 hitting Resident 4. CNA 4 took CNA 5 to see Residents 4 and 9 to identify the alleged staff. This failure created the potential for not protecting the residents from the alleged staff. Findings: Review of the facility's P&P titled Abuse Prevention program dated 6/12/24, showed under the section for Immediate Actions, the Administrator or designated representative will provide for a safe environment for the resident as indicated by the situation. If the suspected perpetrator is an employee, remove the employee immediately from the care of the resident(s) and immediately suspend the employee pending the outcome of the investigation in accordance with the facility policies. Medical record review of Resident 4 was initiated on 7/9/24. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's History and Physical examination dated 11/2/23, showed Resident 4 could make needs known but could not make medical decision. Medical record review of Resident 9 was initiated on 7/9/24. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's progress notes dated 7/3/24, showed Resident 9 was alert and oriented x3 (person, place, and time), communicated verbally with clear speech, and able to understand and be understood when speaking. On 7/9/24 at 1115 hours, during an interview, CNA 4 stated on 7/3/24 at around 0700 hours, when she was going to give a shower to Resident 9, the resident had informed her that a man described as a staff was hitting Resident 4 yesterday. Then, CNA 4 asked CNA 5 (alleged staff) to come to see Residents 4 and 9 to identify the alleged staff. Resident 9 stated, yes, it was him. On 7/10/24 at 0800 hours, a concurrent interview and medical record review was conducted with the DON. The DON was asked if he was aware CNA 4 took CNA 5 (alleged staff) to ask Residents 4 and 9 to identify the alleged staff. The DON stated she was aware of it and told the CNA 4 that she should not be doing it. The DON acknowledged they should remove the alleged staff immediately from the care of the residents and should not bring the alleged staff to see Residents4 or 9. The DON verified the findings.