STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055575	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Haven Subacute and Healthcare Center	12072 Trask Ave. Garden Grove, CA 92843

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 observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the abuse allegations were thoroughly investigated for one of three sampled residents (Resident 6) reviewed for abuse. * The facility failed to conduct a thorough investigation into Resident 6's abuse allegation prior to allowing CNAs 5 and 6 to return to work. This failure had the potential to leave the vulnerable residents for further abuse, mistreatment, and injury.Findings: Review of the facility's P&P titled Abuse: Prevention of and Prohibition Against revised 12/2023 showed it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. Under the Investigation section showed after receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. The facility will conduct investigation of the incident(s). Under the Protection section showed if the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves an employee, the facility will:- Immediately remove the employee from the care of any resident.- Suspend the employee during the pendency of the investigation. 1.a. Review of the facility's SOC 341 dated 4/9/26, showed on 4/9/26 at 1050 hours, Resident 6 alleged CNA 5 threw the call light to her. Medical record review for Resident 6 was initiated on 4/16/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 9/25/25, showed the resident was alert. Review of Resident 6's Physician's Progress Note dated 4/9/26, showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's CNA Skin Observation dated 4/9/26, showed Resident 6 had two scratch marks on the right arm. Review of Resident 6's IDT Progress Note dated 4/9/26, showed Resident 6 was assessed by the RN and was noted with two horizontal scratches to the inner right forearm. Resident 6 stated she did not know how the scratches came about. Review of the facility's Nursing Assignment - South Station dated 4/9/26, showed CNA 5 was scheduled to work at 1500 hours. Further review of the facility's document failed to show CNA 5 was suspended. On 4/16/26 at 1511 hours, an interview was conducted with CNA 5. CNA 5 stated she worked on 4/9/26, and was not assigned to Resident 6. On 4/17/26 at 0843 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD acknowledged the facility used the Counseling/Disciplinary Notice form for the suspended staff, however, there was no Counseling/Disciplinary Notice form on CNA 5's employee file. The DSD verified CNA 5 worked on 4/9/26 at 1500 hours, and was not suspended on 4/9/26. On 4/17/26 at 1057 hours, an interview was conducted with the DSD. The DSD stated according to the Administrator and DON, CNA 5 was cleared to work before her shift started on 4/9/26. b. Review of the facility's SOC 341 dated 4/9/26, showed on 4/9/26 at 1050 hours, Resident 6 alleged CNA 6 unplugged her call light. Review of the facility's Nursing Assignment - South Station dated 4/9/26, showed CNA 6 was scheduled to work at 1500 hours and assigned to Resident 6. Further review of the facility's document failed to show CNA 6 was suspended. On 4/16/26 at 1540 hours, an interview was conducted with CNA 6. CNA 6 stated the last time he cared for Resident 6 was when the police arrived on 4/9/26. On 4/17/26 at 0900 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD verified (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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 6 had no Counseling/Disciplinary Notice form in his employee file. The DSD acknowledged CNA 6 was not suspended on 4/9/26. The DSD verified CNA 6 worked on 4/9/26 at 1500 hours and was assigned to Resident 6. On 4/17/26 at 1038 hours, an interview and concurrent facility document review was conducted with the SSD. The SSD stated she completed the resident interviews and investigation of the alleged abuse at around 1700 hours on 4/9/26. The SSD stated the police arrived at the facility at 1600 hours on 4/9/26. On 4/17/26 at 1059 hours, an interview was conducted with the DSD. The DSD stated according to the Administrator and DON, CNA 6 was cleared to work before his shift started on 4/9/26. On 4/17/26 at 1333 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator stated he and the SSD started the interview and investigation for the alleged abuse of Resident 6 on 4/9/26 at approximately 1615 hours. When the Administrator was asked if he interviewed Resident 7 (Resident 6's roommate), the Administrator stated Resident 7 was not in the room at that time and he was not able to interview the resident. The Administrator stated he should have followed up the interview of Resident 7. On 4/17/26 at 1401 hours, a follow up interview and concurrent facility document review was conducted with the Administrator. The Administrator stated the allegations against CNA 5 were unsubstantiated before 1500 hours on 4/9/26. The Administrator stated multiple interviews with other facility staff who worked with CNA 5 and data review from the room rounds to ensure for the call light functionality and response time were completed before clearing CNA 5. On 4/17/26 at 1422 hours, a follow up interview and concurrent facility document review was conducted with the Administrator. The Administrator stated CNA 6 was cleared to work before 1500 hours on 4/9/26. The Administrator stated he reviewed Resident 6's call light data and did not show any anomalies of the employees unplugging it. The Administrator stated other facility staff interviewed corroborated with CNA 6's statements. The Administrator verified the facility's Summary of Investigations did not show the time of the interviews and investigations. On 4/17/26 at 1603 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. The DON stated she interviewed Resident 7 (Resident 6's roommate) on 4/10/26 at around 0839 hours with the Administrator. The DON stated the call light investigation was done before the police arrived. The DON stated CNAs 5 and 6 were suspended and cleared before the police arrived. However, the DON was unable to provide documentation to show CNAs 5 and 6 were suspended.