STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055816	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Care Center	12232 Chapman Ave Garden Grove, CA 92840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the activity staff failed to immediately report to the Charge Nurse when witnessing Family Member 1 hitting Resident 1 on his head with her hand. This failure had the potential to delay the alleged abuse investigation and mandatory reporting requirements. Findings: Review of the facility's P&P titled Abuse Reporting and Prevention revised 8/2018 showed the staff should notify the Charge Nurse as soon as possible. If the Charge Nurse is notified, the Charge Nurse will immediately notify the Administrator (Abuse Coordinator) and Director of Nursing. Social Services notified and begin the interventions as indicated. On 6/17/24, CDPH, L&C Program received a report from the facility which showed Family Member 1 was witnessed pushing Resident 1's head with a playing chip and yelling at the resident on 6/16/24. Medical record review for Resident 1 was initiated on 6/18/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severe cognitive impairment. Review of Resident 1's H&P examination dated 5/23/24, showed Resident 1 had no capacity to understand and make decisions andhad severe dementia (general term for memory loss and mental changes that are severe enough to interfere with daily life). On 6/18/24 at 0839 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was asked about the incident that happened in the activity room on 6/16/24. Resident 1 stated he could not remember. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 1439 hours, an interview was conducted with AA 1. When AA 1 was asked about the alleged abuse on 6/16/24, AA 1 stated they were playing loteria and she was passing around the playing card and chips. AA 1 stated while she was passing the playing card and chips, Resident 1 had an episode of confusion and grabbed a circle playing chip and tried to put it in his mouth. Family Member 1 aggressively yelled at Resident 1 and took the playing chip out of his hand. AA 1 stated while the playing chip was still on Family Member 1's hand, she pressed her hand on the left side of Resident 1's head and pushed it to the right. AA 1 further stated Resident 1 groaned in pain. AA 1 stated the incident happened in the activity room on 6/16/24 at 1430 hours. When AA 1 was asked if she reported the incident to a licensed nurse, AA 1 stated she notified the AD, but she was told to go to the social services staff for a formal report. AA 1 stated she reported the incident to the social services staff on 6/17/24 at 1230 hours. AA 1 stated she did not report it right away because she had 10 residents in the activity room at the time of the incident. On 6/19/24 at 1337 hours, an interview was conducted with the Administrator. The Administrator stated she was notified on 6/17/24 at 1230 hours, about the incident between Resident 1 and Family Member 1 that had occurred on 6/16/24 at 1420 hours, approximately 22 hours after the alleged abuse incident. On 6/20/24 at 0810 hours, an interview was conducted with Resident 4. When Resident 4 was asked about the alleged abuse on 6/16/24, Resident 4 stated she saw a lady hit Resident 1's head with her hand. Resident 4 further stated the lady took the chip from Resident 1's hand and threw it on the table. On 6/20/24 at 1410 hours, a follow-up interview was conducted with the Administrator. The Administrator acknowledged the staff should have reported the abuse allegation immediately. The Administrator stated the staff were expected to report any incidents of abuse immediately.