STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056271	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Palms Healthcare Center	240 Hospital Circle Westminster, CA 92683

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 - 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** 49324 Based on interview, medical record review, 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 the facility staff for one of three sampled residents (Resident 1). * Resident 1 was slapped on the face by CNA 1 and sustained a redness to the right cheek. This failure had violated the resident's rights to be free from the abuse and negatively affected the resident's psychological well-being. Findings: Review of the facility's P&P titled Abuse Prevention Program revised on 12/1/22, showed the facility should promote an environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment. Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Physical Abuse includes but not limited to hitting, slapping, pinching, and/or kicking. It also includes controlling behavior through corporal punishment. Review of the facility's P&P titled Resident Rights revised 8/2022 showed the resident has the rights to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. Facility staff shall treat all residents with kindness, respect, and dignity. The section for Policy Interpretation and Implementation showed the Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to a dignified existence; be treated with respect, kindness, and dignity; be free from abuse, neglect, misappropriation of property and exploitation; be free from corporal punishment or involuntary seclusion , and physical or chemical restraints not required to treat the resident's symptoms; self-determination; communicate with and access to people and services, both inside and outside the facility; exercise his or her right as resident of the facility and as a resident or citizen of the United States; be supported by the facility in exercising his or her rights; be informed about his or her rights and responsibilities. (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 0600

Level of Harm - Actual harm

Residents Affected - Few

Review of the facility's SOC-341 dated 8/21/24, showed Resident 1 reported to the charge nurse that her CNA had slapped her on the right cheek. Further review of the form showed an assessment of Resident 1 was done and Resident 1's right cheek appeared to be slightly red. The incident happened on 8/21/24.

Medical record review for Resident 1 was initiated on 8/23/24. Resident 1 was admitted to the facility on [DATE].

Review of the facility's CNA Assignment on 8/21/24 for 0700-1300 hours shift, showed CNA 1 was assigned to Resident 1.

Review of Resident 1's SBAR Communication Form dated 8/21/24, showed around 0900 hours, the charge nurse called the supervisor to check on Resident 1. Upon Resident 1's interview, Resident 1 claimed she was slapped on her right cheek when CNA 1 had to transfer her to the wheelchair. The form further showed a body assessment was done by the treatment nurse and a slight redness was noted on Resident 1's right cheek.

Review of Resident 1's Nurses Notes dated 8/21/24 at 0930 hours, showed a head to toe assessment done with the RN supervisor. Resident 1's right cheek had a slight redness.

On 8/23/24 at 0858 hours, an interview was conducted with RN 1. RN 1 stated on 8/21/24 around 0840 to 0900 hours, the charge nurse called her to check Resident 1. Upon interview with Resident 1 translating by a Vietnamese speaking OT student, RN 1 stated Resident 1 kept telling her she was slapped by the CNA who was assigned to her. RN Supervisor 1 observed Resident 1's cheek was slightly red.

On 8/23/24 at 1300 hours, an interview was conducted with Resident 1 translating by a Vietnamese translator via CDPH Language Line. Resident 1 stated a male staff had slapped her in the facility, but she was unable to recall his name. Resident 1 stated and questioned why he hit her twice on the head. Resident 1 further stated she planned to transfer because she did not feel safe and felt afraid in the facility.

On 8/23/24 at 1412 hours, an interview was conducted with the SSD. The SSD stated on 8/21/24, she conducted an interviewed with Resident 1. Resident 1 informed the SSD that the CNA was trying to get her up; however, Resident 1 was so tired and so sleepy that she could not wake up, so she kicked the CNA, then the CNA slapped her two times on the face and head. The SSD stated Resident 1 was unable to recall the CNA's name but identified him as a male CNA. The SSD stated she observed Resident 1's right cheek was a little [NAME] than the left cheek. The SSD further stated Resident 1 felt scared and did not want him to be her CNA. Resident 1 wanted to go home because she felt afraid the CNA would come back to hit her.

On 8/23/24 at 1434 hours, an interview was conducted with the DSD. The DSD stated on 8/22/24, she conducted a telephone interview with CNA 1. The DSD added CNA 1 informed her that while he was trying to put Resident 1 back to bed, Resident 1 was kicking, then Resident 1 hit him three times. The DSD added CNA 1 stated it was a reflex and hit Resident 1's face but did not mean to do it, and he did not know why he did it. The DSD verified CNA 1 admitted he physically hit Resident 1 on her face and CNA 1's behavior was physical abuse and was not right and not acceptable.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/26/24 at 1435 hours, an interview was conducted with the Administrator. The Administrator stated she conducted a telephone interview with CNA 1 with the DSD as her witness on 8/22/24. The Administrator stated her understanding about the phone call was that CNA 1 slapped Resident 1 reflexively or gently. The Administrator further stated when she clarified with CNA 1 if he had hit Resident 1, CNA 1 responded with yes. The Administrator verified it was not an appropriate behavior and the DSD was the witness during the telephone conversation with CNA 1. Review of the facility's Summary of Investigation letter dated 8/24/24, showed the facility conducted a telephone interview with CNA 1. The facility letter showed CNA 1 had explained himself stating Resident 1 was hitting and kicking him and CNA 1 reflexively slapped Resident 1 back. The facility letter further showed the Administrator and DSD verified and CNA 1 had admitted to hitting Resident 1 saying I gently slap her because she was kicking and slapping me. Review of CNA 1's employee file was conducted on 8/26/24 at 1056 hours, and showed CNA 1 received counseling/disciplinary action notice on 3/15/23, for using vulgar or profane language and on 7/19/24, for not following the charge nurse's instructions for resident care, answering in a loud voice, and being argumentative; and also a resident complained of CNA 1 not listening to the resident, answering in a loud voice which made the resident upset. Further review of CNA 1's personnel file showed CNA 1 was terminated with the last working date on 8/21/24. On 8/27/24 at 1315 hours, a follow-up interview and concurrent document review was conducted with the DSD. The DSD verified CNA 1 was involuntary terminated and not rehireable.