STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555141	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town & Country	555 East Memory Lane Santa Ana, CA 92706

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** 48882 Based on interview, medical record review, facility document review and facility P&P review, the facility failed to remove a staff (CNA 1) from resident care areas pending an alleged violation of abuse for one of two sampled residents (Resident 1) as per the facility's P&P. This failure had the potential to expose Resident 1 to abuse. Findings: Review of the facility's P&P titled Reporting Allegations of Abuse/Neglect/Exploitation revised 10/21/22, showed under the Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation section, when thereports of abuse/neglect/exploitation occur, the following procedure will be initiated: 1. The Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident. b. Remove the accused employee from resident care areas. 2. The Administrator or designee will: c. Suspend the accused employee pending completion of the investigation. Review of the facility's SOC 341 (a form to report suspected abuse) dated 4/8/24, showed the facility reported Resident 1 reported to a staff that CNA 1 hit her left shoulder on 4/7/24 at 2000 hours. Medical record review for Resident 1 was initiated on 4/9/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility Census dated 4/7/24, showed Resident 1 was in room [ROOM NUMBER]A. Review of the facility's Nursing Assignment Sheet on 4/7/24, for the PM shift from 1500 to 2300 hours, showed CNA 1 was assigned to Rooms 406B and 417A to 419B. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/24 at 1120 hours, a telephone interview was conducted with CNA 1. When asked about the abuse allegation related to Resident 1, CNA 1 verified she provided care for Resident 1 on 4/7/24. CNA 1 was asked if she was sent home on 4/7/24, pending the investigation of the abuse allegation with Resident 1. CNA 1 stated after the allegation reported, she was reassigned to care for another resident and remained at work until the completion of her shift. On 4/9/24 at 1457 hours, an interview was conducted with LVN 3. LVN 3 verified she provided care for Resident 1 on 4/7/24. LVN 3 stated she and LVN 1 interviewed Resident 1 regarding her allegation of abuse. LVN 3 was asked if CNA 1 was sent home after the abuse allegation. LVN 3 stated CNA 1 was not sent home. On 4/9/23 at 1555 hours, an interview was conducted with the Administrator. When asked about the facility's protocol for the allegations of abuse involving the staff to resident abuse, the Administrator stated for the abuse allegations involving staff members, the alleged staff would immediately be excused from the facility and should be suspended pending the investigation of the abuse. When asked if CNA 1 was sent home on 4/7/24, the Administrator stated CNA 1 completed her shift and clocked out at 2251 hours, on 4/7/24. When the Administrator was asked about the potential risk of having the alleged perpetrator remain in the facility, the Administrator stated if the abuse did occur, having the perpetrator in the facility may create an opportunity for retaliation against the victim. On 4/9/24 at 1651 hours, the Administrator and DON were informed and acknowledged the above findings.