

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Fountain Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 11680 Warner Avenue Fountain Valley, CA 92708	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40617</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to implement their P&P to ensure the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility staff failed to immediately report an abuse allegation involving a CNA to the facility's Administrator or DON for one of two residents reviewed for abuse (Resident 1). This failure had the potential for not protecting the resident from abuse.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Patient Protection Abuse, Neglect, Mistreatment and Misappropriation Prevention dated October 2021 showed the following:</p> <ul style="list-style-type: none"> - Employees are educated upon hired and annually on the abuse prevention program, including the immediate reporting of any suspicious of abuse, neglect, exploitation, mistreatment, misappropriation or crime involving a resident. - Resident protection actions include immediately remove the resident from contact with the alleged abuser during the investigation. If the incident involves an employee, the employee is suspended immediately after obtaining their statement. <p>Review of the Report of Suspected Dependent Adult/Elder Abuse dated 4/19/24, showed Resident 1 made an abuse allegation against a CNA, which occurred on 4/17/24.</p> <p>Medical record review for Resident 1 was initiated on 4/25/24. Resident 1 was admitted to the facility on [DATE].</p> <p>On 4/25/24 at 0912 hours, an interview was conducted with CNA 1. CNA 1 stated he was assigned to Resident 1 on 4/17/24, during the 1500-2300 hours shift. CNA 1 stated while he assisted Resident 1 with the shower around 1600 to 1630 hours, the resident became aggressive, yelling, using crude language, and attempted to hit CNA 1. CNA 1 stated after the shower, he brought Resident 1 back to the resident's room where the resident told him to go away and alleged CNA 1 had hit him. CNA 1 stated he notified RN 1. CNA 1 stated CNA 2 assisted with Resident 1 after the allegation was made. CNA 1 stated later in the shift, he went to answer Resident 1's call light twice. The first time, the resident seemed fine and the second time, Resident 1 yelled at CNA 1 to go away and stated to call the law enforcement because CNA 1 had hit him earlier. CNA 1 stated he went and told the RN Supervisor.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 1112 hours, an interview was conducted with CNA 2. CNA 2 stated on 4/17/24, in the beginning part of the 1500 to 2300 hours shift, she heard Resident 1 said you hit me to CNA 1. Once CNA 2 heard that, she told CNA 1 to stay out of Resident 1's room and she would take over his care. CNA 2 stated they did not report the abuse allegation because CNA 1 stated he already told RN 1.</p> <p>Review of CNA 1's timecard detail showed CNA 1 worked on 4/17/24 from 1426 to 2324 hours, and 4/18/24 from 0703 to 2302 hours.</p> <p>On 4/25/24 at 1240 hours, an interview was conducted with the DON. The DON stated the first time she heard about Resident 1's abuse allegation was from the Social Service Coordinator on 4/19/24.</p> <p>On 4/25/24 at 1255 hours, an interview and concurrent medical record review was conducted with the Social Service Coordinator. The Social Service Coordinator stated when she came on 4/19/24, she reviewed Resident 1's progress notes showing the resident had some aggressive behaviors. The Social Service Coordinator stated she followed up with Resident 1 to get the resident's perspective on the situation. The Social Service Coordinator stated when she asked the resident about his striking out at the staff, he became upset and informed her that he did not strike out at anyone, and CNA 1 had hit him. The Social Service Coordinator stated she notified the DON and completed the Report of Suspected Dependent Adult/Elder Abuse.</p> <p>On 4/25/24 at 1312 hours, a telephone interview was conducted with RN 1. RN 1 stated on 4/17/24, CNA 1 notified her of Resident 1's aggressive behaviors, but not that the resident accused CNA 1 of hitting the resident.</p> <p>On 4/25/24 at 1519 hours, a follow-up interview was conducted with the DON. The DON stated all abuse allegations should be reported to the Administrator or DON, and the facility was to start the abuse investigation right away, and if the staff was the alleged perpetrator, the facility was to remove them from the schedule pending the investigation and notify the CDPH, local law enforcement, and Ombudsman of the allegation.</p>		