Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555391	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freedom Village Healthcare Center	23442 El Toro Road Lake Forest, CA 92630

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** 50003 Based on interview, medical record review, and facility P&P review, the facility failed to follow the abuse protocol during the facility investigation period for one of two sampled residents (Resident 1). * The facility failed to suspend CNAs 2 and 3 from work when Resident 1 reported an allegation of physical abuse against these two CNAs on 11/10/24. This failure had the potential to place Resident 1 and other residents at risk of not being protected against the alleged abusers. Findings: Review of the facility's P&P titled Abuse Policy and Procedure revised 3/1/24, showed during and after the investigation, the residents will be protected from the alleged harm through the following methods: - staff will closely and frequently supervise the resident, and - if a staff member is accused or suspected of abuse, that staff member will be suspended pending the completion of the investigation. On 11/12/24, the CDPH, Licensing and Certification Program received a report from the facility regarding Resident 1's allegation of physical abuse by CNAs 2 and 3 on 11/10/24. Medical record review for Resident 1 was initiated on 11/26/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 11/5/24, showed Resident 1 could make her own medical decisions. On 11/26/24 at 0920 hours, a review of the facility's investigation file was conducted. The document showed the interviews and statements of the facility's staff members and residents. However, further review of the documents failed to show the two alleged CNAs were suspended during the investigation period from 11/10/24 to 11/13/24. (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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NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	

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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 11/26/24 at 1042 hours, a telephone interview was conducted with CNA 2. CNA 2 stated she was aware Resident 1 just had a hip surgery and being gentle when providing the care to Resident 1. When asked if she had worked from 11/10/24 to 11/13/24, CNA 2 stated the Administrator consented her to return to work the following day after the reported abuse allegation, but she was given a different assignment and not working directly with Resident 1. On 11/26/24, at 1115 hours, a telephone interview was conducted with CNA 3. CNA 3 stated she helped CNA 2 changed the brief for Resident 1. CNA 3 further stated Resident 1 was calm and did not complain of any issues related to the care they provided. When asked if she worked from 11/10 to 11/13/24, CNA 3 stated she was instructed to not provide care to Resident 1 but could return to work immediately after the reported abuse allegation. Review of the facility's Staffing Sheets for 11/11 to 11/13/24, showed CNAs 2 and 3 were not assigned to Resident 1. However, CNA 2 worked from 11/11 and 11/13/24, and CNA 3 worked on 11/11/24. On 12/6/24 at 1230 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the facility's abuse investigation was initiated on 11/10/24, and completed on 11/13/24. The DON acknowledged the findings and stated both the alleged CNAs should have been suspended during the investigation period to ensure the safety of Resident 1 and other residents in the facility.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50003 Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of two sampled residents (Resident 1) attained and/or maintained her highest practicable physical well-being. * The facility failed to monitor Resident 1's safety and psychosocial wellbeing and developed a care plan after Resident 1 had reported an abuse allegation on 11/10/24. This failure had the potential for Resident 1 not to receive the necessary care and services. Findings: On 11/12/24, the CDPH, Licensing and Certification Program received a report from the facility regarding Resident 1's allegation of physical abuse by CNAs 2 and 3 on 11/10/24. Medical record review for Resident 1 was initiated on 11/26/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Progress Note dated 11/10/24, showed Resident 1 alleged two CNAs were changing her diaper and being rough with care. The note also showed the CNAs were laughing at her. Further review of Resident 1's Progress Note failed to show Resident 1 was monitored for 72 hours after reporting the abuse allegation. In addition, further review of Resident 1's medical record failed to show a care plan was established to include the goals and interventions to address Resident 1's safety and psychosocial wellbeing after reporting the physical abuse allegation against the two CNAs. On 12/6/24 at 0915 hours, an interview and concurrent interview was conducted with RN 1. RN 1 verified the above findings and further stated Resident 1's medical record should have a care plan developed for the abuse allegation as well as the 72 hours monitoring from the nursing and social services. On 12/6/24 at 1230 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. The DON stated Resident 1 should have a care plan and 72 hours monitoring for the resident's safety from the nursing and social services after the allegation of abuse.