STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555859	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER: Kindred Hospital Brea D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE: 875 N Brea Blvd Brea, CA 92821	

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 - Minimal harm or potential for 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** 32179 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 verbal abuse by CNA 1 for one of two sampled residents (Resident 1) when CNA 1 yelled at Resident 1. Additionally, the facility staff failed to report the incident and intervene in the timely manner as per the facility's P&P. These failures had the potential to cause psychosocial harm to the residents. Findings: Review of the Facility's P&P titled Abuse, Neglect, Misappropriation and Exploitation dated 10/2022 showed the staff report any alleged violations involving verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, injuries of unknown source, and misappropriation immediately to the Senior Clinician, or Operational Leader, or District, or National Level and to other officials. Each resident is treated with dignity and respect and focuses on assisting the residents in maintaining, enhancing his or her self-esteem and self-worth and incorporates the residents' individuality as well as honor and value their input. Review of the facility's Investigation Report dated 10/7/24, showed the investigation of the incident between Resident 1 and CNA 1. The facility substantiated the allegation of verbal/emotional abuse. The report further showed a few staff members were able to confirm both the resident and accused CNA had a verbal exchange. Per the report, the CNA appeared to be frustrated due to the resident repeatedly pressing the call light after the CNA had explained to the resident that the social worker had been notified of Resident 1's request to speak with her and would come once she had a moment. CNA 1 was heard speaking to the resident in the elevated tone, this is why nobody visits you, this why your son doesn't like you, and this is why nobody likes you or visits you. The resident responded back, I hope you end up in a hospital with broken legs. The CNA responded with, I will pray for you and walked out of the door. Resident 1 slammed the door shut, and CNA 1 was heard repeating the same comments regarding Resident 1 in the hallway. Closed medical record review of Resident 1 was initiated on 10/14/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. (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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Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 1630 hours, a telephone interview was conducted with CNA 1. CNA 1 was asked about the incident with Resident 1. CNA 1 stated Resident 1 had been calling multiple times, asking for the social worker and inquiring about her discharge. CNA 1 stated she had informed the social worker and Resident 1 had to wait for the social worker. However, Resident 1 still pressed the call light. CNA 1 went into the room and told Resident 1 that she had been excessively pressing the call light. CNA 1 explained she could not answer the questions beyond her scope and Resident 1 was taking her time away from another resident. Resident 1 became upset, and CNA 1 walked out of the room to check on the resident next door. Then, Resident 1 slammed the door. CNA 1 told CNA 2 that Resident 1's neighbor and family member did not like the resident. CNA 1 stated she did not talk directly to Resident 1 but was venting about Resident 1 to CNA 2 in the hallway. CNA 1 stated she assumed Resident 1 shut the door and did not hear what she was saying. On 10/15/24 at 0830 hours, an interview was conducted with Resident 1. Resident 1 stated CNA 1 was upset and told her that she called 11 times every five minutes on 9/28/24. CNA 1 yelled at Resident 1 and said nobody wanted to take care of her, nobody liked her, and her family member did not like her. Resident 1 stated the other day, she was feeling sad and shared her life story with CNA 1. Resident 1 could not take it anymore, so she shut the door. CNA 1 broke the confidentiality of her personal life by telling other staff. Resident 1 was sad and upset. Resident 1 stated CNA 1 was unprofessional. CNA 1 had an attitude when Resident 1 called for assistance another time. CNA 1's attitude made Resident 1 felt that CNA 1 did not want to be bothered. On 10/15/24 at 1050 hours, an interview was conducted with LVN 1. LVN 1 was asked what happened on 9/28/24. LVN 1 stated she saw CNA 1 talking to Resident 1 as CNA 1 was walking toward Resident 1's door. CNA 1 stated, nobody likes you; your son does not like you, nobody visits you inside the room. Then, LVN 1 heard CNA 1 repeated the same statement in the hallway. LVN 1 reported this to RN 1. LVN 1 mentioned CNA 1 had a standoffish and unhelpful attitude when LVN 1 asked questions or needed help with the residents. On 10/15/24 at 1345 hours, a concurrent interview and closed medical record review was conducted with the DON. The DON was asked if he was aware of the incident happened on 9/28/24. The DON stated he became aware when Resident 1 filed the complaint about CNA 1. The DON said no staff reported the incident happened on 9/28/24, to the DON and Administrator. The DON was asked if there was any documentation of the incident and care plan to address the verbal altercation between Resident 1 and CNA 1. The DON was unable to provide the documentation. The DON stated the staff should have reported the incident to the DON and Administrator, documented it, and started the investigation and interventions early. The DON verified the findings.

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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** 48332 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure the resident maintained their highest physical well-being for one of two sampled residents (Resident 2). * Resident 2 had a new skin discoloration on her wrist. The facility failed to create a change in condition, notify the physician, develop a care plan, and monitor Resident 2's skin discoloration on her right wrist area. This failure had the potential for the resident to not receive the appropriate care and services needed. Findings: Review of the facility's P&P titled Condition Change of a Patient release dated 10/2022 showed upon recognition of a potentially life threatening or significant change in status, the nurse should communicate with other health care providers to meet the needs of the patient. Under the Definitions, Change of Condition sections, the P&P showed to communicate the changes from the patient's normal status at the time of admission, at preset intervals based on the patient's condition and regulatory requirements, and whenever there is a change in the patient's medical condition. Medial record review for Resident 2 was initiated on 10/15/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 3/01/24, showed Resident 2 had the capacity to understand choices and make healthcare decisions. Review of Resident 2's MDS dated [DATE], showed the BIMS score was 15, indicating the resident was cognitively intact. Review of Resident 2's Physician's Order for October 2024 showed an order dated 9/20/24, for enoxaparin (anticoagulant medication) 40 mg/0.4 ml subcutaneous syringe. On 10/14/24 at 1530 hours, a concurrent observation and interview was conducted with Resident 2. Resident 2's right wrist area had a purplish skin discoloration. Resident 2 stated two days ago, she noticed a new skin discoloration to her right hand. Resident 2 did not remember if she informed the staff. On 10/14/24 at 1550 hours, CNA 2 was asked if she saw Resident 2's right wrist discoloration. CNA 2 stated it was new yesterday and spoke with LVN 1. CNA 2 stated Resident 2 told her that she might have hit into something. Further review of the medical record failed to show documentation regarding the resident's skin discoloration. There were no documented evidence the physician was notified and the resident was monitored for 72 hours. There were no change of condition and a care plan for the resident's skin discoloration. (continued on next page)

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	555859	A. Building B. Wing	10/15/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/24 at 1620 hours, an interview was conducted with RN 1. RN 1 stated a weekly assessment was done every Thursday and next one was due on Thursday. RN 1 verified the new skin discoloration on the right wrist was found 10/13/24, and acknowledged no new skin assessment was completed. On 10/15/24 at 0930 hours, a concurrent observation and interview was conducted with Resident 2. Resident 2 had a skin discoloration on her right wrist area and right lower forearm. Resident 2 stated she got the bruise on the wrist last Sunday and probably had hit something.