

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Plaza Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1209 Hemlock Way Santa Ana, CA 92707	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>45560</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide a homelike environment for one of 21 sampled residents (Resident 20).</p> <p>* Resident 20's room (Room A) had a hole on the dry wall, exposed drywall, and multiple areas of dark stains on the walls.</p> <p>* Room A's restroom had a crack behind the sink, large unpainted area above the sink, crack on the door connecting the restroom to the adjacent room and dark stains on the floor and walls near the toilet.</p> <p>These failures had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Resident Rooms and Environment revised 1/1/12, under the Policy section, showed the facility provides the residents with a safe, clean, comfortable, and home like environment; and the facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences.</p> <p>On 5/23/24 at 1015 hours, an observation and concurrent interview was conducted with Resident 20 in Room A. Room A and Room A's restroom were observed with the following:</p> <ul style="list-style-type: none"> - the wall adjacent to Bed C had a hole approximately three inches by three inches in size. The wall had a napkin rolled up in a ball placed in the opening of the hole; - an approximately 12 inches by twainches area of exposed dry wall was observed near Bed A; - the black stained areas were observed all throughout the walls; - an approximately 14 inches long crack was observed on the door connecting the Room A's restroom to the adjacent room; <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45560</p> <p>Based on interview, medical record review, and facility document review, the facility failed to ensure one of 21 sampled residents (Resident 18) was free from the physical abuse when Resident 19 hit Resident 18 with an open hands. This failure had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Abuse-Prevention, Screening, & Training Program revised July 2018 showed the facility does not condone any form of resident abuse, neglect, misappropriation of resident's property, exploitation, and or/mistreatment and develops facility policies, procedures, training programs, and screening and prevention systems to promote an environment free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. Under the section for Definitions showed the following:</p> <ul style="list-style-type: none"> - abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, physical or chemical restraint, not required to treat symptoms and/or imposed for the purpose of discipline or convenience, intimidation, exploitation, misappropriation of resident property, mistreatment, and injury of unknown source or punishment with resulting physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, mental abuse, or abuse facilitated or enabled by the use of technology that causes physical harm, pain, or mental anguish. -physical abuse is defined as, but not limited to, hitting, slapping, punching and/or kicking. <p>Review of the facility's SOC 341 dated 5/19/24, showed Resident 19 approached Resident 18 while she was sitting in her wheelchair and bit her left thumb.</p> <p>a. Medical record review for Resident 18 was initiated on 5/23/24. Resident 18 was admitted to the facility on [DATE], and readmitted on ,d+[DATE] and 12/9/23.</p> <p>Review of Resident 18's MDS dated [DATE], showed Resident 18 was cognitively intact and had a medical history to include schizophrenia (a mental illness that affects how a person thinks, feels, and behaves), bipolar disorder (a mental illness that causes unusual shifts in mood), and anxiety (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).</p> <p>Review of Resident 18's Progress Notes - SBAR Summary dated 5/19/24, showed while Resident 18 was sitting in her wheelchair in the hallway by the dining room and Resident 18 was verbally aggressive to Resident 19. Resident 19 was observed to proceed towards Resident 18 attempting to strike out and bit Resident 18's thumb. Resident 18 was observed with the superficial redness on the bottom of thumb.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 18's Progress Notes dated 5/20/24, showed the facility conducted an IDT meeting to discuss the incident involving Residents 18 and 19. The Progress Notes showed Resident 18 was bit on her left thumb by Resident 19 on 5/19/24. The IDT Note further showed visible teeth marks and redness were noted on Resident 18's skin assessment.</p> <p>b. Medical record review for Resident 19 was initiated on 5/23/24. Resident 19 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 19's MDS dated [DATE] showed Resident 19 had moderate cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), and had a medical history to include schizophrenia and anxiety disorder.</p> <p>Review of Resident 19's Progress Notes - SBAR Summary dated 5/19/24, showed Resident 19 bit Resident 18's left thumb.</p> <p>Review of Resident 19's Progress Notes dated 5/20/24, showed the facility conducted an IDT meeting to discuss the incident on 5/19/24, involving Residents 18 and 19. The Progress Notes further showed Residents 18 and 19 were verbally aggressive with one another prior to the incident.</p> <p>Review of Resident 19's Care Plan initiated on 2/17/24, and revised on 5/21/24, showed Resident 19 had a behavior problem of being verbally and physically aggressive towards staff and other residents. The interventions included for staff to intervene as necessary to protect the rights and safety of others.</p> <p>On 6/3/24 at 0845 hours, a telephone interview was conducted with CNA 12. CNA 12 stated on 5/19/24 at 1200 hours, she observed Resident 18 sitting in her wheelchair in the hallway near the kitchen when Resident 19 quickly approached Resident 18 and began to strike Resident 18 with open hands directed towards her head. CNA 12 stated Resident 18 had her hands up near her head to protect her face. CNA 12 stated she called for help and Resident 19 walked away from the scene. CNA 12 further stated she saw blood on the floor and Resident 18 after the incident. However, CNA 12 stated she did not observe Resident 19 bite Resident 18's finger.</p> <p>Review of the facility's Summary Report dated 5/23/24, showed the facility acknowledged Resident 19 was witnessed by staff striking Resident 18 with open hands and the bleeding was observed coming from the fingers of Resident 18 after the incident occurred.</p> <p>On 6/4/24 at 1340 hours, the DON was notified and acknowledged the above findings.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of 21 sampled residents (Resident 13) attained and maintained their highest practicable well-being.</p> <p>* The facility failed to ensure Resident 13 was assessed and offered the pain medication as per the physician's order after complaining of the severe left knee pain. This failure posed the risk of not providing appropriate and consistent care to Resident 13.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Change of Condition Notification revised 4/1/2025, showed the licensed nurse will assess the change of condition and determine what nursing interventions are appropriate. Before notifying the Attending Physician, the Licensed Nurse must observe and assess the overall condition utilizing a physical assessment and chart review. Notification to the Attending Physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on and/or sign and symptoms for which the notification is required. The Change of Condition is defined as any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Attending Physician and a change in the treatment plan. The licensed nurse will document date, time, and pertinent details of the incident and subsequent assessment in the Nursing Notes.</p> <p>Closed record review for Resident 13 was initiated on 6/3/24. Resident 13 was admitted to the facility on [DATE], readmitted on [DATE], and discharged to the acute care hospital on 5/30/24.</p> <p>Review of Resident 13's Order Summary Report showed a physician's order dated 5/1/24, to administer hydrocodone-acetaminophen tablet 5-325 mg orally every six hours as needed for severe pain for 30 days.</p> <p>Review of Resident 13's Progress Notes - SBAR Summary dated 5/29/24, showed Resident 13 had severe left knee pain on 5/28/24.</p> <p>Review of Resident 13's MAR for May 2024 showed Resident 13 had a pain level of 0 (on a 0 to 10 pain scale with 0 = no pain and 10 = worst pain) for 5/28/24, during the day shift.</p> <p>Review of Resident 13's medical record failed to show an assessment was completed for Resident 13's complaint of severe left knee pain on 5/28/24.</p> <p>Review of Resident 13's medical record failed to show Resident 13 was offered pain medication for the complaint of severe left knee pain on 5/28/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/3/24 at 1555 hours, an interview was conducted with LVN 8. LVN 8 verified Resident 13 complained of severe left knee pain on 5/28/24. LVN 8 stated Resident 13 has not complained of severe left knee pain before and would ask for pain medication occasionally for moderate pain. LVN 8 verified he did not perform a complete assessment on Resident 13 due to being busy doing other things. LVN 8 verified he did not document that pain medication was offered to Resident 13.</p> <p>On 6/4/24 at 1000 hours, an interview was conducted with CNA 10. CNA 10 verified Resident 13 had a new complaint of severe left knee pain on 5/28/24, and had notified LVN 8.</p> <p>On 6/4/24 at 1300 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the above findings. The DON stated there should have been an assessment done for Resident 13 on 5/28/24, when Resident 13 complained of severe left knee pain. The DON stated the pain medication should have been offered to Resident 13.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45560</p> <p>Based on observation, interview, medical record review, and facility record review, the facility failed to ensure one of 21 final sampled residents (Resident 10) remained free from the accident hazards.</p> <p>* The facility failed to provide the bilateral floor mats as per the physician's order for Resident 10. This failure had the potential to place the resident at risk for serious injury.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Fall Management Program revised 3/13/21, showed the purpose is to provide the residents a safe environment that minimizes complications associated with falls.</p> <p>Medical record review for Resident 10 was initiated on 6/4/24. Resident 20 was admitted to the facility on [DATE].</p> <p>Review of Resident 10's IDT note dated 3/31/23 at 1232 hours, showed Resident 10 [NAME] fall while attempting to self-transfer to the commode on 3/29/24.</p> <p>Review of Resident 10's IDT note dated 8/14/23 at 1827 hours, showed Resident 10 [NAME] fall while self-transferring from the commode to her bed on 8/13/24.</p> <p>Review of Resident 10's IDT note dated 11/16/23 at 1012 hours, showed Resident 10 had a fall while attempting to transfer to the bedside commode.</p> <p>Review of Resident 10's IDT note dated 12/13/23 at 1357 hours, showed Resident 10 [NAME] fall from her bed on 12/7/23.</p> <p>Review of Resident 10's Care Plan initiated on 6/26/23 and revised on 1/22/24, showed Resident 10 was at high risk for falls related to receiving psychotropic medication, impaired physical mobility, impaired balance/coordination, unsteady gait, sensory deficits, poor safety awareness, fatigue, non-compliant with using the call lights, transfers without assistance, multiple-falls history in the past two months, and impaired vision. The interventions included the use of floor mats.</p> <p>Review of Resident 10's Order Summary Report showed a physician order dated 12/28/23, for Resident 10 to have a low bed with bilateral floor mat.</p> <p>On 6/4/24 at 1245 hours, an observation was conducted in the room for Resident 10. Resident 10 was observed in bed with no floor mats in place.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/24 at 1300 hours, a concurrent interview, record review, and observations were conducted with LVN 4. LVN 4 verified Resident 10 had an active order for bilateral floor mats. LVN 4 also verified the bilateral floor mats were not in place for Resident 10. LVN 4 acknowledged Resident 10 had multiple falls and the bilateral floor mats should have been provided to Resident 10 as ordered by the physician.</p> <p>On 6/4/24 at 1340 hours, an interview and concurrent record review was conducted with the DON. The DON acknowledged Resident 10 had multiple falls and had an active order for bilateral floor mats. The DON also acknowledged that Resident 10 should have been provided with bilateral floor mats as ordered by the physician.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the needs of two of 21 sampled residents (Residents 8 and 9).</p> <p>* The facility failed to administer citalopram hydrobromide (antidepressant medication) to Resident 8 as ordered by the physician.</p> <p>* The facility failed to administer Austedo XR (medication used to treat tardive dyskinesia) to Resident 9 as ordered by the physician.</p> <p>These failures had the potential to negatively affects the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration revised 1/1/12, showed medication will be administered upon the order of a physician or licensed independent practitioner. Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines.</p> <p>1. On 6/3/24 at 0940 hours, a medication administration observation was conducted with LVN 7. During the medication administration observation, LVN 7 administered the following medications due at 0900 hours, to Resident 8:</p> <ul style="list-style-type: none"> - vitamin c (supplement) 500 mg one tablet by mouth; - Risperdal (antipsychotic) 2 mg one tablet by mouth; and - Namenda (medication used to treat dementia) 10 mg one tablet by mouth. <p>Medical record review for Resident 8 was initiated on 6/3/24. Resident 8 was admitted to the facility on [DATE].</p> <p>Review of Resident 8's Order Summary Report showed a physician's order dated 3/21/24, to administer citalopram hydrobromide 20 mg one tablet by mouth one time a day for depression manifested by poor motivation.</p> <p>On 6/3/24 at 1030 hours, a concurrent interview and medical record review was conducted with LVN 7. LVN 7 verified the physician's order for Resident 8's citalopram hydrobromide. LVN 7 acknowledged the citalopram hydrobromide medication was not administered to Resident 8 as ordered by the physician during the above medication administration observation.</p> <p>On 6/4/24 at 1300 hours, an interview was conducted with the DON. The DON acknowledged Resident 8's citalopram hydrobromide medication should have been administered as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 6/3/24 at 0955 hours, a medication administration observation was conducted with LVN 7. During the medication administration observation, LVN 7 administered the following medications due at 0900 hours, to Resident 9:</p> <ul style="list-style-type: none"> - Depakote DR (mood stabilizer) 500 mg one tablet by mouth; - docusate sodium (stool softener) 100 mg one tablet by mouth; - Lactulose (laxative) 30 ml oral solution by mouth; - multivitamin (supplement) one tablet by mouth; and - Namenda (medication used to treat dementia) 10 mg one tablet by mouth. <p>Medical record review for Resident 9 was initiated on 6/3/24. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 9's Order Summary Report showed a physician's order dated 5/22/24, to administer Austedo XR 24 mg one tablet by mouth one time a day.</p> <p>On 6/3/24 at 1030 hours, a concurrent interview and medical record review was conducted with LVN 7. LVN 7 verified the physician's order for Resident 9's Austedo XR. LVN 7 acknowledged the Austedo XR medication was not administered to Resident 9 as ordered by the physician during the above medication administration observation.</p> <p>On 6/4/24 at 1300 hours, an interview was conducted with the DON. The DON acknowledged Resident 9's Austedo XR medication should have been administered as ordered by the physician.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45560</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were safely stored.</p> <p>* The facility failed to ensure Medication Cart A was locked when left unattended. This failure had the potential for unauthorized person to have access to the medications and drug diversion in the facility.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Storage in the Facility effective 04/2008 showed under the Procedures Section B, only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medications rooms, carts, and medications supplies are locked or attended by persons with authorized access.</p> <p>On 5/23/24 at 0946 and 0952 hours, Medication Cart A was observed parked in the hallway near Station 2. Medication Cart A was observed unlocked and unattended. The Medication Cart A drawer was opened and observed to have multiple prescription medications. Multiple residents were observed ambulating in the hallway near the unlocked medicationcart.</p> <p>On 5/23/24 at 0952 hours, a concurrent observation and interview was conducted with LVN 10. LVN 10 verified the Medication Cart A was left unlocked. LVN 10 stated the medication cart should not be left unlocked when unattended.</p> <p>On 6/4/24 at 1340 hours, an interview was conducted with the DON. The DON was informed of the findings and acknowledged the medication carts should be locked when left unattended.</p>		