

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 10/07/2024
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on interview, observation, medical record review, and facility P&P review, the facility failed to provide the necessary interventions and services for two of four sampled residents (Residents 1 and 2) to prevent further decline in their ROM functions.</p> <p>This failure posed the risk of the decline to the residents' ROM functions.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Restorative Nursing Program Guidelines dated 9/19/19, showed the RNA carries out the restorative program according on the care plan. The RNA documents the frequency of the program, the amount of time the resident spent in the activity and their tolerance to the program. In addition, the RNA completes a written weekly summary for all the residents on a Restorative Nursing Program. The Restorative Nursing Program Coordinator co-signs the weekly progress note.</p> <p>1. Medical Record review of Resident 1 was initiated on 10/2/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the Order Summary Report dated 10/2/24, showed the following physician's order dated 1/19/24:</p> <ul style="list-style-type: none"> - to provide RNA services for the assisted active ROM to the bilateral lower extremities five times per week every day or as tolerated during the day shifts. - to provide RNA services for sit to stand with a front wheel walker five times per week every day or as tolerated during the day shifts. <p>Review of the Restorative Nursing Program for July 2024 showed to provide RNA services to Resident 1 for sit to stand with a front wheel walker five times per week every day or as tolerated. The section to show the RNA services were provided to Resident 1 on 7/30/24, was blank.</p> <p>Review of the Restorative Nursing Program for August 2024 showed to provide RNA services to Resident 1 for assisted active ROM to the bilateral lower extremities five times per week every day or as tolerated. The section to show the RNA services were provided to Resident 1 on 8/6/24, was blank.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055206
		If continuation sheet Page 1 of 3

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 10/07/2024
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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Restorative Nursing Program for September 2024 showed to provide RNA services to Resident 1 for sit to stand with a front wheel walker five times per week every day or as tolerated. The section to show the RNA services were provided to Resident 1 on 9/17 and 9/20/24, was blank.</p> <p>On 10/2/24 at 1540 hours, an interview was conducted with Resident 1's family member. Resident 1's family member expressed the concerns regarding the resident's ROM exercises.</p> <p>On 10/3/24 at 1015 hours, an interview and concurrent medical record review was conducted with RNA 1. RNA 1 stated the resident was provided with the RNA services for the bilateral lower extremity and the nursing assistant provided for the sit to stand with a front wheel walker. RNA 1 was asked about the blank RNA documentation for 7/30, 8/6, 9/17, and 9/20/24. RNA 1 stated the RNAs sometimes were pulled to work on the floor as CNAs and the RNAs did not provide the RNA services to Resident 1. RNA 1 verified the findings.</p> <p>2. Medical record review of Resident 2 was initiated on 10/2/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the Order Summary Report dated 10/3/24, showed a physician's order dated 4/1/24, to provide RNA program for ambulation with front wheel walker every day five times per week distance as tolerated during the day shifts.</p> <p>Review of the Restorative Nursing Program for July 2024 showed the section to show the RNA services were provided to Resident 2 for ambulation on 7/17 and 7/31/24, was blank.</p> <p>Review of the Restorative Nursing Program for September 2024 showed the section to show the RNA services were provided to Resident 2 for ambulation on 9/20/24, was blank.</p> <p>On 10/3/24 at 1400 hours, an interview and concurrent medical record review was conducted with RNA 2. RNA 2 stated the resident was provided with the RNA services for ambulation with the front wheel walker. RNA 2 was asked about the blank RNA documentation for 7/17, 7/31, and 9/20/24. RNA 2 stated the RNAs sometimes were pulled to work in the floor as CNAs. RNA 2 further stated if it was blank, they did not provide the RNA services. RNA 2 verified the above findings.</p>		

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 10/07/2024
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 0880</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the staff wore the appropriate PPE when providing care for one nonsampled resident (Resident A) with Covid 19. This failure posed the residents at risk for the spread of infection.</p> <p>Findings:</p> <p>According to California Diseases Center and Control dated 6/2024 titled Infection Control Guidance: SARS-Cov-2 showed under the section Personal Protective Equipment, health care provider who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).</p> <p>Medical record review of Resident A was initiated on 10/7/24. Resident A was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>On 10/7/24 at 0900 hours, CNA 1 was observed changing the bed linen and sheet for Resident A. Resident A was observed standing with the IV pool at the foot of his bed. CNA 1 was observed wearing a regular mask and gloves without the gown and googles/face shield. CNA 1 then proceeded to check the bed of Resident 4 for linen changes. A sign of posted for precaution instructions for the staff to require wearing a gown and gloves, and a procedure mask with eye protection when within two meters of the resident and keeping two meters between the residents.</p> <p>On 10/7/24 at 0930 hours, an interview was conducted with Resident A. Resident A stated he was moved to this room because he was diagnosed with Covid 19.</p> <p>On 10/7/24 at 0940 hours, an interview was conducted with CNA 1. CNA 1 was informed she was observed in the isolation room for Covid 19 while changing the bed linen without a gown, face google, and N95. CNA 1 stated, she forget. CNA 1 verified the findings.</p> <p>On 10/7/24 1400 hours, an interview was conducted with the IP. The IP was asked regarding the P&P for the use of personal protective equipment for the staff providing care with Covid 19. The IP stated she could not find the facility P&P. The IP stated the staff should wear gown, gloves, google/face protection, and N95. The IP had provided them in front of each room for Covid 19 isolation.</p>		