STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility document review, the facility failed to provide the shower as per the resident's request for one of three final sampled residents (Resident 87). This failure had the potential for the resident's need to not be met promptly. Findings: Review of the facility's P&P titled Showering and Bathing dated 1/2012, showed a tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Medical record review for Resident 87 was initiated on 4/29/24. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's care plan dated 11/1/23, showed a care plan problem addressing the resident at risk or a self-care deficit bathing, dressing, and feeding related to dementia with behavioral disturbance, psychosis, major depressive disorder, anxiety disorder, insomnia, fatigues, impaired physical mobility and benign prostatic hyperplasia (a medical condition in men which the prostate gland is enlarged and not cancerous). The interventions included providing assistance with the resident's ADL care as needed. On 5/1/24 at 1230 hours, Resident 87 was observed turning the call light on. CNA 4 entered the room. Resident 87 stated he would like to have a shower. On 5/1/24 at 1240 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 87 would like to have a shower, but she told Resident 87 the CNAs were busy and would help him later. On 5/1/24 at 1535 hours, Resident 87 was standing in the hallway and asked if he was getting his shower. Resident 87 stated the staff told him he would get it later around 5 PM or in the afternoon. On 5/2/24 at 1000 hours, an interview was conducted with Resident 87. Resident 87 was asked if he received his shower yesterday. Resident 87 stated no because the staff said they were busy, and he would get it tomorrow. Resident 87 further stated he felt hopeless, and would just accept it because there was nothing he could do about it. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 1445 hours, CNA 4 was asked if she let RNA 1 know about Resident 87's shower. CNA 4 stated RNA 1 informed CNA 4 the resident would get the shower as scheduled in the afternoon. They went back to him but he was sleeping and ran out of time. They told Resident 87 he was scheduled to get a shower in the afternoon. On 5/2/24 at 1500 hours, an interview and concurrent facility document review was conducted with RNA 1. RNA 1 stated she was assigned to Resident 87 yesterday. RNA 1 stated she went to the resident's room however he was asleep and it was almost the end of her shift. RNA 1 stated she thought he would get his shower in the afternoon as scheduled. When RNA 1 was asked to provide the shower schedule for Resident 87, RNA 1 stated the resident did not get the shower yesterday. RNA 1 was asked if she endorsed it to the next shift and stated she did not. RNA 1 verified the findings and stated the resident should have received the shower yesterday as per the facility's schedule and the resident's request.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **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 follow up on the grievance for four of six nonsampled residents (Residents 6, 60, 77, 80, 94, and 123). This failure had the potential for the residents to not be fully informed about the resolution to the grievances. Findings: Review of the facility's P&P titled Grievance and Complaints dated 12/2017, showed the facility ensures there is no retaliation for filling a grievance or complaint and ensures that there is a prompt review, investigation and response to and resolution of grievances and complaints. Under section Grievance investigation, the facility will inform the resident or his or her representative of findings of the investigation and any corrective actions recommended in a timely manner 1. Medical record review for Resident 6 was initiated on 4/29/24. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 6's H&P examination dated 7/13/23, showed Resident 6 had mental capacity to make decisions. 2. Medical record review for Resident 60 was initiated on 4/30/24. Resident 60 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 60's H&P examination dated 1/11/24, showed Resident 60 had mental capacity to make decisions. 3. Medical record review for Resident 77 was initiated on 4/30/24. Resident 77 was admitted to the facility on [DATE]. 4. Medical record review for Resident 80 was initiated on 4/30/24. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 4/23/24, showed Resident 80 was competent to make decisions. 5. Medical record review for Resident 94 was initiated on 4/30/24. Resident 94 was admitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 2/2/23, showed the resident had the mental capacity to make decisions. 6. Medical record review for Resident 123 was initiated on 4/30/24. Resident 123 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 123's H&P examination dated 3/7/24, showed Resident 123 can make needs known but cannot make medical decisions. Review of the facility's Grievance form dated 3/14/24, showed there were issues identified by the resident council including to wait over two hours to answer the call light, an LVN not logging in medicine correctly, taking multiple days to get medicine refills, and nursing staff needing to be nicer. The explanation and or response or action taken by department to resolve the issues identified included the DON and Administrator to be inservicing the nurses on all of the above concerns. Review of the facility's Grievance from dated 4/11/24, showed the issues identified by the resident council included being short of staff, the medications still coming out late, CNAs on the phone too much, and the LVNs closing the room doors when the residents called for help. The explanation and or response or action taken by department to resolve the issues identified included the DON and Administrator to be inservice all the licensed staff regarding all the above issues. On 4/30/24 at 1000 hours, an interview was conducted within the resident council meeting. Residents 6, 60, 77, 80, 94, and 123 verbalized they had issues with the medication administration being late and refills for the medications were not available. For example, Resident 80 verbalized her insulin and blood sugar check was administered late and the Norco (opiod analgesic) refill medication was not available. Resident 6 had morning medication administered late in the afternoon, and the refill for Risperdal (antipsychotic) and Temazepam (sedative) were not available two weeks ago. Resident 77 had concerns with the refill for Ambien (sedative) not being available. Resident 94 did not get her morning medication on time and the Tramadol (opiod analgesic) refill was not available. Resident 60 had morning medication administered late. The residents stated they brought up these issues in the last two resident council meetings and their grievances had not been followed up. Residents 6, 77, 94, and 123 had expressed their concerns regarding the call light. They waited more than two to three hours to get assistance from the staff. The nurse came in and turned off the call light without attending to their needs, and sometimes they had to call the main line or receptionist to get a nurse for assistance. The night shift staff took longer time to answer the call especially on the weekends. Residents 123 and 94 expressed of not getting their shower when the facility was short of staff. On 5/1/24 at 0909 hours, an interview and facility record review was conducted with the DON and Director of Activities. Both were asked if they were aware of the grievances regarding late medication administration, call lights, residents not getting showers, and late medication refills. Both the DON and the Director of Activities stated they were aware of it and the residents brought it up in resident council. When asked which residents had issues with their medications and call lights, both were not able to provide the information and stated they did not document the specific issues of the residents who verbalized their concern. The DON and Director of Activities verified the above findings.

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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 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to provide the written information regarding the advance directive and/or obtain and maintain copies of the advance directives in the medical records for two of three final sampled residents (Residents 49 and 123). These failures had the potential for confusion or failure to provide care and life sustaining measures in accordance with the residents' treatment wishes. Findings: Review of the facility's P&P titled Advance Directives revised 7/2018, showed upon admission, the admission staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directive. During the Social Services Assessment process, the Director of Social Services or designee will also ask the resident whether he or she has a written advance directive. If the resident has an advance directive, the facility shall obtain a copy of the document and place it in the resident's medical record. 1. Medical record review for Resident 49 was initiated on 4/29/24. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's Advance Healthcare Directive (AHCD) Acknowledgement Form dated 3/19/24, showed Resident 49 had an AHCD; however the boxes indicating please find [the AHCD] attached and copy [of the AHCD] requested by facility were left unmarked. Review of Resident 49's H&P examination dated 3/27/24, showed Resident 49 could make his needs known but he could not make medical decisions. Review of Resident 49's medical records failed to show a copy of Resident 49's Advance Directive. Review of Resident 49's Social Services assessment dated [DATE], showed Resident 49 had no Advance Directive, and was interested in initiating an advance directive. On 5/1/24 at 0848 hours, an interview and concurrent medical record review for Resident 49 was conducted with the SSD. The SSD reviewed Resident 49's medical records and verified the above findings. The SSD verified a copy of Resident 49's advance directive was not in Resident 49's medical record. On 5/1/24 at 0903 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 stated on 3/19/24, she spoke with Resident 49's family member and was informed Resident 49 had an advance directive. RN 1 stated it was the Social Services' responsibility to follow-up and obtain a copy. (continued on next page)

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/1/24 at 1004 hours, a follow-up interview and concurrent medical record review for Resident 49 was conducted with the SSD. The SSD verified there were no documentation the facility attempted to obtain a copy of Resident 49's advance directive. The SSD stated the facility should have followed up to obtain a copy of Resident 49's advance directive. On 5/6/24 at 0959 hours, the DON was informed and acknowledged the above findings. 2. Medical record review for Resident 123 was initiated on 4/29/24. Resident 123 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 123's MDS dated [DATE], showed Resident 123 was cognitively intact. Review of Resident 123's Social Service assessment dated [DATE], showed Resident 123 had no Advance Directive. Review of Resident 123's medical record failed to show documented evidence Resident 123 was provided information on formulating an advance directive. On 5/1/24 at 0840 hours, an interview and concurrent record review was conducted with the SSD. The SSD stated, upon admission, residents would be asked if they have an advance directive. If the residents had no advance directive, a literature would be provided to the residents on how to formulate an advance directive. If the resident declined to create an advance directive, they would sign an advance directive acknowledgement form. On 5/1/24 at 1002 hours, a follow up interview and concurrent medical record review was conducted with the SSD. The SSD reviewed Resident 123's medical record and verified the above findings. The SSD was unable to locate an Advance Healthcare Directive (AHCD) Acknowledgement Form for Resident 123. The SSD verified there was no documentation the facility provided literature and discussed the formulation of an advance directive with Resident 123. On 5/6/24 at 0959 hours, the DON was informed and acknowledged the above findings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the physician was informed of a change of condition for one or three final sampled residents reviewed for weight loss (Resident 332). The facility failed to notify the physician of Resident 332's six-pound weight loss. This failure had the potential for Resident 332 to have a delay in care and treatment. Findings: Review of the facility's P&P titled Change of Condition Notification revised 4/2015 showed the facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to a significant change in the resident's physical, mental, or psychosocial status. A licensed nurse will document the following: date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes, the time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received .complete an incident report per facility policy. The P&P further showed a licensed nurse will document each shift for at least 72 hours. Review of the facility's P&P titled Evaluation of Weight Nutritional Status revised 11/2022 showed weight loss was defined as unplanned wight loss in a resident. Significant weight loss was defined as 2% in one week, 5% and/or 5 lb. in one month, 7.5% in three months, or 10% in six months. Review of Resident 332's Weights and Vitals Summary dated 5/2/24, showed the following weights and comparison: * On 1/28/24 =131 lbs., * On 2/4/24 = 132 lbs., * On 3/4/24 = 129 lbs., * On 4/5/24 = 122 lbs., -7 lbs., a 5.4% significant weight loss in one month [comparison weight on 3/4/24, 129 lbs.], -13 lbs., a 9.6% severe weight loss in three months [comparison weight on 1/10/24, 135 lbs.], * On 4/14/24 = 121 lbs., -14 lbs., a 10.4% severe weight loss in three months [comparison weight on 1/10/24, 135 lbs.]. * On 4/21/24 = 119 lbs., -12 lbs., a 9.2% severe weight loss in three months [comparison weight on 1/28/24, 131 lbs.]; -14 lbs., a 10.5% severe weight loss in five months [comparison weight on 11/6/23, 133 lbs.]; and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 4/28/24= 113 lbs., -9lbs., a 7.5 % severe weight loss in a month [comparison weight on 4/5/24, 122 lbs.]; -19 lbs., a 14.4% severe weight loss in two months [comparison weight on 2/4/24, 132 lbs.]; -20 lbs., a 15% severe weight loss in five months and half [comparison weight on 11/6/23, 133 lbs.]. On 5/1/24 at 1614 hours, an interview and concurrent medical record review for Resident 332 was conducted with RN 1. When asked to explain the policy on weight loss, RN 1 stated for weight loss of three pounds in a week, the physician, family, and dietitian would be notified, a change of condition (COC) would be initiated, an IDT meeting would ensue to discuss the weight loss, and the resident's care plan would be updated. RN 1 stated weights were reviewed by the RN Supervisor on the weekends and entered into the electronic system. RN 1 verified the following weight loss for Resident 332: * On 4/14/24= 121 lbs., * On 4/21/24= 119 lbs., and * On 4/28/24= 113 lbs. RN 1 verified from 4/21 to 4/28/24, Resident 332 had lost six lbs. Concurrent medical record review for Resident 332 was conducted with RN 1. RN 1 verified the medical record failed to show documentation the physician was informed of Resident 332's severe weight loss of six pounds in one week, and a Change of Condition assessment was not completed on 4/28/24. On 5/2/24 at 1011 hours, an interview and concurrent medical record review for Resident 332 was conducted with the RD Consultant. The RD Consultant stated for best practice, for a 2% change in weight in a week, the facility should inform the physician, the resident's responsible party, and notify the RD and IDT team. The RD Consultant verified Resident 332 lost six pounds in one week from 4/21/24 (119 lbs.) to 4/28/24 (113 lbs.), a 5% weight loss in a week. The RD Consultant stated he expected the staff to alert the IDT team, as well as inform the physician and RD. On 5/2/24 at 1426 hours, an interview was conducted with RNA 2. RNA 2 stated weights were done every Sunday and documented in the weight binder. RNA 2 stated the DON, Supervisors, and Dietary were provided a copy of the weights. RNA 2 stated upon obtaining residents' weights she also compared the residents' weight from the previous week. If the resident lost weight, they would be weighed again to obtain an average weight. RNA 2 stated if the resident lost or gained weight, she would fill out a COC form called a Stop and Watch tool and submit it to the charge nurse and/or give it to the DON or slip it under his door. On 5/2/24 at 1450 hours, an interview and concurrent medical record review for Resident 332 was conducted with the DON. The DON stated for weekly weights, the RNA was responsible for obtaining the weights. For weight variances, the RNA would inform the charge nurse, the licensed nurse would confirm the weight variance and would inform the physician. The DON stated for a weight variance of five pounds in a week, he expected the charge nurse to complete a COC assessment and inform the physician of the weight variance. The DON verified the above findings. The DON was asked about the risks of not informing the physician of the resident's weight variance. The DON stated the physician would be unaware of the resident's weight loss and would not be able to order supplements or appropriate interventions for the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 1556 hours, an interview was conducted with Physician 1. Physician 1 stated he expected to be informed if the resident had a five-pound weight loss, so he could order a dietitian consult, labs, supplements, and/or appetite stimulants. Physician 1 stated he was not aware of Resident 332's weight loss. On 5/6/24 at 1010 hours, the DON was informed and acknowledged the above findings.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 35346 Based on observation and interview, the facility failed to ensure the residents' medical records were kept secure and confidential. This failure posed the risk of unauthorized personnel having access to the residents' medical records and also not maintaining the medical records intact. Findings: The facility was equipped with two medication storage rooms. On 4/30/24 at 1407 hours, a concurrent observation and interview of the facility's medication storage rooms was conducted with the DON. Inside medication storage Room B, an open box containing MDS records for the residents was observed with liquid medications and alcohol wipes on top of the MDS medical records. The DON verified the findings. The DON acknowledged there was a potential for the unlicensed staff who entered the medication room with the licensed staff could view the confidential MDS medical records. Additionally, the DON also acknowledged the liquid medications could spill onto the MDS medical records and ruin the integrity of the MDS medical records.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation and interview, the facility failed to maintain a clean and homelike environment for two of 27 final sampled residents (Residents 8 and 115) and six nonsampled residents (Residents 9, 26, 30, 582, 22, and 94) reviewed for environment. * Resident 9 resided in Room D. Room D was observed with several unpainted patched areas on the walls throughout the room. * Residents 26 and 582 were roommates who resided in Room B. Room B was observed with bed linens and beverage cups on the floor. The residents' trash can was observed overflowing with trash. The room walls were observed with several unpainted patched areas. * Residents 8 and 30 were roommates who resident in Room C. Room C was observed with cereal lying on the floor adjacent to Resident 30's bed. * Residents 22 and 94 resided together in Room A. Room A was observed with incontinence briefs and chucks stored underneath Resident 22's bed. Room A was observed with unfinished patched walls. * Resident 115 resided in Room E. Room E was observed with multiple white patches, of various sizes, on the wall behind Resident 115's bed, and the adjacent wall had multiple scratch marks. These failures had the potential to negatively impact the residents' quality of life. Findings: 1. On 5/1/24 at 1650 hours, an observation and concurrent interview was conducted with Resident 9. Resident 9 was observed sitting on her bed in Room D. Room D was observed with several unpainted patched areas on the walls throughout the room. Resident 9 stated her room made her feel depressed and she felt she was not worth the effort for the facility to provide her with a nice room. 2. On 4/29/24 at 0955 hours, an observation of Room B was conducted. Residents 26 and 582 resided in Room B. Room B was observed with bed linens and beverage cups on the floor. The residents' trash can was observed overflowing with trash. The room walls were observed with several unpainted patched areas. 3. On 4/29/24 at 0959 hours, an observation of Room C was conducted. Residents 8 and 30 resided in Room C. Room C was observed with cereal lying on the floor adjacent to Resident 30's bed. On 5/2/24 at 0925 hours, an interview was conducted with the DON. The DON observed photos taken of Rooms B, C, and D, which showed the condition of the rooms. The DON verified the findings and stated the new facility Administration is in the process of fixing the resident rooms, which included painting over patch work. The DON stated the current condition of Rooms B, C, and D were not a homelike environment for the residents currently living in these rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	32179 4. Medical record review of Resident 22 was initiated on 4/29/24. Resident 22 was admitted to the facility on [DATE]. On 4/29/24 at 0845 hours, Resident 22 had incontinence brief and chuck stored under the bed and on the floor. Resident 22 stated she was blind and she did not know why they put the diaper and blue chuck underneath. Resident 94 (roommate of Resident 22) stated the staff put it there and did not know why they were doing it. On 4/30/24 at 1145 hours, the DON was informed of the resident's environment. The DON stated it should not be kept under the bed and on the floor. The DON verified the above findings. 5. On 4/29/24 at 0830 hours, Room A's wall was observed with wall paint patches and peeled. On 5/2/24 at 0920 hours, Room A was observed with wall paint patches and peeled. RN 2 was summoned to Room A. RN 2 acknowledged Room A was not homelike environment and stated will inform the maintenance to repaint it. RN 2 verified the findings. 48882 6. On 4/29/24 at 1157 hours, during the initial tour of the facility, the wall behind Resident 115's bed was observed with multiple white patches, of various sizes. The adjacent wall was also observed with multiple scratch marks. On 5/2/24 at 1607 hours, an observation and concurrent interview was conducted with the DON. The DON verified the wall behind Resident 115's bed had multiple white patches of various sizes, and verified the adjacent wall had multiple scratch marks. The DON stated any repairs needed on the walls were done by the maintenance department and the maintenance would be informed of any needed repairs via the Maintenance Log Book. On 5/6/24 at 0833 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was not aware of any repairs needed for the walls in Resident 115's room. When asked how he was made aware of any repairs needed, the Maintenance Director stated he was informed of any repairs or maintenance required through the Maintenance Log Books, located at Stations 1 and 2. A concurrent review of the Maintenance Log Books for Stations 1 and 2 was conducted with the Maintenance Director. The Maintenance Director verified there was no requests for repairs to Resident 115's walls documented in the log books. A concurrent observation of the walls in Resident 115's room was conducted with the Maintenance Director. The Maintenance Director stated the walls should be painted one color and should not have scratch marks. The Maintenance Director stated the staff should have filled out the maintenance log book and requested for repairs of the walls in Resident 115's room. On 5/6/24 at 1015 hours, the DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop/implement the comprehensive plans of care to reflect the individual care needs for three of 27 final sampled residents (Residents 23, 69, and 115) and one nonsampled resident (Resident 29) reviewed for care plans. * The facility failed to develop the comprehensive person-centered care plan to address the use of PICC (peripherally inserted central catheter- intravenous access used for a prolonged period of time) line for Resident 115. * The facility failed to implement care plan interventions per Resident 29's plan of care addressing Resident 29's swallowing problem. * The facility failed to develop a care plan to address Resident 69's pain and use of bed rails. * The facility failed to ensure a care plan was developed to address Resident 23's need for one-to-one supervision. These failures had the potential risk of not providing appropriate, consistent, and individualized care to the residents. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 8/2023 showed the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The P&P further showed, within seven days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the residents. 1. On 4/29/24 at 1130 hours, an observation and concurrent interview was conducted with Resident 115. Resident 115 stated he had a wound infection in his right leg and was receiving antibiotic through his PICC line. Resident 115 was observed with a PICC line on his right upper arm with a single lumen port. Medical record review for Resident 115 was initiated on 4/29/24. Resident 115 was admitted to the facility on [DATE]. Review of Resident 115's Order Summary Report dated 4/20/24, showed the following physician's orders: - dated 4/20/24, to administer cefepime hcl (antibiotic) two grams IV three times a day for right lower extremity wound until 5/23/24 (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/1/24, to monitor the right upper arm PICC line site for signs and symptoms of infection such as: fever, redness, swelling, pain, tenderness and to report to MD promptly, every shift - dated 3/29/24, may reinsert PICC line - dated 3/25/24, to change the PICC dressing and cap weekly and as needed if soiled, every Sunday day shift - dated 3/23/24, to flush the lumen with 10 ml normal saline before and after medication administration, every shift Review of Resident 115's PICC insertion record dated 3/29/24, under the section Comments, showed the previous PICC line was inserted prior to the admission and is now clogged unable to flush . old PICC removed to tip fully intact to 40 cm. New PICC inserted in right upper extremity (RUE) without difficulty. Review of Resident 115's plan of care failed to show a care plan was developed to address Resident 115's use of right upper arm PICC line. On 5/1/24 at 1114 hours, an interview and concurrent medical record review for Resident 115 was conducted with RN 1. RN 1 stated Resident 115 had a PICC line on the right upper arm. RN 1 stated the site was checked by an RN every shift, and the dressing was changed weekly, every Sunday. RN 1 stated the residents should have a care plan for the IV site to ensure care and monitoring of the IV. RN 1 verified a care plan for Resident 115's use of the PICC line on the right upper arm was not formulated. RN 1 further stated Resident 115 was admitted to the facility with a PICC line, and there should have been a care plan formulated specific to Resident 115's PICC line. On 5/6/24 at 0947 hours, an interview and concurrent medical record review for Resident 115 was conducted with the DON. The DON verified Resident 115 did not have a care plan for his right upper arm PICC line. The DON stated he expected staff to create a care plan specific to the residents' IV access to ensure proper monitoring and care. The DON was informed and acknowledged the above findings. 2. On 4/29/24 at 1408 hours, Resident 29 was observed independently eating lunch in bed. Medical record review for Resident 29 was initiated on 4/29/24. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 29's Order Summary Report dated 4/30/24, showed a physician's order dated 10/31/23, for two grams sodium diet, pureed texture, and regular/thin consistency. Review of Resident 29's plan of care showed a care plan problem developed on 7/18/23, addressing Resident 29's swallowing problem related to dysphagia (difficulty or inability to swallow). The interventions showed resident to eat only with supervision. On 5/2/24 at 0810 hours, Resident 29 was observed eating breakfast in bed. Resident 29 was observed eating independently, and staff was not observed supervising at his bedside. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 0815 hours, an observation and concurrent interview was conducted with RN 1 and CNA 5. RN 1 was asked if Resident 29 required supervision during meals. RN 1 was observed asking CNA 5. CNA 5 stated she only assisted Resident 29 with meal set up and she did not supervise Resident 29 with his meals. CNA 5 verified she did not supervise Resident 29 during his breakfast. On 5/6/24 at 0818 hours, an interview and concurrent medical record review for Resident 29 was conducted with RN 1. RN 1 verified Resident 29's care plan addressing the resident's swallowing problem and the resident was supposed to have supervision while eating. On 5/6/24 at 1001 hours, an interview was conducted with the DON. The DON stated the interventions in the residents' care plans should be implemented. The DON was informed and acknowledged the above findings. 49258 3. Review of the facility's P&P titled P-PA01 Pain Management revised 5/2023, showed: a. The Interdisciplinary Team will review the pain assessment and develop a resident centered care plan for pain management, including non-pharmacological interventions including but not limited to turning and repositioning, application of heat or cold (referral to therapy as indicated), and massage if appropriate for resident's condition; b. The goal for pain management will be resident centered and determined by the resident's acceptable level of pain; and c. The licensed nurse will update the care plan for pain management with any change in treatment and/or medication. Review of the facility's P&P titled Administration of Pain Medication revised 11/2016, showed the facility should review the resident's care plan to assess for any special needs of the resident. Review of the facility's P&P titled NP 120 Bed Rails revised 11/2022, showed under the section Evaluating the Resident's Need for Bed Rails: - The licensed nurse will initiate a care plan around the use of bed rails. On 4/29/24 at 0828 hours, an observation and concurrent interview was conducted with Resident 69. Resident 69 was observed lying in bed with elevated bilateral side rails . Resident 69 was observed rubbing her abdomen and stated she had occasional pain in her abdomen, neck, and back. Resident 69 further stated she had five of ten pain level at this time. Resident 69 stated she was not able to use the side rails because she was in pain when she moved in bed. Resident 69 further stated she had the bed rails for a long time. Medical record review for Resident 69 was initiated on 4/29/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's H&P examination dated 10/27/23, showed Resident 69 had no capacity to make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 69's Quarterly MDS dated [DATE], showed under the section J-Health Conditions: - Resident received prn pain medications was answered yes - Presence of pain in the last five days was answered yes - Pain frequency was answered occasionally - Pain interference with activity therapy was answered occasionally - Pain interference with day to day activities was answered occasionally - Pain intensity was answered five, verbal descriptor Review of Resident 69's Order Summary Report dated 4/30/24, showed the following physician's orders: - dated 10/25/23, to administer Tylenol (acetaminophen, anti-pain and anti-fever medication) 325 mg by mouth to give two tablets every six hours as needed for mild pain. - dated 12/15/21, to monitor for pain every shift using pain scale: 0= no pain, 1-4= mild, 5-7= moderate, 8-9= severe, and 10= horrible; every shift non-pharmacological interventions: A= heat, B= repositioning, C= relaxation breathing, D= food/fluids, E= massage, F= exercise, G= immobilization of joints, H= other (document in the nurse's note), and N= not needed. Review of Resident 69's plan of care dated 3/19/24, failed to show documented evidence a care plan problem was developed to address Resident 69's pain and use of bed rails. On 4/29/24 at 1020 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 69's bilateral side rails were elevated. CNA 1 stated Resident 69 used the side rails to reposition herself in bed. CNA 1 further stated Resident 69 had not complained of any pain to her. On 5/2/24 at 1113 hours, an interview and concurrent medical record review for Resident 69 was conducted with LVN 1. LVN 1 stated Resident 69 was able to express her needs and ask for pain medication if she needed it. LVN 1 further stated Resident 69 complained of mild pain at times. LVN 1 further stated a plan of care to address Resident 69's pain was important to monitor and best manage her pain. LVN 1 verified there was no plan of care developed to address Resident 69's pain. On 5/2/24 at 1127 hours, an interview and concurrent medical record review for Resident 69 was conducted with RN 1 who was the supervisor. RN 1 verified there was no care plan developed to address Resident 69's pain and use of bed rails. Cross reference to F697 and F700, example #1 39670 (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 4/29/24 at 1057 hours, and 4/30/24 at 1358 hours, Resident 23 was observed with one-to-one supervision with the private caregiver. Medical record review for Resident 23 was instead on 5/1/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's plan of care failed to show a care plan addressing Resident 23's one-to-one supervision. On 5/1/24 at 1145 hours, an interview for Resident 23 was conducted with CNA 1. CNA 1 stated Resident 23 had one-to-one supervision due to Resident 23's behavior hurting himself and others. On 5/2 24 at 0944 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23's one-to-one supervision because of Resident 23's behavior. RN 1 was asked about the plan of care about the use of Resident 23 one-to-one supervision. RN 1 verified there was no care plan formulated for the one-to-one supervision. On 5/6/24 at 103 hours, an interview and concurrent medical review for Resident 23 was conducted with the DON. The DON was informed of the above finding and verified the finding. Cross Reference to F 740.

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	055206	A. Building B. Wing	05/06/2024

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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** 39670 Based on observation, interview, medical record review, and facility document review, the facility failed to provide the necessary care and services to ensure one of four final sampled residents (Resident 71) attained and maintained their highest practical well-being. * The facility failed to ensure Resident 71's right leg fracture with the immobilizer was assessed and monitored. This failure had the potential for the resident to not receive appropriate care and treatment. Findings: On 4/29/24 at 1101 hours, an observation and concurrent interview was conducted with Resident 71. Resident 71 stated he fell and broke his bone on the right leg. Resident 71 stated he was wearing a leg immobilizer which came from the acute care hospital. Resident 71 was asked regarding the care of the leg immobilizer. Resident 71 stated the nurses were not taking care of the right leg immobilizer. Resident 71 added, there were no staff who opened and looked at the leg immobilizer including the bone doctor. Medical record review for Resident 71 was initiated on 4/30/24. Resident 71 was admitted to the facility on [DATE]. Review of Resident 71's MDS for significant change dated 3/27/24, showed Resident 71 was intact cognitively. In addition, Resident 71 had incident of fall with major injury and was dependent to staff on all ADL care. Review of the H&P examination dated 3/29/24, showed Resident 71 had the capacity to understand and make decisions. Review of Resident 71's Change in Condition Evaluation dated 3/26/24, showed Resident 71 had an incident of fall and had an injury to right lower leg with swelling below the right knee. Review of Resident 71's Weekly Skin/Wound assessment dated [DATE], showed Resident 71 was sent out to the acute care hospital and returned to the facility with a right lower extremity immobilizer. Review of Resident 71's Order Summary Report dated 5/1/24, showed a physician's order dated 3/27/24, to always keep the right lower extremity immobilizer, and to monitor the circulation and skin integrity every day. Review of Resident 71's plan of care, showed a care plan problem dated 3/26/24, addressing Resident 71's at risk for fall and with injury. The interventions included to monitor the right lower extremity for circulation and skin integrity. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 1138 hours, an interview was conducted with CNA 1. CNA 1 verified Resident 71 had a right lower leg immobilizer. CNA 1 stated Resident 71 fell and broke his bone on the right leg. CNA 1 stated Resident 71 always had the right leg immobilizer and had not seen the nurse or other staff removing the immobilizer. On 5/1/24 at 1320 hours, an observation and concurrent interview for Resident 71 was conducted with LVN 6. Resident 71 was observed in bed and the right lower leg immobilizer was in placed. LVN 6 stated Resident 71 had a fracture on the right lower leg after the incident of fall. LVN 6 stated and verified the assessment and monitoring of Resident 71's right leg immobilizer was not done. LVN 6 acknowledged she did not check the circulation on the right leg of Resident 71. On 5/1/24 at 1527 hours, another observation and concurrent interview for Resident 71 was conducted with LVN 6. LVN 6 asked Resident 71 to assess the right lower leg and if the strap on the leg immobilizer may be released to check the skin, Resident 71 agreed. LVN 6 released the strap on the immobilizer and observed a slight swelling and yellowish discoloration bruising. Resident 71 stated he felt good when the immobilizer strap was released. Resident 71 was very thankful and observed smiling. On 5/2 24 at 0919 hours, an interview and concurrent medical record review for Resident 71 was conducted with RN 1. RN 1 verified Resident 71 had a right lower leg immobilizer due to fracture. RN 1 verified there were physician's orders for the right lower extremity immobilizer and to monitor for circulation and skin integrity. RN 1 verified the monitoring of the right leg immobilizer was documented in the Treatment Administration Record (TAR). RN 1 was asked if there were any documentation in the medical records for the specific assessment of the skin integrity and circulation of the right lower leg, RN 1 verified there was no documentation of the assessment. On 5/2/24 at 1127 hours, an interview and concurrent medical record review for Resident 71 was conducted with LVN 7 who was also the treatment nurse. LVN 7 verified Resident 71 had an immobilizer on the right lower leg. LVN 7 verified and acknowledged there were no documentation for the skin assessment and circulation on the right lower leg. On 5/6/24 at 1102 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to ensure two of two final sampled residents (Residents 32 and 41) and one nonsampled resident (Resident 582) remained free from accident hazards. * The facility failed to implement the floor mats as per the physician's order for Residents 582, 32, and 41. This failure had the potential to place the residents at risk for serious injury. Findings: 1. Medical record review for Resident 582 was initiated on 4/29/24. Resident 582 was admitted to the facility on [DATE]. Review of Resident 582's care plan titled At Risk for Falls developed on 2/28/24, showed Resident 582 was at risk for falls related to osteoarthritis, depression, neuropathy, and dementia. The care plan showed a goal of Resident 582 remaining free of falls. Review of Resident 582's care plan titled Actual Fall developed on 3/8/24, showed Resident 582 sustained an actual fall having sustained a skin tear on her right knee. Review of Resident 582's care plan titled Unwitnessed Fall developed on 3/11/24, showed Resident 582 sustained an unwitnessed fall and was sent to the emergency room for evaluation and treatment. Review of Resident 582's Order Summary Report showed a physician's order dated 3/11/24, for bilateral floor mats for fall risk. On 4/30/24 at 1532 hours, Resident 582 was observed lying in bed without floor mats in place adjacent to Resident 582's bed. On 4/30/24 at 1542 hours, an observation and concurrent interview was conducted with RN 1. Resident 582 was observed lying in bed without floor mats in place adjacent to Resident 582's bed. RN 1 verified the findings and stated Resident 582 had a history of falls. On 4/30/24 at 1610 hours, an observation, interview, and concurrent medical record review was conducted with RN 1. Resident 582 was observed lying in bed without floor mats in place adjacent to Resident 582's bed. RN 1 verified the findings and verified Resident 582 had a physician's order for bilateral floor mats for fall risk. 32179 2. Medical record review for Resident 32 was initiated on 4/29/24. Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32's Order Summary Report dated 5/1/24, showed a physician's order dated 4/3/24, to apply floor mats on the left and right side of the bed. Review of Resident 32's care plan dated 2/22/24, showed a plan of care addressing the resident for high risk for fall related to physical mobility, receiving psychotropic medication, impaired balance or coordination, poor safety awareness, sensory deficits, fatigues, receiving antihypertensive medication, dementia, and status post intracranial hemorrhage. The interventions included for the floor mat on the right and left side of bed. Review of Resident 32's Fall Risk Evaluation dated 4/2/24, showed a score of 11 (high risk for potential falls). On 4/29/24 at 0830 hours and 1000 hours, Resident 32 was observed lying in bed and the floor mattress was on the right side of Resident 32's bed. On 4/30/24 at 0900 hours and 1100 hours, Resident 32 was observed lying in bed and the floor mattress was on the right side of Resident 32's bed. On 4/30/24 at 1500 hours, a concurrent observation and interview was conducted with LVN 2. LVN 2 was asked if Resident 32 had bilateral floor mats. LVN 2 stated the resident leans forward to the right side so only the right side needed the floor mats. LVN 2 stated she was not sure about the bilateral mats and would need to check the physician's order. On 4/30/24 at 1530 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated the physician had ordered the bilateral floor mats and the resident had a history of falls. Resident 32 was high risk for fall and the care plan included the bilateral floor mats. LVN 2 verified the findings. 48882 3. On 4/30/24 at 1447 hours, Resident 41 was observed lying in bed, there were no bedside floor mats noted. Medical record review for Resident 41 was initiated on 4/29/24. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's Order Summary Report dated 5/1/24, showed a physician's order dated 1/8/24, for a low bed with the bilateral mats. Review of Resident 41's plan of care showed a care plan problem dated 4/8/24, addressing Resident 41's unwitnessed fall on 4/7/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 41's IDT Progress Note- Falls, dated 4/8/24, showed the resident stated he had an episode of seizure while he was getting out of his bed while putting on his helmet, and he fell on the floor. Further review of the progress notes showed the current plan of care was to apply the helmet when out of bed, a low bed with the bilateral mat, bed in a low position, non skid socks or proper fitting footwear, and adequate supervisions provided by the staff. Under the section IDT recommendation, showed the IDT will continue to monitor the resident's response to his plan of care with emphasis on maintaining his safety and his dignity On 5/1/24 at 0745 hours and 1454 hours, Resident 41 was observed sleeping in bed, with no floor mats observed. On 5/1/24 at 1536 hours, an interview and concurrent record review for Resident 41 was conducted with LVN 3. LVN 3 verified the physician's order for the bilateral mats. A concurrent observation was conducted with LVN 3. LVN 3 verified there were no mats in place at Resident 41's bedside. LVN 3 stated the purpose of the mats was to prevent any injuries in case the resident falls. On 5/6/24 at 1001 hours, an interview was conducted with the DON. The DON stated he expected for the staff to carry out all physician's orders. The DON was informed and acknowledged the above findings.

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	055206	A. Building B. Wing	05/06/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 35346 Based on observation, interview, and facility P&P review, the facility failed to ensure one of one final sampled resident reviewed for GT care (Resident 23) received the appropriate GT care. This failure posed the risk of the resident's GT not being kept patent. Findings: Review of the facility's P&P titled Feeding Tube - Administration of Medication revised 11/2018 showed when administering the medications via GT, the placement and residual were to be checked prior to administering the medications. The P&P showed the medications were to be administered by the syringe via gravity into the feeding tube and flushing after each medication administration. On 4/30/24 at 0839 hours, a medication administration observation was conducted with LVN 4. During the medication administration pass, LVN 4 was observed not checking Resident 23's GT for placement or residual prior to administering Resident 23's medications. LVN 4 was observed administering the medications into Resident 23's GT, without waiting for each medication to flow into Resident 23's GT by gravity before flushing the tube with water and administering the next medication. The findings were verified with LVN 4.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one of one final sampled resident reviewed for IV therapy(Resident 115). * The facility failed to ensure the PICC (peripherally inserted central catheter- intravenous access used for a prolonged period of time) line external catheter and arm circumference measurements were completed and documented in the medical record for Resident 115. This failure had the potential to delay the identification of catheter related complications for the residents. * The facility failed to label Resident 115's IV medication tubing with the date and time when it was hung. This failure posed the potential risk for infection or phlebitis (inflammation of a vein) for Resident 115. Findings: Review of the facility's P&P titled PICC Dressing Change dated 6/2018 showed the length of the external catheter is obtained: upon admission, during dressing changes, and if signs or symptoms of complications are present. Documentation in the medical record includes but is not limited to: date and time, site assessment, length of external catheter, resident response to procedure and/or medication, and resident teaching. Review of the facility's P&P titled IV Therapy dated 6/2018, showed the IV tubings will be changed every 72 hours for continuous therapy, and every 24 hours for intermittent, TPN (total parenteral nutrition, IV administered nutrition as the only source of nutrition the resident is receiving) and lipids. IV tubings will be labeled with the date, time, and nurse hanging tubing. a. On 4/29/24 at 1130 hours, an interview was conducted with Resident 115. Resident 115 stated he had a wound infection in his right leg and was receiving antibiotic through his PICC line. Resident 115 was observed with a PICC line on his right upper arm with a single lumen port. Medical record review for Resident 115 was initiated on 4/29/24. Resident 115 was admitted to the facility on [DATE]. Review of Resident 115's Order Summary Report dated 4/20/24, showed the following physician's orders : - dated 4/20/24, to administer cefepime hcl (antibiotic) two grams intravenously three times a day for right lower extremity wound until 5/23/24, - dated 4/1/24, to monitor the right upper arm PICC line site for signs and symptoms of infection such as: fever, redness, swelling, pain, tenderness and to report to the physician promptly, every shift, - dated 3/29/24, may reinsert PICC line, (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/25/24, to change the PICC dressing and cap weekly and as needed if soiled, every Sunday day shift. Review of Resident 115's PICC Insertion Record dated 3/29/24, under the section Comments showed Resident 115's previous PICC was inserted prior to admission and is now clogged unable to flush . old PICC removed to tip fully intact to 40 cm. New PICC inserted in right upper extremity (RUE) without difficulty. The document also showed the external length of the catheter was two centimeters (cm), and the resident's arm circumference was 34 cm. Review of Resident 115's IVT Administration Record for April 2024, showed PICC dressing and cap was changed on 4/7/24, 4/14/24, 4/26/24. Review of the IVT Administration Record showed the monitoring of the right upper arm PICC line site for signs and symptoms of infection such as; fever, redness, swelling, pain, tenderness was done every day shift from 4/2/24 to 4/29/24, and every evening/noc shift from 4/1/24 to 4/24/24, and from 4/26/24 to 4/29/24. However, further review of the IVT Administration Record failed to show documentation of measurement of the external length of the PICC were obtained or recorded for each PICC dressing change. On 5/1/24 at 1114 hours, an interview and concurrent medical record review for Resident 115 was conducted with RN 1. RN 1 stated Resident 115 had a PICC line on the right upper arm and the site was checked by an RN every shift, and the dressing was changed weekly, every Sunday. RN 1 stated during the dressing changes, she did not measure the resident's arm circumference or the external catheter length. RN 1 verified Residents 115's medical record failed to show documentation of the PICC line external catheter measurements during each dressing change. On 5/6/24 at 0947 hours, an interview and concurrent medical record review for Resident 115 was conducted with the DON. The DON was informed and verified the above findings. The DON stated upon admission, and during the IV dressing changes the staff should measure the upper arm circumference and external catheter length and monitor for any discrepancies in the measurements, which may indicate swelling of the arm or dislodgement of the catheter. b. Medical record review for Resident 115 was initiated on 4/29/24. Resident 115 was admitted to the facility on [DATE]. Review of Resident 115's Order Summary Report dated 4/30/24, showed physician's order dated 4/20/24, to administer cefepime hcl (antibiotic) two grams intravenously three times a day for the right lower extremity wound until 5/23/24. Review of Resident 115's IVT Administration Record for April 2024 showed Resident 115 was administered cefepime hcl two grams intravenously on the following dates: - at 0600 hours, from 4/1 to 4/23/24, 4/25, and 4/27 to 4/29/24, - at 1400 hours, from 4/1 to 4/19/24 and 4/21 to 4/28/24, - at 2200 hours, from 4/1 to 4/19/24, 4/21 to 4/24/24, and 4/26 to 4/29/24. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/24 at 1137 hours, in Resident 115's room, an IV tubing was observed hanging on an IV pole. The IV tubing was observed not labeled with the date or time. The luer lock connector end (end of the IV tubing that connects to the resident's IV access) was observed not capped and exposed to air; and the plastic spike (the part that connects to the antibiotic) was observed exposed, not connected to an antibiotic. On 4/29/24 at 1144 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated IV tubings were changed every 24 hours, and should be labeled with the date and time. RN 1 verified the above findings. RN 1 stated the IV tubing should be capped, and the spiked end of the tubing should not be exposed. RN 1 further stated there was a potential risk of infection and risk for safety, due to the exposed spike end. On 5/6/24 at 0947 hours, an interview was conducted with the DON. The DON stated in between the IV administrations, the RN was responsible for disconnecting the IV tubing from the resident. The DON stated the end of the IV tubing should be capped with a sterile plastic cap for infection control. The DON further stated the antibiotic medication should still be connected to the IV tubing. The DON was informed and acknowledged the above findings.

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	055206	A. Building B. Wing	05/06/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the oxygen therapy equipment was stored in a sanitary manner for two of three final sampled residents reviewed for respiratory care (Residents 8 and 36). * The facility failed to ensure Resident 8's nasal cannula and oxygen mask were stored in a sanitary manner. * The facility failed to ensure the administration of oxygen therapy had a physician's order, and the care plan for respiratory problem was updated for the use of oxygen for Resident 36. In addition, the oxygen tubing was labeled and not in the floor for Resident 36. These failures posed the risk for equipment contamination and associated respiratory complications. Findings: Review of the facility's P&P titled Oxygen Therapy revised 11/2017 showed oxygen is administered under safe and sanitary conditions to meet the residents' needs. 1. Medical record review for Resident 8 was initiated on 4/29/24. Resident 8 was admitted to the facility on [DATE]. On 4/29/24 at 0959 hours, an observation and concurrent interview was conducted with Resident 8. An oxygen concentrator was observed adjacent to Resident 8's bed. Unlabeled oxygen tubing/nasal cannula was observed lying on top of the oxygen concentrator. An oxygen mask was observed lying on Resident 8's bed side table. Neither the nasal cannula nor the oxygen mask was stored in a clean bag. Resident 8 stated he utilized the oxygen mask and nasal cannula at night to help him breath. On 4/29/24 at 1005 hours, an observation and concurrent interview was conducted with the DON. The DON verified the findings and stated Resident 8's oxygen mask and nasal cannula should be stored in a clean bag and labeled with the date when the equipment was provided to Resident 8 to ensure infection control. 39670 2. On 4/29/24 at 1102 hours, Resident 36 was observed in bed with oxygen at 5 liters per minute on concentrator machine via nasal cannula. The oxygen tubing was observed not labeled. Medical record review for Resident 36 was initiated on 4/30/24. Resident 36 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 36's Order Summary Report dated 5/1/24, failed to show a physician's order for the administration of oxygen therapy. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 36's plan of care and a care plan problem to address the risk of ineffective airway clearance dated 7/10/23, failed to show the use of the oxygen therapy. On 4/30/24 at 0842 hours, Resident 36 was observed on her wheelchair. The oxygen tubing was observed on the floor. Resident 36 stated she removed herself the oxygen tubing because she did not need it. On 4/30/24 at 0842 hours, an observation and concurrent interview for Resident 36 was conducted with CNA 11 at Resident 36's bedside. CNA 11 verified Resident 36 was using an oxygen while in bed and sleeping. CNA 11 verified the oxygen tubing was on the floor and not labeled. CNA 11 stated the oxygen tubing should be placed in a plastic bag if not in use. On 4/30/24 at 0846 hours, an observation and concurrent interview for Resident 36 was conducted with RN 1 at Resident 36's bedside. RN 1 verified the oxygen tubing nasal cannula was on the floor, not labeled and not placed on a clear plastic bag. RN 1 stated the oxygen nasal cannula tubing should have been labeled and placed in a clear plastic bag when not in use. On 5/6/24 at 1029 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	055206	A. Building B. Wing	05/06/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to offer or provide adequate and appropriate pain management for one of two final sampled residents reviewed for pain (Resident 69). This failure had the potential to cause the resident unnecessary pain and complications from worsened pain. Findings: Review of the facility's P&P titled P-PA01 Pain Management revised 5/25/23, showed the licensed nurse will administer pain medication as ordered and document the medication administered on the Medication Administration Record (MAR) and after medications/interventions were implemented, the licensed nurse will reevaluate the resident's level of pain within one hour. Review of the facility's P&P titled Administration of Pain Medication revised 11/2016, showed to document if the resident refuses pain medication. On 4/29/24 at 0828 hours, an observation and concurrent interview was conducted with Resident 69. Resident 69 was observed lying in bed rubbing her abdomen. Resident 69 stated she had occasional pain in her abdomen, neck, and back when asked why she was rubbing her abdomen. Resident 69 further stated she had five of ten pain level at this time. Resident 69 further stated she received Tylenol (analgesic) for pain and sometimes warm compress helped with her pain. Medical record review for Resident 69 was initiated on 4/29/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's H&P examination dated 10/27/23, showed Resident 69 had no capacity to make decisions. Review of Resident 69's Order Summary Report dated 4/30/24, showed the following physician's orders: - dated 12/15/21, to monitor for pain every shift using pain scale: 0= no pain, 1-4= mild, 5-7= moderate, 8-9= severe, and 10= horrible; every shift non-pharmacological interventions: A= heat, B= repositioning, C= relaxation breathing, D= food/fluids, E= massage, F= exercise, G= immobilization of joints, H= other (document in the nurse's note), and N= not needed. - dated 10/25/23, to administer Tylenol (acetaminophen, anti-pain and anti-fever medication) 325 mg by mouth to give two tablets every six hours as needed for mild pain. Review of Resident 69's MARs for February, March, and April 2024 showed Resident 69 was monitored for pain with levels of 3 to 4 of 10; however, no Tylenol was administered or documentation showing Resident 69 refused it on the following days: - 2/7, 2/14/24, the pain level was at 4 of 10 and no Tylenol was administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/16, 2/23, 2/25, 3/1, 3/20, 3/29, and 4/5/24, the pain levels were at 3 of 10 and no Tylenol was administered. Further review of Resident 69's MAR for February, March, and April 2024 showed non-pharmacological interventions were rendered to all the listed dates; however, there was no specified interventions documented as per physician's order. Further review of the MARs showed under the section for Chart Codes #2 for drug: refused. Further medical record review for Resident 69 did not show documented evidence the pain was reassessed after the Tylenol was administered nor after the non-pharmacological interventions were rendered. On 5/2/24 at 1113 hours, an interview and concurrent medical record review for Resident 69 was conducted with LVN 1. LVN 1 stated Resident 69 was able to express her needs and ask for pain medication if she needed it. LVN 1 stated Resident 69 complained of mild pain at times. LVN 1 stated the Tylenol ordered for Resident 69 was effective with her and most of the time the non-pharmacological interventions were helpful with her pain. LVN 1 stated the pain reassessment should be done to assess if the interventions provided were effective. LVN 1 further stated if the resident refused the pain medication, it should be documented in the MAR as evidenced that it was offered to the resident. LVN 1 verified there was no documented pain reassessment for Resident 69 and the MAR did not show any documentation the Tylenol was refused by Resident 69 on the days she was monitored with the pain level of 3 to 4. On 5/2/24 at 1127 hours, an interview and concurrent medical record review for Resident 69 was conducted with RN 1. RN 1 verified the above findings. Cross reference to F656, example #3

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observations, interview, medical record review, and facility P&P review, the facility failed to ensure the proper monitoring, documentation, initiation of a plan of care addressing the dialysis site, and reporting to the physician of the weight variances for one of two final sampled residents reviewed for dialysis services (Resident 49). These failures had the potential to delay identifying and responding to dialysis access site issues, and delay of care and treatment for Resident 49. Findings: Review of the facility's P&P titled Dialysis Management revised 1/2024 showed the facility will initiate a plan of care based on the resident's needs. Under the section Vascular Access Site showed the facility will assess, observe and document care of the access sites daily, as applicable, such as auscultation/palpation of the AV fistula (pulse, bruit and thrill) to assure adequate blood flow. All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. Review of the facility's P&P titled Evaluation of Weight Nutritional Status revised 11/2022 showed weight gain is defined as unplanned weight gain in a resident with an elevated BMI (over 27) that has significant health implications that may result in a negative outcome. Rapid or abrupt increases in weight may also identify significant fluid and electrolyte imbalance. Significant weight gain is 2% in one week, 5% and/or 5 lbs in one month. Review of the facility's P&P titled Change of Condition revised 4/2015 showed a change in condition related to the attending physician notification is defined as when the attending physician must be notified when 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 medical assessment, coordination and consultation with the attending physician and a change in treatment plan. On 4/29/24 at 1219 hours, an interview was conducted with Resident 49. Resident 49 stated he received dialysis on Mondays, Wednesdays, and Fridays. Resident 49 was observed with a left arm hemodialysis (the process by which a machine filters wastes, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) access site. Medical record review for Resident 49 was initiated on 4/29/24. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 3/27/24, showed Resident 49 had a diagnosis of End Stage Renal Disease (a loss of kidney function) and was dependent on hemodialysis. a. Review of Resident 49's Order Summary Report dated 4/30/24, showed the following physician's orders: - dated 3/28/24, to monitor the AV shunt (arteriovenous shunt, a surgically created connection between an artery and vein for hemodialysis) in the left arm for bruit and thrill every shift, (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/2/24, for hemodialysis services off-site, every Monday, Wednesday, and Friday. Review of Resident 49's MAR for April 2024 showed the following documentation for monitoring of Resident 49's AV shunt in the left arm, for bruit and thrill, for the day shift: - from 4/1 to 4/4, 4/8 to 4/13, and 4/19/24, documented as NA (not applicable) - on 4/5, 4/20, 4/25, and 4/26/24, documented as 0 and - on 4/6/24, documented as - Review of Resident 49's Physician Progress Note dated 4/3/24, showed for some reason the pt (patient) missed the dialysis today. Continue all therapies and treatments. Monitor for overload, any confusion. Review of Resident 49's Vital Signs and Weight Record showed the following weights: * On 3/31 and 4/7/24 = 210 lbs., * On 4/14/24 = 212 lbs., * On 4/21/24 = 225 lbs. Review of the facility's document titled Stop and Watch Early Warning Tool dated 4/21/24, showed RNA 2 reported to the Licensed Nurse Resident 49 had a 13 lb. weight increase in a week. Review of Resident 49's Progress Notes for April 2024 failed to show any documentation the physician was notified of the weight increase, or any physician notification for the absence of bruit or thrill upon assessment of Resident 49's AV Shunt for the above dates. Review of Resident 49's plan of care showed a care plan problem developed on 3/20/24, addressing Resident 49's dialysis related to end stage renal disease. However, the plan of care failed to show a care plan problem addressing Resident 49's hemodialysis site in the left arm. On 5/1/24 at 0928 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 stated Resident 49 was on dialysis, and his dialysis access was in his left arm. LVN 3 stated the bruit and thrill were checked every shift. LVN 3 stated Resident 49 should have a care plan addressing the monitoring of his left arm dialysis access. A concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 verified Resident 49 did not have a care plan specific to his left arm dialysis access. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 1153 hours, a follow-up interview and concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 stated the process for monitoring of Resident 49's hemodialysis access site was to auscultate for bruit and feel for thrill. LVN 3 stated monitoring was done every shift and documented in the MAR. LVN 3 stated she documented + to indicate the presence of bruit and thrill. When asked what -, or 0, meant, LVN 3 stated it meant bruit or thrill was not present and the physician should then be informed. A concurrent medical record review of Resident 49's MAR for April 2024 was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 was asked what NA meant and LVN 3 stated documentation should not be NA. b. On 5/2/24 at 1426 hours, and interview was conducted with RNA 2. RNA 2 stated weights were done every Sunday and documented in the weight binder. RNA 2 stated the DON, Supervisors, and Dietary were provided a copy of the weights. RNA 2 stated upon obtaining weights for residents she also compared the resident's weight from the previous week. If there was a weight variance (weight lost or gained), she would fill out a form called a Stop and Watch Early Warning Tool and submit to the charge nurse and/or give to the DON or slip under his door. RNA 2 stated she worked on 4/21/24, and recalled Resident 49's 13 lb weight gain. RNA 2 stated she completed the form and submitted to the charge nurse. On 5/2/24 at 1439 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 stated any weight variance was considered a change in condition, and the physician should be informed, as well as the RD and IDT Team. A concurrent record review of Resident 49's weight trend was conducted with LVN 3. LVN 3 verified on 4/14/24 Resident 49 weighed 212 lbs and on 4/21/24 Resident 49 weighed 225 lbs, a 13 lbs weight increase. LVN 3 was asked if the physician was informed of the weight increase. LVN 3 verified Resident 49's medical record failed to show documentation the resident's physician was informed, or a change of condition assessment was initiated. On 5/2/24 at 1450 hours, an interview and concurrent record review for Resident 49 was conducted with the DON. The DON stated for the weekly weights, the RNA was responsible for obtaining the residents weights. For weight variances, the RNA would inform the charge nurse, the licensed nurse would confirm the weight variance and would inform the physician. The DON stated for a weight variance of five pounds in a week, he expected the charge nurse to complete a COC assessment and inform the physician of the weight variance. The DON verified the above findings. The DON was asked about the risks of not informing the physician of the resident's weight variance. The DON stated there may be a possibility of fluid overload. On 5/6/24 at 0955 hours, a follow up interview and concurrent record review was conducted with the DON. The DON stated he expected the staff documentation to be accurate and complete every shift. The DON was asked about his expectation of the staff on the monitoring of Resident 49's HD access. The DON stated staff should be monitoring for bruit and thrill every shift and documenting if observed. If the bruit or thrill was not observed, staff should inform the physician. The DON was informed of the above findings. The DON stated the staff should not document NA, and for documentations of -or 0 the nurse should have notified the physician.

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	055206	A. Building B. Wing	05/06/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to obtain a physician's order and an informed consents prior to the use of elevated side rails for one of one final sampled resident (Resident 69) and one nonsampled resident (Resident 582) reviewed for use of bed rails. This failure had the potential to put the residents at risk for serious injuries. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled NP 120 Bed Rails revised 11/16/22, showed: - The facility will attempt alternatives prior to the installation of bed rails. Prior to installation, assess the resident's risk for entrapment with bed rails; - The facility will review the risks and benefits of bed rails with the resident and resident's representative and obtain informed consent prior to installation; and - A detailed order by a healthcare provider (e.g., a physician, nurse practitioner) is required before any restraints can be utilized. 1. On 4/29/24 at 0828 hours, an observation and concurrent interview was conducted with Resident 69. Resident 69 was observed lying in bed with the bilateral side rails elevated. Resident 69 stated she was not able to use the side rails because she was in pain when she moved in bed. Resident 69 further stated she had the side rails for a long time. Medical record review for Resident 69 was initiated on 4/29/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's H&P examination dated 10/27/23, showed Resident 69 had no capacity to make decisions. Review of Resident 69's Quarterly MDS under Section P-Bed Rail dated 3/13/24, showed no use of bed rail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 69's Bed Rail assessment dated [DATE], showed side rails/assist bars were not indicated at this time. Further review of Resident 69's medical record review failed to show documented evidence the physician's order and informed consent for the use of the side rails were obtained, and initiated a care plan for the use of side rails. On 4/29/24 at 1020 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 69's bilateral side rails were elevated. CNA 1 stated Resident 69 used the side rails to reposition herself in bed. On 4/29/24 at 1050 hours, an interview and concurrent medical record review for Resident 69 was conducted with RN 1. RN 1 verified there were no physician's order for the use of the side rails, no informed consent and no care plan was developed prior to installing the side rails. On 5/1/24 at 1008 hours, an interview for Resident 69 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F656, example #3. 37726 2. On 4/30/24 at 1532 hours, an observation was conducted of Resident 582. Resident 582 was observed lying in bed with bilateral siderails elevated at the middle of her bed. Medical record review for Resident 582 was initiated on 4/29/24. Resident 582 was admitted to the facility on [DATE]. Review of Resident 582's care plan titled Impaired Thought Processes/Impaired Cognitive Function initiated 2/28/24, showed Resident 582 had a diagnosis of dementia. The care plan goals included Resident 582 will develop skills to cope with cognitive decline and maintain her safety. Review of Resident 582's medical record failed to show for an informed consent prior to the use of elevated side rails was obtained. On 4/30/24 at 1542 hours, an observation and concurrent medical record review was conducted with RN 1. Resident 582 was observed lying in bed with bilateral siderails elevated at the middle of the bed. RN 1 verified the findings. RN 1 then reviewed Resident 582's medical record and verified consent for the use of elevated side rails was not obtained prior to use.

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	055206	A. Building B. Wing	05/06/2024

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Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 32179 Based on interview and facility document review, the facility failed to ensure the performance evaluations were completed every 12 months for two of three CNA employee's files reviewed (CNAs 6 and 7). This resulted in the CNA's not being provided with the appropriate training or in-service education based on their performance review, which had the potential to negatively impact resident care. Findings: On 5/6/24 at 1140 hours, an interview was conducted with the DON. The DON was asked if he knew if CNAs 6 and 7 had done annual performance review. The DON stated he was not aware of the CNA who had it already or not. The DON stated the performance annual evaluations should be completed and the CNA's in-services should be based on the outcome of their individual performance evaluations. On 5/6/24 at 1432 hours, an interview and employees' files review was conducted with the Administrator. The Administrator was asked for annual performance for CNAs 6 and 7. The Administrator was unable to provide the documentation. The Administrator verified the above findings.

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	055206	A. Building B. Wing	05/06/2024

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, and medical record review, the facility failed to ensure the individualized behavioral health care needs and services for one of one final sampled resident reviewed for behavioral management (Resident 23) were met. * Resident 23 was diagnosed with schizophrenia (a severe brain disorder in which people interpret reality abnormally) with a thorough clinical assessment and was prescribed a risperidone (antipsychotic medication). However, the facility failed to ensure a physician's order was obtained for one-to-one supervision and the IDT or Bioethics Committee meeting was conducted where a possible psychotropic medications and behavior management of Resident 23 were discussed and recorded. This failure had the potential for the resident not able to attain the highest practicable wellbeing. Findings: On 4/29/24 at 1057 hours and 4/30/24 at 1358 hours, Resident 23 was observed with one-to-one supervision with the private caregiver. Medical record review for Resident 23 was initiated on 5/1/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 12/22/23, showed Resident 23 had no mental capacity to make decisions due to impaired judgement and psychosis (a condition of the mind that results in difficulties determining what is real and not real). Review of Resident 23's Order Summary Report dated 5/1/24, showed the following physician's orders: -On 2/1/24, to administer Clonazepam (antianxiety medication) tablet 1 mg by GT three times a day for anxiety manifested by inability to relax. -On 2/1/24, to administer risperidone (antipsychotic medication) 0.5 mg tablet by mouth three times a day for schizophrenia manifested by angry outburst. -On 2/1/24, to administer sertraline (antidepressant medication) 125 mg via GT one time a day for depression manifested by over concern of health condition. However, further review of the physician's order failed to show a documented evidence a physician's order was obtained for one-to-one supervision. In addition, the medical records failed to show documented evidence an IDT or Bioethics Committee meeting was conducted where a possible psychotropic medications and behavior management of Resident 23 were discussed and recorded. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 0944 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23's use of psychotropic medication and one-to-one supervision due to Resident 23's behavior of hurting himself and others. RN 1 verified there was no physician's order for one-to-one supervision and unable to show documented evidence an IDT or Bioethics Committee meeting was conducted. On 5/6/24 at 1103 hours, an interview and concurrent medical record review for Resident 23 was conducted with the DON. The DON was informed and verified the above findings. Cross reference F656, example #4.

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	055206	A. Building B. Wing	05/06/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to ensure the pharmacy services were provided as evidenced by: * The medications for two of two final sampled residents (Residents 6 and 23) and two nonsampled residents (Residents 77 and 80) reviewed for medication administration were not acquired in a timely manner. This failure had the potential for the residents to not consistently receive their medications as ordered. *The staff's personal items were stored inside a medication room. This failure posed the risk of not keeping an accurate account of medications stored inside the medication room. Findings: 1.a. Medical record review for Resident 23 was initiated on 4/30/24. Resident 23 was readmitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 12/22/23, showed Resident 23 had no capacity to make decisions. On 4/30/24 at 0839 hours, a medication administration observation for Resident 23, was conducted with LVN 4. Review of Resident 23's MAR for March 2024, showed Resident 23 was to be administered with Calcium Oyster Shell (supplement) tablet 1250 mg at 0900 hours, daily. On 4/30/24 at 1432 hours, a post medication administration observation interview was conducted with LVN 4. When asked about Resident 23 not being administered with the Calcium Oyster Shell medication, LVN 4 stated the medication was not administered because it was not available. b. Medical record review for Resident 80 was initiated on 5/2/24. Resident 80 was admitted to the facility on [DATE]. Review of Resident 77's H&P examination dated 1/2/24, showed Resident 77's diagnoses included diabetes and depression. Review of Resident 77's MAR for April 2024 showed Resident 77 was to be administered Ambien (sedative/hypnotic) 10 mg at bedtime for insomnia. Review of this MAR showed on 4/14/24, Resident 77 was not administered her Ambien. On 5/3/24 at 0900 hours, concurrent interview and medical record review was conducted with the DON. When asked about Resident 77's Ambien, the DON verified Resident 77 did not receive her Ambien on 4/14/24, because it was not available. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 5/2/24 at 1600 hours, an interview was conducted with Resident 80. When asked about her insulin pen injection, Resident 80 verbalized the injection was due every Friday, but she did not receive her insulin twice in April 2024 because the facility did not have the medication on hand. According to Resident 80 she now wanted to receive it on Saturdays and she usually asked staff every Friday to ensure her insulin will be available. Medical record review for Resident 80 was initiated on 5/2/24. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 8/19/23, showed Resident 80's diagnoses included diabetes. Review of Resident 80's MAR for April 2024 showed Resident 80 was to be administered with Trulicity (an injectable diabetes medicine that helps control blood sugar levels) subcutaneous solution pen-injector 0.75 mg every Friday for her diabetes. Futher review of the MAR showed on 4/5 and 4/12/24, Resident 80 was not administered with Trulicity medication. On 5/3/24 at 0900 hours, concurrent interview and medical record review was conducted with the DON. When asked about Resident 80's Trulicity medication, the DON verified Resident 80 did not receive her Trulicity on 4/5 and 4/12/24, because it was not available. d. Medical record review for Resident 6 was initiated on 5/2/24. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's Order Summary Report for April 2024, showed Resident 80 was to be administered with temazepam (sedative) 15 mg at bedtime for insomnia. On 5/1/24 at 1120 hours, a medication cart inspection was conducted with LVN 1. When asked about Resident 6's temazepam, the bubble pack for Resident 6's temazepam 15 was observed and verified with LVN 1 to be empty. On 5/3/24 at 0900 hours, a concurrent interview and medical record review was conducted with the DON. When asked about Resident 6's temazepam, the DON stated all medications should be requested from the facility's pharmacy, five days before the medication packs became empty. 2. The facility was equipped with two medication storage rooms. On 4/30/24 at 1407 hours, a concurrent observation and interview of one of two medication storage rooms was conducted with the DON. Inside medication storage Room B, three staff purses were observed open and stored inside this medication storage room. The finding was verified with the DON. The DON acknowledged the purses of the staff should not have been stored inside the medication room.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure seven out of seven final sampled residents reviewed for unnecessary psychotropic drugs (Residents 23, 36, 49, 105, 112, 124, and 332) were free from unnecessary psychotropic drugs (any drug that affects brain activity associated with mental process and behavior). * The facility failed to ensure Resident 49's monitoring for orthostatic blood pressure (blood pressure obtained when sitting or lying down, and after standing; used when monitoring for potential side effects from antipsychotropic use), for the use of clozapine (antipsychotic) and aripiprazole (antipsychotic) was accurate. * The facility failed to ensure Resident 332's monitoring of orthostatic blood pressure, for the use of quetiapine fumarate (antipsychotic) was accurate. * The facility failed to ensure Resident 23's episodes of behavior for the use of psychotropic medications were made available to the prescriber on a monthly basis to serve as a reference for the gradual dose reduction. In addition, the facility failed to ensure the risperidone (antipsychotic medication) medication order was clarified to the physician. The physician's order for the risperidone was to administer by mouth. However, Resident 23 had a physician's order for nothing by mouth. * The facility failed to ensure Resident 36's monitoring of the orthostatic blood pressure were accurate for the use of antipsychotic medications. * The facility failed to ensure the informed consent was obtained for Resident 112 for the use of Aripiprazole (antipsychotic medication) for psychosis manifested by aggressive behavior. * Resident 105's manifestations of auditory hallucinations were not consistently being tallied as ordered. * Resident 124 did not have behavior monitoring for the use of Rexulti. These failures had the potential for the residents to experience adverse consequences from the drugs. Findings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility P&P titled Behavior/Psychoactive Drug Management revised 11/2018 under the section Monitoring for Side Effects, showed depending on the specific classification of psychoactive medication, the resident should be observed and/or monitored for side effects and adverse consequences. Under Cardiovascular side effects, orthostatic hypotension and arrhythmias (an irregular heart rhythm) were listed . whenever an order for psychotropic drug is obtained, the Licensed Nurse verifies with the Attending Physician/Prescriber that informed consent has been obtained and the Licensed Nurse will contact the resident and/or responsible party and verify that the physician obtained informed consent for the medication. Should the resident or responsible party refuse the medication order, the Licensed Nurse will notify the Attending Physician/Prescriber and document this in the clinical record. Review of the facility's P&P titled Orthostatic Hypotension revised 1/2012 showed the orthostatic vital signs will be taken and recorded when ordered by the physician. All documentation is maintained in the resident's medical record. 1. Medical record review for Resident 49 was initiated on 4/29/24. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 49's Order Summary Report dated 4/30/24, showed the following physician's orders dated 3/28/24: - to administer one tablet of aripiprazole (antipsychotic medication) 20 mg one time a day for schizophrenia manifested by paranoid delusion, - to administer clozapine (antipsychotic medication) 300 mg at bedtime for schizophrenia manifested by auditory hallucination as evidenced by hearing voices telling him to hurt himself - to monitor orthostatic blood pressure lying and sitting every day shift, on Sunday for the use of clozapine and aripiprazole Review of Resident 49's MAR for April 2024 showed Resident 49 was administered with the following: - aripiprazole 20 mg one time a day at 0900 hours from 4/1 to 4/19/24, and from 4/21 to 4/29/24 - clozapine 300 mg at bedtime at 2100 hours on 4/1/24 and from 4/3 to 4/29/24 Further review of Resident 49's MAR for April 2024 showed the following documentation for monitoring of the resident's orthostatic blood pressure: - on 4/7 and 4/21/24, Resident 49's lying and sitting blood pressures were documented as y, - on 4/14/24, Resident 49's lying and sitting blood pressures were documented as x. Review of Resident 49's Progress Notes for April 2024 failed to show documented evidence the orthostatic blood pressure readings for lying and sitting were obtained on 4/7, 4/14, and 4/21/24. 2. Medical record review for Resident 332 was initiated on 4/29/24. Resident 332 was admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 332's Order Summary Report dated 5/2/24, showed the following physician orders: - dated 4/5/24, to administer one tablet of quetiapine fumarate (antipsychotic) 50mg by mouth one time a day for schizophrenia m/b aggressive behavior - dated 4/5/24, to administer one tablet of quetiapine fumarate 200 mg by mouth at bedtime for schizophrenia m/b aggressive behavior; and - dated 4/9/24, to monitor the orthostatic blood pressure lying and sitting, every day shift, on Saturdays Review of Resident 332's MAR for April 2024 showed Resident 332 was administered with the following: - quetiapine fumarate 50 mg, one tablet by mouth one time a day at 0900 hours, from 4/5 to 4/30/24 - quetiapine fumarate 200 mg, one tablet by mouth at bedtime at 2100 hours, from 4/5 to 4/30/24 Further review of Resident 332's MAR for April 2024 showed the following documentation for the monitoring of the resident's orthostatic blood pressure: - on 4/7/24, BP: 132/71 mmHg, lying, sitting, and standing blood pressures were documented as y - on 4/20/24, lying and sitting blood pressures were documented as 0 - on 4/27/24, lying and sitting blood pressures were documented as NA. Review of Resident 332's Progress Notes for April 2024 failed to show documented evidence the orthostatic blood pressures readings for lying and sitting were obtained on 4/7, 4/20, and 4/27/24. On 5/6/24 at 1006 hours, an interview and concurrent medical record review for Residents 49 and 332 were conducted with the DON. The DON stated for the residents on the antipsychotic medications, the orthostatic blood pressure should be monitored to ensure residents do not have side effects. The DON further stated the orthostatic blood pressure was measured weekly with the resident in two positions, lying and sitting, or per the physician's order. The DON verified the above findings. The DON stated the documentation of orthostatic blood pressures in Residents 49 and 332's MAR was inaccurate, and staff should document the blood pressure readings for the lying and sitting positions to determine if the resident's blood pressure was affected by the position change. The DON stated the resident's blood pressure for each position should be recorded to determine whether the resident's blood pressure was affected by the position change. The DON further stated staff was not correctly documenting or monitoring orthostatic blood pressure. 39670 3. Medical record review for Resident 23 was initiated on 5/1/24. Resident 23 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of Resident 23's H&P examination dated 12/22/23, showed Resident 23 had no mental capacity to make decisions due to impaired judgement and psychosis (a condition of the mind that results in difficulties determining what is real and not real). Review of Resident 23's Order Summary Report dated 5/1/24, showed the following physician's orders: - On 2/1/24, to administer Clonazepam (antianxiety medication) tablet 1 mg by GT three times a day for anxiety manifested by inability to relax - On 2/1/24, to administer risperidone (antipsychotic medication) 0.5 mg tablet by mouth three times a day for schizophrenia (a mental illness that affects how a person thinks, feels, and behaves) manifested by angry outburst - On 2/1/24, to administer sertraline (antidepressant medication) 125 mg via GT one time a day for depression manifested by over concern of health condition Further review of the medical records failed to show the monthly psychotropic summary for the use of the above psychotropic medications. In addition, there was no documented evidence an IDT Care Conference for Behavior and Psychotropic Management were completed, where a possible gradual dose reduction for psychotropic medications were discussed and recorded. b. Review of Resident 23's Order Summary Report date 5/1/24, showed a physician's order dated 3/3/24, for Resident 23's diet was nothing by mouth. However, another physician's order dated 2/1/24, to administer risperidone (antipsychotic medication) 0.5 mg tablet by mouth three times a day for schizophrenia manifested by angry outburst. Further review of the medical records failed to show a documented evidence the physician's order for risperidone medication was clarified to the prescribing physician. On 5/2/24 at 0944 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23's use of psychotropic medication. RN 1 verified there was no documented evidence a monthly behavior summary of psychotropic medication use for Resident 23. Also, RN 1 verified Resident 23 was on GT feeding and with an order for nothing by mouth. RN 1 verified the physician's order for risperidone medication should have been clarified to the physician and should have been administered via GT. 4. Medical record review for Resident 36 was initiated on 4/30/24. Resident 36 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of Resident 36's Order Summary Report dated 5/1/24, showed the following physician's order: - On 3/13/24, to administer olanzapine (antipsychotic medication) 10 mg tablet by mouth two times a day for schizophrenia manifested by anger outburst - On 3/8/34, to administer quetiapine (antipsychotic medication) 100 mg tablet by mouth every 12 hours for schizophrenia manifested by yelling out with no apparent reason (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/8/24, to monitor orthostatic blood pressure every Sunday for antipsychotic medication use in lying and sitting position Review of the MAR for the month of April 2024, showed the monitoring of the orthostatic blood pressure every Sunday with the following results: - On 4/7/24, the blood pressure reading for lying position was 145/76 mmHg, and for sitting position was 145/76 mmHg - On 4/14/24, the blood pressure reading for lying position was 127/87 mmHg, and for sitting position was 127/87 mmHg - On 4/21/24, the blood pressure reading for lying position was 137/82 mmHg, and for sitting position was 137/82 mmHg - On 4/28/24, the blood pressure reading for lying position was 139/79 mmHg, and for sitting position was 139/79 mmHg On 5/6/24 at 1014 hours, an interview and concurrent medical record review for Resident 36 was conducted with RN 1. RN 1 verified Resident 36's use of antipsychotic medication. RN 1 stated the side effects of the antipsychotic medication included a low blood pressure. RN 1 was asked to review the orthostatic blood pressure monitoring in the MAR. RN 1 verified the blood pressure monitoring results were the same results for lying and sitting position. RN 1 verified the blood pressure reading were inaccurate. On 5/6/24 at 1103 hours, an interview and concurrent medical record review for Residents 23 and 36 was conducted with the DON. The DON was informed of the above findings and verified the findings. 50003 5. Medical record review for Resident 112 was initiated on 4/30/24. Resident 112 was admitted to the facility on [DATE]. Review of Resident 112's H&P examination dated 2/22/24, showed Resident 112 did not have the capacity to understand and make decisions and has a Power of Attorney. Review of Resident 112's Physician Order dated 4/30/24, showed a physician's order for Aripiprazole 20 mg one tablet by mouth daily at bedtime for psychosis manifested by aggressive behavior initiated on 2/22/24. Review of Resident 112's MAR for April 2024 showed Resident 112 was administered Aripiprazole 20 mg one tablet daily at bedtime for psychosis manifested by aggressive behavior from 4/1 to 4/30/24 at 2100 hours. Further review of Resident 112's medical record failed to show Resident 112 and the resident's responsible party were informed of the risks, benefits, and alternatives of taking the psychotropic medication Aripiprazole and consented to the use of the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 1505 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated for antipsychotic medications, an informed consent showing the name of the medication, dose, frequency, and manifestations would be obtained. RN 1 further stated the informed consent would include signatures of the physician and resident or resident's representative. RN 1 verified there was no informed consent completed for the use of Aripiprazole. On 5/1/24 at 1010 hours, an interview was conducted with the DON. The DON acknowledged the above findings and emphasized the importance of obtaining an informed consent prior to the start of any antipsychotic medications to the residents. 35346 6. On 5/2/24, medical record review for Resident 105 was initiated. Resident 105 was readmitted to the facility on [DATE]. Review of Resident 105's psychiatrist's progress note dated 4/8/24, showed Resident 105's diagnoses included schizophrenia, psychosis, suicide ideation, and traumatic brain injury related to post status motor vehicle accident. Review of Resident 105's MAR for April 2024 showed the following orders: - clozapine 50 mg, four tablets for manifestations of auditory hallucinations - Zyprexa 10 mg for manifestations of auditory hallucinations - benztropine 1 mg twice daily for extra pyramidal symptoms Further review of this MAR showed the staff were to start tallying by hashmark every shift for the manifestations of Resident 105's auditory hallucinations for the use of clozapine and Zyprexa on 4/20/24. However, the MAR failed to show the manifestations were tallied on 4/20, 4/21, 4/22, 4/23, 4/24, 4/27, and 4/30/24, to show the number of auditory hallucinations Resident 105 had experienced. On 5/3/24 at 0900 hours, the above findings were verified with the DON. 7. On 5/2/24, medical record review for Resident 124 was initiated. Resident 124 was readmitted to the facility on [DATE]. Review of Resident 124's H&P examination dated 1/15/24, showed Resident 124's diagnoses included advanced dementia. Resident 124 had no capacity to understand and make decisions. Review of Resident 124's MAR for April 2024 showed she was administered with quetiapine 200 mg for manifestations of continuous screaming with no apparent reason and Rexulti 1 mg for manifestations screaming out. Further review of this MAR failed to show Resident 124's behaviors for the use of Rexulti were being monitored. On 5/3/24 at 0900 hours, the above findings were verified with the DON.

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	055206	A. Building B. Wing	05/06/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was lower than five percent. This failure posed the risk of the residents not receiving appropriate care. Findings: The facility's total medication error rate was 11.54%. 1a. On 4/30/24 at 0839 hours, a medication administration observation for Resident 23 was conducted with LVN 4. Medical record review for Resident 23 was initiated on 4/30/24. Resident 23 was readmitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 12/22/23, showed Resident 23's diagnoses included paralysis and adrenal insufficiency. Review of Resident 23's March 2024 MAR showed Resident 23 was to be administered with Calcium Oyster Shell (vitamin supplement) 1250 mg daily at 0900 hours and docusate sodium (stool softener) 100 mg daily at 0800 hours. On 4/30/24 at 1432 hours, a post medication administration observation interview was conducted with LVN 4. LVN 4 verified he did not administer Resident 23's Calcium Oyster Shell and docusate sodium medication as scheduled. b. On 5/1/24 at 1007 hours, a medication administration observation for Resident 37 was conducted with LVN 6. LVN 6 was observed administering a total of two pills of divalproex pills each 125 mg to Resident 37. However, the bubble pack containing the medications showed to give 4 capsules. Medical record review for Resident 37 was initiated on 4/30/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 3/12/24, showed Resident 37's diagnoses included schizoaffective disorder. Review of Resident 37's April 2024 MAR showed Resident 37 was to be administered with divalproex 125 mg capsule, give 500 mg daily at 0900 hours. On 5/1/24 at 1500 hours, a post medication administration observation interview was conducted with LVN 6. LVN 6 acknowledged she administered two capsules of divalproex, 125 mg each (total of 250 mg), instead of four capsules.

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 35346 Based on observation and interview, the facility failed to ensure the medications for Resident 48 stored inside an IV medication cart were kept locked. This failure posed the risk of unauthorized persons having access to the medications stored inside the IV medication cart. Findings: On 4/30/24, at 0921 hours, a medication administration observation was conducted with RN 1. RN 1 was observed removing Resident 48's IV medication. RN 1 was then observed walking into Resident 48's room, helping Resident 48. The IV cart was observed left unsupervised and out of RN 1's sight. The findings were verified with RN 1. RN 1 acknowledged the IV medication cart should be locked when out of sight.

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview and medical record review, the facility failed to ensure one nonsampled resident (Resident 29) received the appropriate mechanically altered diet (the texture of the diet is altered) as ordered by the physician. This failure had the potential for the resident to choke and/or aspirate (inhalation of foreign object into the airway and/or lungs). Findings: On 4/29/24 at 1408 hours, Resident 29 was observed eating lunch in his room. Review of Resident 29's meal ticket (used to identify the resident's diet and food preferences for meal service) showed Resident 29 required a pureed consistency diet (the food is put in a blender and blended into a puree consistency). Resident 29 had a cup of coleslaw (shredded raw cabbage and carrots), which was not pureed. On 4/29/24 at 1410 hours, an interview was conducted with LVN 2. LVN 2 reviewed Resident 29's meal ticket and stated Resident 29 should receive a pureed consistency diet. LVN 2 verified the coleslaw on Resident 29's meal tray, and stated the resident should not have the coleslaw. LVN 2 further stated Resident 29 was on a pureed diet and could choke. Medical record review for Resident 29 was initiated on 4/19/24. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 29's Order Summary Report dated 4/30/24, showed a physician's order dated 10/31/23, for a two grams sodium diet, pureed texture, and regular/thin consistency. Review of Resident 29's plan of care showed a care plan problem created on 7/18/23, addressing Resident 29's swallowing problem related to dysphagia (difficulty swallowing). The interventions showed the resident to eat only with supervision, and the diet to be followed as prescribed. On 5/6/24 at 1001 hours, an interview and concurrent record review was conducted with the DON. The DON stated the diet orders should be carried out as ordered. The DON further stated if a resident was prescribed a pureed diet, and was given regular consistency diet, there may be a risk of aspiration. The DON verified the above findings. The DON was informed and acknowledged the findings.

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the heavy-duty blender used for puree preparation was air dried prior to use. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good conditions. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. These failures had the potential to cause foodborne illnesses for the residents in the facility. Findings: Review of the facility's Resident Assessment Report (CMS-802) dated 4/29/24, showed 133 of 137 residents residing in the facility received food prepared in the kitchen. 1. Review of the facility's P&P titled Blender Use and Cleaning revised 10/2014 showed to allow the container and lid to air dry. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. During the puree preparation observation on 5/1/24 at 1204 hours, a concurrent observation and interview was conducted with the Food Service Supervisor. A heavy-duty blender was observed washed in the dishwashing machine and was still wet and with visible water was dried using a paper towel by the [NAME] 2. The Food Service Supervisor verified the above findings and stated it was supposed to be air dried to prevent cross contamination. 2. Review of the facility's P&P titled Discarding of Chipped/ Cracked Dishes and Single Service Items revised 10/1/14, showed the dietary staff will maintain a sanitary environment in the dietary department by discarding compromised service ware and single service items. The dietary staff will discard chipped or cracked dish or glass ware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/29/24 at 0857 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Food Service Supervisor. The following was identified and verified by the Food Service Supervisor: - One stainless spatula with black handle worn off (rubber part) which resembled burn mark. The Food Service Supervisor stated the spatula should have been discarded to prevent cross contamination. - One basting brush used for butter was observed with a frayed bristle, wooden handle discolored which resembled burn mark. The Food Service Supervisor stated the basting brush should have been discarded to prevent cross contamination. 3. Review of the facility's P&P titled Can Opener Use and Cleaning revised date 10/1/14, showed the dietary staff will use the can opener according to the manufacturer's guidelines. The can opener will be sanitized between uses. Inspect the blade and replace if notched. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 4/29/24 at 0844 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Food Service Supervisor. The following was identified and verified by the Food Service Supervisor: - One counter mounted can opener was observed with brownish discoloration (metal part) which resembled rust and had dry food residue. The Food Service Supervisor stated blade has been changed and should have been clean after each used. - Four knives with black handles and one knife with white handle stored in the knife rack were observed dirty with dry food residue, dry water spots, and one black handle was discolored. The Food Service Supervisor stated the knives should have been clean after each used to prevent cross contamination. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Three scoops with blue handles used for food portioning were observed dirty with dry food residue. The Food Service Supervisor stated the scoops should have been washed, dried, and should have no food particles for next use. - Four slotted stainless spoon was observed dirty with dry food particles and dry water spots. The Food Service Supervisor stated the spoons should have been washed, dried, and should have no food particles to prevent cross contamination. - Two stainless spoon was observed dirty with dry food particles and dry water spots. The Food Service Supervisor stated the spoons should have been washed, dried, and should have no food particles to prevent cross contamination. - One stainless spatula with black handle was observed dirty with dry food particle. The Food Service Supervisor stated the spatula should have been washed, dried, and should have no food particles to prevent cross contamination. 4. Review of the facility's P&P titled Hood and Filter - Operation and Cleaning revised date 10/1/14, showed the hood and filter system should be cleaned at least weekly, or more often as necessary. Hoods will be kept free of grease and dust. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. During the initial kitchen tour on 4/29/24 at 0857 hours, a concurrent observation and interview was conducted with the Food Service Supervisor. Blackish dirt residue was observed on the kitchen hood. The Food Service Supervisor verified the findings and stated the dietary staff were supposed to clean the hood monthly and an outside company serviced and cleaned the hood every six months. The Food Service Supervisor stated it should have been cleaned for proper airflow and fire hazard.

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	055206	A. Building B. Wing	05/06/2024

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Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 43119 Based on observation and interview, the facility failed to ensure the garbage was properly stored in two of four garbage dumpsters. The failure had the potential to attract pests/rodents that carried diseases. Findings: According to the 2022 FDA (Food and Drug Administration) Food Code, outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 5/2/24 at 1358 hours, an observation and concurrent interview was conducted with the Maintenance Director. Two of four facility's outside garbage dumpsters were observed to have the lids partially propped open by the garbage, preventing the lids from fully closing. The Maintenance Director verified the findings. The Maintenance Director stated he had reminded the staff to keep the lids completely closed to contain the trash, prevent flies, avoid odor and for infection control purposes.

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview and medical record review, the facility failed to ensure the medical record was accurately maintained for one of 27 final sampled residents (Resident 104). *Resident 104's POLST failed to show documentation as to whether Resident 104 had formulated an Advance Directive. This failure had the potential for the resident's care needs not being met as the medical record was incomplete. Findings: Medical record review for Resident 104 was initiated on 4/29/24. Resident 104 was admitted to the facility on [DATE]. On 5/2/24 at 1011 hours, an interview and concurrent medical record review was conducted with RN 1. Review of Resident 104's POLST, Section D (advance directive) dated 6/28/23, failed to show documentation as to whether Resident 104 had formulated an advance directive. RN 1 verified the findings and stated the medical record needed to be complete specific to whether Resident 104 had formulated an advance directive, to ensure facility staff had the information necessary to honor Resident 104's medical treatment wishes.

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their infection control surveillance program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program from February 2024 through April 2024. The IP was unable to show documentation for the facility's monthly resident infection surveillance from of February 2024 through April 2024. The IP stated she did not complete the facility mapping of resident infections nor did she complete the Infection Control Monthly Summary Report from February 2024 through April 2024. Additionally, the facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications met the facility's criteria for infection (McGeer's Criteria or Loeb's Criteria) and thus failed to include these residents in the facility's infection control surveillance program from February 2024 through April 2024. * Five of six of the facility's clean linen cart covers were tattered and soiled with stains. * CNA 2 and CNA 3 failed to perform hand hygiene before and after feeding Resident 7. * The Laundry Aide failed to perform hand hygiene after she handled dirty laundry and went to clean area to handle clean laundry. Additionally, there were personal staff items in the laundry room. * CNA 8 failed to follow the enhanced barrier precautions for Resident 30. These failures posed the risk of infection and transmission of disease-causing microorganisms. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program Description dated 10/2022 showed the infection prevention and control program is a set of comprehensive processes that address the prevention, identification, reporting, investigation and control of infections and communicable diseases for residents. The major activities of the program are: Surveillance of infections, including ongoing monitoring to identify possible communicable diseases/infections before they can spread to others in the facility. The Infection Preventionist develops, implements, monitors, and maintains the infection prevention and control program. In order to carry out the major activities of the program, including oversight, the Infection Preventionist has the following responsibilities: Facilitate the implementation of the program policies and procedures. Performs surveillance to monitor the rate of healthcare acquired infections (HAI). Analyze data and perform root cause analysis to develop action plans. Complete monthly infection control report and share with the appropriate clinical partners. As an active member of the facility's QAPI committee, review information obtained from the infection prevention, surveillance, and control activities to improve resident care, employee work practices, and the environment of care. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at 0832 hours, an interview, facility P&P review, and concurrent facility document review was conducted with the IP. The IP stated in accordance with the facility's P&P for Infection Prevention and Control Program, the IP performs surveillance of resident infections at the facility. The IP stated infection surveillance included monitoring the rate of HAIs, analysis of the data, and performing root cause analysis. The IP stated she documented the residents' infections on the facility's Infection Surveillance Monthly Report. The IP stated she also completed an Infection Control Monthly Summary Report which included information specific to HAI and CAI rates and the type of resident infections in the facility. The Infection Control Monthly Summary Report also showed issues identified, and plan of action implemented. The IP stated she would also complete a monthly mapping of resident infections within the facility to identify and monitor resident infections in the facility. The IP stated the mapping of the resident infections allowed for the identification of staff infection control practices, which included hand hygiene, and personal protective equipment. The IP stated the facility utilized McGeer's Criteria and Loeb's Criteria to determine if a resident had an infection. The IP stated facility nurses utilized McGeer's Criteria or Loeb's Criteria when a resident exhibited signs and symptoms of infection and was prescribed an antimicrobial medication. Review of the facility's infection surveillance program from February 2024 through April 2024, failed to show documented evidence of the resident infection surveillance. Further review of the facility's infection surveillance program failed to show for a mapping of the resident's infections was completed and failed to show the Infection Control Monthly Summary Report was completed from February 2024 through April 2024. The IP verified the above findings. The IP confirmed she was unable to show documentation of the facility's monthly infection surveillance was completed from February 2024 through April 2024. The IP stated she did not complete the mapping of the residents' infections or complete the Infection Control Monthly Summary Report from February 2024 through April 2024. The IP was asked how she determined if a resident had an infection in the facility. The IP stated the facility utilized McGeer's Criteria and Loeb's Criteria. The IP stated the McGeer's and Loeb's Criteria was utilized when residents in the facility had signs and symptoms of infection and were prescribed antimicrobial mediations. The IP was asked how many residents met either McGeer's Criteria or Loeb's Criteria who exhibited signs and symptoms of infection, and were not prescribed antimicrobial medications (February 2024 through April 2024). The IP stated she was unable to provide that information as the facility only utilized McGeer's Criteria or Loeb's Criteria if a resident exhibited signs and symptoms of infection and was prescribed antimicrobial medications. 35346 2. On 5/3/24 at 0941 hours, an inspection of the facility's clean linen carts was conducted with the Maintenance Director. The Maintenance Director verified five out of six clean linen cart covers were tattered and soiled with stains. 49780 3. Review of the facility's P&P titled Hand Hygiene 9/2020 showed the facility staff need to perform hand hygiene before and after assisting a resident with dining. (continued on next page)

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	055206	A. Building B. Wing	05/06/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at 1255 hours, Resident 7 was observed sitting on the wheelchair during lunch time. Resident 7 ate his hamburger but needed help to eat his pudding and drink his beverage. CNA 2 came to help Resident 7 eat but did not perform hand hygiene prior to assisting the resident. CNA 3 came to help Resident 7 eat the rest of the food but did not perform hand hygiene prior to assisting the resident. CNA 3 put a straw into the cup of cranberry juice and gave it to the resident. Resident 7 leaned to the left side of wheelchair and CNA 3 helped adjust him to the middle of chair. CNA 3 helped clean Resident 7's mouth after eating. On 4/29/24 at 13:13, an interview was conducted with CNA 3. CNA 3 stated Resident 7 needed assistanceduring meals, and verified she did not perform hand hygiene before and after feeding the resident. CNA 3 further stated per the facility's policy, she should have performed hand hygiene before and after feeding resident. On 5/2/24 at 0845 hours, an interview was conducted with RN 1. RN 1 stated the CNAs would pass the trays to all the residents and then go to the residents who need to be fed to help them eat. The CNAs needed to wash their hands before passing the tray to the residents and before feeding them. 4. Review of the facility's P&P titled Laundry Services 1/2012 showed the onsite laundry is maintained in a clean and sanitary condition. On 5/6/24 at 1046 hours, an observation and concurrent interview with the Housekeeping Supervisor was conducted at the laundry room. The Laundry Aide was observed to have a gown and gloves on while putting the dirty laundry into the washer machine. The Laundry Aide changed to a new pair of gloves, adjusted the cycle number and started the machine. The Laundry Aide went to the clean area and started folding the clean linens and clothes. The Laundry Aide did not perform hand hygiene after handling the dirty laundry. In addition, there were many personal items including a cell phone, cups, drinking bottle, lotions, spray bottle, and deodorant placed along the window at the folding area. A backpack, shopping bag, lunch box and clothes were observed next to the clean linens. On 5/6/24 at 1135 hours, the Housekeeping Supervisor verified the Laundry Aide did not perform hand hygiene when coming from the dirty area to clean area. The Housekeeping Supervisor also verified all staff personal items were placed in the laundry room and should not have been. 32179 5. Medical record review of Resident 30 was initiated on 4/29/24. Review of Resident 30 was initiated on 3/9/16 and readmitted on [DATE]. Review of Resident 30's physician's order dated 4/29/24, showed Resident 30 was placed on the enhanced barrier precautions for hemodialysis port. On 4/29/24 at 1220 hours, Resident 30 was observed asking for toileting assistance. CNA 8 assisted Resident 30 to the restroom, helped to put the resident back to the wheelchair and assisted with dressing the resident. CNA 8 did not use a gown and perform hand hygiene after assisting toileting Resident 30. CNA 8 did not take off the gloves used to assist the resident with toileting. Resident 30 was observed on isolation for the enhanced based precaution. After assisting the resident, CNA 8 went out the room and wheeled the resident to the nursing station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	05/06/2024

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Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at 1235 hours, an interview was conducted with CNA 8. CNA 8 was asked if she needed to use the PPE (personal protective equipment). CNA 8 stated yes and verified she did not wear the proper PPE and perform hand hygiene because she was rushing to get Resident 30 ready for the dialysis.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 35346 Based on observation and interview, the facility failed to ensure one of two medication rooms' refrigerator freezer compartment was free of ice buildup. This failure posed the risk of the medication room refrigerator not maintained in safe operating temperature and condition. Findings: On 4/30/24, at 1432 hours, a Medication Room A inspection and concurrent interview was conducted with LVN 4. A refrigerator containing the facility's emergency medications, tuberculin and insulin vials were observed inside the Medication Room A. However, the refrigerator freezer compartment was observed with ice buildup. LVN 4 verified the freezer compartment of the refrigerator used for resident's medications was observed with ice buildup. LVN 4 stated the refrigerator's daily temperature log showed the last time the refrigerator including the freezer compartment was checked was on 4/30/24. LVN 4 further stated the nursing staff were responsible for ensuring the refrigerator was free of ice buildup. When asked if the ice buildup was reported, LVN 4 acknowledged it should have been reported to the Maintenance Supervisor.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the resident's bed was inspected and with the record of the bed inspection when identifying areas of possible entrapment with the use of bed rails for one of two final sampled residents reviewed for bed siderail use (Resident 69). This failure had the potential to negatively impact the residents for possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled NP 120 Bed Rails revised 11/16/22, showed under the section for Safety: - The facility's maintenance team is responsible for installing bed rails. - The entrapment zone review will focus on the following: a) Any gaps that exist between the mattress, bed frame or bed rail that is wide enough to entrap the resident's head, body, arm or legs; b) Observation will occur when the resident is in bed to witness situations that could be caused by the resident's weight, movement or position in the bed; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) The mattress is appropriate for the dimensions of the bed; and d) Bed rails are properly installed to and fit correctly (no bowing or shifting; the rails in use are appropriate for the resident's height and weight per manufacturer's specifications and proper distance from the headboard and footboard. - The maintenance department will routinely inspect beds and bed rails for preventive maintenance, safety standards, and assess for need for repair: a) Monthly preventative maintenance will be conducted to make sure bed rails are installed correctly and connections have not become loose or shifted; and b) Annual bed measurement inspections to review and document the entrapment areas in accordance with the FDA's Potential Zones of Entrapment using the Bed System Measurement Worksheet. On 4/29/24 at 0828 hours, an observation and concurrent interview was conducted with Resident 69. Resident 69 was observed lying in bed with the bilateral bed rails elevated. Resident 69 stated she was not able to use the side rails because she was in pain when she moved in bed. Resident 69 further stated she had the bed rails for a long time. Medical record review for Resident 69 was initiated on 4/29/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's medical record did not show an entrapment zone assessment and bed inspection were conducted. On 5/1/24 at 1512 hours, an interview for Residents 69 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including maintaining, inspecting, and installing the bed rails after he received the request from the nurses to install the bed rails. The Maintenance Director stated the bed inspections were done monthly or as needed. When asked if he had done the entrapment zone assessment for the bed rails, the Maintenance Director was unable to state the danger zone areas in the bed system where there was potential for entrapment. The Maintenance Director stated he did not do any entrapment assessment or bed inspection as he did not receive any request from the nursing department to install the bed rails for Resident 69. On 5/1/24 at 1530 hours, an interview for Resident 69 was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F700, example #1.