STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055237	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Healthcare and Rehabilitation Center	340 Victoria Street Costa Mesa, CA 92627

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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 0554 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if it was safe for a resident to self-administer the medication for one of 17 final sampled residents (Resident 26). Resident 26 was observed with a medication at the bedside. Resident 26 had no physician's order, assessment, or a care plan in place for self-administration of medications. This failure had the potential for Resident 26 to administer the medication inaccurately.Findings: Review of the facility's P&P titled Self-Administration of Medication revised 12/2019 showed it is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medication choosing to and capable of self-administration. To determine the ability of alert residents to participate in self-administration of medications. To maintain the safety and accuracy of medication administration.- If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. - If the resident is a candidate for self-administration of medications, this will be indicated in the chart. - Resident will be instructed regarding proper administration of medication by the nurse. - Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage Medical record review for Resident 26 was initiated on 7/15/25. Resident 26 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 26's MDS Quarterly assessment dated [DATE], showed a BIMS score of 12, indicating the resident had moderately impaired cognition. On 7/15/25 at 0922 hours, during the initial tour of the facility, an observation, interview, and concurrent medical record review for Resident 26 was conducted with LVN 2. Resident 26 was observed sitting in a wheelchair, and a Flonase nasal spray medication (nasal spray primarily used to relieve symptoms associated with allergies and other conditions affecting the nasal passages) was observed on the resident's overbed table. Resident 26 stated the Flonase nasal spray medication was his medication and he used it to spray his nose. LVN 2 stated Resident 26 should not have the medications at the bedside because other residents could get the medication and use it. LVN 2 verified there was no physician's order for the Flonase medication, no order to self-administer, no self-administration assessment, and no care plan for the use of Flonase nasal spray medication. On 7/17/25 at 1203 hours, an interview and concurrent medical record review for Resident 26 was conducted with DON. The DON verified the above findings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the MDS discharge assessment was completed for one nonsampled resident (Resident 86) when the resident was discharged on 3/28/25. This failure posed the risk of not being able to monitor the resident's progress over time. Findings: Review of the facility's P&P titled Resident Assessment Instrument revised 10/2024 showed the MDS nurse will schedule each resident for an MDS assessment following the requirements for the OBRA assessments, tracking records, discharge assessments, Medicare-required scheduled, and unscheduled assessments. Review of the facility's P&P titled Resident Assessment and Associated Processes revised 4/2025 showed the facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system. Transmission of MDS data will include the following documents: resident's transfer, entry, reentry, discharge, & death. Closed medical record review for Resident 86 was initiated on 7/17/25. Resident 86 was admitted to the facility on [DATE], and discharged home on 3/28/25. Review of Resident 86's Order Summary Report showed a physician's order dated 3/26/25, to discharge Resident 86 home on 3/28/25, with the remaining medications including the controlled substances if applicable with home health PT and RN and front wheel walker. Review of Resident 86's MDS assessment failed to show the discharge assessment was completed when the resident was discharged on 3/28/25. On 7/17/25 at 1529 hours, an interview and concurrent medical record review for Resident 86 was conducted with the MDS Coordinator. The MDS Coordinator stated the when the resident was discharged from the facility, a discharge assessment should be done by the MDS nurse and should be submitted to the CMS within 14 days. The MDS coordinator stated the system the facility was using would automatically populate the due dates of the resident's assessment needed to be done and that was how they monitored when to complete the resident's assessment when asked how the facility monitored who were the residents due for assessment completion in the MDS. The MDS Coordinator verified the MDS discharge assessment was not completed for Resident 86 when the resident was discharged on 3/28/25. The MDS Coordinator stated if the MDS discharge assessment was not completed and submitted to the CMS, it would show the resident was still in the facility, nothing was happening with the resident, and it would show the assessments were missed. On 7/23/25 at 0805 hours, an interview was conducted with the DON. The DON acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 17 final sampled residents (Resident 1) maintained the highest practicable well-being. * Resident 1 was transferred inappropriately, via use of Resident 1's armpits and back of Resident 1's pants. * Resident 1's change of condition to her foot was not documented. These failures had the potential to cause injury and not provide appropriate care to the resident. Findings: Medical record review for Resident 1 was initiated on 7/15/25. Resident 1 was readmitted to the facility on [DATE]. a. On 7/18/25 at 1430 hours, an observation of Resident 1 and concurrent interview was conducted with CNAs 7 and 8. Resident 1 was observed sitting in her wheelchair which was positioned to the left side of her bed. CNA 8 placed her arm underneath Resident 1's left armpit. CNA 7 placed their arm underneath Resident 1's right armpit, and used their other hand to hold the back of Resident 1's pants. Both CNAs lifted and transferred Resident 1 from her wheelchair to the edge of the bed. CNA 8 stated the therapy trained the CNAs 7 and 8 to transfer Resident 1 in that way. On 7/18/25 at 1507 hours, an observation and concurrent interview was conducted with the Director of Rehab. When asked about transferring Resident 1, the Director of Rehab verbalized a gait belt was to be used for Resident 1's transfers. The Director of Rehab stated there were hooks inside the residents' rooms to place the gait belts. The Director of Rehab was informed the staff were observed transferring Resident 1 without a gait belt. Furthermore, the Director of Rehab verified there was no gait belt inside Resident 1's room. b. Review of the facility's P&P titled Change of Condition Reporting, dated 5/2019 showed a change in condition for the residents was to be documented. On 7/18/2025 at 0807 hours, an interview was conducted with LVN 5. When asked about doing a body check on Resident 1, LVN 5 stated he completed Resident 1's wound treatment after the resident's morning shower. On 7/18/25 at 1530 hours, a head to toe assessment was conducted with LVN 5 and Resident 1's responsible party. Resident 1's right foot was observed with a superficial break in skin and redness. When asked about redness and superficial break in the skin to the outer side of Resident 1's right big toe, LVN 5 stated he had not seen nor been informed about this change to Resident 1's skin. Resident 1's responsible party verified this was a change to Resident 1's foot. On 7/18/25 at 1630 hours, an interview was conducted with CNA 10. CNA 10 verified she completed Resident 1's morning shower. When asked about documenting the break in skin and wound to Resident 1's right toe, CNA 10 verified she observed the change to Resident 1's right toe but did not document it. Further review of Resident 1's medical record failed to show documented evidence of Resident 1's change in skin condition, redness and superficial break in skin to Resident 1's right toe.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of three final sampled resident (Residents 1 and 7) reviewed for catheter care received the appropriate care and services for an indwelling urinary catheter. * The facility failed to continuously monitor Resident 7 after the resident had a change in condition when the resident's suprapubic catheter was not draining.* The facility failed to ensure Resident 1's indwelling urinary catheter did not touch the floor.These failures had the potential for the residents to develop complications associated with the use of the indwelling urinary catheter. Findings: 1. Review of the facility's P&P titled Change of Condition Reporting dated 5/2019 showed the licensed nurse should document resident’s change of condition and response in eInteract Change of Condition UDA and in nursing progress notes, and update resident care plan, as indicated. The licensed nurse responsible for the resident will continue assessment and documentation for at least 72 hours or until the condition is stable. On 7/16/25 at 1004 hours, an observation of Resident 7 and a concurrent interview was conducted with CNA 11. Resident 7 was sitting in the wheelchair inside the room. Resident 7 was non-verbal but acknowledged when his name was called by looking at the SA. Resident 7 was observed with an indwelling urinary catheter. CNA 11 stated Resident 7 had a suprapubic urinary catheter. CNA 11 stated the urine was draining fine in the suprapubic urinary catheter. CNA 11 further stated she would report to the charge nurse if there was no urine output, if the urine looked dirty with sediments, and if there was presence of foul odor. Medical record review for Resident 7 was initiated on 7/16/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's MDS assessment dated [DATE], showed Resident 7 had a short- and long-term memory problem. Review of Resident 7’s eInteract Change in Condition V4.2 note dated 7/1/25 at 2024 hours, showed Resident 7’s suprapubic urinary catheter was not draining. The suprapubic urinary catheter was flushed, no resistance but the side was bulging. The physician was notified with order to send Resident 7 to the acute care hospital. Review of Resident 7’s Progress Notes dated 7/2/25 at 0022 hours, showed Resident 7 would be returning to the facility from the acute care hospital ER with a new suprapubic urinary catheter and intravenous antibiotics for UTI. Further review of Resident 7's medical record failed to show documented evidence of continued monitoring/assessment for Resident 7’s change in condition related to suprapubic urinary catheter by the licensed nurses. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at 1514 hours, an interview and concurrent medical record review for Resident 7 were conducted with LVN 2. LVN 2 verified Resident 7 had a change in condition on 7/1/25, related to the resident’s suprapubic urinary catheter not draining. LVN 2 stated when the resident went to the ER and came back to the facility within 24 hours, it would be considered continuity of care. LVN 2 stated for any change in condition, the licensed nurses had to monitor the resident every shift for 72 hours. LVN 2 further stated it was important to continuously monitor the resident when there was a change in condition to make sure the resident is doing well, no signs and symptoms of complications or infection, no pain, and the vital signs are within normal range because if these symptoms were present then the nurses could report it right away to the physician and necessary treatment could be provided to the resident. LVN 2 verified Resident 7 was not continuously monitored for his change in condition. On 7/23/25 at 0805 hours, an interview was conducted with the DON. The DON stated the licensed nurses should continuously monitor the resident when there was a change in condition every shift for 72 hours and could be extended as needed. The DON stated the continued monitoring was important to determine if effective interventions were provided to the resident, if the plan of care was effective, or if they needed to update it, and for the nurses to inform the physician immediately of any complications or abnormalities related to the change in condition. The DON was informed of and acknowledged the above findings for Resident 7. 2. On 7/18/25 at 1019 hours, an observation of Resident 1 and concurrent interview was conducted with LVN 5. Resident 1's indwelling urinary drainage catheter was observed inside a privacy bag to the right side of Resident 1's bed, touching the floor. LVN 5 verified the finding and stated the indwelling urinary drainage catheter bag should not be touching the floor. Medical record review for Resident 1 was initiated on 7/15/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's medical record showed Resident 1 was dependent on staff for her ADLs. Resident 1 had an indwelling urinary drainage catheter bag in place for wound management.

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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 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 17 final sampled residents (Resident 14) and one nonsampled resident (Resident 43) were provided with the appropriate respiratory care and services. The facility failed to ensure Resident 14 and 43's nebulizer masks and storage bags were changed every seven days. This failure had the potential to affect the respiratory health and well-being of the residents in the facility.Findings: Review of the facility's P&P titled Oxygen, Use of revised 5/2021 showed it is the policy of this facility to promote resident safety in administering oxygen. The following guidelines will be observed in oxygen administration.- The oxygen cannula or mask will be changed at least every seven days, as well as the disposable humidifier. Tubing, masks, humidifier and other disposables used for oxygen administration will be dated in an identifiable fashion.- Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. 1. On 7/15/25 at 0929 hours, during the initial tour of the facility, Resident 43's nebulizer mask was observed inside a plastic bag. The plastic bag was labeled with Resident 43's name, but did not show the date when it was changed. Medical record review for Resident 43 was initiated on 7/15/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 6/27/25, showed Resident 43 had the capacity to understand and make medical decisions. Review of Resident 43's Order Summary Report dated 7/16/25, showed the following physician's orders: - dated 6/26/25, to administer budesonide inhalation suspension (medication to treat and prevent breathing difficulties caused by lung disease) 0.5 mg/2 ml inhale orally via nebulizer two times a day for COPD.- dated 6/26/25, to administer ipratropium bromide (medication to treat and prevent breathing difficulties caused by lung disease) inhalation solution 0.02% one vial inhale orally via nebulizer two times a day for COPD.- dated 6/26/25, to administer levalbuterol (medication to treat and prevent breathing difficulties caused by lung disease) inhalation nebulization solution 1.25 mg/3 ml to give 3 ml inhale orally via nebulizer every six hours. 2. On 7/15/25 at 0943 hours, during the initial tour of the facility, Resident 14's nebulizer mask was observed inside a plastic bag. The plastic bag was labeled Resident 14's name, but did not show the date it was changed. Medical record review for Resident 14 was initiated on 7/15/25. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 6/23/25, showed Resident 14 had the capacity to understand and make medical decisions. Review of Resident 14's Order Summary Report dated 7/17/25, showed the following physician's orders: - dated 6/20/25, to administer acetylcysteine inhalation solution 10% (medication to relieve chest congestion by loosen thick mucus) to give 2 ml inhale orally via nebulizer two times a day for COPD.- dated 6/26/25, to administer arformoterol tartrate (medication to treat airway obstruction) inhalation nebulization solution 15 mcg/2 ml to give 2 ml inhale orally via nebulizer two times a day for COPD. On 7/15/25 at 0949 hours, an interview for Residents 14 and 43 was conducted with LVN 2. LVN 2 stated the nebulizer mask and tubing should be changed every week and should be labeled with the resident's name and the date when it was changed. LVN 2 verified the nebulizer masks/bags were not dated. On 7/22/25 at 1359 hours, an interview was conducted with the DON. The DON stated the nurses who change the nebulizer mask and tubing should label the masks/bags with the resident's name and the date when it was changed. The DON verified and acknowledged the above findings.

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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** Based on interview, medical record review, and facility P&P review, the facility failed to provide adequate and appropriate pain management for one of 17 final sampled residents (Resident 9). * The facility failed to ensure the pain medication was administered per Resident 9's physician's order. This failure had the potential for residents not to receive the appropriate treatment for pain.Findings: Review of the facility's P&P titled Administration of Drugs revised 5/2007 showed it is the policy of this facility that medications shall be administered as prescribed by the attending physician. Medications must be administered in accordance with the written orders of the attending physician. 1. Medical record review for Resident 9 was initiated on 7/15/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 6/29/25, showed Resident 9 had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report dated 7/17/25, showed the following physician's orders: - dated 6/26/25, to administer Tylenol (analgesic medication) 325 mg two tablets by mouth every four hours as needed for mild pain (pain scale 1-3; using the pain scale of 0 to 10 with 0 = no pain and 10 = worst pain). - dated 7/7/25, to administer hydrocodone-acetaminophen (narcotic medication) 5-325 mg one tablet by mouth every eight hours as needed for moderate pain (pain scale 4-6).- dated 7/7/25, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every eight hours as needed for severe pain (pain scale 8- 10). Review of Resident 9's MAR for 7/2025 showed: - on 7/9/25 at 0700 hours, Resident 9 received hydrocodone 5-325 mg medication one tablet for a pain level of eight.- on 7/9/25 at 2336 hours, Resident 9 received Tylenol 325 mg medication two tablets for a pain level of six.- on 7/10/25 at 0900 hours, Resident 9 received hydrocodone-acetaminophen 5-325 mg medication one tablet for a pain level of eight.- on 7/11/25 at 0111 hours, Resident 9 received hydrocodone-acetaminophen 5-325 mg medication one tablet for a pain level of eight. - on 7/13/25 at 0038 hours, Resident 9 received hydrocodone 5-325 mg medication one tablet for a pain level of eight.- on 7/13/25 at 2348 hours, Resident 9 received hydrocodone-5-325 mg medication one tablet for a pain level of eight. On 7/22/25 at 0745 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 verified Resident 9 did not receive the right medication for the pain and the MD order was not followed. On 7/22/25 at 1538 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON verified the above findings and stated the pain medication would be effective if it was given accurately.

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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. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary dialysis care to one of three final sampled residents (Resident 93) reviewed for dialysis care. The facility failed to ensure Resident 93's dialysis access site was accurately assessed. Resident 93 had a vascular dialysis access on the right upper chest, however, the resident was assessed for shunt, and bruit and thrill post-dialysis. In addition, Resident 93's care plan to address the dialysis included monitoring for the fistula. These failures had the potential for Resident 93 not being provided with appropriate dialysis care, and the possibility of medical complications related to dialysis care. Findings: Medical record review for Resident 93 was initiated on 7/15/25. Resident 93 was admitted to the facility on [DATE]. Review of Resident 93's Order Summary Report showed the following physician's orders:dated 7/9/25, for dialysis on Tuesday, Thursday, and Saturday;dated 7/9/25, to observe and maintain no pressure on the shunt or dialysis catheter on the right upper chest every shift; anddated 7/9/25, for post-dialysis, to check shunt for bleeding. Remove pressure dressing after three hours. Review of Resident 93's LN - Initial admission Record dated 7/9/25, under the Dialysis section, showed Resident 93 received hemodialysis, and had a vascular catheter on the right upper chest. The record also showed thrill and bruit are not applicable. Review of Resident 93's plan of care showed a care plan problem initiated on 7/9/25, to address Resident 93's dialysis related to renal failure, and right upper chest dialysis catheter site. The interventions included the following:- To monitor dialysis access site on the right upper chest for signs and symptoms of infection, swelling, and bleeding;- To observe and maintain no pressure on shunt or dialysis catheter on the right upper chest;- To check and change dressing daily at access site, and document;- To check arteriovenous fistula every day for bruit and thrill;- Do not draw blood or take the blood pressure in arm with graft;- To check the shunt post-dialysis for bleeding. Remove pressure dressing after three hours. Review of Resident 93's Facility - Dialysis Center Communication Record dated 7/10/25, under Facility Nurses/ Post Dialysis section showed bruit and thrill are present. Review of Resident 93's Facility - Dialysis Center Communication Record dated 7/12/25, under Facility Nurses/ Post Dialysis section, showed bruit and thrill are present. On 7/18/25 at 0815 hours, an observation and concurrent interview was conducted with Resident 93. When asked about the dialysis access site, Resident 93 stated she only had one dialysis access site on the right upper chest. On 7/18/25 at 1342 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 93's dialysis access site was a vascular catheter on her right upper chest. RN 1 verified the physician's orders included to check the shunt post-dialysis. RN 1 stated the resident's medical records were reviewed during the stand-up meeting. RN 1 also verified Resident 93's dialysis communication record showed documentation for the presence of bruit and thrill. RN 1 stated there should be no bruit and thrill present because the resident had a vascular catheter, not a shunt or fistula. RN 1 further verified the Resident 93's plan of care to address dialysis included interventions not applicable to the resident such as changing the dressing at access site, not drawing blood or taking the blood pressure on the arm with graft, checking the fistula daily, checking shunt post-dialysis. On 7/18/25 at 1455 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated the MDS staff initiated the care plan, then the licensed nurses could update the care plan too. The MDS Coordinator stated the licensed nurses get the residents' information from the admission records, medication lists, and diagnoses then formulate the care plan. The MDS Coordinator verified Resident 93's plan of care to address the dialysis included interventions not applicable to Resident 93. The MDS Coordinator stated the resident's care plan to address dialysis was initiated by the MDS Assistant, and did not know why the MDS Assistant included the interventions not applicable to Resident 93. On 7/22/25 at 1554 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON stated Resident 93 had a vascular access dialysis site so there should be no bruit and thrill. The DON stated the MDS staff initiated the care plan for all the residents, and the MDS nurse might have clicked the inapplicable interventions from the care plan library in the electronic health record.

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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** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services as per the facility P&P for one nonsampled resident (Resident 30).* The facility failed to ensure the administration of the controlled medication for Resident 30 was documented on the MAR. This failure had the potential for the medications to be administered in error and opportunities for drug diversion or drug misuse.Findings: Review of the facility's P&P titled Pharmacy Services Controlled Medication revised 12/2019 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration, amount administered, signature of the nurse administered the dose, completed after the medication is actually administered. Review of facility's P&P titled Medication Administration revised 5/2007 showed all the current drug and dosage schedules must be recorded on the resident's electronic medication administration record (eMAR). Medical record review for Resident 30 was initiated on 7/16/25. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 3/31/25, showed Resident 30 had the capacity to understand and make decisions. Review of Resident 30's Order Summary Report dated 7/16/25, showed a physician's order dated 4/6/25, to give hydrocodone-acetaminophen (controlled pain medication) 5-325 mg one tablet by mouth every eight hours as needed for moderate pain (pain level of 4-7) and two tablets for severe pain (pain level of 8-10, , using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain). Review of Resident 30's Narcotic and Hypnotic Record showed one tablet of hydrocodone-acetaminophen 5-325 mg was dispensed and signed out on 7/6/25 at 2028 hours. Review of Resident 30's July 2025 MAR failed to show the documentation one tablet of hydrocodone-acetaminophen 5-325 mg was administered on 7/6/25 at 2028 hours. On 7/16/25 at 1100 hours, an interview and concurrent medical record review for Resident 30 was conducted with the DON. The DON verified the above findings.

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	055237	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Healthcare and Rehabilitation Center	340 Victoria Street Costa Mesa, CA 92627

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage and labeling of medications. * The facility failed to ensure the medical label on the on the bubble pack of losartan (antihypertensive medication) was correct. * The facility failed to ensure LVN 1 did not leave medications unattended at bedside during medication administration observation. * The facility failed to ensure LVN 1 did not leave the medication cart (Medication Cart A) unlocked and unattended. These failures had potential to result in unsafe medication administration, cross-contamination of the medications and post the risk for non-licensed staff to have access to the medicationsFindings: 1. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy revised 1/2018 showed each prescription medication label includes.specific directions for use. Improperly or inaccurate labeled medications are rejected and returned to the dispensing pharmacy. Review of the facility's P&P titled Medication Storage in the Facility revised 1/2018 showed only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications such as medication aides permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. On 7/17/25 at 0903 hours, a medication administration for Resident 77 was conducted with LVN 1. The following was observed: a. The label on the bubble pack of losartan for Resident 77 showed to hold the losartan medication when SBP was more than 130 mmHg. Medical record review for Resident 77 was initiated on 7/15/25. Resident 77 was admitted to the facility on [DATE]. Review of Resident 77's Order Summary Report showed a physician's order dated 7/4/25, to administer losartan 50 mg one tablet by mouth two times a day. To hold if SBP is less than 130 mmHg, and to notify the physician if held more than 72 hours. On 7/17/25 at 0933 hours, an interview was conducted with LVN 1. LVN 1 verified the label on the bubble back for losartan medication did not match the physician's order. LVN 1 also verified there was no change of direction sticker on the bubble pack. b. LVN 1 was observed preparing medications for Resident 77 and placed all the prepared medications on a small tray. Medication Cart A was parked by LVN 1 by the resident's doorway. LVN 77 was observed entering Resident 77's room, Resident 77 was observed lying in bed, and a Resident 77's family member was seated near the bed, with the curtains drawn. LVN 1 was observed placing the tray with the medications at bedside, then LVN 1 was observed using the alcohol-based hand rub by the door and was also observed talking to a staff. The medications were left at the bedside unattended and unsupervised. Then LVN 1 went back and placed a straw on the resident's cup, and LVN 1 went to the sink to wash her hands. The medications were left at bedside unattended and unsupervised. Then LVN 1 was observed going back to the medication cart to get a spoon. The medications were left at the bedside unattended and unsupervised. Then LVN 1 administered the oral medications to Resident 77. LVN 1 was observed going back to the medication cart to get tissue papers. The nasal spray medication was left at bedside unattended and unsupervised. On 7/17/25 at 1109 hours, an interview was conducted with LVN 1. LVN 1 verified she left the medications at the bedside, while Resident 77 was lying in bed and Resident 77's family member was seated near the bedside, with the curtains drawn. LVN 1 stated she forgot to get the straw, spoon, and tissue paper so she had to go back to the medication cart. 2. On 7/17/25 at 1106 hours, an observation and interview was conducted with LVN 1. Medication Cart A was observed parked in front of the nurses' station, facing the hallway. LVN 1 was observed going inside the nurses' station, and left Medication Cart A unlocked and unattended while a CNA was observed passing by. LVN 1 verified the above findings. LVN 1 stated she forgot to lock the medication cart. On 7/22/25 at 1608 hours, an interview was conducted with the DON. The DON stated the losartan medication was initially ordered to hold if the SBP was more than 130 mmHg, but the physician's order was changed to hold if the SBP was less than 130 mmHg. The DON stated the nurses should have placed a change of direction sticker. The DON stated the medications and medication cart should not be left unattended.

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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. Based on observation and interview, the facility failed to ensure sanitary conditions were maintained and foods were stored in safe conditions. * There were expired food items stored inside the facility's freezer.* The stock pot was observed with black discoloration, warped and dented.* Two ceiling vents were dusty and corroded. Additionally, the meat products stored under the vents were also dusty with yellow stains/discoloration.* One cook did not wear a beard restraint.* One dietary aide placed his hands in a red bucket containing sanitizing solution and a dish rag instead of performing hand hygiene. These failures posed the risk of foodborne illness to the 68 of 68 residents who received food prepared in the facility's kitchen.Findings: 1. On 7/15/25 at 0800 hours, an initial tour of the facility's kitchen was conducted with the Dietary Supervisor. The following food items were observed inside the freezer:- one bag of bread with expiration date of 7/12/25.- one bag hamburger buns, with expiration date of 7/12/25.- one bag English muffins, with expiration date of 6/8/25. The Dietary Supervisor verified the above findings. 2. On 7/15/25 at 0800 hours, an initial tour of the facility's kitchen was conducted with the Dietary Supervisor. One stock pot measuring approximately 22 quarts was observed warped, dented on one side, and with a black substance surrounding the inner top part of the pot. The Dietary Supervisor verified the above findings. s3. On 7/15/25 at 0800 hours, an initial tour observation and concurrent interview was conducted with the Maintenance Supervisor. Two air conditioner ceiling vents located above the kitchen's ice machine and freezers were observed with dust and corrosion, and the paint surrounding the vents was peeling. Additionally, the meat products underneath the ceiling vents were observed dusty, with yellow stains and yellow discoloration. The Maintenance Supervisor verified the finding. 4. On 7/17/25 at 1130 hours, during an observation, [NAME] 1 was inside the kitchen with his moustache not covered. [NAME] 1 was not wearing a beard restraint. On 7/18/25 at 0821 hours, an observation of [NAME] 1 and concurrent interview was conducted with the Dietary Supervisor. [NAME] 1 was not wearing a beard restraint while inside the kitchen. The Dietary Supervisor verified the finding and stated [NAME] 1 should be wearing a beard restraint. 5. On 7/18/25 at 0851 hours, a dishwashing observation was conducted with Dietary Aide 2. After Dietary Aide 2 rinsed dirty dishes, he placed his hands into a red bucket with a clear solution and a dish rag in it. Dietary Aide 2 stated the bucket contained sanitizing solution and the solution was used in case of emergencies to sanitize inside the kitchen. When asked why Dietary Aid 2 placed his hands inside the solution after rinsing dirty dishes, Dietary Aide 2 stated he was sanitizing his hands. When asked if this was the process for dishwashing and hand hygiene, Dietary Aid 2 acknowledged he should have performed handwashing at the kitchen sink.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the trash bins were not overflowed with trash. This failure posed the risk of unsanitary conditions and of harboring unwanted pests. Findings: On 7/16/25 at 0730 hours, during an observation, three out of five facility trash bins were observed with the lids open and overfilled with trash. On 7/16/25 at 0858 hours, an observation was conducted of the trash bins. The trash bins were observed in an enclosed area with a wooden fence and door surrounding them. The door was open and one trash bin was visible with the lid open and overfilled with trash. On 7/16/25 at 0915 hours, an observation and concurrent interview was conducted with the Dietary Supervisor. The Dietary Supervisor verified the trash bins used for the facility had the lids open with trash overflowing.