

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/12/2024
NAME OF PROVIDER OR SUPPLIER  Advanced Rehab Center of Tustin		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 E. First Street Santa Ana, CA 92705	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</b></p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to notify the physician of changes for one of seven sampled residents (Resident 1).</p> <p>* Resident 1's physician was not notified when Resident 1's inhaler ran out and Resident 1 had increased anxiety. This failure had the potential for the resident not to get the necessary care and services as the physician was not notified of changes.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Change in Resident's Condition or Status revised ,d+[DATE] showed the nurse will notify the resident's attending physician or physician on call where there has been a significant change in resident's physical/emotional/mental condition and a specific instruction to notify the physician of changes in resident's condition.</p> <p>Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's Order Summary Report showed a physician's order to administer the following medications:</p> <ul style="list-style-type: none"> <li>- albuterol sulfate inhalation aerosol powder (breathing treatment), inhale two puffs every six hours as needed for SOB/wheezing ordered on [DATE];</li> <li>- ipratropium-albuterol solution 0.5 - 2.5 mg (breathing treatment), inhale orally via nebulizer every six hours for shortness of breath/wheezing ordered on [DATE]; and</li> <li>- Ativan (antianxiety medication) 1 mg by mouth every six hours as needed for anxiety manifested by verbalization of feeling anxious or nervous ordered on [DATE], for 14 days.</li> </ul> <p>Review of Resident 1's MARfor [DATE] showed an order for Ativan 1 mg by mouth every six hours as needed for anxiety for 14 days ordered on [DATE], and ended on [DATE].</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Progress Note dated [DATE] at 0656 hours, showed the physician/NP notification was placed requesting for Resident 1's Ativan to be reinstated for anxiety. The note also showed Resident 1's albuterol inhaler ran out and the pharmacy would not refill the albuterol inhaler due to the medication being too early to be refilled. The note further showed the facility was waiting for the physician's response.</p> <p>Review of Resident 1's Progress Note dated [DATE] at 1018 hours, showed at 0845 hours, Resident 1 asked the LVN for the inhaler. The note showed Resident 1's oxygen level was 97%, and the LVN offered Resident 1 an ipratropium-albuterol nebulizer treatment instead. The note showed at 0900 hours, during the nebulizer breathing treatment, Resident 1 refused the nebulizer treatment stating, I can't breathe, I need my inhaler. Resident 1 also refused the supplemental oxygen and was very anxious. The note further showed Resident 1's blood oxygen levels decreased, Resident 1 became unresponsive and around 0915 hours, Resident 1's heart rate was 48 beats per minute, and the blood oxygen saturation level reading was 54%. Resident 1 then became pulseless, and CPR was performed until the paramedics arrived.</p> <p>On [DATE] at 1643 hours, a telephone interview was conducted with LVN 3. LVN 3 stated on [DATE], Resident 1 was experiencing increased anxiety and requested for the albuterol inhaler; however, the pharmacy was not able to refill the prescription. LVN 3 stated they called the physician for further instructions, but the physician had not responded by the end of their 2300 to 0700 hours shift. LVN 3 could not recall if they called the physician or NP. LVN 3 stated they did not make a follow-up phone call. When asked if LVN 3 endorsed to the oncoming shift to follow-up for the physician's response, LVN 3 could not recall.</p> <p>On [DATE] at 1013 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated the process for the physician/NP notification of changes was when there was no reply, the staff should place a follow-up phone call to the NP and physician. If still no response, the staff should call the Medical Director. The DON reviewed Resident 1's progress notes and verified there was no documented evidence to show further attempts were made to notify the physician of Resident 1's albuterol inhaler unavailability, the resident's anxiety from the initial physician/NP notification at 0656 hours, until the Resident 1 went into cardiopulmonary arrest at 0920 hours. The DON stated the staff should have followed up by calling the physician or NP.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49644</p> <p>Based on interview, observation, medical record review, and facility P&amp;P review, the facility failed to implement their P&amp;P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the report of an abuse allegation was not reported to the State Agency, Ombudsman, and local law enforcement for one of seven sampled residents (Resident 2). This failure had the potential for delay of investigation.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 4/2021 showed the facility will report all allegations of abuse within the required timeframes and will identify and investigate any allegations of abuse within the required timeframes.</p> <p>Medical record review for Resident 2 was initiated on 6/13/24. Resident 2 was admitted to the facility on [DATE].</p> <p>Review of Resident 2's Social Services Note dated 5/31/24 at 1718 hours, showed while the SSD was sitting in on a tele-visit with Resident 2 and the psychologist, Resident 2 alleged Family Members 3 and 4 had been verbally abusing her, and the psychologist felt it was appropriate to report the allegation to the APS and Ombudsman office.</p> <p>On 6/13/24 at 1436 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated she was present when Resident 2 made the verbal abuse allegation, but since the resident was in a SNF, it was not appropriate to notify the APS. The SSD stated only the Ombudsman office needed to be notified. When asked about the timelines and requirements for reporting an abuse, the SSD stated she was not sure. The SSD stated she was not aware the abuse allegations had to be reported to the law enforcement and State agencies. The SSD verified the facility did not report Resident 2's abuse allegation to the Ombudsman office, State agency, and local law enforcement agency.</p> <p>On 6/13/24 at 1500 hours, an interview was conducted with the Administrator. The Administrator stated anyone who was aware of the abuse allegation could report the allegation. The Administrator stated he was made aware of the abuse allegation several days later when the Ombudsman came to the facility and mentioned it. The Administrator stated the SOC-341 should have been filed by anyone in the facility.</p> <p>On 6/13/24 at 1520 hours, an interview was conducted with Resident 2 at bedside. Resident 2 stated Family Member 2 was verbally abusive to her prior to and while at the facility. Resident 2 stated she reported the abuse allegation to the facility.</p> <p>On 6/13/24 at 1536 hours, a telephone interview was conducted with the Nurse Consultant. The Nurse Consultant stated no abuse allegation was reported to him and he did not report or investigate any abuse allegation.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</b></p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to timely investigate an abuse allegation for one of seven sampled residents (Resident 2). This failure had the potential for not protecting the resident from abuse.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 04/2021 showed the facility will identify and investigate any allegations of abuse within the required timeframes.</p> <p>Medical record review for Resident 2 was initiated on 6/13/24. Resident 2 was admitted to the facility on [DATE].</p> <p>Review of Resident 2's Social Services Note dated 5/31/24 at 1718 hours, showed while the SSD was sitting in on a tele-visit with Resident 2 and the psychologist, Resident 2 alleged Family Members 3 and 4 had been verbally abusing her, and the psychologist felt it was appropriate to report the allegation to the APS and Ombudsman office.</p> <p>On 6/13/24 at 1500 hours, an interview was conducted with the Administrator. The Administrator stated anyone who was aware of the abuse allegation could report the allegation. The Administrator stated he was made aware of the abuse allegation several days later when the Ombudsman came to the facility and mentioned it. When asked if the abuse allegation was investigated when it was brought to his attention on 5/31/24, the Administrator stated the Interim DON should have investigated the abuse allegation.</p> <p>On 6/13/24 at 1520 hours, an interview was conducted with Resident 2 at bedside. Resident 2 stated Family Member 2 was verbally abusive to her prior to and while at the facility. Resident 2 stated she reported the abuse allegation to the facility.</p> <p>On 6/13/24 at 1536 hours, a telephone interview was conducted with the Nurse Consultant. The Nurse Consultant stated no abuse allegation was reported to him and he did not report or investigate any abuse allegation.</p>

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<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49644</p> <p>Based on interview, medical record review and facility P&amp;P review, the facility failed to develop a plan of care for one of seven sampled residents (Resident 1).</p> <p>* Resident 1's plan of care did not address the resident's need for monitoring while smoking and history of keeping medication in their nightstand. This failure had the potential for the resident not to receive the necessary care and interventions to promote resident's safety.</p> <p>Findings:</p> <p>Closed medical record review for Resident 1 was initiated on 6/12/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>a. Review of the facility's P&amp;P titled Smoking Policy - Residents revised 10/2023 showed any smoking-related privileges, restrictions, or concerns (for example, the need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.</p> <p>Review of Resident 1's Admission/Readmission Initial assessment dated [DATE], under the section for Smoking Assessment showed Resident 1 wished to smoke and the smoking was to be supervised was needed.</p> <p>Review of Resident 1's Plan of Care failed to show a care plan problem and interventions to address Resident 1's smoking-related privileges, restrictions, and the needed supervision while smoking.</p> <p>On 6/26/24 at 1520 hours, an interview and concurrent record review was conducted with the DON. The DON reviewed Resident 1's Admission Assessment for smoking and verified the supervision was needed while smoking. The DON reviewed the facility's P&amp;P and Resident 1's plan of care and verified the plan of care failed to address the need for supervision while smoking for Resident 1.</p> <p>b. Review of Resident 1's SBAR Communication Form - General dated 4/2/24, showed Resident 1's albuterol inhaler was found in the resident's nightstand, and Resident 1 refused to give the inhaler to the LVN.</p> <p>Review of Resident 1's Plan of Care failed to show the care plan problem to address Resident 1's history of keeping the inhaler in a bedside drawer without a physician's order.</p> <p>On 6/26/24 at 1520 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON reviewed Resident 1's SBAR Communication Form - General dated 4/2/24, and stated Resident 1's plan of care should show the resident had a history of having an inhaler in their nightstand, to communicate with the care team so they could monitor for any medication at bedside.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</b></p> <p>Based on interview, observation, medical record review, and facility P&amp;P review, the facility failed to ensure the necessary care and services were provided for two of seven sampled residents (Residents 1 and 3). In addition, the facility failed to ensure the facility's Emergency Procedure - Cardiopulmonary Resuscitation P&amp;P was current.</p> <p>* The Daily Skilled Nursing Notes were not completed for Resident 1 who received skilled services.</p> <p>* Resident 3's psychiatry (a branch of medicine dealing with mental illness) consult was not completed timely.</p> <p>These failures had the potential to negatively impact the resident's quality of care due to incomplete medical records, delay of care and the facility P&amp;P not being followed.</p> <p>Findings:</p> <p>1. Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's Order Summary Report dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- Medicare Initial Certification to certify skilled services for the resident's needs was ordered on [DATE];</li> <li>- The physical therapy services five days a week was ordered on [DATE]; and</li> <li>- The occupational therapy services five days a week was ordered on [DATE].</li> </ul> <p>Review of Resident 1's medical record failed to show any daily skilled nursing notes.</p> <p>On [DATE] at 1013 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated all residents with orders for skilled services, including PT and OT should have the daily skilled nursing notes. The DON reviewed Resident 1's Physician Orders and verified the resident should have daily skilled nursing notes. The DON reviewed Resident 1's medical record and verified there were no documentation of the daily skilled nursing notes.</p> <p>2. Medical record review for Resident 3 was initiated on [DATE]. Resident 3 was readmitted to the facility on [DATE].</p> <p>Review of Resident 3's Order Summary Report dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- Psychiatry consult and treatment as needed was ordered on [DATE];</li> <li>- lurasidone HCl (an antipsychotic medication) 100 mg at bedtime was ordered on [DATE]; and</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- valproic acid (a mood stabilizer) 500 mg twice a day was ordered on [DATE].</p> <p>Review of Resident 3's Progress Notes showed the Psychiatry Note was completed on [DATE]. Further review of Resident 3' medical record did not show any psychiatry notes prior to [DATE].</p> <p>On [DATE] at 1632 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for the psychiatry consults order, the consult should be done within three days, especially if the resident was on antipsychotic medications. The DON reviewed Resident 3's medical record and verified the psychiatry consult was ordered on [DATE], and the psychiatry visit was done on [DATE]. The DON acknowledged the psychiatry consult was not completed timely.</p> <p>3. Review of the facility's P&amp;P titled Emergency Procedure - Cardiopulmonary Resuscitation revised , d+[DATE] showed the following:</p> <ul style="list-style-type: none"> <li>- Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest.</li> <li>- Instruct the staff to retrieve the automatic external defibrillator (AED).</li> <li>- When the AED arrives, assess for the need, and follow the AED protocol.</li> </ul> <p>On [DATE] at 1401 hours, an interview and observation were conducted with LVN 4. LVN 4 stated the facility had a crash cart, it was more of an emergency cart, but they did not have a defibrillator. The observation of Crash Cart 1 failed to show a defibrillator or medication, other than an oxygen cylinder.</p> <p>On [DATE] at 1614 hours, an interview was conducted with the Administrator and DON. Both the Administrator and DON stated they did not have a defibrillator in the facility.</p> <p>On [DATE] at 1407 hours, an interview and concurrent record review was conducted with the DON. The DON stated the corporate's Nurse Consultant who was previously the facility's Interim DON, pulled the requested P&amp;Ps and they were the current P&amp;Ps for the facility. The DON reviewed the facility's P&amp;P titled Emergency Procedure - Cardiopulmonary Resuscitation revised ,d+[DATE] and verified the P&amp;P showed an AED would be used, which was not part of the facility's emergency protocol. The DON stated the P&amp;P should have been revised to match the facility's emergency protocol.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49644</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to implement the safety interventions and provided supervision to 21 of 27 sampled residents (Residents 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26) who smoked. This failure had the potential for the residents to be at risk for injury while smoking.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Smoking Policy - Residents approved 1/2024 showed this facility shall establish and maintain safe resident smoking practices,</p> <ul style="list-style-type: none"> <li>- Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.</li> <li>- Smoking is only permitted in designated resident smoking patio.</li> <li>- The resident will be evaluated on admission to determine if they are a smoker or non-smoker. If a smoker, a smoking assessment/evaluation will be completed.</li> <li>- Only disposable safety lighters are permitted but will be kept/stored by the facility staff only. All other forms of lighters, including matches, are prohibited.</li> <li>- Residents are not permitted to give smoking articles to other residents.</li> <li>- The last smoking time is 8PM.</li> </ul> <p>Medical record review for Residents 4, 5 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 23, and 25 were initiated on 7/12/24.</p> <p>Review of the Smoking Assessments dated 7/12/24, for Residents 4, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 23, and 25 showed the residents could smoke independently in the designated areas.</p> <p>Review of the medical records for Residents 19, 21, 22, 24, and 26 was initiated on 7/12/24.</p> <p>Review of the Smoking Assessments dated 7/12/24, for Residents 19, 21, 22, 24, and 26 showed the residents required supervision while smoking.</p> <p>On 7/12/24 at 1011 hours, an observation and concurrent interview was conducted with Resident 17 in Room B. There were cigarettes and one lighter found on the resident's walker and one lighter found on the resident's bedside table. Resident 17 stated they could smoke anytime they wanted and anywhere outside and/or in the patio.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/12/24 at 1046 hours, an observation and concurrent interview was conducted with Resident 18 in the hallway near the patio. Resident 18 had one cigarette and one lighter in his hand. Resident 18 stated he smoked wherever and at any time, and they smoked in the patio. When asked if the staff was present when the residents smoked, Resident 18 stated no.</p> <p>On 7/12/24 at 1044 hours, an observation of the outside patio and concurrent interview was conducted with Residents 17 and 23. Nine residents were observed sitting in the patio and five residents were observed smoking. However, there was no staff monitoring the residents while they were smoking. When asked if a staff was present when the residents were outside smoking, Resident 17 stated no. When Resident 23 was asked where her cigarettes and lighter were stored, Resident 23 stated she kept the cigarettes and lighters with her.</p> <p>On 7/12/24 at 1138 hours, an interview was conducted with the Administrator and DON. The Administrator stated the residents who smoke had a smoking assessment done on admission, and smoke breaks fluctuated throughout the day. The Administrator further stated the residents' cigarettes and lighters were kept in the medication carts. The DON stated there [NAME] been designated times or proper storage of the resident's cigarettes and lights in the past. The DON further stated the facility would work on a structured process with designated smoking times and supervision in the smoking patio area.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</b></p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of seven sampled residents (Resident 1) received the respiratory medications as per the physician's orders. This failure had the potential for the resident not having their ordered medications being available when needed.</p> <p>Findings:</p> <p>Closed medical record review for Resident 1 was initiated on 6/12/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's Order Summary Report dated 3/23/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> <li>- An order dated 4/1/24, for albuterol sulfate inhalation aerosol powder (bronchodilator), inhale two puffs every six hours as needed for SOB/wheezing.</li> <li>- An order dated 4/6/24, ipratropium-albuterol solution 0.5 - 2.5 mg (bronchodilator), inhale orally via nebulizer every six hours for shortness of breath/wheezing.</li> </ul> <p>Review of Resident 1's MAR for April 2024 showed the resident had last received albuterol on 4/13/24 at 1922 hours.</p> <p>Review of Resident 1's Progress Note dated 4/15/24 at 0656 hours, showed the resident's inhaler ran out and pharmacy would not refill the albuterol inhaler. The note showed Resident 1 was adamant about needing the albuterol inhaler and the LVN notified the resident that they were waiting for the physician to text back.</p> <p>Review of Resident 1's Progress Note dated 4/15/24 at 1018 hours, showed at 0845 hours, Resident 1 asked the LVN for albuterol inhaler. The note showed at 0900 hours, the LVN administered an unscheduled dose of the resident's ipratropium-albuterol solution.</p> <p>On 7/2/24 at 1643 hours, a telephone interview was conducted with LVN 3. LVN 3 stated on 4/15/24, Resident 1 was experiencing increased anxiety and requested for the albuterol inhaler, but the resident's albuterol was out, and the pharmacy was not able to refill the prescription. LVN 3 stated the resident frequently asked for his albuterol, often before the next dose was able to be given.</p> <p>On 7/3/24 at 1013 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON reviewed Resident 1's physician orders and progress notes and stated the resident's albuterol should have been in supply and available to administer as per the physician's orders. The DON also stated Resident 1's ipratropium-albuterol solution was scheduled to be routinely administered at 0000, 0600, 1200, and 1800 hours, and should not have been administered at 0900 hours, without a physician's order.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Advanced Rehab Center of Tustin		STREET ADDRESS, CITY, STATE, ZIP CODE  2210 E. First Street Santa Ana, CA 92705	

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 1156 hours, a telephone interview was conducted with the pharmacy staff. The pharmacy staff stated Resident 1's Albuterol was delivered to the facility on [DATE], and was to be refilled after 25 days. The pharmacy staff stated their records showed on 4/11/23, a refill the request for Resident 1's albuterol was faxed to the pharmacy. The refill request was denied by insurance due to it being too early, so the pharmacy faxed a form to the facility on [DATE] at 0335 hours, for the facility to authorize the refill and cover the cost of the medication. The Pharmacy Staff stated on 4/13/24, a staff from the facility called regarding a refill, and the pharmacy refaxed the request form to the facility. The Pharmacy Staff stated they never received a completed form from the facility, but if the facility was to complete and submit the form authorizing the pharmacy to bill the facility for the albuterol, the pharmacy would refill the medication.</p> <p>On 7/10/14 at 1244 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated Resident 1 always had their inhaler with him before coming to the facility. Family Member 1 stated on 4/2/24, she told the nurse that the resident always needed the inhaler on him because having it accessible for him to self-administer to help with his anxiety.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49644</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure the accurate controlled medication reconciliation for two of seven sampled residents (Residents 1 and 3).</p> <p>* Residents 1 and 3's Ativan (a controlled medication for anxiety) administration were not documented accurately as the controlled count sheet did not match the residents' MAR. This failure had the potential for drug diversion.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Controlled Substances, revised 11/2022 showed the following:</p> <ul style="list-style-type: none"> <li>- Receipt, dispensing and disposition of controlled medications include records of personnel access usage, medication administration records, declining inventory records, and destruction, waste records.</li> <li>- Waste of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.</li> </ul> <p>1. Medical record review for Resident 3 was initiated on 6/26/24. Resident 3 was readmitted to the facility on [DATE].</p> <p>Review of Resident 3's Antibiotic or Controlled Drug Record for Ativan 0.5 mg tablet showed the following:</p> <ul style="list-style-type: none"> <li>- On 6/21/24 at 0600 hours, one tablet was removed from the supply.</li> <li>- On 6/22/24 at 1800 hours, one tablet with wasted written next to it. There was no co-signature.</li> <li>- On 6/23/24 at 0600 hours, one tablet with wasted/refused written next to it. There was no co-signature.</li> <li>- On 6/23/24 at 1800 hours, one tablet was removed from the supply.</li> </ul> <p>Review of Resident 3's MAR for June 2024 showed the following for Ativan 0.5 mg:</p> <ul style="list-style-type: none"> <li>- On 6/21/24 at 0600 hours, the MAR was blank for the scheduled dose.</li> <li>- On 6/22/24 at 1800 hours, the Ativan was coded with 2.</li> <li>- On 6/23/24 at 0600 hours, the Ativan was coded with 2.</li> <li>- On 6/23/24 at 1800 hours, the Ativan was coded with 2.</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Chart Codes listed on the MAR showed,2-drug refused.</p> <p>On 6/27/24 at 0918 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated when wasting the controlled medications, a co-signature was required on the count sheet. The DON reviewed Resident 3's Antibiotic or Controlled Drug Record for Ativan and MAR and verified the above doses on 6/22 and 6/23/24, were documented as not administered and should have a co-signature for wastage. The DON also verified the above dose on 6/21/24, was not documented as administered, and should have been documented to show it was administered, or why it was not administered.</p> <p>2. Closed medical record review for Resident 1 was initiated on 6/12/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's Antibiotic or Controlled Drug Record for Ativan 1 mg showed on 3/29/24 at 2200 hours, one tablet of Ativan 1 mg was removed from the supply.</p> <p>Review of Resident 1's MAR for March 2024 failed to show Ativan 1 mg was administered on 3/29/24.</p> <p>On 6/26/24 at 1614 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated when a controlled medication was removed from the medication supply, the nurse should document on the MAR when it was administered. The DON reviewed Resident 1's Antibiotic or Controlled Drug Record for Ativan 1mg and MAR and verified the Ativan was not documented as administered in March and should have been.</p>

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NAME OF PROVIDER OR SUPPLIER  Advanced Rehab Center of Tustin		STREET ADDRESS, CITY, STATE, ZIP CODE  2210 E. First Street Santa Ana, CA 92705	
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<p>F 0761</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49644</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to ensure the medications were not left unattended.</p> <p>* Three medication cups containing medications were left unattended on the medication cart near the nurses' station. This failure had the potential for other residents to have access to medications.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Medication Storage In The Facility effective 4/2008 showed medications are stored safely and securely, and is accessible only to licensed nursing personnel.</p> <p>On 6/26/24 at 1632 hours, three medication cups containing medications were observed on top of the medication cart near the nurses' station. Two cups had liquid medications and one cup had a capsule medication. LVN 5 was observed coming in from the patio door. LVN 5 stated she was assisting another resident into the patio area and verified she should not have left the medications on the cart.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49644</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infections.</p> <p>* CNA 4 failed to perform hand hygiene before entering a room with Enhanced Barrier Precautions signage. This failure had the potential to increase the risk for the spread of infection.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Hand Hygiene revised 10/2022 showed the facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>On 7/11/24 at 0840 hours, an Enhanced Barrier Precautions sign was observed outside Room A's doorway. The sign showed everyone must clean their hands, including before entering and when leaving the room. The isolation cart and hand sanitizer were also available before entering Room A.</p> <p>On 7/11/24 at 0842 hours, CNA 4 was observed answering the call light for Room A. CNA 4 did not perform hand hygiene before entering the room. CNA 4 came out of Room A, placed the food tray inside a food cart, and performed hand hygiene.</p> <p>On 7/11/24 at 0845 hours, an interview was conducted with CNA 4. CNA 4 confirmed there was an Enhanced Barrier Precautions signage before entering the door. CNA 4 verified he did not perform hand hygiene before going to Room A. CNA 4 stated he should have done hand hygiene for infection control.</p> <p>On 7/12/24 at 1115 hours, an interview was conducted with IPN. The IPN stated the staff should have done hand hygiene before entering the room that has Enhanced Barrier Precautions sign to prevent infection.</p> <p>On 7/12/24 at 1620 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.</p>