STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055330	A. Building B. Wing	08/07/2024

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

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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 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview and medical record review, the facility failed to follow the physician's orders for one of three sampled residents (Resident 3). * The facility failed to carry out the physician's order for Resident 3's STAT psychiatric consultation order until nine days later. This failure had the potential for the delay of necessary treatment and services and can negatively impact the resident's health conditions. Findings: Closed medical record review for Resident 3 was initiated on 7/25/24. Resident 3 was admitted to the facility on [DATE], and discharged to a psychiatric facility on 7/29/24. Review of Resident 3's Physicians Order Summary Report showed a physician's order dated 7/2/24, for STAT psych evaluation. Further review of Resident 3's closed medical record showed Resident 3 was seen by the psych NP on 7/11/24, nine days after it was ordered as STAT. On 8/2/24 at 1004 hours, an interview and concurrent closed medical review for Resident 3 was conducted with the DON. When asked who responsible for ensuring STAT referrals were followed up, the DON stated the ADON was responsible. The DON further sated. those STATS are prioritized. The DON verified Resident 3 had an order for STAT psych evaluation on 7/2/24; however, Resident 3 was not seen by the psych NP until 7/11/24, nine days later. When asked if evaluation was done nine days after the order date considered STAT, the DON acknowledged and stated, it is not STAT.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 49348 Based on interview, medical record review, and facility P& P review, the facility failed to ensure one of three sampled residents (Resident 3) was free from the unnecessary psychotropic (any drug that affects brain activity) medications. * The facility failed to obtain the informed consent from Resident 3 for the use of Ativan (its generic name, lorazepam, anti-anxiety medication). * The facility failed to ensure Resident 3's informed consent for the use of Seroquel (antipsychotic medication) was signed and dated by the physician. * The facility failed to ensure the monitoring for Resident 3's behaviors of agitation and restlessness for the use of PRN Ativan medication and the inability to sleep for the use of PRN Restoril (medication used to aid with sleep) medication were completed. * The facility failed to ensure the PRN Ativan and Restoril medications were administered only when Resident 3 had the behaviors of agitation and restlessness, and inability to sleep as ordered. * The facility failed to monitor Resident 3 for the adverse effects of Ativan and Restoril medications. These failures had the potential to negatively affect the residents' well-being. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 10/2016 showed the following: - a psychotropic drug is any medication that affects brain activities associated with mental process and behavior, which includes but not limited to antipsychotics, anxiolytics, hypnotics, and antidepressants. - facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic mediations, per facility policy or applicable state regulation. - the facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart of behavioral assessment record for resident's psychotropic medications for BPSD (Behavioral or Psychological Symptoms of Dementia). Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions. - medications used to treat behaviors be monitored for: (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Efficacy b. Risks c. Benefits d. Harm or adverse consequences Closed medical record review for Resident 3 was initiated on 7/25/24. Resident 3 was admitted to the facility on [DATE], and discharged to a psychiatric facility on 7/29/24. Review of Resident 3's H&P examination dated 7/2/24, showed Resident 3 had the capacity to make medical decisions. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 7/2/24, for Seroquel 200 mg tablet by mouth at bedtime for psychosis m/b delusional statements ordered 7/2/24. - dated 7/2/24, for Restoril 30 mg one capsule by mouth at bedtime PRN for insomnia m/b inability to sleep for 15 days. - dated 7/4/24, for Ativan 0.5 mg one tablet by mouth every eight hours PRN for agitation and restlessness for 14 days. - dated 7/12/24, for Ativan 0.5 mg one tablet by mouth every six hours PRN for agitation and restlessness. - dated 7/19/24, for Restoril 30 mg one capsule by mouth at bedtime PRN for insomnia m/b inability to sleep for 14 days. - dated 7/26/24, for Ativan 0.5 mg one tablet by mouth every six hours PRN for agitation and restlessness. 1. Review of Resident 3's MAR for July 2024 showed Ativan 0.5 mg was administered PRN for agitation and restlessness from 7/4 - 7/29/24. Further review of Resident 3's medical record failed to show the informed consent was obtained from Resident 3 for the use of PRN Ativan. On 8/2/24 at 1004 hours, an interview and concurrent record review was conducted with the DON. The DON stated the process for residents receiving psychotropic medications would include obtaining the consent form and verifying the order and consent from the physician. The DON verified there was no informed consent for Resident 3's Ativan medication use. 2. Review of Resident 3's MAR for July 2024 showed Resident 3 received the Seroquel medication at bedtime from 7/3 - 7/28/24. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's Informed Consent dated 7/2/24, showed Resident 3 and facility staff's signatures for the consent of Seroquel 200 mg at bedtime for psychosis m/b delusional use. However, the consent form did not show that it was signed and dated by the physician. On 8/2/24 at 1004 hours, an interview and concurrent record review was conducted with the DON. The DON verified the findings and stated the physician should have signed Resident 3's Informed Consent form for the use of Seroquel. 3. Review of Resident 3's MAR for July 2024 showed the following medication administrations and behavior monitoring: - from 7/4 - 7/11, the PRN Ativan medication was administered to Resident 3 without the documented behavior observations of agitation and restlessness; - from 7/13 - 7/26/24, the PRN Ativan medication was administered to Resident 3 with the behavior observations marked as yes, no or x; - from 7/26 - 7/29/24, the PRN Ativan medication was administered to Resident 3 without the documented behavior observations of agitation and restlessness; and - from 7/6 - 17/24, the PRN Restoril medication was administered to Resident 3 with the behavior observations marked as x or no; and - from 7/20 - 7/28/24, the PRN Restoril medication was administered to Resident 3 without the documented behavior observations of inability to sleep. Further review of Resident 3's closed medical record failed to show the documentation of the number and/or intensity of Resident 3's behaviors of agitation and restlessness, and inability to sleep. On 8/2/24 at 1442 hours, an interview was conducted with LVN 3. When asked if the behavior of residents with an order for PRN psychotropic medications were being monitored, LVN 3 stated yes. On 8/6/24 at 1640 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified Resident 3 was administered with the PRN Ativan and Restoril, and the behavior monitoring for agitation and restlessness, and the inability to sleep were missing and incomplete. The DON acknowledged the above findings. 4. Review of Resident 3's MAR for July 2024 showed the Ativan medication PRN for agitation and restlessness was administered with the behavior observation marked as x on the following dates and times: - on 7/13/24 at 1604 and 2238 hours; - on 7/14/24 at 1056 hours; - on 7/15/24 at 0300 hours; - on 7/16/24 at 0459, 1218, and 1840 hours; and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/17/24 at 0412, 1012, and 1622 hours. Review of Resident 3's MAR for July 2024 showed the Ativan medication PRN for agitation and restlessness was administered with the behavior observation marked as no on the following dates and times: - on 7/18/24 at 0154 hours; - on 7/19/24 at 1107 hours; - on 7/20/24 at 0250 and 1539 hours; - on 7/21/24 at 0400, 1022, and 1638 hours; - on 7/22/24 at 0128 and 1037 hours; - on 7/34/24 at 2147 hours; - on 7/24/24 at 1255 hours; and - on 726/24 at 0250 hours. Review of Resident 3's MAR for July 2024, showed the Restoril medication PRN for insomnia manifested by inability to sleep was administered with the behavior observation marked as x on the following dates and times: - on 7/6/24 at 2022 hours; - on 7/7, and 7/8/24 at 1910 hours; - on 7/8/24 at 1910 hours; - on 7/9/24 at 2029 hours; - on 7/10/24 at 2010 hours; - on 7/11/24 at 1929 hours; - on 7/13/24 at 1933 hours; - on 7/14, and 7/15/24 at 2100 hours; - on 7/16/24 at 2011 hours; and - on 7/17/24 at 2006 hours, was marked no. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 1300 hours, an interview and concurrent closed medical record review was conducted with the DON. When asked what the x and no meant for Resident 3's Ativan and Restoril behavior observation, the DON stated the behaviors were not observed. The DON verified Resident 3 was administered the PRN Ativan and Restoril medications on the above dates and times. When asked when Resident 3 should be given the PRN Ativan and Restoril, the DON stated when behavior for agitation and restlessness, and inability to sleep were observed. The DON acknowledged Resident 3 should have not been given the PRN Ativan and Restoril medications when there were no behaviors observed. 5. Review of Resident 3's MAR for July 2024 showed Resident 3 was administered the following medications: - PRN Ativan from 7/4 - 7/11, and 7/13 - 7/29/24; and - PRN Restoril from 7/6 -7/17, and 7/20 - 7/28/24. On 8/2/24 at 1442 hours, an interview was conducted with LVN 3. LVN 3 stated her standard of practice when putting the orders for scheduled and PRN psychotropic medications included the monitoring of the side effects of the medications. On 8/7/24 at 1330 1358 hours, an interview was conducted with RN 2. When asked if the resident was being monitored for the side effects of psychotropic medications, RN 2 stated, yes, I believe so. Further review of Resident 3's closed medical record failed to show the monitoring of the adverse effects of the PRN Ativan and Restoril medications use. On 8/7/24 at 1002 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 3 was administered with the PRN Ativan and Restoril medications and there were no documented evidence Resident 3 was monitored for the adverse effects of the Ativan and Restoril medications.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three residents (Resident 2) was free from the significant medication errors when Resident 2 was not given the medications as ordered by the physician on multiple occasions. In addition, the facility failed to notify the resident's physician. These failures had the potential to cause significant adverse effects to the residents. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. Medical record review for Resident 2 was initiated on 8/8/24. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed the following physician's orders dated 8/19/23, to administer the following medications: - amlodipine besylate (a medication used to treat high blood pressure) oral tablet 10 mg orally one time a day for hypertension; - apixaban (its brand name is Eliquis, a medication used to thin the blood) oral tablet 5 mg one tablet by mouth two times a day for DVT prophylaxis; - bumetanide (a medication used to reduce extra fluid in the body caused by conditions such as heart failure, liver disease, and kidney disease) oral tablet 1 mg one tablet by mouth one time a day for edema, hold if the SBP less than 110 mmHg; - metoprolol succinate (a medication used to treat high blood pressure and heart failure) oral capsule ER 24 hour sprinkle 50 mg by mouth one time a day for hypertension, hold if the SBP less than 110 mmHg or HR less than 60 beats per minute; and - nifedipine (a medication used to treat high blood pressure and to control chest pain) oral capsule 10 mg one capsule by mouth three times a day for hypertension, hold if the SBP less than 110 mmHg or HR less than 60 beats per minute. Review of Resident 2's MAR for August and September 2023 showed Resident 2 was not given the following medications as ordered by the physician and marked as 9 (other/see progress notes) on the following dates: - amlodipine on 8/21, 8/28, 8/29, 8/31, 9/3, 9/4, 9/6, 9/9, and 9/10/23. - bumetanide on 8/21, 8/25, 8/26, 8/28 - 8/31, 9/3, 9/4, 9/8, and 9/9/23. - metoprolol on 8/21, 8/25, 8/30, 8/31, 9/3, 9/4, and 9/6/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- apixaban on 8/26/23 at 1700 hours, and 8/29 - 8/31, 9/3, 9/4 and 9/9/23 at 0900 hours. - nifedipine on 8/26 and 9/4 at 1300 hours, 8/26 at 1700 hours, and 8/29-8/30 at 0900 hours. Review of Resident 2's Progress Notes for the above listed dates showed the following order administration notes: - on 8/21/23, for the amlodipine, bumetanide, and metoprolol medications, showed, waiting delivery. - on 8/25/23, for the bumetanide and metoprolol succinate medications, showed, waiting pharmacy delivery. - on 8/26/23, for the bumetanide medication, showed, waiting pharmacy delivery. - on 8/26/23, for the apixaban and nifedipine medications showed, resident on out on pass with family. - on 8/28/23, for the amlodipine and bumetanide medications, showed, medication not available. - on 8/29/23, for the amlodipine, bumetanide, apixaban and nifedipine medications, showed, medication not available to give. - on 8/30/23, for the bumetanide, apixaban, metoprolol, and nifedipine medications, showed, no available, waiting for pharmacy delivery. - on 8/31/23, for the amlodipine and metoprolol medications, showed, waiting for medication delivery. - on 9/3/23, for the amlodipine, bumetanide, apixaban and metoprolol medications, showed, medication not available. - on 9/4/23, for the amlodipine, bumetanide, apixaban and metoprolol medications, showed, waiting pharmacy delivery. - on 9/4/23, for the nifedipine medication, showed, resident out on pass with husband. - on 9/6/23, for the amlodipine and metoprolol medications, showed, pending on delivery. - on 9/8/23, for the amlodipine and bumetanide medications, showed, waiting pharmacy delivery. - on 9/9/23, for the amlodipine, bumetanide, and apixaban medications, showed, medication not available/awaiting pharmacy delivery. - on 9/10/23, for the amlodipine medication, showed, awaiting pharmacy delivery. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 1134 hours, an interview and concurrent medical record review was conducted with Pharmacist 1 from the facility's contracted pharmacy. Pharmacist 1 stated they sent the medications to the facility within four to six hours of receiving the medication orders from the facility. Pharmacist 1 reviewed Resident 2's medication orders placed on 8/19/23, and verified the orders were faxed on 8/19/23. Pharmacist 1 verified the amlodipine and bumetanide medication were not delivered on 8/19/23, because the facility order stated, do not fill, and could not state why the medications were not to be filled. Pharmacist 1 verified the apixaban, metoprolol, and nifedipine medications were received by LVN 5 on 8/19/23 at 1951 hours. Pharmacist 1 verified none of the above listed medications were available in the facility's E-Kit (medications kept on hand by the facility for emergency use) and the pharmacy would have to fill the medications. On 8/7/24 at 1431 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was asked to review Resident 2's MAR and Orders - Administration Notes for August and September 2023. The DON verified the above findings. The DON was unable to find the documentation showing the physician was notified, or if the pharmacy was contacted regarding Resident 2's missed medications.