

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  08/23/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 35346</b></p> <p>Based on interview and medical record review, the facility failed to ensure the care plan was implemented related to informing all staff caring for Resident 1 of the special feeding needs for Resident 1. This failure had the potential for Resident 1 not receiving care and services to meet the care needs.</p> <p>Findings:</p> <p>Closed medical record review for Resident 1 was initiated on 8/21/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 1's Physician Progress Note dated 8/6/24, showed Resident 1's diagnoses included dementia.</p> <p>Review of Resident 1's Plan of Care showed a care plan problem initiated on 7/15/24, addressing Resident 1's swallowing problem related to dysphagia. The interventions included for all staff to be informed of the resident's special dietary and safety needs, alternate small bites and sips, use a teaspoon for eating, and instruct the resident to eat in upright position, eat slowly and chew each bit thoroughly.</p> <p>Further review Resident 1's closed medical record showed CNA 1 had fed the resident dinner on 8/14/24 at 1757 hours.</p> <p>Review of CNA 1's personal file showed the hiring date of 8/13/24. The file showed the skilled checks including meal services and feeding were completed on 8/15/24, after CNA 1 had started to feed the resident on 8/14/24.</p> <p>The resident's care plan was not implemented related to informing all staff of the resident special feeding and safety needs.</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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