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	09/26/2024

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

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)
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** 49348 Based on observation, interview, medical record review, and the facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for one of five sampled residents (Resident 1). * The facility failed to show documented evidence the physician was notified of Resident 1's missed dialysis appointments on 9/10 and 9/11/24. * The facility failed to follow through on Resident 1's Dialysis Unit Communication form to notify the attending physician for Resident 1's complaints of blood in her bowel movements. * The facility failed to follow through with the attending physician for Resident 1's change in condition regarding the right ear redness. These failures had the potential to negatively affect the resident's health and well-being. Findings: Review of the facility's P&P titled End Stage Renal Disease, Care of a Resident revised 11/2023 showed the nursing staff, dialysis provider staff, and the attending physician will collaborate on a regular basis concerning the resident's care as needed: Nursing staff will keep the attending physician, the resident, and the resident's family informed of any change in conditions. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 7/2024 showed the nurse will notify the resident's attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending or physician on call when there has been a(an) refusal of treatment or medications two (2) or more consecutive times. Medical record review for was initiated on 9/20/24. Resident 1 was admitted to the facility on [DATE]. Resident 1 had a diagnosis of end stage renal disease. Review of Resident 1's H&P examination dated 7/26/24, showed Resident 1 had the capacity to understand and make medical decisions. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's MDS dated [DATE], showed Resident 1 was cognitively intact with a BIMS score of 13 (meaning cognitively intact). a. Review of Resident 1's Physicians Order Summary dated 4/11/24, showed may have hemodialysis at a dialysis facility on Tuesdays, Thursdays, Fridays, and Saturdays from 0900 to 1330 hours. Review of the facility's document titled SNF Pre-Dialysis Assessment form dated 9/6/24, showed Resident 1 received dialysis on this day. Review of Resident 1's Progress Notes for September 2024 showed the following: - On 9/7/24, Resident 1 was out for dialysis. - On 9/10/24, Resident 1 returned from dialysis around 1200 hours and was not dialyzed due to Resident 1 having an accident. Resident 1 was rescheduled for makeup on 9/11/24 at 1015 hours. - On 9/12/24 Resident 1 was out for dialysis. Further review of Resident 1's medical record review showed Resident 1 did not receive dialysis from 9/8 to 9/11/24. There was no documented evidence Resident 1's attending physician was notified of the missed dialysis appointments on 9/10 and 9/11/24. On 9/26/24 at 1345 hours, an interview was conducted with Physician 1 for Resident 1. When asked what the expectation was when the residents had missed their dialysis appointments, Physician 1 stated to be informed, document, and convince the resident to go. When asked how many missed dialysis treatments would require a physician's notification, Physician 1 stated, one, just by missing a single one, they tell me. On 9/26/24 at 1353 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 1 had refused dialysis on her make-up day for 9/11/24, and stated any missed dialysis appointments would require a change in condition, and the physician should had beennotified. b. Review of the facility's document titled Dialysis Unit communication form dated 8/27/24, showed special instructions to address to the attending physician regarding the complaints of blood every time Resident 1 had a bowel movement. Review of Resident 1's medical records for August and September 2024 did not show documented evidence the facility had assessed or notified the attending physician of Resident 1's complaints of blood in her bowel movements as per the special instructions on the Dialysis Unit communication form dated 8/27/24. On 9/25/24 at 1257 hours, an interview and concurrent medical record review was conducted with the DON for Resident 1. The DON was informed and verified the above findings. c. Review of Resident 1's SBAR Communication form dated 9/10/24, showed Resident 1 complained of discomfort and redness to the right ear. The physician wasmade aware with a pending response from the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's medical record for September 2024 did not show documented evidence the follow up was made regarding the physician's pending response, the redness in the right ear was reassessed after the SBAR was initiated on 9/10/24, or the right ear was being monitored following a change in condition. d. Review of Resident 1's Care Plan dated 9/10/24, showed the intervention included to assess for the location, onset, and cause of pain. Review of Resident 1's Physician's Order Summary dated 7/23/24,showed an order for hydrocodone-acetaminophen (opioid analgesic) 10-325 mg one tablet by mouth every eighthours as needed for moderate pain (4-6, on a 0-10 pain scale, 0 = no pain and 10 = worst). Review of Resident 1's MAR for September 2024 showed the following: - on 9/8/24, hydrocodone-acetaminophen was administered for a pain level of 7. - on 9/11/24, hydrocodone-acetaminophen was administered for a pain level of 6. Review of Resident 1's Progress Notes with E-MAR for September 2024 did not show documented evidence the care plan interventions were followed for assessing the location, onset, and cause of pain. On 9/25/24 at 0927 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated as a treatment nurse, she would be notified of any skin changes for the residents. LVN 2 stated when a SBAR is initiated, the treatment nurses would be notified on the computer dashboard in Point Click Care, or it would be added to the communication board. LVN 2 stated there were no communications in the dashboard, or communication board regarding Resident 1's right ear. When asked if Resident 1's right ear should have been reassessed or monitored, LVN 2 stated, absolutely. LVN 2 stated the redness to the skin should be monitored every day. LVN 2 verified there were no assessments or monitoring for Resident 1. On 9/25/24 at 1034 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated the nurse who initiated the SBAR for the right ear should have followed up with the physician or endorsed it to the next shift. RN 1 stated after an SBAR was initiated, there would be a post monitoring. RN 1 verified there were no follow-ups to the physician, and no assessments or monitoring were documented for Resident 1's right ear. RN 1 verified after Resident 1's SBAR, there should have been follow up monitoring to ensure symptoms were not worsening. On 9/26/24 at 1645 hours, the DON was informed and verified the above findings.