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	03/24/2025

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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs of one of 20 final sampled residents (Resident 107). * The facility failed to ensure the call light for Resident 107 was within the resident's reach. This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Call System, Resident dated September 2022 showed when the resident needed assistance, a communication system was provided to call the staff for assistance. The staff answered the call as soon as possible by available staff, and urgent needs would be answered immediately. During the initial tour of the facility on 3/17/25 at 0922 hours, Resident 107's call light button was observed hanging over a cord near the wall above Resident 107's head of the bed. Resident 107's call button was not placed within the resident's reach. Medical record review for Resident 107 was initiated on 3/18/24. Resident 107 was admitted to the facility on [DATE]. Review of Resident 107's MDS assessment dated [DATE], showed Resident 107 had severe cognitive impairment and needed maximum assistance from the facility staff with the ADL care. On 3/17/25 at 1122 hours, an observation and concurrent interview was conducted with CNA 1 for Resident 107. Resident 107's call light button was observed not within the resident's reach. CNA 1 stated Resident 107 needed assistance from the facility staff. CNA 1 verified and acknowledged the resident's call light button was hung and clipped on the wall and not within the resident's reach. On 3/19/25 at 1352 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 stated Resident 107 needed assistance from the facility staff with the ADL care. LVN 2 stated Resident 107 was able to use the call light system when the resident needed assistance from the facility staff. LVN 2 was informed and acknowledged the above finding. LVN 2 stated Resident 107's call light should have been within the resident's reach. (continued on next page)

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

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	03/24/2025

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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	On 03/24/25 at 1347 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	03/24/2025

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on interview, medical record review, and facility document review, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 and Notice of Medicare Non-Coverage (NOMNC) for one of three nonsampled residents (Resident 51) reviewed for beneficiary notices. This failure had the potential to not allow the resident or their representative to make informed decisions regarding their Medicare services. Findings: Review of the facility's SNF ABN Form CMS-10055 instructions dated 2024 showed the SNF ABN Form CMS-10055 provided information to allow the beneficiaries to decide whether to receive care that may not be paid for by Medicare and allow for the beneficiary to assume the financial responsibility. Review of the facility's NOMNC Form CMS 10123 with an expiration date of 11/30/27, showed the NOMNC Form CMS 10123 provided information to the beneficiaries of when the service coverage will end and the process to appeal the Medicare coverage. Medical record review for Resident 51 was initiated on 3/21/25. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's NOMNC Form CMS 10123 dated 2/21/25, did not show the signature of the resident or their representative. Review of Resident 51's SNF ABN Form CMS-10055 dated 2/21/25, did not show the signature of the resident or their representative. On 3/21/25 at 1320 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD was asked if the NOMNC Form CMS 10123 and SNF ABN Form CMS-10055 were provided to Resident 51 or Resident 51's representative. The SSD stated the NOMNC Form CMS 10123 and SNF ABN Form CMS-10055 were not provided to Resident 51's representative before Resident 51's last cover day. Furthermore, the SSD stated she sent the notices via email to Resident 51's representative on 2/21/25. However, the SSD stated she did not receive confirmation from Resident 51's representative and/or the signed forms. On 3/24/25 at 1252 hours, an interview was conducted with the Medical Record Director. The Medical Record Director provided a copy of Resident 51's SNF Beneficiary Notification Review Form CMS-20052, completed by the SSD on 3/21/25. The form showed Resident 51's Medicare Part A Skilled Services started on 1/13/25, and the last cover day for the Part A services was on 2/25/25. The Medical Record Director also provided a copy of Resident 51's NOMNC Form CMS 10123 completed by the SSD on 3/21/25, which was signed by the resident's responsible party. The Medical Record Director acknowledged the form was not completed timely. On 3/24/25 at 1443 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	03/24/2025

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 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** 48882 Based on interview and medical record review, the facility failed to transmit the MDS timely for one of 20 final sampled residents (Resident 61) and two nonsampled residents (Residents 97 and 103). This failure had the potential for not having current information in the residents' medical records. Findings: Review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1. 19.1 dated 10/2024 showed the MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. For a Discharge Assessment (return not anticipated and return anticipated), the MDS completion date should be no later than the discharge date plus 14 calendar days. Additionally, the MDS must be transmitted no later than the MDS completion date plus 14 calendar days. 1. Closed medical record review for Resident 97 was initiated on 3/20/25. Resident 97 was admitted to the facility on [DATE], and discharged home on 12/30/24. Review of Resident 97's Discharge MDS assessment dated [DATE], showed Resident 97 was discharged from the facility on 12/30/24, and Resident 97's return to the facility was not anticipated. Further review of Resident 97's MDS Assessment showed the MDS Discharge Assessment was signed as complete on 3/19/25, more than nine weeks past the required MDS completion date of 1/13/25. 2. Closed medical record review for Resident 103 was initiated on 3/20/25. Resident 103 was admitted to the facility on [DATE], and discharged home on 12/18/24. Review of Resident 103's Discharge MDS assessment dated [DATE], showed Resident 103 was discharged from the facility on 12/18/24, and Resident 103's return to the facility was not anticipated. Further review of Resident 103's MDS assessment showed the MDS Discharge Assessment was signed as complete on 3/13/25, more than 10 weeks past the required MDS completion date of 1/1/25. On 3/20/25 at 1056 hours, an interview and concurrent closed medical record review for Residents 97 and 103 was conducted with MDS Coordinator 1. MDS Coordinator 1 verified the above findings and stated the Discharge MDS Assessments for Residents 97 and 103 were late. On 3/24/25 at 1321 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 47476 3. Medical record review for Resident 61 was initiated on 3/17/25. Resident 61 was admitted to the facility on [DATE], discharged on [DATE], and readmitted on [DATE]. (continued on next page)

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	03/24/2025

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 61's MDS - Discharge Assessment - Return Anticipated dated 2/21/25, and completed by MDS Coordinator 2 showed the assessment with a completion date of 3/20/25. On 3/24/25 at 1043 hours, an interview and concurrent medical record review was conducted with MDS Coordinator 2. MDS Coordinator 2 stated the facility had a 14-day window to complete the MDS Discharge Assessment - Return Anticipated. The MDS Coordinator 2 stated sometimes the facility would get backed up with the MDS submissions. The MDS Coordinator 2 verified she completed Resident 61's MDS discharge assessment later than the due date of 3/7/25. On 3/24/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.

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	03/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of new pressure ulcers (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) and promote healing of existing pressure ulcer for one of one final sampled resident (Resident 72) reviewed for pressure ulcers. * The facility failed to ensure the LAL mattress unit was not on the static setting(in static mode, the mattress provides a firm surface that makes it easier to transfer or reposition) when care or repositioning was not being rendered. This failure posed the potential risk for Resident 72 to not benefit from the therapy provided by the LAL mattress. Findings: Review of the facility's P&P titled Pressure Ulcers/Skin Breakdown-Clinical Protocol revised 4/2018 showed the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing, and debridement approaches, dressings, and application of topical agents. Review of the user manual titled Med-Aire Essential 14508 8-inch Alternating Pressure and Low Air Loss Mattress System (undated), showed the Med-Aire Essential 14508 pump and mattress are intended to help reduce the incidence of pressure ulcers while optimizing patient comfort. Press the static button to set it in static mode, and the static indicator will come on. Press the static button again to switch back to alternating mode. NOTE! In static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. Medical record review for Resident 72 was initiated on 3/17/25. Resident 72 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 was at risk for developing pressure ulcers/injuries and admitted to the facility with a Stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, and muscle are not exposed) pressure injury/ulcer. Further review of the MDS showed Resident 72 required substantial/maximal assistance to roll from the left and right sides. Review of Resident 72's Order Summary Report for March 2025 showed a physician's order dated 3/1/25, for the low air loss mattress for wound management according to the resident's weight and comfort; and to check for the appropriate setting daily and adjust as needed. Review of Resident 72's plan of care showed a care plan problem dated 10/21/24, for Resident 72's right heel Stage 3 pressure injury. The interventions included to provide a pressure relieving mattress/LAL mattress for skin management. (continued on next page)

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	03/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 72's Follow Up LTC Wound Progress Note dated 3/13/25, showed the physician's documentation that Resident 72 was at high risk of wound incidence due to impaired mobility and co-morbid conditions. The recommendation showed to implement pressure relieving measures and offloading as tolerated. On 3/18/25 at 1439 hours, Resident 72 was observed lying in bed. The LAL mattress device was observed on with the static setting. On 3/19/25 at 0754 and 1000 hours, Resident 72 was observed lying in bed with the LAL mattress and static setting on. A Staff was not observed in the room providing care to Resident 72. On 3/19/25 at 1018 hours, during the wound treatment observation for Resident 72 with LVN 9, LVN 9 did not check the LAL mattress unit. On 3/19/25 at 1031 hours, an observation and concurrent interview was conducted with LVN 9. LVN 9 stated Resident 72 was bed bound and unable to reposition and turn himself in bed. LVN 9 stated Resident 72 had a slow healing pressure injury to the right heel and the interventions for the pressure injury was to elevate and offload the right heel, provide treatment and nutrition via the GT, and use of the LAL mattress. LVN 9 stated the licensed nurses and treatment nurse were responsible for checking the LAL mattress unit to ensure the setting on the LAL mattress was appropriate for the resident. LVN 9 stated checking the LAL mattress unit consisted of ensuring the weight setting matched the resident's current weight and checking the lights on the LAL mattress unit, which could alert the staff if there were any issues with the LAL mattress unit. LVN 9 stated the static setting on the LAL mattress unit was used when the staff were changing or repositioning the resident. LVN 9 further stated when the static light on the LAL mattress unit was on, it indicated the LAL mattress was on the static setting which meant the LAL mattress was firm. LVN 9 stated the CNAs were able to push the static button and put the LAL mattress in the static mode when providing incontinent care, turning, or repositioning the resident. LVN 9 further stated once the care was rendered, the CNA was expected to turn the static setting off. LVN 9 stated the static setting should only be on when the staff are providing care, changing, or repositioning/turning the resident and the risk of the static mode being on for a prolong period would result in the resident not being provided with the low air loss pressure of the mattress. LVN 9 verified Resident 72 was on a LAL mattress unit, verified the above findings, and stated the LAL mattress device should not be on the static setting. LVN 9 turned the static setting off. On 3/19/25 at 1423 hours, an interview was conducted with CNA 7. CNA 7 stated she was the CNA assigned to Resident 72 and familiar with his care. CNA 7 stated Resident 72 had a LAL mattress; and during incontinent care, turning, or reposition of the resident, she put the LAL mattress unit on the static mode and should turn off the static mode when she was done with the care provided. CNA 7 stated she checked the LAL mattress unit every time she entered Resident 72's room to ensure the LAL mattress unit was on. When asked if she checked if the LAL mattress was on the static mode today, CNA 7 stated she did not. CNA 7 stated she only checked to see if the LAL mattress unit was on by checking the on indicator on the LAL mattress unit. CNA 7 stated sometimes she forgot to check the settings on the LAL mattress and only checked that the LAL mattress device was on. CNA 7 stated she provided incontinent care for Resident 72 today at 1100 hours, and prior to that she did not put the LAL mattress on the static mode. (continued on next page)

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	03/24/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 1321 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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	03/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for one of 20 final sample residents (Resident 421) and four nonsampled residents (Resident 120, 424, 425, and 771). * The facility failed to ensure the safe smoking practices were followed for three residents (Residents 421, 424, and 425) who smoked in the facility as evidenced by: - The residents were not accurately and thoroughly assessed to determine if they could safely store their own cigarettes or lighters. - The residents who were assessed as requiring supervision while smoking or those with a history of non-compliance with the facility's smoking P&P were permitted to keep the cigarettes, lighters, and other smoking articles/materials in their possession. * The facility failed to ensure the fall admission assessment was accurate and fall care plan was developed for Resident 120. * The facility failed to ensure a care plan was developed to address Resident 771's high risk for fall. These failures posed the risk of injuries from fall and fire and serious injuries to the residents who smoked and to the other residents who resided in the facility. Findings: 1. Review of the facility's P&P titled Smoking Policy - Residents, undated showed the facility shall establish and maintain safe resident smoking practices. The residents will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the revaluation will include their ability to smoke safely with or without supervision. The staff shall consult with the attending physician and DON to determine if safety restrictions need to be placed on a resident's smoking privileges. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Only the residents who have independent smoking privileges are permitted to keep cigarettes and other smoking articles in their possession. The residents are not permitted to give smoking articles to other residents. Residents without independent smoking privileges may not have or keep any smoking articles. (continued on next page)

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	03/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On [DATE] at 1626 hours, Resident 425 was observed sitting in the chair and smoking in the patio. Resident 425 was observed inhaling several puffs from the cigarette, flicking the cigarette ashes onto the ground, and putting out his cigarette on the ground. Resident 425 was observed smoking in a nonsmoking patio, with no smoking ash tray nearby, and/or facility staff supervision. Resident 425 kept his own cigarettes and lighter in his possession. On [DATE] at 1630 hours, the Administrator and RN 1 was summoned to the facility's nonsmoking patio where Resident 425 was observed smoking. The Administrator and RN 1 were informed about the observation of the resident smoking in the patio not designated for smoking with no staff supervision, and possessing his own smoking materials. The Administrator stated Resident 425 should not be smoking in the nonsmoking patio, and there was a designated area and time for smoking with facility staff supervision. The Administrator and RN 1 went to the patio and talked to Resident 425. Resident 425 was observed escorted going back inside the facility. Medical record review for Resident 425 was initiated on [DATE]. Resident 425 was admitted to the facility on [DATE]. Review of Resident 425's Admission Initial Assessment under the smoking assessment dated [DATE], showed Resident 425 was a smoker and had no cognitive loss and no dexterity problem. Resident 425 needed supervision when he smoked. Review of Resident 425's plan of care showed a care plan problem dated [DATE], addressing Resident 425's non-compliance with the facility's smoking policy. The interventions included to provide supervision while the resident was smoking. Review of Resident 425's Smoking assessment dated [DATE], showed Resident 425 was a smoker, with episodes of non-compliance related to the facility's smoking P&P. The Smoking Assessment further showed Resident 425 needed supervision when he smoked and required a setup of his smoking materials provided from the facility staff. Review of Resident 425's Order Summary Report dated [DATE], showed a physician's order dated [DATE], to monitor and check for smoking materials in the room or with the resident every shift. However, further review of the Order Summary Report failed to show documented evidence for a physician's order to monitor Resident 425 smoking materials was obtained prior to [DATE], or upon the initial smoking assessment completed on the resident's admission to the facility. On [DATE] at 1637 hours, an interview for Resident 425 was conducted with RN 1. RN 1 stated Resident 425 went to the patio designated for smoking with the facility staff's supervision. RN 1 stated the smoking materials for the residents who smoked were kept in a special box located at the nurse's station. RN 1 verified Resident 425 could not keep his own smoking materials. RN 1 verified and acknowledged Resident 425 should not keep his own smoking materials and should have been supervised when smoking in the designated smoking area. On [DATE] at 1645 hours, an interview for Resident 425 was conducted with the Administrator and DON. The Administrator and DON verified and acknowledged Resident 425 should not be smoking unsupervised in the patio and possessing his own smoking materials. The DON stated the facility reminded Resident 425 about the facility's smoking policy. The Administrator stated Resident 425 verbalized his understanding. (continued on next page)

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	03/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During the initial tour of the facility on [DATE] at 1021 hours, an observation and concurrent interview was conducted with Resident 421. Resident 421 stated he smoked cigarettes and kept his own smoking materials. Resident 421 was observed in the smoking patio with his smoking materials coming out from his pant pocket. Medical record review for Resident 421 was initiated on [DATE]. Resident 421 was admitted to the facility on [DATE]. Review of Resident 421's Smoking assessment dated [DATE], showed Resident 421 was a smoker, with episodes of impulsivity and risk-taking behavior. The Smoking Assessment further showed Resident 421 needed supervision when he smoked and required a setup with his smoking materials provided by the facility staff. Review of Resident 421's plan of care showed a care plan problem dated [DATE], addressing Resident 425 as a smoker. The interventions included to provide supervision while the resident was smoking. On [DATE] at 1327 hours, an interview for Resident 421 was conducted with RN 1. RN 1 verified Resident 421 was a smoker, and the facility kept the resident's smoking materials at the nurse's station. RN 1 stated the residents who smoked were not allowed to keep their own smoking materials. RN 1 was informed of the observation about Resident 421's keeping his own smoking materials. RN 1 stated Resident 421 should not be keeping his own smoking materials as per the facility's smoking policy. c. During the initial tour of the facility on [DATE] at 1329 hours, an observation and concurrent interview was conducted with Resident 424. Resident 424 was observed awake in bed and stated he smoked cigarettes. Resident 421 verified he kept his own smoking materials with him and showed a box of cigarette coming out from his pant pocket. Medical record review for resident 424 was initiated on [DATE]. Resident 424 was admitted to the facility on [DATE]. Review of Resident 424's plan of care showed a care plan problem dated [DATE], addressing Resident 425 as a supervised smoker. The interventions included to store Resident 424's smoking supplies at the nurse's station. Review of Resident 424's Smoking assessment dated [DATE], showed Resident 424 was a smoker. The Smoking Assessment further showed Resident 424 needed supervision when he smoked and required a setup of his smoking materials provided by the facility staff. On [DATE] at 1341 hours, an interview for Resident 424 was conducted with LVN 10. LVN 10 verified Resident 424 was a smoker, and he went to the patio to smoke with the facility staff's supervision. LVN 10 stated the facility kept the smoking materials in a special box located at the nurse's station. LVN 10 stated the resident who smoked could not keep their own smoking materials. LVN 10 was informed of the observation of Resident 424's possession of his own smoking materials. LVN 10 stated Resident 424 should not be keeping his own smoking materials as per the facility's smoking policy. On [DATE] at 1347 hours, an interview and concurrent medical record review for Residents 421, 424, and 425 was conducted with the DON. The DON was informed and verified the above findings. (continued on next page)

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	03/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50967 2. Review of the facility's P&P titled Managing Falls and Fall Risk revised on ,d+[DATE] showed the facility staff, with the input of the attending physician, will implement a resident centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with history of falls. Closed medical record review for Resident 120 was initiated on [DATE]. Resident 120 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 120's H&P examination dated [DATE], showed Resident 120 had no capacity to make medical decisions. Further review of Resident 120's closed medical record showed the resident's diagnoses included difficulty in walking, muscle weakness, schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), epilepsy (a neurological condition involving the brain that makes people more susceptible to having recurrent unprovoked seizures), Parkinson's (a progressive neurodegenerative disorder that affects the brain's ability to produce and use dopamine) disease, and hypertension (high blood pressure). However, review of Resident 120's Admission/Readmission Initial assessment dated [DATE], showed the resident's fall score was zero. Under the Gait/Balance section showed the gait/balance was marked normal. Under the Section G (Medication) assessment showed Resident 120 did not have the following medications: antihypertensives (high blood pressure), antiseizures, benzodiazepines, and/or psychotropics in the last seven days. In addition, under the Section H (Predisposing Disease) assessment showed Resident 120 had no predisposing conditions like Parkinson's disease, seizures, and arthritis (joint inflammation). Review of Resident 120's SBAR assessment dated [DATE], showed Resident 120 had an unwitnessed fall on [DATE]. Reviewed Resident 120's plan of care failed to show a care plan was developed addressing the resident's risk for fall prior to [DATE]. On [DATE] at 1334 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 was asked if she completed the admission assessment for Resident 120 on [DATE]. LVN 4 stated she was the admission nurse on [DATE]. Review of Resident 120's Admission/Readmission Initial assessment dated [DATE], showed the assessment was inaccurate. LVN 4 verified the finding and stated she entered the answers incorrectly. LVN 4 stated under Section G, she was supposed to mark three which equaled to four points; and under Section H, she was supposed to mark two which equaled to two points. LVN 4 recalculated the assessment and verified Resident 120 would have a fall risk score of six, which placed Resident 120 at risk for fall. LVN 4 stated Resident 120 was at risk for fall, and a care plan for fall risk prevention should have been developed. (continued on next page)

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	03/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0912 hours, an interview and concurrent medical record review was conducted with the DON. Review of Resident 120's Admission/Readmission Initial assessment dated [DATE], was conducted with the DON. The DON verified the assessment was inaccurate. The DON stated the RN supervisor was responsible to review the admission initial assessments for accuracy. In addition, the DON stated if Resident 120's admission fall assessment was completed accurately, the resident would have been at risk for fall. The DON verified Resident 120 did not have a care plan for fall prevention upon admission on [DATE] through [DATE]. 3. Closed medical record review for Resident 771 was initiated on [DATE]. Resident 771 was readmitted to the facility on [DATE], and had expired on [DATE]. Review of Resident 771's H&P examination dated [DATE], showed Resident 771 had no capacity to make informed decisions. Review of Resident 771's MDS dated [DATE], showed Resident 771's BIMS score of 4, indicating cognitively impaired. Review of Resident 771's Fall Assessments dated ,d+[DATE], [DATE], and [DATE], showed Resident 771 was at high risk for fall. Review of Resident 771's SBAR Assessment showed Resident 771 had a witnessed fall on [DATE] and [DATE]. Review of Resident 771's plan of care failed to show a care plan addressing the resident's high risk for fall was developed upon the resident's readmission to the facility on [DATE], and post fall on [DATE] and [DATE]. On [DATE] at 1016 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 reviewed Resident 771's care plan for the fall after the resident's readmission to the facility on [DATE]. RN 2 verified there were no care plans developed to address the resident's high risk for fall upon readmission to the facility through [DATE], when the resident expired. RN 2 verified there was a fall care plan initiated only on [DATE], after Resident 771 had expired. Furthermore, RN 2 stated a care plan must be created when the resident had a change of condition, at risk for fall, or after a fall incident. On [DATE] at hours, an interview was conducted with the Medical Record Director. The Medical Record Director verified the only fall care plan for Resident 771 was created in the resident's EHR on [DATE], and no other fall care plans were developed in the resident's EHR or medical record since the resident's readmission to the facility on [DATE]. On [DATE] at 1443 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	03/24/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV accesses for two of 20 final sampled residents (Residents 421 and 671), and two nonsampled residents (Residents 422 and 423). * The facility failed to ensure the PICC line external catheter baseline measurements were obtained and documented for Residents 421 and 423. * The facility failed to ensure Residents 422 and 671's PIV sites were labeled with the date, time, and licensed nurse's initials. These failures had the potential to delay the identification of intravenous catheter related complications for the residents. Findings: Review of the facility's P&P titled General Policies for IV Therapy dated March 2023 showed confirmation of the PICC placement is to be on the resident's medical record and recommended the PICC insertion documentation included the internal and external lengths of the catheter. Review of the facility's P&P titled PICC Dressing Change dated March 2023 showed the PICC external catheter length should be obtained upon admission and during dressing change. 1. Medical record review for Resident 421 was initiated on 3/18/25. Resident 421 was admitted to the facility on [DATE]. On 3/17/25 at 1021 hours, Resident 421 was observed in bed. Resident 421 stated he had the surgeries to both of his feet due to infection. Resident 421 stated he had a PICC line on the right upper arm and showed his PICC line with the transparent dressing. The PICC line dressing was observed with a label dated 3/13/25. Review of Resident 421's Order Summary Report dated 3/18/25, showed a physician's order dated 3/17/25, to measure the midline external catheter length with each dressing change and as needed and to document the arm circumference in centimeters upon admission. However, further review of Resident 421's medical record failed to show the baseline measurement for the length of the external catheter and arm circumference above the insertion site were obtained upon admission to the facility. Review of Resident 421's plan of care failed to show a care plan was formulated to address Resident 421's use of the PICC line. Review of Resident 421's IV Administration Record for March 2025 failed to show documented evidence the arm circumference measurement was documented upon Resident 421's admission to the facility. (continued on next page)

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	03/24/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 423 was initiated on 3/18/25. Resident 423 was admitted to the facility on [DATE]. On 3/17/25 at 1042 hours, Resident 423 was observed with a PICC line on the left upper arm with a transparent dressing. The transparent dressing was observed with a label dated 3/13/25. Resident 423 was also observed with a PIV to the right upper arm with a transparent dressing not labeled with the date, time, and licensed nurse's initials. Review of Resident 423's Order Summary Report dated 3/19/25, showed a physician's order dated 3/13/25, to measure the midline external catheter length with each dressing change and as needed. However, further review of Resident 423's medical record failed to show the baseline measurement for the length of the external catheter and arm circumference above the insertion site were obtained upon admission to the facility. Review of Resident 423's plan of care failed to show a care plan was formulated to address Resident 423's use of the PICC line. Review of Resident 423's IV Administration Record for March 2025 failed to show documented evidence the length of the external catheter measurement was documented upon Resident 423's admission to the facility. 3. Medical record review for Resident 422 was initiated on 3/17/25. Resident 422 was admitted to the facility on [DATE]. On 3/17/25 at 0944 hours, Resident 422 was observed sitting in her wheelchair. Resident 422 was able to show a PIV to her left forearm with a transparent dressing not labeled with the date, time, and licensed nurse's initials. Review of Resident 422's IV Administration Record for March 2025 showed the following physician's orders: - dated 3/14/25, to administer piperacillin-tazobactam (antibiotic medication) solution 2.25 grams intravenously every eight hours for UTI until 3/17/25. - dated 3/13/25, to rotate the PIV site when clinically indicated and dressing change with site changes or at least every seven days and as needed. Review of Resident 422's plan of care showed a care plan problem dated 3/14/25, addressing Resident 422's UTI. However, the plan of care interventions failed to show documented evidence for the care and use of the PIV access line for Resident 422. (continued on next page)

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	03/24/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 1317 hours, an observation, interview, and concurrent medical record review for Residents 421, 422, and 423 was conducted with RN 1. RN 1 verified Residents 421 and 423 had a PICC line on the upper arm, and Resident 422 had a PIV line on the left forearm. RN 1 verified Residents 421 and 423 had a physician's order to measure the length of the external catheter for the PICC line. RN 1 was asked if there were baseline measurements for the length of the external catheter and arm circumference for Residents 421 and 423 obtained upon admission to the facility. RN 1 reviewed Residents 421 and 423's medical records and verified there were no baseline measurements for the length of the external catheter and arm circumference for Residents 421 and 423. RN 1 verified Resident 422's PIV was not labeled with the date, time, and licensed nurse's initials. On 3/24/25 at 1347 hours, an interview and concurrent medical record review for Residents 421, 422, and 423 was conducted with the DON. The DON was informed and verified the above findings. 48882 4. Medical record for Resident 671 was initiated on 3/17/25. Resident 671 was admitted to the facility on [DATE]. On 3/17/25 at 1016 hours, Resident 671 was observed with a PIV line to her right arm with a transparent dressing not labeled with the date, time, and licensed nurses initials. Review of Resident 671's Order Summary Report for March 2025 showed the following physician's orders: - dated 3/16/25, to administer piperacillin-tazobactam (antibiotic) solution 3.375 gm intravenously every eight hours for UTI for seven days, - dated 3/17/25, to rotate the PIV site when clinically indicated, and to change the dressing with site changes at least every seven days and as needed. Review of Resident 671's IV Administration Record for March 2025 showed Resident 671 was administered the piperacillin-tazobactam solution 3.375 gm medication intravenously on 3/17/25 at 0600 hours. On 3/17/25 at 1138 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated for the residents admitted to the facility with an existing PIV line, the PIV dressing should be labeled with the insertion date. RN 1 stated if the PIV dressing was not labeled with the insertion date, a new PIV line should be started. RN 1 further stated prior to the administration of the IV antibiotics, the RN should check the PIV site to ensure the PIV was clean and dry and the PIV dressing was labeled with the date and time. RN 1 verified Resident 671's PV dressing was not labeled with the date, time, and licensed nurse's initials. On 3/24/25 at 1033 hours, an interview was conducted with the DON. The DON stated for the residents admitted to the facility with a PIV, the PIV dressing should be labeled with the insertion date and/or the date when the PIV dressing was changed. The DON stated the admitting licensed nurse was expected to assess the PIV site and dressing, and check the PIV was labeled with the date, time, and licensed nurse's initial. Additionally, the DON stated when administering the IV antibiotics, the RN was expected to check the PIV site and dressing and check the PIV was labeled with the date, time, and the licensed nurse's initial. (continued on next page)

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	03/24/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 1321 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	03/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 20 final sampled residents (Resident 58) and three nonsampled residents (Residents 92, 106, and 423) were provided with the appropriate respiratory care when: * The facility failed to ensure Resident 58's oxygen tubing was labeled, dated, and not on the floor. In addition, there was no physician's order obtained and a care plan developed for the use of oxygen. There was no posted signage for the oxygen use in the doorway as per the facility's P&P. * The facility failed to ensure Resident 92's oxygen tubing and mask were labeled and dated. In addition, there was no posted signage for the oxygen use in the doorway as per the facility's P&P. * The facility failed to ensure Resident 106's nebulizer tubing was dated and placed inside a clear plastic bag when not in use. * The facility failed to ensure Resident 423's nasal cannula was not touching the floor, and the nebulizer tubing was dated and placed inside a clear plastic bag when not in use. These failures had the potential to negatively impact the residents' medical conditions. Findings: Review of the facility's P&P Oxygen Administration revised October 2010 showed it is the policy of the facility to provide guidelines for the safe administration of oxygen. Review of the facility's P&P titled Fire Safety and Prevention dated May 2011 under the oxygen safety section, showed the facility will use visible No Smoking signs where oxygen is stored or being administered. 1.a. During the initial tour of the facility on 3/17/25 at 0957 hours, Resident 58 was observed in bed. The oxygen tubing and mask were observed on the floor and not labeled with the date and name of the resident. In addition, there was no posted signage for the oxygen use on the doorway. Medical record review for Resident 58 was initiated on 3/18/25. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's Order Summary Report dated 3/19/25, failed to show a physician's order for the oxygen use. Review of Resident 58's plan of care failed to show documented evidence a care plan was formulated for the use of the oxygen. b. Medical record review for Resident 92 was initiated on 3/18/25. Resident 92 was admitted to the facility on [DATE]. (continued on next page)

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	03/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour of the facility on 3/17/25 at 0955 hours, Resident 92 was observed in bed asleep. The oxygen tubing and mask were observed inside the clear plastic bag and not labeled with the date and name of the resident. In addition, there was no posted signage for the oxygen use on the doorway. Review of Resident 92's Order Summary Report dated 3/19/25, showed a physician's order dated 3/4/25, to monitor the oxygen saturation level (percentage of oxygen in the blood) every shift and administer oxygen at 2 LPM via nasal cannula as needed for shortness of breath. c. Medical record review for Resident 106 was initiated on 3/18/25. Resident 106 was admitted to the facility on [DATE]. During the initial tour of the facility on 3/17/25 at 0958 hours, Resident 106 was observed in bed asleep. Resident 106's nebulizer tubing was observed on the floor and not labeled with the date. Review of Resident 106's Order Summary Report dated 3/19/25, showed a physician's order dated 3/15/25, to administer ipratropium-Albuterol (breathing treatment) inhalation solution 0.5-2.5 (3) mg per 3 ml inhalation orally every six hours for shortness of breath for five days. On 3/17/25 at 1132 hours, an observation and concurrent interview for Residents 58, 92, and 106 was conducted with LVN 11. LVN 11 was informed of the observation Resident 58's oxygen tubing and mask on the floor. LVN 11 verified and acknowledged Resident 58's oxygen tubing and mask were on the floor. LVN 11 stated the oxygen tubing and mask should have been labeled with the date and name of the resident, and placed inside a clear plastic bag when not in use. LVN 11 verified Resident 92's oxygen tubing and Resident 106's nebulizer tubing were not labeled with the date and name of the resident. In addition, LVN 11 verified there was no posted signage for the oxygen use on Residents 58 and 92's doorway. On 3/20/25 at 0958 hours, an interview and concurrent medical record review for Residents 58, 92, and 106 was conducted with RN 2. RN 2 verified Resident 58 had no physician's order for the use of oxygen and there was no care plan formulated. RN 2 added there should have been a posted signage for the oxygen use on the doorway of Residents 58 and 92. RN 2 verified and acknowledged the oxygen tubing and nebulizer mask should not be touching the floor and should have been placed inside a clear plastic bag when not in use. 2. During the initial tour of the facility on 3/17/25 at 1042 hours, Resident 423 was observed receiving oxygen at 1 LPM via nasal cannula from the oxygen concentrator. Resident 423's nasal cannula tubing was observed touching the floor. In addition, Resident 423's nebulizer machine was observed on top of the bedside drawer and the nebulizer tubing was undated and placed inside the drawer. Medical record review for Resident 423 was initiated on 3/17/25. Resident 423 was admitted to the facility on [DATE]. Review of Resident 423's Order Summary Report dated 3/19/25, showed the following physician's orders: - dated 3/13/25, to administer oxygen at 1 LPM via nasal cannula continuously for CHF. (continued on next page)

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	03/24/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/13/25, to administer ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg per 3 ml inhalation orally every six hours for shortness of breath. On 3/17/25 at 1324 hours, an observation and concurrent interview for Resident 423 was conducted with RN 1. RN 1 was informed of the observation regarding the resident's oxygen tubing, nebulizer tubing, and mask. RN 1 verified the above findings. RN 1 stated the nebulizer mask and tubing should have been placed in a clear plastic bag when not in use and labeled. RN 1 stated the oxygen tubing should not be touching the floor and for the staff to change the oxygen tubing when observed it touching the floor. On 3/24/25 at 0955 hours, an interview and concurrent medical record review for Residents 58, 92, 106, and 423 was conducted with the DON. The DON was informed and verified the above findings.

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	03/24/2025

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 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** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to provide the appropriate pain management for two of three final sampled resident (Residents 8 and 94) reviewed for pain management. * The facility failed to administer the pain medication according to the physician's order for Resident 8 and develop a care plan to address Resident 8's pain and use of the Norco (narcotic) pain medication. * The facility failed to accurately document the monitoring of pain for Resident 94 and administer the pain medication according to the physician's order. In addition, the facility failed to ensure the non-pharmacological pain interventions were provided prior to the administration of the pain medication and develop a care plan to address Resident 94's pain and the use of the Norco pain medication. These failures had the potential to put Residents 8 and 94 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication. Findings: Review of the facility's P&P titled Pain- Clinical Protocol revised 3/2018 showed with input from the resident to the extent possible, the physician and staff will establish goals of pain treatment; for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. The physician will order the appropriate non-pharmacologic and medication interventions to address the individual's pain. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regiment should utilize the simplest regiment and lowest risk medications before using more problematic or higher risk approaches. Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 12/2016 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. include measurable objectives and timeframe; b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; e. include the resident's stated goals upon admission and desired outcomes; g. incorporate identified problem areas; h. incorporate risk factors associated with identified problems; and (continued on next page)

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	03/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. reflect treatment goals, timetables and objectives in measurable outcomes; Further review of the facility's P&P showed the comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS). Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change. Review of the facility's P&P titled Administering Medications revised 4/2019 showed medications are administered in accordance with the prescriber orders, including any required time frame. 1. On 3/17/25 at 0843 hours, an interview was conducted with Resident 8. Resident 8 stated she had pain in her left hip and was being administered pain medication for her pain. Medical record review for Resident 8 was initiated on 3/17/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 12/7/24, showed Resident 8 had a displaced intertrochanteric fracture of the left femur (thigh bone) and had the following medications for pain management: acetaminophen (analgesic medication) 650 mg every four hours as needed and Norco 5-325 mg every eight hours as needed. Review of Resident 8's Order Summary Report for March 2025 showed the following physician's orders: - dated 12/6/24, to administer Norco 5-325 mg one tablet by mouth every eight hours as needed for severe pain level of 7-10 (on a 0 to 10 pain scale, 0 = no pain and 10 = worst pain), - dated 12/15/24, to administered acetaminophen 325 mg two tablets by mouth every four hours as needed for mild pain level 1-3. Review of Resident 8's MAR for March 2025 showed Resident 8 was administered Norco 5-325 mg for severe pain (7-10) on the following dates and times: - dated 3/9/25 at 0320 hours, for a pain level of 6, - dated 3/12/25 at 0112 hours, for a pain level of 6, and - dated 3/17/25 at 0447 hours, for a pain level of 6. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8 received the PRN pain medication or was offered and declined PRN pain medication. Review of Resident 8's plan of care showed a care plan problem addressing Resident 8's alteration on musculoskeletal status related to muscle spasms. The medication Baclofen (muscle relaxant medication) 5 mg tablet was listed under the care plan. However, further review of Resident 8's plan of care failed to show a care plan problem addressing Resident 8's left hip pain or use of the Norco pain medication. (continued on next page)

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	03/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 1109 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 6. LVN 6 stated the pain medications were administered as per the physician's orders and within the ordered pain parameters. LVN 6 stated if the pain medications were administered outside of the physician's ordered pain parameters, the physician should be informed, and the licensed nurse should document in the resident's medical record. LVN 6 further stated for the residents who reported pain and were administered with the pain medications, the resident should have a care plan to address the resident's pain. LVN 6 reviewed Resident 8's medical record and verified the above findings. 2. Medical record review for Resident 94 was initiated on 3/17/25. Resident 94 was admitted to the facility on [DATE], with a diagnosis of fracture of an unspecified part of the neck of the left femur. Review of Resident 94's H&P examination dated 11/27/24, showed Resident 94 was admitted to an acute care hospital status post fall, UTI, pain and had a left hip open reduction surgery (a surgical procedure used to repair broken bones [fractures]. It involves exposing the fractured bone, realigning the bone fragments, and stabilizing them with internal fixation devices such as screws, plates, rods, or wires). Further review of Resident 94's H&P examination showed Resident 94 had the capacity to understand and make decisions. Review of Resident 94's Order Summary Report for March 2025 showed the following physician's orders: - dated 11/26/24, to monitor Resident 94's level of pain every shift, on a 0-10 pain scale, and document 0= no pain, 1-3= mild pain, 4-6= moderate pain, and 7-10= severe pain, - dated 11/26/24, to administer acetaminophen 325 mg two tablets every six hours as needed for mild pain (pain level of 1-3), and - dated 12/17/24, to administer Norco 10-325 mg one tablet every six hours as needed for pain level of 7-10. Review of Resident 94's quarterly MDS assessment dated [DATE], showed Resident 94 was coded for receiving PRN pain medication or was offered and declined pain medication. Further review of the MDS assessment, under the use of high-risk drug class, showed Resident 94 was coded for the use of opioid medication. Review of Resident 94's MAR for March 2025 showed Resident 94 was administered Norco 10-325 mg for severe pain (pain level of 7-10) on the following dates and times and documented pain levels: - dated 3/2/25 at 0301 hours, for a pain level of 6. - dated 3/14/25 at 0306 hours, for a pain level of 6. Further review of Resident 94's MAR for March 2025 showed Resident 94 was administered Norco 10-325 mg one tablet by mouth every six hours as needed for severe pain (pain level of 7-10) for the following dates and times: (continued on next page)

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	03/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/1/25 at 0754 hours, for a pain level of 9. - dated 3/2/25 at 1924 hours, for a pain level of 7. - dated 3/3/25 at 0758 hours, for a pain level of 9; and at 1900 hours, for a pain level of 7. - dated 3/4/25 at 0548 hours, for a pain level of 8. - dated 3/5/25 at 0829 hours, for a pain level of 9. - dated 3/6/25 at 1930 hours, for a pain level of 7. - dated 3/8/25 at 0805 hours, for a pain level of 9; and at 1930 hours, for a pain level of 7. - dated 3/9/25 at 0816 hours, for a pain level of 10; and at 1930 hours, for a pain level of 8. - dated 3/10/25 at 0821 hours, for a pain level of 9; and at 1900 hours, for a pain level of 8. - dated 3/11/25 at 1858 hours, for a pain level of 7. - dated 3/12/25 at 1900 hours, for a pain level of 8. - dated 3/13/25 at 1936 hours, for a pain level of 7. - dated 3/14/25 at 0306 hours, for a pain level of 6; and at 1900 hours, for a pain level of 8. - dated 3/17/25 at 1745 hours, for a pain level of 7. However, review of Resident 94's MAR showed the licensed nurses documented Resident 94's pain level as 0 for no pain for the following dates and shifts: - for the day shifts (from 0700 to 1500 hours) on 3/1, 3/3, 3/5, 3/8, 3/9, and 3/10/25, - for the evening shifts (from 1500 to 2300 hours) on 3/2, 3/3, 3/6, 3/8 to 3/14, and 3/17/25, - for the night shift (from 2300 hours to 0700 hours) on 3/3 and 3/13/25. Further review of Resident 94's MAR for March 2025 showed Resident 94 was administered Norco 10-325 mg for severe pain (pain level of 7-10) on 3/9/25 at 1930 hours and on 3/10/25 at 1900 hours. However, the MAR showed the non-pharmacological pain interventions were documented as N/A (not applicable) for those dates. Review of Resident 94's plan of care failed to show a care plan problem to address Resident 94's pain or the use of the Norco pain medication, a high risk-medication. On 3/20/25 at 0905 hours, an interview was conducted with Resident 94. Resident 94 stated she fell at home and had stitches on her left leg. Resident 94 stated she had pain in her left hip every day and was being administered the Norco pain medication for her pain. (continued on next page)

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	03/24/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 1127 hours, an interview and concurrent medical record review for Resident 94 was conducted with LVN 1. LVN 1 stated Resident 94 complained of left hip pain and requested for her pain medication every day, prior to the physical therapy. LVN 1 stated prior to the administration of the pain medications, the non-pharmacological pain interventions should be implemented and documented in the MAR. LVN 1 stated if the non-pharmacological pain interventions were effective, then the resident would not need to be administered with the pain medication. LVN 1 reviewed Resident 94's medical record and verified the above findings. LVN 1 stated if the pain medications were administered, the non-pharmacological pain interventions should not be documented as N/A. LVN 1 further stated if the resident refused the non-pharmacological pain interventions, then the licensed nurse should document in the progress notes. LVN 1 reviewed Resident 94's medical record and stated there were no documentation to show Resident 94 refused the non-pharmacological pain interventions. Additionally, LVN 1 stated Resident 94 had been taking the Norco pain medication for some time. LVN 1 stated Resident 94 should have a care plan to address Resident 94's left hip pain and use of the Norco pain medication. LVN 1 reviewed Resident 94's plan of care and verified Resident 94's care plan for pain was created on 3/20/25 (same day), and verified Resident 94 did not have a care plan specific to the use of Norco pain medication. On 3/24/25 at 1033 hours, an interview and concurrent medical record review for Resident 94 was conducted with the DON. The DON stated the pain medication should be administered as per the physician's order and within the ordered pain parameters. The DON stated a care plan should be developed for the residents who had pain. The DON further stated the Norco pain medication was a high- risk medication (drugs that have a heightened potential to cause serious harm or death if used incorrectly) and there should be a care plan developed for the residents who were taking the high-risk medications. Additionally, the DON stated the non-pharmacological pain interventions should be implemented and the effectiveness should be documented, prior to the administration of the pain medication, to prevent unnecessary administration of the pain medication (if the non-pharmacological pain interventions were effective). The DON stated the non-pharmacological pain intervention should not be documented as N/A if the pain medication was administered to the resident. When asked about the monitoring of pain every shift, the DON stated the monitoring of the resident's pain should be documented at the end of each shift to ensure an accurate assessment and tracking of the resident's pain level. The DON further stated if the licensed nurse assessed and documented the resident's pain as 0, and the nurse later administered the pain medication to the resident during their shift, the DON expected the licensed nurse to update the pain assessment/documentation. The DON reviewed Resident 94's MAR for March 2025 and verified the above findings. The DON stated the nurse should have updated the pain monitoring to accurately reflect Resident 94's pain during those shifts. On 3/24/25 at 1321 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings

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	03/24/2025

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 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** 35346 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services for four of 20 sampled residents (Residents 3, 36, 43, and 47) and one nonsampled residents (Resident 113). * The facility failed to ensure the Controlled Drug Record matched the MAR for Residents 3 and 371's hydrocodone-acetaminophen (narcotic pain medication) administration. In addition, the facility failed to document the residents' pain assessment before and after the administration of the hydrocodone-acetaminophen medication. This failure posed the risk of diversion of the controlled medication. * Resident 43's insulin (used to lower blood sugar level) injection sites were not rotated. This failure had the potential for the resident to suffer from unnecessary side effects. * One of five licensed nurses (LVN 5) who was observed during the medication administration observation was found to have an error. LVN 5 failed to instruct Resident 113 to chew the aspirin 81 mg chewable medication. * The facility failed to ensure the administration of medication for Resident 36 was accurately documented in the MAR. * The facility failed to administer insulin glargine to Resident 47 as ordered by the physician. These failures had the potential to negatively affect the residents' well-being. Findings: 1.a. On 3/20/25 at 0829 hours, an inspection for Medication Cart A, facility document review and concurrent medical record review was conducted with RN 2. RN 2 verified a bubble pack of Resident 371's hydrocodone-acetaminophen 5-325 mg tablets and the Controlled Drug Record were stored inside the medication cart. Further review of the Controlled Drug Record showed on 12/4 (December 4, no year was documented) one tablet was signed out for Resident 371. The medication label for the hydrocodone-acetaminophen medication showed a fill date of 12/4/23. Review of Resident 371's medical record with RN 2 showed Resident 371 was admitted to the facility on [DATE], and discharged from the facility on 2/29/24. Review of Resident 371's MAR for December 2023 failed to show documented evidence the hydrocodone-acetaminophen medication was administered on 12/4 to Resident 371. Further review of Resident 371's MAR failed to show if Resident 371's pain level was assessed before and after the narcotic medication was administered and if the non-pharmacological interventions were provided prior to the administration of the medication. RN 2 verified the above findings. (continued on next page)

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	03/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 3/20/25 at 1030 hours, a medication cart inspection for Medication Cart B was conducted with the IP. The IP verified the Controlled Drug Record for Resident 3's hydrocodone-acetaminophen 5-325 mg showed the medication was signed out on 3/13 (March 13, no year was documented) at 1900 hours, and on 3/18 (March 18, no year was documented) at 0800 hours. Review of Resident 3's MAR for March 2025 failed to show documented evidence the hydrocodone-acetaminophen medication was administered on the above dates and times to Resident 3. Further review of Resident 3's MAR failed to show if Resident 3's pain level was assessed before and after the narcotic medication was administered and if the non-pharmacological interventions were provided prior to the administration of the medication. The IP verified the above findings. Medical record review for Resident 3 was initiated on 3/20/25. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 1/30/25, showed Resident 3 had episodes of confusion and had arthritis (pain, stiffness and swelling of the joints), neuropathy (nerve pain), and dementia (loss of memory, language, problem-solving and other thinking abilities). 2. Medical record review for Resident 43 was initiated on 3/19/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 2/11/25, showed Resident 43 had fluctuating capacity to understand and make medical decisions. The H&P examination also showed Resident 43 had diabetes (high blood sugar). Review of Resident 43's plan of care showed a care plan problem addressing Resident 43's insulin injections. The interventions included to rotate the injection sites when administering the insulin medication. However, review of Resident 43's Location of Administration Report for March 2025 for Resident 43's insulin injection showed the injection sites were not rotated on the following dates and times: - on 3/8/25 at 1125 hours, the insulin medication was administered to the LUQ of the abdomen. - on 3/9/25 at 1115 hours, the insulin medication was administered to the LUQ of the abdomen. - on 3/13/25 at 1132 hours, the insulin medication was administered to the RLQ of the abdomen. - on 3/13/25 at 1605 hours, the insulin medication was administered to the RLQ of the abdomen. - on 3/14/25 at 0534 hours, the insulin medication was administered to the LUQ of the abdomen. - on 3/14/25 at 1144 hours, the insulin medication was administered to the LUQ of the abdomen. - on 3/19/25 at 1648 hours, the insulin medication was administered to the LLQ of the abdomen. - on 3/20/25 at 1148 hours, the insulin medication was administered to the LLQ of the abdomen. (continued on next page)

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	03/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48882 3. Review of the facility's P&P titled Administering Medications revised 4/2019 showed medications are administered in accordance with the prescriber orders, including any required time frame. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. According to the National Library of Medicine, low-dose chewable aspirin (nonsteroidal anti-inflammatory medication) should be chewed or crushed completely before swallowing. Do not swallow the tablets whole. Medical record review for Resident 113 was initiated on 3/18/25. Resident 113 was admitted to the facility on [DATE]. On 3/18/25 at 0900 hours, a medication administration observation for Resident 113 was conducted with LVN 5. LVN 5 prepared and administered the following medications to Resident 113: - one fluid ounce of Prostat (supplement) 17 gm; - one tablet of aspirin chewable 81 mg; - one tablet of memantine (dementia medication) 10 mg; and - one tablet of multivitamin with mineral (supplement). During the medication administration observation, LVN 5 was observed handing Resident 113 one tablet of aspirin chewable 81 mg. Resident 113 was observed swallowing the aspirin chewable medication and then drinking juice. LVN 5 was not observed instructing Resident 113 to chew the aspirin chewable tablet. On 3/18/25 at 0917 hours, an interview and concurrent medical record review for Resident 113 was conducted with LVN 5. LVN 5 verified she did not instruct Resident 113 to chew the aspirin chewable medication during the medication administration observation. LVN 5 stated Resident 113 was able to follow simple commands; however, in the past, Resident 113 was not able to follow the instruction to chew the aspirin tablets. LVN 5 stated the physician had been informed. When asked to show the documentation showing the physician was informed or to show the physician's order to continue to administer the aspirin chewable medication despite the resident being unable to chew the aspirin medication, LVN 5 was unable to provide the documentation. On 3/24/25 at 1033 hours, an interview was conducted with the DON. The DON stated the medications should be administered as ordered by the physician, following the right time, dose, and route. The DON stated for the administration of the aspirin chewable medication, the licensed nurse should instruct the resident to chew the aspirin medication. The DON further stated if the resident was unable to chew the aspirin chewable medication, the licensed nurses were expected to attempt to coach the resident to chew the medication; and if unsuccessful, the licensed nurse should inform the physician to clarify the order to a more appropriate form of the aspirin medication and to document the physician notification and order clarification in the resident's medical record. (continued on next page)

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	03/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 1321 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 50967 4. Review of the facility's P&P titled Administering Medications revised on 4/2019 showed the individual administering the medication records in the resident's medical record the date and time the medication was administered and the signature and title of the person administering the drug. Medical record review for Resident 36 was initiated on 3/19/25. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 36's MDS assessment dated [DATE], showed Resident 36's BIMS score was 13, indicating cognitively intact. Review of Resident 36's Order Summary Report dated 3/19/25, showed a physician's order dated 11/21/24, to administer famotidine 20 mg by mouth one time a day for gastroesophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus) before breakfast. Review of Resident 36's MAR for March 2025 showed missing documentation for the administration of the famotidine 20 mg medication on 3/2/25, which was scheduled at 0630 hours. On 3/21/25 at 1115 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the missing documentation for the famotidine medication on 3/2/25. When asked about the expectation regarding the medication administration with the licensed nurses, the DON stated the licensed nurses must pour (prepare the medication), pass (administer the medication) and then sign the MAR. Furthermore, the DON stated she would check which licensed nurse was assigned to administer Resident 36's famotidine on 3/2/25. Review of Resident 36's Medication Administration Audit Report for the famotidine 20 mg medication scheduled on 3/2/25 at 0630 hours, showed LVN 8 documented the medication as administered on 3/21/25 at 2330 hours. On 3/24/25 at 1443 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 47476 5. Review of the facility's P&P titled Diabetes - Clinical Protocol revised 9/2017 showed the physician will order the desired parameters for monitoring and reporting information related to blood sugar management. The facility staff will incorporate such parameters into the Medication Administration Record and care plan. Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in accordance with the prescriber orders. (continued on next page)

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	03/24/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 47 was initiated on 3/17/25. Resident 27 was readmitted to the facility on [DATE], with a diagnoses of diabetes mellitus. Review of Resident 47's Order Summary Report dated 3/20/25, showed a physician's order dated 12/28/24, to administer insulin glargine (used to lower blood sugar) 27 units subcutaneously (into the fatty tissue) at bedtime for diabetes mellitus. Review of Resident 47's MAR from February and March 2025 showed the insulin glargine was held on the following days: - dated 2/5, 2/7, 2/9, 2/10, 2/11, 2/13, 2/21, 2/23, and 2/24/25, because the vitals were outside of the parameters for administration; - dated 3/3, 3/4, 3/5, 3/8, 3/12, and 3/15/25, because the vitals were outside of the parameters for administration; and - dated 3/16/25, with a hold/see progress note entry. Further review of Resident 47's medical record failed to show any progress notes to indicate why the insulin glargine was held or if the physician was contacted. On 3/24/25 at 1103 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was informed and verified the above findings. RN 2 stated she did not know why the insulin medication was held on the above dates. RN 2 stated there should be a physician's order for the parameters when to hold the medication. On 3/24/25 at 1238 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated there was no physician's order for the parameters for the insulin medication for Resident 47 and she would need to clarify the order with the doctor. On 3/24/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.

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	03/24/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the medications were stored appropriately as evidenced by: * Resident 371's pack of hydrocodone-acetaminophen tablets was stored inside IV cart after the resident discharged . * Four Calmoseptine ointments (a multipurpose, over-the-counter ointment containing menthol and zinc oxide, used to treat and prevent minor skin irritations like diaper rash, burns, cuts, scrapes, and skin irritation from moisture or irritants) without expiration date were stored inside the treatment cart. * Two bins used to dispose medications were unlocked with insulin pens inside. * A bottle of Pro-stat Advanced Wound Care (supplement) was observed with sticky brown residue on and around the cap and bottle. These failures had the potential for diversion of medications and for the residents to experience adverse effects. Findings: 1.a. On 3/20/25 at 0829 hours, an observation of the IV cart and concurrent facility document review was conducted with RN 2. RN 2 verified there was a pack of hydrocodone-acetaminophen 5-325 mg tablets stored in the IV cart. Review of the facility's Controlled Drug Record stored inside the IV cart showed on 12/4 (December 4, no year was documented), one tablet was signed out for Resident 371. The medication label for the hydrocodone-acetaminophen showed a fill date of 12/4/23. Review of Resident 371's medical record with RN 2 showed Resident 371 was admitted to the facility on [DATE], and discharged from the facility on 2/29/24. RN 2 verified the findings and acknowledged the medication should have been given to the DON for destruction. Cross reference to F755, example #1.a. b. On 3/20/25 at 0907 hours, a treatment cart inspection was conducted with LVN 9. LVN 9 verified four Calmoseptine ointments stored inside the treatment cart did not have expiration dates or received dates on them. LVN 9 stated the ointments were to be kept for three years from the receive date. LVN 9 acknowledged the ointments should not have been kept inside the cart since the receive date was unknown. (continued on next page)

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	03/24/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 3/18/25 at 1441 hours, a medication room inspection was conducted with RN 2. Two disposal bins used for medications disposal were unlocked and contained multiple undissolved tablets, sharps containers, liquid medication bottles, nasal spray containers, and insulin pens. RN 2 verified the findings. 48882 3. Review of the facility's P&P titled Medication Labeling and Storage revised 2/2023 showed the nursing staff was responsible for maintaining the medication storage and preparation areas in a clean, safe, and sanitary manner. On 3/18/25 at 0908 hours, during the medication administration observation for Resident 113 with LVN 5, a bottle of Pro-Stat Advanced Wound Care was observed with sticky brown residue on and around the bottle cap and on the bottle. LVN 5 verified the above findings and stated the bottle of Pro-Stat should be wiped and cleaned after each use and before it was placed back inside the medication cart. On 3/24/25 at 1033 hours, an interview was conducted with the DON. The DON stated the licensed nurses assigned to the medication carts were responsible for the cleanliness, storage, and labeling of the medications inside their assigned medication carts. The DON further stated for the dispensing of the liquid medications, the licensed nurses were expected to clean the medication bottles to ensure there were no stickiness or residue prior to placing the medication bottle back in the medication cart. On 3/24/25 at 1321 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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	03/24/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47476 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menus were followed for 20 of 93 residents who received food prepared in the kitchen as evidenced by: * 19 residents who were on a CCHO diet were served the canned fruit instead of the diet gelatin with whip topping as shown on the posted menu. * Resident 87 was not served the gelatin with whipped topping as per the menu. These failures had the potential for the residents to not receive an adequate nutrition and appropriate servings to meet the residents' individual needs. Findings: Review of the facility's Diet Type Report dated 3/17/25, showed 93 of 96 residents residing in the facility received food prepared in the kitchen and 19 of the 96 residents had a CCHO diet. Review of the facility's P&P titled Menus revised 10/2017 showed menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal. Copies of the menus are posted in at least two resident areas, in positions and in print large enough for residents to read them. Review of the facility's P&P titled Substitutions revised 4/2007 showed all substitutions are noted on the menu and filed in accordance with established dietary policy. Review of the facility's document titled Spring Cycle Menus - Week 3 Monday 3/17/25, showed the residents on a regular, mechanical soft diet would be served the gelatin with whipped topping. The document also showed the residents on a CCHO diet would be served the diet gelatin with whipped topping. During the lunch dining observation on 3/17/25 at 1225 hours, an observation and concurrent interview was conducted with CNA 6 for Residents 55 and 87. The following was observed: - Resident 55's meal ticket showed the resident was to receive a regular CCHO diet. Resident 55's was not observed with the diet gelatin with whipped topping dessert. Resident 55 was instead served canned fruit. - Resident 87's meal ticket showed the resident was to receive a regular mechanical soft diet. Resident 87 was not observed with the gelatin with whipped topping dessert. Following the observations, CNA 6 was asked about Residents 55 and 87's missing gelatin with whipped topping dessert per the menu. CNA 6 verified Residents 55 and 87 were not served the gelatin with whipped topping dessert and would need to ask the kitchen staff. (continued on next page)

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	03/24/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 1227 hours, a follow-up observation and concurrent interview was conducted with CNA 6. CNA 6 returned from the kitchen and stated Resident 55 could not have the gelatin because she was on a CCHO diet, but Resident 87 could have it and CNA 6 proceeded to provide Resident 87 with the dessert. On 3/17/25 at 1228 hours, an interview was conducted with the DSS. The DSS stated the facility gave the residents on a CCHO diet canned fruit because the facility did not have the diet gelatin with whipped topping. The DSS stated the facility did not change the menu. The DSS stated he would notify the residents with a note on their meal ticket, but did not get a chance to note it and did not notify the residents of the menu change. On 3/24/25 at 1310 hours an interview was conducted with the DSS and RD. The DSS and RD acknowledged the above findings.

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	03/24/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, and facility document review, the facility failed to ensure the residents received food with preserved nutritive content and palatibility as evidenced by: * The pureed carrots were cooked and held in a hot oven for more than two hours prior to the meal service. This failure had the potential to not meet the nutritional needs for the residents consuming food prepared in the kitchen. * The facility failed to ensure the facility food was palatable when one of 93 final sampled residents (Resident 94) and one nonsampled resident (Resident 57) who received food prepared in the facility kitchen were not satisfied with the facility food. This failure had the potential for the 4 residents to have decreased intake which could lead to unplanned weight loss and other medically related concerns. Findings: 1. Review of the facility's Diet Type Report dated 3/17/25, showed 93 of 96 residents residing in the facility received food prepared in the kitchen and 11 of the 96 residents received pureed food. Review of the facility's document titled Diet Type Report dated 3/17/25, showed 11 residents were on pureed diets. Review of the professional reference titled How Cooking Affects the Nutrient Content of Foods dated 11/7/19, showed the following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxine (B6), folic acid (B9), and cobalamin (B12), fat-soluble vitamins: vitamins A, D, E, and K, and minerals: primarily potassium, magnesium, sodium, and calcium . https://www.healthline.com/nutrition/cooking-nutrient-content. Review of the facility's document titled Meal Times showed the following: breakfast starting at 0715 hours, lunch starting at 1155 hours, and dinner starting at 1725 hours. On 3/18/25 at 0923 hours, an observation of the pureed food preparation and concurrent interview was conducted with [NAME] 1 with translation provided by the DSS. [NAME] 1 was assigned to puree the cooked carrots and followed the pureed vegetables recipe. [NAME] 1 placed the pureed vegetables into a metal serving container, covered with a plastic wrap, and labeled it. On 3/18/25 at 1131 hours, an observation of the kitchen trayline was conducted. The temperature of the pureed carrots on the steam table was 172 degrees F. During the trayline, the DSS was asked where the pureed foods were kept. The DSS stated the cook put all the pureed foods in the oven for holding and the oven was at 200 degrees F. (continued on next page)

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	03/24/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 1600 hours, an interview was conducted with the RD. The RD verified the carrots were cooked prior to the pureed preparation observation. The RD was informed the pureed food preparation was completed at 0945 hours and the pureed carrots had been held in the hot 200 degree F oven until the trayline at 1130 hours. The RD acknowledged the findings. When asked if the pureed carrots could lose nutritive value from being prepared two hours ahead of trayline and held in the oven at 200 degrees F, the RD stated it was not about when it was prepared, but how it was prepared and they did not lose the nutritive value. On 3/24/25 at 1310 hours an interview was conducted with the DSS and RD. The DSS and RD acknowledged the above findings. 48882 2. Review of the facility document titled Weekly Menu Guide, showed for lunch on Monday 3/17/25, the menu was: vegetable rice, soup, corned beef, boiled dill potatoes, cabbage and carrots, wheat roll, and gelatin with whipped topping. Medical record review for Resident 94 was initiated on 3/17/25. Resident 94 was admitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 11/27/24, showed Resident 94 had the capacity to understand and make decisions. Review of Resident 94's Order Summary Report showed a physician's order dated 11/28/24, for a no added salt diet with regular texture, regular liquid consistency, and double portions for malnutrition and advanced age. Review of Resident 94's MDS assessment dated [DATE], showed Resident 94 had no impairment in functional limitation in the upper extremities and was able to eat independently. On 3/17/25 at 1316 hours, an observation and concurrent interview was conducted with Resident 94 and LVN 1 in Resident 94's room. Resident 94 was observed attempting to cut into the corned beef on her lunch plate. Resident 94 was observed moving the knife back and forth and was unable to cut the corned beef into smaller pieces. Resident 94 stated the meat was too tough and that she could not cut into it. Resident 94 informed LVN 1 the corned beef was too tough, and she could not cut the meat. LVN 1 asked Resident 94 if she would like another lunch tray. Resident 94 requested for LVN 1 to bring her the food brought to the facility by her visitors. 3. On 3/18/25 at 1050 hours, during the resident council meeting, Resident 57 stated the corned beef served during the lunch meal on 3/17/25 was hard and she was unable to chew the meat; and Resident 79 stated the corned beef was tough and she was unable to cut the meat. On 3/18/25 at 1409 hours, an interview was conducted with the DSS. The DSS was asked if he was aware of any resident's complaints of the toughness of the corned beef served for lunch on 3/17/25. The DSS stated on 3/17/25, Resident 425 had approached him in the hallway and had complained about the corned beef being tough. Additionally, the DSS stated he was informed by the nurse that Resident 94 had complained about her corned beef being tough. The DSS further stated both Residents 94 and 425 were offered alternatives. (continued on next page)

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	03/24/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 1404 hours, an interview was conducted with CNA 6. CNA 6 stated on 3/17/25, she was in the dining room assisting the residents with their lunch meal. CNA 6 stated there were multiple residents who had reported to her that the corned beef was tough and chewy. CNA 6 stated multiple residents had requested for alternative entrees. CNA 6 further stated she had assisted some of the residents to cut their corned beef into smaller pieces and agreed the corned beef was tough to cut into. On 3/24/25 at 1321 hours, an interview was conducted with the RD and DSS. The RD and DSS were informed and acknowledged the above findings. On 3/24/25 at 1321 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings

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	03/24/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47476 Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure the residents on mechanically altered diets received food in a form that met their individual needs. * One of 11 residents (final sampled resident, Resident 3) who had physician's orders for a regular pureed diet received a regular dysphagia mechanical soft diet. * The pureed BBQ chicken was observed with small chunks of chicken. These failures posed the risk for complications such as choking for the 11 residents who were on pureed diets. Findings: Review of the facility's Diet Type Report dated 3/17/25, showed 93 of 96 residents residing in the facility received food prepared in the kitchen. Review of the facility's document titled Diet Type Report dated 3/17/25, showed 11 residents were on pureed diets. Review of the facility's P&P titled Therapeutic Diets revised 10/2017 showed therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care in accordance with his or her goals and preferences. Review of the facility's document titled Regular Pureed Diet dated 2023 showed the pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape. All foods are prepared in a food processor or blender. 1. During the lunch dining observation on 3/17/25 at 1204 hours, LVN 7 and CNA 5 were observed checking the trays on the meal cart. LVN 7 checked the facility document titled Diet Type Report, then checked the meal on the tray. Resident 3 was served a regular dysphagia mechanical soft meal. Resident 3's meal ticket stated her diet was for regular dysphagia mechanical soft. On 3/17/25 at 1218 hours, an observation of Resident 3 and concurrent interview was conducted with LVN 7, Resident 3 no longer had a regular dysphagia mechanical soft meal and was served a pureed diet instead. LVN 7 stated she changed Resident 3's meal tray because the Diet Type Report showed she should have a regular pureed diet. LVN 7 was unable to state why Resident 3's meal ticket showed a different diet than the Diet Type Report. LVN 7 stated she would have to ask her charge nurse about the correct diet. On 3/17/25 at 1226 hours, an observation and concurrent interview was conducted with Resident 3. Resident 3 stated she did not know why her meal was changed, but the pureed diet did not taste good. (continued on next page)

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	03/24/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 1228 hours, an interview and concurrent facility document review was conducted with the DSS. The DSS stated they would go by the Diet Type Report for the resident's diet. The DSS verified Resident 3 should have not been served the regular mechanical soft diet as per her meal ticket. On 3/18/25 at 1000 hours, am interview was conducted with the ST. The ST stated she had updated Resident 3's diet to a mechanical soft diet on Friday, but something happened on the EHR and the physician's order was not updated. 2. Review of the facility document titled Spring Cycle Menus - Week 3 Tuesday 3/18/25, showed the residents on pureed diets were to receive pureed BBQ chicken. On 3/18/25 at 0923 hours, an observation of the pureed preparation was conducted with [NAME] 1 with translation provided by the DSS. [NAME] 1 had pre-prepared 15 portions of regular BBQ chicken in a pan. [NAME] 1 was observed to use a Robot Coupe blender to blend the whole pieces of BBQ chicken in two separate batches. Once each batch was blended, she placed the pureed chicken into a pan. The pan with the completed BBQ chicken puree was observed with small chunks of chicken throughout the puree. [NAME] 1 then covered and labeled the pureed BBQ chicken. After the pureed food preparation was completed with [NAME] 1 on 3/18/25 at 0945 hours, the pureed BBQ was observed with the DSS. The DSS acknowledged there were small chunks of chicken still in the pureed BBQ chicken and stated they would blend it more.

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	03/24/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure proper labeling and dating of foods in the kitchen and failed to ensure the expired food items in the kitchen were discarded. * The facility failed to ensure the kitchen equipment were in good condition. * The facility failed to ensure proper labeling and dating of foods in the refrigerator used for the residents' food brought in by visitors and failed to ensure the expired foods were discarded. * The facility failed to ensure the microwave used to warm up the residents' food brought in from the outside was maintained in sanitary condition and free of food residue. * The facility failed to ensure the kitchen staff correctly tested the chemical concentration measured in parts per million for the quaternary sanitizing solution used to sanitize food contact surfaces. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's Diet Type Report dated [DATE], showed 93 of 96 residents residing in the facility received food prepared in the kitchen. 1. Review of the facility's P&P titled Food Receiving and Storage revised ,d+[DATE] showed the section titled Refrigerated/Frozen storage, all the foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Review of the facility's P&P titled Foods Brought by Family/Visitors revised ,d+[DATE] showed the foods, beverages, or perishable food that requires refrigeration can be stored for the resident in the facility designated residents' refrigerator. On [DATE] at 755 hours, an initial tour of the kitchen was conducted with the RD. a. In the walk-in refrigerator, the following was observed: - a pack of unpasteurized Lucerne cage free eggs labeled with the name and room number of Resident 423. There were eight eggs left in the container; - one container of sour cream without a use-by date; (continued on next page)

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 03/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- two pans of jello without a use-by date; - a container of buttermilk ranch dressing with an open date of [DATE]. There was dried whitish sticky residue observed on the container and no use-by date; - a container filled with seven pre-prepared sandwiches with a prepared date of [DATE] and unreadable use-by date; - a bag of sliced ham without a use-by date; - a container filled with six ground beef packets with a pulled date of [DATE] and a use-by date of [DATE]; and - a container filled with three ground beef packs and one ground turkey pack with a pulled date of [DATE], and a use-by date of [DATE]. The RD verified the findings and stated he would throw out the sandwiches and ground meats. The RD verified the items should be labeled with the date and use-by date. b. In Freezer 1, the following was observed with the DSS: - five packs of frozen waffles, without a label. The DSS verified the findings. c. On the counter directly adjacent to Freezer 1, a container with two peanut butter jelly sandwiches was observed with a prepared date of [DATE] and use-by date of [DATE]. The DSS verified the findings. d. The juice machine was observed with four juice containers hooked up. The four juice containers were observed without labels. The DSS verified the findings and stated the kitchen staff would change out all the juices. e. In Freezer 2, the following was observed: - one bag of corn on the cob without a label. The DSS verified the findings. 2. According to the USDA Food Code 2022 Section ,d+[DATE].11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. (continued on next page)

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	03/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Sanitization revised ,d+[DATE] showed all utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and shipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. a. On [DATE] at 0820 hours, during the initial tour in the kitchen conducted with the DSS, the plate lowerator was observed to have two loose handles. Additionally, there was dried food debris observed on the bottom panels of the plate lowerator. The DSS verified the findings. b. On [DATE] at 0904 hours, the can opener was observed with a chipped stainless-steel coating, exposing the blade. The DSS verified the findings and stated the kitchen staff would replace the blade. c. On [DATE] at 0904 hours, two upper plate domes were observed with warped and corroded areas. On [DATE] at 1310 hours, the DSS and RD were informed and acknowledged the findings. 3. Review of the facility's P&P titled Food Receiving and Storage revised ,d+[DATE] showed under the section titled Foods and Snacks Kept on Nursing Units, all foods belonging to residents are labeled with the resident's name, the item and the use-by date. Other opened containers are dated and sealed or covered during storage. Review of the facility's P&P titled Foods Brought by Family/Visitors revised ,d+[DATE] showed perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name and the received date. The leftover foods may be kept in the refrigerator per the resident's request, the staff will wrap the leftover container/or food in a plastic bag, then label with name, date and disposed of within 72 hours. Prepared or perishable food if stored in the refrigerator must be disposed of within three days. On [DATE] at 0828 hours, an observation of the residents' refrigerator was conducted with the DSS. The following was observed: - a plastic wrapped box labeled for Resident 94 with a date of [DATE], without a use-by date; - a plastic bag labeled with Resident 89's name, containing an opened container of sour cream undated; - orange containers with food inside wrapped in plastic labeled with Resident 94's name and undated; - an opened package of sliced pepper jack cheese for Resident 51, labeled with his name and undated; - a plastic bag labeled with Resident 95's name and dated [DATE], without a use-by date. The plastic bag contained two containers of partially eaten leftovers. (continued on next page)

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	03/24/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DSS verified the above findings. 4. According to the USDA Food Code 2022 Section ,d+[DATE].11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On [DATE] at 0830 hours, an observation of the residents' microwave was conducted with the DSS. The residents' microwave was observed with spots of dried and crusted brown residues on the walls of the microwave. The DSS verified the findings and stated it was not clean. The DSS stated the housekeeping staff would clean it. 5. Review of the facility's P&P titled Sanitation revised ,d+[DATE] showed the manual washing and sanitizing is a three-step process for washing, rinsing and sanitizing. The chemical sanitizing solutions are used according to manufacturer's instructions. Review of the manufacturer's guidelines for the quaternary sanitizer testing showed testing instructions to withdraw and tear off approximately two inches of paper from dispenser. Dip the paper for 10 seconds and don't shake. In addition, the testing solution should be between 200 - 400 parts per million (ppm). On [DATE] at 0854 hours, an observation and concurrent interview was conducted with the Dietary Aide regarding the facility's manual ware washing. The Dietary Aide was asked to demonstrate how he tested the chemical sanitizing solution. The Dietary Aide was observed filling up a red bucket with the sanitizing solution and obtaining a strip of test paper. The Dietary Aide dipped the strip into the red bucket for one second, read the strip, then stated it was at 200 ppm. The Dietary Aide verified he dipped the test strip in the sanitizing solution for one second. The Dietary Aide verified the strip should be dipped for 10 seconds. On [DATE] at 1310 hours, an interview was conducted with the DSS and RD. The DSS and RD acknowledged all of the above findings.

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	03/24/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 47476 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the education on safe food handling of outside food was provided to the staff, residents, and visitors. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from the outside sources. Findings: Review of the facility's P&P titled Foods Brought by Family/Visitors revised 12/2023 showed the residents, residents' representatives, families, and visitors will be educated on the facility's food policy including safe food handling of foods brought from outside. The educational material on food handling and safety will be available at the reception desk. The Admission Coordinator or designee will review the food policy with emphasis on safe food handling to the resident, and/or representative during initial admission agreement packet review. On 3/19/25 at 1336 hours, an interview was conducted with CNA 2. CNA 2 stated she had the residents who brought in food from the outside. CNA 2 stated she would microwave the food, if the resident requested, in the resident microwave. When asked if she heated it to a specific temperature, CNA 2 stated she would microwave the food for 30 seconds to a minute and would not make it too hot so the resident would not burn themselves. CNA 2 stated the DSD provided in-service about safe food handling. On 3/20/25 at 0814 hours, an interview was conducted with CNA 3. CNA 3 stated she had the residents who brought in food from the outside. CNA 3 stated she did not know any information about safe food handling but would let the resident ate the food at one time and would throw the leftovers away. When asked if she heated the foods in the microwave to a specific temperature, CNA 3 stated she would microwave the food for one half to one minute and no more than that because it would be too hot for the resident. CNA 3 stated she did not know how to check the temperatures of the food. CNA 3 stated the DSD provided in-service about safe food handling. On 3/20/25 at 0824 hours, an interview was conducted with CNA 4. CNA 4 stated he had the residents who brought in food from the outside. When asked how he reheated foods, CNA 4 stated he would ask how hot the resident wanted it and the resident would tell him how long to microwave for. CNA 4 stated he would check the temperature by putting the back of his hand on it. CNA 4 was asked what he knew regarding safe food handling. CNA 4 stated he did not know much and has not had education from the facility for safe food handling. On 3/20/25 at 0829 hours, an interview was conducted with LVN 6. LVN 6 stated for safe food handling, they would make sure the food was clean and not contaminated. When asked what she taught to the residents or visitors who brought food from the outside, LVN 6 stated she would make sure the resident was not allergic to the food and would store the food for only 24 hours. When asked about food temperatures, LVN 6 stated she could not put the food in the refrigerator right away because it was warm and would wait 30 min or an hour. (continued on next page)

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	03/24/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 0838 hours, an interview and concurrent facility P&P review was conducted with the DSD. The DSD stated he provided in-services to the CNAs and charge nurses for food brought in from the outside by going over the facility policy titled Foods Brought by Family/Visitors. The DSD stated he would teach the staff that the food needs to be labeled with the date, after 72 hours they would discard the food, and would tell them if the food was opened, they could not put it back into the refrigerator to prevent infection. When asked what education was provided regarding the safe food handling, the DSD verified he did not provide education specific to safe food handling. On 3/20/25 at 0846 hours, an interview was conducted with RN 2. RN 2 was asked about the safe food handling of the foods brought in from the outside. RN 2 stated she would teach the resident/visitors to wash their hands and when they wanted to microwave the food, to give it to the staff and a CNA would help to microwave the food. RN 2 stated she would make sure the food was labeled with the name, room number, and time and after three days, it would be thrown away. RN 2 stated safe food handling education was provided by the kitchen and DSD. On 3/20/25 at 0853 hours, an interview, concurrent facility document and facility P&P review was conducted with the RD. The RD stated he had not yet given any in-services to the staff outside of the kitchen. When asked about the safe food handling education provided, the RD verified he did not provide safe food handling education to the visitors/family but would do it upon request. The facility educational material on food handling and safety located at the reception desk was reviewed with the RD. The RD verified the educational material did not have any information on safe food handling. On 3/20/25 at 0900 hours, an interview and concurrent facility P&P review was conducted with the Admissions Director. The Admissions Director stated upon admission, she would provide the policy titled Foods Brought by Family/Visitors and the policy titled Reheating Food Brought in for a Resident (which did not show any information regarding safe food handling). The Admissions Director stated she would let the family know if the resident was on a specific diet, they would need to check with the dietician so they would not bring anything that would harm the resident and if there was food that could be stored, would only hold it for 72 hours and would dispose of the food if not consumed. When asked about teaching regarding safe food handling, the Admissions Director verified she only provided the two policies, and she did not provide information specific to safe food handling. On 3/24/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the findings.

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	03/24/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. Resources necessary to care for residents including weekends; 3. A plan to maximize recruitment and retention of direct care staff; and 4. A contingency plan for staffing needs. This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 3/24/25 at 0826 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment was dated 1/16/25, and acknowledged he was not aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care staff, direct care representatives, residents, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no resources necessary to care for the residents including weekends, and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.

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	03/24/2025

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35346 Based on interview and facility document review, the facility failed to ensure the documentation on the Quality Control Log was accurate for one of four medication carts. This failure had the potential for not knowing if the documented blood sugars for the residents were accurate. Findings: On 3/20/25 at 0815 hours, an interview and concurrent facility document review was conducted with LVN 10. Review of the Quality Control Log showed the serial number labeled on the glucometer device did not match the serial number documented on the Quality Control Record. LVN 10 verified the findings.

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	03/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the facility's monthly Infection Prevention and Control Surveillance Log was accurate. * The facility failed to ensure the laundry staff did not reuse the dirty gowns. * The facility failed to ensure there were no facility staff's personal belongings in the extra clean linen cart. * The facility failed to ensure Resident 36 was placed on contact isolation precautions while the clostridum difficile (bacteria that causes diarrhea and inflammation of the colon) test was pending. In addition, Resident 36's shared toilet was observed with brown stains. * The facility failed to implement the EBP per the facility's P&P for Residents 421 and 423 with central lines (thin, flexible tube inserted into a large vein near the heart). * The facility failed to ensure CNA 3 doffed the gown after transferring Resident 52 from the bed to the chair and before coming in contact with Resident 1. * The facility failed to ensure LVN 6 followed the infection control protocols when LVN 6 was observed removing a box of tissue from Resident 78's bedside table and placing the box of tissue on Resident 1's bedside table. Resident 78 was on EBP. These failures posed the risk for not identifying infections and controlling the transmission of communicable diseases to the other residents throughout the facility. Findings: 1. Review of the facility's P&P titled Surveillance for Infections revised 9/2023 showed the facility employs an infection control surveillance program to help prevent to the extent possible the development and transmission of disease and infection. The IP (or designee), under the guidance of the Infection Control Committee and Medical Director shall be responsible to implement the surveillance program. Review of the facility's monthly Infection Prevention and Control Surveillance Log showed inaccurate documentation for the months of January and February 2025. The Meet McGeer Criteria (a set of specific definitions to identify true infections in long term nursing facilities) column on the Infection Prevention and Control Surveillance Log had nine N/A answers for January 2025 and four N/A answers for February 2025. (continued on next page)

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	03/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 0906 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the Meet McGeer Criteria column on the Infection Prevention and Control Surveillance Log had nine N/A answers for January 2025 and four N/A answers for February 2025. The IP stated the answer for the Meet McGeer Criteria column should be Yes or No. The IP further stated there was an error in generating the Excel (a spreadsheet software program) sheet. The IP stated if she had seen the N/A under the Meet McGeer Criteria column, she would have changed her answer from N/A to Yes. The IP stated the Infection Prevention and Control Surveillance Log should be accurate, so if another facility staff would look at the log, the facility staff would know if it was a true infection. On 3/20/25 at 0844 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated there was an error in answering the Meet McGeer Criteria on the surveillance log. The DON stated the IP should have corrected it immediately upon identification so it would not confuse the facility staff who would need to read and interpret the report. 2. Review of the facility's P&P titled Personal Protective Equipment revised 8/2024 showed the personal protective equipment appropriate to specific task requirements is available at all times. Section e showed gown use: iii. Re-use (over multiple days) and extended use (over multiple residents) of gowns are not allowed. On 3/19/25 at 1410 hours, an observation of the facility's laundry room and concurrent interview was conducted with the Housekeeping Manager. A laundry staff was observed removing her dirty gown and hanging the dirty gown in the middle of the two gowns and touching each other. Each hook for the dirty gown was labeled with the name of the facility's staff. The Housekeeping Manager verified the laundry staff's dirty gown was touching other used gowns of the laundry staff. The Housekeeping Manager stated the laundry staff used the gown about four times a day. The Housekeeping Manager further stated the laundry room did not have more space for the gown. The Housekeeping Manager stated the laundry staff washed the gown at the end of the shift for usage on the next day. On 3/19/25 at 1447 hours, an interview was conducted with Laundry Staff 1. Laundry Staff 1 verified she sorted the dirty linen, removed her gown and gloves, and hung the dirty gown in between two dirty gowns. Laundry Staff 1 stated she used the same gown four to five times a day. Laundry Staff 1 further stated she washed all the dirty gowns at the end of her shift. Laundry Staff 1 stated it would be better if the gowns were separated and not touching each other. Laundry Staff 1 stated the facility staff could use the disposable gown so the gown could used one time and thrown away. On 3/19/25 at 1546 hours, an interview was conducted with the IP. The IP acknowledged the above findings. The IP stated the dirty gowns should have been separated. The IP further stated the used gown should have been discarded and not reused. The IP stated if the gown was contaminated and it was touching the other gowns, the contamination could spread. 3. Review of the facility's P&P titled Departmental (Environmental Services)- Laundry and Linen revised 1/2014 showed the purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. Further review of the P&P showed the clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. (continued on next page)

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	03/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 1410 hours, an observation of the facility's laundry room and concurrent interview was conducted with the Housekeeping Manager. A personal lunch bag, jacket, and sweater were observed inside the extra clean linen cart in the laundry room. The Housekeeping Manager verified the laundry staff's personal lunch bag, jacket, and sweater were inside the extra clean linen cart. The Housekeeping Manager stated the laundry staff should store their personal belongings outside of the laundry room. The Housekeeping Manager stated the laundry staff stored their personal belongings in the extra clean linen cart because the locker was too far for the laundry staff. On 3/19/25 at 1546 hours, an interview was conducted with the IP. The IP acknowledged the above findings. The IP stated the personal belongings of the laundry staff might be dirty and it should have been kept in the laundry staff's locker room. The IP stated the personal belongings could cause cross contamination with the clean linen. On 3/21/25 at 1555 hours, the Administrator and DON were informed and acknowledged the above findings. 35346 4. Review of the facility's P&P titled Clostridium Difficile revised 10/2018 showed the residents with diarrhea and suspected clostridium difficile infections were placed on contact precautions while awaiting laboratory results. On 3/18/25 at 0853 hours, an interview was conducted with Resident 36. Resident 36 stated there were brown stains on the shared toilet inside her room. There was no posted signage on the resident's doorway for isolation precautions. Medical record review for Resident 36 was initiated on 3/18/25. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 12/8/24, showed Resident 36's diagnoses included dementia and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania). Review of Resident 36's physician's orders showed an order dated 3/15/25, to obtain laboratory test (collect stool) for the clostridum difficile. Further review of Resident 36's medical record showed Resident 36 had a history of clostridum difficile. On 3/18/25 at 1006 hours, an observation, interview, and concurrent medical record review was conducted with the IP. The IP verified Resident 36's shared toilet had brown stains on it. The IP reviewed Resident 36's medical record and verified Resident 36's laboratory result for the clostridum difficile was not in the resident's medical record. The IP verified Resident 36 had a loose bowel movement on 3/15/25. The IP verified there should have been posted signage outside of Resident 36's room to indicate the contact isolation precautions for Resident 36, while the clostridum difficile laboratory result was pending due to the resident's history of clostridum difficile. (continued on next page)

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	03/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	39670 5.a. Review of the facility's P&P titled Standard Precautions, Enhanced Barrier Precautions and Transmission Based Precautions revised 8/7/24, showed the residents with a medical device such as central/vascular catheters was considered a high risk of infection and would be placed on Enhanced Barrier Precaution to reduce the transmission of pathogens. During the initial tour of the facility on 3/17/25 at 1021 hours, Resident 421 was observed in bed. Resident 421 stated he had a surgery on both of his feet due to an infection. Resident 421 stated he had a PICC line on the right upper arm and showed his PICC line with the transparent dressing. The PICC line dressing was observed with a label dated 3/13/25. However, Resident 421 was not on EBP. There was no posted signage of the EBP and no PPE supply was observed. Medical record review for Resident 421 was initiated on 3/18/25. Resident 421 was admitted to the facility on [DATE]. Review of Resident 421's Order Summary Report dated 3/19/25, showed no documented evidence a physician's order was obtained for Resident 421's EBP related to his central line. b. During the initial tour of the facility on 3/17/25 at 1042 hours, Resident 423 was observed in bed. Resident 423 had a PICC line on the left upper arm with a transparent dressing. The transparent dressing was observed with a date label dated 3/13/25. However, Resident 421 was not on EBP. There were no posted signage of the EBP and PPE supplies. Medical record review for Resident 423 was initiated on 3/17/25. Resident 423 was admitted to the facility on [DATE]. Review of Resident 423's Order Summary Report dated 3/19/25, showed no documented evidence a physician's order was obtained for Resident 423's EBP related to the resident's central line. On 3/17/25 at 1324 hours, an observation and concurrent interview for Residents 421 and 423 was conducted with RN 1. RN 1 was asked about the facility's P&P for the residents who have a PICC lines. RN 1 stated the residents with a central line should be on EBP. RN 1 verified and acknowledged Residents 421 and 423 had PICC lines and were not placed on EBP. On 3/24/25 at 1347 hours, an interview and concurrent medical record review for Residents 421 and 423 was conducted with the DON. The DON was informed and verified the above findings. 48882 (continued on next page)

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	03/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 3/19/25 at 0827 hours, an observation and concurrent interview with CNA 3 was conducted in Room D. CNA 3 was observed wearing a gown and transferring Resident 52 (Resident 1's roommate) from the bed to the chair. After the transfer, CNA 3 was observed brushing Resident 52's hair. LVN 6 was observed in Room D attempting to remove Resident 1's layers of clothes, to obtain a blood pressure reading. LVN 6 was observed asking CNA 3 to assist her to remove Resident 1's sweater. CNA 3 was then observed removing her gloves, performing hand hygiene, and entering Resident 1's environment. CNA 3 was not observed doffing the gown. CNA 3 was then observed removing Resident 1's hat from her head and assisting Resident 1 to remove her right arm from her shirt sleeve. CNA 3 was asked about the protocol for the use of the gown in between residents and CNA 3 stated Residents 1 and 52 were not on isolation so the same gown could be used between the residents. LVN 6 was observed instructing CNA 3 to remove her gown and to don a new gown. On 3/19/25 at 1414 hours, an interview was conducted with the IP. The IP stated the facility staff were expected to adhere to the standard precautions when caring for the residents who were not on EBP. The IP stated the gowns were for single use for one resident only and the same gown should not be used between the residents. The IP stated the facility staff were expected to doff the gown, perform hand hygiene, and don a new gown before assisting another resident with care. On 3/24/25 at 1033 hours, an interview was conducted with the DON. The DON stated the gowns were used for each individual resident. The DON stated regardless of the isolation or precautions, when the facility staff donned a gown, the gown should be used when providing care for one resident only and the same gown should not be used between the residents. On 3/24/25 at 1321 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 7. Medical record review for Resident 78 was initiated on 3/19/25. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's Order Summary Report for March 2025 showed a physician's order dated 1/7/25, for the enhanced barrier precautions related to the resident's sacral pressure ulcer. On 3/19/25 at 0842 hours, a medication administration observation for Resident 1 was conducted with LVN 6. During the medication administration observation, LVN 6 was observed removing the box of tissues from Resident 78 (Resident 1's roommate)'s bedside table and placing the box of tissues on Resident 1's bedside table. LVN 6 was then observed grabbing a tissue and attempted to hand the tissue to Resident 1. LVN 6 was stopped and asked if Resident 78 was on any isolation precautions. LVN 6 stated Resident 78 was on EBP. LVN 6 was then observed asking the a facility staff to retrieve a new box of tissues for Resident 1. On 3/19/25 at 0921 hours, an interview was conducted with LVN 6. LVN 6 verified she removed the box of tissues from Resident 78's bedside table and placed the box of tissues on Resident 1's bedside table. LVN 6 stated Resident 78 was on EBP and everything in Resident 78's surroundings, including her bedside table were considered contaminated. LVN 6 stated there was a potential risk of transmission of organisms between the residents. (continued on next page)

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	03/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 1414 hours, an interview was conducted with the IP. The IP stated for the residents on standard precautions and cohorted in the same room as the residents on EBP, the facility staff were expected to adhere to the standard precautions when caring for non-EBP residents. The IP stated for the residents on EBP, their belongings or items in their environment should not be shared with the other residents in the room due to the risk of the potential transmission of organisms to the other residents in the room. On 3/24/25 at 1321 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	03/24/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to implement the antibiotic stewardship program. * The facility failed to ensure if the McGeer's criteria for true infection was completed and accurate for one of 20 final sampled residents (Resident 61) . This failure had the potential for inaccurately identifying true infections and potentially inhibiting residents from receiving the appropriate treatment and care. Findings: According to the CDC, antibiotics are some of the most commonly prescribed medications in nursing homes. Over the course of a year, up to 70% of nursing home residents get an antibiotic. Roughly 40% to 75% of antibiotics are prescribed incorrectly. In nursing homes, high rates of antibiotics are prescribed to prevent UTI and RTI. Prescribing antibiotics before there is an infection often contributes to misuse. Often residents are given antibiotics just because they are colonized with (carrying) bacteria that are not making the person sick. Prescribing antibiotics for colonization contributes to antibiotic overuse. When patients are transferred between facilities, for example from a nursing home to a hospital, poor communication between facilities about prescribed antibiotics (e.g., rationale, number of days) plus insufficient infection control practices can result in antibiotic misuse and the spread of antibiotic resistance. Antibiotic-related harms, such as diarrhea from C. difficile can be severe, difficult to treat, and lead to hospitalization s and deaths, especially among people over age 65. Review of the facility's P&P titled Antibiotic Stewardship revised 11/2019 showed to optimize the use of the antibiotics by improving prescribing practices and to reduce inappropriate antibiotic use. Section D showed the following Policy and Practice Change: - The facility has chosen to use guidelines developed by McGeer/Loeb and Stone and include newer surveillance information by McGeer/Loeb and Stone Criteria for initiation of antibiotics. The nurse will inform the physician of this prescribing protocol. - The SBAR will be utilized in conjunction with McGeer/Loeb and Stone guidelines to communicate with the physician when there is change of condition. Medical record review for Resident 61 was initiated on 3/19/25. Resident 61 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 61's H&P examination dated 2/27/25, showed the resident had no capacity to understand and make decisions. Review of Resident 61's View Radiology Report reviewed 2/3/25, showed Resident 61 had infiltrate in the left lung base and COPD. (continued on next page)

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	03/24/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 61's Order Summary Report showed a physician's order dated 2/3/25, to administer levofloxacin (antibiotic) oral tablet 500 mg medication one tablet by mouth one time a day for COPD/cough for seven days. Review of Resident 61's Infection SBAR - Respiratory Tract - Pneumonia dated 2/3/25, failed to show if the McGeer's criteria was met for true infection. Additionally, only two instead of three criteria were marked for the McGeer's criteria for Respiratory Tract- Pneumonia. On 3/19/25 at 0906 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified Resident 61's Infection SBAR - Respiratory Tract- Pneumonia form did not show if the McGeer's criteria was met or not met for true infection. The IP acknowledged three criteria must be present to be considered as met the McGeer's criteria for respiratory tract-pneumonia. The IP verified the licensed nurse documented only two out of the three criteria on Resident 61's Infection SBAR - Respiratory Tract-Pneumonia form. The IP stated the third criteria of acute function decline should have been marked as Resident 61 was noted with decline in function. The IP further stated the licensed nurse should have made a note in the SBAR whether the McGreer's criteria was met or not met. The IP stated she would confirm if it was met or not met after the licensed nurse completed the infection SBAR. On 3/20/25 at 0844 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have completed Resident 61's sign and symptoms to meet the McGeer's criteria. The DON stated the licensed nurse should have documented Resident 61 had met the criteria for signs and symptoms of pneumonia. On 3/21/25 at 1555 hours, the Administrator and DON were informed and acknowledged the above findings.