STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055570	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Healthcare Center	2800 N. Harbor Blvd. Fullerton, CA 92835

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure two of three sampled residents (Residents 1 and 3) attained and maintained the highest practicable physical well-being. * The facility to ensure Resident 1's nystatin external cream (a medicated cream used to treat fungal or yeast infections of the skin) was administered as per the physician's order. * The facility failed to ensure Resident 3's fluid restriction was followed as per the physician's order. These failures had the potential to negatively affect the residents' health condition and well- being.Findings: 1. Review of the facility's P&P titled Skin Assessment revised 5/2007 showed wound care/ treatment provided for the residents will be according to the physician's orders and documented in the resident's treatment administration record and/or in nursing progress notes or in the medication administration record if applicable. Medical record review for Resident 1 was initiated on 7/9/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Order Summary dated 6/20/25, showed a physician's order dated 5/20/25, to administer nystatin (antifungal cream) external cream 100000 unit/gm to the affected area topically twice a day. Review of Resident 1's H&P examination dated 6/26/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's TAR for June 2025 failed to show a documentation if the nystatin external cream was administered to the affected area as ordered on the following dates and time: - on 6/5 to 6/8/25, 6/13, 6/14, and 6/16/25 at 1700 hours, and- on 6/15/25 at 0900 and 1700 hours On 7/9/25 at 1213 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 1's TAR for June 2025 failed to show a documentation if the nystatin external cream 100000 unit/gm was administered as ordered on the dates listed above. LVN 2 stated the nurses should place their initials after the administration of the treatment as ordered by the physician. LVN 2 further stated if the treatment administration record was not initialed by the nurse, the treatment was not performed. On 7/10/25 at 0839 hours, an interview was conducted with the DON. The DON was informed of the findings. The DON stated the evening charge nurses should provide the skin treatment to their assigned residents. The DON further stated if the treatment was not documented, it meant the treatment was not administered as prescribed by the physician. 2. Review of the facility's P&P titled Fluid Restriction revised on May 2007 showed it is the policy of the facility to provide fluids as specified by the physician's order. Distribution of fluids will be determined by licensed nursing staff, dietary services supervisor, activities, social services and the resident. Fluid intake will be encouraged to meet minimum requirements as stated in the physician's orders. The dietary supervisor will ensure a care plan entry has been made. The total number of ml distribution among disciplines will be noted on the resident's care plan. The dietary services supervisor will divide the allotted total fluid amount for the dietary among the daily meal pattern and enter the specified amounts on the resident's dietary tray card. Medical record review for Resident 3 was initiated on 7/10/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's Order Summary showed a physician's order dated 6/20/25, for 1500 ml fluid restriction with the following breakdown: - morning shift: nursing 360 ml and dietary 240 ml; - evening shift: nursing 360 ml and lunch meal dietary 120 ml; and - night shift: nursing 180 ml, and dinner dietary 240ml. Review of Resident 3's H&P examination dated 6/23/25, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's plan of care failed to show the ml distribution for the total number or the amount of fluids per discipline per the facility P&P. On 7/10/25 at 0827 hours, an observation and concurrent interview of Resident 3 was conducted in the resident's room. Resident 3 stated she just had her breakfast. Resident 3 was observed in bed with one small and one tall empty plastic cup from the kitchen and one empty coffee mug. In addition, there was one open bottle (591 ml) of Vitamin Zero drink that was almost empty, and a purple water tumbler were on top of Resident 3's bedside table. On 7/10/25 at 0852 hours, an interview was conducted with CNA 2. When asked if Resident 3 was on fluid restriction, CNA 2 stated Resident 3 was not on fluid restriction. On 7/10/25 at 0854 hours, a follow-up interview was conducted with Resident 3. When asked if she was on fluid restriction, Resident 3 stated she did not know she was on fluid restriction. On 7/10/25 at 0938 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 3 had a physician's order for 1500 ml fluid restriction. RN 2 stated the fluids for the resident were measured using the medication cups. RN 2 stated she was not sure of how the bottle of Vitamin Zero and the water tumbler are being accounted for in the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to administer the parenteral fluids consistent with the professional standards of practice and in accordance with the physician orders when Resident 1's IV fluids was administered at 80 ml per hour, the facility failed to close the clamp and remove the IV container from the IV pole when the infusion was completed. In addition, the facility failed to ensure the IV solution was labeled with the date and time the IV solution was hung. These failures posed the risk for the resident to develop complications related to the use of the peripheral IV catheter.Findings: Review of the facility's P&P titled Administration of Intravenous (IV) Infusion Solution reviewed on July 2017 showed the intravenous medications/fluids must be administered in accordance with the written orders of the attending physician. The nurse hanging the IV solutions will label the bag with date, time, and initials. All administration sets should be labeled when hung with date, time, and nurse's initials. Administration sets should be changed as follows: Continuous peripheral set is changed every 48 hours. Review of the facility's P&P titled Changing Infusion Containers (undated) showed when the present container is empty close the roller clamp and remove the old container from the IV pole. Medical record review for Resident 1 was initiated on 7/9/25. Resident was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 6/26/25, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 1's Order Summary showed a physician's order dated 7/7/25, to administer dextrose 5% (D5) - sodium chloride 0.45 (1/2 NS - normal saline) solution use 60 ml intravenously once a day for hydration and nutrition until 7/8/25 at 2359 hours for 500 ml today. Review of Resident 1's IV MAR for July 2025 showed Dextrose 5% - sodium chloride solution use 60 ml intravenously once a day for hydration and nutrition was administered on 7/7/25 and 7/8/25. On 7/9/25 at 0828 hours, an observation of Resident 1 was conducted. An empty IV fluid hydration bag labeled D5 1/2 NS at 60 ml per hour without a date and time indicated was observed hanging in a pole. The D5 1/2 NS hydration bag was empty with air in the tubing from the bottom of the IV bag, the IV administration set tubing clamp was open and the infusion dial was set at 80 ml/hour. The IV hydration fluid bag was attached to Resident 1's IV access on the right hand. On 7/9/25 at 0839 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the empty bag of the IV fluid hydration labeled D5 1/2 NS at 60 ml per hour had no date and time indicated was still hanging in a pole. LVN 2 verified the IV fluid hydration bag had air in the tubing from the bottom of the IV bag, the IV administration set tubing clamp was open, and the administration dial was set at 80 ml/hour was attached to Resident 1's IV access on the right hand. LVN 2 stated she did not know when the D5 1/2 NS was hung but will find out. On 7/9/25 at 1608 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the D5-1/2 NS solution at 60 ml per hour intravenously was ordered for Resident 1. The DON was informed of the above findings. The DON stated she expected the nurses to label the IV fluid hydration bag and administration tubing set according to facility policy, and to administer the IV fluids as ordered by the physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary respiratory care and services were provided for two of three sampled residents (Residents 1and 2). * The facility failed to ensure Resident 1's Yankauer suction tubing was stored in a bag. * The facility failed to ensure Resident 2's nebulizer administration set-up was stored in a bag. These failures had the potential for the residents to have respiratory infections and negatively affect the residents' well-being. Findings: 1. Review of the facility's P&P titled Respiratory Equipment policy reviewed 7/2012 showed it is the policy of the facility to have cleaning and replacement schedule for the respiratory equipment to ensure patient's safety. Respiratory equipment replacement indicated to replace Yankauer suction and bag weekly. Medical record review for Resident 1 was initiated on 7/9/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 6/26/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Order Summary showed a physician's order dated 6/25/25, to suction as needed for increased oral secretions. On 7/9/25 at 0828 hours, an observation was conducted in Resident 1's room. Resident 1 had a suction machine on a bedside table. The Yankauer suction tip attached to the suction tubing was observed exposed to air and not enclosed in a bag. The Yankauer suction tip was placed on top of the suction canister with fluid. Additionally, the Yankauer suction tip and canister were undated. On 7/9/25 at 0839 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the Yankauer suction tip attached to the suction tubing was exposed to air, not enclosed in a bag and was placed on top of the suction canister with fluid. LVN 2 stated the Yankauer suction tip should be stored in a bag when not in use for infection control. LVN 2 removed the Yankauer suction tip and tubing to dispose. On 7/9/25 at 1608 hours, an interview was conducted with the DON. The DON was informed of the findings as above. The DON stated she expects the nurses to store the Yankauer suction tip in a bag after use and to change the Yankauer suction tip, tubing and bag every week with the date label. 2. Review of the facility's P&P titled Respiratory equipment policy reviewed 7/2012 showed it is the policy of the facility to have cleaning and replacement schedule for the respiratory equipment to ensure patient's safety. Respiratory equipment replacement schedule indicated to clean and replace small volume nebulizer tubing and bag weekly. Medical record review for Resident 2 was initiated on 7/9/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 7/7/25, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Order Summary dated 7/9/25 showed a physician's order dated 7/6/25 to administer the following medications: - acetylcysteine (a mucolytic, helps reduce the thickness of mucus) inhalation 2 ml inhale orally two times a day, - ipratropium albuterol solution (bronchodilators work by relaxing the muscles around the airways in the lungs, making it easier to breathe) 0.5-2.5 mg/ml 3 ml inhale orally two times a day, and - levalbuterol hydrochloride (medication used to treat or prevent breathing difficulties) inhalation nebulization solution 0.63 mg/3 ml inhale orally every 6 hours. On 7/9/25 at 0854 hours, an observation was conducted in Resident 2's room. Resident 2's nebulizer tubing was observed on top of the resident's nightstand and exposed to air. Additionally, the nebulizer tubing and storage bag were not labeled with a date to indicate when the set up was changed. On 7/9/25 at 0855 hours, an interview was conducted with Resident 2. Resident 2 stated she had a nebulizer breathing treatment before going to sleep last night. Resident 2 further stated the nurse left the nebulizer tubing uncovered when she completed her treatment last night. On 7/9/25 at 0857 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified the nebulizer tubing was left on top of the resident's nightstand which was exposed to air, and the nebulizer tubing and storage bag were not dated to indicate when the tubing was opened or changed. RN 1 stated the nebulizer administration set should be enclosed in a labeled bag for infection control. RN 1 further stated she will replace the nebulizer tubing and store it in a bag. On 7/9/25 at 1608 hours, an interview was conducted with the DON. The DON was informed of the findings. The DON stated she expected the nurses to store the nebulizer tubing in a bag after use, and to change the nebulizer tubing and bag every week with a date label.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for two of three sampled residents (Residents 2 and 3) were accurate. * The facility failed to ensure the documentation of the intake monitoring for Resident 2 were accurate. * The facility failed to ensure the documentation of the intake monitoring for Resident 3 were accurate. These failures had the potential for the residents' care needs not being met as their medical information were inaccurate.Findings: Review of the facility's P&P titled Intake and Output Documentation revised on February 2023 showed to measure and record all liquids taken by the resident on the intake and output monitoring. Records of enteral and IV intake may be recorded on the eMAR (electronic MAR) and all other intake and output. 1. Medical record review for Resident 2 was initiated on 7/9/25. Resident was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 7/7/25, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Order Summary dated 7/9/25, showed a physician's order dated 7/6/25, to monitor the intake every shift to include oral intake, enteral feeding and flush, IV fluids and IV antibiotics every shift for 30 days. Review of Resident 2's Task - Fluid Intake documented by the CNAs showed the amount of the resident's fluid intakes for the following dates and times: - dated 7/7/25 at 0338 hours = 120 ml, 1459 hours = 840 ml, and 2053 hours = 450 ml- dated 7/8/25 at 0307 hours = 300 ml, 1323 hours = 1480 ml, and 1958 hours = 600 ml- dated 7/9/25 at 0648 hours = 400 ml, and 1305 hours = 500 ml Review of Resident 2's MAR for fluid intake documented by the licensed nurses showed the resident's amount of intakes fluids on the following dates and shifts: - dated 7/7/25 on the night shift = 100 ml- dated 7/8/25 on the day shift = 400 ml, evening shift = 400 ml, and night shift = 100 ml- dated 7/9/25 on the day shift = 550 ml, and night shift = 100 ml Further review of Resident 2's fluid intakes in the Task - Fluid Intake and MAR for the above dates showed the number of ml's the licensed nurses' shift documentation were less than the CNAs and did not match. On 7/9/25 at 1132 hours, an interview and concurrent medical record review was conducted with the DSD. The DSD stated the monitoring of the resident's intake were documented by the CNA in the Task: Fluid intake, the LVN should refer to the intake documented by the CNA then add the amount of fluids given by the licensed nurse to the resident. The DSD further stated the total of the fluid intake should be documented in the MAR at the end of the shift. The DSD verified the fluid intake documentation in Resident 2's MAR were inaccurate when resident's MAR showed lesser fluid amount documented by the licensed nurses than the Task documented by the CNAs. On 7/9/25 at 1608 hours, an interview was conducted with the DON. The DON stated the monitoring of fluid intake documented in the MAR should include the resident's meal intake from dietary tray, all fluids consumed by the resident throughout the shift and the fluid given during the medication administration. The DON stated she expected the nurses to document the resident's intake in the MAR accurately. 2. Medical record review for Resident 3 was initiated on 7/10/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 6/23/25, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's Order Summary dated 6/20/25, showed a physician's order dated 6/19/25, to monitor the intake every shift to include the oral intake, enteral feeding and flush, IV fluids and IV antibiotics every shift for 30 days. Review of Resident 3's Task - Fluid Intake documented by the CNAs showed the amount of the resident's fluid intakes for the following dates and times: - dated 7/1/25 at 0134 hours = 400 ml- dated 7/2/25 at 0303 hours = 200 ml, and 2233 hours = 500 ml- dated 7/3/25 at 0048 hours = 260 ml- dated 7/4/25 at 0618 hours = 240 ml, 0845 hours = 240 ml, and 2220 hours = 400 ml- dated 7/5/25 at 0802 hours = 360 ml, and 2028 hours = 450 ml - dated 7/6/25 at 1058 hours = 360 ml, and 2217 hours = 600 ml - dated 7/7/25 at 0312 hours = 120 ml, 1459 hours = 360 ml, and 2149 hours = 500 ml - dated 7/8/25 at 0834 hours = 240 ml, 1235 hours = 120 ml, and 2259 hours = 500 ml Review of Resident 3's MAR fluid intake documented by the licensed nurses showed the amount of the resident's fluid intakes on the following dates and shifts: - dated 7/1/25 on the night shift = 100 ml- dated 7/2/25 on the night shift = 100 ml and evening shift = 400 ml- dated 7/3/25 on the night shift = 100 ml- dated 7/4/25 on the day shift = 120 ml, evening shift = 140 ml, and night shift = 100 ml- dated 7/5/25 on the day shift = 120 ml, evening shift 120 ml, night shift 100 ml- dated 7/6/25 on the day shift = 360 ml, evening shift = 360 ml, and night shift = 100 ml- dated 7/7/25 on the day shift = 120 ml, evening shift = 400 ml, and night shift = 100 ml- dated 7/8/25 on the day shift = 200 ml, evening shift = 400 ml, and night shift = 100 ml Further review of Resident 3's fluid intakes in the Task - Fluid Intake and MAR for the