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	09/09/2025

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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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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F 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	**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 reasonable accommodations to meet the needs of one of eight sampled residents (Resident 1). *The facility failed to ensure Resident 1 was provided with assistance in a timely manner. The failure had the potential to negatively impact the resident's physical and psychosocial well- being and result in delayed provision of care. Findings Review of the facility's P&P titled Call Light revised 5/2007 showed to answer the call light within a reasonable time and turn off the call light once the request/ need is met. Review of Resident 1's medical record was initiated on 9/8/25. Resident 1 was admitted on to the facility on 7/28/25. Review of Resident 1's H&P examination dated 7/29/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's care plan dated 7/29/25, showed a care plan for bowel and bladder incontinence related to impaired mobility, general weakness, and overactive bladder. The care plan intervention included to check the resident as required for incontinence, wash, rinse, and dry perineum, and change clothing as needed after incontinence episodes. Review of Resident 1's MDS assessment dated [DATE], showed the resident had a BIMS score of 15 (meaning cognitively intact). On 9/9/25 at 0707 hours, an observation was conducted of Resident 1's call light. The call light included a visual light and a sound to indicate it was turned on. On 9/9/25 at 0712 hours, during an observation, CNAs 4 and 5 responded to Resident 1's call light. Resident 1 stated she had been waiting for almost an hour to be cleaned after having a bowel movement. CNA 4 told Resident 1 to make sure a complaint ws made, and CNA 4 would inform the nurse. Both CNAs 4 and 5 left the room. On 9/9/25 at 0715 hours, an interview was conducted with LVN 1. LVN 1 stated she was not aware Resident 1 had not been attended to. On 9/9/25 at 0720 hours, during an observation, Resident 1 was changed by her assigned CNA (CNA 1). On 9/9/25 at 0938 hours, an interview was conducted with CNA 1. CNA 1 stated as soon as she came to the nurses' station, she was told Resident 1 needed to be changed and went to change Resident 1 immediately. CNA 1 stated Resident 1 had a bowel movement. On 9/9/25 at 1037 hours, an interview was conducted with CNA 4. CNA 4 verified she answered the call light in room [ROOM NUMBER] and was told by Resident 1 she has been waiting for an hour to be changed after a bowel movement. CNA 4 stated she told Resident 1 they just came into the room and would find out what was going on. CNA 4 verified she walked out of the room. CNA 4 further stated I know I'm supposed to take care of Resident 1 right away; it is not an excuse I was not thinking right. CNA 4 verified she turned off Resident 1's call light and walked out of the room to find Resident 1's assigned CNA instead of changing the resident right away. On 9/9/25 at 1050 hours, an interview was conducted with CNA 5. CNA 5 verified she went inside Resident 1's room with CNA 4 to respond to the call light. CNA 5 verified Resident 1 needed to be changed and had been waiting for a reasonable amount of time. CNA 5 verified they turned off the call light then left the room. CNA 5 stated she did not change the resident because she was not assigned to her but should have changed the resident right away. On 9/9/25 at 1105 hours, an interview and concurrent facility P&P review was conducted with the DON. The DON stated the reasonable amount of time to answer the call light was three to five minutes. The DON verified Resident 1's call light was not answered timely and CNAs 4 and 5 should not have turned off the call light and left the room. The DON stated this was not acceptable and CNAs 4 and 5 should have just changed the resident right away. On 9/9/25 at 1115 hours, an interview was conducted with Resident 1. Resident 1 stated it was not a good morning. Resident 1 stated I had a bowel movement, I hit the call light at 630 hours, and they showed up at 720 and changed me. Resident 1 was asked how the situation made her feel, Resident 1 stated I was very upset, they were supposed to change me before the shift ends - but no one changed me, I was last changed after 0500 hours but I had a bowel movement.

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F 0605 Level of Harm - Potential for minimal harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure one of three sampled residents (Resident 6) reviewed for unnecessary medications were free from unnecessary medications. * The facility failed to ensure NPI (nonpharmacological intervention) was consistently implemented for Resident 6 prior to administering hydrocodone-acetaminophen (narcotic) 5/325 mg tablet or Ultracet (narcotic) oral tablet 37. 5-325 mg medication. This failure had the potential to negatively impact the resident's well being. Findings: Medical record review for Resident 6 was initiated on 9/2/25. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's Order Summary Report showed the following orders:- dated 7/22/25, for nonpharmacological interventions for pain: 1 = repositioning, 2 = dim light/quiet environment, 3 = relaxation, 4 = distraction, 5 = music, 6 = massage as needed.- dated 8/1/25, for Ultracet 37.5-325 mg, give one tablet by mouth every four hours as needed for moderate to severe pain (7-10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst). Review of Resident 6's MAR for July 2025 showed a physician's order dated 7/22/25, for hydrocodone-acetaminophen 5-325 mg oral tablet, give one tablet by mouth every four hours as needed for moderate (4-6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) to severe (7-10) pain. Resident 6 received hydrocodone medication on the following dates and times: - on 7/24/25 at 1032 hours- on 7/25/25 at 1655 hours- on 7/26/25 at 0317 hours- on 7/27/25 at 1147 hours- on 7/28/25 at 0906 hours- on 7/29/25 at 0930 hours- on 7/30/25 at 0600 hours- on 7/31/25 at 0700 hours The order was discontinued on 8/1/25. Review of Resident 6's MAR for August 2025 showed the resident received Ultracet medication on the following dates and times:- on 8/3 at 0429 and 1846 hours- on 8/4 at 000 hours- on 8/5 at 0245 hours-on 8/6 at 0430 hours-on 8/9 at 1807 hours-on 8/10 at 1346 hours-on 8/11 at 1534 hours Review of Resident 6's medical record failed to show documented evidence NPI was attempted prior to administering the hydrocodone medication on 7/24 to 7/27/25 and Ultracet medication on 8/3, 8/9, and 8/10/25. On 9/9/25 at 1039 hours, an interview was conducted with LVN 2. LVN 2 stated prior to giving the pain medication, the NPIs were implemented such as repositioning, adjusting lighting, reassurance, and redirection. If NPIs were unsuccessful, then pain medication was given. LVN 2 stated NPIs should be documented when assessing the resident's pain. LVN 2 verified there was no documented evidence NPIs were attempted prior to Resident 6 receiving the hydrocodone and Ultracet medications on the above dates and times. On 9/9/25 at 1140 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 6's medical record did not show documented evidence NPIs were attempted on the above dates and times prior to the resident receiving hydrocodone and Ultracet medications. The DON stated the nurses should be implementing NPIs first and document it was attempted.

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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** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 6) reviewed for falls remained free from accident hazards. * The facility failed to include a possible cause of injury in the initial investigation statement for a fall. * The facility failed to collaborate with the IDT (Interdisciplinary Team) following Resident 6's change in condition. These failures had the potential for Resident 6 not to receive adequate supervision, assistance, and sustain additional accidents and/or injuries.Findings: Review of the facility's P&P titled Change in Condition revised on 4/2025 showed it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. Additionally, under the procedure section, the IDT shall collaborate with the attending physician, resident, and/or resident representative to review risk indicators and the plan of care. The IDT will document this collaboration in the EMR in the next scheduled Comprehensive Care Plan Meeting or sooner if deemed necessary by the IDT. On 8/19/25 at 1751 hours, the CDPH L&C Program received a facility investigative report regarding Resident 6's fall and subsequent fracture. The report showed on 7/28/25, Resident 6 sustained a fall from the bed at the facility with no injury. There was no possible cause regarding the fall incident documented on the report. Medical record review for Resident 6 was initiated on 9/2/25. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. a. On 9/2/25 at 1245 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 6 had a fall and the facility had ordered an x-ray. The DON stated the facility should have included the possible cause of the fracture, since the facility was aware of the cause in the conclusion statement. Additionally, the DON stated the fall incident should also have been part of the investigation statement. b. Review of Resident 6's Radiology Report dated 8/12/25, showed Resident 6 had an acute, displaced comminuted distal femoral shaft fracture (a break in the thighbone near the knee) of the right knee. Further review of Resident 6's medical record failed to show documented evidence an IDT meeting was completed following the results Resident 6's x-ray report. On 9/9/25 at 1508 hours, an interview was conducted with the DON. The DON verified there was no documentation of the IDT meeting was conducted following the x-ray result for an acute, displaced comminuted distal femoral shaft fracture of the right knee for Resident 6. The DON also verified the IDT should have collaborated and documented.

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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. Based on interview, medical record review, and facility P&P review, the facility failed to implement the pharmaceutical procedures when the nursing staff did not ensure an accurate controlled substance accountability for one of three sampled residents (Resident 6) reviewed for medications. * Resident 6's medications were signed out of the CDR (Controlled Drug Record) but not documented as administered on the MAR (Medication Administration Record). This failure had the potential for Resident 6 to be exposed to the medication errors and diversion of the controlled medications.Findings: Review of the facility's P&P titled Controlled Medication - Storage and Reconciliation revised 12/2023 showed it is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse using separately locked, permanently affixed compartments, with the exception that controlled medications and those medications subject to abuse may be stored with non-controlled medications as part of a single unit detectable. This facility will maintain a process for monitoring, administration, documentation, reconciliation, and destruction of controlled substances. Review of Resident 6's Order Summary Report showed an order dated dated 7/22/25, to administer hydrocodone-acetaminophen oral tablet 5-325 mg (opioid analgesic) medication give one tablet by mouth every four hours as needed for moderate (4-6) to severe (7-10) pain NTE (not to exceed) 3 gms of APAP (Acetaminophen) in 24 hours from all sources. This order was discontinued on 8/1/25. Review of Resident 6's CDR showed the hydrocodone-acetaminophen medication 5-325 mg tablet was removed/taken out on the following dates and times: - on 7/27/25 at 1610 hours, - on 7/29/25 at 2015 hours, - on 7/30/25 at 1810 hours, and- o 8/1/25 at 1510 hours. Review of Resident 6's MAR for July and August 2025 failed to show the hydrocodone-acetaminophen medication was administered on the above dates and times. On 9/9/25 at 1039 hours, an interview was conducted with LVN 2. LVN 2 stated the process for giving a controlled medication would be to document in the controlled medication log and record the dose, time, date, and initials when given. LVN 2 further stated it also needed to be documented in the MAR. On 9/9/25 at 1058 hours, an interview, medical record review, and concurrent facility document review was conducted with LVN 1. LVN 1 stated the process of giving a controlled medication to a resident was to sign out the medication by documenting the date, time, amount, how it was administered, how many were left, and sign. LVN 1 also stated the documentation of the medication administration was needed to be in the MAR as well. LVN 1 verified the CDR showed the hydrocodone-acetaminophen 5-325 mg tablet medication was signed out for Resident 6 on 7/27/25 at 1610 hours, 7/29/25 at 2015 hours, 7/30/25 at 1810 hours, and 8/1/25 at 1510 hours. LVN 1 also verified Resident 6's MAR did not show the medication was administered. LVN 1 verified the order was discharged on 8/1/25 at 1114 hours. On 9/9/25 at 1140 hours, an interview, medical record review, and concurrent facility document review was conducted with the DON. The DON stated the process of giving a controlled medication was to verify the order, sign the controlled medication log, give the medication to the resident, and then document in the MAR. The DON verified the discrepancy of the controlled medication log for the hydrocodone-acetaminophen 5-325 mg tablet medication to the MAR for Resident 6.