

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055575	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Pacific Haven Subacute and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12072 Trask Ave. Garden Grove, CA 92843	
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 - Some	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 provide the necessary care and services to maintain the intravenous (IV) access for three of three final sampled residents (Residents 13, 34, and 100) reviewed for IV access care. * The facility failed to ensure the midline external catheter measurement was completed and documented upon admission in the medical records for Resident 100. In addition, the care plan failed to include the interventions of measuring the resident's arm circumference and external catheter length of the left upper arm midline catheter. * The facility failed to label Resident 13's IV site with date, time, and initials when the IV was inserted. * The facility failed to ensure the peripheral line was labeled for Resident 34. In addition, the facility failed to ensure the RN documented the initiation of peripheral line for Resident 34. These failures had the potential to delay the identification of catheter related complications for the residents. Findings: 1. Review of the facility's P&P titled Dressing and Injection Cap Change for Central Venous Access Devices (undated) showed during every dressing change document any concerns, site problems. Document dressing change, cap change for all lumens, flush for all lumens, any amount of the catheter out of the skin before the insertion site and the arm circumference. Document arm circumference in inches on treatment record prior to dressing change, compared to measurement from admission. Also document arm circumference after dressing change is complete. Check the resident's chart to confirm the insertion report and chest X-ray report confirming tip placement are there. Review of Resident 100's medical record was initiated on 7/12/26. Resident 100 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 100's H&P examination dated 7/9/26, showed Resident 100 had no capacity to understand and make decisions. Review of Resident 100's Order Summary Report for 7/2026 showed a physician's order dated 7/9/26, to measure the arm circumference in inches on admission and every seven days during dressing changes, and to measure external catheter length in cm from end to hub to insertion site into skin. Review of Resident 100's care plan showed a care plan focus dated 7/9/26, for IV therapy required (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care 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 provide the necessary respiratory care and services for three of five final sampled residents (Residents 21, 35, and 45) and three nonsampled resident (Residents 4, 42, and 68) reviewed for oxygen therapy. * The facility failed to follow the physician's order for Resident 21's oxygen therapy. * The facility failed to ensure Resident 4, 42, and 68's oxygen concentrators were maintained in a clean and sanitary condition. * The facility failed to ensure Resident 45's oxygen nasal cannula tubing was labeled with date. * The facility failed to ensure Resident 35's oxygen tubing was changed every seven days and dated. These failures had the potential for the residents to not receive the appropriate care and may negatively impact on the residents' medical conditions. Findings: Review of the facility's P&P titled Cleaning, Disinfection, and Sterilization of Resident Care Equipment dated 2/2026 showed all equipment and surfaces shall undergo appropriate cleaning and disinfection using the following process: - Pre-cleaning: remove visible organic material using detergent or facility-approved cleaning agents, - Disinfection: apply an EPA-registered disinfectant (chemical product certified by the United States Environmental Protection Agency to kill specific bacteria, viruses and fungi.) ensuring adherence to the manufacturer's recommended contact time. - Frequency: after each use for shared equipment with required process - cleaning: to remove soil using detergent or facility-approved wipes; disinfection- to apply a low- or intermediate-level disinfectant, ensuring proper contact time and frequency: between each resident use for shared equipment; daily and when visibly soiled for surfaces. Review of the facility's P&P titled Use of Oxygen dated 5/2023 showed it is the policy of the facility promote resident safety in administering oxygen. The oxygen equipment should be cleaned regularly. 1. On 7/12/26 at 0928 hours, during the initial tour of the facility, Resident 21 was observed lying in bed with the oxygen on via nasal cannula attached to the oxygen concentrator machine and was set at three liters per minute. During the observation, the oxygen tubing was labeled and dated. On 7/13/26 at 0850 hours, Resident 21 was observed lying in bed with the oxygen on via nasal cannula and was attached to the oxygen concentrator machine and set at half liter per minute instead of the three liters per minute as observed yesterday. Medical record review for Resident 21 was initiated on 7/12/26. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's H&P examination dated 5/11/26, showed Resident 21 had a diagnosis of chronic encephalopathy and cerebellar stroke and was bed bound and non-verbal. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 4's oxygen concentrator had dust-like with white and accumulation of dust like particles on the top of the oxygen concentrator, - Resident 42's oxygen concentrator was observed to have a collection of dust-like with white and black particles in the perimeter of the flow meter and a collection of dust like particles at the back part of the oxygen concentrator by the filter screen. - Resident 68's oxygen concentrator was observed to have dust and hairlike particles in the perimeter of the flow meter. LVN 3 stated It is dirty, I will clean the concentrators on my side but will let my supervisor know. It should be clean for infection control. LVN 3 was asked who was responsible of cleaning the oxygen concentrator machines, LVN 3 responded I have to get back to you on that. On 7/12/26 at 1100 hours an interview was conducted with the IP. The IP acknowledged the above findings on Resident 4, 42, and 68's oxygen concentrator machines. The IP stated I will evaluate the cleaning and disinfecting process of all oxygen concentrator machines, housekeeping cleans them, and I will look for the schedule, the oxygen concentrators should be cleaned regularly. On 7/15/26 at 1445, an interview was conducted with the Administrator and the DON. The Administrator and DON were informed and acknowledged the above findings. 3. Review facility's P&P titled Use of Oxygen revised on 5/2023 showed the oxygen cannula or mask will be changed at least every seven days, as well as the disposable humidifier. Tubing, masks, humidifiers, and other disposables used for oxygen administration will be dated in an identifiable fashion. Medical record review for Resident 45 was initiated on 7/12/26. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's H&P examination dated 6/27/26, showed Resident 45 had the capacity to understand and make decisions. Review of Resident 45's Order Summary Report for July 2026 showed an order dated 7/1/26, to administer oxygen at two liter per minute via nasal cannula continuously every shift. On 7/12/26 at 1043 hours a concurrent observation and interview was conducted with Resident 45. Resident 45 was seated in a wheelchair with oxygen tubing via nasal canula which was connected to an oxygen concentrator machine with oxygen running at two liters per minute. The oxygen tubing and the humidifier were not labeled with a date to indicate when they were last changed. Resident 45 stated the oxygen tubing, and the humidifier was changed maybe a few days ago. On 7/12/26 at 1056 hours, an observation and interview was conducted with LVN 1. LVN 1 verified the oxygen tubing of Resident 45 was not labeled with the changed date. LVN 1 stated Resident 45's oxygen tubing should be labeled to show when it was last changed, and the oxygen tubing should be (continued on next page)		

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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. 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 the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the kitchen utensils had smooth, cleanable surfaces and were maintained in good repair. * The facility failed to ensure the cutting boards were maintained in sanitary condition and had smooth, cleanable surfaces. * The facility failed to ensure the heavy-duty blender used for puree preparation was air dried prior to storage. * The facility failed to ensure the microwave utilized to warm up the residents' food was in a sanitary condition. * The facility failed to maintain the hood over the stove in a clean and sanitary condition. These failures had the potential to cause cross-contamination and/or foodborne illness for the residents consuming the food prepared in the kitchen. Findings: Review of the facility's Diet Type Report dated 7/13/26, showed 59 of 96 residents consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Dishwashing dated 2023 showed all dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. Gross food particles shall be removed by careful scraping and pre-rinsing in running water. Flatware is to be pre-soaked on a solution of water and detergent per manufacturer's instructions. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 7/12/26 at 0818 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Cook. The following were observed: -three stainless steel scoops with gray handles used for food portioning were dirty with dry, crusted residue and had fuzzy films;-two stainless steel scoops with cream handles used for food portioning had dry watermarks and fuzzy films;-two stainless steel scoops with white handles used for food portioning were dirty with dry, crusted residue and had fuzzy films;-six stainless steel scoops with green handles used for food portioning were dirty with dry, crusted residue and had fuzzy films;-four stainless steel scoops with blue handles used for food portioning were dirty with dry, crusted residue, had fuzzy films and dry watermarks;-one stainless steel ladle with orange handle was dirty with dry, crusted residue;-one stainless steel ladle with green handle was dirty with dry, crusted residue;-one stainless steel ladle with cream handle had dry watermarks;-one stainless steel ladle with red handle had dry watermarks;-one stainless steel slotted ladle with black handle had dry watermarks and fuzzy films;-two stainless steel spatulas with black handles were dirty with dry, crusted residue, had dry watermarks and fuzzy films;-three stainless steel knives had fuzzy films and dry watermarks;-one stainless steel knife with white handle had fuzzy films and dry watermarks;-one stainless steel serrated bread knife was dirty with dry, crusted residue and had dry watermarks and fuzzy films;-two stainless steel tongs were dirty and had dry, crusted residue;-one stainless steel tong with blue handle was dirty with dry, crusted residue;-one stainless steel slotted spatula with blue handle had fuzzy films and dry watermarks;-one stainless steel slotted spoon was dirty with dry, crusted residue;-one rubber spatula with red handle was dirty with dry, crusted residue;-one stainless steel (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pacific Haven Subacute and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12072 Trask Ave. Garden Grove, CA 92843	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ladle was discolored and stained. The [NAME] verified the findings and stated all dirty kitchen utensils and kitchenware should have been rewashed and cleaned to prevent contamination. 2. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas. Plastic ware, China and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. Cracked or chipped dishes and glasses will be disposed of. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 7/12/26 at 0818 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Cook. The following were observed: - two stainless steel scoops used for food portioning with gray handles were partially melted;- one stainless steel whisk with gray-greenish handle was partially cracked;- one stainless steel spatula with black handle was partially melted;- one rubber spatula with red handle had a chipped edge. The [NAME] verified the findings and stated all worn-out kitchen utensils and kitchenware should have been replaced. 3. Review of the facility's P&P titled Sanitation dated 2023 showed separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 7/12/26 at 0818 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Cook. One green, one brown and one blue cutting board were observed fuzzy, heavily marred and had deep grooves and pits. The [NAME] verified the findings and stated cutting boards should have been replaced. 4. Review of the facility's P&P titled Dishwashing dated 2023 showed dishes are to be racked loosely without overlapping. Dishes are to be air dried in racks before stacking and storing. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 7/12/26 at 0818 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Cook. One heavy-duty blender used for puree preparation stored on the countertop shelf was observed to be wet with visible water inside. The [NAME] verified the findings and stated the blender should have been air dried. 5. Review of the facility's P&P titled Sanitation dated 2023 showed all the equipment shall be maintained as necessary and kept in working order. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Further review of the facility's P&P titled Electrical Food Machines dated 2023 showed to keep and maintain all food machines in good operating, sanitary condition. This includes mixers, grinders, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	slicers and toasters. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 7/12/26 at 0818 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Cook. The kitchen microwave on a countertop shelf was observed to be dirty with dry, crusted food residue in the microwave door and had dry food splatters inside the microwave. The [NAME] verified the findings and stated the microwave was used to warm up the resident's food and it was cleaned once a day. 6. Review of the facility's P&P titled Hoods, Filters and Vents dated 2023 showed hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 7/12/26 at 0818 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Cook. The kitchen hood over the stove had black, greasy residue. The [NAME] acknowledged the findings and stated the hood was cleaned once a week on Fridays and the hood was also cleaned by an outside company every three months. The sticker on the hood showed it was last serviced on 7/1/26. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility documents review, and facility P&P review, the facility failed to maintain an accurate medical record for five of 19 final sampled residents (Resident 3, 6, 12, 45, and 54). * The facility failed to ensure the section D of the POLST and Advance Directive Acknowledgement form was completed accurately for Resident 6. * The facility failed to ensure section D of the POLST was not left blank for Resident 45. * Resident 54's POLST failed to show if the resident had formulated an advance directive. *The facility failed to accurately document COVID-19 immunization status for Residents 3 and 12; the residents' medical records showed the residents were only tested for COVID-19. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate. Findings: Review of facility's P&P titled Documentation revised 5/2007 showed the clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Review of the facility's P&P titled Immunizations & Residents revised 7/2023 showed each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated or the resident has already been immunized. The facility will document administration details in the resident's medical record, if administered. 1. Medical record review for Resident 3 was initiated on 7/15/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Immunization Report dated 4/27/26, showed Resident 3 was administered the COVID-19 vaccination. However, further review of the report showed the route of administration was documented as in both nostrils. 2. Medical record review for Resident 12 was initiated on 7/15/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's Immunization Report dated 5/19/26, showed Resident 12 was administered the COVID-19 vaccination. However, further review of the report showed the route of administration was documented as in both nostrils. On 7/15/26 at 1021 hours, an interview and concurrent record review for Residents 3 and 12 were conducted with the IP. The IP stated residents could choose or refuse vaccinations and that the licensed staff members documented the administration or refusal, risks and benefits explained, the VIS provided, who received the education, and who administered the vaccine. The IP verified the above findings and stated the licensed staff member who documented Resident 3 and 12's immunization status had tested the residents for COVID-19 and did not provide the vaccination. The IP (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further stated COVID-19 testing was not the same as administering the vaccination, in addition, accurate documentation was needed to correctly monitor residents' immunization status. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 54 was initiated on 7/12/26. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's POLST dated 2/14/26, under Section D Information and Signatures showed the advance directive was left blank. The Advanced Healthcare Directive Acknowledgment form dated 12/2/25, showed Resident 54 had no advance directive and was unable to complete an advance directive. Review of Resident 54's H&P Examination dated 2/15/26, showed Resident 54 had no capacity to understand and make decisions. On 7/13/26 at 0837 hours, an interview was conducted with the SSD. The SSD was asked who was responsible in completing the POLST, the SSD stated it was her responsibility to review and ensure the POLST was complete and accurate to assure the facility can follow the plan of care according to the resident's needs. On 7/13/26 at 0913 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the findings and stated the POLST was incompletely filled out, the licensed nurses can initiate the POLST and should have been completed accurately by the Social Services prior to physician's signature. On 7/15/26 at 1545 hours, the Administrator and DON were informed and acknowledged the above findings. 4. Medical record review for Resident 6 was initiated on 7/12/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's POLST dated 6/9/26, shown under shown under Section D - Information and Signatures, the following check box was checked: Advance Directive not available, VA (Veteran Administration) has it. Review of the Advance Directive Acknowledgement form dated 6/10/26 showed the resident does not have an advance directive and do not want to formulate one at this time. Review of Resident 6's H&P examination dated 6/10/26, showed the resident had no capacity to understand and make decisions due to dementia. On 7/13/26 at 0806 hours, an interview was conducted with FM 1 in her room. FM 1 stated, the resident did not have an advance directive. The resident further stated the facility did provide information on how to formulate and advance directive but did not want to formulate one at this time. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/13/26 at 0821 hours, an interview and concurrent medical record review for Resident 6 was conducted with the SSD. The SSD stated the social services was responsible to review the POLST for completion and accuracy. The SSD review the POLST dated 6/9/26 and Advance Directive Acknowledgement form dated 6/10/26, the SSD verified section D on the POLST was not accurate. The SSD stated it was important to have the POLST fill out accurately, so facility can follow the plan of care according to the residents needs and wishes. 5. Medical record review for Resident 45 was initiated on 7/12/26. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's POLST dated 6/25/26, under Section D showed the Information and Signatures was left blank. Further review of Resident 45's social services assessment notes upon admission showed the resident did not have an advance directive. Review of Resident 45's H&P examination dated 6/27/26, showed the resident had the capacity to understand and make decisions. On 7/13/26 at 0837 hours, an interview and concurrent medical record review for Resident 45 was conducted with the SSD. The SSD verified Resident 45's POLST dated 6/25/26, section D was left blank and not filled out. The SSD stated it was important to have the POLST fill out completely, so the facility could follow the plan of care according to the resident's needs and wishes. On 7/15/26 at 1147 hours, an interview was conducted with the DON in the DON's office . The DON acknowledged and verified the above findings.		

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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** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to implement their infection control surveillance program for the months of January to June 2026. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications met the facility's criteria for infection. * The facility failed to maintain an accurate infection control surveillance program for the Quarterly Infection Surveillance Summary for January and March 2026 and the Monthly Infection Surveillance for June 2026. The facility failed to document the actual number of CAIs (community acquired infection - infections acquired outside of healthcare settings) and HAIs (healthcare associated infection - infections acquired during the course of treatment for other conditions in a healthcare setting). * The facility failed to accurately categorize Resident 12, 34, and 79's source of infection in their infection surveillance log. * The facility inaccurately included Resident 91's liver cirrhosis diagnosis in the facility's infection surveillance log. * The facility failed to fully cover the clean linen was stored in a sanitary condition. * The facility failed to ensure proper handling and containment of soiled linens. * The facility failed to ensure unused washcloths were stored in a clean and sanitary manner. These failures posed the risk of not identifying the residents' infections and controlling the potential transmission of communicable diseases to other residents throughout the facility. Findings: 1. On 7/14/26 at 1444 hour, an interview and facility document review was conducted with the IP. The IP stated she has been the facility's IP since December 2025. The IP was asked to describe the facility's infection surveillance program. The IP stated when a resident was prescribed antimicrobial medications and showed signs and/or symptoms of an infection, the prescribed antibiotic will alert the IP for infection review and entry onto the monthly surveillance log. The IP then stated the facility utilized the McGeer's criteria to determine if a resident required antibiotics, and if the resident did not meet the infection criteria, the physician determined if the antibiotic was necessary to continue. The IP stated she documented this information on the facility's monthly Infection Prevention and Control Surveillance Log to accurately monitor the infection rate within the facility. a. Review of the facility's monthly Infection Surveillance Report from January 2026 through June 2026 showed the following residents infection surveillance data for the HAIs and CAIs: -1/2026, HAI &ndash; 23 and CAI - 8-2/2026, HAI &ndash; 18 and CAI &ndash; 5-3/2026, HAI &ndash; 19 and CAI &ndash; 7 -4/2026, HAI &ndash; 24 and CAI - 7-5/2026, HAI &ndash; 20 and CAI - 10-6/2026, HAI &ndash; 25 and CAI &ndash; 22 Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from January to June 2026 showed documentation all the residents included on the surveillance logs were (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also prescribed antimicrobial medications. The IP was asked when the residents at the facility presented with signs and/or symptoms of infection, and were not prescribed antimicrobial medications, if the facility included these residents in the facility's infection surveillance program. The IP stated the facility conducted surveillance of the resident infections based on whether the residents were prescribed antimicrobial medications. The IP was unable to provide information on how many residents in the facility who had infections and were not prescribed antimicrobial medications from January to June 2026. b. Review of the facility's South Unit Quarterly Infection Surveillance Summary for January to March 2026 showed the following: - 1/2026, total number of CAIs &ndash; 5 - 3/2026, total number of HAIs &ndash; 6 - 3/2026, total number of CAIs - 5 Review of the facility's Subacute Unit Quarterly Infection Surveillance Summary for January to March 2026 showed the following: - 3/2026, total number of CAIs &ndash; 2 - 3/2026, total number of HAIs &ndash; 15 Review of the facility's South Unit Monthly Infection Prevention and Control Surveillance Log showed the following: - 1/2026, total number of CAIs &ndash; 6- 3/2026, total number of HAIs &ndash; 5 - 3/2026, total number of CAIs &ndash; 4 Review of the facility's Subacute Unit Monthly Infection Prevention and Control Surveillance Log showed the following: - 3/2026, total number of CAIs &ndash; 3- 3/2026, total number of HAIs &ndash; 14 The IP confirmed the monthly and quarterly surveillance logs were inconsistent. The IP stated the data collected should be accurate to monitor the infection rates within the facility. 2. Review of the facility's Infection Prevention and Control Surveillance Log for May 2026 showed Resident 34 had a blood infection, which resulted in sepsis (the body's extreme, life-threatening response to an infection). The start date for the ertapenem (antibiotic) was on 5/10/26, while the onset date for symptoms and if the infection was an HAI or CAI were left blank. Review of the facility's Infection Prevention and Control Surveillance Log for June 2026 showed the following: - Resident 12 had a UTI with an indwelling urinary catheter, onset date of symptoms was on 6/1/26. The start date for fluconazole (antifungal) was on 6/10/26. Resident 12 was also listed as having a blood infection, which resulted in sepsis. The start date for the Levaquin (antibiotic) was on 6/1/26 and Meropenem (antibiotic) was on 6/10/26. - Resident 79 had a blood infection, which resulted in sepsis. The start date for the ceftriaxone (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(antibiotic) and metronidazole (antibiotic) was on 6/15/26. a. Medical record review for Resident 34 was initiated on 7/14/26. Resident 34 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident 34's Infection Screening Evaluation dated 5/10/26, showed the following under the evaluation section: - a repeat temperature greater than 99 degrees Fahrenheit, - new onset hypotension, - pulse rate was above 100 breaths per minute, and - respiratory rate was above 25 breaths per minute. Further review of the document did not indicate Resident 34's infection had met the McGeer's criteria for a bloodstream infection. Review of Resident 34's progress note dated 5/10/26, showed Resident 34 was transferred to an acute care hospital due to Resident 34's family members' request. Review of Resident 34's acute care hospital records dated 5/19/26, showed Resident 34 had a diagnosis of urinary tract infection status post septic shock. b. Medical record review for Resident 12 was initiated on 7/14/26. Resident 12 was admitted to the facility on [DATE], and readmitted [DATE]. Further review of Resident 12's medical record failed to show an Infection Screening Evaluation was completed. c. Medical record review for Resident 79 was initiated on 7/14/26. Resident 79 was admitted to the facility on [DATE], and readmitted on [DATE]. Further review of Resident 79's medical record failed to show an Infection Screening Evaluation was completed. Review of Resident 79's acute care hospital records dated 6/9/26, showed Resident 9 had sepsis related to acute hypoxic respiratory failure (lungs fail to supply enough oxygen to the bloodstream), with a concern for pneumonia (infection that inflamed the air sacs in the lungs). On 7/14/26 at 1444 hours, an interview, concurrent medical record review, and facility document review was conducted with the IP. The IP stated the facility utilized the McGeer's criteria to determine if a resident required antibiotics, and if the resident did not meet the infection criteria, the physician determined if the antibiotic was necessary to continue. The IP stated she documented this information on the facility's monthly Infection Prevention and Control Surveillance Log to accurately monitor the infection rate within the facility. The IP stated the infections were categorized as HAIs versus CAIs, and by their source of infection. The HAIs were when the residents showed signs and symptoms of infections 48 hours after they were admitted , while the CAIs were infections the residents had prior to or during admission to the facility. When asked how bloodstream infections were determined to meet McGeer's criteria, the IP stated the residents could show symptoms of a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fever or altered level of consciousness and lab tests were ordered to determine the cause of the infection. The IP stated sepsis was a bloodstream infection, and that was why she categorized Residents 12, 34, and 79 as blood infections in the surveillance logs. The IP verified Resident 12's infection surveillance should include the onset date and whether the infection was classified as an HAI or CAI. The IP verified Residents 12 and 79 did not have an Infection Screening Evaluation completed and further stated the residents should have been evaluated to ensure there were no adverse reactions to their prescribed antibiotics. On 7/15/26 at 1041 hours, a follow-up interview for Residents 12, 34, and 79 was conducted with the IP. The IP verified Residents 12, 34, and 79 should not have been categorized as bloodstream infections due to their sepsis diagnosis, but rather the source of their infection that led to sepsis. 3. Review of the facility's Infection Prevention and Control Surveillance Log for June 2026 showed Resident 91 had an infection categorized as other and CAI, the result was cirrhosis (late stage liver disease, causing scarring to the liver tissue). Resident 91 was monitored for the prescribed rifaximin (antibiotic medication to prevent and manage hepatic encephalopathy). On 7/14/26 at 1444 hours, an interview, concurrent medical record review, and facility document review were conducted with the IP. The IP confirmed cirrhosis was not a community acquired infection, and stated Resident 91 was included in the surveillance log due to the use of the rifaximin medication. 4. On 7/14/26 at 0820 hours, an inspection of the laundry area and central supply room and concurrent interview was conducted with the Maintenance Director. A shelf containing clean curtains was observed not fully covered. The Maintenance Director verified the above findings. 5. Review of the facility's P&P titled Infection Prevention and Control Program dated 10/2022 showed under Reporting Mechanisms for Infection Control (page 2 #4) the facility personnel will handle, store, process and transport linens so as to prevent the spread of infection. On 7/12/26 at 0833 hours during an initial tour of the facility, an uncovered hamper containing soiled linens was observed stored in the hallway in front of Nurses' Station B. On 7/12/25 at 1100 hours, a follow- up observation and concurrent interview were conducted with the IP. The IP verified the soiled linen hamper stored in the hallway in front of Nurses' Station B was not covered. The IP stated, everything should be covered, dirty or clean linens to prevent contamination, it's infection control. On 7/15/26 at 1435 hours, an interview was conducted with RN 1. RN 1 acknowledged the uncovered soiled linen hamper in front of Nurses' Station B. RN 1 stated the dirty linens should be covered, to prevent the risk of spreading the dirty linens and contaminating others. 6. Review of the facility's P&P titled Infection Prevention and Control Program dated 10/2022 showed goals as follows: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- decrease the risk of infection to residents and personnel, - recognize the infection control practices while providing care, - identify and correct problems relating to infection control, - ensure compliance with state and federal regulations, - promote individual residents' rights and well-being while trying to prevent and control the spread of infection, and - monitor personnel health and safety. On 7/14/26 at 1632 hours, during a room visit, two packs of disposable wash cloths were observed placed on top of a trash bin near the door inside Room B. One pack was enclosed in a clear plastic wrapper, and the second pack was unwrapped. On 7/14/26 at 1634 hours, an interview was conducted with LVN 6. LVN 6 verified the presence of the two packs of disposable wash cloths on top of the garbage bin near the door, inside Room B. LVN 6 stated the clean washcloths should not be placed there, it's dirty, it should have not been placed there for infection control. On 7/14/26 at 1635 hours, observation and concurrent interview were conducted with CNA 1 inside Room B. CNA 1 verified the presence of the two packs of disposable wash cloths on top of the garbage bin near the door, inside Room B. CNA 1 stated I just gave a resident a shower, I did not see this, this should not be there, it is dirty, maybe this was left by the previous shift. On 7/14/26 at 1636 hours, an interview and concurrent interview were conducted with RN 1 inside Room B. RN 1 verified the presence of the of the two packs of disposable wash cloths on top of the garbage bin near the door, inside Room B. RN 1 stated I did my rounds earlier, I did not see these, these cannot be here, it is dirty, I will discard these. On 7/15/26 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were made aware and acknowledged the above findings.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 informed consent for the use of the psychotropic medications was obtained and had the complete necessary information prior to the administration of the psychotropic medications medication for two of five sampled residents (Residents 9 and 77) reviewed for unnecessary medications. * The facility failed to ensure Resident 9's informed consent was obtained prior to administering the valproate sodium (mood stabilizer medication) to Resident 9. * The facility failed to ensure the informed consent information were completed for Resident 77's use of Rexulti (antidepressant), diazepam (antianxiety), mirtazapine (antidepressant), and trazadone (antidepressant) medications. These failures posed the risk of the residents and their responsible party to not be aware of the indication of use, duration, and adverse effects related to the use of the psychotropic medications. Findings: Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2025 showed the policy of the facility was to ensure residents were free from chemical restraints. Upon change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to the initiation of the new medication. The facility's IDT will review the psychotropic medication to ensure the medication was prescribed to treat a specific diagnosis condition, as documented in the clinical record; not in excessive dosage; the behavior was not related to delirium or other reversible conditions; the monitoring for adverse consequences and effectiveness of medications were in place; PRN medications were within guidelines; an informed consent was obtained prior to the medication use; review of plan of care showed individualized, person-centered care approaches to manage behavior with non-pharmacological interventions; and an attempt for a GDR, if appropriate. Review of the AFL 25-27 titled AB 48 & Nursing Facility Resident Informed Consent Protection Act of 2023 dated 10/7/25, showed the prescriber must share the material information a reasonable person in the resident's condition and circumstances would consider necessary for the resident or representative to make a decision about the treatment. Material information that the provider shall provide includes but is not limited to: - Possible nonpharmacologic approaches that could address the resident's needs; - Whether the drug has a current boxed warning label along with a summary of, and information about how to find, the contraindications, warnings, and precautions required by the United States FDA; - Whether the proposed drug is being prescribed for a purpose that has or has not been approved by the United States FDA; - Possible interactions with other drugs the resident is receiving; and - How the facility and prescriber will monitor and respond to any adverse side effects and inform the (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident of side effects. The AFL also showed the facility must check the medical record for proper informed consent prior to an initial administration. Review of the AFL 25-38.1, titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 10/7/25, showed effective 1/1/26, the Psychotherapeutic Drug Informed Consent Form or equivalent in-house form must be used for new residents, residents being prescribed a new psychotherapeutic drug, or residents having a psychotherapeutic drug dosage change. The Psychotherapeutic Drug Informed Consent Form Instruction Sheet showed the form will be completed by. entering the drug category and. providing the use and benefits of the psychotherapeutic drug. 1. Medical record review for Resident 9 was initiated on 7/15/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 3/26/26, showed Resident 9 had no capacity to understand and make medical decisions. Review of Resident 9's Order Summary Report showed a physician's order dated 3/27/26, to administer 2.5 ml of valproate sodium 250 mg/5 ml via GT every six hours as a mood stabilizer. In addition, the order included initiated risk and benefits explained by MD 1 informed consent obtained from Resident 9's family member. Review of Resident 9's MAR for July 2025 showed Resident 9 was administered the 2.5 ml of valproate sodium 250 mg/5 ml via GT every six hours from 7/1 to 7/15/26. Further review of Resident 9's medical record failed to show documented evidence an informed consent for the 2.5 ml of valproate sodium 250 mg/5 ml via GT every six hours as a mood stabilizer was obtained. On 7/15/26 at 1217 hours, an interview and concurrent medical record review for Resident 9 was conducted with the MDS Coordinator and ADON. The MDS Coordinator stated Resident 9 was administered the valproate sodium medication to stabilize his mood. The MDS Coordinator and ADON reviewed Resident 9's medical record and stated they could not find an informed consent for Resident 9's use of the valproate sodium medication. On 7/15/26 at 1400 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON verified Resident 9 had no informed consent for the use of the valproate sodium medication. On 7/15/26 at 1413 hours, a follow-up interview for Resident 9 was conducted with the MDS Coordinator. The MDS Coordinator stated the purpose of an informed consent was to ensure the resident and resident's family are aware of the psychotropic medication, side effects and potential adverse reactions. In addition, the MDS Coordinator stated the psychotropic medication should not be administered prior to obtaining the informed consent. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 77 was initiated on 7/12/26. Resident 77 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 77's Order Summary Report showed the following physician's orders: - dated 6/22/26, to administer diazepam 5 mg by mouth at bedtime for anxiety manifested by restlessness; - dated 6/22/26, to administer trazodone 100 mg by mouth at bedtime for depression as manifested by inability to sleep; - dated 6/22/26, to administer Rexulti 0.25 mg by mouth one time a day for psychosis manifested by paranoid thinking that staff against her, discontinued on 7/1/26; - dated 6/28/26, to administer mirtazapine 7.5 mg by mouth at bedtime for depression as manifested by poor po intake; and - dated 7/1/26, to administer Rexulti 0.5 mg by mouth one time a day for psychosis as manifested by yelling and screaming for no apparent reason. Review of Resident 77's MAR for July 2026 showed Resident 77 was administered the following medications: - diazepam 5 mg on 7/1 to 7/11/26 at 2100 hours; - mirtazapine 7.5 mg on 7/1 to 7/11/26 at 2100 hours - trazodone 100 mg on 7/1 to 7/11/26 at 2100 hours; - Rexulti 0.25 mg on 7/1/26 at 0900 hours; and - Rexulti 0.5 mg on 7/2 to 7/12/26 at 0900 hours. Review of Resident 77's Psychotherapeutic Drug Informed Consent form for the trazadone 100 mg medication did not show the duration of therapy, the section for I consent to the treatment described was not checked and date of when the consent was obtained was left blank. Review of Resident 77's Psychotherapeutic Drug Informed Consent form for the Rexulti 0.25 mg medication did not show the duration of therapy, the section for I consent to the treatment described was not checked. In addition, the section for the resident or residents representative's name, signature and date were left blank. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 77's Psychotherapeutic Drug Informed Consent form for the Rexulti 0.5 mg medication dated 7/1/26, did not show the duration of therapy. Review of Resident 77's Psychotherapeutic Drug Informed Consent form for the diazepam 5 mg medication did not show the duration of therapy and date of when the consent was obtained was left blank. Review of Resident 77's Psychotherapeutic Drug Informed Consent form for the mirtazapine 7.5 mg medication did not show the duration of therapy, the section for I consent to the treatment described was not checked and date of when the consent was obtained was left blank. On 7/12/26 at 1430 hours, an interview and concurrent medical record review for Resident 77 was conducted with RN 1. RN 1 verified the above informed consent forms did not include the durations, date of when the consent form was obtained and/or name of the resident or resident representative who gave the informed consent. On 7/15/26 at 1230 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and facility P&P review, the facility failed to maintain safe, clean, and homelike environment for one of 37 rooms (Room A). * Room A was observed with accumulation of brownish, grayish particles along the base moldings; gray stains on the floor between the sink and the toilet in the bathroom; and yellow brown discoloration above the drain stopper of the bathroom sink. This failure posed a serious risk to the residents' health and safety. Findings: Review of the facility's P&P titled Housekeeping Services dated 5/2010 showed the facility will promote a sanitary environment in the resident care areas by cleaning of non-carpeted floors and other horizontal surfaces daily and more frequently, if there is spillage or visible soiling. On 7/14/2026 at 1020 hours, an environmental round was conducted and observed Room A with accumulation of brownish, grayish particles along the base moldings; gray stains on the floor between the sink and the toilet in the bathroom; and yellow brown discoloration above the drain stopper of the bathroom sink. On 7/14/26 at 1016 hours, an interview was conducted with RNA 3. RNA 3 verified the presence floor particles and gray stains which could be cleaned. RNA 3 stated he would call the housekeeping to take care of it. On 7/14/26 at 1020 hours, an interview was conducted with the Maintenance/ Housekeeping Director. The Maintenance/ Housekeeping Director verified the findings in Room A. Maintenance/ Housekeeping Director stated a housekeeper was assigned to clean and disinfect Room A, seven days a week during the day shift and if needed; and a janitor could be called as needed, during the evening shift. When the Maintenance /Housekeeping Director was asked about the multiple accumulations of brownish, grayish particles along the base moldings, he stated they needed to clean it. When the Maintenance/ Housekeeping Director was shown the stains on the floor which were partially removed by a wet paper towel, he replied, Will scrub; and on the yellow brown discoloration on the sink, he replied it was from chlorhexidine (powerful antiseptic and disinfectant used to kill bacteria, yeasts and some viruses) they used and rusted the drainer. When asked if he would just leave it stained, he replied, No, I'll get a pumice to scrub it. On 7/14/26 at 1230 hours, Maintenance/ Housekeeping Director showed the white, stain-free bathroom sink in Room A and stated they were still working on the rest. On 7/14/26 at 1445, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 9) reviewed for unnecessary medications was free from unnecessary psychotropic medications.* The facility failed to ensure nonpharmacological interventions were implemented prior to the use of the valproate sodium medication (anticonvulsant used to manage mood disorder) for Resident 9; and the physician order had an appropriate indication for use. These failures had the potential for poor health outcomes due to adverse effects of the medications. Findings: Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2025 showed to ensure the residents were free from chemical restraints. The facility's IDT will review the psychotropic medication to ensure the medication was prescribed to treat a specific diagnosis condition, as documented in the clinical record; not in excessive dosage; the behavior was not related to delirium or other reversible conditions; the monitoring for adverse consequences and effectiveness of medications were in place; PRN medications were within guidelines; an informed consent was obtained prior to the medication use; review of plan of care showed individualized, person-centered care approaches to manage behavior with non-pharmacological interventions; and an attempt for a GDR, if appropriate. Medical record review for Resident 9 was initiated on 7/15/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 3/26/26, showed Resident 9 had no capacity to understand and make medical decisions. Resident 9 had diagnoses of depression and epilepsy (chronic neurological disorder characterized by recurrent seizures). Review of Resident 9's Order Summary Report showed a physician's order dated 3/27/26, to administer 2.5 ml of valproate sodium 250mg/5 ml via GT every six hours as a mood stabilizer. Documentation showed an informed consent was obtained from Resident 9's family member and the risk and benefits of the medication was explained by MD 1. However, the indication for use of valproate sodium did not identify a target behavior to manage. Review of Resident 9's MAR for July 2025 showed Resident 9 was administered the 2.5 ml of valproate sodium 250mg/5ml via GT every six hours from 7/1 to 7/15/26. Review of Resident 9's care plan showed a care plan problem addressing mood disorder manifested by aggressive verbal outburst, history of suicidal behavior, and depression dated 3/29/26. The care plan included interventions to administer valproate sodium as ordered; and to monitor, record, and report to the physician for increased anger, labile mood or agitation, feeling threatened by others or thoughts of harming someone, and possession of objects that could be used as weapons. Further review of Resident 9's medical record failed to show documented evidence nonpharmacological interventions were implemented prior to the use of valproate sodium. On 7/15/26 at 1217 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 9 was administered the valproate sodium medication to stabilize his mood. When asked what specific behavior the valproate sodium medication was indicated for, the MDS Coordinator stated the medication did not need a target behavior but she would follow up with the physician. On 7/15/26 at 1413 hours, a follow-up interview was conducted with the MDS Coordinator. The MDS Coordinator stated the physician reordered the valproate sodium medication with the indication of use for seizures. The MDS Coordinator further stated the original indication to use as a mood stabilizer was inaccurate. The MDS Coordinator verified nonpharmacological interventions were not implemented prior to the use of the valproate sodium (continued on next page)		

Department of Health & Human Services
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 implement care plan interventions for one of 23 final sampled residents (Resident 9). * Resident 9's medical record failed to show documented evidence the facility monitored Resident 9's side effects and possible adverse reactions related to the use of valproate sodium medication. This failure had the potential risk of not providing appropriate, consistent, and individualized care to Resident 9. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 12/2023 showed the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objects and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. Medical record review for Resident 9 was initiated on 7/15/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 3/26/26, showed Resident 9 had no capacity to understand and make medical decisions. Resident 9 had diagnoses of depression and epilepsy. Review of Resident 9's Order Summary Report showed a physician's order dated 3/27/26, to administer 2.5 ml of valproate sodium 250 mg/5 ml via GT every six hours as a mood stabilizer. Review of Resident 9's MAR for July 2025 showed Resident 9 was administered the 2.5 ml of valproate sodium 250 mg/5 ml via GT every six hours from 7/1 to 7/15/26. Review of Resident 9's care plan dated 3/29/26, showed a care plan problem addressing mood disorder manifested by aggressive verbal outburst, history of suicidal behavior, and depression. The interventions included to monitor, record, and report to the physician for increased anger, labile mood or agitation, feeling threatened by others or thoughts of harming someone, and possession of objects that could be used as weapons; and to observe for side effects and adverse reactions of psychotropic medication including unsteady gait, dry mouth, and vomiting. Further review of Resident 9's medical record failed to show documented evidence the facility monitored Resident 9's side effects and possible adverse reactions related to the use of the valproate sodium medication. On 7/15/26 at 1413 hours, an interview and concurrent medical record review for Resident 9 was conducted with the MDS Coordinator. The MDS Coordinator stated the purpose of a care plan was to provide interventions for the residents, for example of possible interventions for a psychotropic medication plan of care included monitoring for side effects of the medication. The MDS Coordinator was informed and verified the above findings. The MDS Coordinator further stated the care plan for Resident 9 should have been implemented. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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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 interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent further falls and/or injuries for one of two final sampled residents (Resident 9) reviewed for falls. * The facility failed to complete an accurate post fall assessment for Resident 9. This failure poses the risk for the resident to sustain further falls and/or injuries. Findings: Review of the facility's P&P titled Fall Management System revised on 6/2018 showed it is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs; and when a resident sustains a fall, a physical assessment will be completed by a licensed nurse with results documented in the medical record. Review of the facility's P&P titled Change in Condition revised on 6/2019 showed if at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed nurse or Nurse Supervisor should be made aware. Examples would be the following but not limited to fall or another related incident; and the nurse will perform and document an assessment of the resident and identify needs for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. Medical record review for Resident 9 was initiated on 7/15/26. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review Resident 9's change of condition report dated 3/8/26, showed the resident had a witnessed fall on 3/8/26. Resident 9 was seen by the activity staff getting up from the wheelchair and landing on the floor on the left side position with face down. The report showed the following:- Body check was done, with no bruise or swelling noted. - No abrasion on the forehead. - The resident denied pain during assessment. - The PCP was notified and the resident was transferred to the acute care hospital ED for CT scan of the head. Review of Progress Note dated 3/8/26 at 1200 hours, late entry showed Resident 9 had a fall risk score of 6. Review of Resident 9's SBAR (Situation, Background, Appearance, and Review) Communication Form and Progress Note for RNs/LPN/LVNs for the change of condition of Fall dated 3/8/26, showed the following:- Under the skin evaluation section the box had a check mark for not clinically applicable to the change of condition being reported; and- Under the neurological evaluation section: the box had a check mark for not clinically applicable to the change of condition being reported. Review of Resident 9's Neurological Assessment flowsheet dated 3/8/26, showed a legend for pupil response of PERL for pupils equal and reactive to light; B for brisk; S for sluggish; NR for nonreactive PP for pinpoint; D for dilated; and FX for fixated. In addition, under the hand grasp, document = for hand grasps equal; R>L for right grasp greater than left; L>R for left grasp greater than right; U for unable to follow commands; and AB for absent. The neurological assessment findings showed the following:- At 1155 hours, for pupil response the staff placed a check mark under PERL as well as for right and left when in fact there was no option for a check mark for the pupil response. For Resident 9's hand grasp documentation showed a check mark was placed under the hand grasps section.- At 1210 hours, for pupil response the staff placed a check mark under PERL as well as for right and left when in fact there was no option for a check mark for the pupil response. For Resident 9's hand grasp documentation showed a check mark was placed under the hand grasps section. In addition, the documentation showed the codes provided in the flowsheet were not used appropriately, making the assessment inaccurate. Review of Resident 9's Fall Risk Evaluation dated 3/8/26, showed upon admission and quarterly, at a (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pacific Haven Subacute and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12072 Trask Ave. Garden Grove, CA 92843	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below, by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. The prevention protocol should be initiated immediately and documented on the care plan. Resident 9's history of falls in the past three months, marked no falls; however, the resident had a most recent fall on 3/8/26. Review of Resident 9's H&P examination dated 3/26/26, showed Resident 9 had no capacity to understand and make decisions. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9's Brief Interview for Mental Status (BIMS) score was 3, indicating severely impaired cognition. On 7/15/26 at 1032 hours, an interview and concurrent medical record review was conducted with RN 1. Resident 9's SBAR, Neurological Assessment flowsheet, and Fall Risk Evaluation dated 3/8/26, was reviewed with RN 1 and stated the assessments were inaccurate. RN 1 verified the above findings. RN 1 stated the licensed nurse should have selected conditions specific to the resident's skin evaluation if there were changes or no change observed at all. The same was true for the neurological status post fall assessment and marked there were no changes observed if there was none. RN 1 stated the Fall Risk Evaluation score must be the same or higher than previous. Furthermore, RN 1 stated the assessments must be accurate for monitoring the resident's status, providing reports to the physician, and creating a plan of care. On 7/15/26 at 1509 hours, an interview was conducted with the Administrator and DON. The DON stated the neurological check, SBAR, and post fall assessments must be completed and documented accurately. The Administrator and DON were informed and acknowledged the above findings.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary GT care and services for one of final sampled resident (Resident 34). * Resident 34's GT was observed to be undated and the tubing was uncovered. This failure had the potential for the resident to develop health complications, including infection. Findings: On 7/12/26 at 1003 hours, during the initial tour, Resident 34 was observed lying in bed, asleep with the GT disconnected from Resident 34. The GT tubing was observed hanging on the pump pole undated and the tubing tip uncovered. Medical record review for Resident 34 was initiated on 7/14/26. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's Order Summary Report dated 7/15/26, showed an order dated 6/29/26, to provide Glucerna (nutritional formula) 1.5 calories via GT pump at 65 ml per hour for 20 hours to provide 1300 ml per 1950 calories. On 7/12/26 at 1010 hours, an observation and concurrent interview was conducted with RN 3. RN 3 observed Resident 34's GT tubing was undated and the tubing tip was uncovered. RN 3 verified the above findings. RN 3 stated the GT tubing must be dated and the tubing tip must have a cap to cover which would prevent infection. On 7/15/26 at 1509 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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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. Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate pain medication was administered to one nonsampled resident (Resident 101) as per the parameter ordered by the physician. * The facility did not administer Resident 101's pain medication as ordered by the physician. This failure had the potential to put Resident 101 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 Medication Administration revised 8/2021 showed the medication must be administered in accordance with the written order of the attending physician. Medical record review for Resident 101 was initiated on 7/13/26. Resident 101 was admitted to the facility 6/29/26. Review of Resident 101's Order Audit Report showed an order dated 6/29/26, to administer hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg one tablet by mouth every six hours as needed for pain scale from 7 to 10 (0 = no pain, 10 = worst pain) not to exceed 3000 mg of acetaminophen in 24 hrs., hold if respiratory rate < 12 breaths per minute or sedated. Review of Resident 101's MAR for June and July 2026 showed Resident 101 was administered hydrocodone-acetaminophen 5-325 mg on 6/30/26 at 0941 hours, for a pain level of 5; and on 7/1/26 at 2032 hours for a pain level of 6. However, hydrocodone-acetaminophen 5-325 mg was ordered for a pain level from 7 to 10. On 7/13/26 at 1151 hours, an interview and concurrent medical record review for Resident 101 was conducted with RN 1. When RN 1 was asked if the hydrocodone-acetaminophen medication should be administered for a pain level of 5 to 6, RN 1 replied no because the hydrocodone-acetaminophen medication should be administered for a pain level of 7 to 10. RN 1 reviewed Resident 101's MAR for June and July 2026 and verified the above findings. On 7/15/26 at 1145 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to accurately document the resident's pain level and administer the pain medication as ordered by the physician. The DON was informed and acknowledged above findings.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 appropriate dialysis care was provided for one of two final sampled residents (Resident 5) reviewed for dialysis services. * The facility failed to ensure the emergency dialysis kit kept at bedside was complete and had a scissor clamp for Resident 5. In addition, the facility failed to ensure Resident 5's dialysis access site was consistently and accurately assessed as ordered by the physician. This failure had the potential to delay the nursing staff in identifying complications related to the resident's dialysis access site. Findings: Review of the facility's P&P titled Pre and Post Dialysis (Renal) Care revised date 3/2020 showed it is the policy of the facility to assist resident in maintaining homeostasis pre and post-renal dialysis; assess and maintain patency of renal dialysis access; and assess resident daily for function related to renal dialysis. Dialysis access should be assessed upon return to the facility for patency and any unusual redness or swelling. Assess care given and condition of renal dialysis access. All assessments are documented in the clinical records. Medical record review for Resident 5 was initiated on 7/12/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's care plan date initiated 2/2/25, showed the resident has ESRD, on hemodialysis and had a Perma catheter to left upper chest and left upper extremity AV fistula as of 4/15/26. Under the interventions/ tasks showed to check the left upper extremity AV fistula for bruit and thrill daily, monitor the left upper chest Perma catheter for signs and symptoms of infection, monitor/document/report to the physician as needed any signs and symptoms of infection to the access site such as redness, swelling, warmth or drainage. Review of Resident 5's Annual MDS assessment dated [DATE], showed a BIMS of 15 (intact cognition). Review of Resident 5's H&P examination dated 3/31/26, showed Resident 5 was alert and oriented x3 (awake and aware of three fundamental things: who they are (person), where they are (place), and the date or time). In addition, Resident 5 had a diagnosis of ESRD and was on renal dialysis. Resident 5 had a left upper chest tunneled hemodialysis catheter and left upper arm AV fistula. Review of Resident 5's Order Summary Report for 7/2026 showed a physician's order dated 5/27/25, for hemodialysis every Tuesday, Thursday, and Saturday outside the facility. Furthermore, a physician's order dated 5/27/25, showed to check the Perma catheter to left upper chest wall for bleeding, bruising, signs and symptoms of infection every shift. In addition, a physician's order dated 4/15/26, showed an order to assess and document assessment of the left upper extremity AV shunt or fistula for bruit and thrill every shift and as needed. On 7/12/26 at 1102 hours, an observation and concurrent interview was conducted with the DON. A dialysis emergency kit was available in Resident 5's room in a clear bag labeled as dialysis kit contained gauze dressing and a roll of paper tape however, there was no scissor clamp included in the dialysis kit. The DON verified the above findings and stated the dialysis kit was incomplete and does not include a clamp scissor. Review of the Facility/ Dialysis Center Nursing Communication Records for May, June, and July 2026 showed the following:- On 5/2/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre dialysis; - On 5/5/26, the dialysis access location was documented as the left upper chest and left upper arm AV fistula and was not assessed for bruit and thrill pre and post dialysis;- On 5/7/26, the dialysis access location was documented as the left upper arm AV fistula and left upper chest and was not assessed for bruit and thrill, signs of infection, bleeding pre dialysis;- On 5/30/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis;- On 6/2/26, the dialysis access location was documented as the left upper (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chest and was assessed for bruit and thrill post dialysis; - On 6/4/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; - On 6/6/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; - On 6/9/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; - On 6/11/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; - On 6/13/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill post dialysis; - On 6/23/26, the dialysis access location was documented as the left upper arm AV fistula and left upper chest and was not assessed for bruit and thrill, signs of infection post dialysis;- On 7/2/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; - On 7/9/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; - On 7/11/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis; and- On 7/14/26, the dialysis access location was documented as the left upper chest and was assessed for bruit and thrill pre and post dialysis. On 7/15/26 at 1439 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated the licensed nurses were responsible for the documentation on the Facility/ Dialysis Center Nursing Communication Record. RN 1 acknowledged Resident 5's Perma catheter was on the left upper chest and the AV fistula was on the left upper arm and was not properly assessed and documented on the medical records. RN 1 stated Resident 5's dialysis access should have been assessed correctly and documented accurately to ensure dialysis sites are functioning properly. On 7/15/26 at 1545 hours, the Administrator and DON were informed and acknowledged the above findings.		

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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** Based on observation, interview, medical record review, and facility's P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling, and disposal of medications. * The facility failed to ensure Resident 85's medication was stored in a secure and locked compartment. * The facility failed to ensure oral medications were stored separately from non- orally used medications in the medication room. * The facility failed to ensure the medication bin with the medications was maintained in a sanitary manner in the medication room. These failures had the potential to negatively impact the residents' health outcomes. Findings: 1. Review of the facility's P&P titled Medication Access and Storage dated 2/2019 showed the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. On 7/12/26 at 1013 hours, during the initial tour of the facility, Resident 85 was observed lying in bed, awake, non-verbal, with oxygen administered via tracheostomy mask from an oxygen concentrator. A jar of Desitin (skin protectant) maximum strength paste with a handwritten label of Resident 85's name and room number, was observed on top of Resident 85's nightstand. Medical record review was initiated on 7/13/26. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85's Order Summary Report dated 7/13/26, failed to show documented evidence of a physician's order for the Desitin maximum strength paste. Review of Resident 85's Care Plan showed a care plan problem addressing potential for pressure ulcer development and/or skin breakdown. On 7/12/26 at 1050 hours, a follow up observation of Resident 85 and interview were conducted with LVN 3. LVN 3 verified the presence of Desitin jar at bedside, on top of the nightstand. LVN 3 removed the Desitin jar and stated, There should be no medications at bedside, I will let the family know to pick it up, I will also ask the treatment nurse. On 7/12/16 at 1052 hours, an interview was conducted with the IP. The IP was informed and acknowledged the Desitin jar was at Resident 85's bedside and stated, There should be no meds at bedside, let me check her orders. 2. Review of the facility's P&P titled Medication Access and Storage dated 2/2019 showed the medications administered orally are kept separate from medications used externally, e.g., suppositories, liquids, and lotions. On 7/14/26 at 807 hours, a medication storage room inspection of Medication Storage Room B and a concurrent interview with RN 5 were conducted. On the left side of the medication room, the third drawer was observed to contain a bin of medications consisting of oral anti-diarrheal medication boxes, boxes of acetaminophen suppositories and enemas stored together. RN 5 verified the above findings and stated, These oral medications should not be mixed with non- oral medications. When asked why, RN 5 responded, To avoid medication errors. On 7/14/26 at 812 hours an interview was conducted with LVN 5. LVN 5 verified the anti-diarrheal medications were stored with the enemas and suppositories and stated the anti-diarrheal oral medications should not be in the same bin with the enemas and suppositories. 3. Review of the facility's P&P titled Medication Access and Storage dated 2/2019 showed the medications storage areas are kept clean, well-lit and free of clutter. On 7/14/26 at 807 hours, a continuation of medication storage room inspection of Medication Storage Room B and concurrent interview with RN 5 was conducted. The bottles of magnesium (an essential mineral supplement), Renavite (vitamins), acetaminophen (pain medication) and stool softener were observed stored in a blue bin with brown and white stains at the base. The observation was verified by RN 5 and stated, Yes, it is dirty, I will wipe it out, When asked why it is important to (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	keep the medication storage clean, RN 5 stated, It should be clean for risk of contamination. RN 5 further stated all nurses were responsible for cleaning and it was everyone's responsibility. On 7/14/26 at 815 hours, an interview was conducted with the DON. The DON verified the above findings and stated the oral and non-oral medications should not be stored together, These are all anti-diarrhea and for constipation, they are confused. The DON also verified the blue bin had brown and white stains at the base of the bin, It is dirty, we will in-service everyone. On 7/15/26 at 1445, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, facility document review, and facility P&P review, the facility failed to ensure the resident's food preferences were followed for one sampled resident (Resident 5). * Resident 5's lunch tray contained buns, breaded chicken, fries, lettuce, and tomato, even though her meal ticket listed tomato as one of her dislikes. This failure had the potential to result in poor meal intake and negatively impact Resident 5's psychosocial well-being. Findings: Review of the facility's P&P titled Food Preferences dated 2023 showed the resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group. Condiments such as salt, pepper and sugar are available at each meal unless contraindicated by the diet order. On 7/12/26 at 1218 hours, a dining room observation was conducted with Resident 5 in her room. Resident 5 was observed sitting on her bed with a lunch tray positioned in front of her on the overbed table. Resident 5's lunch tray was observed with a plate of buns, breaded chicken, fries, lettuce and tomato. Review of Resident 5's lunch meal ticket (used to identify the resident's diet, consistency, beverages, devices and food preferences) showed Resident 5's dislikes included orange juice, oranges, tomatoes, banana, honeydew, cantaloupe, milk or milk products and fried foods. Medical record review for Resident 5 was initiated on 7/12/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Annual MDS assessment dated [DATE], showed a BIMS of 15 (intact cognition). Review of Resident 5's Order Summary Report for 7/2026 showed a physician's orders dated 11/1/25 for CCHO, NAS diet, Regular, Renal restrictions, no milk or dairy products, oranges, tomatoes, banana, cantaloupe, honeydew, and no fried foods. Review of Resident 5's Nutritional care plan dated 7/1/25 showed under interventions/ tasks included to provide CCHO, NAS diet, Regular, Renal restrictions, no milk or dairy products, oranges, tomatoes, banana, cantaloupe, honeydew, and no fried foods. Honor resident rights to make personal dietary choices and to provide dietary education as needed. On 7/13/26 at 1242 hours, an interview was conducted with the DSS. The DSS was informed of the above observation with a photograph of Resident 5's lunch tray taken on 7/12/26 at 1218 hours. The DSS verified the above findings and stated the resident was non-compliant with her diet, however, the diet order should have been followed and the resident's dislikes should have been honored. On 7/15/26 at 1545 hours, the Administrator and DON were informed and acknowledged the above findings.		

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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** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to accurately determine whether Resident 2's prescribed Zosyn (antibiotic) had met the McGeer's criteria. This failure had the potential to result in adverse reactions associated with antibiotics and the development of antibiotic-resistant bacteria. Findings: Review of the facility's P&P titled Antibiotic Stewardship revised 1/2022 showed the antibiotic stewardship program was incorporated in the overall infection prevention and control program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. The team will assess the residents for any infection using McGeer's criteria. The facility may consider antibiotic time out practices when a resident's diagnostic test or symptoms do not support the diagnosis of infection. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic. Medical record review for Resident 2 as initiated on 7/15/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 2/1/26, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's SBAR Communication Form dated 7/4/26, showed Resident 2's urine culture results were positive for ESBL(extended-spectrum beta-lactamase - an enzyme found in some strains of bacteria). The physician was informed and ordered to administer Zosyn intravenously for seven days. Review of Resident 2's Infection Screening Evaluation dated 7/4/26, showed the following were under the evaluation section: - checked yes: age over [AGE] years old, current active diagnosis of infection, had myalgia (body aches) and urinary incontinence; and - Resident 2 was afebrile, had no indwelling catheter, no new onset of hypotension (low blood pressure), pulse rate was not above 100 bpm, and the respiratory rate was not above 25 breaths per minute. Further review of the document showed the analysis section was incomplete. The document did not indicate if McGeer's criteria was met or not met, and there was no documentation showing the physician was notified Resident 2 did not meet McGeer's criteria. On 7/14/26 at 1444 hours, an interview, concurrent medical record review for Resident 2, and facility document review were conducted with the IP. The IP stated within her role as the facility's infection preventionist, she was responsible for oversight of the facility's antibiotic stewardship program. The IP stated she monitored the residents' prescribed antibiotics daily and determined whether those residents had met McGeer's criteria. The IP stated when a resident's prescribed antibiotic failed to meet McGeer's criteria, the resident's physician would be notified to determine if the antibiotic should be continued. The IP verified the above findings and stated Resident 2's Infection Screening Evaluation was incomplete. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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NAME OF PROVIDER OR SUPPLIER Pacific Haven Subacute and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12072 Trask Ave. Garden Grove, CA 92843	
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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 2) reviewed for immunizations and four out of eight staff members reviewed for COVID-19 vaccinations were offered the COVID-19 vaccination. * The facility failed to ensure Resident 2 had a completed COVID-19 informed consent for the refusal of the vaccination. * The facility failed to maintain documentation if the staff members received COVID-19 vaccinations were provided education regarding the benefits and risks of COVID-19 vaccine and were offered the COVID-19 vaccine per facility P&P. These failures places the residents and staff members at risk of COVID-19. Findings: Review of the facility's P&P titled Immunizations - Staff revised 7/2023 showed the intent of the facility was to help reduce the risk of staff contracting and spreading COVID-19. The facility will educate the staff on the risks and benefits for the specific vaccine, offer to administer the vaccine, and report vaccination data to the CDC National Healthcare Safety Network. Under the COVID-19 section, if staff have received previous vaccinations for COVID-19, the staff will provide verification of vaccine(s) at the time of hire. If an employee declines the vaccine for reasons other than medical contraindications, this shall be documented on the Consent for COVID-19 Vaccination. The consent and record of vaccination shall be maintained in the employees medical record. Review of the facility's P&P titled Immunizations - Residents revised 7/2023 showed the facility will offer and administer COVID-19 immunizations to eligible residents after providing education on the risks and potential side effects of the vaccine and obtaining consent. Before offering any vaccine and to ensure a resident's right to choose, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization. Documentation of the administration, refusal, medical contraindications and education provided will be documented in the resident's medical chart. 1. Medical record review for Resident 2 as initiated on 7/15/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 2/1/26, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's Immunization Details for COVID-19 dated 10/23/24, showed Resident 2's representative refused the vaccination. However, the documentation did not identify which staff member provided education to Resident 2's representative and did not identify Resident 2's representative who refused the vaccination was. On 7/15/26 at 1021 hours, an interview and concurrent record review for Resident 2 was conducted with the IP. The IP stated the residents could choose or refuse vaccinations and the licensed staff members documented the administration or refusal, risks and benefits explained, the VIS (Vaccine Information Statement) provided, who received the education, and who administered the vaccine. The IP verified the above findings and stated the documentation was missing Resident 2's representative name and who provided the education. On 7/15/26 at 1417 hours, a follow-up interview and concurrent record review for Resident 2 was conducted with the IP. The IP provided Resident 2's Consent for Influenza, Pneumococcal and COVID-19 Vaccine dated 1/22/24. Review of Resident 2's Consent for Influenza, Pneumococcal and COVID-19 Vaccine dated 1/22/24, showed Resident 2 did not wish to receive the COVID-19 vaccine. However, the consent did not show Resident 2's representative's name, signature or date for obtaining consent of the refusal. The IP was asked which of Resident 2's representative was informed and was provided education regarding the COVID-19 vaccine, the IP stated the (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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative could be one of Resident 2's family members. The IP verified that no representative signature had been obtained. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 7/15/25 at 1004 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the facility staff vaccination was tracked on a worksheet. Review of the facility's untitled document showed the following information: the name of the staff member, the staff member's vaccination status, the date of the received vaccination, and whether the vaccine was received in-house or outside of the facility. Further review of the document showed the following:- LVN 1 declined the COVID-19 vaccine; and- CNA 4 received the vaccination outside of the facility; and- CNA 5 and LVN 7's vaccination status were not included on the list worksheet. The IP could not provide documentation LVN 1 declined the vaccine and was educated regarding the benefits and potential risks associated with the COVID-19 vaccine and the IP could not provide documented evidence of CNA 4's vaccination status. The IP stated CNA 5 and LVN 7 were recently hired and she believed they were vaccinated because CNA 5 and LVN 7 stated they were already vaccinated upon hire. When asked if the IP verified their vaccination status, the IP stated no. The IP further stated she had staff members' COVID-19 immunization status from 2023 to 2024, however the facility no longer asked for COVID-19 immunization status for their newly hired staff members. The IP verified the above findings. On 7/15/26 at 1059 hours, an interview was conducted with HR Payroll. HR Payroll stated the facility stopped verifying staff members COVID-19 vaccination status in 2025 because they were told from the previous Administrator the information was not needed. On 7/15/26 at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		