STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055653	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Coast Post Acute	1030 W Warner Ave Santa Ana, CA 92707

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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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the privacy was provided for one of one reviewed resident (Resident 1). * The facility failed to ensure Resident 1's adult briefs and bilateral lower extremities were not exposed or seen in the hallway. This failure had the potential to negatively affect the dignity of the resident and violate the resident's right to privacy. Findings: Review of the facility's P&P titled Quality of Life-Dignity revised 2/2020 showed the residents are treated with dignity and respect at all times. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment process. Medical record review for Resident 1 was initiated on 4/18/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 4/15/24, showed Resident 1 had the capacity to make decisions. Resident 1 had a diagnosis of status post open reduction and internal fixation (ORIF, put pieces of a broken bone into place using surgery with screws, plates, sutures, or rods to hold the broken bones together) to the left ankle fracture. During the initial tour of the facility on 4/18/24 at 1017 and 1031 hours, Resident 1 was observed from the hallway awake and lying in bed with bilateral lower extremities and adult brief exposed and seen. On 4/18/24 at 1039 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 verified Resident 1's bilateral lower extremities and adult briefs were visibly seen in the hallway. On 4/18/24 at 1041 hours, an interview was conducted with Resident 1. Resident 1 stated she pushed the call light button a quarter before 1000 hours, because she needed assistance to be clean after a bowel movement. Resident 1 stated she had been waiting for a long time and no staff had answered her call. Resident 1 further stated the therapist told her that he was going to tell the nurse to answer the light. Resident 1 stated, of course, I don't feel good that people can see me from the hallway. They could had put a blanket over me. (continued on next page)

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	On 4/18/24 at 1043 hours, an observation and concurrent interview as conducted with CNA 1. CNA 1 verified the above findings. CNA 1 stated earlier in the day she gave Resident 1 a bed bath. Then, the therapist came and worked with Resident 1. CNA 1 further stated the therapist placed Resident 1 back to bed. CNA 1 stated the therapist could had covered Resident 1 with a blanket or drew the curtain before leaving Resident 1's room. On 4/18/24 at 1107 hours, an interview was conducted with the PTA. The PTA stated she placed Resident 1 back to bed because Resident 1 felt nauseous and had to have a bowel movement. The PTA stated he told Resident 1 to press her call light button when she was finished and needed to be clean. The PTA verified he did not put a sheet over Resident 1 due the sheets might get dirty. The PTA verified he did not draw Resident 1's curtain before leaving her room and stated he should have had drawn the curtain for privacy. On 4/18/24 at 1630 hours, the Administrator and DON were informed and acknowledged the above finding.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the care needs for two of five residents (Residents 1 and 3) reviewed for call lights. * The facility failed to ensure Resident 1's call light was answered in a timely manner. * The facility failed to ensure Resident 3 was assisted promptly or informed of when the resident would get assistant after the staff answered the call light and was unable to fulfill the resident's request. These failures had the potential to negatively impact the resident's psychosocial well-being or result in a delay to provide care and services to the residents. Findings: Review of the facility's P&P titled Answering the Call Light revised 9/2022 showed answer the resident call system immediately. If the resident needs assistance, indicate the approximate time it will take for you to respond. If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. 1. During the initial tour of the facility on 4/18/24 on 1017 hours, Room A's light abovethe door was observed lit up and call light sound triggered. A male staff voice was heard talking to Resident 1 and stated he would press the call light for Resident 1 and would tell the nurse about her nausea. Medical record review for Resident 1 was initiated on 4/18/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 4/15/24, showed Resident 1 had the capacity to make decisions. On 4/18/24 at 1023 hours, a male staff was observed in the hallway placing names of residents outside the room door. A female housekeeper was observed cleaning in front of Room A. On 4/18/24 at 1025 hours, a female staff came out of an office and passed by Room A with the call light button and sound on. On 4/18/24 at 1028 hours, the PT was observed standing in front of Room A, peaked in the room from Room A's entry door, and walked away with the call light and sound on. On 4/18/24 at 1038 hours, CNA 2 was observed entering Room A and answering the call light. On 4/18/24 at 1039 hours, an interview was conducted with CNA 2. CNA 2 stated she went to Room A to answer the call light and Room A's resident in bed B wanted a pain medication. CNA 2 stated she did not notice Room A's call light was on earlier because she was doing something in another room. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 1041 hours, an interview was conducted with Resident 1. Resident 1 stated she pushed the call light button a quarter before 1000 hours, because she needed assistance to be clean after a bowel movement. Resident 1 stated she had been waiting for a long time and no staff had answered her call. Resident 1 further stated the therapist told her that he was going to tell the nurse to answer the light, but no staff came to assist her. On 4/18/24 at 1046 hours, an interview was conducted with the PT. The PT verified she went in from of Room A earlier and peaked in the room to see if the room was clean so she could return another resident back to Room A. The PT stated she did not notice or hear the call light in Room A was on. On 4/18/24 at 1052 hours, an interview was conducted with LVN 3. LVN 3 stated everyone was responsible in answering the resident's call light. LVN 3 stated when a resident pressed the call light button, a light would turn on at the top of a resident's room and a sound wouldbe triggered to alert staff there was a call light on. LVN 3 further stated a call light panel in the nursing station would show which room triggered the call light and a sound would trigger to make staff aware a call light was on. 2. During an observation on 4/18/24 at 1424 hours, the light aboveRoom B's door and noise was triggered. On 4/18/24 at 1425 hours, the MDS Coordinator was observed entering Room B, the light above Room B's door was off, and the MDS Coordinator exited the room. The MDS Coordinator was observed reporting to LVN 1 in the nursing station that Resident 3 wanted to be transferred back to his bed. LVN 1 paged for a CNA to attend to Room B. CNA 3 was observed wheeling another resident and told LVN 1 that she had to assist this resident first and then would go back to help Resident 3. On 4/18/24 at 1435 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator verified she went to Room C to answer the call light for Resident 3. The MDS Coordinator stated Resident 3 wanted to be transferred back to bed. The MDS Coordinator verified she turned off the call light for Resident 1 because she told the Resident 3, she would tell the charge nurse call someone to help him back to bed. The MDS Coordinator stated she did not tell Resident 3 how long it would take for the CNA to transfer him back to bed. On 4/18/24 at 1438 hours, an interview was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated she did not go to Resident 3 to let him know CNA 3 was helping another resident and wouldassist him after. LVN 1 stated she could have asked another CNA to assist Resident 3 or assisted Resident 3 herself. LVN 1 stated it was alright the call light was off because the MDS Coordinator already told her Resident 3's request for assistance. On 4/8/24 at 1630 hours, the Administrator and the DON were informed and acknowledged the above findings. The Administrator stated the call lights should be answered immediately. The Administrator stated everyone was responsible in answering the call light and the first person to see the call light on should answer the call light promptly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure Resident 2's medicationswere administered as per physician's order due to a lack of availability of the medications for one of two sampled residents reviewed for medication administration (Resident 2). * LVN 1 failed to ensure Resident 2's Lasix (medication use to treat fluid retention and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions) supply was available for scheduled administration as per the physician's order. * Resident 2 was admitted to the facility on [DATE]. However, the pharmacy failed to deliver Resident 2's prescribed medication for Entresto (a fixed-dose combined medication used to treat heart failure). * Resident 2's medical record did not show documented evidence Resident 2's physician was notified of Resident 2 not receiving her scheduled Entresto medication on 4/17-4/19/24 at 0900 and 1700 hours. * LVN 1 failed to ensure Refresh Tears (use to treat eye dryness) ophthalmic solution was administered to Resident 2 prior to signing the Resident 2's MAR. These failures posed the risk for negative health outcomes for Resident 2. Findings: Review of the facility's P&P titled Preparation and General Guidelines II2A: Medication Administration-General Guidelines dated 10/2017 showed medications supplied for one resident are never administered to another resident. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary dose were administered and documented. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are verified with a full signature in the space provided on the MAR. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. Documentation procedures may be revised based on electronic MAR protocol. Review of the facility's P&P titled Medication Orders IB1: Prescriber Medication Orders dated April 2008 showed the prescriber is contacted to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, the directions are confusing). The prescriber is contacted for direction when the medication will not be available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.a. During medication administration observation for Resident 2 on 4/19/24 at 0822 hours, LVN 1 stated Resident 2's had a physician's order to administer Entresto medication at 0900 hours. LVN 1 stated the Entresto medication was not available and would follow up with the pharmacy after her medication pass. LVN 1 stated Resident 2 had a physician's order to administer Lasix 40 mg at 0900 hours. However, LVN 1 stated there was no supply for Resident 2's Lasix medication and she borrowed the medication from the afternoon shift or another resident's Lasix supply. LVN 1 was observed taking out two 20 mg tablets from Resident A Lasix bubble pack (a form of tamper-evident where an individual pushes individually sealed tablets through the foil in order to take the medication) to equal to Resident 2's 40 mg of Lasix as per the physician's order. LVN 1 was observed administering the following medications to Resident 2 by mouth: - aspirin chewable (medication use to prevent blood clots) 81 mg one tablet, - bisoprolol (medication use to treat high blood pressure) 5 mg one tablet, - famotidine (medication use to treat heartburn) 20 mg one table, and - Lasix 20 mg two tablets. Medical record review for Resident 2 was initiated on 4/19/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 4/17/24, showed Resident 2 had no capacity to make decisions. Review of Resident 2's Order Summary Report for April 2024 showed the following physician's orders for the medications to be administered at 0900 hours to Resident 2: - dated 4/16/24, aspirin oral tablet 81 mg by mouth one time a day, - dated 4/16/24, bisoprolol fumarate oral tablet 5 mg by mouth one time a day, - dated 4/16/24, Entresto oral tablet 24-26 mg one tablet two times a day, - dated 4/16/24, famotidine oral tablet 20 mg by mouth two times a day, - dated 4/16/24, Refresh Tears ophthalmic solution one drop in both eyes three times a day, and - dated 4/17/24, Lasix oral tablet 20 mg two tablets one time a day. Medical record review for Resident A was initiated on 4/19/24. Resident A was readmitted to the facility on [DATE]. Review of Resident A's Order Summary Report for April 2024 showed a physician's order dated 12/18/23, to administer Lasix oral tablet 20 mg one tablet by mouth two times a day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/24 at 1116 hours, an interview and medical record review was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated if a resident's medication was unavailable, the licensed nurse should follow up with the pharmacy, request for supply, and ask for delivery time, check the E-kit (emergency kit, contains a small quantity of medications that can be dispensed when pharmacy services are not available) if medication was available to use, and notify the doctor if the medication was not available and was not administered. LVN 1 stated the licensed nurses were responsible to request a refill from the pharmacy if a resident only had five days left of medication supplies either by a call or fax. LVN 1 verified there was no documentation to show if there was a refill request of Resident 2's Lasix from the pharmacy. LVN 1 verified Lasix supply was available in the E-kit. LVN 1 stated she should have not borrowed from Resident A's Lasix supply to use to administer to Resident 2. On 4/19/24 at 1145 hours, an interview was conducted with the Pharmacist. The Pharmacist stated he did not see that there was an order of Lasix for Resident 2 that was sent in from the facility and there was no request to refill the Lasix from the facility. b. Review of Resident 2's Medication Administration Record (MAR) for April 2024 showed Resident 2 was not administered Entresto medication as ordered by the physician on 4/17-4/19/24. Review of Resident 2's Drug Regimen Review (DRR) dated 4/16/24, showed the system had identified a possible drug allergy for the Entresto order and a drug-to-drug interaction for spironolactone (medication use to treat high blood pressure or fluid retention) and Entresto for the risk of hyperkalemia (a high level of electrolyte potassium in the blood). On 4/19/24 at 1116 hours, an interview and medical record review was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 verified there was no available supply for Resident 2's Entresto medication. LVN 1 verified there was no documentation to show if there was a request to fill the supply for Entresto to the pharmacy. LVN 1 verified there was no documentation to show the physician was notified Resident 2 was not administered Entresto on 4/17-4/18/24. On 4/19/24 at 1145 hours, an interview was conducted with the Pharmacist. The Pharmacist verified Resident 2's Entresto supply was not delivered to the facility due there was a question Resident 2 had a drug allergy to lisinopril (medication use to treat high blood pressure). The Pharmacist stated they tried to call the facility for a clarification but there was no response from the facility. The Pharmacist stated Resident 2's medication was all delivered except for Entresto, but they sent a drug regimen review documentation for Entresto to be clarified. The Pharmacist verified there was no request to refill the Entresto medication. On 4/19/24 at 1214 hours, an interview was conducted with the DON. The DON stated if resident's medication was unavailable, the licensed nurses should call the pharmacy to follow up and find out the delay of the delivery of the medication. The DON stated they had been working with a new pharmacy on April 1, 2024. The DON stated the licensed nurses were to fax or email medication orders to the pharmacy. The DON stated they had been working with the new pharmacy to send a new fax machine to show confirmation receipt due to their current fax machine did not print confirmation receipt. The DON also stated the electronic physician's orders were not integrated yet from their software to the pharmacy. The DON verified the above findings. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of Resident 2's Progress Notes for April did not show documented evidence the physician was notified Resident 2 was not administered Entresto medication on 4/17-4/18/24. On 4/19/24 at 1116 hours, an interview and medical record review was conducted with LVN 1. LVN 1 verified the above finding and stated the physician should had been notified Resident 2's Entresto medication was not given. On 4/19/24 at 1214 hours, an interview was conducted with the DON. The DON stated if a resident's medication was unavailable and not administered, the physician should be notified, ask the physician to reschedule the administration time of the medication or ask the physician an alternative medication to be administered to the resident, notify the resident of the specific medication not administered, and document. d. on 4/19/24 at 1116 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified she did not administer Resident 2's Refresh Tears eye drops as ordered by the physician. LVN 1 verified she signed Resident 2's MAR to show Refresh Tears eye drops were administered. On 4/19/24 at 1630 hours, the Administrator and DON were informed and acknowledged all the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of one reviewed resident (Resident 2) for unnecessary medication was free from the unnecessary psychotropic drug (any drug that affects brain activity associated with mental processes and behavior). The facility failed to ensure Resident 2's physician's order for Seroquel (antipsychotic medication) had a diagnosis justify for the use of medication, implemented nonpharmacological interventions prior to drug use, monitored targeted behavior, and monitored side-effects of the drug use. These failures had the potential for Resident 2 to have adverse complications from the medication and the potential of not providing the correct data to the prescriber in order to adjust the dose of the psychotropic medication for Resident 2. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed the facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social, or environmental cause of the resident's behaviors. Facility should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. Residents who exhibit new or worsening behavioral or psychological symptoms of dementia will be evaluated by a health care professional and the care team to identify contributing factors: Treatable medical conditions, physical problems, emotional stressors, psychiatric or psychological factors, social issues, or environmental factors. Facility should involve the resident or the resident's representative(s) in the management of behaviors and the involvement should be documented in the resident's medical record. Psychotropic medications may be used to address behaviors only if non-drug approach and interventions were attempted prior to their use. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effects. All residents receiving medications used to treat behaviors should be monitored for efficacy, risks, benefits, harm or adverse consequences. Facility staff should monitor resident's behavior pursuant to Facility policy using a behavioral monitoring chart or a behavioral assessment record for residents receiving psychotropic medication for Behavioral or Psychological Symptoms of Dementia (BPSD). Facility should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions. Medical record review for Resident 2 was initiated on 4/19/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 4/17/24, showed Resident 2 had no capacity to make decisions and had a diagnosis for dementia (loss of mental function such as thinking, memory, and reasoning skills). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Order Summary Report for April 2024 showed a physician's order dated 4/17/24, to administer Seroquel 12.5 mg by mouth at bedtime for restlessness. Review of Resident 2's MAR for April 2024, showed Resident 2 was administered Seroquel 12.5 mg 4/17 and 4/28/24 at 2100 hours. Review of Resident 2's eInteract Change in Condition Evaluation dated 4/17/24, showed Resident 2 had an episode of a fall. In addition, the form showed an on-call physician recommended to start Resident 2 with Seroquel 12.5 mg that night with the family's consent. Further review of Resident 2's medical record did not show documented evidence the physician's order for Seroquel had a diagnosis justify the use of medication, nonpharmacological interventions were attempted prior to Seroquel use, targeted behavior and side-effects were monitored for Seroquel use. On 4/19/24 at 1440 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated before administering Seroquel to the resident, there should be nonpharmacological interventions offered, obtained informed consent, proper diagnosis to the medication, should monitor for the behavior and side-effects of the medication. On 4/19/24 at 1445 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Seroquel order was recommended by the physician when Resident 2 had an episode of fall on 4/17/24. On 4/19/24 at 1630 hours, the Administrator and DON were informed and acknowledged the above findings.