STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055674	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of four sampled residents (Resident 1) was free from accidents when the facility failed to follow their care plan requiring two-person assistance with bed mobility for Resident 1. * Resident 1 fell to the floor while being changed and turned in bed by one CNA. This failure resulted in Resident 1 falling to the floor with profuse bleeding from the head requiring Resident 1 to be transferred to the acute care hospital, which had the potential to negatively impact the resident's well-being. Findings: Review of facility's P&P tilted Activities of Daily Living (ADL), Supporting revised 3/2018 showed the appropriate care and services will be provided for the residents who are unable to carry out ADL care independently with the consent of the resident and in accordance with the plan of care, including the appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care); and mobility (transfer and ambulation, including walking). Review of the facility's P&P titled Falls and Fall Risk Managing revised 3/2018 showed based on the previous evaluation and current data, the staff will identify interventions related to the resident's specific risk and try to prevent the resident from falling and try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Review of the facility's P&P titled Care Plans, Comprehensive Person- Centered revised 12/2016 showed a comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Closed medical record review for Resident 1 was initiated on 5/15/24. Resident 1 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 5/7/24. Resident 1 had a diagnosis which included dependence on a respirator (ventilator, a machine that helps to breathe). (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's History and Physical Examination dated 4/28/24, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS dated [DATE], showed Resident 1 was dependent on the staff to roll from lying on the back, to the left and right sides, and return to be lying on the back on the bed. Further review of the MDS showed to code the resident dependent when the resident did not provide any effort to complete the activity or the assistance of two or more helper was required for the resident to complete the activity. Review of the Resident 1's Plan of Care dated 5/1/24, showed a care plan problem addressing the resident's ADL deficits. Further review of the care plan showed Resident 1 required total care with two-persons assist for bed mobility. In addition, the plan of care showed a care plan problem dated 5/7/24, for Resident 1 rolling out of the bed secondary to the use of LAL mattress. The care plan interventions included to have two plus persons assist for the bed mobility and during ADL care. Review of the Resident 1's Progress Note dated 5/7/24 at 0729 hours, showed at 0450 hours Resident 1 fell from the bed while the CNA was changing him, and according to the CAN, it was so sudden that she was not able to hold the resident as she was on the other side of the bed. The Progress Note further showed Resident 1 sustained an injury on the head and was bleeding profusely, a pressure dressing was applied, 911 was called, and Resident 1 was transferred to the acute care hospital at 0510 hours. Review of the Resident1's Acute Care Hospital record dated 5/7/24, showed Resident 1 fell while being turned and sustained a fracture of the first cervical vertebra which was unstable, no surgery could be done, and the Resident 1 was placed in a collar to stabilize his cervical spine. Review of the Resident 1's Acute Care Hospital's CT head result dated 5/7/24 showed the cervical right anterior and posterior arch acute mildly displaced fracture with prevertebral (muscles of the head and neck) edema (swelling). The CT result further showed withright scalp injury without an underlying acute fracture. On 5/14/24 at 1536 hours, a telephone interview was conducted with CNA 1. CNA 1 stated on 5/7/24 at around 0400 hours to 0430 hours, Resident 1 was about to be transferred to the acute care hospital for a blood transfusion. The RN had asked her to getResident 1 ready for the transfer. CNA 1 stated Resident 1 was not wearing a diaper. The RN asked her to put a diaper on Resident 1. CNA 1 stated she noted a wound on Resident 1's back and notified the LVN. The LVN then performed the treatment on Resident 1's wound and left the room. CNA 1 stated she was at the left side of the bed of Resident 1 when she attempted to turn Resident 1 towards his right side on the bed to clean Resident 1. CNA 1 lost control of Resident 1 and the resident fell on the floor on the right side of the bed. When asked if CNA 1 asked for assistance from another staff before turning Resident 1 on his bed, CNA 1 stated she did not ask for assistance and thought she could change Resident 1 herself. CNA 1 stated it was her first time working with Resident 1. CNA 1 further stated she was not informed Resident 1 needed two-persons assist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1617 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with LVN 2. LVN 2 stated Resident 1 was dependent on the staff for his ADL care. LVN 2 further stated Resident 1 weighed around 180-200 pounds and it would be a safety risk for one person to attempt to turn Resident 1 on his bed and required two-persons staff assistance for bed mobility. LVN 2 verified the care plan for Resident 1 dated 5/1 and 5/7/24, showed Resident 1 required two-persons staff assistance for bed mobility. On 5/15/24 at 1047 hours, an interview was conducted with CNA 4. CNA 4 stated she had taken care of Resident 1. CNA 4 stated Resident 1 occasionally opened his eyes and was not able to move and communicate. In addition, CNA 4 stated Resident 1 was dependent on the staff for his care and required two-persons staff assistance to change and turn Resident 1 on his bed. CNA 4 further stated she always asked for another staff to help her to change or turn the Resident 1 on his bed. On 5/15/24 at 1338 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON was informed and verified of the above findings. The DON verified the care plan identified Resident 1 required two-persons staff assistance for bed mobility. The DON further stated CNA 1 should have asked for assistance from another staff before turning Resident 1 in the bed himself. On 5/15/24 at 1411 hours, a telephone interview was conducted with RN 1. RN 1 stated on 5/7/24 around 0445 hours, a staff from the facility came towards her and said Resident 1 fell from his bed. RN 1 stated she rushed towards Resident 1's room and saw Resident 1 on the floor on his right side of the bed profusely bleeding from his head and a respiratory therapist was putting a pressure on Resident 1 ' s head to control the bleeding. RN 1 further stated she called 911 and transferred Resident 1 to the acute care hospital. On 5/15/24 at 1424 hours, a telephone interview was conducted with LVN 1. LVN 1 stated on 5/15/24 around 0430 hours, Resident 1 was about to be transferred to the acute care hospital for the blood transfusion. LVN 1 stated he performed the dressing change and asked CNA 1 if she needed help to clean Resident 1. CNA 1 told him she did not need assistance and she could clean Resident 1 by herself, so LVN 1 left the room. LVN 1 further stated he heard a noise, rushed towards Resident 1's room, then saw Resident 1 already on the floor bleeding from his head, and a respiratory therapist was putting the pressure on his head to control the bleeding. On 5/15/24 at 1524 hours, a telephone interview was conducted with the DSD. The DSD stated CNA 1 was hired from the registry company and on 5/7/24, it was CNA 1's first day working in the facility. The DSD stated she came to the facility to provide orientation and perform competency evaluation of CNA 1 before her shift started on 5/7/24, and discussed with CNA 1 regardingtaking care of the residents with ventilators, and CNA 1 verbalized she was competent and to only provide care to the residents who were on ventilators in the presence of a respiratory therapist or LVN. The DSD further stated CNA 1 should have called a respiratory therapist or LVN to assist her to provide care to Resident 1. On 5/15/24 at 1605 hours, a telephone interview was conducted with the Rehabilitation Director. The Rehabilitation Director stated Resident 1 required total, two-persons assistance during bed mobility for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 1650 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON were informed and acknowledged the above findings.