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	10/17/2024

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 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** 47476 Based on interview, facility document review, and facility P&P review, the facility failed to ensure Resident 4 was provided care in a manner that promoted dignity and respect. * The facility failed to consistently honor Resident 4's request not to assign CNA 1 for her ADL care needs. This failure had the potential to negatively impact the resident's psychosocial well-being. Findings: Review of the facility's P&P titled Resident's Rights revised on December 2016 showed Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to a dignified existence, be treated with respect, kindness, and dignity; exercises her rights as a resident of the facility, be informed of and participate in, his or her care planning and treatment. On 10/17/24 at 1126 hours, an interview was conducted with CNA 3 for Resident 4. CNA 3 stated Resident 4 had complained about CNA 1 and requested not to have CNA 1 assigned to her care. On 10/17/24 at 1335 hours, an interview was conducted with Resident 4. Resident 4 stated she complained about CNA 1 to the facility and requested not to have CNA 1 assigned to her care. Resident 4 stated CNA 1 had not cared for her since she complained. However, Resident 4 stated CNA 1 was assigned to her during the night shift on 10/16/24, and changed her incontinence brief. Resident stated she informed CNA 1 not to touch her, but CNA 1 told Resident 4 that she needed to check if Resident 4's incontinence brief was soiled. Resident 4 verified she gave CNA 1 the permission to change her incontinence brief on 10/16/24. Review of the facility's Assignment Binder showed the following signage: Attencion License Nurses when making assignments please do not assign these residents in room [ROOM NUMBER]C (Resident 4) and resident in room [ROOM NUMBER]B to CNA 1 per residents request.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 3) was free from the unnecessary drugs. * The facility failed to ensure Resident 3's metoprolol tartrate (a beta-blocker, a medication a medication that works by affecting the nerve impulses in the body such as the heart and slows the heartbeat and decreases blood pressure) and hydralazine (medication used to treat high blood pressure) were administered as per the physician's orders. This failure had the potential for the resident to receive unnecessary medications and develop significant side effects. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the medications are administered in accordance with prescriber orders, including any required time frame. Medical record review for Resident 3 was initiated on 10/17/24. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed the following physician's orders: - On 2/16/22, to administer metoprolol tartrate 25 mg one tablet orally two times a day for HTN and to hold if SBP less than 110 mmHg or HR less than 60 beats per minute; and - On 2/16/22, to administer hydralazine HCl 100 mg one tablet orally three times a day for HTN, and to hold if SBP less than 110 mmHg. Review of Resident 3's eMAR for October 2024 showed Resident 3 was administered the following medications: - The metoprolol medication was administered on 10/12/24 at 0600 hours, with the BP (blood pressure) of 105/54 mmHg, 10/13/24 at 0600 hours, with the HR of 55, and on 10/13/24 at 1800 hours, with the HR of 55 beats per minute. - The hydralazine medication was administered on 10/11/24 at 1400 hours, with the BP of 106/55 mmHg. Review of Resident 3's plan of care showed a care plan problem initiated on 7/27/24, addressing Resident 3's hypertension. The interventions included to check and verify the vital signs for each resident prior to their medication administration if necessary. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 1515 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the blood pressure medications were not administered per the physician's orders and parameters. LVN 1 stated upon administering the blood pressure medications, the blood pressures were checked, and the results were compared with the ordered parameter. LVN 1 stated administering the blood pressure medications outside of the ordered parameters could further lower the resident's blood pressures and/or heart rates and lead to negative outcomes. On 10/17/24 at 1610 hours, an interview was conducted with the DON. The DON stated the nurses administering the blood pressure medications were expected to read the physician's orders and administer the medications as ordered. On 10/17/24 at 1615 hours, an interview was conducted with the AIT and DON. The AIT and DON acknowledged the above findings.