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	04/18/2024

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

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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** 39683 Based on observation, interview, medical record review, and facility document review, the facility failed to provide the residents' care timely for the residents on the SNF unit and two nonsampled residents (Residents A and 32). * The residents on the SNF unit were not repositioned or provided their usual care when only two CNAs were on duty. * Residents A and 32 waited more than an hour for incontinent care. These failures resulted in a delay of the residents' care, putting them at risk for negative outcome and resulting in feelings of discomfort. Findings: 1. Review of the Nursing Staffing Assignment and Sign-In Sheet for 3/20/24, for the 2300 to 0700-hours shift, showed two CNAs were assigned to care for 43 residents. On 4/17/24 at 1614 hours, a telephone interview was conducted with CNA 4. CNA 4 stated they worked on 4/14/24 at night shift, when there was a sick call, so they only had two CNAs for 43 residents. CNA 4 stated they were not able to get to the residents timely and some of the residents got angry. CNA 4 stated one resident had the call light on, and the charge nurse explained to the resident there were only two CNAs for the shift and they was busy with another resident. Then 10 minutes later, the resident used the call light again. CNA 4 stated, I went in their room to let them know I would be there as soon as possible to change her incontinent brief, and the resident said, yeah, but I'm hurting. On 4/18/24 at 0617 hours, an interview was conducted with CNA 2. CNA 2 stated on 3/20/24, the third assigned CNA called off, and there were only two CNAs for all the SNF residents. CNA 2 stated they had 22 residents each that night. CNA 2 stated there was too much to do and they were not able to perform their routine care during that shift. CNA 2 stated they usually did the incontinent care for the incontinent residents two to three times a shift but was only able to change them twice during that shift. CNA 2 stated the residents were not repositioned during her shift. 2. Review of the Nursing Staffing Assignment and Sign-In Sheet for 4/14/24 for the 2300 to 0700 hours shift, showed two CNAs were assigned to care for 43 residents. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Medical record review for Resident 32 was initiated on 4/16/24. Resident 32 was readmitted to the facility on [DATE]. Review of Resident 32's MDS dated [DATE], showed the resident was cognitively intact. On 4/16/24 at 0924 hours, an interview was conducted with Resident 32. Resident 32 stated sometimes it took an hour for staff to change her incontinent brief after using the call light; and specially when they were short of a CNA on the night shift, there was only one CNA for the entire hall of the residents. Resident 32 stated they had watched their wall clock that was how they knew it took an hour; and being in a soiled incontinent brief, it made them feel yucky. b. Medical record review for Resident A was initiated on 4/16/24. Review of Resident A's MDS dated [DATE], showed the resident was cognitively intact. On 4/17/24 at 1531 hours, an interview was conducted with Resident A. Resident A stated there was only one CNA for their hallway on 4/14/24, during the night shift and it took over an hour for their incontinent brief to be changed. Resident A stated the nurse explained they were short of a CNA. Resident A stated they were in pain and uncomfortable and wanted their incontinent brief to be changed, and it took more than an hour for the CNA to come and change them. On 4/18/24 at 0602 hours, an interview was conducted with LVN 9. LVN 9 stated on 4/14/24 at 2300 to 0700 hours shift, they had two CNAs instead of their usual three CNAs for 43 residents. LVN 9 stated most of the residents needed things and the CNAs were unable to answer all the call lights. LVN 9 stated the nurses tried their best to help, but they also had two LVNs for 43 residents. LVN 9 stated the nurses tried and helped by answering the call lights and getting water. When asked what cares were delayed that she was aware of, the LVN replied the incontinent cares. LVN 9 stated they explained to the residents they only had two CNAs and most of them were understanding. On 4/18/24 at 1007 hours, an interview and concurrent record review was conducted with the DON. The DON stated for the 2300 to 0700 hours shift, they staffed with three CNAs. If there was a sick call, the facility would try and get other staff to come in, or would call a registry. If they were unable to find anyone to come in, then the two CNAs would just have to split the number of residents in the SNF unit. The DON stated the Director of Staff Development Assistant was responsible for the CNA scheduling. On 4/18/24 at 1024 hours, an interview and concurrent record review were conducted with the Director of Staff Development Assistant. The Director of Staff Development Assistant stated they were staffed with three CNAs for the 2300 to 0700 hours shift, and if there was a sick call, they would see if other staff wanted to stay extra and try and get the registry staff to come in and work. The Director of Staff Development Assistant reviewed the staffing sheets for 3/20/24 and 4/14/24, for the 2300 to 0700 hours shift, and verified there were a CNA called off for both dates, and they were unable to find other staff to work. The Director of Staff Development Assistant reviewed the staff time punched for those days and verified the 1500 to 2300 hours shift staff did not stay over, and the following 0700 to 1500 hours shift did not come in early, apart from a CNA coming clocking in at 0630 hours, 30 minutes early for their shift, to assist.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide two of three final sampled residents reviewed for the Notice of Medicare Non-coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (Residents 901 and 902). The NOMNC and SNF ABN Forms were used to inform the residents of their potential financial liability and appeal rights and protections should they wish to receive care and services that may not be covered by Medicare. This failure had the potential for not allowing Residents 901 and 902 to make an informed decision regarding their Medicare services. Findings: Review of the facility's P&P titled Medicare Non-Coverage Notice dated April 2018 showed a Medicare provider or health plan must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services not later than two days before the termination of services. 1. Medical record review for Resident 901 was initiated on 4/17/24. Resident 901 was admitted to the facility on [DATE], and discharged home on 10/31/23. Review of Resident 901's Physician's Orders dated 10/31/23, showed Resident 901 was discharged home. However, further medical record review for Resident 901 did not show Resident 901 and Resident 901's representative were provided a NOMNC. 2. Medical record review for Resident 902 was initiated on 4/17/24. Resident 902 was readmitted to the facility on [DATE], and discharged home on 10/20/23. Review of Resident 902's Physician Orders List showed the following orders: - dated 10/6/23, to discharge skilled services; and, - dated 10/18/23, to discharge home 10/19 or 10/20/23, as per the family's request with medications and instructions. However, further medical record review for Resident 902 did not show Resident 902 and Resident 902's representative were provided a NOMNC or SNF ABN Form. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 1326 hours, an interview and concurrent facility document review for Residents 901 and 902 was conducted with the Administrator. The Administrator stated Resident 901's Medicare Part A skilled services episode start date was 10/26/23, and the last covered day of Part A service was 10/31/23. The Administrator also stated Resident 902's Medicare Part A skilled services episode start date was 8/8/23, and the last covered day of Part A service was 10/6/23. The Administrator was asked to provide the original notice or documentation Resident 901 was provided with the NOMNC and Resident 902 was provided with the NOMNC and the SNF ABN Form CMS-10055. The Administrator stated she was unable to find copies or documentation to show the NOMNC was provided to Residents 901 and 902 or the SNF ABN Form CMS-10055 was provided to Resident 902. The Administrator stated the previous SSD did not keep copies of the forms.

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50003 Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain the clean, sanitary, and homelike environment for one of 10 restrooms observed. * Resident 84's restroom was observed with multiple streaks of yellow stain on the wall near the mirror and sink. In addition, the restroom's floor was also observed with multiple brown circular stains. This failure posed the risk for unsanitary conditions and a negatively effect on Resident 84's well-being. Findings: Review of the facility's P&P titled Homelike Environment revised February 2021 showed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment. Medical record review for Resident 84 was initiated on 4/15/24. Resident 84 was readmitted to the facility on [DATE]. Review of the Resident 84's MDS dated [DATE], showed Resident 84's cognitive skills for daily decision making was severely impaired. On 4/15/24 at 1150 hours, during the initial tour, the shared restroom of Resident 84 was observed with multiple yellow streak stains on the wall by the mirror and multiple brown circular stains on the floor. On 4/16/24 at 1425 hours, Resident 84's restroom was observed with multiple yellow streak stains on the wall by the mirror and multiple brown circular stains on the floor. Family Member 1 stated he was pleased with the care provided to the resident, however, had a concern with the cleanliness of the restroom. On 4/18/24 at 0935 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified the above finding and stated the housekeeper was expected to clean the residents' room daily and as needed. On 4/18/24 at 0933 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the above finding and stated he was not aware of the stains. The Maintenance Director stated he would talk to the housekeeper to clean the restroom. The Maintenance Director stated he was in the process of replacing the floor tiles in the restroom; however, he stated he would have the housekeeper remove the stains in the meantime.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the restraint free periods for two of three final sampled residents reviewed for restraints (Residents 39 and 46). * The facility failed to ensure the mittens (mitten which look like boxing gloves with a Velcro or tie at the wrist to hold them in place and immobilize the resident's fingers) were released every two hours as per the resident's care plan and physician's order to release at least 10 minutes for Residents 39 and 46's both hands. These failures posed the risk of compromising the residents' independence and psychosocial well-being. Findings: Review of the facility's P&P titled Use of Restraints dated 4/2017 showed the following safety guidelines shall be implemented and documented while a resident is in restraints: A resident placed in restraint will be observed at least every thirty minutes by nursing personnel and an acoount of the resident's condition shall be recorded in the resident's medical reword. The opportunity of motion and exercise is provided for a period of not less than 10 minutes during each two hours in which restraints are employed. 1. Medical record review of Resident 39 was initiated on 4/15/24. Resident 39 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Order Summary Report of April 2024 showed a physician order dated 4/5/24, to apply the bilateral hand mittens, remove the restraints every two hours for at least 10 minutes and change the resident's position; and to exercise resident as tolerated and check the circulation, mobility, and sensation. On 4/15/24 at 0930 and 1220 hours, Resident 39 was observed lying in bed with the bilateral hand mitten. On 4/16/24 at 0955 hours, an interview and concurrent medical record review of Resident 39 was conducted with LVN 1. LVN 1 was asked how often she checked for the hand mitten. LVN 1 stated every two hours and released it sometimes for five minutes but most of the time for 10 minutes. On 4/17/24 at 1315 hours, an interview and concurrent medical record review of Resident 39 was conducted with RN 5. RN 5 was asked to provide documentation about the release of the bilateral hand mitten and assessment of skin and mobility. RN 5 acknowledged the MAR did not show the release of the hand mitten was documented for 10 minutes of the release period, and there was no assessment of the resident's skin and mobility was documented for 10 minutes release. RN 5 verified the findings. 39670 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/15/24 at 1020 hours, and 4/16/24 at 0938 hours, Resident 46 was observed in bed with the hand mittens on both hands. Medical record review for Resident 46 was initiated on 4/15/24. Resident 46 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 46's H&P examination dated 10/28/23, showed Resident 46 did not have the capacity to understand and make decisions. Review of Resident 46's Physician Orders for the month of April 2024 showed an order dated 10/26/23, to apply the bilateral hand mittens and monitor for pulling out devices every day and night shift; and to remove the bilateral hand mittens every two hours for at least ten minutes and change the resident position. The order also showed to exercise the resident as tolerated and check for circulation, mobility, and sensation. Review of Resident 46's plan of care showed a care plan problem dated 10/26/23, addressing the use of the bilateral hand mitten due to pulling out of the vital tubings and medical devices. The interventions included to check and release every two hours for circulation. Review of Resident 46's Medical Administration Record for the month of April 2024 showed documented evidence the bilateral hand mittens were checked and released every two hours as per the plan of care. However, there was no documented evidence the bilateral hands mittens were released at least for ten minutes duration as per the physician's order. Further review of Resident 46's medical record failed to show documented evidence for monitoring of the bilateral hand mitten for at least ten minutes duration after every two hours of released. On 4/17/24 at 0922 hours, an interview was conducted for Resident 46 with CNA 10. CNA 10 verified Resident 46 was always wearing the hand mittens on both hands because Resident 46's pulling out the medical devices and tubings. On 4/17/24 at 0936 hours, an interview and concurrent medical record review for Resident 46 was conducted with RN 5. RN 5 verified Resident 46's use of the bilateral hand mittens due to Resident 46's behavior of pulling out devices and hitting the staff. RN 5 was asked for the documentation about the release of the hand mittens every two hours with a duration of at least ten minutes and the assessment of the resident circulation and mobility. RN 5 verified there was no documentation for the assessment of the skin and mobility of the resident when the bilateral hand mittens were released after two hours. On 4/18/24 at 1026 hours, an interview and concurrent medical record review for Resident 46 was conducted with the DON. The DON verified 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** 39856 Based on observation, interview, and facility P&P review, the facility failed to ensure the comprehensive resident centered care plan was developed for one nonsampled residents (Resident 40) when the perishable and nonperishable food items were stored in Resident 40's room. This failure posed the risk to not provide appropriate, consistent, and individualized care. Findings: 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. Medical record review for Resident 40 was initiated on 4/5/24. Resident 40 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/5/24 at 1511 hours, an observation and concurrent interview was conducted with Resident 40. Resident 40's room had multiple nonperishable food items: chips, dehydrated soup, pastries, instant hot chocolate, canned goods, fresh potatoes and tomatoes stored on shelves in her room. Resident 40 had a small refrigerator stored on the shelf in her room. Resident 40 stated the small refrigerator was a cooler to chill items. The cooler contained pudding, potato salad, butter, and cheese. Resident 40 stated it was her right to have the food items stored in her room. On 4/16/24 at 1007 hours, an interview was conducted with LVN 11. LVN 11 stated it was nursing's responsibility to create a baseline care plan for each resident and was revised as needed, quarterly, and annually. LVN 11 confirmed Resident 40 was not compliant with facility's P&P regarding the storage of food from the outside and this should be on Resident 40's care plan. LVN 11 confirmed there was no care plan for Resident 40 regarding storage of food from the outside.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P, the facility failed to ensure the comprehensive plan of care for one of four final sampled residents reviewed for care plans (Resident 25) was revised to reflect the resident's current care needs and interventions. * Resident 25's care plan for behavior of anxiety manifested by inability to relax was not revised to address the new order for diazepam (an antianxiety medication). This posed the risk of not providing the resident with individualized and person-centered care. Findings: 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. The P&P showed a comprehensive person-centered care plan will incorporate identified problem areas and assessments of the residents are ongoing and care plan are revised as information about the residents and the resident's condition change. Medical record review for Resident 25 was initiated on 4/15/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 2/16/24, showed Resident 25 had major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. Review of Resident 25's Physician Orders for April 2024 showed a physician's order dated 3/30/24, to administer diazepam 5 mg one tablet by mouth two times a day for anxiety manifested by verbalization of panic attack, and to record the number of behaviors noted. Review of Resident 25's MAR for April 2024 showed Resident 25 was administered diazepam 5 mg one tablet by mouth two times a day for anxiety manifested by verbalization of panic attack from 4/1 to 4/16/24 at 0900 and 2100 hours, and on 4/17/24 at 0900 hours. Review of Resident 25's plan of care showed a care plan problem dated 10/30/23, addressing Resident 25's behavior of anxiety manifested by inability to relax. The care plan showed a black box warning for Xanax (an antianxiety medication). The care plan failed to include diazepam or indicate the manifestations of verbalizations of panic attacks. On 4/18/24 at 0937 hours, an interview was conducted with the DON. The DON verified the above findings. The DON stated Resident 25's care plan for anxiety was not revised to address the resident's order for diazepam on 3/30/24. The DON stated the care plan should have been updated or revised to indicate the new medication, dose, and manifestations of verbalization of panic attacks.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50003 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the services provided met the professional standards of care when LVN 7 failed to properly administer the medication for one nonsampled resident (Resident 44). This failure had the potential to negatively impact the resident's health due to malabsorption and reduction in the effectiveness of the medication. Findings: Review of the facility's P&P titled Nasal Inhalers, Sprays, and Pumps Administration Procedure dated 03/2023 showed the following instructions: - have the resident keep upright, - press a finger against the side of the nose to close one nostril, - keeping mouth closed, tip of pump, spray or inhaler is inserted into the nostril, - have resident sniff in through open nostril while pump or inhaler is quickly and firmly squeezed or activated, - instruct resident to hold his/her breath for a few seconds and then breathe out through mouth, and - repeat for other nostril if indicated. On 4/17/24 at 0846 hours, a medication administration observation was conducted with LVN 7 for Resident 44. LVN 7 was observed administering Flonase Allergy (use to treat allergy symptoms like sneezing, itching and a runny nose) nasal spray to Resident 44. LVN 7 primed the nasal spray, administered two consecutive sprays to Resident 44's left nostril, primed nasal spray again, then immediately administered two consecutive sprays to Resident 44's right nostril. LVN 7 did not instruct the resident to press a finger against the side of the nose to close one nostril, keep his mouth closed, and sniff in through the open nostril while the nasal spray was squeezed as per the P&P. In addition, LVN 7 did not instruct Resident 44 to hold his breath for a few seconds then breathe out through mouth after squeezing the nasal spray. On 4/17/24 at 1134 hours, an interview was conducted with LVN 7. LVN 7 verified he did not provide Resident 44 with any directions when he administered the nasal spray and stated the resident already knew how the medication worked. On 4/18/24 at 1458 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43156 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for one of 21 final sampled residents (Resident 33) to ensure the residents maintained their highest physical well-being. * The facility failed to ensure the heel protector boots were applied to Resident 33's BLEs as per the physician's order. This failure had the potential to affect the resident's well-being. Findings: On 4/17/24 at 0832 hours, a medical record review of Resident 33 was initiated. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's physician's order dated 3/3/24, showed an order to apply heel protector boots to the BLEs every shift for wound management and prevention while in bed. On 4/17/24 at 0832 hours, an observation and concurrent interview was conducted with CNA 8. Resident 33 was observed without the bilateral heel protectors while in bed. CNA 8 verified Resident 33 was not wearing heel protectors while in bed, and stated the nurses or physical therapy usually placed the heel protectors on. On 4/17/24 at 0832 hours, an observation and concurrent interview was conducted with LVN 12. LVN 12 verified Resident 33 was not wearing the bilateral heel protectors while in bed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126 Based on interview, medical record review, and facility P&P review, the facility failed to provide the RNA services as ordered by the physician for one of two final sampled residents reviewed for ROM functions (Resident 87). This failure had the potential for decline in the resident's range of motion and mobility. Findings: Review of the facility's P&P Charting and Documentation dated July 2017 shows documentation in the medical record may be electronic, manual, or a combination of both. The following information is to be documented in the resident's medical record: - treatments or services performed. Medical record review for Resident 87 was initiated on 4/15/24. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's Physician Orders List dated 9/1 to 9/30/23, showed the following orders dated 9/29/23, for RNA services: - RNA to provide PROM on BUE every day five times a week or as tolerated. - RNA to provide PROM on BLE every day five times a week or as tolerated. - RNA to apply RUE elbow extension splint every day five times a week for one to two hours or as tolerated. - RNA to monitor skin check before and after application of splints. - RNA to apply RLE knee extension splint every day five times a week for one to two hours or as tolerated. Review of Resident 87's Restorative Record for February and April 2024 showed there were no RNA's initials to show RNA services were provided as ordered on 2/10, 2/24, 4/7, and 4/13/24. On 4/16/24 at 1224 hours, an interview and concurrent medical record review was conducted with RNA 5. RNA 5 verified Resident 87's Restorative Record for February and April 2024 were missing documentation for 2/10, 2/24, 4/7, 4/13/24. RNA 5 stated he was not working on those days listed above. On 4/16/24 at 1239, an interview and concurrent medical record review was conducted with the DON. The DON verified the above finding and stated if the RNA missed the ROM exercises on a Saturday, the exercises could be done on the following Thursday.

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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** 48882 Based on observation, interview, and medical record review, the facility failed to ensure one of one final sampled resident reviewed for fall risks (Resident 23) remained free from accident hazards. The facility failed to implement the bilateral floor mats as per the physician's order and plan of care. This failure had the potential to place Resident 23 at risk for serious injury. Findings: On 4/15/24 at 0857 hours, during the initial tour of the facility, Resident 23 was observed lying in bed with a yellow wrist band (indicating fall risk), and no fall matts were observed in place. Medical record review for Resident 23 was initiated on 4/15/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 4/15/23, showed Resident 23 could make her needs known but could not make medical decisions. Review of Resident 23's Physician's Orders for April 2024 showed a physician's order dated 8/28/23, to implement bilateral floor mats to prevent from injury in the event of a fall. Review of Resident 23's plan of care showed a care plan problem dated 1/20/23, addressing Resident 23's risk for falls/injury related to history of falls, balance problems, poor safety awareness, hearing/vision problems, fall assessment score of eight. The interventions included to implement matt on the floor as ordered and apply a yellow star sticker beside resident's name to alert the staff that the resident at high risk for fall/has history of fall. On 4/16/24 at 0910 hours, Resident 23 was observed lying in bed, with the head of the bed elevated. A yellow star sticker was observed by Resident 23's name on the door. No fall matts were observed. On 4/16/24 at 1047 hours, an interview was conducted with LVN 3. LVN 3 was asked if Resident 23 was a fall risk resident. LVN 3 stated yes, Resident 23 had a history of falls; and the residents at high risk for falls were identified with a star by their name and a yellow wristband. A subsequent interview, medical record review, and concurrent observation of Resident 23 was conducted with LVN 3. LVN 3 verified Resident 23 did not have bilateral floor mats at the bedside as per the physician's order and the resident's care plan. LVN 3 was asked about the potential risk and LVN 3 stated there was a potential for injury in the instance Resident 23 fell . On 4/16/24 at 1100 hours, LVN 3 was observed asking staff to place the bilateral floor matts for Resident 23. A subsequent observation was conducted of the staff placing the bilateral floor mats beside Resident 23's bed. On 4/17/24 at 0910 hours, the DON was informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 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 IV accesses for two of two final sampled residents reviewed for IV care (Residents 53 and 67). * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented in the medical record for Residents 53 and 67 upon admission to the facility. In addition, the facility failed to obtain a physician's order for care and maintenance of the PICC line, and failed to develop a plan of care for the use of PICC. These failures had the potential to delay the identification of catheter related complications for these residents. Findings: Review of the facility's P&P titled Peripheral and Midline IV Dressing Changes with a revised 3/22 showed for central line catheters, to measure arm circumference and compare to baseline when clinically indicated to assess for possible complications. The P&P also showed to document the indication for use, insertion date, and type of catheter in the resident's medical record. 1. On 4/15/24 at 1221 hours, Resident 53 was observed in bed. Resident 53 was observed with a PICC line on the right upper arm with a transparent dressing dated 4/14/24. Medical record review for Resident 53 was initiated on 4/15/24. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/16/24 at 1414 hours, an observation and concurrent interview for Resident 53 was conducted with LVN 13. LVN 13 verified Resident 53's PICC line on the right upper arm. LVN 13 stated the PICC line was use for Resident 53's IV antibiotic medication. Review of Resident 53's Intravenous Therapy Medication Record for the month of April 2024 showed the care and maintenance of the PICC line on the resident's right upper arm. However, there was no documented evidence the measurement of the length of the PICC line above the insertion site and arm circumference were obtained upon admission. Review of Resident 53's physician's order failed to show documented evidence an order for the care and maintenance of the PICC line were obtained. In addition, review of Resident 53's plan of care failed to show documented evidence a care plan problem was developed to address the use of the PICC line. On 4/16/24 at 1422 hours, an interview and concurrent medical record review for Residents 53 was conducted with RN 1. RN 1 verified Residents 53's medical record did not show the PICC line external catheter and arm circumference measurements documented upon admission to the facility. 2. On 4/16/24 at 0945 hours, Resident 67 was observed in bed. Resident 67 was observed with a PICC line on the left upper arm with a transparent dressing dated 4/15/24. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 67 was initiated on 4/16/24. Resident 67 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 67's Intravenous Therapy Medication Record from 3/18/24 to 4/16/24, showed the care and maintenance of the PICC line on the resident's left upper arm. However, there was no documented evidence the measurement of the length of the PICC line above the insertion site and arm circumference obtained upon admission. Review of Resident 67's physician's order failed to show documented evidence an order for the care and maintenance of the PICC line were obtained. In addition, review of Resident 67's plan of care failed to show documented evidence a care plan problem was developed to address the use of the PICC line. On 4/16/24 at 1439 hours, an interview and concurrent medical record review for Residents 67 was conducted with RN 1. RN 1 verified Residents 67's medical record did not show the PICC line external catheter and arm circumference measurements documented upon admission to the facility. On 4/17/24 at 1352 hours, an interview and concurrent medical record review for Residents 53 and 67 was conducted with RN 6. RN 6 verified Residents 53 and 67's use of PICC line. RN 6 verified there was no physician's order for the care and maintenance of the PICC line obtained. On 4/18/24 at 0908 hours, an interview and concurrent medical record review for Residents 53 and 67 was conducted with the MDS Coordinator. The MDS Coordinator verified there were no specific plan of care developed for the use of PICC line for Residents 53 and 67. The MDS Coordinator stated there should have been a plan of care formulated for the use of PICC line of the residents. On 4/18/24 at 1018 hours, an interview and concurrent medical record review for Residents 53 and 67 was conducted with the DON. The DON was informed and verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the safe respiratory care to meet the needs for three of four final sampled residents (Residents 10, 16, and 53) and one nonsampled resident reviewed for respiratory care (Resident 51). * The facility failed to ensure Resident 16's ventilator machine alarms were set for high pressure alarms. In addition, the facility failed to ensure the nebulizer machine tubing was labeled. * The facility failed to ensure Resident 53's ventilator machine alarms were set for high pressure alarms. In addition, the facility failed to ensure the oxygen tubing labeled. * The facility failed to ensure Resident 10 received the amount of oxygen as ordered by the physician. * The facility failed to ensure Resident 51's oxygen concentrator was clean. These failures had the potential to result in poor health outcomes to the resident and posed the risk of delayed intervention in the event of an emergency. Findings: Review of the facility's P&P titled Ventilator Alarm and Corrective Action undated showed it is the responsibility of all health care providers to respond immediately to all ventilator alarms and perform corrective action to resolve the problem. Failure to respond immediately to ventilator alarms can be life threatening to the residents. 1. On 4/15/24 at 1438 hours, and 4/16/24 at 1017 hours, Resident 16 was observed in bed with a tracheostomy tube in place and connected to a mechanical ventilator. Resident 16's ventilator machine was observed set to 55 for high pressure alarm and 10 for low pressure alarm. The ventilator machine display showed a flashing of red light for the high pressure. However, there was no audible sound alarm heard in the resident's room, hallways, and nurse's station. Medical record review for Resident 16 was initiated on 4/16/24. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 16's Physician's Order showed an order dated 3/8/24, to set Resident 16's ventilator to AC mode, rate of 22, tidal volume of 450 ml, PEEP of +5, and FIO2/LPM: 2 LPM. Review of Resident 16's plan of care showed a care plan problem dated 3/8/24, addressing the ventilator alarm. The interventions included for the staff to respond promptly and assess the resident for any signs of respiratory distress when there was an audible alarm sound. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 1130 hours, an observation and concurrent interview at Resident 16's bedside was conducted with RT 3. RT 3 verified Resident 16's use of the ventilator machine. RT 3 verified the flashing red light on the ventilator machine. RT 3 stated the resident might have been coughed earlier and the ventilator machine alarmed. RT 3 verified there was no audible sound of the ventilator machine alarm. In addition, RT 3 verified there was no label in place for the tubing of the nebulizer machine. 2. On 4/15/24 at 1145 hours, and 4/16/24 at 0843 hours, Resident 53 was observed in bed with a tracheostomy tube in place and connected to a mechanical ventilator. The ventilator machine display showed a flashing of red light for the high pressure. However, there was no audible sound alarm heard in the resident's room, hallways, and nurse's station. Medical record review for Resident 53 was initiated on 4/15/24. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/16/24 at 1043 hours, an observation and concurrent interview at Resident 53's bedside was conducted with RT 4. RT 4 verified Resident 53's use of ventilator machine. RT 4 verified the flashing red light on the ventilator machine. RT 4 was asked why the ventilator machine had no audible alarm when flashing a red light. RT 4 verified and stated he accidentally silenced the alarm. In addition, RT 4 verified there was no label of the oxygen tubing in place. On 4/18/24 at 0952 hours, an interview was conducted for Residents 16 and 53 with the DON. The DON was informed of the above findings. The DON stated the ventilator machine alarms should have been placed on a setting that sounded an alarm to alert staff and attended the needs of the residents. The DON verified the findings. 48882 3. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the purpose of this procedure is to provide guidelines for safe oxygen administration. The Preparation section showed to verify that there is a physician's order for this procedure; review the physician's orders or facility protocol for oxygen administration; and review the resident's care plan to assess for any special needs of the resident. On 4/15/24 at 0929 hours, Resident 10 was observed lying in bed. Resident 10 was observed wearing an oxygen nasal cannula tubing (flexible tube to deliver oxygen into the nose) connected to an oxygen concentrator machine (a machine to provide continuous flow of oxygen). The oxygen meter was not on. Medical record review for Resident 10 was initiated on 4/15/24. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 12/23/23, showed Resident 10 had a diagnosis of chronic obstructive pulmonary disease (a progressive lung disease which blocks air flow making breathing difficult). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's Physician's Orders for April 2024 showed a physician's order dated 2/16/24, may administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath. Review of Resident 10's MAR for April 2024 showed the physician's order dated 2/16/24, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath. The MAR showed Resident 10 was administered with oxygen from 4/1/24 to 4/15/24, for all the shifts, day, evening, and night. On 4/16/24 at 1430 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 4. LVN 4 stated per the physician's order, Resident 10 was on two liters per minute of oxygen, continuously. A subsequent interview and concurrent observation was conducted at Resident 10's bedside. LVN 4 verified the oxygen concentrator flow meter was set at 2.5 liters per minute. LVN 4 stated per the physician's order, the resident should be receiving two liters per minute of oxygen. On 4/18/24 at 0924 hours, an interview was conducted with the DON. The DON was asked about her expectation of staff regarding the orders for oxygen therapy. The DON stated the staff should check the oxygen meter every day and compare it to the physician's orders. The DON stated the residents should be administered what ordered by the physician. When asked about the potential risk for a resident with COPD receiving more oxygen than ordered, the DON stated there may be a possibility of over oxygenation. The DON was informed and acknowledged the findings. 32179 4. Review of facility's P&P titled Respiratory equipment change and cleaning schedule, undated, showed on Sunday for day shift, all non disposable equipment (oxygen concentrators) will be disinfected by wiping down exterior casing of the unit using batercidal wipes. Medical record review of Resident 51 was initiated on 4/15/24. Resident 51 was admitted to the facility on [DATE]. On 4/15/24 at 0830 and 1120 hours, Resident 51 was observed receiving oxygen at three liters via TBAR (T piece connect endotracheal tube to deliver supplemental oxygen) from an oxygen concentrator. Resident 51's oxygen concentrator exterior was observed to have black and brown stained and dirty. On 4/15/24 at 1430 hours, RN 3 was summoned to the resident's room. Resident 51's oxygen concentrator was observed to have black and brown stained and dirty. RN 3 stated the oxygen concentrator should be cleaned. RN 3 verified the 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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care and services were provided for two of two final sampled residents reviewed for dialysis care (Residents 10 and 74). * The facility failed to ensure emergency supplies/kits were accessible at Resident 10's bedside in the event of dialysis (a treatment to rid the body of wastes and toxins when the kidneys fail to function) access bleeding/emergency. * The facility failed to ensure Resident 74's emergency dialysis kit was available at the bedside. These failures had the potential for Residents 10 and 74 not being provided appropriate care and treatment, and possibility of medical complications. Findings: Review of the facility's P&P titled Hemodialysis Catheters- Access and Care of revised 2/23, under the section for Care Immediately Following Dialysis Treatment, showed mild bleeding from site (post-dialysis) can be expected, and to apply pressure to insertion site and contact the dialysis center for instructions. If there is major bleeding from the site (post dialysis), apply pressure to the insertion site and contact the emergency services and dialysis censer; and to verify that clamps are closed on lumens. This is a medical emergency. 1. On 4/15/24 at 1516 hours, an interview was conducted with Resident 10. Resident 10 stated she received dialysis on Tuesdays, Thursdays, and Saturdays. Resident 10 stated her dialysis access site was located on her right upper chest. Medical record review for Resident 10 was initiated on 4/15/24. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 10 had a diagnosis of end stage renal disease (a loss of kidney function) which required dialysis. Review of Resident 10's MDS dated [DATE], showed Resident 10 had a BIMS score of 12 (indicating moderately impaired cognition). Review of Resident 10's Physician's Orders for April 2024 showed the following physician's orders dated 12/21/23: - hemodialysis treatment three times a week on Tuesday, Thursday, and Saturday. - to check the right chest perma catheter (a special catheter used for short-term dialysis treatment) site every shift for redness, swelling, and unusual color. - to check the right chest perma catheter dressing every day and night shift for bleeding. If present, reinforce dressing and document in nurse's notes and notify physician and dialysis center promptly. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- hemodialysis- if bleeding occurs, apply pressure and call the physician. On 4/18/24 at 0956 hours, an interview was conducted with LVN 7. LVN 7 was asked about the protocol if Resident 10's dialysis access started bleeding. LVN 7 stated the protocol was to apply a pressure dressing with sterile gauze and apply a dressing over it. When asked if Resident 10 had the supplies available at her bedside, in the event of an emergency or bleeding, LVN 4 stated Resident 10 should have supplies at her bedside. On 4/18/24 at 1002 hours, an interview and concurrent observation was conducted with LVN 4. LVN 4 was observed checking Resident 10's bedside, drawers, and closet. LVN 4 verified Resident 10 did not have a dialysis kit at the bedside. On 4/18/24 at 1006 hours, an interview was conducted with the DON. The DON was asked about the protocol for the dialysis residents in the event of an emergency, or bleeding. The DON stated all dialysis residents, regardless of their dialysis access, should have a dialysis kit at their bedside. The kit contained a tourniquet, tape, kerlex, clamp, and gauze. The DON further stated the dialysis kit should be kept at the resident's bedside. A subsequent interview and concurrent observation was conducted with the DON. The DON verified Resident 10 did not have a dialysis kit at her bedside. The DON verified the above findings. 43156 2. Medical record review for Resident 74 was initiated on 4/15/24. Resident 74 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease requiring hemodialysis. Review of Resident 74's H&P examination dated 03/12/24, showed Resident 74 had no capacity to understand and make decisions. Review of the physician's order dated 03/11/24, showed Resident 74 was to receive dialysis every Mondays, Wednesdays, and Fridays at a dialysis center. On 4/18/24 at 1020 hours, a concurrent observation and interview was conducted with RN 2. RN 2 verified Resident 74's emergency dialysis kit was not found and not available at the resident's bedside. On 4/18/24 at 1040 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings

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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** 50003 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the resident's needs for one of 21 final sampled residents (Resident 39). * The facility failed to ensure Resident 39's lorazepam (antianxiety medication) was accurately reconciled. The lorazepam tablets removed as shown on the Record of Controlled Substances was not recorded as administered on the electronic MAR. This failure had the potential for drug diversion. Findings: Review of the facility's P&P titled Control Substances revised November 2022 showed controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. Review of the facility's P&P titled Documentation of Medication Administration revised November 2022 showed a nurse documents all medications administered to each resident on the resident's medication administration record. Medical record review for Resident 39 was initiated on 4/15/24. Resident 39 was readmitted to the facility on [DATE]. Review of Resident 39's H&P examination dated 1/17/24, showed Resident 39 did not have the capacity to understand and make decisions. Review of the Physician Orders for April 2024 showed a physician's order dated 4/15/24, to administer lorazepam 2 mg one tablet via GT every four hours as needed for anxiety. On 4/16/24 at 0914 hours, a controlled medication reconciliation for Resident 39 was conducted with LVN 1. Review of Resident 39's Record of Controlled Substances showed lorazepam was signed out on 4/16/24 at 0507 hours. Resident 39's medication bubble pack (a package used to dispense medication) for lorazepam showed seven tablets remaining, which matched with the number of lorazepam tablets on the Record of Controlled Substances. However, review of Resident 39's electronic MAR for April 2024 failed to show documented evidence the lorazepam was administered to Resident 39 on 4/16/24 at 0507 hours, as shown in the Record of Controlled Substances. LVN 1 verified the above finding. LVN 1 stated the staff were expected to sign the narcotic count sheet and MAR immediately after the medication was removed from the bubble pack. On 4/18/24 at 1458 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding.

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	055674	A. Building B. Wing	04/18/2024

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Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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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** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents sampled reviewed for unnecessary medications (Residents 25 and 42) were free from unnecessary psychotropic drugs (any drug that affects brain activity associated with mental processes and behavior). * The facility failed to ensure the informed consent was obtained from Resident 42 for the use of Seroquel (quetiapine fumarate, an antipsychotic medication). In addition, the facility failed to ensure the non-pharmacological interventions were implemented prior to administering Resident 42's Seroquel. * The facility failed to ensure Resident 25's informed consent for diazepam (an antianxiety medication) was signed and dated by the physician. These failures had the potential for the residents receiving the unnecessary psychotropic medications. Findings: Review of the facility's P&P titled Psychotropic medication use dated 7/2022 showed non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. 1. Medical record review for Resident 42 was initiated on 4/15/24. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's H&P examination dated 3/22/24, showed Resident 42 had the capacity to understand and make decisions. Review of Resident 42's Physician's Orders dated April 2024 showed an order dated 3/21/24, to administer Seroquel 50 mg tablet one table via GT at bedtime for psychosis manifested by screaming and yelling for 30 days. Review of Resident 42's Informed Consent undated for Seroquel 50 mg tablet one tablet via GT at bedtime for 30 days showed the informed consent was obtained from the responsible party; however, there was no indication of who contacted, how and when the responsible party was contacted. In addition, the consent was not signed or dated by the physician, nor the licensed nurse who verified the informed consent. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 42's medical record failed to show non-pharmacological interventions were ordered or completed for Resident 42 for the use of Seroquel. On 4/18/24 at 1058 hours, a concurrent interview and medical record review was conducted with LVN 12. LVN 12 stated the informed consents for the psychotropic medication use were done with the responsible party and the admission nurse would do the consents. LVN 12 stated it was the charge nurses' responsibility to follow up if there was no informed consent for the psychotropic medication use. LVN 12 was informed of the above findings. LVN 12 verified Resident 42's informed consent for the use of Seroquel was not complete. In addition, LVN 12 verified there were no non-pharmacological interventions done for Resident 42 for the use of the Seroquel medication. 48882 2. Medical record review for Resident 25 was initiated on 4/15/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25'S H&P examination dated 2/16/24, showed Resident 25 had the capacity to understand and make decisions. The H&P examination also showed Resident 25 had the following diagnoses: major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. Review of Resident 25's Physician's Orders for April 2024 showed a physician's order dated 3/30/24, to administer diazepam 5 mg one tablet by mouth two times a day for anxiety manifested by verbalization of panic attack; and to record the number of behaviors noted. Review of Resident 25's MAR for April 2024 showed Resident 25 was administered diazepam 5 mg one tablet by mouth two times a day for anxiety manifested by verbalization of panic attack from 4/1/24 to 4/16/24, at 0900 and 2100 hours, and 4/17/24 at 0900 hours. Review of Resident 25' s Informed Consent for the use of diazepam showed a consent for diazepam 5 mg tablet by mouth two times a day for anxiety manifested by panic attack. The Informed Consent failed to show a physician's signature and date and the signature of the nurse verifying the consent. On 4/18/24 at 0925 hours, an interview was conducted with the DON. The DON stated for antipsychotic medications, an informed consent showing the medication, dose, frequency, and manifestations would be obtained. The DON stated the consent would be signed by the physician who provided the informed consent to the resident. The consent was then verified by the nurse prior to administration of the medication. On 4/18/24 at 0937 hours, an interview and concurrent record review for Resident 25 was conducted with the DON. The DON reviewed the informed consent and verified the consent was not signed or dated by the physician and failed to show a signature by the verifying nurse. On 4/18/24 at 1417 hours, the DON was informed and acknowledged the findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50003 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 6.06%. Two of the four licensed nurses (LVNs 6 and 7) who were observed during the medication administration were found to have made errors. * LVN 6 failed to ensure Resident 12's vitamin B12 (supplement) was administered as ordered. * LVN 7 failed to ensure Resident 44's aspirin was administered as ordered. These failures had the potential to negatively impact the residents' health and safety and posed the risk for possible complications. 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. 1. On 4/17/24 at 0814 hours, a medication administration observation was conducted with LVN 6 for Resident 12. LVN 6 prepared and administered Resident 12's medications which included the following: - one tablet of finasteride 5 mg (medication use to shrink enlarged prostates in men) - one tablet of metformin 1000 mg (use to treat diabetes) - one tablet of multivitamin with mineral (supplement) - two tablets of acetaminophen 325 mg (use to treat minor aches and pains, and reduces fever). The number of medication tablets were verified with LVN 6 prior to administering the medications to Resident 12. Review of Resident 12's Physician Orders for April 2024 showed a physician's order dated 3/28/24, for vitamin B12 500 mcg one tablet via GT daily at 0900 hours. However, LVN 6 was observed not administering the medication during the above medication administration. On 4/17/124 at 1111 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified he missed the dose of vitamin B12 during the medication administration observation. 2. On 4/17/24 at 0846 hours, a medication administration observation was conducted with LVN 7 for Resident 44. LVN 7 prepared and administered Resident 44's medications which included the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one tablet of amlodipine besylate 10 mg (antihypertensive) - one tablet of carvedilol 25 mg (antihypertensive) - one tablet of clopidogrel 75 mg (medication used to prevent blood clots) - one tablet of losartan potassium 100 mg (antihypertensive) - one soft gel of docusate sodium 250 mg (use to treat occasional constipation) - one tablet of multivitamin with mineral (supplement) - one tablet of metformin 1000 mg (use to treat diabetes) - one tablet of Jardiance 10 mg (use to treat diabetes) - one soft gel of fish oil 1000 mg (supplement) - two sprays of fluticasone 50 mcg to both nostrils (use to treat sneezing, itchy or runny nose) The number of medication tablets, soft gels, and nasal spray were verified with LVN 7 prior to administering the medications to Resident 44. Review of Resident 44's Physician Orders for April 2024 showed a physician's order dated on 10/20/22, aspirin 81 mg chewable tablet by mouth daily at 0900 hours. However, LVN 7 was observed not administering the aspirin medication during the above medication administration. On 4/17/24 at 1134 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 verified he missed the dose of aspirin during the medication administration observation. On 4/18/24 at 1458 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50003 Based on observation, interview, and facility P&P review, the facility failed to ensure the staff implemented the proper storage, labeling, and disposal of medications in a safe manner as evidenced by: * The facility failed to ensure the medications were properly stored in Medication Cart A. In addition, thexpired medications and two blood glucose strip bottles were found in Medication Cart A. * The facility failed to dispose the expired [NAME] luer lock caps (use as a protective cap on access ports on medical devices or intravenous sets when not in use) inside Medication Cart C. * The facility failed to ensure the medications were not stored with the odor eliminator spray in Medication Cart B. * The facility failed to dispose of the expired medication in Medication Cart D and failed to ensure the medications administered orally were stored separately from the externally used medications in Medication Cart D. * The facility failed to dispose of the expired BinaxNOW COVID-19 Ag card (test kit to check for COVID-19) in Medication Cart F. * The facility failed to ensure medications were not stored with disinfecting wipes, odor eliminator spray, and personal perfume in Medication Cart G. * The facility failed to ensure the medications administered orally were stored separately from the externally used medications in Medication room [ROOM NUMBER], dispose of the expired medication in Medication room [ROOM NUMBER], and ensure completion of signatures and co-signatures on the Facility Medication Destruction Form for February and March in Medication room [ROOM NUMBER]. * Unauthorized personnel was observed inside Medication room [ROOM NUMBER] without supervision. * The facility failed to ensure the medications administered orally were stored separately from the externally used medications in Medication Cart H. In addition, Med Cart H was observed with two unknown loose pills in the top drawer. * The facility failed to ensure the medications administered orally were stored separately from the externally used medications in Medication Cart E. These failures had potential to result in unsafe medication administration, cross-contamination of the medications and posed the risk for non-licensed staff to have access to the medications. Findings: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Medication Labeling and Storage revised February 2023 showed the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Medications are stored in an orderly manner in cabinet, drawers, carts or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. For over the counter medications in bulk containers the label contains: the medication name, strength, quantity, accessory instructions, lot number and expiration date. Medications for external uses, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications. Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications. Review of the facility's P&P titled Discarding and Destroying Medications revised October 2014 showed the medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. 1. On 4/16/24 at 0914 hours, an inspection of Medication Cart A was conducted with LVN 1, the following was observed: - Two Assure Platinum blood glucose strip bottles (use to test blood glucose levels) lot numbers and expiration dates not readable. - One box of povidone iodine (antiseptic to help prevent infection in minor cuts and burns) swab sticks stored with two bottles of lactulose (use to treat constipation) solution, one bottle of potassium chloride (supplement) solution, two bottles of Keppra (use to treat seizures) solution and one bottle of Megace (appetite stimulant) oral suspension. - One box of oxymetazoline HCL (use to relieve nasal discomfort caused by colds or allergies) nasal spray stored with one bottle of vitamin D (supplement) capsules. - One box of Arginaid (supplement) powder stored with one bottle of expired fiber (prevents constipation) powder (expired on 2/25/24), one box of bisacodyl (laxative) suppository, one bottle of milk of magnesia (laxative) liquid, two bags of enoxaparin sodium (blood thinner) subcutaneous injection, one box of Gvoke hypopen (use to treat high blood glucose level) subcutaneous injection, one bag of lidocaine (pain reliever) transdermal patch and one box of povidone iodine swab sticks. - A container of Sani-Cloth germicidal disposable wipes was stored with one bottle of hydrogen peroxide (antiseptic to help prevent infection in minor cuts and burns) topical solution. LVN 1 verified the above findings. 2. On 4/16/24 at 1004 hours, an inspection of Medication Cart C was conducted with RN 1. One box of [NAME] luer lock caps had expired on 3/31/24. RN 1 verified the above finding. 3. On 4/16/24 at 1014 hours, an inspection of Medication Cart B was conducted with RT 1. One bottle of Bye Bye odor eliminator spray was stored with ten bottles of chlorhexidine gluconate (use to treat and prevent oral bacterial growth) oral rinse. RT 1 verified the above finding. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 4/16/24 at 1022 hours, an inspection of Medication Cart D was conducted with LVN 10. The following was observed: - One box of fluticasone propionate (use to treat sneezing, itchy or runny nose) nasal spray was stored with one bottle of aspirin tablets, one bottle of acetaminophen tablets, on bottle of vitamin D tablets and one bottle of nitroglycerin (use to treat chest pain) tablets in the top drawer. - One open box of budesonide (use to prevent difficulty breathing or wheezing caused by asthma) inhalation solution was stored with one box of rufinamide (use to prevent seizures) oral suspension and 13 packets of Lokelma (use to treat high levels of potassium) oral suspension in the second drawer. - One box of povidone iodine swabsticks stored with one box of rufinamide oral suspension and one box of ipratropium and albuterol (use to prevent wheezing or difficulty breathing caused by lung diseases) inhalation solution in the third drawer. - One bottle of sore throat spray had expired on 3/24. LVN 10 verified the above findings. 5. On 4/16/24 at 1054 hours, an inspection of Medication Cart F was conducted with RN 2. One box of BinaxNOW COVID-19 Ag cards had expired on 2/16/23. RN 2 verified the above finding. 6. On 4/16/24 at 1105, an inspection of Medication Cart G was conducted with Treatment Nurse 1. The followings was observed: - One bottle of antidandruff shampoo was stored with one bottle of Dakin's (use to clean infected wounds) solution and one container of Sani-Cloth germicidal disposable wipes. - One bottle of povidone iodine prep solution and a bottle of hydrogen peroxide were stored with the Bye Bye odor eliminator spray and personal perfume. Treatment Nurse 1 verified the above finding. 7. On 4/16/24 at 1113 hours, an inspection of Medication room [ROOM NUMBER] was conducted with LVN 2. The following was observed: - One bottle of lactulose solution had expired on 9/9/23. - Five bottles of lactulose solution and one bottle of theophylline (use to treat symptoms of asthma) were stored with one box of ipratropium and albuterol inhalation solution. - One box of Juven Ensure therapeutic nutrition powder (supplement for wound healing) was stored with one box of povidone iodine swabsticks. - Four boxes of ipratropium and albuterol inhalation solution were stored together with one box of lidoderm transdermal patches. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In addition, review of the facility's Facility Medication Destruction Forms for January to March 2024 showed missing signatures from the licensed nurse who prepared the list of medications for destruction and/or the licensed nurse who verified the medication destruction on 1/27, 2/4, 2/8, 2/18, 3/3, 3/7, 3/9, and 3/31/24. LVN 2 verified the above findings. LVN 2 stated the non-controlled medication destruction was done weekly; however, there were no specific licensed nurses responsible for the task. LVN 2 stated there should be two signatures from the licensed nurses on the Facility Medication Destruction Forms. On 4/16/24 at 1147 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the Facility Medication Destruction Forms for 1/27, 2/4, 2/8, 2/18, 3/3, 3/7, 3/9, and 3/31/24, were missing the signatures from the licensed nurse who prepared the list of medications for destruction and/or the licensed nurse who verified the medication destruction. The DON stated two licensed nurses should sign the Facility Medication Destruction Form after completing the non-controlled medication destruction. The DON stated the second licensed nurse who signed the form was the witness of the medication destruction. 8. On 4/16/24 at 1052 hours, an observation and concurrent interview was conducted with the DON and Electrician 1. Medication Room A's door was observed propped open. Electrician 1 was observed inside Medication Room A unaccompanied. Electrician 1 stated he was working on the electrical panel for the fire alarm located inside Medication room [ROOM NUMBER]. The DON verified the finding and stated any unlicensed personnel should be accompanied by a licensed nurse when accessing the medication rooms. The DON verified Medication Room A had medications inside. The DON stated the licensed nurses were the only authorized personnel to have access to the medication rooms. 9. On 4/16/24 at 1147 hours, an inspection of Medication Cart H was conducted with LVN 3. The following was observed: - Three boxes of artificial tears (use to relieve dry eyes) eye drops were stored with one bottle of ibuprofen (use to treat fever and pain) tablets and one bottle of guaifenesin (use to relieve chest congestion) tablets. -One bottle of acetaminophen suppository was stored with one box of budesonide inhalation solution, two boxes of ipratropium and albuterol inhalation solution and one bottle of hyoscyamine (use to decrease acid production in the stomach) tablets. -One box of povidone iodine swabsticks was stored with one fluticasone propionate nasal spray. -Multiple bags of enoxaparin sodium subcutaneous injections and one bag of heparin (blood thinner) injections were stored with one bag of lidoderm patches and three naloxone (use to treat opiate overdose) nasal spray. -One tube of diclofenac sodium (pain reliever) topical gel was stored with two boxes of albuterol sulfate inhalers. -Two unknown orange loose pills were found in the top drawer. LVN 3 verified the above findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 4/16/24 at 1450 hours, an inspection of Medication Cart E was conducted with LVN 4. The following was observed: -Two bottles of nitroglycerin tablets were stored with one box of Transderm-Scop patches in the top drawer. -Two boxes of Gvoke hypopen were stored with three boxes of ipratropium and albuterol inhalation solutions. -Three boxes of lidoderm transdermal patches were stored with multiple bags of enoxaparin sodium subcutaneous injections and one bag of heparin injections. LVN 4 verified the above findings. On 4/18/24 at 1458 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47476 Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure 36 of 94 residents who received food from the kitchen received the proper diets and portion sizes when the facility's menus were not followed. * The facility failed to follow the menu for the BBQ Chicken puree recipe. * The facility failed to ensure the kitchen staff served the correct portion size as per the menu when serving the ground BBQ chicken and the potato salad. * The facility failed to ensure the residents who were on CCHO diets (diet for diabetics) received homemade BBQ sauce with their BBQ chicken as per the menu. These failures had the potential for the resident's nutritional needs not being met which could result in medical complications. Findings: Review of the CMS 802 Matrix For Providers completed by the facility 4/15/24, showed 36 of 94 residents in the facility received food prepared in the kitchen. Review of the facility's P&P titled Menus revised 10/2017 showed menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council and National Academy of Sciences. 1. Review of the facility's document titled Spring Cycle Menus, Week 3 Tuesday dated 4/16/24, showed the pureed BBQ chicken was to be served for lunch for the residents on a pureed diet. The BBQ chicken portion size was 3 ounces (equivalent to a #10 scoop). Review of the facility's recipe titled Recipe: Puree Meats dated 4/2017 showed the directions to make the pureed meats for 12 servings. The directions showed to complete the regular recipe and measure out the number of portions needed for pureed diets, and gradually add warm liquid (low sodium broth or gravy), 1 1/2 to 3 cups. If meat is moist, to start with only a few ounces of liquid. These amounts are only an average and may vary. Puree should reach a consistency slightly softer than whipped topping, and may add more liquid if needed to reach this consistency. On 4/16/24 at 1033 hours, an observation of the puree preparation and concurrent interview with Cook 1 was conducted. Cook 1 stated he was preparing 10 portions of pureed BBQ chicken. Cook 1 added six overfilled #6 scoops of the previously prepared BBQ chicken which was made with BBQ sauce and salt to the robot coupe (a device used to puree foods). Cook 1 then blended the contents and stated it needed more BBQ sauce. Cook 1 then poured 1/2 cup of BBQ sauce and another 1/2 #6 scoop of BBQ chicken into the robot coupe and blended the contents. Afterwards, Cook 1 placed the contents into a pan. Cook 1 stated he would make a little more chicken then added another three #6 scoops of BBQ chicken and poured an unmeasured amount of BBQ chicken into the robot coupe, blended, then put into the pan. (continued on next page)

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	055674	A. Building B. Wing	04/18/2024

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 1112 hours, a telephone interview was conducted with the RD. The RD confirmed all the recipes should be followed. On 4/17/24 at 1639 hours, the DSS, DON, and Administrator were informed of and acknowledged the above findings. 2. Review of the facility's document titled Spring Cycle Menus, Week 3 Tuesday dated 4/16/24, showed the BBQ chicken for the mechanical soft texture diet would be served with a #10 scoop (3/8 cup) for regular portion and a #16 (1/4 cup) scoop for small portion. The menu also showed the regular diet potato salad would be served with a #8 (1/2 cup) scoop and a #16 scoop for the small portion. The pureed potato salad showed a P under the menu, indicating the potato salad would be pureed and served a regular size portion #8 scoop. On 4/16/24 at 1146 hours, during the lunch tray line observation, Cook 1 was observed using a #8 scoop to serve the mechanical soft texture BBQ chicken. Cook 1 was also observed to use a #6 (2/3 cup) scoop for the regular portion potato salad, a #12 (1/3 cup) scoop for the regular small portion potato salad, and a #12 scoop for the pureed potato salad. Cook 1 stated he would use a #12 scoop for the pureed potato salad because the menu spreadsheet did not indicate a scoop size. On 4/17/24 at 1112 hours, a telephone interview was conducted with the RD. The RD confirmed all menu and recipes should be followed. On 4/17/24 at 1639 hours, the DSS, DON, and Administrator were informed of and acknowledged the above findings. 3. Review of the facility's document titled Spring Cycle Menus, Week 3 Tuesday dated 4/16/24, showed the BBQ chicken for the CCHO diets was to be served with homemade BBQ sauce. On 4/16/24 at 1146 hours, during the lunch tray line observation, Cook 1 was observed to serve the prepared BBQ chicken for all of the therapeutic diets with the same BBQ sauce. On 4/17/24 at 0814 hours, an interview was conducted with Cook 1. Cook 1 stated he used a bottled BBQ sauce for all the diets for all the BBQ chicken. Cook 1 was informed on the menu from 4/16/24, showed the CCHO diet stated to use homemade BBQ sauce. Cook 1 verified he used the same bottled BBQ sauce for the CCHO diets and verified he did not use or make a homemade BBQ sauce. The homemade BBQ sauce recipe was reviewed with the DSS and Cook 1. The DSS verified they did not make the homemade BBQ sauce.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation, interview and facility document review, the facility failed to ensure the residents on mechanically altered diets received food in a form that met their individual needs when: 1. The pureed bread was not prepared according to the recipe. 2. One of 21 sampled residents (Resident 33) on a mechanical soft NAS (No added salt) CCHO (consistent carbohydrate- a diet to control blood sugar) diet received regular textured meat. 3. One of 73 nonsampled residents (Resident 29) on a mechanical soft finely chopped meat diet received a pureed diet. These failures posed the risk for complications such as choking for nine residents on mechanically altered diets: seven residents on a pureed diet and two residents on mechanical soft diets. Findings: 1. Review of the facility document titled Therapeutic Diet Count dated 4/16/24, showed seven residents were on a puree diet. Review of the facility's recipe titled pureed breads, cakes, cookies, pancakes, french toast, sweet rolls, waffles, tortillas, sandwiches and other bread products dated 3/2017 showed the directions: 3. Puree should reach a consistency of applesauce, 6. Serve on tray line at room temperature or warm. During the lunch meal tray line observation on 4/16/24 at 1150 hours, with Cook 1, the temperature of the pureed rolls was 190 degrees Fahrenheit (F). The pureed rolls were stored on the heated steam table covered with foil. The edges of the pureed rolls in the pan on the steam table were a dark brown color and appeared thick and gummy. A photo was taken of the pureed rolls. On 4/16/24 at 12:39 hours, a test tray of the pureed lunch meal was performed with the Dietary Services Supervisor (DSS) and Registered Dietitian (RD). Upon tasting the pureed roll, both the DSS and RD confirmed the pureed roll did not have a smooth texture but was sticky, gummy and had pieces of thickened bread throughout the product. On 4/16/24 at 16:01 hours, an interview was conducted with the Speech Language Pathologist (SLP). The SLP confirmed pureed bread should have a very smooth texture. The SLP verified the pureed bread should not have a sticky or gummy texture. Upon review of the photograph taken of the pureed rolls on the lunch meal tray line, the SLP confirmed of the pureed rolls appeared dried out and hardened. On 4/17/24 at 11:12 hours, a telephone interview was conducted with the RD. The RD stated all the recipes should be followed. The RD agreed that the pureed bread should not be heated. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's document titled Spring Cycle Menus, Cooks Spreadsheet dated 4/16/24, showed the mechanical soft diets should receive three ounces of ground BBQ chicken with homemade BBQ sauce. Review of the medical record for Resident 33 was initiated on 4/17/24. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's physician's order dated 3/3/24, showed an order for a mechanical soft NAS, CCHO diet. On 4/16/24 at 1150 hours, an observation of the lunch meal tray line was conducted with the DSS. The lunch meal tray for Resident 33 was observed with the DSS. Resident 33's lunch meal ticket showed Resident 33 was on a mechanical soft, NAS, CCHO diet. Resident 33's lunch meal contained regular texture chicken. The DSS confirmed the finding and corrected Resident 33's lunch meal tray. 3. Review of the facility's document titled Spring Cycle Menus, Cooks Spreadsheet dated 4/16/24, showed the diets for Mechanical Soft and Dysphagia Mechanical, but the menu did not include a diet titled Mechanical Soft finely chopped. The lunch meal the Dysphagia Mechanical diet was to receive three ounces ground BBQ chicken, 1/2 (half) cup pureed potato salad, 1/2 cup chopped carrots, and chopped 1/2 inch roll soaked in milk. Review of the medical record for Resident 29 was initiated on 4/17/24. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's physician's order dated 3/1/24, showed an order for a mechanical soft diet with finely chopped meat and honey thick liquids. On 4/16/24 at 1150 hours, an observation of the lunch meal tray line was conducted with the DSS. The lunch meal tray for Resident 29 was observed with the DSS. Resident 29's lunch meal ticket showed Resident 29 was on a mechanical soft finely chopped diet. When questioned what a mechanical soft finely chopped diet was, the DSS stated the facility followed the dysphagia mechanical diet that appeared on the cook's spreadsheet. The lunch meal for Resident 29 was a pureed diet. The DSS corrected the meal tray to match the dysphagia mechanical diet per the cook's spreadsheet. On 4/16/24 at 1601 hours, an interview was conducted with the SLP. The SLP was asked to define a mechanical soft finely chopped diet. The SLP defined a mechanical soft finely chopped diet as all food finely chopped. The SLP added if the diet order specified mechanical soft finely chopped meat, only the meat was finely chopped. The SLP stated each facility had different terminology for mechanically altered diets. The SLP was informed the facility Cook's Spreadsheet did not include a diet titled mechanical soft finely chopped. The SLP confirmed it was important to verify what terminology was to be used to distinguish between the different mechanically altered diets. The SLP stated he would be more specific in the future when writing diet orders.

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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** 39856 Based on observation, interview and facility document review, the facility failed to provide the food substitute of similar nutritive value when the meal alternate recipes were not followed for four of 36 sampled residents who received meals from the kitchen (Residents 13, 21, 32, and 80). This failure had the potential for Residents 13, 21, 32, and 80 who received a meal alternate from the kitchen to not meet their nutritional needs. Findings: 1. Review of the facility's document titled Standard Substitutes for Dinner and Supper undated showed a grilled cheese sandwich and a cheese quesadilla were available for a meal substitute. Review of the facility's document titled Spring Cycle Menus, Cook's Spreadsheet dated 4/15/24, showed the mechanical soft diet was to receive ground Roast Turkey #10 scoop (three ounces), 1/2 (half) cup of parsley and herb penne (pasta), 1/2 cup of green beans with garlic, one wheat roll, one teaspoon of margarine, one serving of apple crisp, and four ounces of milk. Review of the facility's document titled Spring Cycle Menus, Cook's Spreadsheet dated 4/16/24, showed the mechanical soft diet was to receive ground BBQ chicken #10 scoop (three ounces), #8 scoop (1/2 cup) potato salad, 1/2 cup of cooked carrots, a wheat roll, one teaspoon of margarine, strawberry gelatin whip, and four ounces of milk. Review of the facility's document titled Recipe: Peanut Butter and Jelly Sandwich dated 2024 showed one portion size: one sandwich = one ounce protein. The directions showed to spread two tablespoons (rounded #40 scoop) of peanut butter plus one to two Tablespoons (#40 scoop) jelly per sandwich. Medical record review of Resident 32 was initiated on 4/16/24. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. During the lunch meal observation in the dining room on 4/15/24 at 1207 hours, an observation and concurrent interview was conducted with Resident 32. Resident 32's meal tray ticket showed she was on a mechanical soft No Added Salt (NAS) diet. Resident 32 complained the food was lousy and stated she always got a peanut butter and jelly sandwich with her meals, so she had something she liked to eat instead of the meal. Resident 32 stated the lunch was too salty, and she refused to eat the meal provided and would eat the peanut butter and jelly sandwich instead. On 4/16/24 at 1224 hours, an observation of the lunch meal tray line was conducted with the DSS. Resident 32's lunch meal tray was observed with a peanut butter and jelly sandwich. The DSS stated Resident 32 received a peanut butter and jelly sandwich with each meal in case she did not like the meal. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 0808 hours, an interview and concurrent observation was conducted with Cook 3. Cook 3 was asked to make a peanut butter and jelly sandwich. Cook 3 used two slices of bread then used a knife to spread an unmeasured quantity of peanut butter thinly on one slice of bread. Cook 3 then spread a thin layer of jelly on the other slice of bread. Cook 3 stated she did not use a recipe to make the peanut butter and jelly sandwiches because she had made the sandwiches for a long time. The peanut butter and jelly sandwich as prepared by Cook 3 provided less than one ounce of protein as indicated by the peanut butter and jelly recipe as compared to the three ounces of roast turkey served on 4/15/24, and three ounces of BBQ chicken served on 4/16/24. 2. Review of the facility's document titled Recipe: Grilled Two-Cheese Sandwich dated 2024 showed the ingredients included cheese of choice (suggest one ounce cheddar and one ounce Monterey [NAME] cheese). The directions showed the following: - To make sandwiches: two ounces cheese per sandwich (sliced cheese may not weigh one ouncer per slice. Make sure to weigh cheese to know how many slices equal two ounces. If using shredded cheese, 1/2 cup = two ounces cheese. Do not use American Cheese. Review of the facility's document titled Recipe: Cheese Quesadilla undated showed portion size, one = two ounces protein. The directions showed to add 1/2 cup cheese per tortilla, on one half. Medical Record review of Resident 80 was initiated on 4/17/24. Resident 80 was admitted to the facility on [DATE]. Medical Record review of Resident 13 was initiated on 4/17/24. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Medical Record review of Resident 21 was initiated on 4/17/24. Resident 21 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/16/24 at 1150 hours, an observation and concurrent interview was conducted with Cook 1. A grilled cheese sandwich and two cheese quesadillas were observed prepared on two plates for the lunch meal. Cook 1 stated the grilled cheese sandwich and cheese quesadillas were for the resident's lunch requests. On 4/16/24 at 1230 hours, an interview was conducted with Cook 1. Cook 1 was asked how he prepared the grilled cheese sandwich. Cook 1 stated he used two slices of American cheese and two slices of bread, then grilled the sandwich. Cook 1 was asked to describe how he prepared a cheese quesadilla. Cook 1 stated he used 1/2 a # 20 scoop (equivalent to 0.6 tablespoon) of shredded white cheese for each corn tortilla (total one #20 scoop equivalent three and 1/3 tablespoons) of shredded white cheese. Review of the nutritional information for the American cheese used to make the grilled cheese sandwich showed one slice of American cheese provided 70 calories and three grams of protein. The grilled cheese sandwich as prepared by Cook 1 provided a total of six grams of protein; equivalent to less than one ounce of protein compared to the three ounces protein of BBQ chicken on the weekly menu. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nutritional information of the shredded white cheese used to make the cheese quesadillas showed one ounce (1/4 cup) cheese provided 100 calories and seven grams of protein. The cheese quesadilla as prepared by Cook 1 provided seven grams of protein equivalent to one ounce of protein as compared to the three ounce protein of BBQ chicken on the weekly menu. On 4/17/24 at 0926 hours, an interview was conducted with the DSS. The DSS was asked how many residents received meal alternates. The DSS explained the residents were given a weekly menu and they had the option to write in a meal alternate. Review of the weekly menus for the week 4/15/24-4/21/24, showed Resident 80 ordered two cheese quesadillas four times in the week, Resident 13 ordered two cheese quesadillas once in the week, and Resident 21 ordered a grilled cheese sandwich everyday for lunch and dinner. On 4/17/24 at 0945 hours, the DSS confirmed she did not have a recipe for a cheese quesadilla and would need to contact the menu company. On 4/15/24 at 1112 hours, a telephone interview was conducted with the RD. The RD confirmed the recipes should always be followed and meal alternates should be equivalent in the protein and nutrients to the weekly menu entree.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety guidelines were met in the kitchen as evidenced by: * The facility failed to ensure Time Temperature Control for Safety (TCS) Food (food that require time and temperature controls to limit the growth of illness causing bacteria) were monitored with a cool down log. * Resident 40's room was observed with non-perishable and perishable food items brought from the outside. The food items were not labeled and dated and the mini fridge with perishable food was not being monitored by the facility. * The residents' food items brought from outside were not labeled and dated. * The facility failed to ensure the ice machine drainpipe located in the kitchen had an air gap. These failures had the potential to place the 34 residents who received food prepared in the facility kitchen at risk for foodborne illness. Findings: The facility had 36 of 94 residents receiving food from the kitchen. 1. According to the USDA Food Code 2022 Section ,d+[DATE].14 Cooling, (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celsius (C) [135 Fahrenheit (F)] to 21 C (70 F); and (2) Within a total of six hours from 57 C (135 F) to 5 C (41 F) less. On [DATE] at 1330 hours, an interview was conducted with Cook 2 and the DSS regarding the preparation of egg salad sandwiches. Cook 2 stated the menu had egg salad sandwiches for dinner and would cook their own eggs the day before and put them in the fridge unpeeled. Cook 2 stated she would peel the eggs around 1430 hours, the next day and start prepping them so they could be in the fridge an hour before prep. Cook 2 stated tray line was at 1640 - 1650 hours, and the DSS stated dinner was at 1700 hours. Cook 2 was asked about temperature monitoring when she made the egg salad. Cook 2 stated she took the temperature of the egg salad the day she served the food and verified there was no documentation of the time or temperature for the egg salad being made. The DSS stated the menu had an egg salad once a month. The DSS verified they did not use a cooling log to monitor the time or temperature of the egg salad. 2.a. Review of the facility's P&P titled Food Brought by Family/Visitors revised ,d+[DATE] showed food brought by the family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. Non-perishable foods are stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1431 hours, an interview was conducted with the IP. The IP stated if a resident wanted food from the outside, it would depend on the resident's diet and if the physician was okay with it. The IP stated they stored the food in a refrigerator located in the medication room. On [DATE] at 1434 hours, an observation and concurrent interview was conducted with LVN 11 regarding the facility's refrigerator used for the residents' food brought in by the resident's family or visitors. LVN 11 stated after 24 hours, if there was something leftover and the resident did not eat it, by the next day the food would get discarded. LVN 11 stated for the residents who brought in food, they wrote the name and room number and use the expiration date on the food. The refrigerator was observed to contain the following items: - Eight sealed meal kits containing cheese and meat labeled with a resident's room number but without a resident's name or use by date. - One mighty shake without a resident's name or use by date. - Four packages of six pudding cups labeled with a resident's room number but without a resident's name or use by date. - One carton of heavy whipping cream labeled with a resident's room number but without a resident's name or use by date. - One opened gallon of milk without a resident's name or use by date, expired on [DATE]. During the inspection of the freezer portion of the refrigerator, there were four ice cream bars and one Stouffers frozen dinner lasagna observed without a resident's name or use by date. LVN 11 verified the above findings and stated the food should be labeled with both the resident's name and date. LVN 11 stated the refrigerator was supposed to be checked daily. On [DATE] at 1449 hours, an interview was conducted with the DON. The DON stated it was the LVN's responsibility for checking the refrigerator when they were in the medication room daily. b. On [DATE] at 1511 hours, a concurrent observation and interview was conducted with Resident 40 in her room. The wall to the left of the bed was observed with shelves filled with food items, including opened bags of chips sealed with a clip, instant noodles, potatoes stored in a plastic bag, and tomatoes. In addition, there was a mini refrigerator Resident 40 referred to as a cooler containing perishable food items such as a container of opened potato salad, a carton of creamer, butter, and two packets of Cracker Barrel cheese. The food items were labeled with a room number, however, were not labeled with the resident's name or date. Resident 40 stated her family member was the one who bought the food and the nursing staff did not give her guidelines on shelf storage. Resident 40 stated she used the cooler to chill items and stated the staff did not look into the cooler. Resident 40 stated the nursing staff did not check the cooler and verified the nursing staff did not monitor the temperature of the refrigerator. On [DATE] at 1527 hours, the DSD was informed of the above findings. The DSD stated she was not aware Resident 40 had a mini refrigerator and verified Resident 40 should not be storing perishable food in the mini refrigerator without monitoring the temperature of the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0836 hours, an interview was conducted with the DON. The DON stated she did not know Resident 40 had a mini refrigerator and verified the non-perishable food should be sealed as per the facility's policy. On [DATE] at 1639 hours, the DSS, DON, and Administrator were informed of and acknowledged the above findings. 3. According to the USDA Food Code 2022 Section ,d+[DATE].13, Backflow Prevention, Air Gap, an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment, shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). On [DATE] at 0930 hours, an initial tour of the kitchen was conducted with the DSS. The ice machine drainpipe was observed with no air gap and touching the rim of the floor sink. On [DATE] at 1131 hours, a concurrent observation and interview was conducted with the Maintenance Director in the kitchen. The Maintenance Director verified there was not an air gap on the ice machine drainpipe and would need to fix it.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, and facility P&P review, the facility failed to ensure the P&P regarding outside food for residents was followed. * The facility failed to ensure the facility staff responsible for handling food brought for the residents from the outside and visitors who brought food for residents from the outside were educated on safe food handling procedures. * The facility failed to provide appropriate equipment needed to reheat food items brought in for residents from the outside. These failures posed the risk for food borne illness in residents who consume food from outside sources. Findings: Review of the facility's P&P titled Foods Brought by Family/Visitors revised 3/2022 showed: - Foods brought by family/visitors for individual residents are not shared with or distributed to other residents. - Family/visitors are asked to prepare and transport food using safe food handling practices, including safe cooling and reheating processes, holding temperatures, preventing cross-contamination with raw or undercooked foods, and hand hygiene. - Safe food handling practices are explained to family/visitors in a language and format they understand. On 4/15/24 at 1431 hours, an interview was conducted with the IP. The IP stated if a resident wanted food from the outside, it would depend on the resident's diet and if the resident's physician was okay with it. The IP stated they stored the food in a refrigerator located in the medication room. On 4/15/24 at 1434 hours, an interview was conducted with LVN 11. LVN 11 was asked if she had received any safe food handling education and if she provided information about safe food handling to visitors when they bring food from the outside. LVN 11 was unable to recall if she had received any education and stated she was not aware of any education about safe food handling given to the visitors. LVN 11 stated she would explain to the visitors they would put the food in the fridge, label it, and the food would get discarded after 24 hours. On 4/15/24 at 1449 hours, an interview was conducted with the DON. The DON was asked how the visitors who brought food from the outside for residents were informed of safe food handling practices and how the residents would heat up the food from the outside. The DON verified they did not give education to the visitors for safe food handling practices. The DON verified the facility did not have a microwave for the residents to heat up their food. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 1455 hours, an interview was conducted with the DSD. The DSD stated she had not given any in-service education to the staff about safe food handling practices to the staff. Medical record review for Resident 40 was initiated on 4/15/24. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's MDS dated [DATE], showed Resident 40 was cognitively intact. Review of Resident 40's medical record failed to show a care plan addressing Resident 40's food brought in from the outside. In addition, the care plan failed to show education was given to Resident 40 on safe food handling practices. On 4/15/24 at 1511 hours, a concurrent observation and interview was conducted with Resident 40 in her room. The wall to the left of the bed was observed with shelves filled with food items, including opened bags of chips sealed with a clip and a portable mini refrigerator containing perishable food items such as a container of opened potato salad and a carton of creamer. Resident 40 stated the facility did not give her any education about safe food handling. On 4/16/24 at 0836 hours, a follow-up interview and facility P&P review was conducted with the DON. The DON verified when the resident had food brought in from the outside, it was only for the resident and stated the food should not be shared.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48882 Based on interview and medical record review, the facility failed to ensure the medical records for three of 21 final sampled residents (Residents 23, 25, and 61) were complete and accurate. * The facility failed to ensure Resident 23's CNA flowsheet for meal percentages and nourishments were complete and accurately documented. * The facility failed to ensure Resident 25's Advance Directive Acknowledgment form was complete to reflect Resident 25's wishes; and failed to ensure Resident 25's informed consent for Xanax (an antianxiety medication) had the correct date as the physician's order date. * The facility failed to ensure Resident 61's POLST information had the same information with the Advance Directive Acknowledgement form. These failures had the potential for the residents' care needs not being met as their medical information was incomplete and inaccurate. Findings: 1. Medical record review for Resident 23 was initiated on 4/15/24. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Physician Orders for April 2024 showed the following physician's orders: - dated 2/15/24, to provide health shake two times per day, between meals for nourishment. - dated 3/7/24, to provide a pureed diet with thin liquids. Review of Resident 23's MAR for April 2024, under Supplements, showed to give health shake two times a day between meals for nourishment. The MAR showed check marks from 4/1 to 4/15/24, at 1000 and 1400 hours. Review of Resident 23's plan of care showed a care plan problem dated 1/25/23, addressing Resident 23's risk for altered nutrition related to dementia, dysphagia (difficulty swallowing), end stage disease, on hospice care, and underweight. The intervention included to provide supplements as ordered. Review of Resident 23's CNA Flow Sheet for April 2024, under meal percentage, showed to enter the percentage (%) consumed, if less than 50 % or refused, substitute. If the resident refused substitute, to document on the additional notes page. Under the nourishment section showed to put A for accepted, or R for refused. The CNA Flow sheet showed missing entries for the following meals: - Breakfast: on 4/13/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lunch: on 4/5, 4/12, and 4/13/24. - Dinner: on 4/1, 4/2, 4/5, 4/6, 4/9, and 4/14/24. - Nourishment at 1000 hours: on 4/13/24. - Nourishment at 1400 hours: on 4/5, 4/8, and 4/13/24. Further review of Resident 23's Flow Sheet showed on 4/1/24, Resident 23 consumed 30 % of lunch. Under the substitute section showed the entry as 0. The additional notes page failed to show any documentation of what Resident 23 was offered. Under nourishments, the entries were documented as 0 or 09- not applicable from 4/1-4/17/24. On 4/17/24 at 1417 hours, an interview and concurrent record review was conducted with the DON. The DON stated Resident 23 was previously on monitoring for weight loss and the nourishment shakes were ordered for the resident between meals. When asked where the information should have been documented, the DON stated the documentation was done by CNAs on their flowsheet, under nourishments. Concurrent review of Resident 23's CNA Flowsheet for April 2024 was conducted with the DON. The DON verified the above findings. The DON stated the entries should be completed to accurately track the resident's intake. On 4/18/24 at 0920 hours, a follow-up interview was conducted with the DON. The DON stated she expected the staff documentation to be precise and complete by the end of their shift. When asked about the potential risks for incomplete or inaccurate documentation on CNA flowsheet, the DON stated the actual food intake and consumption of meals by the resident would have been inaccurate, in the instance the resident was losing weight, the facility would not have been able to determine if the weight loss was due to the disease process, an issue with swallowing, or resident's appetite. On 4/18/24, at 1417 hours, the DON was informed and acknowledged the above findings. 2.a. Medical record review for Resident 25 was initiated on 4/15/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 2/16/24, showed Resident 25 had the capacity to understand and make decisions. Review of Resident 25's Physician Orders for Life-Sustaining Treatment (POLST) dated 2/11/24, showed no advance directive, (a legal document that states a person's wishes about receiving medical care if that person is not longer able to make decision) was selected. Review of Resident 25's Advance Directive Acknowledgement form signed and initialed by the resident on 10/30/23, under I have not executed an Advance Directive failed to show Resident 25's selection whether he wished to decline, or wished to execute an advance directive. The Advance Directive Acknowledgement form was also missing a facility representative's signature. On 4/16/24 at 1408 hours, an interview was conducted with Resident 25. When asked, Resident 25 stated he vaguely remembered discussing about an advanced directive. Resident 25 stated he did not remember what was signed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 0954 hours, an interview was conducted with the SSD. The SSD stated on admission, she would go over the advance directive with the resident or responsible party (RP). If the resident or RP wished to execute or decline to formulate an advanced directive, she would provide them an acknowledgement form. The SSD stated the nursing or Social Services staff were responsible for reviewing the form, and to check for completion. The SSD further stated the form was reviewed on admission, quarterly, and after any change of condition. A concurrent review of Resident 25's Advance Directive Acknowledgement form was conducted with the SSD. The SSD stated the form was missing a selection as to whether Resident 25 wished to decline or execute an advance directive, and also missing a facility representative signature. On 4/17/24 at 1045 hours, an Advance Directive Acknowledgment form was provided for Resident 25. The form showed the date of admission as 10/30/24, and I decline to execute an Advance Directive was selected. The form also showed two facility staff signatures, with a note that indicated the resident refused to sign at this time. The form failed to show a date or time for the encounter. On 4/17/24 at 1101 hours, an interview was conducted with LVN 11. LVN 11 stated she saw the resident with the previous SSD to discuss his selection for the formulation of an advance directive. LVN 11 stated Resident 25 refused to sign as documented on the form. LVN 11 stated she signed as a witness with the previous SSD. LVN 11 verified the form failed to show a date or time of the encounter, and the admitted was incorrect. When asked if the encounter was documented by her or the previous SSD, LVN 11 stated there was no documentation. On 4/18/24 at 0925 hours, an interview was conducted with the DON. The DON stated she expected the documentation of the staff to be precise and complete at the end of shift. On 4/18/24 at 1417 hours, the DON was informed and acknowledged the above findings. b. Medical record review for Resident 25 was initiated on 4/15/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination, dated 2/16/24, showed Resident 25 had major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. Review of Resident 25's Physician Order List for October 2023, showed a physician's order dated 10/30/23, to administer Xanax (an anti anxiety medication) 2 mg one tablet by mouth every 12 hours for anxiety manifested by inability to relax. Review of Resident 25's Physician Orders for April 2024 showed a physician's order dated 2/9/24, to administer Xanax 2 mg one tablet by mouth at 0730 hours every day for anxiety manifested by inability to relax. Review of Resident 25's Informed Consent for Psychotropic Drug showed a consent dated 10/30/23, for Xanax 2 mg by mouth every day at 0730 hours, for anxiety manifested by inability to relax. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 0925 hours, an interview was conducted with the DON. The DON stated for antipsychotic medications, an informed consent indicating the medication, dose, frequency, and manifestations would be obtained. The DON stated the consent would be signed by the physician who provided the informed consent to the resident. The consent was then verified by the nurse prior to administration of the medication. When asked when a new consent must be obtained, the DON stated a new consent would be obtained when the dose or frequency was increased. On 4/18/24 at 0935 hours an interview and concurrent record review was conducted with the DON. The DON verified the date on Resident 25's consent dated 10/30/23, for Xanax 2 mg every day at 0730 hours, did not match the ordered date on 2/9/24. The DON also verified the frequency on the consent did not match the physician's order dated 10/30/23, for Xanax 2 mg every 12 hours. On 4/18/24 at 1417 hours, the DON was informed and acknowledged the findings. 39670 3. Medical record review for Resident 61 was initiated on 4/15/24. Resident 61 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 61's H&P Examination dated 3/10/24, showed Resident 61 did not have the capacity to understand and make decisions. Review of Resident 61's POLST dated 3/9/24, showed Resident 61 had no advance directive. However, the Advance Directive Acknowledgement form dated 4/3/24, showed the responsible party had executed an advance directive. Further review of Resident 61's medical record failed to show documented evidence of the advance directive for Resident 61. On 4/16/24 at 1214 hours, an interview and concurrent medical record review for Resident 61 was conducted with the SSD. The SSD verified Resident 61's POLST and Advance Directive Acknowledgement form had different information. The SSD verified there was no documentation found in the medical record for Resident 61's advance directives. On 4/18/24 at 1023 hours, an interview and concurrent medical record review for Resident 61 was conducted with the DON. The DON stated the advance directive and POLST of Resident 61 should have been consistent and should have been clarified with the family representative. The DON verified the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, and medical record review, the facility failed to ensure the appropriate infection control practices designed to provide a safe and sanitary environment and to prevent the spread of infections within the facility were implemented. * Resident 17's urinary tubing and Resident 81's indwelling catheter drainage bag were laying on the floor. * One of two clean linen wheeled bins had layers of peeling tape on the hard plastic cart. These failures posed the risk of transmission of nfectious organisms from the floor to the urinary tract and transmission of infection in the facility. Findings: Review of the facility's P&P titled Catheter Care, Urinary dated 9/2014 showed under the section for Infection Control, be sure the catheter tubing and drainage bag are kept off the floor. 1. Medical record review for Resident 17 was initiated on 4/15/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report for April 2024 showed a physician's order dated 3/27/24, to apply indwelling catheter attached to bedside drainage bag for diagnosis benign prostatic hyperplasia (enlarged prostate which can cause urgent or frequent need to pee). On 4/16/24 at 0900, 1100 and 1430 hours, Resident 17's urinary catheter tubing was observed not hooked on Resident 17's bed frame. The urinary collection tubing was laying on the floor. This observation was verified by LVN 6. LVN 6 acknowledged the urinary collection tubing should not have been touching the floor. 2. Medical record review for Resident 81 was initiated on 4/15/24. Resident 81 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 81's Order Summary Report for April 2024, showed a physician's order dated 4/15/24, to apply indwelling catheter attached to bedside drainage bag for diagnosis of wound management, neurogenic bladder, or urinary retention. On 4/16/24 at 1045 hours and at 1210 hours, Resident 81's urinary catheter drainage bag with cover was observed laying on the floor. On 4/17/24 at 1405 hours and at 1500 hours, Resident 81's urinary catheter drainage bag with cover was observed laying on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 1500 hours, RN 4 was summoned to Resident 81's room. RN 4 stated the urinary catheter drainage bag should not be laying on the floor. RN 4 stated she would take a basin to prevent the bag from touching the floor. RN 4 verified the findings. 39683 3. On 4/16/24 at 1404 hours, an interview and concurrent inspection of the laundry area was conducted with the Maintenance Director and Laundry Staff 1. In the clean side of the laundry area, there were two wheeled linen bins for transporting clean linen: from the washer to the dryer and from the dryer to the folding area. On the hard plastic bin, layers of peeling red tape were observed on two corners and along the side edge or the top rim. Threadlike fibers were observed exposed under the peeling layers of tape in all three areas. Laundry Staff 1 stated they cleaned the bin every two hours with disinfecting wipes and grabbed a large container of Super Sani-Cloth germicidal disposable wipes. The wipe label showed it was to disinfect hard, nonporous surfaces. The Maintenance Director verified the peeling layers of tape with exposed string-like fibers were not cleanable hard, nonporous surfaces.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the essential kitchen equipment was maintained in safe operation condition when the ice machine manufacturer cleaning and sanitizing instructions were not followed. This failure had the potential to result in the equipment to not function in the way it was intended which could affect the health status of the residents. Findings: Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the ice machine needs to be cleaned and sanitized monthly. Clean inside of ice machine with a sanitizing agent per the manufacturer's procedures to clean and sanitize the machine. Review of the ice machine instruction manual titled LB Series Ice Machine Installation and maintenance instructions, undated, showed in part, in order to make the operation of the ice machine stable and efficient, the user is responsible for the operation according to the cleaning and disinfection requirements. Under the section 14.1 cleaning process showed to add two packs of cleaning agent ([NAME] DELIMER, 56.7g/pack) or mixed cleaning liquid into the ice maker water tank. Further review of the manual, under the section 14.2 Disinfection process, showed to mix 8 liters warming water (45 - 50 C) and two packages of disinfectant (KAY5, 28.4/package) into a disinfectant. Soak the cleaned parts in the prepared disinfectant. Use 1 liter of water and 1/2 package of disinfectant (KAY5, 28.4/package) to make a disinfectant .when water starts to flow on the evaporator, add the disinfectant solution that has been prepared into the ice machine skink and at the same time, spray the outer surface of the sink with a spray can containing disinfectant water. On 4/15/24 at 1124 hours, an observation of the facility's ice machine located in the kitchen and concurrent interview was conducted with the Maintenance Director. The Maintenance Director stated the ice machine was cleaned by an outside company (Maintenance Company 1) once a month. Review of the facility invoices from Maintenance Company 1 dated 6/9/23, 9/25/23, and 11/13/23, showed the service of the ice machine preventative of maintenance. The invoice stated Maintenance Company 1 cleaned the evaporator coil with nickel safe ice machine cleaner and cleaned and sanitized the entire ice machine and storage bin by diluting 5.25% chlorine bleach with warm water. On 4/16/24 at 0848 hours, a telephone interview was conducted with Maintenance Company 1. Maintenance Company 1 stated he used Calgon nickel safe cleaner and bleach to sanitize the ice machine. Maintenance Company 1 verified he used a generic cleaner and sanitizer because he cleaned many types of ice machines. On 4/17/24 at 1639 hours, the DSS, DON, and Administrator were informed of and acknowledged the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the residents' entrapment assessments were complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for six of 21 final sampled residents (Residents 16, 18, 33, 61, 62, and 351). These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: Review of the facility's P&P titled Proper use of side rail dated 12/2016 showed an assessment will be made to determine the resident's symptoms, risk for entrapment. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may carry depending the type of bed and mattress being used). According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. 1. On 4/15/24 at 0900 hours, 4/15/24 at 1215 hours, and 4/16/24 at 0915 hours, Resident 351 was observed lying in bed with bilateral upper side rails elevated (length from head to waist). Medical record review for Resident 351 was initiated on 4/15/24. Resident 351 was admitted to the facility on [DATE], and readmitted on [DATE]. (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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 351's Order Summary Report showed a physician's order dated 1/9/24, to apply bilateral upper side rail for security purpose as per the family request. Review of Resident 351's bedside rail entrapment risk dated 4/2/24, showed bed side rail entrapment score was 7 (high risk). However, the document failed to show the assessments of the entrapment for each entrapments zone of the bed. On 4/16/24 at 1040 hours, an interview and concurrent medical record review for Resident 351 was conducted with the MDS coordinator. The MDS coordinator was asked if Resident 351's use of the side rails in bed was assessed for the entrapment for each entrapments zone of the bed. The MDS coordinator was unable to provide the documentation. The MDS coordinator stated she completed side rail entrapment risk assessment based on question that they asked in the computer, but the MDS coordinator did not measure the bed side rail or zone for risk entrapment. The MDS acknowledged Resident 351 was at high risk of entrapment and stated the maintenance might have measured it. The MDS coordinator verified the finding. On 4/16/24 at 1100 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he did not do measurement of bed rails or inspect for entrapment and verified the finding. On 4/16/24 at 1115 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director was observed measuring the side rail for Resident 351's bed and the side rail was observed to have three gaps: two small gaps with one big middle gap. The Maintenance Director stated the gap for small one measurement was 2.5 inches (length) x 3.5 inches in width and big one was 23 inches X 4 inches. The Maintenance Director verified the gap could be a possible risk for hand or arm to be trapped and verified the finding. 39670 2. On 4/15/24 at 1438 hours, and 4/16/24 at 0935 hours, Resident 16 was observed in bed with bilateral side rails elevated. Medical record review for Resident 16 was initiated on 4/16/24. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 16's MDS dated [DATE], showed Resident 16 was cognitively intact and required extensive assistance of two staff for bed mobility. Review of Resident 16's Physician Orders for April 2024 showed order dated 3/19/24, for Resident 16 to have side rail and to monitor for entrapment every day and night shifts. Review of Resident 16's Side Rail assessment dated [DATE], showed the half side rail was indicated for mobility/transfer purposes as an enabler. Review of Resident 16's Bedside Rails Entrapment Risk Assessment, undated, showed Resident 16's entrapment low risk score. However, the document failed to show the assessment of the different entrapment zones for using the side rail in bed. (continued on next page)

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	04/18/2024

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 at 1028 hours, an interview was conducted for Resident 16 with RNA 2. RNA 2 verified Resident 16's use of the upper side rail in bed. RNA 2 stated the resident was able to grab and hold the rails when repositioning in bed. 3. On 4/15/24 at 1021 hours, and 4/16/24 at 1036 hours, Resident 61 was observed in bed with bilateral side rails elevated. Medical record review for Resident 61 was initiated on 4/16/24. Resident 61 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 61's Physician Orders List showed order dated 3/11/24, for Resident 61 to have upper side rail for security purposes. Review of Resident 61's Side Rail assessment dated [DATE], showed the bilateral side rail was indicated for mobility/transfer purposes as an enabler. However, further review of the medical record for Resident 61 failed to show documentation of entrapment assessment completed for the use of side rails. On 4/17/24 at 0916 hours, an interview was conducted for Resident 61 with CNA 10. CNA 10 verified Resident 61's use of side rails in bed. CNA 10 stated Resident 61 was able to grab and hold the side rail when providing care. On 4/17/24 at 1029 hours, an interview and concurrent medical record review for Residents 16 and 61 was conducted with RN 5. RN 5 verified Residents 16 and 61's use of side rails in bed. RN 5 verified there was no entrapment assessment completed for Resident 61. RN 5 stated the Maintenance Director was responsible for the completion of entrapment assessment of the residents who used the side rails in bed. On 4/17/24 at 1035 hours, an interview was conducted for Residents 16 and 61 with the Maintenance Director. The Maintenance Director stated he was responsible for the bed maintenance. The Maintenance Director was asked about the entrapment assessment for the side rails use in bed of the residents. The Maintenance Director verified and acknowledged the side rail entrapment assessment for the residents were not done and there was no documentation. On 4/18/24 at 1013 hours, an interview was conducted for Resident 16 and 61 with the DON. The DON was informed of the above findings. The DON stated the facility have an inconsistent assessment and acknowledged the facility did not have an entrapment assessment for the residents who used the side rails in bed. 43156 4. On 4/15/24 at 0835 hours, Resident 18 was observed lying in bed, awake, head of the bed elevated with bilateral upper side rails up. On 4/15/24 at 1623 hours, Resident 33 was observed lying in bed asleep, head of bed elevated with bilateral side rails up. (continued on next page)

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	04/18/2024

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Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/24 at 0820 hours, Resident 62 was observed lying in bed, awake, head of the bed elevated watching in his computer. The bilateral upper enablers in his bed were both up. On 4/15/24 at 1415 hours, an interview was conducted with the Maintenance Director. When asked about the inspections of bed frames, mattresses, and side rails, the Maintenance Director stated he only checked on the side rails when the staff reported problems with the rails. When asked if he performed measurements of side rails before installation, the Maintenance Director stated he did not do measurements of bed side rails, only installed them. The Maintenance Director verified the residents' bed side rails had wide gap wide enough to entrap a resident's head or body. On 4/18/24 at 1035 hours, an interview and concurrent facility P&P review was conducted with the DON. The DON verified the facility's Bed Safety and Bed Rails P&P showed the maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail, and mattress will have no wide gap wide enough to entrap a resident's head or body.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39856 Based on observation, interview, and facility document review, the facility failed to ensure the kitchen was free of pests. This failure posed the risk for pests to transmit disease to residents by contaminating food and food contact surfaces for 36 residents who received food prepared in the kitchen. Findings: Review of the facility's P&P titled Pest Control revised 5/08 showed this facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Review of the facility's pest control invoices showed the pest control company had performed pest control maintenance in the kitchen for cockroaches on 1/16, 2/20, and 3/20/24. During the initial tour of the kitchen on 4/15/24 at 0810 hours, with the DSS, a live bug which resembled a Jerusalem cricket (a large flightless insect) was observed under the manual ware washing sink. The DSS stated the pest control company came to treat the kitchen for pests monthly. The DSS confirmed the live bug observed under the manual ware washing sink. On 4/15/24 at 1622 hours, an observation of the kitchen back door and screen was conducted with the DSS. A gap of approximately one inch was observed between the ground and the bottom of the door and between the ground and the bottom of the metal screen door. The kitchen back door and metal screen opened to the back parking lot where the trash dumpsters were stored. On 4/15/24 at 1624 hours, an interview was conducted with the Maintenance Director. The Maintenance Director confirmed the door and metal screen had a gap between the bottom of the door and metal screen and the ground. The Maintenance Director stated he would attach a door sweep to cover the gaps. The Maintenance Director was asked if he had contacted the pest control company since the last pest treatment, the Maintenance Director stated he had not contacted the pest control company. The Maintenance Director stated the pest control company treated the facility kitchen for pest monthly. On 4/16/23 at 0919 hours, an interview was conducted with the facility Administrator. The Administrator stated the pest control company was scheduled monthly or as needed and the DSS or Maintenance Director could contact the pest control company more frequently if needed. On 4/17/24 at 0810 hours, an interview was conducted with the DSS. The DSS confirmed she had not contacted the pest control company for additional pest treatment since the treatment on 3/20/24.