Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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 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 49780

Based on interview, medical record review, and facility document review, the facility failed to complete the post fall neuro-checks at the specific time frames as per the facility's 72 hours Neuro-check Monitoring process for one of three sampled residents (Resident 1). This failure had the potential for Resident 1 to experience medical complications which could go unnoticed post fall.

Findings:

Review of the facility's 72 hours Neuro-check Monitoring showed the neuro-checks must be monitored every 30 min for two times, every hour for three times, every two hours for two times, every four hours for four times, and every eight hours for six times.

Medical record review for Resident 1 was conducted on 6/4/24. Resident 1 was admitted to the facility on [DATE], with diagnoses including Parkinson's disease, OPD, lack of coordination, difficulty in walking, cognitive communication deficits, muscle weakness, and osteoarthritis.

Review of Resident 1's progress note dated 5/31/24 at 0300 hours, showed Resident 1 fell from his wheelchair and hit his left hip on the floor.

Review of Resident 1's neuro-check report dated 5/31/24, showed the neuro-checks were monitored at 0300, 0330, 0630, 0930, and 1230 hours.

Further review of the medical record showed the resident was transferred to the acute care hospital on 5/31/24 at 1250 hours.

On 6/5/24 at 0840 hours, an interview and concurrent medical record review was conducted with LVN 1. When asked about the facility's protocol after the resident having a fall, LVN 1 stated the nurse would need to assess the resident, do the neuro-checks for 72 hours, and complete the change of condition's fall risk assessment, progress notes, and care plan. LVN 1 verified the neuro-checks for Resident 1 were completed on the following dates and times:

- 5/31/24 at 0300 hours

- 5/31/24 at 0330 hours

- 5/31/24 at 0630 hours

(continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/31/24 at 0930 hours - 5/31/24 at 1230 hours LVN 1 confirmed the nurses did not assess Resident 1's neuro-checks for the specified time frames, every 30 min for two times, every hour for three times, and every two hours for two times from 0300 hours until 1250 hours when the resident was transferred to the acute care hospital. On 6/5/24 at 1237 hours, an interview was conducted with the DON. When asked about the unwitnessed fall on 5/31/24, and the completed neuro-checks, the DON verified the nurses did not monitor the resident every 30 min for two times, every hour for three times, every two hours for two times, every four hours for four times as per the facility's 72 hours Neuro-check Monitoring process. The DON stated the nurses should have monitored the resident at the appropriate intervals.

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49780 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the accuracy of medication administration documented on the MAR for one of three sampled residents (Resident 1). This failure posed the risk of having error in medical care and delay in treatment. Findings: Review of the facility's P&P titled Medication Administration General Guidelines revised 1/2019 showed the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given and when PRN medications are administered, date and time of administration, dose, route of administration, complaint and results achieved from giving the dose are documented. Medical record review for Resident 1 was conducted on 6/4/24. Review of the nurses' notes dated 5/31/24 at 1104 hours, show the resident had a new order for Norco 10 mg/325 mg one time for severe pain. Review of the E-kit log dated 5/31/24, showed Norco 10 mg/325 mg was taken out from the E-kit on 5/31/24 at 1110 hours. However, review of Resident 1's MAR for May 2024 showed Norco 10 mg/325 mg was administered to Resident 1 on 5/31/24 at 1230 hours. On 6/5/24 at 0840 hours, an interview was conducted with LVN 1. LVN 1 stated at 0830 hours, the assigned nurse followed up and documented the resident's pain scale of 10 (on a pain scale of 0 to 10 with 0 = no pain and 10 = worst pain). The assigned nurse notified the doctor and received an order for Norco10 mg/325 mg (narcotic pain medication). LVN 1 checked the MAR and stated Norco 10 mg/325 mg was given at 1230 hours. On 6/5/24 at 1237 hours, an interview was conducted with the DON. The DON stated the assigned morning nurse had received the order for Norco 10 mg/325 mg at 1100 hours. The assigned nurse took the medication from the E-kit at 1110 hours and gave the medication to Resident 1 right away. However, the assigned nurse was busy and did not document the pain medication administration until 1230 hours. The DON also stated the MAR showing the Norco 10 mg/325 mg given at 1230 hours, was incorrect. The DON confirmed the assigned nurse should have documented it right away after giving the medication to the resident at 1110 hours.