STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055689	A. Building B. Wing	07/02/2025

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 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** Based on observation, interview, medical record review, and facility P&P, the facility failed to ensure the protocols were followed for oxygen administration for four of four sampled residents (Residents 1, 2, 3, and 4). * Residents 2, 3, and 4 were administered with more than the liters per minute ordered by the physician. * Resident 1's MAR failed to show documentation of the administration of the oxygen PRN. These failures had the potential for adverse respiratory outcomes and resulted in inaccurate administration records for the residents. Findings: Review of the facility's P&P titled Oxygen Administration reviewed 2/2023 showed the oxygen shall be administered as ordered by the physician. Review of the facility's P&P titled Guidelines For Medication Administration (undated) showed the medication administration shall be recorded on the appropriate documentation record. 1. Medical record review for Resident 1 was initiated on 6/6/25. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed a physician's order dated 11/30/24, for continuous oxygen to be administered at 2 LPM via nasal cannula or mask. On 6/6/25 at 1348 hours, Resident 2 was observed lying in bed with the supplemental oxygen being administered via nasal cannula. The regulator dial showed 5 LPM was administered to the resident. On 6/6/25 at 1455 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 2's bedside. LVN 1 observed Resident 2's oxygen regulator and verified the resident was currently receiving the oxygen at 5 LPM. On 6/6/25 at 1459 hours, a follow-up interview and concurrent medical record review for Resident 2 was conducted with LVN 1. LVN 1 reviewed Resident 2's physician's orders and verified the order for the oxygen administration was for 2 LPM. (continued on next page)

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 1502 hours, an interview was conducted with LVN 2. LVN 2 she was Resident 2's nurse and had not changed the resident's oxygen during her shift. 2. Medical record review for Resident 3 was initiated on 6/6/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed a physician's order dated 5/28/25, to administer supplemental oxygen at 2 LPM PRN via nasal cannula or mask to keep the oxygen saturation levels above 90%. On 6/6/25 at 1344 hours, Resident 3 was observed sitting up in bed with the oxygen being administered via nasal canula. The regulator showed the oxygen was being administered at 4 LPM. On 6/6/25 at 1456 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 3's bedside. LVN 1 observed Resident 3's oxygen regulator and verified the resident was currently receiving the oxygen at 4 LPM. The LVN stated she did not change the resident's oxygen during her shift. On 6/6/25 at 1459 hours, a follow-up interview and concurrent medical record review for Resident 3 was conducted with LVN 1. LVN 1 reviewed Resident 3's physician's orders and verified the order was for 2 LPM PRN. 3. Medical record review for Resident 4 was initiated on 6/6/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 4/19/25, to administer supplemental oxygen at 2 LPM PRN via nasal cannula or mask, to keep the oxygen saturation above 90%. On 6/6/25 at 1344 hours, Resident 4 was observed sitting up in bed with the oxygen being administered via nasal canula at 3 LPM. On 6/6/25 at 1456 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 4's bedside. LVN 1 observed the resident's oxygen regulator and verified the resident was currently receiving the oxygen at 3 LPM. LVN 1 stated she did not adjust the resident's oxygen during her shift. On 6/6/25 at 1459 hours, a follow-up interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 reviewed Resident 3's physician's orders and verified the order was to administer the oxygen for 2 LPM PRN. 4. Closed medical record for Resident 1 was initiated on 6/6/25. Resident 1 was admitted to the facility on [DATE], and discharged to an acute care hospital on 5/19/25. Review of Resident 1's Order Summary Report showed a physician's order dated 4/16/25, for oxygen to be administered PRN at 2 LPM via nasal cannula or mask, to keep the resident's oxygen saturation levels above 90%. (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 1's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 1's MAR for 5/2025 showed PRN oxygen at 2 LPM was administered on 5/19/25 at 0000 hours. There was no other documentation in the MAR to show the oxygen was administered on any other days. However, review of Resident 1's Weights and Vitals Summary showed the resident was on oxygen via nasal cannula daily from 5/1 to 5/19/25. Review of Resident 1's LN - Nursing Summary - Weekly dated 5/11/25, showed PRN oxygen was administered to the resident at 2 LPM. Review of Resident 1's LN - Nursing Summary - Weekly dated 5/16/25, showed the resident received continuous oxygen at 2 LPM. Review of Resident 1's Dialysis Communications Records showed the following: - On 5/1/25 at 1820 hours, Resident 1 was on oxygen via nasal cannula. - On 5/10/25 at 1835 hours, Resident 1 was on oxygen at 2 LPM via nasal cannula. Review of Resident 1's N Adv (Nursing Advanced) Skilled Evaluations showed the following: - dated 5/1, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 5/17, and 5/18/25, showed Resident 1 received oxygen via nasal cannula. - dated 5/2 and 5/10/25, showed Resident 1 received PRN oxygen at 2 LPM via nasal cannula. On 7/2/25 at 0916 hours, a telephone interview was conducted with Resident 1. Resident 1 stated he was on continuous oxygen while at the facility. On 7/2/25 at 1033 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with LVN 3. LVN 3 stated Resident 1 was on continuous oxygen when she was assigned to him. LVN 3 reviewed Resident 1's physician's orders and verified the order was for PRN oxygen use. LVN 3 reviewed Resident 1's MAR for 5/2025 and verified the MAR failed to show Resident 1 frequently received the oxygen PRN. LVN 3 stated the oxygen administered should be documented in the MAR. On 7/2/25 at 1125 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON stated per Resident 1's medical record, the resident was pretty much on continuous oxygen, and verified the order was for PRN and should have clarified the order to match the resident's needs.