

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2025
NAME OF PROVIDER OR SUPPLIER Chapman Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12232 Chapman Ave Garden Grove, CA 92840	

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)
<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop a care plan problem for one sampled resident (Resident 8) who was placed on the EBP due to the presence of a GT. This failure placed the resident at risk to not receive the appropriate interventions needed for GT care and EBP status. Findings:Review of the facility's P&P titled Enhanced Standard Precautions revised10/2017 showed the following:- It is the policy of the facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. Medical record review for Resident 8 was initiated on 7/8/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report dated 7/8/25, showed the following physician's order:- dated 12/26/24, to check the GT placement and patency every shift; and- dated 12/27/24, for EBP every shift due to gastrostomy tube. Review of Resident 8's care plan problems dated 12/27/24, failed to show a care plan was developed to address the resident was on the EBP due to the presence of the GT as ordered by the physician. On 7/8/25 at 1520 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 1. RN 1 verified there was no care plan developed for the resident's EBP due to the presence of a GT. RN 1 stated for the newly admitted residents, the admitting nurse would initiate the baseline care plan and the other RNs or MDS staff would add more care plans as needed. RN 1 verified Resident 8 had a GT since readmission and the physician ordered for the EBP on 12/27/25. On 7/8/25 at 1650 hours, an interview was conducted with the Administrator and DON. The DON stated the care plan must be initiated after receiving the physician's order for the EBP. The DON stated the MDS staff would review the residents' care plans for completion. The DON and Administrator were informed and acknowledged the above findings.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment to help prevent the development and transmission of diseases and infections for one sampled resident (Resident 8) observed for infection control practices. * The facility failed to ensure CNA 1 donned the appropriate PPE when providing care to Resident 8 with a physician's order for EBP. This failure posed the risk of transmission of infections to the residents throughout the facility. Findings: Review of the facility's P&P titled Enhanced Standard Precautions revised on 5/2024 showed the following:- Enhanced Standard Precautions provide the Skilled Nursing Facility a framework for reducing Multi-Drug Resistant Organism (MDRO) transmission through Healthcare Professional (HCP) use of gowns and gloves while caring for residents at high risk for MDRO transmission at the point of care during specific activities with the greatest risk for MDRO contamination of HCP hands, clothes, and the environment. Also is a resident-centered and activity-based approach for preventing MDRO transmission in SNF;- Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of Staphylococcus aureus and MDROs;- California Department of Public Health (CDPH) recommends the use of ESP primarily the use of gowns and gloves for specific high contact care activities based on the resident's characteristics that are associated with a high risk of MDRO colonization and transmission including presence of indwelling devices such as urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters and wounds; and- Six Moments of Enhanced Standard Precautions include everyone must perform hand hygiene before entering the room. Anyone participating in any of the following six moments must don gown and glove, which includes during morning and evening care, toileting or changing of incontinence briefs, care for devices, invasive procedures sites and giving medical treatment, wound care, mobility assistance and preparing to leave the resident's room and cleaning of the environment. Medical record review for Resident 8 was initiated on 7/8/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 12/28/24, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's MDS assessment dated [DATE], showed the BIMS assessment was not conducted for Resident 8 due to not having the capacity to understand. Review of Resident 8's Order Summary Report dated 7/8/25, showed the following physician's order:- dated 12/26/24, to check the GT placement and patency every shift; and- dated 12/27/24, for EBP every shift due to GT. On 7/7/25 at 0925 hours, an EBP signage was posted outside Resident 8's room and a PPE cart was also observed outside the resident's room. CNA 1 was observed providing care to Resident 8 and was not wearing a gown. On 7/7/25 at 0930 hours, an observation and concurrent interview for Resident 8 was conducted with RN 2. RN 2 was asked regarding the use of PPE for the residents on EBP. RN 2 stated the PPE was used when the staff were providing care to the residents as shown on the six moments of the EBP signage posted outside Resident 8's room. RN 2 stated all the residents in Resident 8's room were on EBP due to the presence of a Foley catheter or GT. RN 2 observed CNA 1 was providing incontinent care to Resident 8 and not wearing a gown. RN 2 verified the above findings. RN 2 stated Resident 8 had a GT and was on EBP. Furthermore, RN 2 stated the staff must wear the appropriate PPE which included the gloves and gowns when providing the incontinence care for the residents on the EBP. On 7/7/25 at 1105 hours, an observation and concurrent interview for Resident 8 was conducted with the DSD. The DSD observed and verified Resident 8's room was on EBP and the resident had a GT. The DSD was asked about the facility's practice pertaining to the residents on the EBP. The DSD stated the staff must wear the appropriate PPE (gloves and gowns) inside Resident 8's room during the specified six moments signage posted outside the resident's door. The DSD stated the staff must wash their hands and don a gown and gloves prior to providing care on each resident in the room. The DSD stated the staff's failure to follow the infection control protocol for the residents on the EBP would compromise the residents' health. On 7/7/25 at 1330 hours, an interview was conducted with CNA 1. CNA 1 was asked about the EBP in Resident 8's room. CNA 1 stated for the resident's on the EBP, there was a signage posted outside Resident 8's room with the information on what PPE to use and when to use it. CNA 1 stated it was his mistake for not wearing a gown when he provided the incontinent care to Resident 8. CNA 1 stated Resident 8 had a GT, and he must wear the appropriate PPE which included the gloves and gown during care. On 7/7/25 at 1525 hours, an interview was conducted with the IP. The IP was</p>		