STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055816	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Care Center	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)
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** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide the safe and sanitary environment were implemented for two of four sampled residents (Residents 1 and 2). * The facility failed to ensure RN 1 wore the proper PPEs when assessing Resident 1 who had tracheostomy, gastrostomy tube, and history of C-auris. * The facility failed to ensure CNA 1 performed proper hand hygiene and handling of linens when providing care for Resident 2. * The facility failed to ensure the dirty equipment was not touching the clean surfaces when cleaning Room A. These failures posed the risk for transmission of disease-causing microorganisms and infections.Findings: Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24, and effective 4/1/24, showed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed EBP recommendations now include use of EBP for the residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Review of the facility's P&P titled Enhanced Standard Precautions revised on 5/2024 showed the following:- Enhanced Barrier Precaution (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of Staphylococcus Aureus and Multi-Drug Resistant Organisms (MDROs);- wear gowns and gloves while performing the following high-contact care tasks associated with the greater risk for MDRO contamination of health care professional (HCP) hands, clothes, and the environment during resident care like bathing, pericare, assisting with toileting, changing incontinence briefs and respiratory care, device care for example urinary catheter, feeding tube, tracheostomy and vascular catheter, wound care, changing bed linens, mobility assistance cleaning and disinfection performed by environmental services (EVS) personnel, and bundled high-contact care activities whenever possible;- always follow Standard Precautions, including hand hygiene; use of gowns and gloves, masks, or eye shields when contact with moist body fluids is likely; injection safety practices, respiratory hygiene/cough etiquette, and recommended environmental infection control practices in all care settings for all residents;- hand hygiene in accordance to CDC or World Health Organization guidance. Hand hygiene before and after touching any resident is critical under all circumstances;- standard precautions include the following practices like hand hygiene. Hand hygiene refers to hand washing with soap or using alcohol-based hand rubs. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom;- ensure that environmental surfaces, beds, bedside equipment, and other frequently touched surfaces are appropriately cleaned; and- handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membranes exposures. 1. On 5/4/26 at 0836 hours, an observation was conducted with CNA 1. CNA 1 was observed providing care to Resident 2. A blue gown and plastic bag with a yellow brief was observed on the floor. CNA 1 (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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed his gloves and picked up the blue gown and plastic bag from the floor with his bare hands. CNA 1 left Resident 2's room, and touched the soiled linen receptacle to dispose of the blue gown. In addition, CNA 1 touched the wheelchair handles and his mask without performing hand hygiene and continued to walk towards Nursing Station A while holding the plastic bag with a yellow brief. On 5/4/26 at 0844 hours, an interview was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the staff must perform hand hygiene after providing care to any residents, or touching dirty areas. On 5/4/26 at 1347 hours, an interview was conducted with CNA 1. CNA 1 verified the above findings and stated he did not perform hand hygiene after he picked up the blue gown and plastic bag with soiled brief from the floor. CNA 1 stated the negative outcome of not following proper hand hygiene was the spread of infection. 2. On 5/4/26 at 0907 hours, an observation was conducted with Environmental Service (EVS) staff 1. EVS staff 1 was observed in Room A. EVS staff 1 was cleaning the floor with a mop then placed the mop against the clean Bed A. EVS staff 1 touched Bed A's footboard then took the mop and continued to clean the floor with the same gloves. On 5/4/26 at 0912 hours, an interview was conducted with EVS staff 1, EVS Manager, and RN 2. EVS Manager and RN 2 were informed of above findings. EVS Manager verified the above findings with EVS staff 1. EVS Manager stated dirty cleaning supplies such as a mop must not touch any clean areas. 3. Medical record review for Resident 1 was initiated on 5/4/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 5/2/26, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report dated 5/4/26, showed a physician's order dated 5/1/26, for Enhanced Barrier Precaution due to tracheostomy (a surgical procedure creating an opening (stoma) in the neck into the trachea (windpipe) to create a direct airway for breathing), gastrostomy tube (a surgical opening (stoma) made through the abdomen into the stomach to insert a feeding tube (gastrostomy tube) for long-term nutritional support or decompression), and Candida Auris (also known as Candidozyma Auris is a type of yeast that can cause severe illness and spread easily among very sick patients in healthcare facilities). On 5/4/26 at 0944 hours, an interview was conducted with RN 1. RN 1 stated Resident 1 was in the hallway when Resident 1 became unresponsive on 4/27/26. RN 1 stated she wore a mask and gloves; no gown, then assessed the resident; however, Resident 1 was not responding to any stimuli. Resident 1 was brought back to the room and RN 1 called the paramedics. RN 1 stated when the residents were on EBP, all staff must wear masks, gowns, and gloves when providing high contact activity like medication administration, assessments, repositioning, incontinence care/toileting, and wound care. On 5/4/26 at 1406 hours, an interview was conducted with Infection Preventionist (IP). The IP stated all staff must wear gowns and gloves when touching residents on EBP while in the room or outside the room. The IP stated EVS' cleaning supplies or equipment must not touch any clean surfaces or clean bed; it was considered cross contamination since the supplies were dirty. In addition, the IP stated proper hand hygiene must be performed by all staff before and after providing care to residents or touching any dirty areas. Furthermore, the IP stated there must be no linens, gowns or plastic bags on the floor. The IP verified the above findings. The IP stated the negative outcome for not following infection control was the possible exposure of harmful organisms to the residents and staff. On 5/4/26 at 1656 hours, an interview was conducted with Administrator and DON. The Administrator and DON were informed and acknowledged the above findings