

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 12/06/2024
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 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, medical record review, and interview, the facility failed to ensure the resident care was provided in a manner to promote dignity and respect for one of 18 final sample residents (Resident 70).</p> <p>* The facility failed to ensure the staff sat next to Resident 70 while assisting the resident to eat. This failure had the potential to negatively impact the resident's feelings of self-worth and well-being.</p> <p>Findings:</p> <p>On 12/3/24 at 1225 and 1235 hours, Resident 70 was observed being assisted to eat by CNA 1. CNA 1 was observed standing over Resident 70 who was seated in bed.</p> <p>On 12/3/24 at 1245 hours, an interview was conducted with CNA 1. CNA 1 acknowledged she was standing over Resident 70 when assisting the resident with eating. CNA 1 stated she was standing over Resident 70 because if she sat down, it would be too high to feed the resident. When asked about the facility's policy for assisting the residents with meals, CNA 1 stated she needed to get a chair, and sit down when assisting a resident with meals.</p> <p>Medical record review for Resident 70 was initiated on 12/3/24. Resident 70 was admitted to the facility on [DATE].</p> <p>Review of the MDS dated [DATE], showed Resident 70 had a moderate cognitive impairment, and required substantial/maximal assistance for eating.</p> <p>On 12/6/24 at 1301 hours, an interview was conducted with the DSD. When asked about the facility's policy for assisting the residents with meals, the DSD stated the staff should be seated beside the resident or at the resident's eye level when assisting the residents to eat to promote the resident's dignity.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 343) was safe to self-administer a medication.</p> <p>* Resident 343 had self-administered the lidocaine 5% cream (local anesthetic used to temporarily numb and relieve pain) and kept it at the bedside. However, there was no physician's order for the lidocaine cream and self administration. Resident 343 was not a candidate for self-administer the medications as per the assessment. This failure had the potential for Resident 343 to administer the medication inaccurately.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication - Self-Administration dated 1/2017 showed the following:</p> <ul style="list-style-type: none"> - It is the policy of the facility that residents have the right to self-administer medications if the IDT determines that this practice is clinically appropriate; - On admission or shortly thereafter, each resident will be assessed to determine if they wanted to self-administer their medications; and - It is the responsibility of the IDT to determine if it safe for the resident to self-administer drugs before the resident may exercise that right. The IDT must determine whether the resident or the nursing staff will be responsible for storage and documentation of the administration of the medications, as well as the location where the medications will be administered. These determinations should appear on the resident's comprehensive care plan. <p>On 12/4/24 at 0845 hours, Resident 343 was observed lying in bed, and a container of lidocaine 5% cream was observed on the resident's bedside table. Resident 343 stated he applied the lidocaine cream on his left leg, and the nurses were aware that he was applying the lidocaine cream by himself.</p> <p>On 12/4/24 at 0847 hours, an observation for Resident 343 and concurrent interview was conducted with RN 5. Resident 343 was observed lying in bed, and a container of lidocaine 5% cream was observed on the resident's bedside table. RN 5 verified the above findings. RN 5 stated the residents were allowed to self-administer if they had been assessed to be able to self-administer their medications.</p> <p>Medical record review for Resident 343 was initiated on 12/3/24. Resident 343 was admitted to the facility on [DATE].</p> <p>Review of Resident 343's H&P evaluation dated 11/27/24, showed Resident 343 had the capacity to understand and make decisions.</p> <p>Review of Resident 343's Self-Administration of Medication assessment dated [DATE], showed Resident 343 was not a candidate for safe self-administration of medications.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 343's Order Summary Report for December 2024 did not show the physician's orders to administer the lidocaine cream and for Resident 343 to self-administer the lidocaine medication.</p> <p>On 12/6/24 at 1232 hours, an interview and concurrent medical record review for Resident 343 was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the residents were assessed upon admission whether they could self-administer any medications. LVN 1 verified Resident 343 did not have the physician's orders for the administration of lidocaine and self-administer any medications; and Resident 343 was not a candidate for safe self-administration of medications as per the assessment.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs for one of 18 final sampled residents (Resident 339) and one nonsampled resident (Resident 45).</p> <p>* The facility failed to ensure the call light was within reach and accessible for Residents 45 and 339. This failure had the potential to negatively impact the residents' psychosocial well-being or result in a delay to receive care.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Call Lights dated 1/2017 showed when the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident.</p> <p>1. On 12/3/24 at 1222 hours, Resident 339 was observed sitting in the wheelchair on the left side of the bed and near the foot of the bed. Resident 339 asked for her call light. The call light was observed clipped on the right side of the headboard and was not within Resident 339's reach. Resident 339 stated the CNA changed her bed and forgot to place the call light where she could reach it. Resident 339 stated she needed her call light so she could call the staff when she needed assistance.</p> <p>On 12/3/24 at 1223 hours, an observation for Resident 339 and concurrent interview was conducted with CNA 2. Resident 339 was observed sitting in the wheelchair on the left side of the bed and near the foot of the bed. The call light was observed clipped on the right side of the headboard and was not within Resident 339's reach. CNA 2 verified the above findings.</p> <p>Medical record review for Resident 339 was initiated on 12/3/24. Resident 339 was admitted to the facility on [DATE].</p> <p>Review of Resident 339's MDS dated [DATE], showed Resident 339 was cognitively intact and dependent on toileting and lower body dressing.</p> <p>2. On 12/3/24 at 1233 hours, Resident 45 was observed sitting in bed. Resident 45 asked, Can you help me look for my call light? The call light was observed clipped on the left side rail. Resident 45 was informed her call light was on the left side rail. Resident 45 observed attempting to use her right arm to reach the call light. Resident 45 stated the call light was too short and she could not reach the call light.</p> <p>On 12/3/24 at 1235 hours, an observation for Resident 45 and concurrent interview was conducted with CNA 3. Resident 45 was observed sitting in bed. The call light was observed clipped on the left side rail and was not within Resident 45's reach. CNA 3 verified the above findings.</p> <p>On 12/6/24 at 1301 hours, an interview was conducted with the DSD. When asked about the residents' call light, the DSD stated the call light should be within the resident's reach at all times when the resident was in bed, chair, wheelchair, and in the bathroom.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</p> <p>Based on interview, medical record review, and facility document review, the facility failed to ensure one of 18 final sampled residents (Residents 55) was referred to PASRR level II review when Resident 55's diagnosis was changed from Alzheimer's with psychosis to schizoaffective disorder. This failure had the potential for Resident 55 to not receive the specialized care and services appropriate for her condition.</p> <p>Findings:</p> <p>Review of the facility's P&P titled PASRR revised 3/2019 showed it is the policy of the facility to screen each resident, regardless of payment source, when applying for admission to, or residing in the facility, which is a Medicaid-certified facility, for mental illness and intellectual disability.</p> <p>Medical record review for Resident 55 was initiated on 12/4/24. Resident 55 was admitted to the facility on [DATE].</p> <p>Review of Resident 55's Department of Health Care Services PASRR Level I Screening dated 7/1/24, showed Resident 55 had no diagnosis of serious mental disorder.</p> <p>Review of Resident 55's MDS dated [DATE], showed Resident 55 had severe cognitive impairment.</p> <p>Review of Resident 55's Psychiatric Evaluation Note dated 11/15/24, showed Resident 55's diagnosis was changed from Alzheimer's with psychosis to schizoaffective disorder.</p> <p>Review of Resident 55's Order Summary Report for December 2024 showed a physician's order dated 11/15/24, to administer risperidone (antipsychotic medication) 1 mg by mouth two times a day for schizoaffective disorder manifested by poor impulse control as evidenced by getting up from bed/wheelchair unassisted.</p> <p>Further review of Resident 55's medical record failed to show documented evidence the resident was referred for level II resident review when newly diagnosed with schizoaffective disorder.</p> <p>On 12/5/24 at 1513 hours, an interview and concurrent record review for Resident 55 was conducted with the ADON. Resident 55's PASRR Level I Screening's section for serious mental illness diagnosis was reviewed with the ADON. The ADON verified the answer to the question Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? was documented as no. The ADON acknowledged Resident 55's new diagnosis of schizoaffective disorder. The ADON stated the schizoaffective disorder diagnosis was added after the PASRR Level I Screening was conducted. The ADON stated there should have been a review of Resident 55's PASRR because of the new diagnosis. The ADON further stated Resident 55's PASRR level should have been reviewed so the facility could determine Resident 55's accurate PASRR level and update the PASRR level. The ADON stated the facility could update the care plan once the facility got an accurate PASRR level.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/6/24 at 1252 hours, an interview and concurrent medical record review for Resident 55 was conducted with the DON. The DON verified the above findings and stated a PASRR resident review should have been done. The DON stated the PASRR system would show if the resident was positive or needed a follow up.</p> <p>On 12/6/24 at 1650 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.</p>		

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<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** 51920</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the care plan problem addressing fall risk for one of 18 sampled residents (Resident 18).</p> <p>* The facility failed to ensure Resident 18 had the yellow colored ID band to identify a high risk for falls as per the resident's fall care plan. This failure had the potential for not providing necessary care and services to the resident.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Fall Risk/Prevention revised 07/2018 showed approaches to prevent falls may include the use of a yellow colored ID band to identify that the resident has been placed on the falling star program to alert staff that the resident has been assessed at high risk for falls.</p> <p>On 12/3/24 at 0933 hours, Resident 18 was observed lying in bed with the bed in low position and bilateral floor mats.</p> <p>Medical record review for Resident 18 was initiated on 12/5/24. Resident 18 was admitted to the facility on [DATE].</p> <p>Review of Resident 18's H&P examination dated 3/19/24, showed Resident 18 could make needs known but could not make medical decisions.</p> <p>Review of Resident 18's plan of care showed a care plan dated 4/15/24, addressing Resident 18's high risk for falls due to cognitive deficit, impaired safety awareness, weakness, polypharmacy, impaired mobility, fall risk score, seizure disorder. The interventions showed to use the yellow-colored ID band to identify that the resident had been assessed to be high risk for falls.</p> <p>On 12/5/24 at 1416 hours, an observation and concurrent interview was conducted with LVN 11. LVN 11 verified Resident 18 had a seizure condition and the fall precaution interventions included for Resident 18 to have a fall risk arm band. However, Resident 18 was observed without the yellow colored ID band on his wrist. LVN 11 stated the arm band indicated a fall risk. LVN 11 verified Resident 18 did not have the yellow colored ID band on his wrist. LVN 11 was then observed going to the nurse's station and retrieving a yellow fall risk ID band. LVN 11 was observed applying the fall risk ID band on Resident 18's right wrist.</p> <p>On 12/05/24 at 1441 hours, an interview was conducted with the DON. The DON verified Resident 18's care plan intervention to address his high risk for falls included the use of yellow colored ID band.</p>		

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<p>F 0690</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services to one of two residents (Resident 48) observed with an indwelling urinary catheter.</p> <p>* The facility failed to ensure the indwelling urinary tubing and catheter bag of Resident 48 was placed below the bladder level. This failure had the potential to cause the resident to develop urinary tract infection.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Indwelling Catheter Use- Indications revised 10/2017, under the section for Procedures, showed the catheter and tubing must remain patent, with the drainage bag kept below the level of the bladder, to maintain unobstructed urine flow and prevent pooling and back flow of the urine into the bladder.</p> <p>On 12/3/24 at 0935 hours, Resident 48 was observed with an indwelling urinary catheter. Resident 48's indwelling urinary catheter bag was filled with yellowish urine. Resident 48 indwelling urinary catheter bag was placed higher than the bladder.</p> <p>Medical record review for Resident 48 was initiated on 12/4/24. Resident 48 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 48's Order summary Report dated 12/4/24, showed a physician's order dated 4/23/24, for indwelling urinary catheter 16 FR/10 ml for obstructive uropathy.</p> <p>Review of Resident 48's Care Plan initiated on 4/24/24, showed a care plan problem addressing Resident 48's risk for infection due to the use of indwelling urinary catheter due for obstructive uropathy. The goals included for Resident 48 to be free from signs and symptoms of urinary tract infection and interventionsto keep the indwelling urinary catheter below the level of bladder.</p> <p>On 12/3/24 at 1537 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 was asked about the indwelling urinary catheter bag for Resident 48. LVN 5 stated if the resident was turned to the left or right side, the catheter bag should be either on the left or right side, and the catheter tubing and catheter bag should be below the urinary bladder. LVN 5 verified Resident 48's indwelling urinary catheter bag was placed higher than the bladder. LVN 5 was asked what could happen if the catheter bag was placed above the bladder. LVN 5 stated the urine might back flow and cause urinary tract infection.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of two residents (final sampled resident, Resident 26) reviewed for nutrition received the appropriate services needed to maintain acceptable parameters of nutritional status when:</p> <p>* The facility failed to ensure the RD recommendations on 9/26/24, were followed-up with the physician and addressed in the IDT weight variance meeting when Resident 26 had severe weight loss of 11 lbs in 20 days. This failure had the potential for Resident 26 not to receive the necessary intervention to prevent further weight loss.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Weight Variance Committee dated 4/2017 showed it is the policy of the facility to review and monitor the residents with weight variances, at an interdisciplinary team (IDT) meeting on a regular scheduled basis. Under the section for Procedure showed the following:</p> <ul style="list-style-type: none"> - Screening of weights variances will be done on a regular basis per nursing (DON or Designee) or dietary (RD in house or consultant RD or supervisor); - The list of residents with weight variances will be established and shall be referred to the interdisciplinary committee members; - These residents will be reviewed at the next weight variance committee meeting; - The committee meeting will be held as established by the committee members. Members may include nursing staff, dietary, occupational therapy, speech pathology and social service; - The recommendation from the committee will be carried out by the designated responsible discipline; - The resident with weight variances will continue to be reviewed at the committee meeting until the IDT determines the problem has been resolved or is unable to be impacted, due to resident diagnoses or condition; - Documentation including assessments and care planning will be maintained in the resident's medical record; - Any weight gain/loss of greater than 3% per week should be reviewed by the IDT for cause and further recommendation. <p>Medical record review for Resident 26 was initiated on 12/3/24. Resident 26 was admitted to the facility on [DATE], with diagnoses which included right heart failure, acute respiratory failure, and dysphagia.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 26's H&P examination dated 6/17/24, showed Resident 26 had no capacity to understand and make decisions.</p> <p>Review of Resident 26's MDS dated [DATE], showed Resident 26 had severe cognitive impairment, and required set up assistance for eating.</p> <p>Review of Resident 26's Nutritional assessment dated [DATE], showed Resident 26 was 59 inches in height, ideal body weight range 86-96-106 and Resident 26's body weight was 132 lbs.</p> <p>Review of Resident 26's Weights and Vitals Summary showed Resident 26's weight was documented as follows:</p> <ul style="list-style-type: none"> - on 9/3/24, 132 lbs; - on 9/24/24, 121 lbs, a loss of 11 lbs /8.33% in 20 days compared to 9/3/24; - on 10/1/24, 121 lbs; - on 10/8/24, 122 lbs; - on 10/15/24, 120 lbs; - on 10/22/24, 121 lb; - on 10/29/24, 119 lbs; - on 11/7/24, 116 lbs; - on 11/12/24, 120 lbs; - on 11/19/24, 117 lbs; - on 12/3/24, 117 lbs, a loss of 15 lbs/11.4% in three months compared to 9/3/24. <p>Review of the facility document titled RD Reviewed and With Recommendations dated 9/26/24, showed the following recommendations for Resident 26:</p> <ul style="list-style-type: none"> - appetite stimulant, reason for recommendation showed poor PO intake and weight loss; - snacks TID, reason for recommendation showed wound and weight loss; and - VHC boost (very high calorie nutritional drink) BID. <p>a. Review of Resident 26's Physician Order Summary dated 9/1/24 to 12/6/24, showed an order dated 9/26/24, for RD review for significant weight loss and variable PO intake.</p> <p>Further review of Resident 26's medical record failed to show the documentation the facility had followed up with the physician regarding the RD recommendations on 9/26/24.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 0925 hours, a concurrent interview and medical record review for Resident 26 was conducted with the ADON. The ADON stated he was one of the members of the weight variance committee in the facility. The ADON further stated if the resident had a significant weight changes, the resident would be added to the weight variance list, then the physician and/or the weight variance committee would request for an RD consultation. The ADON stated the physician would be notified if he would like to order what the RD had recommended for the resident. When asked who was responsible to follow up with the physician regarding the RD recommendations, the ADON stated he was responsible to make sure the RD recommendations were relayed to the physician and the DON would oversee if the recommendations from the RD were followed. The ADON stated the physician's notification of the RD recommendations should be documented in the resident's medical record.</p> <p>The ADON verified the above findings and stated he was not able to find the documented evidence if the RD recommendations for Resident 26 from 9/26/24, for the appetite stimulant, snacks TID, VHC boost BID were followed up with the physician.</p> <p>On 12/5/24 at 1442 hours, a concurrent interview and medical record review for Resident 26 was conducted with the RD. The RD stated she worked in the facility on a consultant basis, she stated she visited the facility once a week and reviewed the resident's weekly and monthly weights and provided the recommendations. The RD stated she provided the recommendations she made to the DSS, then the DSS provided the RD recommendations to the nursing department, and the nursing department followed up with the physician if he would like to order the RD recommendations for the resident. The RD verified Resident 26's 11 lbs weight loss from 9/3/24 to 9/24/24, and the recommendations she made on 9/26/24, was not followed up by the facility. The RD stated Resident 26 had multiple comorbidities which could lead to weight loss for Resident 26; however, the RD recommendations were crucial to maintain the nutritional status of Resident 26.</p> <p>On 12/6/24 at 1120 hours, a telephone interview was conducted with Physician 1. Physician 1 stated he had been taking care of Resident 26 for a long time. When asked Physician 1 if he was aware of the weight loss of 11 lbs on 9/24/24 in 20 days for Resident 26, Physician 1 stated he was aware about the Resident 26's weight loss. Physician 1 stated Resident 26 had multiple co morbidities and was at high risk for weight changes. When asked Physician 1 if he was notified of the RD recommendations on 9/26/24, with appetite stimulant, snacks TID, and VHC boost BID, Physician 1 stated he was not able to remember if he was contacted with the above recommendations for Resident 26.</p> <p>b. Review of Resident 26' s Weight Variance Progress Note showed the following:</p> <ul style="list-style-type: none"> - on 9/24/24, Resident 26 had 11 lbs weight loss since 9/3/24. Resident 26 had sporadic PO intake with Alzheimer and dementia (memory loss). The physician was notified. Resident 26 was admitted to weight variance. The RD was to review and Resident 26's representative was made aware about the weight loss. - on 10/2/24, Resident 26's weight was 121 lbs. Resident 26's ideal body weight range was between 86-106 lbs. Resident 26 had variable PO intake, and to continue the current plan of care. <p>Further review of the weight variance progress notes did not show the RD recommendations on 9/26/24, was discussed in the weight variance IDT meeting.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/6/24 at 1518 hours, an interview and medical record review for Resident 26 was conducted with the DON. The DON verified the above findings. The DON confirmed the above weight changes for Resident 26. The DON stated the DSS, ADON, and RN supervisor from subacute unit, were in the IDT Weight Variance Committee. When asked, the DON stated the RD came to the facility on ce a week and was not part of the Weight Variance Committee. When asked if the RD recommendations were discussed in the IDT weight variance meeting, the DON stated the facility would discuss the RD recommendations in the IDT weight variance meetings. The DON verified the RD recommendations for Resident 26 on 9/26/24, were not discussed in the subsequent IDT weight variance meetings. The DON further stated the facility missed to discuss the RD recommendations on 9/26 and 10/3/24, for Resident 26. The DON verified and acknowledged the above findings.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure necessary care and services related to GT feeding were provided for two of 18 final sampled residents (Residents 18 and 58) reviewed for tube feeding.</p> <p>* The facility failed to ensure Residents 18 and 58 had the updated tube feeding care plans following a revision of tube feeding orders.</p> <p>* The facility failed to ensure Residents 18 and 58's physician's orders for tube feeding had a start time and specified stop time or until dose complete.</p> <p>These failures posed the risk for developing complications related to a GT.</p> <p>Findings:</p> <p>18</p> <p>Review of the facility's P&P titled Gastrostomy Tube Feeding via Continuous Pump revised 1/2017 showed it is the policy of the facility to provide nourishment via continuous pump to residents who are unable to obtain adequate nourishment orally, as ordered by the resident's attending physician, verify that there is a physician's order for this procedure and review the resident's care plan and provide for any special needs of the resident.</p> <p>1.a. Medical record review for Resident 58 was initiated on 12/4/24. Resident 58 was admitted on [DATE].</p> <p>Review of Resident 58's H&P examination dated 8/12/24, showed Resident 58 had the capacity to understand and make decisions.</p> <p>Review of Resident 58's Order Summary Report showed a physician's order dated 10/23/24, for every shift to provide 1200 cc/1800 kcal of Isosource 1.5 (feeding formula) via GT and enteral pump at 60 ml/hr over 20 hours.</p> <p>Review of Resident 58's Care Plan: Tube Feeding dated 8/3/24, showed to provide tube feedings as per MD, Jevity 1.2 1320 kcal/1100 ml over 20 hours.</p> <p>b. Medical record review for Resident 18 was initiated on 12/5/24. Resident 18 was admitted to the facility 2/23/16.</p> <p>Review of Resident 18's H&P examination dated 3/19/24, showed Resident 18 could make needs known but could not make medical decisions.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 18's Order Summary Report showed a physician's order dated 11/18/24, to provide 1000 cc/1200 kcal/day of Diabetisource (feeding formula) via GT and enteral pump at 50 cc/hr over 20 hours.</p> <p>Review of Resident 18's Care Plan: Tube Feeding dated 4/15/24, showed Glucerna 1.2 at 55 cc/hr for 20 hrs via GT enteral pump.</p> <p>On 12/5/24 at 1441 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified when a resident had a tube feeding order, the order should be reflected in the resident's care plan. The DON reviewed Residents 18 and 58's care plans and order summary reports. The DON verified the information on Residents 58 and 18's care plans did not reflect the revisions made to the tube feeding orders.</p> <p>2.a. Medical record review for Resident 58 was initiated on 12/4/24. Resident 58 was admitted on [DATE].</p> <p>Review of Resident 58's H&P examination dated 8/12/24, showed Resident 58 had the capacity to understand and make decisions.</p> <p>Review of Resident 58's Order Summary Report showed a physician's order dated 10/23/24, for every shift to provide 1200 cc/1800 kcal of Isosource 1.5 via GT and enteral pump at 60 ml/hr over 20 hours.</p> <p>b. Medical record review for Resident 18 was initiated on 12/5/24 at 1040 hours. Resident 18 was admitted to the facility on [DATE].</p> <p>Review of Resident 18's H&P examination dated 3/19/24, showed Resident 18 could make needs known but could not make medical decisions.</p> <p>Review of Resident 18's Order Summary Report showed a physician's order dated 11/18/24, to provide 1000 cc/1200 kcal/day of Diabetisource via GT and enteral pump at 50 cc/hr over 20 hours.</p> <p>However, Residents 18 and 58's physician's orders for GT feeding did not include the start and stop times.</p> <p>On 12/5/24 at 0951 hours, an interview was conducted with LVN 11. LVN 11 verified when a resident had an order for a tube feeding, the type of formula, rate, frequency, and duration needed to be verified. LVN 11 stated he knew when to start and stop the tube feeding based on the physician's order. LVN 11 stated if the physician's order did not include a start and stop time, he must call the doctor to clarify the order. LVN 11 stated if the total dose of tube feeding was not infused in the time specified, he needed to let it run until the feeding completed. LVN 11 verified the tube feeding order should state until dose complete.</p> <p>On 12/5/24 at 1030 hours, a concurrent interview and medical record review was conducted with LVN 11 at his designated medicine cart. LVN 11 reviewed the tube feeding orders for Residents 18 and 58. LVN 11 verified the orders did not specify the start time or include the verbiage until dose complete. LVN 11 stated they usually started the tube feedings around 1200 hours, but the start and stop time should be included in the physician's order.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 1441 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated when a resident had a tube feeding order, the nurses needed to verify the type of formula, rate, and dose as ordered by the physician. The DON verified the start time for the tube feeding should be in the physician's order. The DON verified all orders needed to have a start time and specify until dose complete. The DON verified the tube feeding order for Residents 58 and 18 were missing the start time and missing the verbiage until until dose complete.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for six of 18 final sampled residents (Residents 51, 58, 70, 76, 339, and 588) and four nonsampled residents (Residents 23, 37, 338, and 340) reviewed for respiratory care.</p> <p>* The facility failed to ensure the oxygen administration to Resident 70 was performed by a licensed nurse and failed to ensure Resident 70's oxygen administration was documented in the MAR. In addition, the facility failed to ensure a No Smoking/Oxygen in Use sign was posted outside the resident's door per the facility's P&P.</p> <p>* The facility failed to ensure a No Smoking/ Oxygen in Use sign was posted outside the resident's door as per the facility's P&P for Resident 23, 37, 51, 76, and 339.</p> <p>* The facility failed to ensure Resident 340's suction was stored in a sanitary manner.</p> <p>* The facility failed to ensure Resident 338's nasal cannula tubing was stored in a sanitary manner.</p> <p>* The facility failed to ensure Resident 588 was administered with oxygen as ordered by the physician. In addition, the facility failed to ensure Resident 558's suction tubing and canister was replaced as ordered by the physician.</p> <p>* The facility failed to monitor Resident 58's ventilator settings as ordered by the physician.</p> <p>These failures had the potential to affect the respiratory health and well-being of the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Oxygen Administration dated 3/2017 showed the following:</p> <ul style="list-style-type: none"> - To verify that there is a physician's order for oxygen administration and to review the resident's care plan for any special needs of the resident; - Oxygen therapy is administered by way of an oxygen mask, nasal cannula or non-rebreather mask; and - A No Smoking/Oxygen in use signs were necessary. <p>Review of the facility's document titled Lesson Plan on Oxygen Safety and Administration (undated) showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The oxygen tubing should be changed weekly and as needed, including changing the mask, cannula, nebulizer equipment, etc. When not in use, the oxygen tubing should be stored in a clean set-up bag; and</p> <p>- Oxygen usage and storage areas will be mark with oxygen use.</p> <p>Review of the facility's document titled Lesson Plan on Oxygen Administration: P&P (undated) showed the oxygen will be administered to the residents as needed per the attending physician's orders by a licensed personnel, and since oxygen is based on a physician's order, it is considered a licensed staff procedure.</p> <p>1.a. On 12/3/24 at 0925 hours, during the initial tour of the facility, Resident 70 was observed in bed receiving two liters per minute of oxygen via nasal cannula. A No Smoking/Oxygen in Use sign was not posted at the door of Resident 70's room.</p> <p>b. On 12/5/24 at 0909 hours, Resident 70 was observed sleeping in bed. The oxygen concentrator adjacent to Resident 70's bed was turned off, and the nasal cannula tubing was inside a set-up bag.</p> <p>On 12/5/24 at 0943 hours, a concurrent observation for Resident 70 and interview was conducted with the Hospice Aide. Resident 70 was observed awake, lying in bed, and receiving two liters of oxygen via nasal cannula. When asked about Resident 70's oxygen, the Hospice Aide stated when she came in the morning, she checked Resident 70's oxygen saturation level and it was 78%. The Hospice Aide stated she turned on Resident 70's oxygen concentrator and provided the resident with two liters of oxygen via nasal cannula. The Hospice Aide stated Resident 70's oxygen saturation level was at 80% after receiving two liters of oxygen via nasal cannula. When asked if she spoke to the licensed nurse, the Hospice Aide stated she asked the licensed nurse earlier to borrow the pulse oximeter before providing oxygen to Resident 70 but had not reported to the licensed nurse about Resident 70's oxygen saturation level of 80% with two liters per minute of oxygen. When asked about the normal oxygen saturation level, the Hospice Aide answered, about 80% for her.</p> <p>On 12/5/24 at 1009 hours, an interview was conducted with LVN 2. When asked about Resident 70's oxygen use, LVN 2 stated the Hospice Aide informed her about Resident 70's oxygen concentrator being turned off. LVN 2 stated she let the Hospice Aide borrowed her pulse oximeter, and the Hospice Aide turned the oxygen concentrator on and placed the nasal cannula tubing on Resident 70. LVN 2 stated the Hospice Aide did not report Resident 70's oxygen saturation at 78% nor at 80%.</p> <p>Medical record review for Resident 70 was initiated on 12/3/24. Resident 70 was admitted to the facility on [DATE].</p> <p>Review of Resident 70's Order Summary Report dated 11/21/24, showed the following physician's orders dated:</p> <p>- 9/19/24, to administer oxygen at two liters per minute via nasal cannula to keep oxygen saturation level above 92%; and</p> <p>- 10/16/24, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath or wheezing.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Cross reference to F849.</p> <p>c. Review of Resident 70's MAR for November 2024 did not show the documentation of oxygen administration to Resident 70 on 12/3, 12/4, and 12/5/24.</p> <p>On 12/5/24 at 1221 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 reviewed Resident 70's MAR for November 2024 and LVN 2 verified the oxygen administration to Resident 70 was not documented in the MAR.</p> <p>2. On 12/3/24 at 0916 hours, during the initial tour of the facility, Resident 339 was observed in bed and receiving two liters of oxygen via nasal cannula. A No Smoking/Oxygen in Use sign was not posted at the door of Resident 339's room.</p> <p>On 12/3/24 at 0937 hours, an observation for Resident 339 and concurrent interview was conducted with RN 5. RN 5 verified the above findings. RN 5 verified the No Smoking/Oxygen in Use sign was not posted at the door for Residents 70 and 339.</p> <p>3. On 12/3/24 at 0959 hours, during the initial tour of the facility, Resident 338 was observed in bed. An undated and unlabeled nasal cannula tubing was observed hanging on the right grab rail and was not stored in a clean set-up bag.</p> <p>On 12/3/24 at 1008 hours, an observation for Resident 338 and concurrent interview was conducted with RN 5. RN 5 verified the above findings.</p> <p>4. On 12/3/24 at 0959 hours, during the initial tour of the facility, Resident 340 was observed in bed. A Yankauer suction tip was observed inside an undated and unlabeled set-up bag. The Yankauer suction tip was connected to a suction canister with yellowish fluid.</p> <p>On 12/3/24 at 0934 hours, an observation for Resident 340 and concurrent interview was conducted with the DON. The DON verified the above findings. The DON stated the Yankauer suction should be changed weekly.</p> <p>48332</p> <p>5. Medical record review for Resident 51 was initiated on 12/3/24. Resident 51 was initially admitted to facility on 4/24/23, and readmitted on [DATE].</p> <p>Review of Resident 51's medical record showed the resident's diagnoses included Acute and Chronic Respiratory Failure with hypoxia and dependence on respiratory ventilator status.</p> <p>Review of Resident 51's Order Summary Report showed physician's order dated 4/24/24, for tracheostomy tube on admission, Portex size 7 (seven) cuffed, and to titrate oxygen flow to maintain oxygen saturation level equal or greater than 92 %.</p> <p>On 12/3/24 at 0912 and 1025 hours, an observation was conducted for Resident 51. Resident 51 was observed in bed with head slightly elevated and had tracheostomy tube connected to the ventilator machine that was connected to an oxygen concentrator. Resident 51 room had no No smoking/Oxygen in Use sign posted at the door.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/3/24 at 1108 hours, an observation of Resident 51 and concurrent interview was conducted with LVN 4. Resident 51 had no No smoking/Oxygen in Use sign posted at the door. LVN 4 verified there was no No smoking/Oxygen in Use sign posted at Resident 51's door. LVN 4 stated there should be a sign at the door.</p> <p>6. Medical record review for Resident 76 was initiated on 12/3/24. Resident 76 was admitted to the facility on [DATE].</p> <p>Review of Resident 76's medical record showed the resident's diagnoses included acute respiratory failure whether with hypoxia or hypercapnia and dependence on respirator/ventilator status.</p> <p>Review of Resident 76's Order Summary Report showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 7/8/24, for the tracheostomy tube on admission, Shiley size 8 (eight) cuffed, and to titrate the oxygen flow to maintain oxygen saturation equal or greater than 92 %, and - dated 8/22/24, for the ventilator settings of TV-450, and oxygen at five liters per minute every shift. <p>On 12/3/24 at 1050 hours, an observation was conducted with Resident 76. Resident 76 was observed in bed with head slightly elevated, and had a tracheostomy tube connected to the ventilator machine, that was connected to an oxygen concentrator. Resident 76's room had no No smoking/Oxygen in Use sign posted at the door.</p> <p>On 12/3/24 at 1105 hours, an observation of Resident 76 and concurrent interview was conducted with LVN 4. LVN 4 verified there was no No smoking/Oxygen in Use sign posted at Resident 76's door. LVN 4 stated there should be a sign at the door.</p> <p>7. Medical record review for Resident 37 was initiated on 12/3/24. Resident 37 was admitted to the facility on [DATE].</p> <p>Review of Resident 37's medical record showed the resident's diagnoses included acute respiratory failure whether with hypoxia or hypercapnia, dependence on respirator/ventilator status, and tracheostomy.</p> <p>On 12/3/24 at 1148 hours, an observation was conducted for Resident 37. Resident 37 was observed in bed with tracheostomy in placed, connected to the ventilator machine that was connected to an oxygen concentrator. Resident 37 room had no No smoking/Oxygen in Use sign posted at the door.</p> <p>On 12/3/24 at 1315 hours, an observation of Resident 37 and concurrent interview was conducted with LVN 4. LVN 4 verified there was no No smoking/Oxygen in Use sign posted at Resident 37's door. LVN 4 stated the Infection control nurse might have removed the no smoking sign when she placed the contact isolation sign on the door. LVN 4 acknowledged there should be Oxygen In Use sign posted at the door.</p> <p>8. Medical record review for Resident 23 was initiated on 12/3/24. Resident 23 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 23's medical record showed the resident's diagnoses included acute respiratory failure whether with hypoxia or hypercapnia, dependence on respirator/ventilator status, and tracheostomy.</p> <p>Review of Resident 23's Order Summary dated 12/6/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 9/03/24, for tracheostomy tube on admission, Shiley size 6 (six) cuffed, and to titrate the oxygen flow to maintain oxygen saturation equal or greater than 92 %, and - dated 12/05/24, for the ventilator settings of TV-400 and oxygen at three liters per minute four times a day. <p>On 12/3/24 at 1126 hours, an observation of Resident 23 and concurrent interview was conducted with LVN 4. Resident 23 was observed in bed with head slightly elevated, and had tracheostomy tube connected to ventilator machine that was connected to an oxygen concentrator. There was no No smoking/Oxygen in Use sign posted at the door. LVN 4 verified there was no No smoking/Oxygen in Use sign posted at Resident 23's door.</p> <p>44175</p> <p>9. Review of the facility's P&P titled Oxygen Administration dated 3/2017 showed it is the policy of the facility to provide guidelines for the administration of oxygen. Under the section for Procedure, showed to verify if there is a physician's order for oxygen administration.</p> <p>On 12/3/24 at 0921 hours, Resident 588 was observed lying in bed receiving oxygen through nasal cannula at 1.5 liters per minute. An open package of suction tubing and suction canister was observed stored in a set up bag on the nightstand on the left side of the Resident 588's bed. The set-up bag was dated 11/24/24.</p> <p>Medical record review for Resident 588 was initiated on 12/3/24. Resident 588 was admitted to the facility on [DATE].</p> <p>Review of Resident 588's Care Plan dated 11/24/24, showed a care plan problem addressing Resident 588's ineffective breathing pattern related to COPD, the interventions included oxygen as ordered.</p> <p>Review of Resident 588's Order Summary Report showed following physician's orders:</p> <ul style="list-style-type: none"> - dated 11/24/24, to administer oxygen at two liters per minute via nasal cannula continuously to keep the oxygen saturation above 92%. - dated 12/3/24, to change the suction canister, Yankeur, and tubing every Tuesday and Friday and as needed to prevent infection. <p>On 12/3/24 at 0934 hours, a concurrent observation and interview was conducted with LVN 7. LVN 7 verified the above observation and verified Resident 588 was receiving oxygen at 1.5 liters per minute, and the set-up bag containing an open package of suction tubing and canister was labeled 11/24/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/3/24 at 0944 hours, a concurrent follow-up interview and medical record review for Resident 588 was conducted with LVN 7. LVN 7 verified the above findings and stated Resident 588 should have been receiving oxygen at two liters per minute, and the suction tubing and canister should have been changed every Tuesday and Friday as ordered by the physician.</p> <p>On 12/5/24 at 1426 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>51920</p> <p>10. Medical record review for Resident 58 was initiated on 12/4/24. Resident 58 was admitted to the facility on [DATE].</p> <p>Review of Resident 58's H&P examination dated 8/12/24, showed Resident 58 had the capacity to understand and make decisions.</p> <p>Review of Resident 58's Order Summary Report showed a physician's order dated 8/6/24, for the ventilator settings of Mode: AC VT: 450 Rate: 20 O2: 3 LPM Peep: 5 PS: 0 every four hours, every shift.</p> <p>Review of Resident 58's Care Plan initiated on 8/3/24, showed a care plan problem addressing Resident 58's respiratory distress. The interventions for tracheostomy/ventilator included respiratory therapy as ordered, oxygen as ordered, respiratory treatment as ordered, notify MD for any changes.</p> <p>On 12/5/24 at 1120 hours, an interview and concurrent medical record review was conducted with RT 1. RT 1 verified the respiratory therapy staff were responsible for setting, modifying, and monitoring the ventilators. RT 1 reviewed Resident 58's ventilator settings and verified the physician's order showed to monitor the ventilator setting for Resident 58 every 4 hours. RT 1 provided Resident 58's Continuous Ventilator Flow Sheets from 11/15/24 to 12/5/24. Resident 58's Continuous Ventilator Flow Sheets provided by RT 1 indicated the frequency of verification for the ventilator settings should be every four hours. However, further review of the Continuous Ventilator Flow Sheets showed the respiratory staff documented Resident 58's ventilator settings every six hours.</p> <p>On 12/5/24 at 1441 hours, an interview and concurrent medical record review was conducted with the DON regarding the ventilator monitoring for Resident 58. The DON reviewed Resident 58's ventilator orders and stated she interpreted the order as the respiratory staff were supposed to verify the ventilator settings every four hours. Upon review of Resident 58's Continuous Ventilator Flow Sheets, the DON verified the respiratory staff documented Resident 58's ventilator settings every six hours.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to attain or maintain the highest physical well-being for one of one final sampled residents (Resident 341) reviewed for hemodialysis care.</p> <p>* The facility failed to ensure the physician's order for Resident 341's dialysis and plan of care addressing Resident 341's hemodialysis care showed the correct location of the permacath site on the right upper chest. This failure had the potential for the delay in Resident 341's dialysis site assessment and resident's poor health outcomes.</p> <p>Findings:</p> <p>Medical record review for Resident 341 was initiated on 12/9/24. Resident 341 was admitted to the facility on [DATE].</p> <p>Review of Resident 341's Initial Nursing History and assessment dated [DATE], showed the permacath site on the right upper chest.</p> <p>Review of Resident 341's Order Summary Report dated 12/5/24, showed a physician's order dated 11/26/24, to monitor the permacath site on the left upper chest for any signs of infection, bleeding, itchiness or tenderness and signs of malfunction.</p> <p>Review of Resident 341's plan of care showed a care plan problem dated 11/29/24, addressing Resident 341's dialysis care. The plan of care showed the type of catheter as permacath [NAME].</p> <p>On 12/5/24 at 1605 hours, an observation for Resident 341 and concurrent interview was conducted with LVN 3. Resident 3's permacath site was observed on the right upper chest. LVN 3 verified the above findings.</p> <p>On 12/5/24 at 1610 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the above findings. RN 2 verified the physician's order and plan of care for Resident 341's dialysis care showed the wrong site of the permacath.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 18 final sampled residents (Residents 29 and 339) remained free from accident hazards associated with the use of elevated side rails.</p> <p>* The facility failed to obtain an informed consent and initiate a care plan for the use of the bilateral grab bars for Resident 29.</p> <p>* The facility failed to ensure the least restrictive alternatives were implemented prior to the installation of the grab rails for Resident 339. In addition, the facility failed to ensure the informed consent forms for the use of the grab rails showed who obtained the consent from Resident 339.</p> <p>These failures had the potential to place the residents at risk for an entrapment and serious injury.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Siderails or Bedrails revised 8/2018 showed the informed consent for the physical restraint, including the use of bed or siderails even for episodic use is required to be obtained from the resident or legal representative. Potential negative outcomes and benefits should be discussed. The use of anything attached to a normal bed (i.e., one-fourth rails as an enabler, grab bar attached to the bed, any assistive device, etc.) requires a comprehensive assessment, physician's order, informed consent and a care plan to address the use.</p> <p>1. Medical record review for Resident 29 was initiated on 12/4/24. Resident 29 was admitted to the facility on [DATE].</p> <p>Review of Resident 29's H&P examination dated 4/1/24, showed Resident 29 had the capacity to understand and make decisions.</p> <p>Review of Resident 29's Order Summary Report showed a physician's order dated 5/13/23, for the bilateral grab bars to facilitate bed independence with turning and repositioning every shift for medical necessity.</p> <p>On 12/3/24 at 1002 hours, an observation was conducted for Resident 29. Resident 29 was observed awake in bed, watching TV with the bilateral grab bars elevated.</p> <p>On 12/5/24 at 0851 hours, an observation was conducted for Resident 29. Resident 29 was in bed sleeping with the bilateral grab bars elevated.</p> <p>On 12/6/24 at 0932 hours, an interview was conducted with Resident 29. Resident 29 stated she used the grab bars on her own and the grab bars helped her to reposition and get out of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/6/24 at 1511 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the informed consent for the side rails in Resident 29's chart was from the previous admission and there was no current informed consent obtained from Resident 29 for the use of the bilateral grab bars. In addition, RN 1 was unable to locate a care plan for the side rails use in Resident 29's chart.</p> <p>On 12/6/24 at 1343 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified that obtaining an informed consent and initiating a care plan were part of the facility's policy when a resident needed the side rails. The DON was unable to locate an inform consent was obtained or the care plan was developed for Resident 29's bilateral grab bar use.</p> <p>39453</p> <p>2. The FDA issued a Safety Alert titled Entrapment Hazards with Hospital Bed Side Rails (1995), which showed the residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment.</p> <p>On 12/3/24 at 0916 and 0937 hours, 12/4/24 at 0900 hours, 12/5/24 at 0941 hours, and 12/6/24 at 0906 hours, Resident 339 was observed in bed with the bilateral grab rails elevated.</p> <p>Medical record review for Resident 339 was initiated on 12/3/24. Resident 339 was admitted to the facility on [DATE].</p> <p>Review of Resident 339's MDS dated [DATE], showed Resident 339 was cognitively intact with no impairment on the upper and lower extremities, and required a substantial/maximal assistance from the staff member for bed mobility.</p> <p>Review of Resident 339's Bedrail/ Grab Bar Use and Entrapment Risk Evaluation dated 11/12/24, showed the grab bars were considered to promote the independence of the resident and to aid in turning and repositioning.</p> <p>Review of Resident 339's Order Summary Report dated 12/4/24, showed a physician's order dated 11/12/24, for the bilateral grab bars to increase independence with turning and repositioning while in bed.</p> <p>Review of Resident 339's Informed Consent for the use of Bedrails/ Siderails as an Enabler/ Restraint/ Assistive Device showed Resident 339's signature and was dated 11/12/24. However, the informed consent did not show who obtained the informed consent from Resident 339. In addition, the form did not show any less restrictive, alternative approaches prior to the installation of the grab bars.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 339's medical record showed another informed consent for the use of the bilateral grab bars. Review of Resident 339's Informed Consent for the use of Bedrails/ Siderails as an Enabler/ Restraint/ Assistive Device, under the section to document the less restrictive, alternative approaches prior to the installation of the grab bars showed a handwritten note assist the resident doing ADLs while on bed and provide assistance with bed mobility. The consent form showed a verbal consent was received on 11/12/24, and with Resident 339's signature dated 12/2/24. However, the informed consent did not show who obtained the informed consent from Resident 339.</p> <p>On 12/6/24 at 1007 hours, a concurrent interview and medical record for Resident 339 was conducted with the ADON. The ADON verified the above findings. When asked about the informed consents for the grab rail obtained from Resident 339, the ADON stated he could not find the initial consent from Resident 339, so he went to the resident's room and asked for Resident 339's consent on 12/2/24. The ADON stated Resident 339 did not sign the consent form but Resident 339 verbally agreed with the grab bar use, so he wrote the date 11/12/24 when the verbal consent was obtained from the resident. The ADON further stated he wrote the less restrictive approaches on the second consent, after Resident 339 verbally agreed with the grab bar use. When asked who obtained Resident 339's signatures on the two informed consent forms dated 11/12 and 12/2/24, the ADON stated he did not know and verified the two informed consent forms for the grab rails did not show who obtained Resident 339's signatures on 11/12 and 12/2/24.</p> <p>Cross reference to F909.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346</p> <p>Based on interview, medical record review, and facility document review, the facility failed to ensure the Pharmacy Consultant's recommendations were acted upon for one of 18 final sampled residents (Resident 29) and one nonsampled resident (Resident 6).</p> <p>* The Pharmacy Consultant's recommendation for the tramadol (narcotic pain medication) label be changed to show the medication was for pain management and not for severe pain level (7-10) was not followed for Resident 6.</p> <p>* The Pharmacy Consultant's recommendation to have the A1C level monitoring every three months until treatment goal was met, then every six months months, was not followed for Resident 29.</p> <p>These failures had the potential to put Residents 6 and 29 at risk for adverse consequences.</p> <p>Findings:</p> <p>1. On 12/3/24 at 1628 hours, a concurrent inspection of Medication Cart D, interview, and medical record review for Resident 6 was conducted with RN 1. The bubble pack of the tramadol medication for Resident 6 showed a label showing the tramadol medication was for severe pain (pain levels 7-10).</p> <p>Medical record review for Resident 6 was initiated on 12/3/24. Resident 6 was admitted to the facility on [DATE].</p> <p>Review of Resident 6's Order Summary Report showed a physician's order dated 10/28/24, to administer tramadol 50 mg one tablet via GT for pain management.</p> <p>Review of the facility's document titled Note To Attending Physician/Prescriber for November 2024 showed a pharmacy recommendation for the tramadol medication label to be changed to show the medication was for pain management and not for severe pain level (pain levels 7-10).</p> <p>Further review of Resident 6's medical record did not show the label on the bubble pack for the tramadol medication was changed to show it was for pain management. In addition, there was no documentation to show why the pharmacy recommendation was not acted upon.</p> <p>On 12/4/24 at 1025 hours, a concurrent interview and medical record review for Resident 6 was conducted with RN 1. RN 1 verified the above findings.</p> <p>51920</p> <p>2. Medical record review for Resident 29 was initiated on 12/04/24. Resident 29 was admitted to the facility on [DATE].</p> <p>Review of Resident 29's H&P examination dated 4/1/24, showed Resident 29 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's document titled Note To Attending Physician/Prescriber printed on 10/17/24, showed a pharmacy recommendation for Resident 29 to have an A1C level monitoring every three months, then every six months, once the goal is met due to Resident 29's last A1C results was in January 2024. The form showed a signature on the physician signature line. However, the form was undated and had no documentation of the response.</p> <p>Further review of Resident 29's medical record showed no documentation of an A1C level results completed after 10/17/24.</p> <p>On 12/06/24 at 1343 hours, an interview and concurrent medical record review for Resident 29 was conducted with the DON. The DON verified there were no physician's orders for Resident 29 to have an A1C level drawn after 10/17/24. Additionally, the DON verified there were no nurses' notes indicating a follow up was made on the pharmacy recommendation for Resident 29. The DON stated she would forward the pharmacy recommendations to RN 1 as soon as they came through and it was RN 1's responsibility for DRR follow-through.</p>		

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<p>F 0757</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on interview and medical record review, the facility failed to provide adequate monitoring of the blood pressure to ensure one of 18 final sampled residents (Resident 341) was free from the unnecessary drugs.</p> <p>* The facility failed to ensure Resident 341's blood pressures were checked prior to administering metoprolol (antihypertensive medication) as prescribed by the physician. This failure had the potential to negatively affect Resident 341's health condition and well-being.</p> <p>Findings:</p> <p>Medical record review for Resident 341 was initiated on 12/3/24. Resident 341 was admitted to the facility on [DATE].</p> <p>Review of Resident 341's Order Summary Report showed a physician's order dated 11/27/24, to administer metoprolol 25 mg one tablet by mouth in the evening every Monday, Wednesday, and Friday for hypertension, and to hold if the systolic blood pressure less than 110 mmHg.</p> <p>Review of Resident 341's MAR for November and December 2024 showed Resident 341 was administered the metoprolol medication on 11/27, 11/29, and 12/2/24 at 1700 hours. However, there was no documented evidence to show the licensed nurses had monitored Resident 341's blood pressures prior to the administration of metoprolol medication on these days.</p> <p>On 12/5/24 hours, an interview and concurrent medical record review for Resident 341 was conducted with RN 2. RN 2 verified the above findings.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920</p> <p>Based on interview and medical record review, the facility failed to ensure one of 18 final sampled residents (Resident 29) was free from the unnecessary psychotropic medications.</p> <p>* The facility failed to ensure Resident 29 was monitored for the orthostatic hypotension related to the use of Wellbutrin (a medication used to treat depression), quetiapine (medication used to treat bipolar disorder), and trazodone (a medication used to treat depression). This failure had the potential for the residents to have adverse complications from the psychotropic medications.</p> <p>Findings:</p> <p>Medical record review for Resident 29 was initiated on 12/06/24. Resident 29 was admitted to the facility on [DATE].</p> <p>Review of Resident 29's H&P examination dated 4/1/24, showed Resident 29 had the capacity to understand and make decisions.</p> <p>Review of Resident's 29 Order Summary Report showed the following physician's orders:</p> <ul style="list-style-type: none"> - date 4/5/24, to administer Wellbutrin XL (extended release) 300 mg one tablet orally one time a day for depression m/b crying spells. - dated 6/10/24, to administer quetiapine fumarate 25 mg three tablets (75 mg) by mouth at bedtime for major depressive disorder m/b feeling of sadness. - dated 9/23/24, to administer trazodone HCl 100 mg one tablet via GT at bedtime for depression m/b inability to sleep. <p>Further review of Resident 29's medical record failed to show if Resident 29 was monitored for the orthostatic hypotension related to the use of the psychotropic medications.</p> <p>On 12/06/24 at 1511 hours, an interview was conducted with RN 1. RN 1 verified there was no order to monitor Resident 29 for orthostatic hypotension. RN 1 verified Resident 29 should have an order to monitor orthostatic hypotension for the use of psychotropic drugs.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate during the medication administration observation was less than five percent (5%). The facility had a cumulative medication error rate of 7.41% when two of 27 opportunities for errors were observed on one licensed nurse (LVN 7) who administered medications to one nonsampled resident (Resident 688). The observed medication administration errors were:</p> <p>* LVN 7 failed to administer the Metamucil 4 in 1 Fiber oral packet (fiber supplement/laxative) medication to Resident 688 as ordered by the physician.</p> <p>* LVN 7 administered 100 mg of enoxaparin sodium (anticoagulant) instead of 10 mg of enoxaparin sodium as ordered by the physician to Resident 688.</p> <p>These failures had the potential to compromise the health and safety of Resident 688.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Ordering and Receiving Medications from the Dispensing Pharmacy dated 4/2008 showed the medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. The Procedures section showed if not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form, ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: reorder medication five days in advance of need to assure an adequate supply is on hand.</p> <p>Review of the facility's P&P titled Medication Administration - General Guidelines dated 10/2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. The Procedure section showed prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label.</p> <p>Review of the facility's P&P titled Procedures for All Medications dated 4/2008 showed to administer medications in a safe and effective manner. The Procedure section showed to read medication label before administering.</p> <p>On 12/4/24 at 0815 hours, a medication administration observation for Resident 688 was conducted with LVN 7. LVN 7 prepared and administered Resident 688's medications which included the following:</p> <ul style="list-style-type: none"> - 20 ml of amantadine hydrochloride oral solution (antidyskinetic) 50 mg/5ml; - 1 tablet of vitamin C (supplement) 500 mg; <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - 1 capsule of Creon DR (a medication used to treat exocrine pancreatic insufficiency) 36,000 units; - 1 tablet of levetiracetam (anticonvulsant) 500 mg; - 1 capsule of omeprazole DR (proton pump inhibitor) 20 mg; - 2 tablets of Geri-Kot (stool softener) 8.6 mg; - 1 tablet of multi-vitamin (supplement); - 1 tablet of sodium chloride (electrolyte replenisher) 1 gram; - 1 capsule of dronabinol (a medication that treats nausea and vomiting) 2.5 mg; and - 1 syringe of enoxaparin (anticoagulant) 100 mg/ml. <p>Medical record review for Resident 688 was initiated on 12/4/24. Resident 688 was admitted to the facility on [DATE].</p> <p>Review of Resident 688's H&P examination dated 11/20/24, showed Resident 688 had DVT Prophylaxis (a set of treatments that prevent blood clots from forming in blood vessels).</p> <p>Review of Resident 688's MDS dated [DATE], showed Resident 688's cognition was intact.</p> <p>a. Review of Resident 688's Order Summary Report showed a physician's order dated 11/17/24, to administer Metamucil 4 in 1 fiber (fiber supplement) oral packet, give one gram by mouth one time a day for bowel management mix with eight ounces of water/juice.</p> <p>On 12/4/24 at 0953 hours, an interview for Resident 688 was conducted with LVN 7. LVN 7 stated the Metamucil 4 in 1 fiber oral medication was not administered to Resident 688 because it was not available and pending pharmacy delivery.</p> <p>On 12/4/24 at 1618 hours, an interview and concurrent medical record review for Resident 688 was conducted with the DON. The DON acknowledged the Metamucil 4 in 1 fiber oral medication was not given to Resident 688. The DON stated the Metamucil 4 in 1 fiber oral medication was not a house supply and pending pharmacy delivery. The DON stated the charge nurse should have checked the availability of Metamucil 4 in 1 fiber oral medication and ordered it from the pharmacy.</p> <p>b. On 12/4/24 at 0907 hours, a medication administration observation for Resident 688 was conducted with LVN 7. LVN 7 was observed administering one syringe of enoxaparin sodium (anticoagulant) injection solution (100 mg) to the right upper quadrant of Resident 688's abdomen.</p> <p>On 12/4/24 at 0908 hours, an interview for Resident 688 was conducted with LVN 7. LVN 7 verified she gave all the medication in the syringe that contained enoxaparin sodium 100 mg. LVN 7 washed her hands after discarding the syringe and removing her gloves.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 688's Order Summary Report showed a physician's order dated 11/17/24, to administer enoxaparin sodium injection solution 10 mg subcutaneously one time a day for DVT prophylaxis and to alternate the site of injection.</p> <p>On 12/4/24 at 0955 hours, an interview and concurrent medical record review for Resident 688 was conducted with LVN 7. LVN 7 verified Resident 688 had a physician's order for enoxaparin 10 mg; however, she administered 100 mg of enoxaparin sodium instead of the 10 mg of enoxaparin sodium as ordered by the physician.</p> <p>On 12/4/24 at 1020 hours, an interview for Resident 688 was conducted with the DON. The DON verified the above findings for Resident 688. The DON stated she was aware of the above incident and would notify the physician, do the incident report, and monitor Resident 688.</p> <p>On 12/6/24 at 1650 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.</p> <p>Cross reference to F760.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three residents (Resident 688) observed for medication administration was free from the significant medication errors.</p> <p>* Resident 688 received 100 mg of enoxaparin sodium (anticoagulant medication) instead of 10 mg of enoxaparin sodium as ordered by the physician. This failure posed the risk for adverse consequences to the resident.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration - General Guidelines dated 10/2017 showed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. The Procedure section showed prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label.</p> <p>Review of the facility's P&P titled Procedures for All Medications dated 4/2008 showed to administer medications in a safe and effective manner. The Procedure section showed to read medication label before administering.</p> <p>Medical record review for Resident 688 was initiated on 12/4/24. Resident 688 was admitted to the facility on [DATE].</p> <p>Review of Resident 688's H&P examination dated 11/20/24, showed the resident had DVT Prophylaxis.</p> <p>Review of Resident 688's MDS dated [DATE], showed Resident 688's cognition was intact.</p> <p>On 12/4/24 at 0907 hours, a medication administration observation for Resident 688 was conducted with LVN 7. LVN 7 was observed administering one syringe of enoxaparin sodium injection solution on the right upper quadrant of Resident 688's abdomen.</p> <p>On 12/4/24 at 0908 hours, a concurrent observation and interview was conducted with LVN 7. LVN 7 verified she gave all the medication in the syringe that contained enoxaparin sodium 100 mg. LVN 7 washed her hands after discarding the syringe and removing her gloves.</p> <p>Review of Resident 688's Order Summary Report for December 2024 showed a physician's order dated 11/17/24, to administer enoxaparin sodium injection solution 10 mg subcutaneously one time a day for DVT prophylaxis and to alternate site of injection.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/4/24 at 0955 hours, a concurrent interview and medical record review for Resident 688 was conducted with LVN 7. LVN 7 verified she administered 100 mg of enoxaparin sodium instead of 10 mg of enoxaparin sodium as ordered by the physician to Resident 688. LVN 7 stated she would tell her RN Supervisor and the DON she administered 100 mg instead of 10 mg of Enoxaparin to Resident 688. LVN 7 further stated she would start monitoring the resident and would complete Resident 688's change of condition. LVN 7 stated she would notify the physician and Resident 688's family. LVN 7 stated she would discuss with the supervisor on how to avoid the mistake on medication administration.</p> <p>On 12/4/24 at 1020 hours, an interview was conducted with the DON. The DON verified the above findings for Resident 688. The DON stated she was aware of the above incident. The DON stated she would notify the physician, do the incident report, and monitor Resident 688. The DON stated the ADON was currently assessing Resident 688.</p> <p>On 12/4/24 at 1548 hours, a telephone interview was conducted with the Pharmacy Consultant. The Pharmacy Consultant stated she did not review the enoxaparin sodium order for Resident 688 because Resident 688 was admitted after she went to the facility. The Pharmacy Consultant stated the licensed nurses should be careful on reading the medication's direction and should follow the rules.</p> <p>On 12/4/24 at 1630 hours, a telephone interview was conducted with Physician 1. Physician 1 stated the nurses gave enoxaparin sodium to Resident 688 in the past few days and there was no issue. Physician 1 stated it was a personal medication error from one licensed nurse and it could happen sometimes anywhere. Physician 1 stated the facility needed to give in-service so the medication administration error would not happen again. Physician 1 stated he saw Resident 688 this morning and did not see any sign of bleeding. Physician 1 further stated they could observe a resident in the facility and most of the time the medication wears off without significant side effect. Physician 1 stated they could transfer the resident if the resident had significant side effect or complication. However, Resident 688's family requested for Resident 688 to be transferred to the ER. Physician 1 stated Resident 688 was sent to the ER to be monitored to give Resident 688's family peace of mind.</p> <p>On 12/6/24 at 1650 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.</p> <p>Cross reference to F759.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of medications for three of six medication carts (Medication Carts A, B, and C), one of 18 final sampled residents(Resident 339), and two nonsampled residents (Residents 6 and 338).</p> <p>* The facility failed to ensure Medication Cart A was not left unlocked and unattended.</p> <p>* The facility failed to ensure the IV medications on hold were not stored with the current IV medications in Medication Cart B.</p> <p>* The facility failed to ensure the medications on hold were not stored with current medications, orally administered medications were stored separate from externally used medications, and the bubble packs containing medications remained intact and free from tears in Medication Cart C.</p> <p>* The facility failed to ensure a bottle of Zenpep (pancrelipase) was not left at Resident 338's bedside table.</p> <p>* The facility failed to ensure a cup with zinc oxide cream (a medicated cream, ointment or paste used to treat or prevent skin irritation) was not left at Resident 339's bedside table.</p> <p>* The facility failed to ensure the label on the bubble pack of the tramadol medication for Resident 6 matched the physician's order to show the tramadol medication was for pain management, and not for severe pain (7-10).</p> <p>These failures had the potential to negatively impact the residents' well-being, the potential for the medications to lose the stability and effectiveness, unsafe administration of the medications, and the potential for the residents, staff, and visitors to have access to the medications.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Storage in the Facility dated 4/2008, under the Storage of Medications section, showed the following:</p> <ul style="list-style-type: none"> - Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access; - Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions; and <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.</p> <p>1. On 12/4/24 at 1127 hours, Medication Cart A was observed parked in front of the nursing station and facing the hallway. Medication Cart A was observed unlocked and unattended. Several staff and visitors were observed passing by the hallway.</p> <p>On 12/4/24 at 1128 hours, RN 4 was asked to check on Medication Cart A. RN 4 verified Medication Cart A was left unlocked and unattended.</p> <p>2. On 12/4/24 at 1134 hours, a concurrent inspection of Medication Cart B and interview was conducted with the ADON. Four one-liter bags of IV dextrose 5% and 0.45% sodium chloride were observed stored with other current IV solutions. The ADON stated the four one-liter bags of IV dextrose 5% and 0.45% sodium chloride were on hold. The ADON stated these should have been taken out from Medication Cart B and stored in a separate area in the medication room.</p> <p>3. On 12/4/24 at 1438 hours, a concurrent inspection of Medication Cart C and interview was conducted with the IP. The following was observed:</p> <p>a. Two bubble packs of Eliquis (anticoagulant) medication were stored with the other medications. The IP stated the Eliquis medication was on hold.</p> <p>b. A bottle of oral Clearlax (laxative) medication was stored with a box of rivastigmine (a cholinesterase inhibitor used to treat mild to moderate dementia) transdermal patches, a box of scopolamine (anticholinergic) patches, and a bottle of nasal moisturizing spray.</p> <p>c. A box of oral Lokelma (potassium-binder) medication was stored with a box of enoxaparin (anticoagulant) infections, albuterol sulfate (bronchodilator) inhalation solutions, a box of Refresh eye drops, a box of ipratropium/ albuterol (bronchodilator) inhalation solutions, and two boxes of naloxone (an opioid antagonist medication used to block or reverse the effects of opioid drugs) nasal spray.</p> <p>d. Three bubble packs containing levothyroxine (thyroid hormone) medications, and one bubble pack containing pantoprazole (proton pump inhibitor medication used for the management of GERD) medications were observed with tears on the foil blister packs. In addition, one bubble pack containing levothyroxine medications was observed taped with white stickers on the back of the bubble pack.</p> <p>The IP verified the above findings.</p> <p>4. On 12/3/24 at 0959, during the initial tour of the facility, a bottle of Zenpep 40,000 units was observed on the bedside table in Resident 338's room.</p> <p>On 12/3/24 at 1008 hours, a concurrent observation for Resident 338 and interview was conducted with RN 5. A bottle of Zenpep 40,000 units was observed on the bedside table in Resident 338's room. RN 5 verified the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review for Resident 338 was initiated on 12/3/24. Resident 338 was admitted to the facility on [DATE].</p> <p>5. On 12/3/24 at 0916 hours, during the initial tour of the facility, a cup containing a white cream was observed on the bedside table in Resident 339's room.</p> <p>On 12/3/24 at 1008 hours, a concurrent observation for Resident 339, and interview was conducted with RN 5. A cup containing a white cream was observed on the bedside table in Resident 339's room. RN 5 verified the above findings. RN 5 stated the cup contained zinc oxide cream and was not sure why it was left at the bedside unattended.</p> <p>Medical record review for Resident 339 was initiated on 12/3/24. Resident 339 was admitted to the facility on [DATE].</p> <p>6. On 12/3/24 at 1628 hours, a concurrent observation of Medication Cart D, interview, and medical record review for Resident 6 was conducted with RN 1. The bubble pack of the tramadol medication for Resident 6 showed a label showing the tramadol medication was for severe pain (pain levels 7-10).</p> <p>Medical record review for Resident 6 was initiated on 12/3/24. Resident 6 was admitted to the facility on [DATE].</p> <p>Review of Resident 6's Order Summary Report showed a physician's order dated 10/28/24, to administer tramadol 50 mg one tablet via GT for pain management.</p> <p>The label on the bubble pack of the tramadol medication did not match the physician's order to show the tramadol medication was for pain management, and not for severe pain (7-10).</p> <p>RN 1 verified the above findings.</p> <p>Cross reference to F756.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920</p> <p>Based on observation and interview, the facility failed to ensure one nonsampled resident (Resident 5) was provided with the prescribed therapeutic diet.</p> <p>* The facility failed to ensure Resident 5 was served a meal consistent with the ordered therapeutic diet of mechanical soft, finely chopped diet. Resident 5 was served large pieces of meat with a half piece of hard toast. This failure had the potential for Resident 5's nutritional needs to not be met and aspiration.</p> <p>Findings:</p> <p>Medical record review for Resident 5 was initiated on 12/3/24 at 1352 hours. Resident 5 was admitted to the facility on [DATE].</p> <p>Review of Resident 5's H&P evaluation dated 9/30/24, showed Resident 5 could make needs known but could not make medical decisions.</p> <p>Review of Resident 5's physician's order dated 6/26/24, showed fortified diet mechanical soft texture, regular/thin liquid consistency, liberalized fortified mechanical soft diet (finely chopped meat/vegetables) with regular think liquids for finely chopped meat and vegetable.</p> <p>Review of Resident 5's care plan dated 11/11/22, showed under nutritional status, the goal was for the resident to not have no signs and symptoms of choking every meal. The interventions included diet as ordered, assist resident with eating, feed resident, monitor for signs and symptoms of choking and swallowing problem.</p> <p>On 12/3/24 at 1218 hours, during the initial lunch dining observation, Resident 5 was observed in the dining room being fed by CNA 3. CNA 3 stated Resident 5 was unable to feed himself. The meal card showed Resident 5 had a fortified mechanical soft diet, with finely chopped meat and vegetables. Resident 5's lunch tray contained large chunks of meat, a half piece of hard toast, mashed potatoes, spinach, fruit cobbler, bowl of soup, and various beverages.</p> <p>On 12/3/24 at 1221 hours, a concurrent observation and interview was conducted with RN 4. RN 4 viewed Resident 5's lunch tray and verified the toast needs to be chopped due to high risk for aspiration. RN 4 verified meal trays need to be checked by the nurses, but did not personally check the lunch tray for Resident 5. RN 4 confirmed the meat on Resident 5's lunch tray could have been chopped more into more tiny pieces. RN 4 further confirmed the toast consistency was hard when they tried to cut it with a butter knife.</p> <p>On 12/3/24 at 1227 hours, a concurrent observation and interview with conducted with the DSS. The DSS stated it was her responsibility to check the right ingredients were served and that everything is ok with the meals served. The DSS viewed Resident 5's lunch tray and verified the meat was not finely chopped. The DSS further stated Resident 5 should have received plain bread, not toasted bread.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/3/24 at 1232 hours, a concurrent observation and interview was conducted with the ADON. The ADON stated the nurse would check each resident's tray against a clipboard located in the dining room and verify the resident's name, consistency, and any other additional directions. The ADON verified he checked the tray for Resident 5 prior to serving it. The ADON viewed Resident 5's lunch tray and confirmed the meat was not finely chopped. The ADON further confirmed the toast consistency was hard when he tried to cut it with a butter knife. The ADON verified Resident 5 should not have received toast for a mechanical soft diet and should not have received this tray.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44175</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when:</p> <ul style="list-style-type: none"> * The facility failed to ensure four blenders were not stored wet. * The facility failed to ensure a red cutting board had cleanable surface. * The facility failed to ensure the ice machine was maintained in a sanitary condition. * The facility failed to ensure safe storage of the food brought in by the family. <p>These failures had the potential to result in foodborne illnesses for residents receiving kitchen services.</p> <p>Findings:</p> <p>Review of the facility's document titled Diet Type Report dated 12/3/24, showed 69 of 87 residents were receiving food prepared from the kitchen.</p> <p>1. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow.</p> <p>On 12/3/24 at 0850 hours, an observation and concurrent interview was conducted with the DSS. Four blenders were observed in the food preparation area and the blenders were observed covered with the lids. When the DSS opened the lids of the blenders, the four blenders were observed to be stored wet. The DSS verified the observation and stated the staff should have air dried the blenders before storing.</p> <p>2. According to FDA Food Code 2022, Section 4-501.12, Cutting Surfaces, surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces.</p> <p>On 12/3/24 at 0850 hours, an observation and concurrent interview was conducted with the DSS. A red cutting board was observed to be heavily marred with brownish discoloration. The DSS verified the observation and stated the cutting board needed to be replaced.</p> <p>3. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils. Equipment food - contact surfaces and utensils shall be clean to sight and touch.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's P&P titled Dietary, Sanitation in dated 10/2007 showed the ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner.</p> <p>On 12/4/24 at 0810 hours, an observation of the ice machine and concurrent interview was conducted with the Maintenance Director in the presence of the DSS. When the Maintenance Director was asked to open the metal cover of the ice machine, dry dust was observed on both outer sides of the ice machine, and white dry residue was observed on the front lining of the machine (where the ice was made). The Maintenance Director and DSS verified the observation. The Maintenance Director stated an outside company cleaned the ice machine every month as per the manufacturer guidelines. The Maintenance Director stated it was last cleaned by an outside company on 12/2/24, and the facility did not clean the inside of the ice machine. The Maintenance Director stated she should have made sure the ice machine was cleaned thoroughly by the outside company.</p> <p>On 12/4/24 at 0826 hours, an interview was conducted with the DSS. The DSS verified the above findings and stated the dry dust on the outer sides of the ice machine could come in contact with the ice made. The DSS further stated she would throw the ice from the machine and have the maintenance cleaning the ice machine thoroughly.</p> <p>4. Review of the facility's P&P titled Food and Liquids from Outside Sources or Other Than the Dietary Department dated 9/2017, showed the food items brought into the facility for the resident cannot be reheated or stored. They are to be consumed or discarded.</p> <p>On 12/3/24 at 1137 hours, an observation of Resident Refrigerator and concurrent interview was conducted with LVN 9. During the observation of the resident refrigerator, the following was observed:</p> <ul style="list-style-type: none"> - Three jellos with no label. - One onion dip with no opened date and the sell by date showed 7/5/24. - Cottage cheese with no opened date. - Mild cheddar cheese in a zip lock plastic bag with no opened date. - Undated, unlabeled food item wrapped in the aluminum foil, inside a plastic bag. <p>LVN 9 verified the above observation and stated all of the above items should have been properly labeled and stored. LVN 9 further stated the facility only stored food brought in from outside sources for 24 hours and discharged after. LVN 9 stated she would discard all of the items above.</p> <p>On 12/4/24 at 1015 hours, an interview was conducted with the DSS. The DSS was informed of the above findings. The DSS stated the facility should not store the food items for the residents brought in from the outside sources. The DSS further stated the food brought in from the outside sources should be consumed immediately or discarded.</p> <p>On 12/6/24 at 1034 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Cross reference to F813</p>

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>39453</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the facility staff assisted the residents regarding the use and storage of food brought in by the family or visitors for the residents.</p> <p>* The facility failed to ensure the food items in the unlabeled and undated containers on Resident 81's nightstand, and inside a small refrigerator in the resident's room were properly stored. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consume food brought from outside sources.</p> <p>Findings:</p> <p>Review of the CMS S&C-09-39 Food Procurement, and Self-Determination and Participation, dated 5/29/09, showed the following:</p> <ul style="list-style-type: none"> - The residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices; and - The facility has the responsibility under the food safety regulation to help visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. <p>Review of the facility's P&P titled Food and Liquids from Outside Sources or Other Than the Dietary Department revised 9/2017 showed the following:</p> <ul style="list-style-type: none"> - Food and liquids brought in by visitors for the residents is discouraged due to problems of infection control and conflicts between diets and consistency; - Food or liquids brought into the facility by family members or visitors should be checked by the dietary department or nursing to confirm that the food or liquid is not in conflict with the resident's prescribed diet texture or consistency; - Visitors are discouraged from bringing in potentially hazardous foods, such as meat, fish, eggs, custards, milk products, etc. If such foods are brought to the resident, they should be consumed immediately and not shared with other residents within the facility; - Non-perishable foods retained in the resident's room are to be stored in plastic containers with tight-fitting lids or sealable bags and dated; and - Food items brought into the facility for residents cannot be reheated or stored. They are to be consumed or discarded. <p>On 12/3/24 at 0945 and 1015 hours, during the initial tour of the facility, the following was observed in Resident 81's room:</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- A pouch of unopened Caprisun juice, a pouch of opened Caprisun juice, an unlabeled and undated container of sliced apples, an unopened bag of seaweeds, and a small red refrigerator were observed on Resident 81's nightstand; and</p> <p>- An unlabeled and undated bag of nuts, and a bag with several Sweet and Low sugar packets were observed on Resident 81's bedside table.</p> <p>On 12/5/24 at 0956 hours, an observation for Resident 81, and concurrent interview was conducted with CNA 4. The following was observed in Resident 81's room:</p> <p>- A pouch of unopened Caprisun juice, an unlabeled and undated container of sliced apples, and a small red refrigerator were observed on Resident 81's nightstand; and</p> <p>- A bag of Sweet and Low sugar packets was observed on Resident 81's bedside table.</p> <p>CNA 4 verified the above findings. CNA 4 stated the residents were allowed to have a refrigerator in the room, but they were not allowed to use the outlet surge protectors. CNA 4 also stated the container of sliced apple should be inside the refrigerator. When asked about the facility's policy on the food brought in from outside such as family members or visitors, CNA 4 stated he was not aware of the policy.</p> <p>On 12/5/24 at 1034 hours, an interview was conducted with LVN 2. When asked about the facility policy on food brought in from outside such as family members or visitors, LVN 2 stated the residents were allowed to have food from outside as long as there were no food restrictions such as their salt and sugar intake. LVN 2 stated the residents were allowed to have snacks at bedside, but the fresh fruits should be stored for one day and should be thrown away after a day.</p> <p>On 12/06/24 at 1348 hours, an observation for Resident 81, and concurrent interview was conducted with the DSD. A pouch of unopened Caprisun juice, an unlabeled and undated container of sliced apples, and a small red refrigerator were observed on Resident 81's nightstand. The DSD verified the above findings. The DSD opened the small refrigerator and observed no thermometer in the refrigerator. There were three containers of food items stored inside the refrigerator. The DSD stated the food items had to be discarded.</p> <p>On 12/6/24 at 1401 hours, an observation for Resident 81, and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified a small refrigerator was on Resident 81's nightstand. The Maintenance Supervisor stated she was not aware Resident 81 had a small refrigerator in the room. The Maintenance Supervisor stated this was not allowed in the facility, and Resident 81 or the resident's family member should have reported this to the charge nurse or social services department first.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920</p> <p>Based on interview, medical record review, and P&P review, the facility failed to ensure the medical records were accurate for one of 18 sampled residents (Resident 29) and one nonsampled resident (Resident 64).</p> <p>* The facility failed to ensure the error on the H&P evaluation form was properly documented for Resident 64 as per the facility's P&P.</p> <p>* The facility failed to ensure the psychotropic medication consent forms for Resident 29 were properly completed by the physician.</p> <p>* The facility failed to ensure the route of medication for Resident 29 was correctly ordered on the MAR.</p> <p>These failures had the potential for the residents' needs not being met as the medical information were incomplete.</p> <p>Findings</p> <p>1. Review of the facility's P&P titled Documentation Principles revised 2/2018 showed one line or an x should strike out a mistake, which should be initialed and dated. A signature should be entered if there is no entry after the x or line indicating a mistake.</p> <p>Medical record review for Resident 64 was initiated on 12/4/24 at 1401 hours. Resident 64 was admitted to the facility on [DATE].</p> <p>Review of Resident 64's H&P examination dated 8/8/24, showed an error on the date line, scribbled out and not corrected.</p> <p>On 12/4/24 at 1409 hours, an interview was conducted with the DON. The DON verified the correct way to make the correction was to draw a line through the incorrect entry and initial it. The DON further stated it should not be scribbled out.</p> <p>2.a. Review of the facility's P&P titled Informed Consent revised 9/2018 showed the attending physician, PA or NP must obtain the informed consent of the resident or their responsible party for the purposes of prescribing, ordering or increasing an order for a medication.</p> <p>Medical record review for Resident 29 was initiated on 12/4/24. Resident 29 was admitted to the facility on [DATE].</p> <p>Review of Resident 29's H&P examination dated 4/1/24, showed Resident 29 had the capacity to understand and make decisions.</p> <p>Review of Resident 29's Informed Consents showed the following consents:</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-dated 6/10/24, for wellbutrin (antidepressant medication) XL 300 mg one tablet by mouth daily for depression manifested by crying spells</p> <p>-dated 6/10/24, for quetiapine (antipsychotic medication) 75 mg at bedtime for major depressive disorder manifested by feeling of sadness , and</p> <p>-dated 6/10/24, for trazodone (antidepressant medication) 100 mg every at bed time for depression with insomnia manifested by inability to sleep for six to eight hours at night.</p> <p>The resident's Informed Consents showed the section for the following items were not completed or checked off:</p> <ul style="list-style-type: none"> - I have not disclosed the risks related nto the restraints, psychotherapeutic drug, or prolonged use of a device to the resident or the resident's representative based on Section 72528 (a) and (b), but I have still provided other material information as listed above. - I have not obtained informed consent from responsible party or family prior to admission. <p>On 12/6/24 at 1343 hours, an interview was conducted with the DON. The DON verified all three consent forms for Resident 29 were incorrectly completed by the physician.</p> <p>b. Review of the facility's P&P titled Documentation Principles revised 2/2018 showed it is the policy of the facility that resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident.</p> <p>Review of Resident 29's Order Summary Report dated 12/1/24, showed an order for trazodone HCl oral tablet 100 mg to be administered via GT.</p> <p>Review of Resident 29's medical record failed to show the resident had a GT.</p> <p>On 12/6/24 at 1511 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified the medication route on the physician's order for the trazodone was incorrect and Resident 29 did not have a GT.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of one final sampled residents (Resident 70) reviewed for hospice services.</p> <p>* The facility failed to ensure the Hospice Aide did not provide oxygen to Resident 70 and notified the licensed nurse when Resident 70's oxygen saturation was 80%. In addition, the facility failed to ensure the physician's order on the frequency of the hospice staff visits were carried out, to clarify the frequency of the skilled nursing as needed visits, and to ensure there were no missing skilled nursing and hospice clinical notes. These failures posed the risk for delays in providing Resident 70 immediate care, and delays in the communication between the hospice provider and the facility which may affect the resident care.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Hospice Care dated 9/2018 showed the following:</p> <ul style="list-style-type: none"> - The facility retains primary responsibility for implementing care that is not related to the duties of the hospice. It is the facility's responsibility to continue to meet the resident's personal care and nursing needs; - The facility is responsible for ensuring that hospice services meet professional standards and principles and the timeliness of the services; and - The facility's responsibility continues to include conducting the comprehensive assessments, providing care, activities, medication administration, required physician visits, monthly drug regimen review by the Pharmacy Consultant, support for ADL cares, social services as appropriate, nutritional support and services and monitoring the condition of the resident. <p>Review of the Inpatient Services Agreement between the facility and Hospice Provider signed 10/16/24, showed the following:</p> <ul style="list-style-type: none"> - Under Facility Services section, the facility will ensure that all services are provided in accordance with federal and state law and other professional standards of practice; - Under Medical Records section, the medical records will contain all documents related to the management of services called for in the hospice's plan of care and will include a record of the hospice personnel involved in the care of the resident, procedures for accessing the 24-hour hospice on call system, information on all medications, physician orders, standing orders, a signed healthcare proxy, if appropriate, and any other information; and - All medical record entries must be current, legible, signed and dated (including time of day) by the person providing the service and recorded in dark ink to facilitate photocopying. The person furnishing such service shall make a signed record entry at the time such service is rendered. <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review for Resident 70 was initiated on 12/3/24. Resident 70 was admitted to the facility on [DATE].</p> <p>Review of Resident 70's Order Summary Report showed the following physician's orders dated:</p> <ul style="list-style-type: none"> - 9/19/24, to administer oxygen at two liters per minute via nasal cannula as needed to keep oxygen saturation level above 92%; - 10/16/24, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath/ wheezing; and - 10/16/24, to admit the resident under Hospice Provider 1. <p>Review of Resident 70's medical record did not show the frequency of the visits from Hospice Provider 1's skilled nursing, hospice aide, social services, and spiritual counselor.</p> <p>Review of Hospice Provider 1's Initial Order and Plan of Care Worksheet dated 10/16/24, under the Orders for Discipline and Treatments section, showed the skilled nursing visits were twice per week and one visit as needed for the pain and symptom management.</p> <p>Review of Hospice Provider 1's Physician's Order Details showed the following physician's order dated 10/16/24, showing the frequency of visits:</p> <ul style="list-style-type: none"> - for physician visits, once a month as needed per the family's request; - for skilled nursing visits, twice per week and two as needed visits for a change of condition; - for hospice aide visits, twice per week for ADL assistance and bathing; - for social worker visits, one visit for evaluation for grief counseling, any psychosocial issues and needs; and - for spiritual counselor visit, one visit for evaluation for spiritual needs. <p>a. Review of Resident 70's medical record did not show documented evidence the physician's orders on the frequency of visits of the skilled nurses, hospice aide, social worker, and spiritual counselor from the Hospice Provider 1 were carried out.</p> <p>b. Review of Resident 70's medical record showed there were two different numbers for frequency of skilled nursing visits as needed. Further review of Resident 70's medical record did not show documented evidence the physician's orders for the frequency of skilled nursing visits as needed from Hospice Provider 1 were clarified.</p> <p>c. Review of Resident 70's medical record and hospice binder showed the following:</p> <ul style="list-style-type: none"> - the Skilled Nursing Clinical Notes were missing for 10/16, 11/14, 11/21, and 11/29/24; and - the Hospice Aide Progress Notes were missing for 11/5 and 12/3/24. <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 1136 hours, an interview and concurrent medical record for Resident 70 was conducted with the DON. The DON verified the above findings.</p> <p>d. On 12/5/24 at 0909 hours, Resident 70 was observed sleeping in bed. The oxygen concentrator adjacent to Resident 70's bed was turned off, and the nasal cannula tubing was inside a set-up bag.</p> <p>On 12/5/24 at 0943 hours, an observation for Resident 70 and concurrent interview was conducted with the Hospice Aide. Resident 70 was observed awake, lying in bed, and receiving two liters of oxygen via nasal cannula. The Hospice Aide stated she turned on Resident 70's oxygen concentrator and provided the resident with two liters of oxygen via nasal cannula, because the resident's oxygen saturation level was 78%. The Hospice Aide stated Resident 70's oxygen saturation level was at 80% after receiving two liters of oxygen via nasal cannula. When asked about the normal oxygen saturation rate, the Hospice Aide answered, about 80% for her.</p> <p>On 12/5/24 at 1009 hours, an interview was conducted with LVN 2. When asked about Resident 70's oxygen use, LVN 2 stated the Hospice Aide informed her about Resident 70's oxygen concentrator being turned off. LVN 2 stated the Hospice Aide borrowed her pulse oximeter, and the Hospice Aide turned the oxygen concentrator on and placed the nasal cannula tubing for Resident 70. LVN 2 stated the Hospice Aide did not report Resident 70's oxygen saturation level at 78% nor 80%.</p> <p>On 12/6/24 at 1220 hours, an interview and concurrent medical record review for Resident 70 was conducted with the DON. When asked about Resident 70's oxygen administration by the Hospice Aide, the DON stated the Hospice Aide could provide the oxygen to Resident 70, to which the DON showed Hospice Aide's job description.</p> <p>Review of Hospice Provider 1's Hospice Aide Job description (undated) showed the following:</p> <ul style="list-style-type: none"> - The hospice aide is responsible for observing the resident, reporting these observations, and documenting observations and care performed; and - The essential job functions/responsibilities included meeting safety needs of the resident and using equipment safely and properly (foot stools, side rails, oxygen, etc.) <p>Review of the Hospice Provider 1's Initial Competency Assessment Skills Checklist for Hospice Aide dated 12/3/24, showed the Hospice Aide's competency for observation and reporting to the RN/Supervising nurse and other professional were not validated. The checklist form did not show the Hospice Aide was competent to check and monitor a resident's oxygen saturation level.</p> <p>Review of the Hospice Provider 1's Orientation Checklist - Hospice Aide showed the Hospice Aide had a satisfactory performance on oxygen equipment delivery systems such as turning the unit on/off, and application of nasal cannula. However, the Hospice Aide was not evaluated on checking and monitoring for the resident's oxygen saturation level; and reporting any respiratory symptoms and low oxygen saturation level to the licensed nurses.</p> <p>The DON verified the above findings.</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>Provide and implement an infection prevention and control program.</p> <p>39453</p> <p>Based on observation, interview, and facility P&P review , the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections.</p> <p>* The facility failed to ensure the clean linen cart was covered during the transportation.</p> <p>* The facility failed to ensure the staff performed hand hygiene in between assisting Residents 36 and 50 with meals.</p> <p>* The facility failed to ensure the staff performed hand hygiene before and after wearing gloves during the wound treatment observation for one final sampled resident (Resident 24).</p> <p>These failures had the potential for cross-contamination and spread of infectious organisms in the facility.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Infection Control Policy - Laundry Services dated 7/2019 showed it is the facility's responsibility to ensure that all laundry is handled, stored, processed and transported in a safe and sanitary manner.</p> <p>On 12/6/24 at 1354 hours, Laundry Aide 1 was transporting a clean linen cart. The linen cart was observed open with sheets and towels. Laundry Aide 1 had her right arm across the inner upper shelf of the linen cart. Laundry Aide 1 was touching the clean towels while pushing the linen cart instead of using the handlebars of the linen cart.</p> <p>On 12/6/24 at 1358 hours, an interview was conducted with Laundry Aide 1. Laundry Aide 1 verified the above findings. Laundry Aide 1 stated she pushed the linen cart by placing her right arm on the upper shelf of the linen cart because she could drive the cart better, and it was hard to push the linen cart using the handlebars on the linen cart.</p> <p>On 12/6/24 at 1359 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated the linen cart should be closed when transporting the hallway.</p> <p>44175</p> <p>2. Review of the facility's P&P titled Hand Hygiene dated 7/2019 showed facility staff member to perform hand hygiene before and after direct resident care and after contact with potentially contaminated surfaces to prevent, to extent possible, the spread of the infection. Further review of the P&P showed hand hygiene will be performed before touching resident; if gloves will be worn, before gloving and after touching resident.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Chapman Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12232 Chapman Ave Garden Grove, CA 92840	
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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>On 12/3/24 at 1209 hours, during the dining room observation, RNA 3 was feeding Resident 36. Resident 55 was eating by herself on the right side of the Resident 36. RNA 3 was wearing plastic gloves and feeding Resident 36 with a spoon. RNA 3 then assisted Resident 55 and touched Resident 55's hand without changing the gloves and performing hand hygiene.</p> <p>On 12/3/24 at 1235 hours, an interview was conducted with RNA 3. RNA 3 was informed of the above observation. RNA 3 confirmed the above observation and acknowledged she should have changed gloves and performed hygiene before assisting Resident 55.</p> <p>On 12/6/24 at 1045 hours, an interview was conducted with the IP. The IP acknowledged the above findings and stated the staff should have performed hand hygiene in between assisting two residents during meal.</p> <p>On 12/6/24 at 1050 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.</p> <p>49644</p> <p>3. Review of the facility's P&P titled Hand Hygiene revised 7/19 showed it is the policy of the facility that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. The Procedure section showed hand hygiene will be performed by staff immediately after glove removal.</p> <p>On 12/6/24 at 0810 hours, during the wound treatment observation, LVN 10 was wearing a gown, donning the gloves, sanitizing Resident 24's side table, removing the gloves and touching the treatment cart. LVN 10 did not perform hand hygiene before and after wearing the gloves.</p> <p>On 12/6/24 at 0818 hours, an interview was conducted with LVN 10. LVN 10 verified she did not perform hand hygiene before and after wearing the gloves. LVN 10 stated she just washed her hands before going to Resident 24's room. LVN 10 stated she should have done hand hygiene to prevent the spread of infection.</p> <p>On 12/6/24 at 1322 hours, an interview was conducted with the IP. The IP stated the staff needed to sanitize their hands before putting on the gloves. The IP further stated after taking off the gloves, the staff needed to wash their hands or use the hand sanitizer. The IP stated the staff had to do hand hygiene to prevent the spread of infection and protect the residents.</p> <p>On 12/6/24 at 1650 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility document review, the facility failed to conduct the regular bed inspection as part of a regular maintenance program to identify areas of possible entrapment for three of four final sampled residents (Residents 29, 51, and 339) investigated for the side rail use. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.</p> <p>Findings:</p> <p>According to the FDA 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:</p> <ul style="list-style-type: none"> - 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. <p>According to the facility's P&P titled Bed Safety dated 8/2018 showed to try to prevent death/ injury from the beds and related equipment including the frame, mattress, side rails, grab bar, headboard, foot boards, and bed accessories, the facility shall promote the following approaches:</p> <ul style="list-style-type: none"> -Inspection by maintenance staff of all beds and related equipment as part of the facility's bed safety program to identify any risks or problems including potential entrapment risks; -Review to ensure that gaps in the bed system do not present a hazard to the resident due to the resident's height and/or weight or due to the resident's movement or bed position; <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Ensure that if a grab bar or bed siderails are to be utilized, they are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit such as avoid bowing, ensure proper distance from the headboard and footboard, etc.; and</p> <p>-Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment such as altered mental status, restlessness, etc.</p> <p>In addition, the facility's P&P titled Side rails or Bedrails revised on 8/2018 showed if a bed or siderail is used even for episodic use, the facility will make sure that it is installed correctly, used correctly and maintained.</p> <p>- The facility must attempt to use appropriate alternatives prior to their use</p> <p>- Review the risks and benefits of their use with the resident or their representative and obtain informed consent prior to their use</p> <p>- The resident will be assessed for the risk of entrapment from the bedrails prior to their installation and the facility will make sure the beds dimensions are appropriate for the resident's size and weight. Maintenance department will check siderails or bedrails prior to their use and monthly for proper installation and functioning and will maintain a log of the siderail checks.</p> <p>1. On 12/3/24 at 0916 and 0937 hours, 12/4/24 at 0900 hours, 12/5/24 at 0941 hours, and 12/6/24 at 0906 hours, Resident 339 was observed in bed with the bilateral grab rails elevated.</p> <p>Medical record review for Resident 339 was initiated on 12/3/24. Resident 339 was admitted to the facility on [DATE].</p> <p>Review of Resident 339's Order Summary Report dated 12/4/24, showed a physician's order dated 11/12/24, for the bilateral grab bars to increase the independence with turning and repositioning in bed.</p> <p>Review of Resident 339's plan of care showed a care plan problem dated 11/12/24, addressing the use of the bilateral grab rails, and the benefits and potential risks associated with the use of siderails/bedrails and to include the risk for entrapment. The interventions included the maintenance to check the bed rails monthly.</p> <p>Review of Resident 339's Bed rail/Grab Bar Use and Entrapment Risk Evaluation dated 11/12/24, showed the bedrails/grab rail placed the resident at high risk for strangulation, entanglement, or asphyxiation, and that the resident was informed anytime rail/bar is attached to a bedframe or mattress, the risk of entrapment, bodily injury of body part is caught in between rail, bedframe or mattress, and the bed dimensions have been checked and were appropriate for the resident's size and weight. The evaluation form showed the boxes for Zones 1 to 4, which showed the recommended measurements, were checked yes as based on the evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 1449 hours, a concurrent interview and medical record review for Resident 339 was conducted with LVN 9, with LVN 1 present. When asked about Zones 1 to 4 as shown in the Bedrail/Grab Bar Use and Entrapment Risk Evaluation form, LVN 9 stated she checked the boxes for yes. When asked if she measured Zones 1 to 4, LVN 9 stated she did not measure, but it was based on her evaluation by looking at the rails. LVN 9 stated the maintenance department was responsible for checking and measuring the different zones of entrapment.</p> <p>On 12/6/24 at 1442 hours, a concurrent interview and facility record review for Resident 339 was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated she was responsible for the bed inspection in the facility, including checking the side rails, bed motor, brakes, wheels, and mattresses. When asked about the entrapment assessment, the Maintenance Supervisor stated he was not familiar with any entrapment assessment, and he was not familiar with the seven areas in the bed system where there was a potential for entrapment. When asked if he had conducted any measurements of the side rails, mattress, headboard or the footboard, the Maintenance Supervisor stated she did not measure because all the beds, mattresses and side rails were standard. When asked if she conducted a regular bed inspection of all the beds in the facility, the Maintenance Supervisor answered yes, to which she showed her documentation of the monthly bed inspection.</p> <p>Review of the facility's document titled Monthly Schedule - Manual and Electric Bed inspection form did not show the zones of entrapment were measured. There was no documentation to show the bed inspection was conducted for each bed.</p> <p>Review of the facility's document titled Manual and Electric Bed Repair did not show the zones of entrapment were measured.</p> <p>The Maintenance Supervisor verified the above findings. The Maintenance Supervisor stated the beds were inspected monthly but did not complete an individual documentation for each of the facility bed. The Maintenance Supervisor also stated she would check the beds including the side rails when she was informed by the facility staff member that a bed was needed to be inspected because it was broken, and she needed to fix it.</p> <p>48332</p> <p>2. Medical review for Resident 51 was initiated on 12/3/24. Resident 51 was initially admitted to facility on 4/24/23 and readmitted on [DATE].</p> <p>Review of Resident 51's Order Summary dated 12/4/24, showed physician's order dated 4/23/24, for the bilateral side rails on the lower part of the bed due to the resident sliding down from the bed and attempting to get up unassisted, every shift for safety, and informed consent obtained by the physician from the resident's family member.</p> <p>Review of Resident 51's care plan dated 4/23/24, showed the use of the side rails/bed rails as an enabling or assistive device would not limit the freedom of movement. Resident/ family aware of the benefits and potential risks associated with the use of the side rails/bed rails including the entrapment. Interventions included for the maintenance to check the bed rails monthly; and to assess the resident for the risk of entrapment prior to the installation of the bedrails.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/3/24 at 0900 hours, during an observation, Resident 51 was in bed watching television, with the bilateral upper grab bars and bilateral 1/4 (quarter) lower side rails. Resident 51's right lower side rail was loosely screwed to the bed frame, moving, unstable, and tilted outward of the bedframe.</p> <p>On 12/3/24 at 1502 hours, a concurrent observation of Resident 51 and interview was conducted with LVN 4. LVN 4 verified the right lower side rail screw was loose and the side rail was tilted outward, moving and unstable. LVN 4 stated there was the risk for Resident 51 being entrapped and getting caught between the bed rails and the mattress. LVN 4 stated she would inform the maintenance right away to fix the siderail.</p> <p>On 12/6/24 at 1442 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor was asked about the process for the bed inspection. The Maintenance Supervisor stated inspecting the bed every month to include the side rails, only for the residents with the side rails. The Maintenance Supervisor stated, regarding Resident 51's side rail, she did not get a report that it was loose and moving. The Maintenance Supervisor stated she did not measure the spaces in between the bed rails/side rails, and mattress, and no individualized measurement was being done for the resident's with bed rails.</p> <p>On 12/6/24 at 1510 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 stated the facility did not do the measurement of the gaps between the side rails and the mattress. Review of Resident 51's medical record failed to show documented evidence of the measurements done in different Zones 1 to 7. RN 1 verified the findings.</p> <p>51920</p> <p>3. Medical record review for Resident 29 was initiated on 12/6/24. Resident 29 was admitted to the facility on [DATE].</p> <p>Review of Resident 29's H&P examination dated 4/1/24, showed Resident 29 had the capacity to understand and make decisions.</p> <p>Review of Resident 29's Order Summary Report showed a physician's order dated 5/13/23, for the bilateral grab bars every shift to facilitate bed independence with turning and repositioning for medical necessity.</p> <p>On 12/3/24 at 1002 hours, Resident 29 was observed awake in bed watching TV with the bilateral grab bars elevated.</p> <p>On 12/5/24 at 0851 hours, Resident 29 was observed in bed sleeping with the bilateral grab bars elevated.</p> <p>On 12/6/24 at 0932 hours, an interview was conducted with Resident 29. Resident 29 stated she used the grab bars on her own and they helped her to reposition and get out of bed. Resident 29 stated she did not recall anyone ever coming to check the grab bars for proper positioning.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/6/24 at 1343 hours, an interview was conducted with the DON regarding Resident 29's use of the grab bars. The DON stated she was aware of Resident 29's use of the grab bars. The DON was unable to find Resident 29's entrapment assessment and verified it should have been done.</p> <p>On 12/6/24 at 1511 hours, an interview was conducted with RN 1. RN 1 was unable to find the entrapment assessment for Resident 29's use of the grab bars.</p>		