STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056145	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Grove Post Acute	12882 Shackelford Lane Garden Grove, CA 92841

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the services to attain or maintain the highest practicable well-being for two of 18 final sampled residents (Residents 4 and 5). * The facility failed to ensure the Xeloda (capecitabine - chemotherapy drug used to treat colorectal cancer) medication was administered as per the physician's orders for Resident 5. * The facility failed to follow up with the physician timely when Resident 4 had a change of condition involving an episode of hypertension (high blood pressure) of 180/100 mmHg. These failures had the potential to negatively affect the resident's health conditions and well-being. Findings: Review of the facility's P&P titled Significant Change in Conditionrevised 4/2017 showed all staff member shall communicate any information about resident status change to appropriate licensed personnel immediately upon observation. A licensed nurse shall assess the resident for signs and symptoms of physical or mental change of condition. This assessment shall be reported to the primary physician or designated alternate. Family members or responsible parties will also be notified of a change of condition. Notification of the physician, time, and date (month, day, and year) are to be documented in nurses' notes. The licensed nurse must speak directly to the physician; you may not leave a message with answering service or receptionist. Physician must call back. If the primary physician or alternate does not respond, then the Medical Director must be notified. Each condition change shall be documented on the 24-hour nursing/change of condition report. Each change of condition shall be documented on every shift for 72 hours post resolution in the nurses' progress notes. 1. Medical record review for Resident 5 was initiated on 3/7/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's MDS dated [DATE],showed Resident 5 was cognitively intact. Review of Resident 5's Physician's Order dated 8/9/23,showed the following order summary: - to administer capecitabine 1,500 mg PO BID for two weeks on 7/31/23 to 8/15/23; (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one week off from the capecitabine medication on 8/16/23 - 8/23/23; and - to administer capecitabine 1,500 mg PO BID for two weeks on 8/24/23 to 9/7/23. - Appointment with the oncologist on 9/5/23. Review of Resident 5's MARs from July to September 2023 showed the capecitabine medication was administered to the resident on 8/1 - 8/16/23, 8/23 - 8/31/23, and 9/1-9/6/23. There was no documented evidence the resident received capecitabine medication on 7/31/23, as ordered. Review of Resident 5's Oncology Progress Note dated 9/5/23, showed Resident 5 had a diagnosis of malignant neoplasm of colon (colon cancer) diagnosed on 7/25/23, and Resident 5 was taking Xeloda (brand name for capecitabine)with no issues, two weeks on and one week off. Further review of the oncologist's note showed the plan for six months of therapy given for high risk disease and for Resident 5 to continue taking Xeloda 1500 mg PO BID, two weeks on and one week off, a 21-days cycle for eight cycles. Review of Resident 5's Oncology Progress Note dated 10/3/23, showed Resident 5 was taking Xeloda with no issues, two weeks on and one week off. Further review of the oncologist's note showed Resident 5 to continue taking the Xeloda 1500 mg by PO BID, two weeks on and one week off cycle. Review of Resident 5's Licensed Personnel Weekly Progress Note dated 10/3/23, showed a note by LVN 6 regarding Resident 5's oncology follow-up appointment on 11/1/23, and lab work orders. However, the progress note failed to show any follow up was conducted with the oncologist regarding the Xeloda medication after Resident 5's visit on 10/3/23. Review of Resident 5's medical record failed to show the physician orders for the Xeloda medication for 10/2023. Further review of Resident 5's MARs failed to show the Xeloda was administered to Resident 5 in October 2023. Review of Resident 5's Oncology Progress Note dated 11/1/23, showed Resident 5 was taking Xeloda two weeks on and one week off; however, the nursing home stopped giving the Xeloda medication according to Resident 5. Resident 5stated the nursing home was not consistently giving him the Xeloda and missed several months of Xeloda. Further review of the oncologist note showed the nursing home was not reliably giving Resident 5 his Xeloda and wouldcontact the nursing home to continue the Xeloda 1,500 mg PO BID, two weeks on and one week off cycle. On 4/4/24 at 0925 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 was informed and verified the above findings. On 4/4/24 at 1023 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 was informed of the above findings. LVN 6 stated when the resident came back from a doctor's appointment, the charge nurse would always look for the information from the doctor's appointment when the patient came back. LVN 6 stated the charge nurse would follow up if the packet did not have information, would call the doctor's office, and ask for the orders and note. LVN 6 was unable to state the reasonwhy Resident 5 did not receive the Xeloda medication last October 2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1129 hours, an interview and concurrent medical record review was conducted with the DON and LVN 6. The DON was informed and verified the above findings. The DON stated Resident 5 had a routine order for the Xeloda medication for two weeks on and one week off and would continue until he was seen by the oncologist. The DON stated the oncologist would make a decision to continue and discontinue the medication. The DON was informed of no copy of Resident 5'sOncology Progress note dated 10/3/23, until the document was requested from the oncology office on 4/3/24. The DON stated when a resident came back from an appointment, LVN 6 or the next shift would follow up. The DON verified there was no follow up to the oncologist regarding the Xeloda medication to be given in October 2023. The DON verified the Xeloda medication was not given as per the physician's progress note dated 10/3/23, and the physician's orders dated 8/9/23. 2. Review of the American Heart Association's health topic titled Hypertensive Crisis: When You Should Call 911 for High Blood Pressure dated 5/2023, showed a hypertensive crisis is when blood pressure rises quickly and severely with readings of 180/120 mmHg or greater. The consequences of uncontrolled blood pressure in this range can be severe and include stroke and heart attack. Medical record review for Resident 4 was initiated on 3/25/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Resident Care plan dated 10/5/23, showed a care plan problem to address Resident 4's diagnosis of hypertension. The care plan goal was for Resident 5's BP would be maintained between 110/60 mmHg to 130/80 mmHg. The care plan interventions were unchecked and showed the handwritten checkmarks next to the medications that Resident 4 had the physician's orders for. The Care Plan further showed a care plan problem to address Resident 4'scurrent diagnosis or history of CVA with a risk for repeat CVA. The care plan approach included the interventions to monitor the vital signs as indicated, stabilize the resident, and notify the physician of the abnormal ranges (high or low). Review of Resident 4's Weight and Vitals Summary dated 10/5/23 - 10/6/23, showed the following BP: - on 10/5/23 at 2107 hours, 155/81 mmHg - on 10/6/23 at 0750 hours, 215/112 mmHg - on 10/6/23 at 1328 hours, 184/85 mmHg Review of Resident 4's SBAR Communication form dated 10/6/23, showed Resident 4 had a change of condition for elevated blood pressure of 180/100 mmHg and Resident 4 would not open her eyes and mouth to take the medications. The standing PRN clonidine (blood pressure medication) for SBP greater than 160 mmHg and hydralazine (blood pressure medication) for SBP greater than 140 was given as ordered. However, Resident 4 wasresistive to open her mouth and had spitted out the hydralazine. The clonidine was given sublingual instead. Review of Resident 4's Licensed Personnel Weekly Progress Notes dated 10/6/23 at 0730 hours, showed Resident 4 was sleeping in bed, eyes closed, with no acute distress noted; and had BP of 215/112 mmHg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Licensed Review of the Licensed Personnel Weekly Progress Notes dated 10/6/23, written by RN 2 showed the following: - at 0740 hours, RN 2 reassessedResident 4. Resident 4 was in bed, with eyes closed, calm, respirations even and non-labored. Resident 4 was non-responsive to verbal stimuli, responsive only to tactile and painful stimuli, and had a BP of 180/100 mmHg. - at 1200 hours, the physician called back and gave the new orders. - at 1300 hours, Resident 4'sBP was 184/86 mmHg, not in acute distress. Resident 4 still refused to open mouth and eyes and refused medications, foods, and fluids. Further review of Resident 4's medical record failed to show the time Resident 4'sphysician was notified regarding Resident 4's change of condition. There was no documented evidence of follow up to Resident 4's physician nor the Medical Director regarding Resident 4's change of condition prior to the 1200 hours on 10/6/23, when the physician called back. Review of Resident 4's Licensed Personnel Weekly Progress Notes dated 10/6/23 at 1520 hours, written by RN 1, showed Resident 4 was unresponsive to verbal and tactile stimuli and had a BP of 205/110 mmHg. Resident 4's family member was at bedside and said the physician was aware and said to hold off on transfer until the responsible party agreed for transfer to an acute care hospital. Further review of RN 1's showed at 1550 hours, Resident 4's physician was contacted and said to transfer Resident 4 to the acute care hospital. On 4/3/24 at 1053 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated she was preoccupied the whole shift with Resident 4. RN 2 stated she received the resident with high blood pressure and tried to give her theclonidine and hydralazine; however, Resident 4 spittedit out and did not take the whole medication. RN 2 stated she notified Resident 4's physician on 10/6/23 at 0830 hours, in regard to Resident 4's change of condition but did not get a response until 12 noon. RN 2 stated at 1300 hours, Resident 4's BP was still high, and the family was at bedside and discussing possible hospice services. RN 2 was unable to recall if she had followed up with Resident 4's physician. RN 2 verified there was no documented evidence she followed up with the physician. RN 2 stated she would follow up with the physician if they did not respond within one hour; and if the physician didnot respond, she would speak with the responsible party and would call the Medical Director. RN 2 verified she did not contact the Medical Director. RN 2 stated Resident 4's responsible party refused for Resident 4to be transferred to the hospital; however, RN 2 could not provide documented evidence Resident 4's responsible party refused the transfer. On 4/4/24 at 1043 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated Resident 4 had three kinds of BP medications and the physician was called at the time and did not call back before 1200 hours. The DON stated the staff should follow up with the resident's physician within an hour, would call three times; and if the physician did not respond right away, the staff were in-serviced to contact the Medical Director.