| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0554<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the safe self-administration of medication for one of 19 final sampled residents (Resident 745).<br><br>* Resident 745 had a bottle of the Glucosamine/Chondroitin (supplement) medication at the bedside. Resident 745 did not have a physician's order to keep the medication at bedside. Resident 745 reported to self-administer the medication despite not being qualified to self-administer. This failure had the potential to negatively impact Resident 745's physiological well-being as well as the potential for the medication interactions and inappropriate use of medications.<br><br>Findings:<br><br>Review of the facility's P&P titled Medication- Self Administration revised 1/2017 showed on admission or shortly thereafter, each resident would be assessed to determine if they want to self-administer their medication. It is the responsibility of the IDT to determine if it is 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 would be responsible for storage and documentation of the administration of the medications, as well as the location where the medications will be administered.<br><br>Medical record review for Resident 745 was initiated on 3/5/25. Resident 745 was admitted to the facility on [DATE].<br><br>On 3/6/25 at 0814 hours, during an observation in Resident 745's room, there was a bottle of the Glucosamine/Chondroitin medication in the resident's bedside drawer.<br><br>Review of Resident 745's H&P examination dated 3/2/25, showed Resident 745 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 745's Order Summary Report dated 3/1/25, failed to show a physician's order for the self-administration of the Glucosamine/Chondroitin medication.<br><br>Review of Resident 745's Self Administration of Medication assessment dated [DATE], showed Resident 745 was not a candidate for the self-administration of medications.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0554<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | On 3/6/25 at 1113 hours, a concurrent interview, observation, and medical record review for Resident 745 was conducted with RN 2. Resident 745 was observed in bed with the Glucosamine/Chondroitin medication at Resident 745's bedside. RN 2 verified the above findings. When asked, Resident 745 stated his daughter brought the medication to the facility and he had self-administered two tablets the day before. RN 2 reviewed Resident 745's medical record and stated Resident 745 was not a candidate for the self-administration of medications. RN 2 further stated the potential risks of having the medication at the bedside when the resident was not a candidate for the self-administration of medication were the drug to drug interactions or the over consumption of the medications.<br><br>On 3/10/25 at 1234 hours, an interview was conducted with the DON. The DON stated all the residents who wanted to self-administer their medications should have a self-administration medication assessment completed. If the assessment showed the resident was not qualified to self-administer the medications, then the resident should not have any medication at the bedside.<br><br>On 3/10/25 at 1319 hours, the DON, Administrator, and Nurse Consultant were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on interview and medical record review, the facility failed to ensure the MDS was coded accurately for one of 19 final sampled residents (Resident 34). This failure had the potential for the resident to not receive individualized plans of care to address individual care needs.<br><br>Findings:<br><br>Medical record review for Resident 34 was initiated on 3/5/25. Resident 34 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 34's H&P examination dated 12/27/24, showed Resident 34 had ESRD and was receiving hemodialysis (a medical procedure that filters waste products and excess fluid from the blood when the kidneys are unable to do so).<br><br>Review of Resident 34's Quarterly MDS assessment dated [DATE], showed Resident 34 was not coded for receiving dialysis treatments.<br><br>On 3/6/25 at 1003 hours, an interview and concurrent medical record review for Resident 34 was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 34 had been receiving dialysis treatments for over a year. The MDS Coordinator reviewed Resident 34's medical record and verified the above findings. The MDS Coordinator stated the MDS assessment was coded incorrectly.<br><br>On 3/10/25 at 1319 hours, the DON, Administrator, and Nurse Consultant were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0657<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>Based on observation, interview, and medical record review, the facility failed to update the care plan regarding removing of oxygen for one of 19 sampled residents (Resident 49). This failure had the potential for not providing necessary care and services to the resident.<br><br>Findings:<br><br>On 3/5/25 at 0838 hours, during the initial tour of the facility, Resident 49 was observed lying in bed with a nasal cannula on Resident 49's face. The nasal prong was not in Resident 49's nose. Resident 49's nasal cannula was distributing oxygen at 2 LPM and connected to the oxygen concentrator.<br><br>Medical record review was initiated for Resident 49 on 3/5/25. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 49's MDS assessment dated [DATE], showed Resident 49 had severe cognitive impairment.<br><br>Review of Resident 49's Order Summary Report for 2/25/25, showed a physician's order dated 2/1/25, to administer oxygen at 2 LPM continuously via nasal cannula to keep oxygen saturation level up to 92% every shift.<br><br>On 3/5/25 at 0842 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified the nasal cannula was on Resident 49's face but the nasal prong was not in Resident 49's nose. LVN 3 stated the licensed nurses checked Resident 49's nasal cannula every two hours because the resident pulled out his nasal cannula. LVN 3 placed back the nasal prong in Resident 49's nose. LVN 3 took Resident 49's oxygen saturation level and it was 91%.<br><br>However, Resident 49's plan of care did not address the resident's behavior of pulling out the nasal cannula.<br><br>On 3/7/25 at 1335 hours, an interview was conducted with RN 2. RN 2 acknowledged the above findings. RN 2 stated the licensed nurse should do visual checks of the residents including the placement of nasal cannula every two hours. RN 2 further stated the licensed nurse should adjust the nasal cannula on the neck area so it would not be dislodged right away. RN 2 stated the licensed nurse should also take into consideration that the nasal cannula was not too tight so it would not cause pressure injury on the resident's ear.<br><br>On 3/7/25 at 1645 hours, the Administrator and DON were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on observation, interview, medical record review, and facility document review, the facility failed to provide the necessary care and services to ensure one of 19 sampled residents (Resident 745) and one nonsampled resident (Resident 31) attained and maintained their highest practicable physical well-being.<br><br>* Resident 745's measurements of abdominal girth were not documented.<br><br>* The licensed nurse did not check Resident 31's last bowel movement prior to administering the stool softener medication to determine if it needed to be hold as per the physician's order.<br><br>These failures had the potential for delay in providing the necessary care and services to the residents.<br><br>Findings:<br><br>1. Medical record review for Resident 745 was initiated on 3/5/25. Resident 745 was admitted to the facility on [DATE], with a diagnosis of perforated gastric ulcer (a condition where an ulcer in the stomach wall breaks through, creating a hole that allows stomach contents to leak into the abdominal cavity).<br><br>Review of Resident 745's H&P examination dated 3/2/25, showed Resident 745 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 745's Order Summary Report dated 3/6/25, showed a physician's order dated 3/2/25, to measure Resident 745's abdominal girth before breakfast every two days at 0630 hours. If the abdominal girth was greater than 3 cm in size, the staff was to call the physician.<br><br>Review of Resident 745's MAR for March 2025 showed for the measurements of Resident 745's abdominal girth on 3/3 and 3/5/25 at 0630 hours, were documented with a check. However, there were no measurements documented for 3/3 and 3/5/25.<br><br>Review of Resident 745's Licensed Nurses Progress Notes failed to show the documentation of the measurements of Resident 745's abdominal girth.<br><br>On 3/6/25 at 1125 hours, an interview and concurrent medical record review for Resident 745 was conducted with RN 2. RN 2 stated Resident 745 was at the facility for status post a perforated ulcer. RN 2 reviewed Resident 745's medical record and verified the above findings. RN 2 stated the check meant the nurses had measured Resident 745's abdominal girth. When asked what the measurements were, RN 2 was unable to find the documentation of the measurements and whether the measurements were compared. RN 2 further stated the measurements should be documented and compared with the resident's baseline abdominal girth to determine if there was an increase in the girth size.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/10/25 at 1234 hours, an interview was conducted with the DON. The DON stated if there was a physician's order to measure the abdominal girth, she expected the staff to measure and document the measurements to track and trend the size of the abdomen.<br><br>On 3/10/25 at 1319 hours, the DON, Administrator, and Nurse Consultant were informed and acknowledged the above findings.<br><br>49644<br><br>2. 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.<br><br>On 3/6/25 at 0902 hours, during a medication administration observation, LVN 2 administered one capsule of docusate sodium (stool softener) 250 mg to Resident 31.<br><br>Medical record review was initiated for Resident 31 on 3/6/25. Resident 31 was admitted to the facility on [DATE].<br><br>Review of Resident 31's H&P examination dated 10/8/24, showed the resident had the capacity to understand and make decisions.<br><br>Review of Resident 31's Order Summary Report for 2/26/25, showed a physician's order dated 8/18/15, to administer dioctyl sodium sulfosuccinate (same as docusate sodium) oral capsule 250 mg one capsule by mouth in the morning as stool softener for constipation, and to hold if with loose stool.<br><br>On 3/6/25 at 1125 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified she did not ask Resident 31 if she had loose stool. LVN 2 stated she forgot to ask when Resident 31's last bowel movement was. LVN 2 stated Resident 31 was alert and could verbalize if he had loose stool. LVN 2 further stated she should have checked Resident 31's medical record if he had bowel movement before she gave the medication. LVN 2 stated she should have asked Resident 31 too if he had bowel movement.<br><br>On 3/7/25 at 1402 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have asked Resident 31 about his bowel movement before giving the medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided to prevent a decline in ROM functions for one of 19 final sampled residents (Resident 80).<br><br>* The physician's order to apply an extension splint to Resident 80's left elbow was not followed. In addition, Resident 80's skin was not assessed when the splint was applied. These failures had the potential for Resident 80 to sustain a decline in ROM functions, leading to muscle atrophy and decrease in functioning.<br><br>Findings:<br><br>Review of the facility's P&P titled Splint Application dated 5/2017 showed the splints should be applied correctly to maintain the resident's ROM and prevent contractures and further loss of range of motion.<br><br>During the initial tour of the facility on 3/5/25 at 0922 hours, Resident 80 was in bed asleep and noted to have contractures to the left arm. There was no splint applied to Resident 80's left arm contracture. Also, the splint was observed in the clear plastic bag on Resident 80's cabinet.<br><br>Medical record review for Resident 80 was initiated on 3/6/25. Resident 80 was admitted to the facility on [DATE].<br><br>Review of Resident 80's Order Summary Report dated 2/26/25, showed a physician's order dated 9/27/24, to apply the left elbow extension splint to the left elbow for four to six hours a day as tolerated every Monday, Tuesday, Friday, Saturday, and Sunday. However, there was no physician's order to include the skin assessment when the left elbow splint was applied.<br><br>Review of Resident 80's plan of care showed a care plan problem dated 9/29/24, addressing the potential decline in the resident's ROM and mobility. The interventions included the application of the left elbow extension splint for four to six hours as per the physician's order. However, there were no interventions to include Resident 80's skin assessment on the care plan.<br><br>Review of Resident 80's Restorative Nursing Record for January and March 2025 showed the RNA had applied the left extension elbow splint to Resident 80. However, the record failed to show an accurate record of the time when the splint was applied and removed. In addition, there was no documented evidence a skin assessment was completed when the left elbow splint was applied to Resident 80's left elbow.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/6/25 at 0939 hours, an interview and concurrent medical record review for Resident 80 was conducted with RNA 2. RNA 2 verified Resident 80 had an RNA services ordered and the application of left elbow splint. RNA 2 was asked what time she applied the left elbow splint to Resident 80. RNA 2 stated she applied the left elbow splint to Resident 80's left elbow at 0800 hours, and taken off at 12 noon, for four hours total every day. RNA 2 verified there was no documentation of the exact time when the left elbow splint was applied and removed from Resident 80's elbow. RNA 2 was asked about Resident 80's skin when the left elbow was applied. RNA 2 stated she checked the skin after she had taken off the left elbow splint from Resident 80's elbow. RNA 2 was asked where she documented the skin assessment of Resident 80. RNA 2 verified and acknowledged there was no documentation about the skin assessment of Resident 80's left elbow when the left elbow splint was applied.<br><br>On 3/10/25 at 0919 hours, an interview and concurrent medical record review for Resident 80 was conducted with RN 2. RN 2 verified Resident 80's physician's order for RNA services and the application of left elbow splint to Resident 80's left elbow. RN 2 verified there was no physician's order to assess the resident's skin while the splint was applied. RN 2 reviewed the RNA record and verified the hours of application for the left elbow splint to Resident 80's elbow was not documented, and the skin assessment was not included in the documentation. RN 2 stated a physician's order for the skin assessment at least every two hours should have been obtained and carried out to prevent any skin problem related to placement of the splint on the resident. RN 2 verified the care plan for the use of splint did not include the skin assessment of the resident when the splint was in use.<br><br>On 3/10/25 at 1348 hours, an interview for Resident 80 was conducted with the DON. The DON was informed and verified the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for one of 19 final sampled residents (Resident 68).<br><br>* The facility failed to ensure the floor mats were in place as per Resident 68's physician's order and care plan. This failure put Resident 68 at high risk for falls and serious injuries.<br><br>Findings:<br><br>Review of the facility's P&P titled Fall Risk/Prevention dated 7/2018 showed the residents who were assessed upon admission have a high risk for fall, a care plan will be developed and with approaches to prevent falls may include the provision of floor mats at the bedside.<br><br>On 3/5/25 at 1037 hours, and 3/6/25 at 0813 hours, Resident 68 was observed in bed. The bed was observed to be in the lowest position. There were no floor mats on both sides of the bed.<br><br>Medical record review for Resident 68 was initiated on 3/6/25. Resident 68 was admitted to the facility on [DATE].<br><br>Review of Resident 68's Fall Risk Evaluation dated 2/15/25, showed Resident 68 was at high risk for falls.<br><br>Review of Resident 68's plan of care showed a care plan problem dated 2/15/25, addressing Resident 68's high risk for falls and injuries related to bowel incontinence, bladder incontinence, poor balance, and fall history. The interventions included to place the bilateral floor mats to prevent and/or minimize injuries from fall.<br><br>Review of Resident 68's MDS dated [DATE], showed Resident 68 had a severe cognitive impairment and required extensive assistance from staff for ADL care.<br><br>Review of Resident 68's Order Summary Report dated 2/26/25, showed a physician's order dated 2/17/25, to apply bilateral floor mats on the floor to prevent and/or minimize injury from fall.<br><br>Review of Resident 68's SBAR Communication Form dated 1/23/25, showed Resident 68 had an incident of a witnessed fall.<br><br>On 3/6/25 at 0914 hours, an observation and concurrent interview was conducted with CNA 5 at Resident 68's bedroom. CNA 5 stated Resident 68 had a history of fall, and they monitored the resident frequently. CNA 5 was asked what they would need to place on the floor if the resident had a history of fall. CNA 5 stated they would place a floor mat on both side of the bed. CNA 5 stated Resident 68 had the floor mat on both side of the bed. CNA 5 was asked to check and acknowledged there were no floor mats on both sides of the bed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/6/25 at 1108 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 68 had a fall risk and needed assistance from staff. LVN 2 verified Resident 68's physician order included a floor mat on both sides of the bed. LVN 2 verified there were no floor mats placed at Resident 68's bedside.<br><br>On 3/10/25 at 0929 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 68 was a high risk for fall and had a physician's order for the floor mats on both side of the bed. RN 2 verified Resident 68 had an incident of fall on 1/23/25. RN 2 verified there were no floor mats in placed on both sides of the bed. RN 2 acknowledged there should have been a floor mat on both sides of the bed in placed to minimize any harm or injury of the resident in the event of fall.<br><br>On 3/10/25 at 1348 hours, an interview was conducted with the DON. The DON was informed of the findings and verified the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one of one final sampled resident (Resident 745) reviewed for IV care and failed to ensure the enteral feeding water bag was accurately labeled with the resident's name for one of 19 final sampled residents (Resident 30) reviewed for enteral feeding care.<br><br>* The facility failed to ensure the baseline measurements of the PICC line external catheter length and arm circumference were confirmed and documented in the medical record prior to the administration of the IV antibiotics for Resident 745. In addition, the facility failed to ensure the PICC line external catheter length and arm circumference were measured and documented during the PICC dressing change as per the facility's P&P and Resident 745's care plan. These failures had the potential to delay the identification of catheter related complications for Resident 745.<br><br>* The facility failed to ensure the enteral feeding water bag was accurately labeled with the resident's name for one of 19 final sampled residents (Resident 30). This failure had the potential for the resident's care needs to not be met as their medical information was not complete and accurate.<br><br>Findings:<br><br>1. Review of the facility's P&P titled PICC Dressing Change dated 3/2023 showed the dressing changes using transparent dressings are performed: upon admission (if not dated or site not visible for assessment), at least weekly, and if the integrity of the dressing had been compromised. The length of the external catheter is obtained: upon admission, during dressing changes, and if sign or symptoms of complications are present. Further review of the facility's P&P showed documentation in the medical record includes, but is not limited to: the date and time of the dressing change, the site assessment, the length of the external catheter, the resident's response to the procedure and/or medication, and resident teachings.<br><br>On 3/5/25 at 0959 hours, Resident 745 was observed in bed with a PICC line with a two-port external catheter to the right upper arm. A transparent dressing with paper tape was observed with a label dated 3/5/25.<br><br>Medical record review for Resident 745 was initiated on 3/5/25. Resident 745 was admitted to the facility on [DATE], with a diagnosis of perforated gastric ulcer.<br><br>Review of Resident 745's care plan for IV therapy dated 3/1/25, showed the interventions included to measure the external catheter length for the PICC and midlines upon admission and with each dressing change.<br><br>Review of Resident 745's H&P examination dated 3/2/25, showed Resident 745 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 745's Order Summary Report dated 3/6/25, showed the following physician's orders:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - dated 3/1/25, to administer piperacillin-tazobactam sodium solution (antibiotic medication) 3.375 gm intravenously every six hours for infection of the perforated ulcer status post sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection) for 10 days.<br><br>Review of Resident 745's IV Medication Administration Record for March 2025 showed Resident 745 was administered the piperacillin-tazobactam sodium 3.375 gm IV every six hours on the following dates and times:<br><br>- from 3/2/25 to 3/5/25 at 0000, 0600, 1200, and 1800 hours; and<br><br>- on 3/6/5 at 0000, 0600, and 1200 hours.<br><br>Further review of Resident 745's IV MAR for March 2025 showed Resident 745's PICC dressing was changed on 3/5/25. However, there was no documentation of the external catheter length measurement obtained during the dressing change on 3/5/25.<br><br>Review of Resident 745's Licensed Nurse Progress Notes showed an RN Admission Note on 3/1/25 at 1500 to 2300 hours shift. The nurse entry showed documentation Resident 745's right upper arm PICC line external catheter length was 11 cm long and the arm circumference was 18 cm. However, further review of Resident 745's Licensed Nurse Progress Notes failed to show documentation the licensed nurse had confirmed the baseline measurements of Resident 745's arm circumference and PICC line external catheter length measurement prior to the use of the PICC line to administer the antibiotic medication.<br><br>On 3/6/25 at 1046 hours, an interview and concurrent medical record review for Resident 745 was conducted with RN 2. RN 2 stated for the residents admitted to the facility with a PICC line, the baseline arm circumference and PICC external catheter length should be verified with the transferring facility or the medical records. RN 2 also stated the baseline measurements should be verified and documented in the medical record. RN 2 stated the PICC dressing changes were done weekly and as needed if soiled. RN 2 stated for every PICC dressing change, the external catheter length and arm circumference should be measured and documented in the IV administration record or the nurse's progress notes. RN 2 reviewed Resident 745's medical record and verified the above findings. RN 2 stated the measurements should be documented and compared with the baseline measurements to determine if there were any complications related to the PICC line.<br><br>On 3/10/25 at 1234 hours, an interview was conducted with the DON. The DON stated for the residents admitted to the facility with a PICC line, the nurse was expected to communicate with the acute care hospital about the baseline PICC measurements, to verify the resident's baseline measurements with the measurements obtained upon admission, and document the verification in the resident's medical record prior to the use of the PICC line.<br><br>On 3/10/25 at 1319 hours, the DON, Administrator, and Nurse Consultant were informed and acknowledged the above findings.<br><br>49324<br><br>2. On 3/6/25 at 0822 hours, during an observation, Resident 30's enteral feeding water bag was incorrectly labeled with Resident 46's name.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Medical record review for Resident 30 was initiated on 3/6/25. Resident 30 was admitted to the facility on [DATE].<br><br>On 3/6/25 at 0833 hours, a concurrent observation and interview was conducted with LVN 8. LVN 8 verified Resident 30's enteral feeding water bag was incorrectly labeled with Resident 46's name.<br><br>On 3/6/25 at 1510 hours, an interview was conducted with RN 2. RN 2 verified the enteral feeding bags should always be checked by both licensed nurses from the night and morning shifts to prevent the errors.<br><br>On 3//10/25 at 1102 hours, an interview was conducted with the DON, Nurse Consultant, and Administrator. The DON, Nurse Consultant, and Administrator verified the above finding. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the physician's order for oxygen therapy was followed for one of two final sampled residents (Resident 80) and one nonsampled resident (Resident 695) reviewed for oxygen administration.<br><br>* The facility failed to follow the physician's order for the administration of the oxygen for Resident 695. Additionally, there was no care plan developed for the use of oxygen.<br><br>* The facility failed to ensure Resident 80's nasal cannula was not touching the floor and the nebulizer tubing was dated and placed on a clear plastic bag when not in use.<br><br>These failures had the potential to negatively impact the resident's medical condition.<br><br>Findings:<br><br>Review of the facility's P&P Oxygen Administration revised 3/2017 showed it is the policy of the facility to provide guidelines for the administration of oxygen.<br><br>1.a. Medical Record Review for Resident 695 was initiated on 3/5/25. Resident 695 was admitted to the facility on [DATE].<br><br>Review of Resident 695's Order Summary Report showed a physician's order dated 11/26/24, to administer the oxygen at 2 LPM via nasal cannula as needed for shortness of breath and/or wheezing, to keep pulse oximetry above 92%.<br><br>Review of Residents 695's MDS dated [DATE], showed a BIMS score of 3 which meant the resident was cognitively impaired.<br><br>On 3/5/25 at 0816 hours, during an initial tour of the facility, Resident 695 was observed in bed with oxygen administered via nasal cannula at 2 LPM. There was an oxygen concentrator next to the resident's bed.<br><br>On 3/5/25 at 1215 hours, an observation and concurrent interview was conducted with RNA 1. Resident 695 was sitting in a wheelchair in the main dining room receiving oxygen at 5 LPM via nasal cannula. RNA 1 verified Resident 695 was receiving oxygen at 5 LPM via nasal cannula.<br><br>On 3/5/25 at 1223 hours, an observation, interview, and concurrent medical review was conducted with LVN 1. LVN 1 verified Resident 695's oxygen was at 5 LPM via nasal cannula. LVN 1 stated they were not sure how the resident's oxygen rate increased from 2 to 5 LPM.<br><br>b. Review of Resident 695's care plans failed to show documented evidence a care plan was developed for the use of the oxygen.<br><br>On 3/6/25 at 1234 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no care plan developed for the use of the oxygen.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/10/25 at 1102 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings.<br><br>39670<br><br>2. During the initial tour of the facility on 3/5/25 at 0922 hours, Resident 80 was observed in bed receiving oxygen at 2 LPM via nasal canula from the oxygen machine. Resident 68's nasal canula tubing was touching the floor. In addition, Resident 80's nebulizer machine was observed on top of the bedside drawer and the nebulizer tubing was undated and placed inside the drawer.<br><br>On 3/5/25 at 1102 hours, an observation and concurrent interview for Resident 80 was conducted with LVN 1. LVN 1 verified Resident 80 was receiving an oxygen via nasal cannula. LVN 1 was informed of the observation Resident 80's nasal cannula touching the floor and the nebulizer tubing was undated and placed inside the drawer. LVN 1 verified and acknowledged the observation and stated she would change the oxygen tubing, label the nebulizer tubing, and place inside a clear plastic bag.<br><br>Medical record review for Resident 80 was initiated on 3/6/25. Resident 80 was admitted to the facility on [DATE].<br><br>Review of Resident 80's Order Summary Report dated 2/26/25, showed the following physician's order:<br><br>- dated 2/10/25, to administer oxygen at 2 LPM via nasal cannula continuously for shortness of breath or wheezing.<br><br>- dated 8/20/24, to administer Ipratropium-Albuterol (breathing treatment) inhalation solution 0.5-2.5 (3) mg per 3 ml inhalation orally every six hours for shortness of breath or wheezing.<br><br>On 3/10/25 at 0919 hours, an interview and concurrent medical record review for Resident 80 was conducted with RN 2. RN 2 was asked about the facility's process about the oxygen tubing, nebulizer tubing, and mask. RN 2 stated the licensed nurses changed and labeled the oxygen tubing including the nebulizer mask every Sunday and or as needed. RN 2 stated the nebulizer mask and tubing should be placed in a clear plastic bag when not in use and labeled. RN 2 stated the oxygen tubing should not be touching the floor and would change the oxygen tubing when observed touching the floor. RN 2 was informed of the observation of the resident's oxygen tubing, nebulizer tubing, and mask and verified the findings.<br><br>On 3/10/25 at 1348 hours, an interview for Resident 80 was conducted with the DON. The DON was informed and verified the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of two final sampled residents (Resident 34) reviewed for dialysis care.<br><br>* The facility failed to ensure Resident 34 was assessed upon her return to the facility after dialysis treatment.<br><br>* The facility failed to ensure the accurate documentation for the monitoring of Resident 34's fluid restriction.<br><br>* The facility failed to ensure the emergency dialysis kit was kept at Resident 34's bedside.<br><br>* The facility failed to ensure Resident 34's care plan was updated to include the dialysis transportation information as per the facility's P&P.<br><br>These failures had the potential to negatively affect Resident 34's physical well-being.<br><br>Findings:<br><br>Review of the facility's P&P titled Dialysis Care revised 2/2018 showed in case of an emergency, at the bedside of a dialysis resident, there should be a clamp, tape, 4x4 (gauzes), and Kerlix. An individualized plan of care will be developed to provide caregiver information and quality care to include:<br><br>1. Monitoring of vital signs, weights, lab values, and who to notify with any concerns.<br><br>2. Information regarding transportation of the resident to the dialysis center, name of the company who will transport the resident and the approximate time the resident will be picked up at the facility.<br><br>6. The resident's diet as ordered and any fluid restriction. If fluid restriction is ordered, the plan of care will indicate the breakdown per shift that is to be provided by dietary and nursing.<br><br>Medical record review for Resident 34 was initiated on 3/5/25. Resident 34 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 34's H&P examination dated 12/27/24, showed Resident 34 had ESRD and received hemodialysis treatment.<br><br>Review of Resident 34's MDS dated [DATE], showed Resident 34 had severely impaired cognition.<br><br>Review of Resident 34's Order Summary Report dated 3/6/25, showed the following physician's orders:<br><br>- dated 1/9/25, for dialysis schedule on Mondays, Wednesdays, and Fridays. Chair time: 1300 hours.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - dated 1/9/25, to administer Nepro (enteral formula) 1.8 at 45 ml/hr for 18 hours vi GT to provide 810 ml/1458 kilocalories or until the volume limit is completed.<br><br>- dated 2/6/25, to flush the GT with a minimum of 80 ml of water every shift.<br><br>- dated 2/6/25, to provide fluid restriction of 1000 ml per day.<br><br>Review of Resident 34's care plan for altered renal function due to ESRD on hemodialysis dated 12/26/24, failed to include information regarding the transportation going to the dialysis treatment center. The contact person, contact number, and pick-up time were left blank.<br><br>Review of Resident 34's Dialysis Notes for February and March 2025 showed the following:<br><br>- dated 2/26/25, Resident 34's pre-dialysis weight was documented as 67 kg (147.4 pounds), and post-dialysis weight was 47.8 kg (105.2 pounds). A total of 42.2 pounds difference. The section for comments or special instructions post dialysis from the Dialysis Unit was left blank.<br><br>- dated 2/28/25, there was no documentation of the time when Resident 34 left the facility for dialysis.<br><br>- dated 3/5/25, there was no documentation of the time when Resident 34 returned to the facility after her dialysis treatment. Additionally, there was no documentation of Resident 34's post-dialysis assessment upon her return to the facility, including the pre and post dialysis weights, vital signs, hemodialysis site assessment, or post dialysis body assessment.<br><br>Review of Resident 34's Licensed Nurses Progress Notes failed to show documentation the licensed nurse clarified Resident 34's pre-dialysis weight on 2/26/24, and/or documentation the physician was notified of the significant pre and post dialysis weight variance. Further review of the progress notes failed to show documentation of when Resident 34 left the facility to the dialysis center on 2/28/25, and returned to the facility after her dialysis treatment on 3/5/25.<br><br>Review of Resident 34's MAR for February and March 2025 showed the following:<br><br>- for the Nepro 1.8 at 45 ml/hr for 18 hours via GT to provide 810 ml/1458 kcal showed from 2/1/25 to 2/28/25 and from 3/1/25 to 3/5/25, for the day, evening, and night shifts, the intake was documented as checks each shift.<br><br>- for the fluid restriction of 1,000 ml/day: from 2/7/25 to 2/28/25, and from 3/1/25 to 3/5/25, for the day, evening, and night shifts, the fluid restriction of 1,000 ml/day was documented as checks each shift.<br><br>- for the GT flush with minimum of 80 ml of water each shift: from 2/14/24 to 2/28/25 and from 3/1/25 to 3/5/25, for the day, evening, and night shifts, the MAR showed checks each shift.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/6/25 at 0825 hours, an interview and concurrent observation was conducted with LVN 8. LVN 8 stated Resident 34 received the hemodialysis treatments every Monday, Wednesday, and Fridays and her hemodialysis access was located in her right upper arm. When asked about the potential risks related to Resident 34's hemodialysis access, LVN 8 stated Resident 34 was at risk for bleeding. When LVN 8 was asked about the protocol when bleeding occurred from the dialysis access, LVN 8 stated she would obtain gauze from the medication cart and apply a pressure dressing. When asked about any supplies kept at the resident's bedside in case of an emergency, LVN 8 checked and verified there were no supplies at Resident 34's bedside.<br><br>On 3/6/25 at 1430 hours, a follow-up interview and concurrent medical record review was conducted with LVN 8. LVN 8 reviewed Resident 34's medical record and stated Resident 34 was on a fluid restriction of one liter per day and was receiving 80 ml of water flushes every shift. LVN 8 stated during her medication administration for Resident 34, she also flushed Resident 34's GT with water in between each medication. When asked how the flushes were being monitored and documented, LVN 8 stated the fluid restriction was documented in the MAR. LVN 8 reviewed Resident 34's MAR and verified the above findings. LVN 8 agreed the documentation in the MAR did not show how much fluid Resident 34 received during each shift and whether it added up to one liter per day. Additionally, LVN 8 reviewed Resident 34's Dialysis Notes for 2/26, 2/28, and 3/5/25, and verified the above findings. LVN 8 stated if there was a weight discrepancy/variance in the pre and post dialysis weight, the licensed nurse should call the dialysis center to clarify the resident's weight. LVN 8 stated if the weight was accurate, the nurse should then inform the physician and document in the progress notes. LVN 8 reviewed Resident 34's medical record and stated there was no documentation the physician was informed regarding the weight variance.<br><br>On 3/10/25 at 1234 hours, an interview was conducted with the DON. The DON stated for the residents on dialysis, the facility communicated with the dialysis center using the dialysis communication form. The DON stated the form should be completed before the resident left the facility and should also be completed by the dialysis center upon the residents returned to the facility. The DON stated the licensed nurse was responsible for reviewing the dialysis communication form. Additionally, the DON stated the Dialysis Note, which included the pre and post dialysis assessment of the resident, the documentation of when the resident left the facility and returned to the facility, and the pre and post dialysis weights, should be completed by the licensed nurse before the resident leaving the facility and upon returning to the facility, after the dialysis treatment. The DON stated the nurse completing the post dialysis assessment was responsible for comparing the pre and post dialysis weights and for any weight discrepancy of three pounds or more, the nurse was expected to clarify with the dialysis center and document. For the GT residents on fluid restrictions, the DON stated the routine water flushes and flushes administered during medication administrations should be documented to accurately account for how much fluid the resident received.<br><br>On 3/10/25 at 1319 hours, the DON, Administrator, and Nurse Consultant were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services.<br><br>* The facility failed to ensure the active ingredients for Resident 31's artificial tears medication were the same as the Resident 31's physician's order.<br><br>* The facility failed to ensure the Controlled Drug Record matched the MAR for Resident 66's oxycodone hcl (a narcotic pain medication).<br><br>These failures had the potential to negatively affect the resident's well-being and posed the risk of diversion of the controlled medication.<br><br>Findings:<br><br>1. 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.<br><br>During a medication administration observation on 3/6/25 at 0902 hours, with LVN 2, LVN 2 was observed preparing Artificial Tears (used to relieve dry eyes) lubricant eye drop for Resident 31. However, Resident 31 refused the Artificial Tears lubricant eye drop.<br><br>Medical record review was initiated for Resident 31 on 3/6/25. Resident 31 was admitted to the facility on [DATE].<br><br>Review of Resident 31's H&P examination dated 10/8/24, showed the resident had the capacity to understand and make decisions.<br><br>Review of Resident 31's Order Summary Report for 2/26/25, showed a physician's order dated 10/27/22, to administer artificial tears ophthalmic solution 1% (carboxymethylcellulose sodium ophthalmic, medication used to relieve dry, irritated eyes) one drop in both eyes two times a day for dry eyes.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/6/25 at 1115 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2. The box of the Artificial Tears medication showed the active ingredients for Resident 31's artificial tears were glycerin (a type of carbohydrate known as a sugar alcohol or polyol) 0.2%, hypromellose (a plant-derived semi-synthetic, water-soluble polymer) 0.2%, and polyethylene glycol 400 (eye lubrication) 1%. LVN 2 verified Resident 31's Artificial Tears medication was different from Resident 31's physician's order for the artificial tears ophthalmic medication. LVN 2 acknowledged Resident 31's Artificial Tears medication had different active ingredients compared to the medication the physician had ordered. LVN 2 stated she would ask the person who ordered over the counter medication if she could order the artificial tears medication ordered by Resident 31's physician, if not she would order the artificial tears medication from the pharmacy. LVN 2 stated she would take out Resident 31's Artificial Tears medication from the medication cart and would put it in the medication box disposal.<br><br>On 3/7/25 at 1354 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should order the exact medication per the physician's order from the pharmacy. The DON stated when the medication arrived, the nurse who received the medication from the pharmacy should compare the medication to the physician's order.<br><br>2. Review of the facility's P&P titled Controlled Medications dated 8/2014 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR:<br><br>* Date and time of administration.<br><br>* Amount administered.<br><br>* Signature of the nurse administering the dose on the accountability record of the time the medication is removed from supply.<br><br>* Initials of the nurse administering the dose on the MAR after the medication is administered.<br><br>Medical record review of Resident 66 was initiated on 3/7/25. Resident 66 was admitted to the facility on [DATE].<br><br>On 3/7/25 at 1059 hours, during the inspection of Medication Cart C, an interview, medical record review, and facility document review was conducted with LVN 4. Review of the Antibiotic or Controlled Drug Record showed Resident 66 received the oxycodone hcl 5 mg one tablet on 3/10/24 at 1840 hours, for severe pain. Review of Resident 66's MAR failed to show the administration of oxycodone hcl 5 mg tablet on 3/10/24 at 1840 hours. LVN 4 verified the findings and stated she would ask for help on checking the documentation of the administration of the oxycodone hcl 5 mg tablet on 3/10/24 at 1840 hours, in the MAR.<br><br>Review of Resident 66's Order Summary Report for 3/11/24, showed a physician's order dated 3/8/24, to administer oxycodone hcl oral tablet 5 mg one tablet by mouth every four hours as needed for severe pain.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/7/25 at 1326 hours, a follow-up interview, medical record review, and facility document review was conducted with LVN 4. LVN 4 verified the resident's Antibiotic or Controlled Drug Record for oxycodone hcl did not match the resident's MAR for March 2024. LVN 4 stated she did not know what happened because Resident 66 was in a different station before.<br><br>On 3/7 25 at 1417 hours, an interview and concurrent record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated when the nurse took the narcotic medication from the bubble pack (a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil to take the medication), the licensed nurse should have signed on the controlled drug record. The DON stated the licensed nurse should have signed the MAR showing the medication was given to Resident 66 as soon as the nurse administered the medication.<br><br>On 3/7/25 at 1645 hours, the Administrator and DON were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of five sampled residents (final sampled resident, Resident 56) reviewed for the use of psychotropic medications.<br><br>* Resident 56 who had diagnoses including dementia (a disorder which causes a progressive decline in memory and behavior that affects the ability to perform everyday activities) was prescribed Seroquel (an antipsychotic medication). There was no documented diagnosis prior to starting the Seroquel medication.<br><br>* The facility failed to ensure an informed consent was obtained and least restrictive measures were implemented prior to starting Resident 56's Seroquel medication.<br><br>* The facility failed to ensure a care plan for the use and monitoring of Resident 56's Seroquel medication was created at the time Resident 56 started receiving the medication.<br><br>* The facility failed to ensure the side effects of postural hypotension was monitored for Resident 56's Seroquel medication.<br><br>* Resident 56 was additionally prescribed Ativan (antianxiety medication) as needed for agitation for 14 days. There was no clinical indication or documented behaviors of agitation.<br><br>These failures had the potential to place the resident at risk for receiving unnecessary medications and increased risk of serious medication adverse reactions.<br><br>Findings:<br><br>Review of the FDA black box warning for prescribing Seroquel showed elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for elderly patients with dementia-related psychosis.<br><br>Review of the facility's P&P titled Psychotropic Drug Treatment revised 9/2017 showed the purpose of this procedure is to provide psychotropic drug treatment for a resident with a specific condition as diagnosed and documented in the clinical record. When their use is indicated, the facility should use the least restrictive alternative for the least amount of time and document on-going evaluation of the need for psychotropic drug treatment. The resident or his/her representative will be given information regarding the need for, the desired effects and the potential side effects of the medication. This enables the resident or his/her representative to make an informed decision regarding the use of any psychoactive medication. The facility staff will monitor for side effects, reduce dosage to the minimum required, and when possible, discontinue the use of such medications. The residents who have not used antipsychotic drugs will not be given such drugs unless antipsychotic drug therapy is necessary to treat a specific condition.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility's P&P titled Informed Consent Policy revised 4/2024 showed the attending physician, physician assistant or nurse practitioner must obtain the informed consent of the resident or their responsible party for purposes of prescribing, ordering, or increasing an order for a psychotherapeutic medication. The facility shall verify that informed consent has been obtained prior to the administration of psychotherapeutic medication.<br><br>Medical record review for Resident 56 was initiated on 3/5/25. Resident 56 was readmitted to the facility on [DATE].<br><br>Review of Resident 56's After Visit Summary dated 10/18/24, from Resident 56's Neurologist showed for Resident 56 to start taking Seroquel 25 mg one tablet by mouth two times a day. However, there was no documentation of the diagnosis for the use of Resident 56's Seroquel medication.<br><br>Review of Resident 56"s Licensed Nurses Progress Notes dated 10/18/24 at 1000 and 1200 hours, showed Resident 56 came back from an appointment with the neurologist. The notes showed the ordered Seroquel 25 mg two times a day for hallucination manifested by see animals and small adults. The order was noted and carried out, and the resident's family member was made aware.<br><br>Review of Resident 56's Order Summary Report showed the following physicians orders:<br><br>- dated 10/18/24, and discontinued on 10/27/24, to administer Seroquel oral tablet 25 mg one table by mouth two times a day for hallucination manifested by see animals, small adult.<br><br>- dated 10/18/24, to monitor side effects of Seroquel and record every shift.<br><br>- dated 10/27/24, to administer Seroquel oral tablet 25 mg one tablet by mouth two times a day for psychosis manifested by visual hallucinations as evidenced by seeing animals and small adult.<br><br>- dated 2/27/25, for Ativan oral tablet 0.5 mg one tablet by mouth as needed for agitation for 14 days.<br><br>Review of Resident 56's plan of care showed a care plan problem dated 10/27/24, to address the following:<br><br>- Altered thought process related to psychosis manifested by visual hallucination as evidenced by seeing animals and small adult. The approach plan included to monitor for side effects of the Seroquel medication every shift. The side effects of the medication included postural hypotension.<br><br>- Potential for discomfort and side effects related to use of antipsychotic medication Seroquel 25 mg. The interventions included to monitor for side effects including orthostatic hypotension.<br><br>Review of Resident 56's medical record failed to show Resident 56's risk for postural hypotension was monitored. The medical record showed Resident 56' care plan was created on 10/27/24, after the resident was prescribed Seroquel on 10/18/24.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 56's Psychiatric Evaluation dated 10/28/24, showed Resident 56 was started on Seroquel 25 mg two times a day on 10/18/24, for hallucinations manifested by see animals, small adult. Resident 56 was diagnosed with unspecified psychosis. The document showed the visual hallucination most likely were secondary to dementia. The recommendations showed to continue the Seroquel as prescribed and to change the indication to psychosis manifested by visual hallucinations.<br><br>Review of Resident 56's Informed Consent dated 10/30/24, showed an informed consent for Resident 56's Seroquel 25 mg medication was obtained from Resident 56's Responsible party on 10/30/24.<br><br>Review of Resident 56's MARs from October 2024 through March 2025 showed Resident 56 was administered the Seroquel medication starting on 10/19/24, two times a day, every day.<br><br>Further review of Resident 56's medical record failed to show the least restrictive measures were implemented and informed consent was obtained prior to Resident 56 starting the Seroquel medication on 10/18/25. Furthermore, there was no documented evidence of the informed consent for the Ativan medication.<br><br>On 3/6/25 at 1417 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 stated she reviewed the psychotropic medications for the informed consents, psych consult if indicated, and monthly behavioral reviews. RN 1 stated they obtained the informed consent for the psychotropic medication once they received the order for the medication and before the resident taking the medication, and would look for a diagnosis for the indication of the medication. RN 1 stated the resident should have a correct diagnosis prior to prescribing the medication and would ask for a psych consult so they could properly diagnose the resident. RN 1 reviewed Resident 56's medical record regarding the prescribed Seroquel and Ativan medications. RN 1 verified Resident 56 started receiving the Seroquel medication on 10/19/24. RN 1 verified there was no documented evidence of least restrictive measures implemented or informed consent obtained prior to Resident 56 starting the Seroquel medication. RN 1 verified Resident 56 did not have a clinical indication prior to starting the Seroquel or Ativan medications. RN 1 reviewed Resident 56's plan of care and verified the care plan for Resident 56's Seroquel medication was not initiated until 10/27/25. RN 1 then reviewed the side effects of the Seroquel medication and verified they were not monitoring Resident 56 for postural hypotension. Additionally, RN 1 verified there was no change of condition or informed consent regarding Resident 56's prescribed Ativan medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0761<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644<br><br>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 and disposal of the medications.<br><br>* Medication Cart B had oral medications stored with the externally used medication.<br><br>* Medication Cart D had two expired skin staple removers.<br><br>These failures had the potential to negatively impact the residents' well-being.<br><br>Findings:<br><br>Review of the facility's P&P titled Storage of Medications dated ,d+[DATE] showed the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Procedures section C showed the orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. Procedures section M showed the 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 procedure for medication disposal, and reordered from pharmacy if a current order exists.<br><br>1. On [DATE] at 0959 hours, a concurrent inspection of Medication Cart B and interview was conducted with LVN 5. The diclofenac sodium topical gel 1% (non-steroidal anti-inflammatory) was observed stored next to one bottle of calcium carbonate (supplement) tablets, one bottle of ferrous sulfate (supplement) tablets, and one bottle of acidophilus lactobacilli probiotic (supplement) capsules. LVN 5 verified the external medication diclofenac sodium topical gel was next to the oral medications. LVN 5 stated these medications should not be stored together because of possible cross contamination.<br><br>On [DATE] at 1405 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have checked the medication cart every shift before they started giving the medications. The DON stated the external and internal medications should have been separated.<br><br>2. On [DATE] at 1034 hours, a concurrent inspection of Medication Cart D and interview was conducted with LVN 6. Two skin staple removers were observed with an expiration date of [DATE] and [DATE]. LVN 6 verified the two skin staple removers had expired. LVN 6 stated she needed to double check the expiration date next time.<br><br>On [DATE] at 1410 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the treatment nurse should have checked the treatment cart for expiration items before starting her treatment.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0761<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | On [DATE] at 1645 hours, the Administrator and DON were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen as evidenced by:<br><br>* The facility failed to ensure the opened food items in the freezer were properly dated.<br><br>* The facility failed to ensure the foods in refrigerator were properly labeled and dated, and failed to discard the items in the refrigerator that past the use-by date.<br><br>* The facility failed to ensure the juice boxes and thickener were properly labeled and dated.<br><br>* The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions.<br><br>* The facility failed to ensure the food preparation equipment was in good condition.<br><br>* The facility failed to ensure multiple bags of the English muffins did not have ice buildup inside.<br><br>* The facility failed to ensure the sugar container was properly covered.<br><br>* The facility failed to ensure the food brought from outside was properly labeled and stored for Resident 92.<br><br>* The kitchen staff (Main Cook) had black hairy forearms which were not covered during pureed vegetable food preparation.<br><br>* The kitchen staff (Main Cook) touched and wiped the sink counter with a dirty white towel, then proceeded to touch the scooper to prepare for pureed vegetable food preparation without washing his hands.<br><br>* The facility failed to ensure Resident 42's three expired sauces were discarded.<br><br>These failures had the potential for exposure to food-borne illnesses for a medical vulnerable population of 81 residents who received food prepared in the kitchen.<br><br>Findings:<br><br>Review of the facility document titled Diet Type Report dated [DATE], showed 81 of 94 residents in the facility received food prepared in the kitchen.<br><br>1. Review of the facility's P&P titled Dietary-Labeling and Dating Foods revised ,d+[DATE] showed the frozen foods will be covered, clearly labeled, and dated.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's P&P titled Frozen Storage, undated, showed to store frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. All frozen food should be labeled and dated.<br><br>On [DATE] at 0755 hours, an observation of Freezer 1 was conducted with the Dietary Supervisor. One bag of white English muffins was observed opened and labeled with the date of [DATE]. Five other bags of English muffins were observed unopened and labeled with the date of [DATE]. The Dietary Supervisor was asked when the opened bag of the white English Muffins was opened. The Dietary Supervisor stated she did not know. The Dietary Supervisor stated the received date was [DATE], and if the bag of English muffins was opened on the same day as the received date, it should have been labeled with both received and opened dates.<br><br>2. Review of the facility's P&P titled Dietary-Labeling and Dating Foods revised ,d+[DATE] showed the refrigerated foods will be covered, clearly labeled without using abbreviations, and dated.<br><br>Review of the facility's P&P titled Dietary- Refrigerated Storage revised ,d+[DATE] showed all meat and perishable food, for example, pudding, milkshakes, juices, etc. should be placed in the refrigerator for thawing must be labeled and redated with the date when the item was transferred to the refrigerator.<br><br>On [DATE] at 0755 hours, an observation of Refrigerator 1 and concurrent interview was conducted with the Dietary Supervisor. The following was observed:<br><br>- a tray of yellow colored substance, labeled puree fruit, dated [DATE]. There was no label of the use-by date.<br><br>- an unlabeled tray of multiple covered cups with whitish-light brown colored content, dated [DATE]. The tray was not labeled with the content or the use-by date.<br><br>- a pitcher containing a yellow-colored liquid, dated [DATE]. The pitcher was not labeled with the content or the use-by date.<br><br>- a tray labeled gelatin with the use-by date of [DATE].<br><br>The Dietary Supervisor verified the above findings. The Dietary Supervisor stated all the items in the refrigerator should be labeled with the content, prepared date, and use-by date. The Dietary Supervisor further stated the dietary aide was responsible for checking the refrigerator at the end of each day to remove items that were past the use-by date. The Dietary Supervisor stated the tray of gelatin should have been removed the day before.<br><br>3. On [DATE] at 0755 hours, during the initial tour of the kitchen, the following was observed:<br><br>- a box of apple juice dated [DATE] (over 45 days), connected to the juice dispenser. The label on the box showed to use the product 45 days after connecting.<br><br>- a box of prune juice was observed with an unclear opened date, connected to the juice dispenser. The label on the box showed to use the product 45 days after connecting.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - a box of thickened water, undated, connected to the juice dispenser. The label on the box showed to use the product 45 days after connecting.<br><br>The Dietary Supervisor verified the above findings. The Dietary Supervisor stated the juice boxes should be labeled with the received date. The Dietary Supervisor further stated once opened and connected to the juice dispenser, the juice boxes should be labeled with the opened date and discarded after 45 days.<br><br>4. According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.<br><br>According to the USDA Food Code 2022, ,d+[DATE].13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.<br><br>Review of the facility's P&P titled Sanitation (undated) showed all the utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas.<br><br>On [DATE] at 0755 hours, during an initial tour of the kitchen, the following items were observed:<br><br>- a white scooper observed with multiple crusted residue and whitish dry residue.<br><br>- a yellow scooper observed with dry crusted residue.<br><br>- one white rubber spatula observed with yellow colored dry residue.<br><br>- one clear bin and three large plastic bins containing clean cooking utensils were observed with multiple dry particles and debris at the bottom of the bins.<br><br>- the shelf of the stainless steel cart storing multiple measuring cups and pitchers was observed with multiple dry debris.<br><br>The Dietary Supervisor verified the above findings.<br><br>5. Review of the facility's P&P titled Sanitation (undated) showed all utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas.<br><br>On [DATE] at 0755 hours, during an initial tour of the kitchen, the following items were observed:<br><br>- one can opener in the stand with chipped stainless- steel coating, exposing the blade, and<br><br>- four portion servers (one-white, one-black, and two-brown colored handles) were observed with the handle partially melted.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Dietary Supervisor verified the above findings and stated the can opener blade and portion scoopers with the melted handles should be changed.<br><br>6. Review of the facility's P&P titled Procedure for Freezer Storage dated 2023 showed to store the frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn.<br><br>On [DATE] at 0755 hours, an observation of Freezer 1 was conducted with the Dietary Supervisor. Three unopened bags of white English muffins were observed with a significant amount of ice buildup. The Dietary Supervisor verified the above findings.<br><br>7. According to the USDA Food Code 2022, ,d+[DATE].11, Food shall be protected from cross contamination: by (4) storing the food in packages, covered in containers, or wrappings.<br><br>On [DATE] at 0755 hours, an initial tour of the kitchen was conducted with the Dietary Supervisor. In the dry storage room, the lid for large white container of sugar was not completely closed. The Dietary Supervisor verified the finding and placed the lid completely over the container.<br><br>8. On [DATE] at 0900 hours, during an inspection of the resident refrigerator, the following was observed:<br><br>- a sign on the refrigerator showed all foods/drinks must be labeled with the resident room and date before storing in the refrigerator. Foods/drinks can only be stored for 48 hours and must be discarded after 48 hours.<br><br>- inside the refrigerator, there was a plastic cup of orange colored liquid dated [DATE]; however, there was no label to indicate which resident the drink belonged to.<br><br>- on top of the refrigerator, there was a white plastic bag labeled with Resident 92's name. The plastic bag contained a white steamed bun and a brown colored pastry. The bag was observed undated.<br><br>The Dietary Supervisor verified the above findings. The Dietary Supervisor stated she did not know who the orange-colored drink was for, and she did not see the plastic bag the day before. When asked, the Dietary Supervisor stated she did not know how long the bag was left on top of the fridge.<br><br>On [DATE] at 1303 hours, the DON, Administrator, Nurse Consultant, and RD were informed and acknowledged the above findings.<br><br>49324<br><br>9. According to the USDA Food Code 2022, Section ,d+[DATE].11 Effectiveness, (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 1028 hours, an observation of the pureed vegetable food preparation by the Main [NAME] and concurrent interview was conducted with the Dietary Supervisor. The Main [NAME] had black hairy forearms which were uncovered during the puree food preparation. The Dietary Supervisor was asked what their facility process was regarding body hair like hairy arms. The Dietary Supervisor stated she was not aware about it but would suggest to have one.<br><br>10. According to the USDA Food Code 2022 Section ,d+[DATE].14 When to Wash, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S ,d+[DATE].12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;<br><br>On [DATE] at 1048 hours, an observation of the pureed vegetable food preparation by the Main [NAME] and concurrent interview was conducted with the Dietary Assistant. The Main [NAME] touched a dirty white towel with green food residue and used it to clean the counter sink, touched the scooper, and prepared the pureed vegetable food preparation. The Dietary Assistant verified the Main [NAME] should have washed his hands in between touching the soiled dirty white towel and before preparing the vegetable pureed food preparation. The Dietary Assistant verified the Main [NAME] should not have used a dirty towel to clean the kitchen surfaces.<br><br>On [DATE] at 1055 hours , an interview was conducted with the Dietary Supervisor. The Dietary Supervisor verified the [NAME] should have washed his hands in between touching the dirty white towel and before preparing pureed vegetable food preparation.<br><br>On [DATE] at 1304 hours, an interview was conducted with the DON, Nurse Consultant, and Registered Dietitian. They all verified that something should at least be worn to cover the black hairy forearms and the Main [NAME] should have washed hands in between touching soiled dirty white towel and preparing pureed vegetable food preparation.<br><br>49644<br><br>11. Review of the facility's P&P titled Dietary - Refrigerator for Resident Storage of Food revised ,d+[DATE] showed it is the policy of the facility that provisions for limited storage of food will be available. The facility has a responsibility to help family and visitors understand safe food handling practices in a language that they understand. The procedure section #3 showed the food will be labeled with the resident's name and the date the food is placed in the refrigerator. The procedures section #4 showed the leftover food will be kept for 72 hours after the date on the container and will be discarded after 72 hours or discarded based on the expiration date if opened.<br><br>On [DATE] at 0849 hours, during the initial tour of the facility, there were three plastic containers with sauce dated ,d+[DATE] on Resident 42's side table.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 0855 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 verified there were three plastic containers with sauce inside dated ,d+[DATE] on top of Resident 42's side table. CNA 2 stated the three sauces were soy sauce, chili sauce, and oyster sauce. CNA 2 stated Resident 42's sauces should have been labeled and kept in the refrigerator if it was not expired. CNA 2 stated the three sauces should have been thrown because they were already expired. CNA 2 stated the staff labeled the residents' food, put it in the refrigerator and the food would only be good for 72 hours.<br><br>On [DATE] at 0845 hours, an interview was conducted with LVN 7. LVN 7 acknowledged the above findings. LVN 7 stated the CNAs and licensed nurses should have checked if a resident had food in their room. LVN 7 stated if the food was in the room too long, it would be expired and the resident could get food poisoning.<br><br>On [DATE] at 1645 hours, the Administrator and DON were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>48882<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the P&P regarding the outside food for the residents was updated to meet the state regulations and failed to ensure the visitors and staff were educated on safe food handling of outside food. These failures posed the risk for food borne illness to the residents who consumed food from outside sources.<br><br>Finding:<br><br>Review of the facility's P&P titled Foods and Liquids from Outside Sources or Other than the Dietary Department revised 9/2017 showed the visitors are discouraged from bringing in potentially hazardous foods, i.e., meats, fish, eggs, custards, milk products, etc. If such foods are brought to the residents, they should be consumed immediately and not shared with other residents within the facility. Food items brought into the facility for residents cannot be reheated or stored. They are to be consumed or discarded.<br><br>On 3/6/25 at 1609 hours, an interview was conducted with the DSD. The DSD was asked about the facility's policy for food brought from the outside. The DSD stated the visitors were encouraged to bring food for the residents; however, the food must be consumed. The DSD further stated if the food was not consumed, the resident's family member must take the food home. The DSD stated the facility did not store food for the residents.<br><br>On 3/6/25 at 1628 hours, a follow-up interview and concurrent facility document review was conducted with the DSD. The DSD reviewed the documentation for the in-service provided to the staff on 2/12/25. The attached material used for the in-service was the facility's P&P titled Food and Liquids from Outside Sources or Other than the Dietary Department. The DSD verified the P&P showed the facility did not store or reheat food brought from the outside. When asked if the DSD provided the staff and visitors with education regarding safe food handling to prevent foodborne illnesses, the DSD stated he did not.<br><br>On 3/10/25 at 1234 hours, an interview and concurrent review of the facility's P&P was conducted with the DON. The DON was asked about the facility's policy regarding food brought from outside. The DON stated when the food was brought to the facility, the facility labeled the food with the resident's name and date, and stored the food in the refrigerator for 72 hours. When asked if the facility provided education to the visitors and staff on the safe food handling of the food brought in for the residents, the DON stated no. The DON reviewed the facility's P&P for food brought from outside and verified the P&P showed the facility did not store or reheat the food.<br><br>On 3/10/25 at 1303 hours, the DON, Administrator, Nurse Consultant, and RD were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on observation, interview, and medical record review, the facility failed to ensure the enteral feeding water bag was accurately labeled with the resident's name for one of 19 final sampled residents (Resident 30). This failure had the potential for the resident's care needs to not be met as their medical information was not complete and accurate.<br><br>Findings:<br><br>On 3/6/25 at 0822 hours, during an observation, Resident 30's enteral feeding water bag was incorrectly labeled with Resident 46's name.<br><br>Medical record review for Resident 30 was initiated on 3/6/25. Resident 30 was admitted to the facility on [DATE].<br><br>On 3/6/25 at 0833 hours, a concurrent observation and interview was conducted with LVN 8. LVN 8 verified Resident 30's enteral feeding water bag was incorrectly labeled with Resident 46's name.<br><br>On 3/6/25 at 1510 hours, an interview was conducted with RN 2. RN 2 verified the enteral feeding bags should always be checked by both licensed nurses from the night and morning shifts to prevent the errors.<br><br>On 3//10/25 at 1102 hours, an interview was conducted with the DON, Nurse Consultant, and Administrator. The DON, Nurse Consultant, and Administrator verified the above finding. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections as evidenced by:<br><br>* The facility failed to ensure the water management plan was available which addressed and identified where Legionella and other opportunistic waterborne pathogens could grow and spread, control measures to prevent the growth of the pathogens, and how to monitor them.<br><br>* The facility failed to ensure the Administrator attended the quarterly infection control committee meetings.<br><br>* The facility failed to ensure the Laundry Attendant performed proper hand hygiene prior to touching the clean linens. In addition, there were dirty items stored with the clean linens.<br><br>* The facility failed to ensure the staff donned proper PPE when checking Resident 645's blood sugar level.<br><br>* The facility failed to ensure the staff donned proper PPEs when assisting Resident 745 from the restroom to his bed. Resident 745 had a right upper arm PICC line and a surgical abdominal wound.<br><br>* CNA 1 failed to use proper PPE when feeding Resident 696 on EBP.<br><br>These failures posed the risk for the transmission of disease-causing microorganisms to the residents in the facility.<br><br>Findings:<br><br>1. Review of the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease revised 7/2018 showed the facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. Facilities must have water management plans and documentation that, at a minimum, ensure each facility:<br><br>- Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system.<br><br>- Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air-Conditioning Engineers) industry standard and the CDC toolkit.<br><br>- Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Maintains compliance with other applicable federal, state, and local requirements.<br><br>Review of the facility's P&P titled Policy for Legionnaire's Disease revised 6/2017 showed it is the policy of the facility to have a plan for the prevention of Legionnaire's disease. Under the section titled Process to Develop a Water Management Program showed the following:<br><br>- The facility will develop a Water Management Program which will be reviewed annually.<br><br>- The facility will complete Water Flow Diagram specific to the facility to identify risk areas in which Legionella can grow.<br><br>- The facility will determine risk areas by completing the Building Water System Process Flowchart and implement controls and indicate where these controls are located by completing the Control Area Monitoring Flowchart.<br><br>- During routine inspections of control areas, the facility will attempt to reduce areas of concern with the specific plans that have been developed. Preventative maintenance plans have been developed for each control area.<br><br>Review of the facility's document titled Legionella Risk assessment dated [DATE], showed a form which was filled out in order to determine if the facility needed a water management program to reduce the risk of Legionella growth and spread. The form showed the facility should have a water management program for the building's hot and cold-water distribution systems.<br><br>Review of the facility's document Building Water System Process Flowchart (undated) showed a water flow diagram specific to the facility; however, there was no documentation of identified risk areas in which Legionella could grow or control measures to monitor.<br><br>Further review of the facility's water management program binder failed to show the Control Area Monitoring Flowchart was completed as per the facility's P&P. In addition, there was no documented evidence of a facility water management program which specified testing protocols, acceptable ranges for control measures, and corrective actions taken when control limits were not maintained.<br><br>On 3/6/25 at 0910 hours, a concurrent interview, facility P&P review, and facility document review was conducted with the Maintenance Director. The Maintenance Director verified he was in charge of the facility's water management program. The Maintenance Director stated they tested for Legionella yearly and the facility did not have any areas of standing water. The Maintenance Director was informed of the above findings. The Maintenance Director was unable to provide documented evidence a facility risk assessment was completed to identify where Legionella and other waterborne pathogens could potentially grow and spread. The Maintenance Director verified the Building Water System Process Flowchart was not completed and Control Area Monitoring Flowchart was not completed as per the facility's P&P. The Maintenance Director was not able to provide a documented facility water management plan which addressed the testing protocols, acceptable ranges for control measures, and monitoring for the controls. Further review of the facility's water management program binder showed maintenance logs for the boiler and hot water heater, air conditioning and air handlers, evaporative coolers, and ice machine. When asked why these specific maintenance forms were in the binder, the Maintenance Director stated he included the logs in the program because he was told to and did not know why he filled out the forms.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/6/25 at 1607 hours, a concurrent interview, facility P&P review, and facility document review was conducted with the Administrator. The Administrator verified the facility's water management plan did not specify the areas in the facility water system which Legionella could grow and spread. The Administrator verified the Building Water System Process and Control Area Monitoring Flowcharts were not completed per the facility's P&P and there were no control measures identified.<br><br>2. Review of the facility's P&P titled Infection Control Plan Program revised 3/2021 showed the facility shall establish an infection control committee which will oversee and implement the plan of the infection control program. The infection control committee will establish policies and procedures for the investigation, control, and prevention of transmission of disease and infections within the facility. The infection control committee will consist of at least the following: Medical Director, Administrator, Director of Nursing, Infection Control Nurse, Dietary, Housekeeping/Maintenance.<br><br>Review of the facility document titled Garden Grove Convalescent Quarterly Infection Control Committee Minutes Attendance Sheet dated 5/2, 9/4, and 12/10/24, showed the signatures of the IP, Housekeeping/Laundry, Dietary, Maintenance, DON, and MD. However, there was no signature of attendance from the Administrator for all of the above listed quarterly meetings.<br><br>On 3/6/25 at 1001 hours, an interview and concurrent facility document review was conducted with the DSD and IP. The DSD stated their previous IP had resigned and he was covering until the new IP started. The DSD stated the facility's new IP had started yesterday. The DSD stated the IP attended the infection control committee meeting every quarter and they would review the facility's use of antibiotics and new updates and changes to the infection control program. When asked if the Administrator attended the infection control committee quarterly meetings, the DSD verified there was no Administrator who attended the quarterly meetings for 5/2024, 9/2024, and 12/2024. The DSD stated the Administrator would sometimes just attend the QA meeting but not the infection control committee meeting.<br><br>On 3/10/25 at 1321 hours, the Administrator and DON acknowledged the above findings.<br><br>3. Review of the facility's P&P titled Hand Hygiene Program dated 9/2010 showed the indications for performing hand hygiene, including before handling clean linen, after disposal of soiled linen, and after touching items that are likely to be contaminated (bedpans, urinals).<br><br>Review of the facility's P&P titled Laundry - Nursing P&P Manual revised 8/2016 showed linens are handled, stored, processed and transported in such a manner as to prevent the spread of infection<br><br>Review of the facility's P&P titled Laundry Department - Post in Laundry, P&P Manual and Use for Training revised 8/2016 showed careful precautionary procedures must be followed by laundry personnel for handling, storing, processing and transporting linens to prevent the spread of infectious diseases to other staff members, residents and visitors. All soiled linen is considered potentially infectious. Wash hands each time soiled linen is handled.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/6/25 at 0840 hours, an observation and concurrent interview was conducted with the Laundry Attendant. The Laundry Attendant walked through the dirty linen area and touched the soiled linen barrels and bag of dirty linens. The Laundry Attendant then entered the clean linen area and proceeded to touch the clean linens without performing hand hygiene. The Laundry Attendant then opened the buckets for clean linen storage, and there were the soap opener and scissors stored with the clean linens. The Laundry Attendant stated they should not be stored there. The Laundry Attendant then was asked about the facility's dryers. The Laundry Attendant stated she cleaned the lint every two hours, went outside, and brought a broom and pan into the clean linen area. The Laundry Attendant then proceeded to sweep the lint from the dryer. The Laundry Attendant then touched the clean towels from one of the dryers and restarted the machine. When asked when she should perform hand hygiene, the Laundry Attendant stated she should perform hand hygiene after sorting the dirty linens and verified she did not perform hand hygiene after touching the soiled linen barrels and prior to touching the clean linens.<br><br>On 3/10/25 at 1037 hours, an interview was conducted with the DSD. The DSD stated the laundry staff should perform hand hygiene every time they touched the dirty contaminated linens and if going from the dirty area, before going to the clean area. The DSD was informed of the findings and stated he would need to do a one-to-one in-service with the Laundry Attendant. The DSD stated the soap opener should have been stored in the dirty area.<br><br>49644<br><br>4. Review of the facility's P&P titled Enhanced Standard Precautions revised 5/2024, showed the EBP is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of staphylococcus aureus (a common bacterium found in the nose or on the skin of about 30% of people) and MDRO's. The EBP recommendations now include use of the EBP for the residents with chronic wounds, indwelling medical devices, during high-contact resident care activities regardless of their multiple-drug organism status.<br><br>Review of the EBP signage revised 9/9/24, showed everyone must clean hands on room entry and when exiting. Providers and staff must also wear gloves and gowns for the high-contact resident care activities below:<br><br>1. Activities of daily living (dressing, grooming, bathing, bathing, changing bed linens, feeding).<br><br>2. Toileting and changing incontinence briefs.<br><br>3. Caring for devices and giving medical treatments.<br><br>4. Wound Care.<br><br>5. Mobility assistance and preparing to leave room.<br><br>6. Cleaning the environment.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/6/25 at 1153 hours, during a medication administration observation, LVN 8 was observed donning gloves before checking Resident 645's blood sugar level. However, there was an EBP signage before entering Resident 645's room and LVN 8 did not don a gown before checking Resident 645's blood sugar level.<br><br>Medical record review was initiated for Resident 645 on 3/6/25. Resident 645 was admitted to the facility on [DATE].<br><br>Review of Resident 645's Order Summary Report for 3/12/25, showed a physician's order dated 2/27/25, for EBP due to presence of open wound.<br><br>On 3/6/25 at 1202 hours, an interview was conducted with LVN 8. LVN 8 verified Resident 645 was on the EBP and she did not wear gown when she went into the room to check Resident 645's blood sugar level. LVN 8 stated she should have worn the gown and gloves before checking the blood sugar level because the resident was on the EBP and to prevent infection.<br><br>On 3/7/25 at 1345 hours, an interview was conducted with the DSD. The DSD stated he was covering for the IP because the previous IP resigned last week and the facility just hired another IP. The DSD acknowledged the above findings. The DSD stated the LVN should have worn the PPE before providing patient care and contact care. The DSD stated the LVN should have worn the PPE since the LVN had contact with the resident.<br><br>On 3/7/25 at 1645 hours, the Administrator and DON were informed and acknowledged the above findings.<br><br>48882<br><br>5. On 3/5/25 at 0959 hours, an observation was conducted outside of Resident 745's room. The signage outside of Resident 745's room showed to perform EBP for the resident in Bed A (Resident 745 was in Bed B). Additionally, the EBP sign showed the providers and staff must also wear the gloves and gown for the high contact resident care activities as follows: activities of daily living, toileting and changing incontinence briefs, caring for device and medical treatments, wound care, mobility assistance and preparing to leave the room, and cleaning the environment. Resident 745 was observed in bed with the right upper arm PICC.<br><br>Medical record review for Resident 745 was initiated on 3/5/25. Resident 745 was admitted to the facility on [DATE] with a diagnosis of perforated gastric ulcer.<br><br>Review of Resident 745's H&P examination dated 3/2/25, showed Resident 745 had fluctuating capacity to understand and make decisions.<br><br>Review of Resident 745's Order Summary Report dated 3/6/25, showed the following physician's orders:<br><br>- dated 3/1/25, to administer piperacillin sodium-tazobactam sodium solution (antibiotic medication) 3.375 gm intravenously every six hours for infection of the perforated ulcer status post sepsis for 10 days,<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - dated 3/1/25, for the mid abdomen surgical incision, to cleanse with normal saline, pat dry, and apply the xeroform (non-adherent dressing) gauze, and cover with an abdominal pad and dry dressing for 30 days, every day shift,<br><br>- dated 3/5/25, for the left lower quadrant open wound, to cleanse with normal saline, pat dry and apply the calcium alginate (water-in-soluble dressing to absord excess moisture) and cover with a dry dressing for 30 days, every day shift.<br><br>Further review of Resident 745's Order Summary Report failed to show a physician's order for the EBP for Resident 745.<br><br>Review of Resident 745's medical record failed to show a care plan for the EBP related to Resident 745's PICC and abdominal wounds.<br><br>On 3/6/25 at 0814 hours, an observation was conducted outside of Resident 745's room. The EBP sign only showed to perform EBP for the resident in Bed A (the sign did not include to perform EBP for Resident 745).<br><br>On 3/6/25 at 1450 hours, an interview was conducted with CNA 4. CNA 4 was asked how she was informed which resident needed to be on special isolation or precautions. CNA 4 stated she looked at the signage at the residents' doors. CNA 4 stated the sign would indicate which resident, in which bed was on isolation or precaution. CNA 4 verified Resident 745 had the PICC line and wounds. When asked if Resident 745 had any isolation precautions, CNA 4 checked the signage outside of Resident 745's room and stated the sign only showed to perform EBP for the resident in Bed A.<br><br>On 3/6/25 at 1500 hours, an interview and concurrent medical record for Resident 745 was conducted with LVN 8. LVN 8 stated Resident 745 was currently receiving antibiotics via his PICC line and wound treatments for his perforated abdomen. When asked, LVN 8 stated the EBP was ordered for the residents with wounds, indwelling urinary foley catheter, GT, or IV lines. LVN 8 reviewed Resident 745's medical record and verified Resident 745 had no order for the the EBP. LVN 8 stated Resident 745 should be on the EBP due to his PICC line and abdominal wounds.<br><br>On 3/10/25 at 0810 hours, a concurrent observation and interview was conducted with LVN 8. Resident 745 was observed standing over a walker inside his room by the restroom door. A staff member was observed assisting Resident 745 from the restroom door to his bed. The staff member was observed touching Resident 745 and was not observed wearing a gown. LVN 8 verified the above findings. LVN 8 also verified the signage on the door still did not include Resident 745 for the EBP. LVN 8 stated there was not a physician's order to place Resident 745 on the EBP.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/10/25 at 1007 hours, an interview and concurrent medical record review for Resident 745 was conducted with the IP. The IP nurse stated the EBP was initiated for the residents who had the central lines, pressure wounds, and open wounds. The IP further stated when the staff were entering the room of the residents who were on the EBP to provide care, the staff should don the gown and gloves to minimize the transmission of organisms to other residents. When asked how the EBP was communicated to the staff, the IP stated the signage on the resident's doors would show the room and bed of the resident currently on the EBP. When asked about Resident 745, the IP stated Resident 745 was admitted to the facility with the PICC line and abdominal wounds. The IP nurse verified Resident 745 was not placed on the EBP. The IP further stated the admitting nurse should have placed Resident 745 on the EBP upon admission.<br><br>On 3/10/25 at 1319 hours, the DON, Administrator, and Nurse Consultant were informed and acknowledged the above findings.<br><br>50953<br><br>6. Medical Record Review of Resident 696 was initiated on 3/5/25. Resident 696 was admitted to the facility on [DATE], and readmitted on [DATE]<br><br>Review of Resident 696's Order Summary Report showed an order dated 2/25/25, for EBP due to presence of pressure injury.<br><br>Review of Resident 696's H&P examination dated 2/25/25, showed, Resident 696 had no capacity to understand and make decisions.<br><br>On 3/5/25 at 0908 hours, during the initial tour of the facility, room [ROOM NUMBER] had a sign showing the resident was on the EBP. The sign further showed clean hands on room entry and when exiting, providers and staff must also wear gloves and gowns for the high-contact resident care activities as follow:<br><br>1. Activities of daily living (dressing, grooming, bathing, bathing, changing bed linens, feeding).<br><br>2. Toileting and changing incontinence<br><br>3. Caring for devices & giving medical treatments.<br><br>4. Wound Care.<br><br>5. Mobility assistance & preparing to leave room.<br><br>6. Cleaning the environment.<br><br>On 3/6/25 at 0810 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 was feeding Resident 696 and was not wearing a gown or gloves. CNA 1 verified they did not wear a gown or gloves while feeding Resident 696.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 3/6/25 at 0819 hours, an observation, interview, and concurrent medical record review was conducted with the IP. The IP verified Resident 696 was on the EBP for the pressure injury and stated all the staff needed to use the gown and gloves when performing ADL care to all the resident on the EBP. The IP verified CNA 1 did not use proper PPE when feeding Resident 696.<br><br>On 3/10/25 at 1102 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056145 | A. Building<br>B. Wing | 03/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Garden Grove Post Acute | 12882 Shackelford Lane<br>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 0883<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476<br><br>Based on interview and medical record review, the facility failed to ensure the influenza vaccine (a vaccine which provides immunity to a variety of influenza viruses) was consented to be provided to one of five final sampled residents reviewed for vaccinations (Resident 38).<br><br>* Resident 38 was administered the influenza vaccine on 9/20/24. There was no informed consent from Resident 38's responsible party for the influenza vaccine to be administered to Resident 38. This failure had the potential for violating Resident 38's right to refuse the vaccine.<br><br>Findings:<br><br>Review of the facility's P&P titled Flu (Influenza) Vaccination for Residents revised 1/2024 showed to obtain written, informed consent from the resident or their decision maker prior to administration.<br><br>Medical record review for Resident 38 was initiated on 3/5/25. Resident 38 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 38's IDT Progress Note dated 9/20/24, showed Resident 38 received the influenza vaccine intramuscularly 0.5 ml to the left deltoid.<br><br>Review of Resident 38's H&P examination form dated 12/22/24, showed Resident 38 could make his needs known but could not make medical decisions.<br><br>Further review of Resident 38's medical record failed to show an informed consent was obtained from Resident 38's responsible party to administer the influenza vaccine for the 2024 - 2025 influenza season.<br><br>On 3/10/25 at 1037 hours, a concurrent interview and medical record review was conducted with the DSD. The DSD verified Resident 38 had received the influenza vaccine on 9/20/24, and no informed consent from Resident 38's responsible party prior to the facility administering the vaccine to the resident. The DSD stated they needed to ask for the informed consent prior to administering the influenza vaccine.<br><br>On 3/10/25 at 1321 hours, the Administrator and DON acknowledged the above findings. |