STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555093	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Edna Subacute and Rehabilitation Center	1929 N. Fairview Street Santa Ana, CA 92706

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to develop and implement an individualized care plan for one of two sampled residents (Resident 1). * The facility failed to develop and implement an accurate care plan for Resident 1 to address the use of a PICC line. This failure posed the risk for Resident 1 having developed complications associated with the PICC. Findings: Review of the facility's P&P titled Comprehensive Care Plan dated 12/2017 showed it is the policy of the facility to develop, in conjunction with the resident and resident representative, the comprehensive resident care plan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life. The care plan becomes a comprehensive tool for the IDT to utilize as a reference for identified concerns and approaches to establish guidance for meeting resident individual needs. Medical record review for Resident 1 was initiated on 8/19/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's medical record showed Resident 1 was admitted to the facility with a PICC line located on his right upper arm. Review of Resident 1's H&P examination dated 7/3/24, showed Resident 1 had the right upper arm PICC with slight swelling. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 1532 hours, an interview and concurrent medical record review was conducted with RN 2. Review of Resident 1's care plan title Potential for Infection related to the right upper arm PICC line, initiated by RN 2 on 7/5/24, showed to change the catheter site dressing as ordered and to measure the PICC line external catheter length and upper arm circumference as ordered. RN 2 reviewed Resident 1's medical record and verified the facility failed to obtain an order to change Resident 1's catheter site dressing and to measure the PICC external catheter length and upper arm circumference. RN 2 verified Resident 1's medical record also failed to show documentation the resident's catheter site dressing was changed and failed to show documentation measurements were obtained specific to his PICC external catheter length and upper arm circumference, while Resident 1 resided in the facility (from 7/3/24 through 7/7/24). Cross reference to F694.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the PICC line assessments were conducted and documented, failed to ensure the PICC unused lumens were flushed, and failed to conduct and document a change of condition assessment for the resident who exhibited pain and swelling at the PICC site for one of two sampled residents (Resident 1). These failures posed the risk for not identifying and treating potential complications associated with the PICC line, as evidenced by Resident 1 having sustained an occlusive right axillary deep vein thrombosis. Findings: Review of the facility's P&P titled Central Access Guidelines and Procedures (undated) showed an occlusive dressing shall be maintained over the central venous access site at all times. The PICC dressings shall be changed every seven days from date of insertion. The PICC catheter dressing changes shall be done every seven days and as needed. Document the (resident's) arm circumference in centimeters on the treatment record prior to dressing change, (and) compare to measurement from admission. Also document the arm circumference after dressing change is complete. The arm circumference should be measured 8-10 centimeters above the antecubital. Assess the device insertion site, and observe for the following: skin breakdown, bleeding or exudate at insertion site, erythema, redness, swelling, leaking connections, and note the amount of the catheter from the insertion site. Review of the facility's P&P titled Change of Condition dated 2016 showed the purpose of the Change of Condition policy is to appropriately assess, document, and communicate changes of condition to the primary care provider. To provide treatment and services to address changes in accordance with resident needs. Procedure includes to document assessment findings and communications as soon as practical. To notify the resident and/or responsible party of current status and subsequent actions/orders. 1. Medical record review for Resident 1 was initiated on 8/19/24. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 7/7/24. Review of Resident 1's medical record showed Resident 1 was admitted to the facility with a PICC located on his right upper arm. Review of Resident 1's H&P examination dated 7/3/24, showed Resident 1 had a right upper arm PICC with slight swelling. Review of Resident 1's care plan problem titled Potential for Infection related to right upper extremity PICC line initiated 7/5/24, showed Resident 1 would have no signs and symptoms of IV related complications. The interventions included to change the catheter site dressing and to measure the PICC external catheter length and upper arm circumference as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 1355 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked to describe the facility protocol for caring for a resident admitted to the facility with a PICC. RN 1 stated upon admission to the facility a baseline assessment of the PICC site was conducted, which was then documented in the resident's medical record. RN 1 stated the baseline assessment consisted of an assessment of the PICC insertion site, which included the observation for the following: skin breakdown, bleeding at the insertion site, erythema, swelling, and pain. RN 1 stated thereafter, the PICC insertion site was assessed every shift by a licensed nurse and documented in the resident's medical record. Additionally, RN 1 stated the baseline assessment included obtaining a measurement of the resident's arm circumference. RN 1 stated subsequent measurements of the resident's arm circumference were then compared to the baseline measurement to detect possible catheter associated venous thrombosis. RN 1 stated the arm circumference measurements were documented in the resident's medical record. Furthermore, RN 1 stated a measurement of the PICC external catheter length was obtained upon admission. RN 1 stated subsequent measurements were then compared to the baseline measurement to ensure the PICC line remained in place. Finally, RN 1 stated the unused PICC lumens were to be flushed at a minimum every 12 hours, which was documented in the resident's medical record. RN 1 was then asked to review Resident 1's medical record specific to the assessment and maintenance of Resident 1's right upper arm PICC line. RN 1 was asked to show documentation the facility implemented the protocol (in which RN 1 described) for Resident 1's right upper arm PICC line. RN 1 reviewed Resident 1's medical record and verified Resident 1's medical record failed to contain documentation for the measurements of Resident 1's arm circumference and PICC external catheter length, failed to show documentation for Resident 1's PICC insertion site assessments (every shift), and failed to show documentation for Resident 1's unused PICC lumens having been flushed by nursing staff. RN 1 was asked if she remembered the condition of Resident 1's right upper arm while he resided at the facility, to which RN 1 replied, she could not. On 8/21/24 at 1357 hours, an interview and concurrent medical record review was conducted with the DON. The DON was asked to describe the facility process for caring for a resident admitted to the facility with a PICC line. The DON stated the following: upon admission to the facility, a baseline assessment of the PICC site would be conducted and documented in the resident's medical record. The baseline assessment consisted of an assessment of the PICC insertion site, which included the observation for the following: skin breakdown, bleeding at the insertion site, erythema, swelling, and pain. Thereafter, the PICC insertion site would be assessed every shift by a licensed nurse. The baseline assessment included obtaining a measurement of the resident's arm circumference. Subsequent measurements of the resident's arm circumference would be then compared to the baseline measurement to detect possible catheter associated venous thrombosis. The arm circumference measurements were documented in the resident's medical record. A measurement of the PICC external catheter length was obtained upon admission. Subsequent measurements would be then compared to the baseline measurement to ensure the PICC line remained in place. Unused PICC lumens were to be flushed at a minimum every 12 hours, which would be documented in the resident's medical record. The DON reviewed Resident 1's medical record and verified Resident 1's medical record failed to contain documentation for the following: measurements of Resident 1's arm circumference, the PICC external catheter length measurements, PICC insertion site assessments (every shift), and unused PICC lumens having been flushed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's medical record showed a Radiology Report dated 7/7/24 at 1431 hours. The Radiology Report showed an ultrasound scan of the veins of Resident 1's upper extremity with Doppler flow was performed, which showed Resident 1 was positive for occlusive right axillary deep vein thrombosis. Review of Resident 1's Alert Note dated 7/7/24 at 1713 hours, showed Resident 1 was noted with right arm redness and edema. Per Resident 1's Responsible Party, Resident 1's arm had tripled in size with notable edema since being seen Friday by the physician. Resident 1 expressed pain when his arm was moved and noted tender to touch. Resident 1's arm was noted with redness and (Resident 1's) respiratory rate was 30 (breaths per minute) on 3 liters of oxygen via nasal canula. Resident 1 also expressed having a headache. Resident 1's Responsible Party at the bedside and requested Resident 1 be sent to Acute Care Hospital 1 for further evaluation. Review of Resident 1's General Note dated 7/8/24 at 0458 hours, showed the facility followed up with Acute Care Hospital 1 and was informed Resident 1 would be admitted to Acute Care Hospital 1 with a diagnosis of pulmonary embolism. 2. On 8/19/24 at 1450 hours, an interview and concurrent medical record review was conducted with LVN 2. Review of Resident 1's General Note dated 7/5/24 at 1231 hours, showed LVN 2 documented having obtained and order for a Doppler to be performed on Resident 1. Review of Resident 1's Radiology Interpretation dated 7/7/24, showed and ultrasound scan of the veins of Resident 1's right upper extremity with Doppler flow was performed for pain in Resident 1's right arm. LVN 2 was asked to describe the circumstances specific to having obtained the Doppler order for Resident 1. LVN 2 stated Resident 1's family member said Resident 1's right arm was swollen, and Resident 1 had complained of pain. Further review or Resident 1's medical record failed to show documentation of a change of condition assessment was performed by the licensed nursing staff, specific to Resident 1's complaint of pain in his right arm. LVN 2 verified the findings. LVN 2 stated a licensed nurse should have conducted and documented an assessment, specific to Resident 1's family member having reported Resident 1 had pain and swelling to his right arm (site of PICC). On 8/21/24 at 1357 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified LVN 2 obtained an order on 7/5/24, for an ultrasound scan of the veins of Resident 1's right upper extremity with Doppler flow. The DON verified the Radiology Interpretation dated 7/7/24, showed Resident 1 had a history of pain in the right arm. The DON verified Resident 1's medical record failed to show documentation of a change of condition assessment was performed by the licensed nursing staff, specific to Resident 1's complaint of pain in his right arm, on 7/5/25 at 1231 hours (the time in which LVN 2 documented she obtained the order for the ultrasound scan of the veins of Resident 1's right upper extremity with Doppler flow, for Resident 1's complaint of pain). Cross reference to F656.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure Resident 1's medications were administered as ordered for one of two sampled residents (Resident 1). * Resident 1 did not receive the following medications as ordered by the physician due to a lack of availability: enoxaparin sodium (medication to prevent blood clots), levetiracetam (anti-seizure medication), desmopressin acetate (medication to treat cranial diabetes insipidus), and methocarbamol (muscle relaxant medication). * The facility failed to notify Resident 1's physician when Resident 1 did not receive his medications as ordered as per the facility's P&P. These failures posed the risk for negative health outcomes to Resident 1. Findings: Review of the facility's P&P titled Medication Administration dated 5/2022 showed the medications are administered as prescribed in accordance with written orders of the prescriber. Medications are administered without necessary interruptions. Medications are administered within 60 minutes of scheduled time. Review of the facility's P&P titled Unavailable Medications dated 5/2022 showed the medications used by the residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. The nursing staff shall notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy that is available. Medical record review for Resident 1 was initiated on 8/19/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the physician's orders for the following medications: * enoxaparin sodium 120 mg/0.8 ml subcutaneous injection every 12 hours for DVT prophylaxis, dated 7/3/24. * levetiracetam 1000 mg orally twice a day for seizures, dated 7/3/24. * desmopressin acetate 20 mcg nasal solution twice per day for central cranial diabetes insipidus dated 7/4/24. * methocarbamol 250 mg orally three times a day for muscle spasm, dated 7/3/24. Review of Resident 1's Medication Administration Record dated July 2024 showed documentation the following medications were not administered on the following dates and times due to a lack of availability: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* enoxaparin sodium 120 mg/0.8 ml subcutaneous injection was not administered on 7/4 and 7/5/24 at 0900 hours. * levetiracetam 1000 mg orally was not administered on 7/4/24 at 0900 hours. * desmopressin acetate 20 mcg nasal solution was not administered on 7/4 and 7/5/24 at 0900 hours. * methocarbamol 250 mg orally was not administered on 7/4/24 at 0900 and 1300 hours. Further review of Resident 1's medical record failed to show documentation Resident 1's physician was notified when Resident 1 did not receive his medications as ordered by the physician due to a lack of medication availability. On 8/19/24 at 1504 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated she cared for and administered Resident 1's medications on 7/4 and 7/5/24, during the morning shift (0700 to 1500 hours). LVN 1 verified she documented she was unable to administer the following medications for Resident 1 due to a lack of medication availability: * enoxaparin sodium 120 mg/0.8 ml subcutaneous injection on 7/4 and 7/5/24 at 0900 hours. * levetiracetam 1000 mg orally on 7/4/24 at 0900 hours. * desmopressin acetate 20 mcg nasal solution on 7/4 and 7/5/24 at 0900 hours. * methocarbamol 250 mg orally was not administered on 7/4/24 at 0900 and 1300 hours. LVN 1 was asked if she notified Resident 1's physician when Resident 1 did not receive his ordered medications due to a lack of medication availability. LVN 1 stated she had not notified Resident 1's physician. LVN 1 stated she should have informed Resident 1's physician to ensure the physician was aware of any potential complications associated with Resident 1 not having received his medications as ordered. On 8/22/24 at 1330 hours, an interview was conducted with Physician 1. Physician 1 was asked if the facility notified him of Resident 1 had not received his ordered enoxaparin sodium 120 mg/0.8 ml subcutaneous injection, levetiracetam 1000 mg orally, desmopressin acetate 20 mcg nasal solution, and methocarbamol 250 mg orally. Physician 1 stated the facility had not notified him of Resident 1 having not received these medications. Physician 1 stated his expectation was the facility would notify him if Resident 1 did not receive his medications as ordered, to allow for treatment decisions.