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	05/13/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the physician's order for code status matched the resident's POLST DNR status for one of seven final sampled residents (Resident 102) reviewed for advanced directives. * Resident 102 had a DNR status selected on the POLST signed by Resident 102's responsible party; however, the facility failed to ensure there was a physician's order for Resident 102's code status. This failure had the potential for not honoring the Resident 102's responsible party wishes and providing unwanted life sustaining interventions. Findings: Review of the facility's P&P titled Promoting the Right of Self-Determination for Healthcare Decisions and Advanced Healthcare Directives dated ,d+[DATE] showed the staff should document in the medical chart, the existence of an advance directive, living will and/or standing physician order form (POLST). The staff should review the documents for completeness and confirm with the resident and/or legal healthcare decision maker that the documents are current and have not been revoked or superseded by subsequent documents. The staff should notify the resident's treating physician of current or changes to the advance directives or verbally expressed healthcare and treatment wishes, so that appropriate orders can be obtained and documented in the resident's plan of care. The physician must 'sign' all order to withhold treatment or withdraw life sustain treatment. The orders may not be carried out by the facility until the order has been 'signed', telephone orders for withholding treatment or to withdraw life sustaining treatment are not permitted. Medical record review for Resident 102 was initiated on [DATE]. Resident 102 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 102's H&P examination dated [DATE], showed Resident 102 had no capacity to understand and make decisions, and Resident 102's code status was DNR. Review of Resident 102's POLST dated [DATE], showed Resident 102's responsible party selected treatment as Do Not Attempt Resuscitation/DNR, and to allow a natural death. The form was signed by Resident 102's responsible party on [DATE], and signed by the physician on [DATE], 55 days after the form was signed by the resident's reponsible party. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1541 hours, an interview and concurrent medical record review for Resident 102 was conducted with the SSD. The SSD stated every resident should have a physician's order with the code status. The SSD stated if the resident did not have a physician's order for the code status, the licensed nurse was responsible for contacting the physician. The SSD reviewed Resident 102's POLST form and stated Resident 102's responsible party had signed Resident 102's POLST on [DATE], and chose DNR. The SSD verified the above findings. Review of Resident 102's Order Summary Report showed a physician's order dated [DATE], for DNR, Comfort Measures. On [DATE] at 1437 hours, an interview was conducted with the DON. The DON stated the purpose of the POLST form was to provide directions to the nursing staff on how to respond in the event of emergency. If the POLST form was not signed or completed, the resident was considered a full code (prolonging life by all medically effective means); thus, in the event of an emergency, CPR would be attempted. Additionally, the DON stated all the residents should have a physician's order for the code status. If there was no physician's order for the code status, the resident would be considered a full code. The DON stated if the POLST form was signed by the resident's responsible party, the facility should follow-up to obtain the physician's signature as soon as possible. The DON stated the POLST must be signed by the physician to be effective. The DON stated if the physician would not be in the facility to sign the POLST form, the form could be faxed to the physician to sign as soon as possible. On [DATE] at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation and interview, the facility failed to maintain a homelike environment for one nonsampled resident (Resident 86). * Resident 86 resided in Room A. Resident 86 was observed sitting on his bed eating breakfast. A live pest (later identified as a water bug or roach) was observed on top of Resident 86's bed linen, next to Resident 86. This failure had the potential to negatively impact the resident's quality of life. Findings: Medical record review for Resident 86 was initiated on 5/7/25. Resident 86 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/12/25 at 0750 hours, an observation and concurrent interview was conducted with Resident 86 and CNA 10. Resident 86 was observed sitting on his bed eating breakfast. A live water bug/roach was observed on top of Resident 86's bed linen, next to Resident 86. CNA 10 verified the findings and then attempted to remove the bug/roach from Resident 86's bed, at which time the water bug/roach moved onto the floor. CNA 10 then stepped on the water bug/roach. Resident 86 was asked how the incident made him feel. Resident 86 stated he preferred no pests on his bed while eating. On 5/12/25 at 1500 hours, an interview and concurrent photographic review was conducted with the Pest Control Technician (from Pest Control Company 1). The Pest Control Technician arrived at the facility to conduct an inspection of Room A. The Pest Control Technician was shown a photograph of the pest that was observed on Resident 86's bed linen. The Pest Control Technician identified the pest as either a water bug or roach. The Pest Control Technician stated he placed pest monitors and applied pest gel throughout Room A.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview, medical record review,and facility P&P review the facility failed to ensure three of five final sampled residents (Residents 23, 59, and 112) reviewed for unnecessary medications were free from unnecessary medications. * The facility failed to ensure Resident 112 was monitored accurately for orthostatic hypotension as ordered by the physician for the use of risperidone (antipsychotic). In addition, the facility failed to implement nonpharmacological interventions prior to the use of the mirtazapine (antidepressant) medication and failed to ensure monitoring for the side effects of the mirtazapine medication. * The facility failed to ensure Resident 23's orthostatic blood pressures were accurately monitored for the use of the Seroquel (antipsychotic) medication. * The facility failed to ensure Resident 59's prescription for zolpidem tartrate (sedative-hypnotic) had documentation of the physician's clinical rationale when the PRN order was extended beyond 14 days. This failure had the potential to negatively impact the Resident 59's well-being from the continued use of the zolpidem tartrate medication. These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of psychotropic medication. Findings: Review of the facility's P&P titled Psychotropic Medication Management dated November 2017 showed clinically necessary PRN psychotropic drug orders are limited to 14 days. If the prescribing practitioner determines a need for continued PRN use beyond the original 14 days, it is accompanied by supporting documentation in the electronic health record (EHR) including the rationale for continued use and duration; and Review of the facility's P&P titled Use of Psychotropic Medication, revised 8/2024 showed the residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The Policy Explanation and Compliance Guidelines section of the P&P showed in part, the following: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants anti-anxiety, and hypnotics. 4. The indications for use of any psychotropic drug should be documented in the medical record. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. For psychotropic drugs that are initiated after the admission to the facility, documentation shall include the specific condition as diagnosed by the physician. ii. Non-pharmacological interventions that have been attempted and the target symptoms for monitoring shall be included in the documentation. 1. Medical record review for Resident 112 was initiated on 5/7/25. Resident 110 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 112's H&P examination dated 2/9/25, showed Resident 112 had a history of dementia and Schizophrenia. Further review of the H&P examination showed Resident 112 had no capacity to make medical decisions. a. Review of Resident 112's Order Summary Report dated 5/9/25, showed the following physician's orders: - dated 2/6/25, for risperidone oral tablet 0.25 mg one tablet by mouth in the morning for Schizophrenia manifested by paranoid delusional statements and physical aggression towards others, - dated 2/6/25, for risperidone oral tablet 0.25 mg two tablet by mouth at bedtime for Schizophrenia manifested by paranoid delusional statements and physical aggression towards others, - dated 2/7/25, to monitor for behavior for the use of risperidone medication for manifested by delusions/delusional statements and tally every shift, - dated 2/7/25, to monitor for antipsychotic medication side effects such as urinary retention, dry mouth, constipation, blurred vision, sedation, drowsiness, glaucoma (a group of eye disease that can cause vision loss and blindness), agranulocytosis (a life-threatening condition that involves having severely low levels of white blood cells), seizures, weight gain, diabetes, jaundice (as a yellow discoloration of the body tissue resulting from the accumulation of excess bilirubin), and Neuroleptic Malignant Syndrome (sudden onset of diffuse muscle rigidity, high fever, labile blood pressure, tremors, and notable cognitive dysfunction). - dated 2/7/25, to monitor for orthostatic BP lying down, sitting up, and standing up every week on Wednesday and notify MD if there is a systolic blood pressure drop of 20 mmHg or a diastolic blood pressure drop of 10 mmHg. Review of Resident 112's MARs for February through 5/11/25, showed the following: - Resident 112 was administered risperidone 0.25 mg one tablet by mouth at 0900 hours, from 2/7 to 2/28/25, 3/1 to 3/31/25, 4/1 to 4/30/25, and 5/1 to 5/11/25, and - Resident 112 was administered risperidone 0.25 mg two tablets by mouth at 2100 hours from 2/7 to 2/28/25, 3/1 to 3/31/25, 4/1 to 4/30/25, and 5/1 to 5/11/25, Further review of Resident 112's MARs for February through 5/11/25, showed the orthostatic BP (lying, sitting, and standing) were scheduled to be monitored every Wednesday. However, the BP readings for the three positions were the same as follows: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 2/12/25, the BP readings were 125/76 mmHg for the lying, sitting, and standing position. - on 2/19/25, the BP readings were 127/69 mmHg for the lying, sitting, and standing positions. - on 2/26/25, the BP readings were 121/69 mmHg for the lying, sitting, and standing position. - on 3/5/25, the BP readings were 123/83 mmHg for the sitting and standing position. - on 3/12/25, the BP readings were 105/68 mmHg for the lying, sitting, and standing position. - on 3/19/25, the BP readings were 134/78 mmHg for the lying, sitting, and standing position. - on 3/26/25, the BP readings were 138/84 mmHg for the lying, sitting, and standing position. - on 4/30/25, the BP readings were 127/52 mmHg for the lying, sitting, and standing position. - on 5/7/24, the BP readings were 122/65 mm Hg for the sitting and standing position. On 5/13/25 at 1116 hours, an interview and concurrent medical record review was conducted with the DON for Resident 112. The DON verified the above findings. The DON stated the orthostatic BP readings should not be the same for the lying, sitting, and standing position if the proper procedure was followed. b. Review of Resident 112's Order Summary Report dated 5/9/25, showed an order dated 2/11/25, for mirtazapine oral tablet 15 mg one tablet by mouth at bedtime for depression as manifested by poor appetite (less than 50% of meal intake). Further review of Resident 112's Order Summary Report dated 5/9/25, failed to show a physician's order to monitor for the antidepressant medication side effects related to the use of the mirtapizine medication. Review of Resident 112's medical record failed to show the nonpharmacological interventions which were attempted prior to the use of the mirtapizine medication. Review of Resident 112's MARs for February through 5/11/25, showed Resident 112 was administered mirtazapine 15 mg one tablet at 2100 hours, from 2/11 to 2/28, 3/1 to 3/31/25, 4/1 to 4/30/25, and 5/1 to 5/11/25. Further review of Resident 112's MARs for February through 5/11/25, failed to show Resident 112 was monitored for the adverse effects related to the use of the mirtazapine medication. On 5/12/25 at 1116 hours, an interview and concurrent medical record review was conducted with the DON for Resident 112. The DON verified the above findings. On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON were informed of and acknowledged the above findings. 48882 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 23 was initiated on 5/7/25. Resident 23 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 23's H&P examination dated 1/19/25, showed Resident 23 had no capacity to understand and make decisions. Review of Resident 23's Order Summary Report dated 5/9/25, showed the following physician's orders dated 4/4/25: - to monitor Resident 23's orthostatic BP sitting up every week on Wednesday, during the evening shift; and to notify the physician if there was a drop of 20 mmHg in the systolic BP, or a drop of 10 mmHg in the diastolic BP, - to monitor Resident 23's orthostatic BP lying down every week on Wednesday, during the evening shift; and to notify the physician if there was a drop of 20 mmHg in the systolic BP, or a drop of 10 mmHg in the diastolic BP, and - to administer Seroquel (antipsychotic) 25 mg by mouth two times a day for psychosis manifested by constant repetitive movements. Review of Resident 23's plan of care showed a care plan problem dated 4/8/25, addressing Resident 23's behavior problem of constant repetitive movements. The intervention included monitoring the orthostatic blood pressure as ordered. Review of Resident 23's MARs for April and May 2025 showed the following: - on 4/9/25, the BP readings were 126/52 mmHg for the sitting and lying position, - on 4/30/25, the BP readings were 125/62 mmHg for the sitting and lying position, and - on 5/17/25, the BP readings were 142/78 mmHg for the sitting and lying position. On 5/9/25 at 1057 hours, an interview and concurrent medical record review for Resident 23 was conducted with LVN 5. LVN 5 verified the above findings and stated the BP readings should not be the same for the different positions. On 5/12/25 at 1410 hours, an interview was conducted with the DON. The DON stated the residents on psychotropic medications should be monitored every shift for the side effects related to the use of the psychotropic medication, such as dizziness and orthostatic hypotension. The DON stated for the residents prescribed the antipsychotic medication, there should be a physician's order to monitor the resident for orthostatic hypotension. The DON further stated the monitoring for orthostatic hypotension was done by obtaining the resident's BP in different positions. The DON stated after the licensed nurse obtained the resident's BP readings in the different positions, the licensed nurse was expected to compare the BP readings and determine if there was a drop in the BP, which would indicate orthostatic hypotension. The DON stated the orthostatic BP readings should not be the same for the different positions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 52238 3. Medical record review for Resident 59 was initiated on 5/8/25. Resident 59 was initially admitted to the facility on [DATE]. Review of Resident 59's H&P examination dated 1/2/25, showed Resident 59 had capacity to understand and make decisions. Review of Resident 59's medical record showed the following physician's orders for zolpidem tartrate medication: - dated 4/12/25, to administer ambien oral tablet 5 mg (zolpidem tartrate) one tablet by mouth as needed for inability to sleep, give at bedtime; - dated 4/17/25, to administer ambien oral tablet 5 mg (zolpidem tartrate) one tablet by mouth as needed for inability to sleep until 4/26/25 at 2359 hours, give at bedtime (trial total 14 days from 4/12/25); - dated 4/26/25, to administer zolpidem tartrate tablet 10 mg one tablet by mouth as needed for inability to sleep for 14 days, give at bedtime; and - dated 5/11/25, to administer zolpidem tartrate tablet 10 mg one tablet by mouth as needed for inability to sleep for 14 days, give at bedtime. Further review of Resident 59's medical record did not show documentation of the clinical rationale from the prescribing physician when the use of zolpidem medication was extended and ordered on 4/12, 4/17, 4/26, and on 5/11 to 5/25/25. On 5/13/25 at 1242 hours, an interview and medical record review for Resident 59 was conducted with the DON. The DON verified Resident 59 had the physician's order for the zolpidem tartrate medication, and the initial order was on 4/12/25. The DON verified Resident 59 also had the physician's orders for zolpidem tartrate medication from 4/17 to 4/26/25, 4/26 to 5/10/25, and 5/11 to 5/25/25. The DON was not able to show documented evidence of the clinical rationale from the physician when the PRN order for the zolpidem tartrate was renewed after the initial order on 4/12/25.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview and medical record review, the facility failed to ensure the coded MDS assessment was accurate for two of 30 final sampled residents reviewed for the MDS assessments (Residents 70 and 112). * Resident 112's MDS assessment was incorrectly coded for active diagnoses of hypertension (high blood pressure), hyponatremia (low sodium), and depression. In addition, Resident 112's MDS assessment was not coded to reflect the use of the antidepressant medication and was incorrectly coded to show the last attempted GDR for the use of antipsychotic medication on 2/6/25. * The facility failed to ensure Resident 70's MDS assessment Section I was accurately coded to include the resident's diagnoses of anxiety (disorder where intense feeling of worry and fear of everyday situations interfere with daily living) and depression (mood disorder). These failures had the potential for not providing necessary care and services to meet the care needs for these residents. Findings: 1. Medical record review for Resident 112 was initiated on 5/7/25. Resident 112 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 112's H&P examination dated 2/9/25, showed Resident 112 had no capacity to make medical decisions. a. Review of Resident 112's Order Summary Report showed a physician's order dated 2/6/25, for clonidine HCL oral tablet 0.1 mg one tablet by mouth every six hours as needed for hypertension when SBP greater than 160 mmHg. Review of Resident 112's MDS assessment dated [DATE], showed Resident 112 did not have an active diagnosis of hypertension. b. According to the Mayo Clinic, a normal blood sodium level is between 135 and 145 mEq/L (https://www.mayoclinic.org/diseases-conditions/hyponatremia/symptoms-causes/syc-20373711). Review of Resident 112's Order Summary Report showed a physician's orders dated 2/7/25, for sodium chloride (supplement) oral tablet 250 mg by mouth in the morning for supplement. Review of Resident 112's BMP laboratory blood results dated 2/21/25 and 3/31/25, showed the resident's sodium level of 132 mEq/L. Review of Resident 112's MDS assessment dated [DATE], failed to show the coding for an active diagnosis of hyponatremia. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	c. Review of Resident 112's Order Summary Report showed a physician's order dated 2/11/25, for mirtazapine (antidepressant) oral tablet 15 mg one tablet by mouth at bedtime for depression as manifested by poor appetite (less than 50% of meal intake). Review of Resident 112's MDS assessment dated [DATE], showed no coding for an active diagnosis of depression. Further review of Resident 112's MDS assessment showed the coding included Resident 112 received antidepressant medication. d. Review of Resident 112's MDS assessment dated [DATE], showed coding when the last date of the last attempted GDR for the use of the the resident's antipsychotic medication was on 2/6/25. Review of Resident 112's medical record failed to show documented evidence of the last attempted GDR on 2/6/25. On 5/9/25 at 1154 hours, an interview and concurrent medical record review was conducted with MDS Coordinator 1. MDS Coordinator 1 verified the above findings and stated the MDS assessment was coded incorrectly when it showed Resident 112 did not have a diagnosis of hypertension, hyponatremia, and depression. MDS Coordinator 1 stated for the hypertension diagnosis, Resident 112's physician's order for the clonidine medication might had been initiated while the resident was in the acute care hospital and the order was carried over to the facility without a medical indication. The MDS Coordinator stated he did not code Resident 112's MDS assessment to show a diagnosis of hyponatremia because Resident 112's laboratory results dated [DATE], showed a normal sodium level of 137 mEq/L. MDS Coordinator 1 reviewed Resident 112's MDS assessment dated [DATE], and verified the MDS was coded incorrectly when it showed Resident 112 had no active diagnosis of depression. MDS Coordinator 1 verified Resident 112 was readmitted to the facility on [DATE], and was coded incorrectly when it showed Resident 112's last GDR was 2/6/25. MDS Coordinator 1 stated Resident 112's physician's order for the risperidone medication upon readmission to the facility on [DATE], was different than the physician's order for the risperidone medication prior to Resident 112's transfer to the acute care hospital, and this might had been interpreted by the MDS staff as an attempted GDR. On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of and acknowledged the above findings. 47474 2. Medical record review for Resident 70 was initiated on 5/7/25. Resident 70 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 70's H&P examinations on 2/9/24 and 10/1/24, showed Resident 70 had a past medical history including anxiety disorder and major depressive disorder. Review of Resident 70's MDS assessment dated [DATE], showed Resident 70 had a BIMS score of 15, indicating cognitive intact. Further review of the assessment under Section I - Active Diagnoses failed to show documented evidence the anxiety or depression disorder was coded. Review of Resident 70's MDS assessment dated [DATE], showed Resident 70 had a BIMS score of 13, indicating cognitive intact. Further review of the assessment Section I - Active Diagnoses failed to show documented evidence anxiety or depression disorder was coded. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/12/25 at 1313 hours, an interview and concurrent medical record review was conducted with MDS Coordinator 1. MDS Coordinator 1 verified the above findings. MDS Coordinator 1 stated Section I of Resident 70's MDSs assessment should have been coded to include the diagnosis of anxiety and depression disorders as soon as the physician note indicated the new diagnoses or on the next MDS assessment. On 5/13/25 at 1230 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview and medical record review, the facility failed to coordinate an assessment with the PASARR program for one of two final sampled residents (Resident 70) reviewed for PASARR when the resident had a new diagnosis of anxiety and depression. This failure posed the risk for Resident 70 not receiving the necessary specialized services specific to treat mental illness. Findings: Medical record review for Resident 70 was initiated on 5/7/25. Resident 70 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 70's H&P examinations on 2/9/24 and 10/1/24, showed Resident 70 had a past medical history including anxiety disorder and major depressive disorder. Review of Resident 70's MDS assessment dated [DATE], showed Resident 70 had a BIMS score of 13. Review of Resident 70's PASARR Level I Screening dated 2/8/24 showed the facility marked no when the question asked does the individual have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia and/or schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance. Further review of Resident 70's PASARR failed to show a new PASARR was completed after the resident's new diagnoses of anxiety and depression disorder. Review of Resident 70's care plan titled Pre-Admission Screening Level I Results: Resident has a positive indication of mental illness/intellectual disability and requires Level I or Level II categorical review psychotic and/or psychosis (a type of mental illness) dated 2/9/24, showed interventions included any new diagnosis warrant a Level I or Level II is completed, and to complete Level I and Level II as needed and yearly review if required. On 5/12/25 at 1313 hours, an interview and concurrent medical record review was conducted with MDS Coordinator 1. MDS Coordinator 1 verified the above findings. MDS Coordinator 1 stated a new PASARR should have been submitted with the new diagnoses of anxiety and major depressive disorder. On 5/13/25 at 1230 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview and medical record review, the facility failed to ensure the Level I PASARR contained accurate information for one of two final sampled residents (Resident 15) reviewed for PASARR. * Resident 15 had the diagnoses of psychosis, schizophrenia, and anxiety disorder; however the Level I PASARR showed Resident 15 had no serious mental illness. This failure posed the risk for Resident 15's inappropriate placement in a long-term care nursing home when a PASARR Level II evaluation was not done. Findings: According to the DHCS, federal law requires all individuals seeking admission to a Medicaid Certified Nursing Facility to receive a Level I Screening. The Level I Screening identifies if an individual has a suspected MI or an Intellectual/Developmental Disability or related condition (ID/DD/RC). If MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services. This process is known as the PASARR. Medical record review for Resident 15 was initiated on 5/7/25. Resident 15 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of unspecified psychosis, schizophrenia, and anxiety disorder. Review of Resident 15's H&P examination dated 10/22/24, showed Resident 15 had no capacity to make medical decisions. Review of Resident 15's PASARRLevel I Screening dated 7/28/23, showed Resident 15 had no diagnosis of serious mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia, or symptoms of psychosis, delusions, and/or mood disturbance. The form showed the Level I screening was negative and Level II evaluation was not required. On 5/8/25 at 1507 hours, an interview and concurrent medical record review for Resident 15 was conducted with MDS Coordinator 1. MDS Coordinator 1 stated the PASARR Screening was a tool used to screen and evaluate residents with serious mental disorders and/or intellectual disabilities or neurological conditions. MDS Coordinator 1 stated the purpose of the screening was to ensure those residents were placed in the proper setting. MDS Coordinator 1 reviewed Resident 15's medical record and verified the above findings. MDS Coordinator 1 stated Resident 15's PASARR Level I Screening was inaccurate. On 5/13/25 at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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 document review, the facility failed to ensure a comprehensive care plan was developed for one of 30 final sampled residents (Resident 49). * The facility failed to develop a care plan specific to Resident 49's ability to leave the facility (physician's out on pass order). This failure placed the resident at risk for not being provided appropriate, consistent, and individualized care. Findings: Medical record review for Resident 49 was initiated on 5/7/25. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's Order Summary Report showed the following physician's orders: - dated 10/4/21, for Resident 49 to go out on pass (leave the facility) for up to four hours. - dated 11/6/24, Resident 49 could go out on pass with his responsible party. Review of Resident 49's medical record failed to show the name or contact information for Resident 49's responsible party. Review of the facility's Release of Responsibility for leave of absence log showed on 5/7/25 at 1030 hours, Resident 49 was out of the facility, out on pass in the city of Anaheim. On 5/7/25 at 1200 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was asked if she knew who Resident 49's responsible party was. RN 2 then reviewed Resident 49's medical record and stated his medical record failed to show the name or contact information specific to Resident 49's responsible party. RN 2 reviewed Resident 49's plan of care and verified the facility failed to develop a care plan, specific to Resident 49's ability to leave the facility (out on pass). RN 2 stated she would contact Resident 49's physician and attempt to clarify Resident 49's out on pass orders, to determine whether Resident 49 was able to leave the facility independently or required his responsible party to accompany Resident 49 when he left the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the physician's recommendation was carried out as ordered for one nonsampled resident (Resident 94). This failure had the potential of Resident 94 not receiving care as ordered. Findings: Review of the facility's P&P titled Record Content - Laboratory and Radiology Reports dated 1/2004 showed the facility shall obtain laboratory, radiology, or other diagnostic service to meet the needs of the residents as prescribed by the physician. Contact the laboratory and/or radiology services in accordance with the physician's order. Log this in the lab and/or x-ray control log and complete the appropriate requisition form. The P&P further showed to sign and date the reports when reviewed. The license nurse or other will be responsible for faxing each report to the attending physician promptly after nurse's review. Moreover, the P&P showed to file the reports in the resident's health record when the nurse has signed off these reports. Contact the service and request an immediate copy of the laboratory or radiology reports that are not received within 48 hours. Medical record review for Resident 94 was initiated on 5/7/25. Resident 94 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 94's H&P examination dated 3/31/25, showed Resident 94 was alert and oriented. Review of Resident 94's Order Review Report from 4/1/2024 to 5/31/2024, showed an order dated 5/1/24, for an appointment for MRI of the brain and cervical spine without contrast scheduled on 5/23/24 at 1615 hours. Review of Resident 94's MRI of the Cervical Spine Without Contrast dated 5/23/24, showed the findings indicate in image number six, seven, and eight, there is suggestion for a mass involving the right side of the neck anterior to the sternocleidomastoid; however, this is a very limited observation because only in axial sections is present. The MRI results further showed the estimated size of the mass could be about 2.4 cm. This could be due to positioning; however, a mass cannot be ruled out. Review of Resident 94's Summary of the Visit report written in Spanish dated 12/20/24, showed the physician recommended to bring the result of the MRI on 5/23/24, to the next appointment at this neurology clinic scheduled on 4/11/25. Review of Resident 94's Neurology Clinic Progress Note dated 4/11/25, showed Resident 94 had the MRI performed, but the previous MRI on 5/23/24, was not available for review. The progress note further showed Resident 94 reported he continued to have weakness affecting the right hand and the bilateral legs. The recommendations of the appointment showed to follow up on the results of the MRI brain and C-spine (cervical spine - the first seven stacked vertebral bones of the spine), physical therapy as able, and return to center six months or sooner as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 0935 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated when the residents went to in-office physician appointments, a copy of the resident's face sheet, physician orders, recent laboratory results, a blank telephone order sheet, and a blank progress note form would be given to them to provide to the provider for review and use of the telephone order sheet and progress note. RN 1 stated upon a resident's return from the physician appointment, the receiving nurse, charge nurse, or desk nurse would review and follow up on any orders given by the physician. RN 1 verified Resident 94's MRI results from 5/23/24, were uploaded on the resident's medical records on 5/1/25; however, RN 1 acknowledged the MRI was completed on 5/23/24. RN 1 stated the upload of the MRI results were late and documentation showed the request for a copy of the MRI results was dated 4/30/25. On 5/13/25 at 1051 hours, an interview and concurrent medical record review was conducted with the Case Manager. The Case Manager verified the above findings. The Case Manager stated when a resident returned from physician's appointment and the physician requested for imaging, he completed a form to provide the information where the results of the imaging should be sent directly to the ordering physician. When asked for a copy of the form, the Case Manager stated he did not keep the forms and had discarded it. The Case Manager further stated he did not follow up with the ordering physician's office if the MRI results were sent. On 5/13/25 at 1106 hours, an interview and concurrent medical record review was conducted with the Case Manager and RN 1 present to assist with the translation of Summary of the Visit report written in Spanish dated 12/20/24. RN 1 stated if the receiving license nurse could not read Spanish, the report should have been given to a license nurse who could translate the form. RN 1 translated the Summary of the Visit report and stated the report showed to bring the result of the MRI to the next neurology appointment scheduled on 4/11/25. RN 1 stated a copy of the MRI result from 5/23/24, should have been provided to the ordering physician. On 5/13/25 at 1208 hours, an interview was conducted with the Administrator and the DON. The DON stated she expected the license nurses to enter the orders received by the physician upon return from an appointment and to document. The DON further stated if an after summary visit report was in written in Spanish and the receiving nurse did not know how to read Spanish, the report should be given to a nurse who would be able to translate the report to ensure the physician's orders were carried out. The Administrator and DON were informed and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52238 Based on observation, interview, and medical record review, the facility failed to provide the physician's order for a health shake with every meal for one of 30 final sampled residents (Resident 115). * Resident 115 had a physician's order to receive a four ounces of the health shake three times a day with meals. However, Resident 115 did not receive the health shake with meals. This failure had the potential to compromise Resident 115's nutritional status and posed the risk for negative health outcomes. Findings: Medical record review for Resident 115 was initiated on 5/8/25. Resident 115 was admitted to the facility on [DATE]. Review of Resident 115's H&P examination dated 10/31/24, showed Resident 115 had no capacity to understand and make decisions. Review of Resident 115's Order Summary Report showed a physician's order dated 11/14/24, to provide supplement health shake four oz three times a day with meals. On 5/8/25 at 1256 hours, an observation and concurrent interview was conducted with CNA 8. CNA 8 stated the food tray should have all the items listed on the meal ticket. CNA 8 verified the resident's printed meal ticket showed one health shake; however, there was no health shake observed on Resident 115's meal tray. On 5/9/25 at 0829 hours, an observation and concurrent interview was conducted with CNA 9. CNA 9 stated the food tray and meal ticket were checked in the kitchen to ensure the items match and the food items listed on the resident's meal ticket should be on the food tray. CNA 9 confirmed the meal shake was not on the tray during breakfast for Resident 115. On 5/9/25 at 1010 hours, an interview and concurrent medical record review for Resident 115 was conducted with the DON. The DON verified Resident 115 had a physician's order for a health shake three times a day and acknowledged the resident had not been receiving health shakes with meals.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure five of eight final sampled residents (Residents 52, 65, 70, 84, and 537) and two nonsampled residents (Residents 40 and 90) reviewed for respiratory care were provided with the appropriate respiratory care and services when: * The facility failed to ensure Resident 40's storage bag for the nebulizer was changed weekly and PRN as per the facility's P&P. * The facility failed to ensure Resident 52's storage bag for the nebulizer was changed weekly and PRN as per the facility's P&P. * The facility failed to ensure Resident 65's nebulizer mask and the storage bag was changed every seven days. * Resident 70's nasal cannula was improperly stored, as evidenced by hanging from a portable oxygen tank instead of stored in a clean bag. * The facility failed to ensure Resident 84's oxygen bag was changed weekly and PRN as per the facility's P&P. * The facility failed to ensure Resident 90's nebulizer mask and storage bag were changed every seven days. * The facility failed to ensure a physician's order was obtained for the use of oxygen for Resident 537. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Therapy and Devices dated 2013 showed oxygen is a drug which much be ordered by the physician. The section for Initiation of Oxygen showed to verify the physician order and to document in the resident's file. Review of the facility's P&P titled Oxygen Therapy and Devices dated 2/2013 showed the oxygen devices should be changed weekly and PRN, and placed in a labeled bag when not in use. 1. On 5/7/25 at 0844 hours, an observation and concurrent interview was conducted with Resident 537. Resident 537 was receiving oxygen at three LPM via the nasal cannula. The oxygen tubing was labeled with the date 5/1/25. Resident 537 stated she had been receiving oxygen since the night before. Medical record review for Resident 537 was initiated on 5/7/25. Resident 537 was admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 537's H&P examination dated 4/23/25, showed Resident 537 had the capacity to understand and make medical decisions. Review of Resident 537's Order Summary Report did not show a physician's order for the oxygen administration. Review of Resident 537's MAR for May 2025 did not show documentation of the oxygen administration. On 5/7/25 at 0854 hours, an observation, interview and concurrent medical record review for Resident 537 was conducted with LVN 6. Resident 537 was observed receiving an oxygen via nasal cannula. LVN 6 was observed checking the oxygen concentrator and stated Resident 537 had received an oxygen at three LPM. When asked to show the physician's order for the oxygen, LVN 6 verified there was no physician's order for the oxygen. When asked where the staff should document Resident 537's oxygen therapy, LVN 6 stated the licensed staff documented in the MAR. LVN 6 was unable to find documentation of the oxygen therapy in Resident 537's MAR. LVN 6 further stated she was not able to find documentation why the oxygen was being administered to Resident 537. On 5/9/25 at 1408 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 47474 2. Medical record review for Resident 52 was initiated on 5/7/25. Resident 52 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 52's annual MDS assessment dated [DATE], showed Resident 52 had a BIMS score of 11 which meant the resident's cognition was moderately impaired. Further review of Resident 52's Order Summary Report dated 5/9/25, showed an order dated 5/8/25, to change the nebulizer tubing weekly as needed when visibly soiled and night shift every Wednesday. On 5/7/25 at 0910 hours, during an initial tour of the facility, an observation and concurrent interview was conducted with the ADON in Resident 52's room. The storage bag for the nebulizer was observed with no label and dated 4/3. The ADON verified the storage bag for the nebulizer did not have a name and was dated 4/3. The ADON stated the respiratory storage bags were changed weekly on Wednesdays and done by the NOC shift (11 PM to 7 AM shift). The ADON further stated the storage bag for the nebulizer should be changed weekly and as needed to maintain for infection control. 3. Medical record review for Resident 84 was initiated on 5/7/25. Resident 84 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 84's H&P examination dated 10/18/24, showed Resident 84 had the capacity to understand and make decisions. Further review of Resident 84's Order Summary Report dated 5/9/25, showed the following physician orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/1/24, to change oxygen tubing weekly and when visibly soiled every night shift on Wednesdays. - dated 5/5/25, to administer oxygen at two LPM, may titrate to three LPM via nasal canula continuously to keep oxygen saturation level above 92% every shift. On 5/7/25 at 0816 hours, during an initial tour of the facility, Resident 84's oxygen bag was unlabeled and dated 4/3. On 5/7/25 at 0840 hours, an observation and concurrent interview was conducted with the Unit Manager in Resident 84's room. The Unit Manager verified the findings. The Unit Manager stated the respiratory bags were changed weekly on Wednesday or as needed and were dated and labeled. The Unit Manager further stated Resident 84's oxygen bag should have been changed to ensure infection control. On 5/13/25 at 1208 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings for Residents 52 and 84. 51352 4. Medical Record review for Resident 40 was initiated on 5/7/25. Resident 40 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 40's Order Summary Report dated 5/7/25, showed an order dated 4/6/24, for Ipratropium-Ablbuterol Inhalation Solution (inhaled medication used to treat common lung diseases that cause restricted airflow and breathing problems) 0.5-0.25 (3) mg/3 ml inhale orally every four hours as needed for shortness of breath and wheezing (a high-pitched, musical, lung sound produced by airflow through an abnormally narrow airways). On 5/7/25 at 0858 hours, during a medication administration observation and concurrent interview with LVN 4 for Resident 40, the storage bag for Resident 40's nebulizer mask was observed dated 4/3. LVN 4 verified the storage bag for Resident 40's nebulizer mask was dated 4/3. LVN 4 stated the respiratory storage bags were changed weekly on Wednesdays and Resident 40's nebulizer storage bag should have been changed. On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of and acknowledged the above findings. 37726 5.a. Medical record review for Resident 70 was initiated on 5/7/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70's Order Summary Report showed a physician's order dated 6/3/24, for oxygen to be administered at a rate of 2 LPM as needed for shortness of breath. Review of Resident 70's care plan titled Oxygen Therapy revised 3/13/25, showed to provide Resident 70 with portable oxygen apparatus. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 0746 hours, an observation and concurrent interview was conducted with Resident 70. Resident 70 stated he utilized the oxygen for shortness of breath and used a portable oxygen tank when he used his wheelchair. Resident 70's portable oxygen tank was observed at the entrance to Resident 70's room. A nasal cannula was observed hanging from the oxygen tank. The nasal cannula was not stored in a clean bag. On 5/7/25 at 0747 hours, an observation and concurrent interview was conducted with LVN 4. Resident 70's oxygen tank was observed at the entrance to Resident 70's room. A nasal cannula was observed hanging from the oxygen tank. The nasal cannula was not stored in a clean bag. LVN 4 verified the findings and stated Resident 70's nasal cannula should be stored in a clean bag for infection control. 47476 b. On 5/7/25 at 1104 hours, a concurrent observation and interview was conducted with Resident 70. A portable oxygen was observed at Resident 70's bedside with a nasal cannula inside an unlabeled respiratory bag. An oxygen concentrator was additionally observed, with the nasal cannula tubing attached to a humidifier dated 5/6/25, and hanging on top of Resident 70's front wheeled walker, not stored inside a respiratory bag. The nasal cannula tubing on the oxygen concentrator was not labeled and the respiratory bag placed on the machine was dated 4/17/25. Resident 70 stated he used oxygen at night and as needed and the portable oxygen tank as needed. On 5/7/25 at 1110 hours, a concurrent observation and interview was conducted with LVN 4. LVN 4 observed and verified the above findings. LVN 4 stated the respiratory bag labeled 4/17/25, should be changed when the humidifier and nasal cannula were changed and she would replace it. LVN 4 stated for the nasal cannula in the respiratory bag on Resident 70's portable oxygen tank, she did not label the respiratory bag and proceeded to label the bag and nasal cannula tubing. LVN 4 stated they needed to change the equipment for infection control. On 5/8/25 at 1559 hours, an interview was conducted with the DON. The DON stated the oxygen tubing should be changed weekly by the licensed nurses. The DON stated the nurse should label the set-up bag with the date and store the oxygen tubing in the bag when not in use. The DON stated they labeled and changed the equipment weekly for infection control. 48882 6. On 5/7/25 at 0835 hours, during the initial tour of the facility Resident 65's nebulizer mask was observed inside a plastic bag. The plastic bag was observed labeled 4/24/25. Medical record review for Resident 65 was initiated on 5/7/25. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's Order Summary Report dated 5/8/25, showed a physician's order dated 6/22/24, to administer ipratropium-albuterol solution 0.5-2.5 mg/3 ml via inhalation every four hours for wheezing/shortness of breath. Review of Resident 65's MAR for May 2025 showed Resident 65 was administered the ipratropium-albuterol solution 0.5-2.5 mg/3 ml via inhalation every four hours from 5/1 to 5/7/25 at 0000, 0400, 0800, 1200, 1600, and 2000 hours (except on 5/7/25 at 1600 hours). (continued on next page)

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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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 0839 hours, an interview was conducted with LVN 5. LVN 5 stated for the resident who received breathing treatments, the central supply staff was responsible for changing the nebulizer masks and tubing. LVN 5 stated the central supply staff changed the oxygen equipment once a week and labeled the date on the storage bag. LVN 5 stated prior to administering the breathing treatment to the resident, the licensed nurse was responsible for checking the date labeled on the bag and if the date was more than seven days, the licensed nurse should replace the breathing treatment equipment before administering the breathing treatment. On 5/7/25 at 0842 hours, a concurrent observation and interview was conducted with LVN 5. LVN 5 verified the plastic bag containing Resident 65's nebulizer mask was labeled 4/24/25 (more than seven days). 7. On 5/7/25 at 0818 hours, during the initial tour of the facility, Resident 90's nebulizer mask was observed inside a plastic bag. The plastic bag was observed labeled 4/24/25. Medical record review for Resident 90 was initiated on 5/7/25. Resident 90 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 90's Order Summary Report dated 5/8/25, showed a physician's order dated 2/21/25, to administer budesonide suspension (breathing treatment medication), 500 mcg by mouth via handheld nebulizer two times a day for wheezing/shortness of breath. Review of Resident 90's MAR for May 2025 showed Resident 65 was administered the budesonide suspension medication from 5/1 to 5/7/25 at 0900 and 1700 hours. On 5/7/25 at 0839 hours, a concurrent interview, observation, and medical record review for Resident 90 was conducted with LVN 5. LVN 5 stated for the residents who received breathing treatments, the central supply staff was responsible for changing the nebulizer masks and tubing. LVN 5 stated the central supply staff changed the oxygen equipment once a week and labeled the date on the storage bag. LVN 5 stated prior to administering the breathing treatment to the resident, the licensed nurse was responsible for checking the date labeled on the bag and if the date was more than seven days, the licensed nurse should replace the breathing treatment equipment, before administering the breathing treatment. LVN 5 reviewed Resident 90's medical record and stated Resident 90 received a breathing treatment two times a day for wheezing/shortness of breath. A concurrent observation and interview was conducted at Resident 90's bedside with LVN 5. LVN 5 verified the plastic bag containing Resident 90's nebulizer mask was labeled 4/24/25 (more than seven days). On 5/8/25 at 1538 hours, an interview was conducted with the DON. The DON stated for the oxygen tubing, nebulizer masks, or any oxygen equipment being used by the resident, the oxygen equipment should be changed weekly by the licensed nurses on the 2300 to 0700-hour shift; and the plastic bag used to store the oxygen equipment should be changed and labeled with the date weekly. The DON stated the purpose of changing the oxygen tubing weekly was for infection control purposes and to maintain clean oxygen equipment. The DON further stated prior to the administration of the breathing treatment, the licensed nurses were expected to check the date on the plastic bag. If the date was over seven days, the licensed nurse was expected to change the oxygen equipment, including the clear plastic bag, used for storage of the equipment and label the bag with the new date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview and medical record review, the facility failed to provide adequate and appropriate pain management for one of one final sampled resident (Resident 129) reviewed for pain management. * The facility failed to ensure the pain medication was administered as per the physicians' orders for Resident 129. This failure had the potential for Resident 129 not to receive the appropriate treatment for pain. Findings: Medical record review for Resident 129 was initiated on 5/7/25. Resident 129 was admitted to the facility on [DATE]. Review of Resident 129's Order Review Report showed a physician's order dated 5/5/25, showed to administer tramadol HCL (pain medication) 50 mg one tablet by mouth every six hours as needed for severe pain 7-10 (on a 0-10 pain scale, with 0 = no pain and 10 = worst pain). Review of Resident 129's MAR for May 2025 showed Resident 129 was administered the tramadol HCL 50 mg medication on 5/7/25 at 0933 hours, when the resident's pain level was six, not within the pain levels of 7-10 for tramadol HCL 50 mg as ordered. On 5/8/25 at 1128 hours, an interview and concurrent medical record review for Resident 129 was conducted with the ADON. The ADON verified above findings and stated the pain medication should have been administered as ordered by the physician. On 5/9/25 at 1408 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the necessary pharmaceutical services were provided to meet the needs for three of 30 final sampled residents (Residents 98, 102, and 104 (not in the roster)) and two nonsampled residents (Residents 7 and 90). * The facility failed to ensure accountability for the controlled medications (medications that have the potential for abuse or dependence) for Resident 102 when the hydromorphone (a controlled medication used to treat severe pain) HCl 2 mg tablet was signed out of the Resident 102's Controlled Medication Count Sheet but was not documented as administered in the MAR. * The facility failed to ensure accountability for the controlled medications for Residents 7, 90, and 104 when the unused, discontinued controlled medications were not removed from the medication carts timely. * The facility failed to ensure the medications were not left unattended on Resident 102's bedside table during a medication administration. * The facility failed to ensure the blood pressure medication was held as per the ordered hold parameters for Resident 98. These failures had the potential to result in drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes). In addition, these had the potential for the residents to ineffective treatment, medication errors, and adverse effects from unnecessary medication. Findings: 1. Review of the facility's P&P titled Medication Administration General Guidelines revised 11/2021 showed in part, the following: C. Documentation 1. The individual who administers the medication dose records the administration on the resident's MAR after the medication pass is completed. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented . 5. When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site . d. Signature or initials of person recording the administration and the signature or initials of person recording effects, if different from the person administering the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 102 was initiated on 5/7/25. Resident 102 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 102's H&P examination dated 2/8/25, showed the resident had no capacity to understand and make decisions. Review of Resident 102's MAR for April and May 2025 showed a physician's order dated 4/21/25, to administer hydromorphone HCl 2 mg tablet via the GT every six hours as needed for moderate to severe pain level (pain levels of 4 to 10). The order was discontinued on 5/5/24. Review of Resident 102's Controlled Medication Count Sheet, undated, showed the hydromorphone HCl 2 mg tablet was signed out on the following dates and times: - on 4/24/25 at 1330 hours, - on 4/26/25 at 1450 hours, - on 4/30/25 at 1400 hours, and - on 5/3/25 at 1415 hours. Further review of Resident 102's MAR for April and May 2025 showed no documented evidence the hydromorphone 2 mg tablet medication was administered to Resident 102 on the above dates and times listed on the Controlled Medication Count Sheet. On 5/8/25 at 1228 hours, an interview and concurrent medical record review for Resident 102 was conducted with the Unit Manager. The Unit Manger verified the above findings and stated the licensed staff who administered the controlled medications were required to document the administration of the controlled medications on Resident 102's MAR and the Controlled Medication Count Sheet. On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 5/7/25 at 1052 hours, an inspection of Medication Cart 3 and concurrent review of the Controlled Medication Count Sheets was conducted with the Unit Manager. a. Review of Resident 7's Controlled Medication Count Sheet for hydrocodone/APAP 5-325 mg tablets (a controlled medication used to treat pain) showed 12 tablets of hydrocodone/APAP 5-325 mg were delivered to the facility on [DATE]. Further review of the Controlled Medication Sheet showed none of the tablets were administered to Resident 7. The bubble pack (type of pre-formed, plastic packaging that seal individual tablets until they are taken) for Resident 7's hydrocodone medication was observed with all 12 tablets. On 5/8/25 at 1103 hours, a medical record review for Resident 7 and concurrent interview was conducted with the Unit Manager. Review of Resident 7's medical record failed to show for an active physician's order for the hydrocodone/APAP 5-325 mg medication. Resident 7's medical record showed the physician's order was discontinued on 3/16/25. The Unit Manger verified the above findings. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Resident 104's Controlled Medication Count Sheet for lorazepam (antianxiety) 2 mg tablet showed two tablets were delivered to the facility on [DATE]. Further review of the Controlled Medication Count Sheet showed none of the lorazepam tablets were administered to Resident 104. The bubble pack for Resident 104's lorazepam medication was observed with two tablets. On 5/8/25 at 1103 hours, a medical record review for Resident 104 and concurrent interview was conducted with the Unit Manager. Resident 104's medical record failed to show an active physician's order for the lorazepam 2 mg medication. The Unit Manger verified the above findings. c. Review of Resident 90's Controlled Medication Count Sheets for hydrocodone/APAP 5-325 mg medication showed the following: - Resident 90's first Controlled Medication Count Sheet for hydrocodone/APAP 5-325 mg tablets showed 38 tablets were delivered to the facility on [DATE]. Further review of the Controlled Medication Count Sheet showed none of the hydrocodone/APAP tablets were administered to Resident 90. The bubble pack for Resident 90's hydrocodone/APAP medication was observed with 38 tablets. - Resident 90's second Controlled Medication Count Sheet for hydrocodone/APAP 5-325 mg tablets showed 90 tablets were delivered to the facility on [DATE]. Further review of the Controlled Medication Sheet showed none of the hydrocodone/APAP tablets were administered to Resident 90. The bubble pack with the corresponding prescription number for Resident 90's hydrocodone/APAP medication was observed with 90 tablets. - Resident 90's third Controlled Medication Count Sheet for hydrocodone/APAP 5-325 mg tablets showed 56 tablets were delivered to the facility on [DATE]. Further review of the Controlled Medication Count Sheet showed none of the hydrocodone/APAP tablets were administered to Resident 90. The bubble pack with the corresponding prescription number for Resident 90's hydrocodone/APAP medication was observed with 56 tablets. On 5/8/25 at 1103 hours, a medical record review for Resident 90 and concurrent interview was conducted with the Unit Manager. Resident 90's medical record failed to show the active physician's order for the hydrocodone/APAP 5-325 mg medication. Resident 90's medical record showed the physician's order for the hydrocodone/APAP 5-325 mg medication was discontinued on 2/21/25. The Unit Manger verified the above findings. 3. Review of the facility's P&P titled Medication Administration for Long Term Care Centers revised 7/2008 Section F titled Pouring/Administering the Medications showed the following: a. Prepare the medication just before intending to give it to them (the resident) .do not prepour medications. b. Check the Residents readiness to take the medication before preparing the medication for the resident . never leave medication at the bedside. On 5/7/25 at 0802 hours, a medication administration observation for Resident 102 was conducted with LVN 6. LVN 6 was observed dispensing the following medications into the medicine cups: - One amlodipine (medication to treat high blood pressure) 10 mg tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One chewable aspirin (blood thinner) 81 mg tablet - 10 ml of docusate sodium (stool softener) liquid 50 mg/ml - One fluconazole (antibiotic for overgrowth of yeast) 200 mg tablet - One losartan (medication to treat high blood pressure) 50 mg tablet - One multivitamin with minerals (supplement) tablet - One paroxetine HCl (medication for depression) 10 mg tablet - 15 ml potassium chloride (supplement) 10% 20 mEq per 15 ml On 5/7/25 at 0832 hours, LVN 6 was observed leaving Resident 102's medications unattended on top of the bedside table while she left to the room to get gloves from the medication cart. At 0835 hours, LVN 6 left Resident 102's medications unattended on top of the bedside table a second time when she left the room to get the stethoscope from the medication cart. On 5/7/25 at 1236 hours, a follow-up interview was conducted with LVN 6. LVN 6 verified she left Resident 102's medication unattended on top of the bedside table when she left the room twice to obtain supplies from the medication cart. LVN 6 verified the medications should never be left unattended. On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of and acknowledged the above findings. 39683 4. Review of the facility's P&P titled Medication Administration -General Guidelines updated November 2021 showed the medications are administered per the physician's orders. Medical record review for Resident 98 was initiated on 5/7/25. Resident 98 was readmitted to the facility on [DATE]. Review of Resident 98's Order Summary Report showed a physician's order dated 3/5/25, for midodrine HCl (a medication used to treat low BP) 5 mg one tablet by mouth three times a day for hypotension, and to hold the medication if the SBP greater than 120 mmHg. Review of Resident 98's MAR for April 2025 showed on 5/8/25, midodrine 5 mg medication was administered to the resident at 0700 hours, with a SBP of 122 mmHg which was above the hold parameters the SBP of 120 mmHg. On 5/9/25 at 1039 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated she administered Resident 98's midodrine on 5/8/25 at 0700 hours, and verified the resident's SBP of 122 mmHg was above the ordered parameter to hold the medication, and the medication should not have been administered the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medication side effects were monitored for the use of mirtazapine (antidepressant medication) for one of five final sampled residents (Resident 112) reviewed for unnecessary medications. This failure had the potential for Resident 112 to experience negative side effects of the mirtazapine medication without adequate monitoring. Findings: Review of the facility's P&P titled Consultant Pharmacist Reports IIIA1: Medication Regimen Review (Monthly Report) revised 08/2019, showed the consultant pharmacist performs a comprehensive medication regimen review (MRR) of each resident at least monthly to evaluate the response to medication therapy, determine that the resident maintains the highest practicable level of functioning , and to prevent or minimizes adverse consequences related to medication therapy. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's (active record) and reported to the DON, and/or prescriber as appropriate. Medical record review for Resident 112 was initiated on 5/7/25. Resident 112 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 112's H&P examination dated 2/9/25, showed Resident 112 had a history of dementia. The H&P examination also showed the resident had no capacity to make medical decisions. Review of Resident 112's Order Summary dated 5/9/25, showed a physician's order dated 2/11/25, to administer mirtazapine 15 mg by mouth at bedtime for depression as manifested by poor appetite (less than 50% of meal intake). Further review of Resident 112's medical record failed to show a physician's order to monitor for the side effects related to the use of the mirtazapine medication. Review of Resident 112's MARs from 2/11 to 5/7/25, failed to show documented evidence Resident 112 was monitored for the side effects related to the use of the mirtazapine medication. On 5/12/25 at 1116 hours, an interview and concurrent medical record review was conducted with the DON for Resident 112. The DON verified the above findings. On 5/12/25 at 1415 hours, a telephone interview was conducted with the Consultant Pharmacist. When asked about the procedure for monitoring the residents' responses to medications, the Consultant Pharmacist verified all the residents should be monitored closely for the potential side effects/adverse effects of the medications. The Consultant Pharmacist further stated he was not aware Resident 112 was not monitored by the facility for the side effects related to the use of the mirtazapine medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview and medical record review, the facility failed to ensure one of five final sampled residents (Resident 112) reviewed for unnecessary medications was free from unnecessary medications. * Resident 112 had a physician's order for clonidine (medication to treat hypertension) without an active diagnosis of hypertension (high BP). * Resident 112 was administered sodium chloride daily without regular blood work monitoring her sodium levels. These failures had the potential for Resident 112 to receive the medications unnecessarily and experience adverse effects which could negatively impact the resident's well being. Findings: Medical record review for Resident 112 was initiated on 5/7/25. Resident 112 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 112's H&P examination dated 2/9/25, showed Resident 112 had no capacity to make medical decisions. a. Review of Resident 112's Order Summary Report dated 5/9/25, showed a physician's order dated 2/6/25, to administer clonidine HCl 0.1 mg by mouth every six hours as needed for hypertension when the SBP greater than 160 mmHg. Review of Resident 112's medical record failed to show documentation of an active diagnosis of hypertension. Review of Resident 112's MARs from February to May 2025 showed the resident did not have the blood pressure readings with the SBP greater than 160 mmHg. Further review of the MAR showed Resident 112 was not administered the clonidine medication since the physician's order was placed on 2/6/25. b. According to the Mayo Clinic, a normal blood sodium level is between 135 and 145 mEq/L (https://www.mayoclinic.org/diseases-conditions/hyponatremia/symptoms-causes/syc-20373711). Review of Resident 112's Order Summary Report showed a physician's order dated 2/7/25, to administer sodium chloride 250 mg by mouth in the morning for supplement. Review of Resident 112's MARs for February to May 2025 showed Resident 112 was administered one sodium chloride 250 mg tablet at 0900 hours daily from 2/8 to 5/11/25. Review of Resident 112's BMP laboratory blood results dated 2/21 and 3/31/25, showed the sodium levels of 132 mEq/L. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 112's medical record failed to show for additional testing of Resident 112's sodium levels after 3/31/25. On 5/12/25 at 1116 hours, an interview and concurrent medical record review for Resident 112 was conducted with the DON. The DON verified Resident 112's medical record showed the last laboratory testing for Resident 112's sodium level was on 3/31/25, and the sodium level was outside the normal range. On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of and acknowledged the above findings.

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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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below five percent. The facility's medication error rate was 26.67% for eight medication errors out of 30 medication administration observations. Three of four licensed nurses (LVNs 3, 4, and 6) observed during the medication administration were found to have made errors for one final sampled resident (Resident 102) and two nonsampled residents (Residents 40 and 43). * LVN 6 failed to ensure the potassium liquid medication given to Resident 102 via the GT was diluted as ordered by the physician. LVN 6 failed to ensure the medications were not administered together when administering medications via the GT to Resident 102, and to flush the GT in between the medications. * LVN 4 failed to administer the Refresh Tears (lubricating eye drops) medication to Resident 40 as ordered by the physician. * LVN 3 failed to administer the calcium with vitamin D (supplement) medication to Resident 43 as ordered by the physician. These failures had the potential for poor health outcomes to the residents. Findings: Review of the facility's P&P titled Preparation and General Guidelines IIA2: Medication Administration - General Guidelines revised 11/2021 showed medications are administered in accordance with the written orders of the attending physician. 1. Review of the facility's P&P titled IIA9: General Guidelines for Administering Medications via Enteral Tube (a flexible tube inserted into the stomach or small intestine to deliver nutrition or medications) revised 11/2021 showed the crush medications are not mixed together. The powder from each medication is mixed with water. Each medication is administered separately to avoid interaction and clumping. The enteral tubing is flushed with at least 10-15 ml of water between each medication to avoid physical interaction of the medications. The medications that are GI irritants such as potassium chloride solution (supplement) are diluted as recommended for oral administration since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes. On 5/7/25 at 0802 hours, a medication administration observation was conducted with LVN 6 for Resident 102. LVN 6 prepared the following medications for Resident 102: - one tablet of amlodipine (medication to treat high blood pressure)10 mg; - one tablet of chewable aspirin (blood thinner) 81 mg; - 10 ml of docusate sodium (stool softener) liquid 50 mg/ml; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one tablet of fluconazole (antibiotic for overgrowth of yeast) 200 mg; - one tablet of losartan (medication to treat high blood pressure) 50 mg; - one tablet of multivitamin with minerals (supplement); - one tablet of paroxetine hcl (medication for depression) 10 mg; and - 15 ml of potassium chloride (supplement) 10% 20 mEq per 15 ml. LVN 6 flushed the GT with 20 ml of water. Then, LVN 6 administered the crushed losartan and multivitamin medications into the GT. LVN 6 then poured a liquid medication into the same medicine cup which contained residue from the losartan and multivitamin with minerals medications. LVN 6 did not use a clean cup to administer the liquid medication. LVN 6 did not flush the GT in between administering the crushed and liquid medications. LVN 6 administered two medications into the GT and flushed the GT with 20 ml of water in between the medications. LVN 6 administered the final medication into the GT and then administered the potassium chloride solution. LVN 6 did not flush the GT between the final medication and the potassium chloride medications. Four medication cups were observed with the medication residue. LVN 6 verified the medication residue and identified the residue as paroxetine, diflucan, docusate, and potassium chloride. Medical record review for Resident 102 was initiated on 5/7/25. Resident 102 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 102's Order Summary Report dated 5/7/25, showed the following physician's orders: - dated 4/21/25, for amlodipine besylate 10 mg via PEG (Percutaneous Endoscopic Gastrostomy tube, a flexible tube inserted into the stomach or small intestine to deliver nutrition or medications) tube in the morning; - dated 4/21/25, for losartan potassium 50 mg via PEG tube in the morning; - dated 4/21/25, for multivitamins with minerals via GT in the morning; - dated 4/21/25, for paroxetine hcl 10 mg via PEG tube in the morning; - dated 4/28/25, for aspirin 81 mg via PEG-tube in the morning; - dated 4/28/25, for Diflucan 200 mg enterally (via the GT) two times a day; - dated 4/28/25, for docusate sodium liquid 50 mg/5 ml 10 ml via GT two times a day; - dated 4/28/25, for potassium chloride 20 mEq/15 ml 15 ml via GT in the morning, administer with four to eight ounces of water. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 1236 hours, an interview and concurrent medical record review was conducted with LVN 6 for Resident 102. LVN 6 verified she poured a liquid medication into the medicine cup which contained residue from the crushed multivitamin with minerals. LVN verified the medications were not supposed to be combined when administered via the GT. LVN 6 verified she did not flush the GT between each medication. When asked about the process for administering the potassium chloride medication, LVN 6 stated the physicians order for Resident 102 showed to dilute the medication with four to eight ounces of water prior to administration. LVN 6 verified she did not dilute the potassium chloride medication as ordered by the physician. Additionally, LVN 6 stated she thought she did not need to dilute the potassium chloride medication because the resident would be administered 80 ml of water via the GT pump every hour. 2. On 5/7/25 at 0858 hours, a medication observation was conducted with LVN 4 for Resident 40. LVN 4 was observed administering one drop of GeriCare artificial tears (solution to soothe and moisturize dry eyes) to Resident 40's right and left eyes. Medical record review for Resident 40 was initiated on 5/7/25. Resident 40 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 40's Order Summary Report showed a physician's order to administer one drop of Refresh Tears solution in both eyes two times a day for dry eyes. On 5/7/25 at 1303 hours, an interview and concurrent medical record review was conducted with LVN 4 for Resident 40. LVN 4 verified Resident 40's medical record showed the above physician's order for the Refresh Tears medication. LVN 4 verified she administered GeriTears to Resident 40, and stated this was the medication used by the facility for artificial tears. LVN 4 stated she did not know if the GeriTears medication contained the same ingredients as the Refresh Tears. According to DailyMed (online pharmacological resource), Refresh Tears's active ingredient is Carboxymethylcellulose sodium 0.5% and GeriCare Artificial Tears's active ingredients are Glycerin 0.2%, Hypromellose 0.2%, and Polyethylene glycol 400 1%. 3. On 5/7/25 at 1009 hours, a medication administration observation was conducted with LVN 3 for Resident 43. LVN 3 administered one tablet of oyster shell calcium 500 mg (supplement) to Resident 43. Medical record review for Resident 43 was initiated on 5/7/25. Resident 43 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 43's Order Summary Report dated 5/7/25, showed a physician's order to administer oyster shell calcium/vitamin D (supplement) 500-200 mg by mouth two times a day for supplement. On 5/7/25 at 1230 hours, an interview and concurrent medical record review was conducted with LVN 3 for Resident 43. LVN 3 verified Resident 112's medical record showed the order for the oyster shell calcium with vitamin D medication. LVN 3 stated the medication cart did not have oyster shell calcium with vitamin D at the time of the medication administration for Resident 43. LVN 6 verified the medication she gave to Resident 43 was not ordered by the physician (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1116 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of the medications. * The facility failed to ensure the temperature of Medication Storage room [ROOM NUMBER] was maintained within the acceptable range as per the facility's document. * The facility failed to ensure two open vials of tuberculin purified protein (used as a diagnostic test for inactive TB infection) were observed without an open date in the medication fridge in Medication Storage room [ROOM NUMBER]. * The facility failed to ensure the expired IV medications for Resident 37 were removed from the medication refrigerator in Medication Storage room [ROOM NUMBER]. * The facility failed to ensure timely restocking of the opened e-kit (container of medications to be readily available in the event of an emergency) in the medication refrigerator in Medication Storage room [ROOM NUMBER]. * The facility failed to ensure the medication refrigerator in Medication Storage room [ROOM NUMBER] had a thermometer. * The facility failed to ensure two soiled boxes of Microdot glucose gel 40% w/w (fasting acting gel used to raise blood sugar levels) were removed from Medication Storage room [ROOM NUMBER]. * The facility failed to ensure the expired, opened, and soiled supply packages were removed from Medication Cart 1. * The facility failed to ensure proper labeling of the opened box of artificial tears (lubricating eye drops used to relieve dry eyes and discomfort) in Medication Cart 3. * The facility failed to ensure no loose medication tablet and capsules in Medication Cart 3. * The facility failed to ensure the medication for Resident 86 in Medication Cart 2 had a visible expiration date. * The facility failed to ensure the complete and accurate labeling of two insulin pens stored in Medication Cart 2. * The facility failed to ensure the liquid medication bottles were clean, without sticky residue, in Medication Cart 2. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* The facility failed to ensure the complete disposal of the four tablets and one capsule in the pharmaceutical waste bin. These failures had the potential for expired or deteriorated medications to be administered to the residents. Findings: Review of the facility's P&P titled Medication Storage in the Facility ID1: Storage of Medications revised , d+[DATE] showed the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy, or staff members lawfully authorized to administer medications. All medications dispensed by the pharmacy are stored in the box, bag, or container with the pharmacy label. Medications requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication, and reordered from the pharmacy, if a current order exists. Review of the facility's document titled Temperature Log for Refrigerator - Fahrenheit dated [DATE] showed the acceptable parameters for the temperature of Medication Storage room [ROOM NUMBER] was between 59 degrees F and 77 degrees F. 1. On [DATE] at 1510 hours, an inspection of Medication Storage room [ROOM NUMBER] and concurrent interview was conducted with RN 2. The following was observed: - the temperature of Medication Storage room [ROOM NUMBER] was 78 degrees F; - two vials of opened tuberculin purified protein in the medication fridge were not labeled with an open date; - three bags of the IV medication for Resident 37 were stored in the medication refrigerator with discard dates of ,d+[DATE], ,d+[DATE], and [DATE]; and - one opened refrigerated e-kit with an open date of [DATE]. RN 2 verified the above findings. On [DATE] at 0956 hours, a follow-up inspection of Medication Storage room [ROOM NUMBER] was conducted with RN 2. The temperature of the medication storage room was observed at 78 degrees F. The medication refrigerator was observed without a thermometer. RN 2 verified the findings and stated all the medication refrigerators should have a thermometer to ensure the medications were stored at the correct temperatures. On [DATE] at 0945 hours, an inspection of Medication Storage room [ROOM NUMBER] was conducted with the Unit Manager. Two boxes of Microdot Glucose Gel 40% w/w (rapidly absorbed glucose gel) were observed soiled with a clear, sticky residue. The Unit Manager verified the findings and stated all the medications were to be stored clean, dry, and free from a residue. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On [DATE] at 1030 hours, an inspection of Medication Cart 1 was conducted with the Unit Manager. The following was observed: - one box of 100 multifunction sterile red caps (used to cap syringes) with an expiration date of ,d+[DATE]; - one BD female Luer-Lok cap (used to cap syringes) with an expiration date of [DATE]; - one BD female Luer-Lok cap with an expiration date of [DATE]; - 25 BD female Luer-Lok caps with an expiration date of [DATE]; - one Prevantics antiseptic wipe (used to clean the skin and prevent infection prior to IV insertion) with an expiration date of ,d+[DATE]; - one package of povidine iodine (helps prevent infection in minor cuts, scrapes and burns) antiseptic swab sticks with expiration date of [DATE]; - one package of opened vitamin A&D ointment (moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations); and - one vented micro micro-spike adapter (used to transfer medication from glass vials) package with yellow staining. The Unit Manager verified the above findings. 3. On [DATE] at 1052 hours, an inspection of Medication Cart 3 was conducted with LVN 3. The following was observed: - one bottle of levocetirizine dihydrochloride (medication used to treat allergy symptoms) 5 mg tablets with no visible expiration date; - one box of opened artificial tears (eye drop) was observed labeled with Room B and no resident name; - one loose tablet in the bottom right drawer; and - two loose capsules in the third left drawer. LVN 3 verified the above findings. 4. On [DATE] at 1228 hours, an inspection of Medication Cart 2 was conducted with the Unit Manager. The following was observed: - one insulin Lantus (long-acting insulin, specifically insulin glargine, used to manage blood sugar levels in adults and children with type 1 or type 2 diabetes) 100 units per ml for Resident 94 labeled with an open date of [DATE], and expiration date of [DATE]; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one insulin Lispro (rapid-dacting insulin used to manage blood sugar in adults and children with type 1 or type 2 diabetes) 100 unit/ml pen for Resident 121 observed without an expiration date; - one bottle of potassium chloride (supplement) was observed with sticky orange residue; and - one bottle of lactulose 10 mg/15 ml solution with sticky white residue. The Unit Manager verified the above findings. The Unit Manager verified the expiration date of insulin should be within 28 days of the open date, and expiration dates were to be written on all the insulin pens. The Unit Manager stated the insulin pen for Resident 94 should have been labeled with an expiration date of [DATE]. 5. On [DATE] at 1047 hours, an inspection of the pharmaceutical waste bin located in the biohazard room was conducted with the DON and ADON. Four loose tablets and one loose capsule were observed on top of the locked pharmaceutical disposal bin. The ADON and DON verified the presence of the loose tablets and capsules. The ADON and DON were unable to identify the medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47476 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure 133 of 137 residents who received food from the kitchen received the proper diets and portion sizes when the facility's menus were not followed. * The facility failed to ensure the new Vietnamese menu was posted and communicated to the residents who received Vietnamese menu meals. * The facility failed to ensure the kitchen staff served the correct portion size as per the menu and menu spreadsheet. These failures had the potential for the residents' nutritional needs not being met. Findings: Review of the facility's document titled Resident Count by Diet Order Report dated 5/7/25, showed 133 of 137 residents received food which was prepared in the facility's kitchen. Review of the facility's untitled and undated document showed 22 residents received food from the Vietnamese menu. Review of the facility's P&P titled Menus dated 2/2017 showed the menus are planned in advance to meet the nutritional needs of the residents and are in accordance with the recommended dietary allowances of the Food and Nutrition Board, Institute of Medicine, National Academies. All menus are dated and the current menu is posted in the facility so that it is available to the residents and staff. 1. On 5/7/25 at 1059 hours, an observation was conducted of the facility's posted menus outside of the kitchen. There was a posted Vietnamese menu observed titled Weekly Menu Guide Vietnamese - Week Four, undated, and a posted sign next to it showing it was this week's menu. The Weekly Menu Guide Vietnamese showed the following would be served during lunch: cucumber soup, ginger beef with onions, spicy fish sauce, and steamed rice. On 5/7/25 at 1224 hours, a lunch dining observation was conducted in the facility's dining room. The Vietnamese menu dishes according to the Weekly Menu Guide were not served. On 5/7/25 at 1233 hours, a concurrent observation, interview, and facility document review was conducted with the DSS. The facility's posted menus for the American and Vietnamese diets were observed posted on the wall outside of the kitchen. When asked what Vietnamese Menu that the facility was using, the DSS stated they were using a different menu that was not posted. The DSS stated they were using the new Vietnamese menu since 5/5/25, and verified the new Vietnamese menu had not been posted or made available to the residents. 2. Review of the facility's document titled Week at a Glance, Week 1 Thursday 5/8/25, showed the country fried steak recipe beef patty puree would be served with a #8 scoop (1/2 cup). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document titled Vietnamese Menu, Week 1 Thursday (undated) showed the following: - Nem Nuong (pork ball) regular portion, four each; - Nem Nuong (pork ball) puree portion, to be served with a #8 scoop; - Nem Nuong (pork ball) minced/moist portion, to see recipe instructions; - Steamed rice regular portion, to be served with a #8 scoop; and - Stir fry vegetable regular, puree, and minced/moist portion, to be served with a #8 scoop. On 5/8/25 at 1200 hours, during the lunch tray line observation, [NAME] 1 used a #10 (3/8 cup) scoop to serve the country fried steak beef patty puree. [NAME] 2 provided only two pork balls for the regular portion of the Nem Nuong. [NAME] 2 also used a #12 scoop for a ground pork ball, a #6 (2/3 cup) scoop for the regular portion steamed rice, a #10 scoop for the regular and minced/moist portion of the stir fry vegetables, and two #20 (3 1/3 tablespoons) scoops for the pureed stir fry vegetables. On 5/8/25 at 1615 hours, a concurrent observation, interview, and facility document review was conducted with the DSS. The DSS was informed of the findings. The DSS verified the incorrect scoop sizes were used according to the facility's American and Vietnamese menus.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47476 Based on observation, interview, and facility document review, the facility failed to ensure the nutritive content of the pureed foods for the Vietnamese menu, particularly the pureed stir fry vegetables, were preserved when the pureed vegetables were cooked and held on the steam table for two hours prior to meal service. This failure had the potential to not meet the nutritional needs of the five residents who received a Vietnamese menu pureed diet. Findings: Review of the professional reference titled How Cooking Affects the Nutrient Content of Foods dated 11/7/19, showed the following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxine (B6), folic acid (B9), and cobalamin (B12), fat-soluble vitamins: vitamins A, D, E, and K, and minerals: primarily potassium, magnesium, sodium, and calcium . https://www.healthline.com/nutrition/cooking-nutrient-content. Review of the facility's document titled Resident Count by Diet Order Report dated 5/7/25, showed 133 of 137 residents received food which was prepared in the facility's kitchen and 21 residents received pureed food. Review of the facility's untitled and undated document showed a list of all the facility's residents who received the Vietnamese menu. The document showed 22 residents received food from the Vietnamese menu, and five of the 22 residents received pureed food. Review of the facility's document titled Meal Times showed the lunch time was started at 1215 hours. Review of the facility's document titled Vietnamese Menu, Week 1 Thursday (undated) showed the stir fry vegetable puree would be served. On 5/8/25 at 1057 hours, a concurrent observation and interview was conducted with [NAME] 2. [NAME] 2 stated she already made the Vietnamese menu puree and showed three covered trays which were placed inside the steam table. [NAME] 2 stated she made the pureed foods at 0945 hours, and placed them on the steam table. [NAME] 2 stated the steam table was kept at over 170 degrees F and the temperatures after the foods were cooked were as follows: pureed rice - 180 degrees F, pureed vegetables - 170 degrees F, and pureed pork ball - 175 degrees F. On 5/8/25 at 1200 hours, during the lunch trayline observation, the Vietnamese menu stir fry vegetable puree was observed being served by [NAME] 2. Review of the facility's document titled Food Temperature Log dated 5/8/25, and signed by [NAME] 2 showed the lunch pureed vegetables temperature was 158 degrees F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1053 hours, an interview was conducted with the DSS. The DSS stated the foods would be placed on the steam table 30 minutes before trayline. The DSS was informed and acknowledged the findings. The DSS acknowledged preparing and placing the pureed vegetables on the steam table two hours prior to trayline would decrease the nutritive value of the vegetables.

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St Edna Subacute and Rehabilitation Center	1929 N. Fairview Street Santa Ana, CA 92706

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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 0808 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review and facility P&P review, the facility failed to ensure one final sampled resident (Resident 38) and one nonsampled resident (Resident 1) received the appropriate diet as ordered by the physician. * The facility failed to ensure Resident 1 was served soup with lunch as ordered by the physician. *The facility failed to ensure Resident 38's soup was the appropriate mechanically altered diet. In addition, the facility failed to ensure the extra entree was provided with meals as ordered by the physician. These failures posed the risk of aspiration (inhalation of a foreign object into the airway and/or lungs) and the resident's nutritional needs not being met Findings: Review of the facility's P&P titled Therapeutic Diets dated 2/2009 showed the therapeutic diets and mechanically altered diets are ordered by the physician and planned by the registered dietician. The physician's order is written for all therapeutic and mechanically altered diets. The facility prepares and serves all special diets as planned. 1. Medical record review for Resident 1 was initiated on 5/7/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility document titled Diet Type Report dated 5/7/25, showed Resident 1 was on a fortified, pureed diet. The additional directions showed to include one soup with lunch and dinner and fortified milk with meals. Review of Resident 1's Order Summary Report dated 5/9/25, showed a physician's order dated 8/30/24, to provide Resident 1 with a fortified, pureed texture diet with nectar (mildly thick) consistency; and to provide fortified cereal for breakfast, and soup with lunch and dinner. On 5/7/25 at 1249 hours, a concurrent observation and interview was conducted with CNA 3. Resident 1 was observed eating in her room. Resident 1's lunch tray was observed with one scoop each of pureed Italian crusted fish, orzo (pasta), vegetables, and wheat bread. There was no soup on Resident 1's lunch tray. CNA 3 verified Resident 1's lunch tray did not have soup. On 5/7/25 at 1259 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 5. LVN 5 reviewed Resident 1's medical record and stated Resident 1 should have soup with lunch and dinner. (continued on next page)

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F 0808 Level of Harm - Potential for minimal harm Residents Affected - Some	2. On 5/7/25 at 1243 hours, a concurrent observation and interview was conducted with CNA 2 inside Resident 38's room. CNA 2 was observed preparing Resident 38's meal tray. Review of Resident 38's lunch meal ticket showed Resident 38 required a pureed consistency diet. Further review of Resident 38's meal ticket showed one bowl of soup, one yogurt, one puree fruit cup, and extra entree for the lunch meal. Resident 38's lunch tray was observed with one scoop each of the pureed Italian crusted fish, orzo (pasta), vegetables, and wheat bread; a bowl of pureed fruits, and a bowl of soup. The soup was not pureed and was observed with various vegetables, including carrots and squash, floating in the liquid soup broth. CNA 2 verified the findings and stated the soup should be pureed and Resident 38 should have double entrees on his lunch plate. CNA 2 was observed taking Resident 38's tray back to the kitchen. Medical record review for Resident 38 was initiated on 5/7/25. Resident 38 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 38's H&P examination dated 10/22/24, showed Resident 38 had no capacity to make medical decisions. Review of Resident 38's Order Summary Report showed a physician's order dated 12/29/24, to provide Resident 38 with a pureed texture, honey (moderately thick) consistency diet; to include one extra entree with meals, one soup with lunch and dinner, eight-ounces of water three times a day with meals, fortified food with meals, and one yogurt twice a day with breakfast and lunch. Review of Resident 38's plan of care showed a care plan problem dated 10/21/24, addressing Resident 38's risk for aspiration and excessive weight loss with swallowing precautions related to dysphagia (difficulty swallowing foods or liquids). The intervention included to provide Resident 38's diet as ordered by the physician. On 5/9/25 at 1050 hours, an interview and concurrent medical record review for Resident 38 was conducted with LVN 5. LVN 5 verified the above findings and stated Resident 38 should receive his meals as ordered by the physician. On 5/12/25 at 1410 hours, an interview was conducted with the DON. The DON stated the residents' diet orders were placed and prepared per the physician's orders. The DON stated once the meal trays were complete, the meal cart would be wheeled from the kitchen into the hallway. The DON stated the licensed nurses were then responsible for checking the meal trays to ensure the residents received the appropriate diet and texture as ordered by the physician. The DON stated for the residents on a pureed consistency diet, all the entrees on the resident's meal tray should be pureed consistency. The DON stated the physician's order for extra entree meant the resident should have a double scoop of the items on the plate. On 5/13/25 at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47476 Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when: * The facility failed to ensure proper labeling and dating of food in the kitchen. * The facility failed to ensure the dented cans were sorted away from the intact cans. * The facility failed to ensure the food in the walk-in refrigerator was stored in a sanitary manner. * The facility failed to ensure the kitchen cooking equipment was air dried. * The facility failed to ensure the food preparation equipment was clean. * The facility failed to ensure the cutting board was free of corrosion. * The facility failed to ensure the maintenance tools were stored properly. * The facility failed to ensure there was a designated refrigerator to store the residents' food from the outside. * The facility failed to ensure the residents' food from the outside in the employees' lounge refrigerator was properly labeled and dated. * The facility failed to ensure the refrigerator which stored the residents' food from the outside contained a thermometer was monitored for the temperature and recorded in the temperature log. * The facility failed to ensure the food was not kept on the steam table two hours prior to tray line. * The facility failed to ensure the low temperature dishwasher had a wash and rinse temperature of 120 degrees F. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's document titled Resident Count by Diet Order Report dated 5/7/25, showed 133 of 137 residents received food which was prepared in the facility's kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 5/7/25 at 0809 hours, an initial tour of the kitchen was conducted with the DON. On the bread rack, one opened package of English muffins was observed with two opened dates, 5/4/25 and 5/6/25. The DON verified the findings and stated the food should be labeled with the open and expiration dates. 2. Review of the facility's P&P titled Food Safety in Receiving and Storage dated 2/2009 showed the food will be inspected when it is delivered to the facility and prior to storage for signs of contamination. Examples of signs of contamination include dents. Dented cans are kept in a designated location labeled dented cans until the vendor can pick them up. On 5/7/25 at 0809 hours, an initial tour of the kitchen was conducted with the DON. In the dry storage area, one dented can of diced red peppers was observed stored with the intact cans, not separated into the designated area for dented cans. The DON verified the findings. 3. Review of the facility's P&P titled Food Safety in Receiving and Storage dated 2/2009 showed the food that is repackaged will be placed in a leak-proof, pest-proof, non-absorbent, sanitary container with a tight-fitting lid. The container will be labeled with the name of the contents and dated with the date it was transferred to the new container. On 5/7/25 at 0809 hours, an initial tour of the kitchen was conducted with the DON. Inside the walk-in refrigerator, one opened package of sliced turkey breast was observed to be stored inside a colander and partially covered on the top with foil. The DON verified the findings and later asked a kitchen staff member to throw away the turkey breast. 4. According to the USDA Food Code 2022 Section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried. Review of the facility's P&P titled Manual Cleaning and Sanitizing dated 2/2017 showed to allow all the equipment, utensils, etcetera to drain and air-dry. On 5/7/25 at 0809 hours, an initial tour of the kitchen was conducted with the DON. The following was observed: - Three plastic containers which contained scoops, pitcher lids, and a smaller plastic container which were dripping wet. There was water observed at the bottom of each of the plastic containers and - A stack of plate domes were stacked and stored wet. The DON verified the above findings. 5. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022 Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Manual Cleaning and Sanitizing dated 2/2017 showed the pot and pan equipment and cooking utensils are cleaned and sanitized appropriately after use. a. On 5/7/25 at 0809 hours, an initial tour of the kitchen was conducted with the DON. The following was observed: - The microwave in the kitchen was observed with brown scattered residue all over the top wall and sides; - Stacked clear cups with a white stain on the inside coating; - A knife stored on the clean knife block, with a green dried food residue on it; - The can opener was stored, there was a brown and orange dry residue observed on the blade; - One ladle and one tong with melted handles; and - Plate warmer was observed with dry brown scattered residue all over the bottom of the warmer. Two gloves were observed on the right side of the warmer. The DON verified the above findings and stated she would have the staff clean it. b. On 5/7/25 at 0900 hours, a concurrent observation and interview was conducted with the Activities Director in the facility's employee lounge. There were two refrigerators in the employee lounge. One refrigerator was observed to contain employee's food being stored with resident labeled food items. The refrigerator was observed with brown stains and dry brown residue on the bottom and the back of the refrigerator wall. The Activities Director stated the housekeeping was responsible to clean the refrigerator and verified the refrigerator was not clean. The Activities Director stated they heated up the resident's food in the employee lounge microwaves and there was no separate microwave for the residents. Both microwaves were observed with brown and yellow dried residue on the top and the walls of the microwave. The Activities Director verified the findings. 6. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 5/7/25 at 0834 hours, an initial tour of the kitchen was conducted with the DON. One green cutting board was heavily marred on both sides and melted on one side. The DON verified the findings and stated she would have the staff replace it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. According to the USDA Food Code 2022 Section 6-501.113, .Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be (B)Stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools. On 5/7/25 at 0845 hours, a concurrent observation and interview was conducted with the DSS. In the kitchen chemicals closet, four brooms were observed stored on the floor. The DSS verified the findings. The DSS was observed to hang all of the brooms off of the floor. 8. Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 8/2023 showed the facility may refrigerate labeled/dated prepared items in a designated unit or pantry refrigerator. On 5/7/25 at 0900 hours, a concurrent observation and interview was conducted with the Activities Director in the facility's employees lounge. There were two refrigerators in the employees lounge and the Activities Director verified there was no designated refrigerator for the residents. One refrigerator was observed to contain employees' food being stored with resident labeled food items. The Activities Director verified the employee's food was stored together with the resident's food. The Activities Director stated they used one of the two microwaves in the employees lounge to heat up the residents' food. The Activities Director verified there was no separate microwave for the residents. On 5/7/25 at 0913 hours, a concurrent observation and interview was conducted with the DON and Administrator in the facility's employees lounge. The DON and Administrator observed and verified the resident's food from the outside was being stored in a refrigerator located in the employees lounge, not designated for the residents. On 5/7/25 at 0925 hours, an observation and concurrent interview was conducted with the DSD. The DSD verified there was no resident specific microwave and stated they should have one. 9. Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 8/2023 showed prepared food items brought in by the resident's family or visitors must be labeled and dated. The facility may refrigerate labeled/dated prepared items in a designated unit or pantry refrigerator. On 5/7/25 at 0900 hours, a concurrent observation and interview was conducted with the Activities Director in the facility's employees lounge. One refrigerator was observed to contain employees' food being stored with resident labeled food items. The following was observed: - one plastic bag with undated food containers for Resident 44; - one unlabeled container filled with cut beets; - one pan covered with saran wrap containing an unlabeled partially eaten salad; - one undated box of half eaten pizza for Resident 97; - one unlabeled bag with cooked meat inside; - one unlabeled container of soup, unlabeled; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one unlabeled bag with a wet brown wrapped item; and - a bag filled with containers of undated food for Resident 98. The Activities Director verified the above findings. On 5/7/25 at 0925 hours, an observation and concurrent interview was conducted with the DSD. The DSD verified the residents' food from the outside was kept in one of the refrigerators in the employee lounge. The DSD stated the CNAs would place the residents' food in the refrigerator. The DSD stated she instructed the CNAs to write the last name, first initial of the resident, and date on the food item. 10. Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 8/2023 showed refrigeration units will have internal thermometers to monitor safe storage temperatures. The staff will monitor unit refrigerators daily. The units will be assessed for temperature adjustment/repair needs. On 5/7/25 at 0900 hours, a concurrent observation and interview was conducted with the Activities Director in the facility's employees lounge. One refrigerator was observed to contain employees' food being stored with the resident labeled food items. There was no thermometer observed inside the refrigerator or freezer which contained the resident's food items. The Activities Director verified the findings. On 5/7/25 at 0910 hours, a concurrent observation and interview was conducted with the Maintenance Director in the facility's employee lounge. The Maintenance Director verified there was resident food items being stored inside one of the refrigerators in the lounge. The Maintenance Director verified there was no thermometer located inside the refrigerator used to store the residents' food and verified there was no temperature log to monitor the temperatures. 11. Review of the facility's P&P titled Safe Food Temperatures dated 2/2009 showed food is not put on the steam table more than 30 minutes prior to the start of the meal service. On 5/8/25 at 1057 hours, a concurrent observation and interview was conducted with [NAME] 2. [NAME] 2 stated she had already made the Vietnamese menu puree and showed three covered trays which were placed inside the steam table. [NAME] 2 stated she made the pureed foods at 0945 hours. [NAME] 2 stated the steam table was kept at over 170 degrees F. On 5/8/25 at 1200 hours, during the lunch trayline observation, the Vietnamese menu stir fry vegetable puree was being served by [NAME] 2. On 5/13/25 at 1053 hours, an interview was conducted with the DSS. The DSS stated the foods would be placed on the steam table 30 minutes before trayline. The DSS was informed of the findings and acknowledged the findings. 12. According to the USDA Food Code 2022 Section 4-501.15 Warewashing Machines, Manufacturers' Operating Instruction, to ensure properly cleaned and sanitized equipment and utensils, warewashing machines must be operated properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022 Section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. The wash solution temperature in mechanical warewashing equipment is critical to proper operation. The chemicals used may not adequately perform their function if the temperature is too low. Therefore, the manufacturer's instructions must be followed. The temperatures vary according to the specific equipment being used. Review of the facility P&P titled Dish Machine Usage dated 2/2009 showed to wash the dishes in dish machine according to equipment directions. Review of the Machine Operational Requirements label dated 1/2009 affixed onto the facility's dish machine showed the wash and rinse temperature should be a minimum of 120 degrees F. On 5/12/25 at 0900 hours, an observation was conducted of the facility's dish machine. Dietary Aide 2 was observed clearing dirty dishes, Dietary Aide 1 was observed washing and placing the dishes through the dish machine, and Dietary Aide 3 was observed to place the put away the clean dishes. Dietary Aide 1 was observed to place crates of trays, plates, plate covers through the dish machine and Dietary Aide 3 was observed to stack and put them away. On 5/12/25 at 0924 hours, a concurrent observation and interview was conducted with Dietary Aide 1. Dietary Aide 1 was asked how she ensured the dish machine was working properly. Dietary Aide 1 stated the temperature should be at 120 - 120 degrees F. Four wash cycles were observed. The temperature on the thermometer of the dish machine read the following during the observations: 102 degrees F, 100 degrees F, 102 degrees F, and 110 degrees F. Dietary Aide 1 then stopped placing dishes through the machine. On 5/12/25 at 0937 hours, a concurrent observation and interview was conducted with the Maintenance Assistant and Maintenance Director. The Maintenance Assistant stated the dish machine temperature should be at 120 degrees F. The Maintenance Assistant was observed to press a button on the dish machine to cycle hot water, ran a dish cycle, then showed the dish machine temperature increased to 120 degrees F. The Maintenance Director stated the staff had to constantly bring the hot water into the machine from the pipes before washing and then start washing the dishes once it reached 120 degrees F. The Maintenance Director stated whatever water was sitting in the pipes was not being heated by the water heater and stated the staff did not flush the dish machine prior to starting the wash. Afterwards, the DSS was informed of the findings. The DSS acknowledged the above findings and stated the staff had to flush the dish machine frequently. The DSS stated they would have to rewash the dishes because it was not the right temperature to be safe for sanitization.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, and facility P&P review, the facility failed to ensure the education on safe food handling of outside food was provided to the residents and visitors as per the facility's P&P. In addition, the facility failed to ensure food brought to the facility by the family member were stored, and safe food handling practices were followed for one nonsampled resident (Resident 538). These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from the outside sources. Findings: Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 8/2023 showed it is the facility policy to honor a Resident's Right to have food brought in by family or other visitors, however, food must be handled and stored in a way to facilitate safety. Family members or other visitors may bring the resident food of their choosing. The staff will provide information on safe food storage and handling as deemed appropriate to resident and/or family. The resident and/or resident's representative are responsible for maintaining bedside food storage containers and contents in a safe/sanitary manner. 1. On 5/7/25 at 0913 hours, a concurrent observation and interview with the DON and Administrator was conducted in the facility's employee lounge. The DON and Administrator observed and verified the residents' food brought from the outside was being stored in a refrigerator located in the employees' lounge, not designated for the residents. The Administrator stated the facility did not have a resident refrigerator, the residents were not supposed to put the food in the refrigerator, and they were not supposed to keep any resident food. On 5/12/25 at 1455 hours, an interview was conducted with the Admissions Coordinator. The Admissions Coordinator stated the activities or the kitchen staff would provide the resident's family member safe food handling education. The Admissions Coordinator verified the facility's admission packet did not include information regarding safe food handling. On 5/12/25 at 1505 hours, an interview was conducted with the Activities Director. The Activities Director stated she did not provide education to the families regarding safe food handling. The Activities Director stated the DSD would educate the CNAs to talk to the residents' family members about safe food handling. On 5/12/25 at 1534 hours, an interview was conducted with LVN 7. LVN 7 stated for the residents whose family bring food from the outside, she would educate them if the resident was diabetic. LVN 7 stated she had not been educated or had educated the family about safe food handling practices. On 5/12/25 at 1542 hours, an interview was conducted with CNA 5. CNA 5 stated she would educate the resident's family to label the food and put it in the refrigerator. CNA 5 stated she did not know about safe food handling and did not remember if she had received the education. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 0807 hours, an interview was conducted with the Assistant Receptionist. The Assistant Receptionist stated she did not teach or give a hand out to the residents' family/visitors about safe food handling. On 5/12/25 at 0823 hours, an interview was conducted with LVN 8. LVN 8 stated when the resident's family brought food from the outside for the resident, she told them that the food depended on the resident's diet and restrictions and they could not leave the meals in the facility. LVN 8 stated she had not had any in-service education about safe food handling and assumed the family did safe food handling. On 5/13/25 at 0836 hours, an interview was conducted with the DSS. The DSS stated she did not provide the residents' families education about safe food handling and did not know who provided the education. On 5/13/25 at 0905 hours, an interview was conducted with the DSD. The DSD stated she did not provide the families education about safe food handling and the staff could provide the education if they are asked. On 5/13/25 at 0930 hours, an interview was conducted with the DON. The DON verified she did not provide education to the resident's family regarding safe food handling. 44175 2. On 5/7/25 at 0909 hours, an observation and concurrent interview was conducted with Resident 538. Resident 538 was lying in bed. There were unlabeled cooked sweet potatoes with sauce in a disposable paper cup, and peeled oranges in a closed plastic container stored on the bedside table (in room temperature) at the right side of Resident 538's bed. Resident 538 stated the food was brought in by her family the night before and she was planning to consume it later. Resident 538 stated the staff came into her room multiple times and was not sure if they noticed the food stored at her bedside. Resident 538 did not remember if the facility provided education on how to safely handle the food brought in from outside to her or her family member. Medical record review for Resident 538 was initiated on 5/7/25. Resident 538 was admitted to the facility on [DATE]. Review of Resident 538's MDS assessment dated [DATE], showed Resident 538 was cognitively intact. Review of Resident 538's medical record did not show if education on safe food handling for the foods brought in by the resident's family was provided to Resident 538. On 5/7/25 at 0916 hours, an observation and concurrent interview with the Unit Manager. The Unit Manager verified the above observation. The Unit Manager stated the food brought in by the family should be consumed immediately or thrown out and should not be stored at the bedside. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/9/25 at 0925 hours, an interview and concurrent medical record review for Resident 538 was conducted with the ADON. The ADON was informed of the above findings. The ADON stated the facility did not have the refrigerator to store food for the residents' food items brought in by the family. The ADON also verified there was no documented evidence if the education on safe food handling for the food items brought in by family was provided to Resident 538. On 5/9/25 at 1408 hours, the DON was informed and acknowledged the above findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview and medical record review, the facility failed to ensure the medical records for four of 30 final sampled residents (Residents 41, 52, 84, and 98) and one nonsampled resident (Resident 66) were accurate. * The facility failed to ensure Resident 41's blood sugar levels were documented in the medical record. * The facility failed to ensure of Resident 52's POLST Section D was completed. * The facility failed to ensure Resident 84's POLST was signed and dated by the physician. * The facility failed to ensure Resident 66's Record of Death was complete and accurate. * Resident 98's blood pressure medication incorrectly documented as administered. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate. Findings: 1. Medical record review for Resident 41 was initiated on [DATE]. Resident 41 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy. Review of Resident 41's Order Summary Report dated [DATE], showed a physician's order dated [DATE], to administer insulin glargine (antidiabetic) 15 units subcutaneously in the morning for diabetes mellitus; and to notify the physician if the blood sugar level less than 70 mg/dL or greater than 400 mg/dL. Review of Resident 41's MARs for April and [DATE] showed Resident 41 was administered the insulin glargine medication 15 units subcutaneously from ,d+[DATE] to [DATE], and from ,d+[DATE] to [DATE] at 0900 hours. However, further review of Resident 41's MAR failed to show the resident's blood sugar levels were documented prior to the administration of the insulin glargine medication 15 units subcutaneously in the morning. Review of Resident 41's progress notes failed to show the licensed nurses consistently documented Resident 41's blood sugar levels prior to the administration of the insulin glargine medication 15 units subcutaneously in the morning. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On [DATE] at 1112 hours, an interview and concurrent medical record review for Resident 41 was conducted with LVN 5. LVN 5 reviewed Resident 41's medical record and stated Resident 41 received insulin glargine 15 units subcutaneously every morning at 0900 hours. When asked, LVN 5 stated prior to the administration of the insulin glargine medication, she checked Resident 41's blood sugar level. When asked where she documented the results of the blood sugar check, LVN 5 stated she did not document Resident 41's blood sugar levels in the MAR or progress notes. When asked if Resident 41's blood sugar level was documented for the previous administrations for the insulin glargine medication 15 units subcutaneously at 0900 hours, LVN 5 stated there was no documentation of Resident 41's blood sugar levels. On [DATE] at 1437 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to check and document the blood sugar levels in the resident's MAR prior to the administration of the insulin medication. The DON stated if the licensed nurse was unable to document the resident's blood sugar level in the MAR, the licensed nurse should document the blood sugar level in the progress notes. On [DATE] at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 47474 2. Review of the facility's P&P titled Advance Directives dated ,d+[DATE] showed the facility has the resident or responsible party sign a form that acknowledges they have received information and whether or not an advance directive already exits or if the resident would like to establish one. The P&P further showed the POLST form is a physician order for life sustaining treatment. The physician is the primary person responsible for this form. However, most facilities actually introduce the form to the resident or his/her responsible party though it remains the responsibility of the physician. The POLST form is frequently mis-identified by staff as an advanced directive. Medical record review for Resident 52 was initiated on [DATE]. Resident 52 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 52's annual MDS assessment dated [DATE], showed Resident 52 had a BIMS score of 11 which meant the resident's cognition was moderately impaired. Review of Resident 52's POLST dated [DATE], showed Section D for the advance directives was not completed. On [DATE] at 0807 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified findings. The SSD stated Section D of Resident 52's POLST was left blank and should have been completed. In addition, the SSD verified no documented evidence in Resident 52's medical record showed if the resident or resident's responsible party wanted more information on advance directives. 3. Medical record review for Resident 84 was initiated on [DATE]. Resident 84 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 84's H&P examination dated [DATE], showed Resident 84 had the capacity to understand and make decisions. Review of Resident 84's POLST dated [DATE], failed to show documented evidence the physician signed or dated the POLST form. On [DATE] at 0827 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the findings. The SSD stated the POLST form did not have a physician's signature or date; however, stated it should have. 4. Review of the facility's P&P titled Record Content - Mortician's Receipt dated ,d+[DATE] showed the facility shall include documentation in the resident's health record of the responsible mortuary picking up the remains of a deceased resident. When a resident expires and the physician orders the release of the remains to the mortuary, the licensed nurse shall sign and date the form and include the name of the mortuary, address, and telephone number. The resident's personal possessions, released with the remains, shall be itemized and recorded on the form. Closed medical record review was conducted for Resident 66. Resident 66 was admitted on [DATE], and had expired on [DATE]. Review of Resident 66's Clothing and Possessions form dated [DATE], showed the resident had the lower and upper dentures upon admission. Further review of the facility document upon discharge failed to show documented evidence Resident 66's lower and upper dentures were discharged with the resident. Review of Resident 66's Record of Death form showed the mortician receipt was incompletely filled out as follows: - The personal articles of the resident taken was not completed. - The DON failed to sign the form. On [DATE] at 1612 hours, an interview was conducted with the DON. The DON verified the above findings and stated the Death Record should be completely filled out. The DON further verified the discharge section of Resident 66's Clothing and Possession form was left blank. The DON further verified she should have signed the resident's Record of Death. On [DATE] at 1208 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON were informed and acknowledged the above findings. 39683 5. Review of the facility's P&P titled Medication Administration -General Guidelines updated [DATE], showed medication are administered per the physician's orders. Medical record review for Resident 98 was initiated on [DATE]. Resident 98 was readmitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 98's Order Summary Report showed a physician's order dated [DATE], for midodrine HCl (a medication used to treat low BP) 5 mg one tablet by mouth three times a day for hypotension, and to hold the medication if the SBP greater than 120 mmHg. Review of Resident 98's MAR for [DATE] showed on [DATE], midodrine 5 mg medication was administered to the resident as follows: - On [DATE] at 0700 hours, for a SBP of 131 mmHg. - On [DATE] at 1100 hours, for a SBP of 128 mmHg. On [DATE] at 1039 hours, an interview and concurrent record review was conducted with LVN 1. LVN 1 stated she held Resident 98's midodrine medication on [DATE] at 0700 and 1100 hours, and verified the MAR was incorrect showing the medications were administered.

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F 0867 Level of Harm - Potential for minimal harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39683 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the QAPI committee implemented and monitored the effectiveness of their plan of correction for improvement of repeated deficient practice cited at F695, F761, F842, and F880. This failure had the potential to affect the quality of care for all the residents in the facility. Findings: Review of the facility's Quality Assurance Performance Improvement (QAPI) Program showed QAPI will develop monitoring tools that provide an effective mechanism to ensure residents receive the necessary care. QAPI will develop plans of correction and evaluate corrective actions taken to obtain desired results. Review of the POC submitted by the facility to the CDPH, L&C Program from the last recertification survey completed on 6/21/24, showed the following: - For cited F695, the DON or designer will review physicians' oxygen orders for compliance, and will bring the results to the monthly QAPI meeting for three months and as recommended by the committee. - For cited F761, the DON or designee will review data from facility rounds for medication storage compliance, and will bring the results to the monthly QAPI meeting for three months and as recommended by the committee. - For cited F842, the DON and SSD or designees will bring the results from records review and facility rounds for compliance to the monthly QAPI meeting for three months and as recommended by the committee. - For cited F880, the IP or designee will bring findings from infection control observations to the monthly QAPI meeting for three months and as recommended by the committee. On 5/13/25 at 1451 hours, an interview and concurrent QAPI Program and facility document review was conducted with the Administrator and the DON. The Administrator was unable to show documentation the QAPI committee monitored the effectiveness of their plan of correction for F695, F761, F842, and F880.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, facility document review and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to implement the infection control monitoring and surveillance for April 2025. * The facility failed to perform legionella testing per the facility's Legionella Water Management Program frequency. * The facility failed ton ensure Resident 131's contact enteric precautions were followed. * Staff"s personal cell phone was stored in the treatment cart with the residents' treatment supplies. * Staff placed their face-shield on top of an upside-down dirty linen cart lid. * CNA 1 failed to don the gown when providing high-contact care to Resident 38 who was on EBP. * The facility failed to ensure residents' clean clothes were transported in a way that maintained infection control. * Two of four LVNs (LVNs 4 and 6) observed for medication administration did not follow proper hand hygiene procedure. * The tip of the eye medication dropper touch Resident 40's eyelashes during the medication administration. * The back side of the glucometer (medical device for determining the approximate concentration of glucose in the blood) for Medication Cart 2 was observed with red-brown smudges. These failures posed the risk for transmission of disease-causing microorganisms and infections. Findings: 1. On 5/13/25 at 0800 hours, a concurrent interview and review of the facility's IPCP was conducted with the IP. The IP stated the process was to review the residents' antibiotic orders as soon as possible to determine if their suspected infection met Loeb's Criteria (a set of minimum symptoms and signs used to guide the decision-making process for initiating antibiotic therapy in long-term care settings) or McGeer's Criteria (a set of specific definitions to identify true infections in long term nursing facilities). Infections are monitored for trends to determine if an outbreak occurs, or needed education on infection control practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's antibiotic report for April 2025 showed 25 antibiotics were ordered for suspected infections. The IP stated she did not review the residents' suspected infections for April, to determine if they met criteria. The list showed Resident 123 started piperacillin sodium tazobactam (antibiotic) on 4/30/25. The IP reviewed Resident 123's records and verified the resident did not meet either Loeb's or McGeer's Criteria for infection. The IP verified since she did not review any residents with antibiotic orders for suspected infections in April previously, other residents with suspected infections might not have met criteria. 2. Review of the facility's Legionella Water Management Program showed Legionella testing will be performed quarterly. Legionella testing results were dated 2/14/24 and 3/25/25. On 5/9/25 at 1035 hours, an interview and facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated Legionella testing was conducted annually on 2/14/24 and 3/25/25. The Maintenance Supervisor reviewed the Legionella Water Management Program binder and verified the program showed testing would be done quarterly, and had not been. 3. Medical record review for Resident 131 was initiated on 5/7/25. Resident 131 was admitted to the facility on [DATE]. Review of Resident 131's Order Summary Report showed a physician's order dated 4/23/25, for contact enteric precaution for C. diff (Clostridium difficile-a contagious bacteria that can cause inflammation of the colon) toxin. On 5/7/25 at 0838 hours, an observation and concurrent interview was conducted with the Optometrist at Resident 131's bedside. The Optometrist was observed at the resident's bedside, in a mask, face shield, gown and gloves, in contact with the resident and other surfaces in the resident's room, including the edge of the bed and a bedside tray table. A sign was posted at the resident's doorway which showed for contact enteric precautions and instructed people to wash their hands with soap and water upon leaving the room. The Optometrist stated they were informed by the facility staff that the resident had isolation precautions for a UTI, not C. diff. The Optometrist was observed removing her isolation gown and gloves, and using ABHR for hand hygiene when leaving the room. The Optometrist then donned a new isolation gown and gloves, and entered another resident's room, went to their bedside, and examined the resident. The Optometrist's Assistant stated they were informed by the resident's nurse from the previous shift that Resident 131 was in isolation for a urinary tract infection, and not C. diff. On 5/7/25 at 0855 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 stated Resident 131 had contact enteric precautions for C. diff, and the staff and visitors should wash their hands with soap and water when leaving the room. 4. On 5/9/25 at 1054 hour, a wound care observation for Resident 8 was conducted with LVN 2. While LVN 2 gathered the supplies from the treatment cart, a cell phone was observed being stored in the top drawer with the treatment supplies. LVN 2 stated it was her personal cell phone and verified it should not be stored in the medication cart. The LVN stated there was also a wound care team cell phone, which the LVN was storing in her pocket. On 5/9/25 at 1115 hours, an interview was conducted with the DON. The DON stated the personal cell phones should not be stored in the treatment or medication carts for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 5/9/25 at 0859 hours, a laundry area inspection was conducted with the Maintenance Supervisor and Janitor. Upon entering the dirty linen area, the Janitor was observed wearing a gown and face-shield, putting a clean liner in the dirty linen cart. The Janitor removed his face-shield, placed it on the upside-down dirty linen cart lid, and washed his hands. The Janitor then picked up the mask and placed it on a hook. The Janitor and Maintenance Supervisor verified the face-shield should not be placed on the contaminated surface of the dirty linen cart lid. 48882 6. Review of the facility's P&P titled Infection Prevention Manual for Long Term Care, revised 5/2024 showed it is the policy of the facility to implement enhanced barrier precautions when indicated for the prevention of transmission of multi drug- resistant organisms. The EBP refer to an infection control intervention designed to reduce the transmission of multidrug- resistant organisms that employ targeted gown and gloves use during high contact resident care activities. PPE for EBP is only necessary when performing high-contact care activities. High-contact Resident care activities may include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens. On 5/7/25 at 0803 hours, during the initial tour of the facility, an EBP sign was observed posted outside of Resident 38's room alerting the providers and staff to wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care. A E sticker was observed placed next to Resident 38's name. On 5/7/25 at 0908 hours, CNA 1 was observed turning Resident 38 on his left side to reposition the sheet under Resident 38. CNA 1 was then observed putting on a new gown for Resident 38. CNA 1 was not observed wearing a gown. On the ground, next to Resident 38's bed were two clear bags containing soiled linen inside. On 5/7/25 at 0918 hours, an interview was conducted with CNA 1. CNA 1 stated she was changing Resident 38's linen and sheets and was proving care to him. When asked about the facility's EBP protocol, CNA 1 stated for the residents who were on EBP, a sign would be placed outside of the resident's door and an E sticker would be placed next to the resident's name to notify staff when EBP should be followed. CNA 1 further stated for the residents on EBP, the staff should don a gown and gloves when providing care, changing, providing showers, and repositioning the resident. When asked if Resident 38 was on EBP, CNA 1 stated Resident 38 was on EBP due to the wound on his heel. CNA 1 verified she did not don a gown when providing care to Resident 38 and stated she should have worn a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 38 was initiated on 5/7/25. Resident 38 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 38's H&P examination dated 10/22/24, showed Resident 38 had no capacity to make medical decisions. Review of Resident 38's Order Summary Report showed a physician's order dated 4/1/25, for EBP every shift for the left hallucial diabetic wound. On 5/12/25 at 1410 hours, an interview was conducted with the DON. The DON stated the facility staff were expected to wear a gown and gloves when entering the room, to provide direct care to the residents who were on the EBP. On 5/13/25 at 1207 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 47474 7. Review of the facility's P&P titled Laundry Manual - General Policy (undated) showed the clean linen shall be stored, handled, and transported in a way that precludes cross-contamination. On 5/9/25 at 1023 hours, during an observation, Laundry Assistant 1 transported an uncovered laundry cart containing the residents' clean clothes down the hallway near rooms [ROOM NUMBERS]. The laundry cart was stationed across from room [ROOM NUMBER] and exposed with residents' clean clothes touching the handrails. On 5/9/25 at 1026 hours, an observation and concurrent interview with Laundry Assistant 1 was conducted next to the laundry cart. Laundry Assistant 1 requested for CNA 7 be present during the interview to interpret. Laundry Assistant 1 verified the findings. Laundry Assistant 1 verified she had the laundry cart opened while transporting it down the hallway and verified the residents' clothes were touching the handrails. Laundry Assistant 1 further stated the laundry cart should have been closed to prevent contamination of the clean clothes. On 5/13/25 at 1208 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON were informed and acknowledged the above findings. 51352 8. Review of the facility's P&P titled Review of the facility's P&P titled Preparation and General Guidelines IIA2: Medication Administration - General Guidelines revised 11/2021 showed the person administering the medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, and before and after administration of ophthalmic preparations, and medications given via enteral tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/7/25 at 0802 hours, the GT medication administration observation was conducted for Resident 102 with LVN 6. LVN 6 donned gloves and used Super Sani-Cloth sanitizing wipes to disinfect the BP cuff, tubing, and machine. LVN 6 doffed the gloves. LVN 6 did not perform hand hygiene after doffing the gloves. LVN 6 unlocked Medication Cart 2 and removed the glucometer, lancet (small, sharp, single-use device typically used to prick a finger to obtain a small blood sample for testing), and glucometer test trips and put the items on a tray. LVN 6 picked up the tray and entered Resident 102's room without performing hand hygiene. LVN 6 donned gloves and adjusted the prongs of Resident 102's nasal cannula (flexible tube to deliver oxygen into the nose). LVN 6 did not change her gloves or perform hand hygiene. LVN 6 wiped Resident 102's left ring finger with an alcohol swab for a few seconds. LVN 6 used the lancet on Resident 102's finger and obtained a blood sugar reading from Resident 102. LVN 6 doffed the gloves. LVN 6 left the room without performing hand hygiene. LVN 6 walked to the medication cart at Resident 102's doorway. LVN 6 entered Resident 102's room without performing hand hygiene, picked up Resident 102's remote from the floor, and placed the remote on Resident 102's bed. LVN 6 left the room without performing hand hygiene and walked to Medication Cart 2. LVN 6 donned clean gloves and used Super Sani-Cloth sanitizing wipes to disinfect the BP cuff, tubing, and machine. LVN 6 washed her hands in Resident 102's bathroom. LNV 6 prepared Resident 102's medications. LVN 6 used alcohol-based hand rub, donned a gown, and entered Resident 102's room with the medications. LVN 6 placed the medications on the bedside table and walked out of Resident 102's room without performing hand hygiene. LVN 6 walked to Medication Cart 2, took a pair of clean gloves, and entered Resident 102's room. LVN 6 did not perform hand hygiene before entering Resident 102's room. LVN 6 donned gloves and pulled the privacy curtain in preparation for the medication administration for Resident 102. LVN 6 left the room to walk to Medication Cart 2. LVN 6 did not perform hand hygiene when she left the room. LVN 6 doffed her gloves, picked up the stethoscope from Medication Cart 2 and entered Resident 102's room. LVN 6 did not perform hand hygiene prior to entering Resident 102' room. LVN 6 used Super Sani-Cloth sanitizing wipes to disinfect the stethoscope. LVN 6 donned gloves and began the medication administration for Resident 102. LVN 6 did not perform hand hygiene after using ungloved hands to sanitize the stethoscope or before she began the medication administration for Resident 102. On 5/7/25 at 1236 hours, a follow-up interview was conducted with LVN 6. LVN verified the staff should wash their hands or used alcohol-based hand rub prior to any medication administration. LVN 6 verified the staff should have washed her hands before donning gloves, after doffing gloves, and between tasks. 9. Review of the facility's P&P titled Specific Medication Administration Procedures IIB5: Eye Drop Administration revised 6/2021 showed the staff wash hands before and after the procedure. The tip of the dropper must not touch the eye or any other surface. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/7/25 0858 hours, a medication administration observation for Resident 40 was conducted with LVN 4. LVN 4 donned gloves and used Super Sani-Cloth sanitizing wipes to disinfect the BP cuff and stethoscope. LVN 6 doffed the gloves and did not perform hand hygiene. LVN 4 began medication preparation for administration to Resident 40. LVN 4 finished preparing the medications for Resident 40, performed hand hygiene with alcohol-based hand rub, and entered Resident 40's room. LVN 4 administered Resident 40's oral medications. LVN 4 then donned gloves to administer the GeriCare artificial tears to Resident 40. LVN 6 did not wash her hands prior to donning the gloves. LVN 4 administered one drop of GeriCare artificial tears to Resident 40's left eye. The tip of the dropper of the GeriCare medication touched the eyelashes on Resident 40's left eye. LVN 4 pressed a tissue to the inner corner of Resident 40's left eye. LVN 4 then administered one drop of the GeriCare medication to Resident 40's right eye. On 5/7/25 at 1303 hours, a follow-up interview was conducted with LVN 4. LVN 4 stated staff must wash their hands or use alcohol-based hand rub prior to the administration of ophthalmic (medications to treat conditions of the eye) medications. LVN 4 stated she did not see if the tip of the dropper for the GeriCare medication touched Resident 40's eyelashes during the medication administration. LVN 4 verified the dropper was no longer safe to use if the tip of the dropper touches the resident's eye or any other surface. 10. On 5/8/25 at 1228 hours, an inspection of Medication Cart 2 and a concurrent interview was conducted with the Unit Manager. The back side of glucometer was observed with red-brown smudges. The Unit Manager verified the presence of the red-brown smudges. When asked what the red-brown smudges on the back side of the glucometer were, the Unit Manager stated she did not know. On 5/13/25 at 1116 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
	555093	A. Building B. Wing	05/13/2025

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

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 39683 Based on interview, medical record review, facility record review, and facility P&P review, the facility failed to implement their antibiotic stewardship program including timely monitoring of antibiotic use. * The IP did not review antibiotics for appropriateness for April 2025 which showed 25 antibiotics were ordered. * The IP failed to notify Residents 14 and 26's physicians to re-evaluate the appropriateness of the residents' antibiotics when it was determined their suspected infections did not meet criteria. These failures had the potential of not accurately identifying true infections and exposing the residents to unnecessary antibiotic use. Findings: According to the CDC, repeated and/or improper use of antibiotics was the primary cause of the proliferation of drug-resistant bacteria. Each time a person uses antibiotics, the sensitive bacteria are killed; however, resistant bacteria may result. These resistant bacteria may then grow and multiply. When the antibiotics fail to work, the consequences include longer lasting illnesses, extended hospital stays, and the need for more expensive and toxic medications. Some resistant infections can even cause death. On 5/13/25 at 0800 hours, a concurrent interview and review of the facility's IPCP, antibiotic stewardship, and Residents 14, 26, and 123's medical records was conducted with the IP. The IP stated the process was to review the residents' antibiotic orders as soon as possible to ensure the appropriateness of the antibiotics ordered. The IP stated she would review the residents' medical records, determine if the antibiotic ordered was appropriate and notify the physician to reevaluate. a. Review of facility's antibiotic report for April 2025 showed 25 antibiotics were ordered for suspected infections. The IP stated she did not review the residents' antibiotic orders for April 2025. The list showed Resident 123 was started on the piperacillin sodium tazobactam (antibiotic) medication on 4/30/25. The IP reviewed Resident 123's medical record and verified the resident did not meet the criteria for appropriate antibiotic usage. The IP verified since she did not review any residents' antibiotic orders for April previously and other residents could have received inappropriate antibiotics. The IP reviewed Resident 123's MARs for April and May 2025 and verified the antibiotics were administered to the resident for the full seven days of the ordered therapy. b. Review of the line listing report for March 2025 showed Resident 14 started doxycycline monohydrate (antibiotic) 100 mg medication on 3/5/25, for an infection that did not meet criteria. The IP verified there were no records to show the physician was notified that Resident 14's suspected infection did not meet the criteria and re-evaluated the antibiotics for appropriateness. (continued on next page)

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	05/13/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP reviewed Resident 14's MAR for March 2025 and verified the doxycycline monohydrate 100 mg medication was administered to the resident for the full 10 days of the ordered therapy. c. Review of the line listing report for March 2025 showed Resident 26 started Levaquin 750 mg (antibiotic) on 3/18/25, for a suspected infection that did not meet criteria. The IP verified there were no records to show the physician was notified that Resident 26's suspected infection did not meet criteria and re-evaluated the antibiotics for appropriateness. The IP reviewed Resident 26's MAR for March 2025 and verified the Levaquin 750 mg medication was administered to the resident for the full seven days of the ordered therapy.