STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
French Park Care Center	600 E Washington Avenue Santa Ana, CA 92701

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 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident's family was informed promptly of the transfer and admission to the acute care hospital as per the facility's P&P for one of seven sampled residents (Resident 1). This failure had the potential for the resident's family to not be aware of the resident's changes in condition. Findings: Review of the facility's P&P titled Notification of Changes revised 12/2022 showed the facility must promptly inform the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification including a transfer or discharge of the resident from the facility. Closed medical record review for Resident 1 was initiated on 3/12/24. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 4/9/23. Review of Resident 1's eINTERACT Change in Condition Evaluation dated 4/9/23 at 2356 hours, showed Resident 1 was transferred to the acute care hospital on 4/9/23, for abnormal vital signs. The COC further failed to show documented evidence Resident 1's family member was promptly informed of the resident's transfer to the acute care hospital as per the facility's P&P. The COC showed the resident's family was contacted and left a phone message on 4/10/23 at 2355 hours, one day after Resident 1 was transferred to the acute care hospital. Review of Resident 1's Nurses Progress Note dated 4/10/23 at 0331 hours, showed the staff at the acute care hospital contacted the facility to inform Resident 1 was admitted to the hospital. The progress note further showed the RN would notify family in the AM. Further review of Resident 1's closed medical record failed to show documented evidence the resident's family member was notified promptly of Resident 1's admission to the acute care hospital as per the facility's P&P. On 3/12/24 at 1208 hours, an interview was conducted with LVN 4. LVN 4 stated the families should be notified as soon as possible when the residents were transferred to the acute care hospital. LVN 4 further stated the families were notified to inform them of the resident's condition and location if the resident had been transferred out of the facility. (continued on next page)

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

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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 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	On 3/13/24 at 1225 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the staff did not promptly communicate with Resident 1's family representative as per the facility's P&P when Resident 1 was transferred and admitted to the acute care hospital. The DON stated the facility should have made multiple attempts to contact Resident 1's family representative to ensure they were notified of the transfer.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to maintain an accurate and complete medical record for one of seven sampled residents (Resident 1). This failure posed the risk for changes in Resident 1's health condition not being identified and delay in necessary care and treatment. Findings: Review of the facility's P&P titled Documentation in Medical Record revised 12/2022 showed each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. The P&P further showed documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Closed medical record review for Resident 1 was initiated on 3/12/24. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 4/9/23. a. Review of Resident 1's eINTERACT Change in Condition Evaluation dated 4/9/23 at 2356 hours, showed Resident 1 was transferred to the acute care hospital on 4/9/23, for abnormal vital signs. The COC showed Resident 1's physician was notified; however, there was no documented evidence of the date or time to show when the physician was made aware. b. Review of Resident 1's MAR for April 2023 showed no documented evidence the following medications were administered on 4/9/23 at 0600 hours: - levothyroxine 75 mcg (hypothyroid medication) - diltiazem HCL 60 mg (blood pressure medication) - ipratropium-albuterol 3 ml (breathing treatment) On 3/13/24 at 1115 hours, an interview and concurrent closed medical record review with LVN 1 was conducted. LVN 1 verified Resident 1's MAR showed no documentation levothyroxine, diltiazem HCL, and ipratropium-albuterol were given on 4/9/23 at 0600 hours. LVN 1 further stated there was no documented evidence to show the reason these medications were not administered as ordered or the physician was notified of the missed doses. LVN 1 stated the facility should follow the medication orders because they were essential for the residents to receive as part of their care. On 3/13/24 at 1225 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the COC failed to show documented evidence of the time and date Resident 1's physician was notified of the transfer to the acute care hospital. On 3/13/24 at 1540 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON were informed and acknowledged the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of Resident 1's SNF Transfer Orders from the acute care hospital dated 4/7/23, showed Resident 1's Active Problem list included the following medical diagnoses: - CAP (community acquired PNA) - Pulmonary HTN - Hypothyroidism - Leukocytosis - Pulmonary fibrosis - Severe protein-calorie malnutrition However, review of Resident 1's eINTERACT Change in Condition Evaluation dated 4/9/23, showed Resident 1's medical diagnoses included the following: - Cerebral infarction - Hypertension - Hyperlipidemia - GERD - Vitamin D Deficiency - Pulmonary Fibrosis - Insomnia - Hypothyroidism On 3/13/24 at 1115 hours, an interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 verified Resident 1's medical diagnoses from the acute care hospital records did not match the medical diagnoses listed in the closed medical record. LVN 1 stated the diagnoses were considered inaccurate. On 3/13/24 at 1225 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the medical diagnoses for Resident 1 was inaccurately transcribed and did not match the diagnoses list from the acute care hospital. Furthermore, the DON stated Resident 1's medical diagnoses should have been reviewed by the MDS and Medical Records for accuracy. On 3/13/24 at 1540 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.