| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555103 | A. Building<br>B. Wing | 02/05/2025 |

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| French Park Care Center | 600 E Washington Avenue<br>Santa Ana, CA 92701 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>48853<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of seven sampled residents (Resident 6) attained and maintained the highest practicable physical well-being.<br><br>* The facility failed to ensure the physician was timely notified of Resident 6's change in condition. This failure posed the risk for Resident 6 to not receive the necessary care and services to maintain the resident's highest physical well-being.<br><br>Findings:<br><br>Review of the facility's P&P titled Notification of Changes dated 12/19/22, showed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include significant change in the resident's physical, mental, psychosocial condition such as deterioration in health, mental or psychosocial status this may include life threatening conditions, or clinical complications.<br><br>Review of the facility's P&P titled Medical Emergency Response dated 12/19/22, showed it is the policy of the facility to respond to medical emergencies for residents. A nurse will assess the situation and determine the severity of the emergency, stay with the resident and designate a staff member to announce a code blue, if necessary, notify the physician and call 911 as needed.<br><br>Closed medical record review for Resident 6 was initiated on 1/30/25. Resident 6 was admitted to the facility 12/16/22.<br><br>Review of Resident 6's H&P examination dated 12/28/22, showed the resident had nocapacity to understand and make decisions.<br><br>Review of Resident 6's POLST dated 12/16/22, showed to attempt resuscitation if the resident had no pulse and was not breathing. Under the Medical Intervention section, full treatment was checked off with the primary goal of prolonging life by all medically effective means.<br><br>Review of Resident 6's Order Summary Report for 12/16/22 to 1/22/23, showed a physician's order for full code (a medical term indicating that a patient wishes to receive all possible life-saving measures in the event of a medical emergency).<br><br>(continued on next page) |

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

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident' 6 Orders Administration Note dated 1/22/23 at 0510 hours, showed Resident 6's pantoprazole sodium (a medication used to treat heartburn and certain other conditions caused by too much acid in the stomach) 40 mg was not administered due to the resident desaturating (drop in blood oxygen levels).<br><br>Review of Resident 6's Vital Signs log dated 1/22/25 at 0600 hours, showed the blood pressure was 65/50 mmHg, respiration rate was 25 breaths/minute, pulse rate was 69 bpm, and oxygen saturation level was 83. 0%<br><br>Review of Resident 6's Nurses Progress Note dated 1/22/23 at 0701 hours, showed the resident was found with labored breathing and cold skin, and the oxygen was administered via nasal cannula at four liters per minute with the oxygen saturation level at 96%. The progress notes also showed the physician was notified and waiting for the physician to call back. Further review of Resident 6's progress notes did not show documented evidence the physician was notified of Resident 6's episode of desaturating on 1/22/23 at 0510 hours.<br><br>Review of Resident 6's eINTERACT SBAR Summary for Providers dated 1/22/23 at 0727 hours, showed Resident 6 had a change in condition with the following abnormal vital signs: blood pressure: 65/50 mmHg, pulse: 69 beats per minute, temperature: 97.2 degrees Fahrenheit, respiration: 25 and oxygen saturation level: 83%. The SBAR also showed Resident 6's oxygen saturation continued to drop, and the blood pressure remained extremely low.<br><br>Review of Resident 6's Vital Signs log dated 1/22/25 at 0745 hours, showed the blood pressure was 101/52 mmHg, respiration rate was 26 breaths/minute, pulse rate was 66 bpm, and oxygen saturation level was 70. 0% with oxygen via face mask.<br><br>Further review of Resident 6's Nurses Progress Note dated 1/22/23 at 0757 hours, showed Resident 6's oxygen saturation level was 63% andtransferred to the acute care hospital by the paramedics.<br><br>On 2/5/25 at 1110 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated she expected the nurses to call the paramedics for any medical emergency for the residents to be transported to the acute care hospital immediately. The DON stated the resident's change in condition and medical emergency would be based on the nurse's clinical judgement and assessment. The DON verified Resident 6's scheduled medication was not administered on 1/22/23 at 0510 hours, because the resident was desaturating. The DON verified there was no documentation to show the physician was notified of Resident 6's episode of desaturating until 1/22/23 at 0701 hours, approximately two hours after Resident 6 was initially observed with low oxygen saturation level. The DON was informed and acknowledged the above findings. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for two of seven sampled residents (Residents 4 and 6).<br><br>* The licensed nurse failed to assess and manage Resident 4's pain when providing the wound care treatment.<br><br>* The facility failed to develop a care plan problem to address Resident 6's MASD to the bilateral buttocks extending to sacrococcyx (base of the spine and tailbone), which had deteriorated to a sacrococcyx unstageable pressure injury. In addition, there was no care plan problem developed to address Resident 6's purplish nonblanchable (skin abnormality when the skin does not turn white when pressed) area to the right heel.<br><br>These failures had the potential for not providing the necessary care and services and effectively managing the residents' needs.<br><br>Findings:<br><br>Review of the facility's P&P titled Pressure Injury Prevention and Management dated 12/19/22, showed the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Assessment of Pressure Injury Risk showed a licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale for Predicting Pressure Ulcer Risk, on all residents upon admission/re-admission, weekly times three more weeks, then quarterly or whenever the resident's condition changes significantly. Interventions for Prevention and to Promote Healing showed the following:<br><br>* After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a<br><br>relevant care plan that includes measurable goals for prevention and management of pressure<br><br>injuries with appropriate interventions.<br><br>* Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).<br><br>* Interventions will be documented in the care plan and communicated to all relevant staff.<br><br>1. Medical record review for Resident 4 was initiated on 1/31/25. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 4's MDS Quarterly assessment dated [DATE],showed Resident 4 had a BIMS score of 4, which indicated moderate cognitive impairment. The MDS showed the resident had impairment to one side of the upper extremity and both sides of the lower extremities. The MDS further showed Resident 4 was dependent on the staff member assistance with bed mobility and toileting, and Resident 4 was always incontinent of both bowel and urinary functions.<br><br>Review of Resident 4's Order Summary Report showed the following physician's orders:<br><br>- dated 1/13/25, to provide wound treatment to Resident 4's pressure ulcer on the sacrococcyx as follows: cleanse with normal saline, pat dry, apply Medihoney (a medical-grade honey-based wound care dressing used to treat wounds and burns), apply alginate (absorbent, wound care products made from seaweed, brown algae), and cover with a foam dressing daily for 21 days.<br><br>- dated 11/13/24, to administer acetaminophen 325 mg two tablets by mouth every four hours as needed for mild pain.<br><br>Review of Resident 4's plan of care showed a care plan problem dated 1/13/25, addressing the resident's UTDpressure ulcer on the sacrococcyx. Theinterventions showed the following:<br><br>- Keep resident clean and dry.<br><br>- Monitor for pain and discomfort.<br><br>- Monitor for signs and symptoms of infection.<br><br>- Provide treatment as ordered.<br><br>- Turn and repositioned every two hours.<br><br>Review of Resident 4's Skin Check note dated 1/14/25, showed Resident 4 had an unstageable pressure injury to the coccyx and the pressure injury was acquired in-house. The coccyx pressure injury measured 1.1 cm in length, 0.8 cm in width and 0.1 cm in depth, with 100% slough and serosanguineous exudate (a combination of blood and clear fluid (serum) that drains from a wound) present.<br><br>On 1/31/25 at 1010 hours, a wound care treatment observation was conducted with LVN 4 for Resident 4. The resident was observed lying on her left side, and CNA 5 was providing incontinence care. The resident was observed quiet and did not complain of discomfort while her perianal area was being cleaned by CNA 5. LVN 4 then removed the old wound dressing from Resident 4's sacrococcyx; however, when LVN 4 started cleansing Resident 4's sacrococcyx pressure injury, the resident was observed moaning in discomfort. LVN 4 stated to the resident Sorry, it is almost done and proceeded with the wound treatment. Resident 4 was observed moaning in discomfort while LVN 4 cleaned her pressure injury until LVN 4 covered the pressure injury. LVN 4 did not assess Resident 4's pain level prior to or during the wound care treatment.<br><br>On 1/31/25 at 1028 hours, an interview was conducted with LVN 4. LVN 4 stated Resident 4 was usually observed screaming sometimes when the facility staff member was changing her incontinence brief. LVN 4 verified Resident 4 did not scream when she was being cleaned by the CNA, however, LVN 4 verified Resident 4 was observed moaning during the wound care treatment.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/5/25 at 1110 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated she expected the treatment nurse to assess for pain prior to initiating the wound care treatment. The DON stated if the resident was observed moaning during the wound care treatment, the treatment nurse should not proceed with the wound care. The treatment nurse should check the resident's medical record for any pain medication and administer the pain medication as ordered for pain. The DON verified Resident 4's care plan interventions for the sacrococcyx pressure injury included to monitor for pain and discomfort. The DON was informed and acknowledged the above findings.<br><br>2. Review of facility's P&P titled Comprehensive Care Plans dated 12/19/22, showed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be developed within seven days after the completion of the comprehensive MDS assessment.<br><br>Closed medical record review for Resident 6 was initiated on 1/30/25. Resident 6 was admitted to the facility 12/16/22.<br><br>Review of Resident 6's Braden Scale for Predicting Pressure Ulcer Risks dated 12/16/22, showed Resident 6 had a score of 14, indicating moderate risk of developing a pressure ulcer.<br><br>Review of Resident 6's Skin Only Evaluation dated 12/17/22, showed Resident 6 had MASD to the bilateral buttocks extending to sacrococcyx.<br><br>Review of Resident 6's MDS Admission assessment dated [DATE], showed Resident 6 required extensive assist with one person for bed mobility and toileting. Resident 6 was always incontinent of both bowel and urinary functions.<br><br>Review of Resident 6's Braden Scale for Predicting Pressure Ulcer Risks dated 12/23/22, showed Resident 6 had a score of 12, indicating high risk of developing a pressure ulcer.<br><br>Review of Resident 6's H&P examination dated 12/28/22,showed the resident had no capacity to understand and make decisions.<br><br>Review of Resident 6's Skin Only Evaluation dated 1/17/23, showed Resident 6 had a purplish nonblanchable area to the right heel, measuring three cm in length, two cm in width and depth unable to determine. The MASD to the sacrococcyx had become nonblanchable and the resident expressed pain when sitting up in the wheelchair.<br><br>Review of Resident 6's plan of care showed a care plan problem was initiated on 1/17/23, addressing the resident's potential/ actual impairment to skin integrity related to the sacrococcyx extending to the bilateral buttocks MASD. The interventions included:<br><br>- to educate the resident/ resident representative/ caregiver of causative factors and measure to minimize skin integrity impairments.<br><br>- to follow facility protocols for the treatment of the injury.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - to observe for signs, symptoms or complaints of pain - before, during and after wound management, attempt nonpharmacological interventions and if ineffective, provide medication as per the physician's order, and notify the physician if pain management was ineffective.<br><br>Further review of Resident 6's plan of care failed to show a care plan was developed to address Resident 6's purplish nonblanchable area to the right heel.<br><br>Further review of Resident 6's Skin only Evaluation dated 1/18/23, showed Resident 6 had an unstageable pressure injury to sacrococcyx,measuring 9 cm (length) x 8 cm (width) x UTD (depth).<br><br>On 2/5/25 at 1110 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to reassess the effectiveness of the wound care treatment as needed when managingthe resident's wounds.<br><br>On 2/25/25 at 1540 hours, an interview and a concurrent medical record review was conducted with the DON for Resident 6. The DON stated a comprehensive care plan should have been developed within seven days after the completion of the comprehensive assessment. The DON verified there was no care plan problem developed for Resident 6's MASD to the bilateral buttocks extending to the sacrococcyx until 1/17/23, and no care plan developed for Resident 6's nonblanchable area to the right heel. The DON was informed and acknowledged the above findings. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain the infection control program and practices designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections as evidenced by:<br><br>* The facility failed to ensure Resident 5 had a physician's order for contact precautions related to Klebsiella pneumoniae ESBL (Extended-Spectrum Beta-Lactamase, a bacterium that produces enzymes that make it resistant to many antibiotic). In addition, the facility failed to ensure the facility staff were informed of the resident's contact precautions.<br><br>* The facility failed to ensure Room B (EBP room) had a trash can inside the resident room and near the exit for discarding PPE after removal as per the facility's policy.<br><br>These failures had the potential for the spread of infections in the facility.<br><br>Findings:<br><br>1. Review of facility's P&P titled Transmission-Based (Isolation) Precautions revised 7/18/23, showed it is the policy of the facility to take appropriate precautions to prevent transmission of pathogens, based on the pathogens modes of transmission.<br><br>When implementing transmission-based precautions, the facility will consider the following:<br><br>a. The identification of resident risk factors that increase the likelihood of transmission (such as<br><br>uncontained secretions or excretions, non-compliance, cognition deficits, incontinence, etc.).<br><br>b. The provision of a private room as available/appropriate.<br><br>c. Cohorting residents with the same pathogen; and<br><br>d. Sharing a room with a roommate with limited risk factors (e.g., without indwelling or invasive<br><br>devices, without open wounds, and not immunocompromised) as appropriate based on the pathogen and method of transmission. The P&P further showed an order for transmission-based precautions/isolation will be obtained for residents who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission effectively. The order for transmission-based precautions/ isolation will specify the type of precaution and reason for the transmission-based precaution. The duration will depend upon the infectious agent or organism involved. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility wide. Additionally, either the CDC category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Medical record review for Resident 5 was initiated on 1/31/25. Resident 5 was admitted to the facility on [DATE].<br><br>Review of Resident 5's H&P examination dated 5/1/24, showed the resident had capacity to understand and make decisions.<br><br>Review of Resident 5's urine culture result reported on 1/11/25, showed Klebsiella pneumoniae ESBL, greater than 100,000 CFU/ml.<br><br>Review of Resident 5's MAR for January 2025 showed the resident received minocycline hydrochloride (used to treat bacterial infections) 100 mg tablet two times a day for ESBL in the urine for 10 days from 1/12 to 1/22/25.<br><br>Review of Resident 5's Order Summary Report for January 2025 failed to show a physician's order for the contact precaution related to Resident 5's ESBL infection in the urine.<br><br>Review of Resident 5's Nurses Progress Notes failed to show documentation the contact precaution for Resident 5 was observed.<br><br>On 1/31/25 at 0850 hours, Room A was observed with contact precaution sign by the door.<br><br>On 1/31/25 at 0908 hours, an interview was conducted with CNA 5. When asked which resident was on contact isolation, CNA 5 stated she did not know which resident was on contact precaution in Room A.<br><br>On 1/31/25 at 0915 hours, an interview was conducted with LVN 3. When asked which resident was on contact isolation, LVN 3 stated she did not know who was on contact precaution in Room A because she did not normally work in Nurse Station A. LVN 3 further stated she would check the physician's order to see if the resident was on isolation precaution, or the resident would usually have a Stop sticker by the resident's name on the door.<br><br>1/31/25 at 0916 hours, Room A was observed a Stop sticker next to Resident 5's name by the door.<br><br>On 1/31/25 at 0917 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated she did not know who was on contact precaution in Room A because she did not usually work in Nurse Station A. RN 2 verified Resident 5 did not have a physician's order for contact precaution.<br><br>On 1/31/25 at 1028 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified there was no physician's order for the contact precaution and no documentation in the Nurses Progress notes to show the contact precautions were observed for Resident 5. The IP stated Resident 5 should have a physician's order for contact precaution related to her Klebsiella pneumoniae ESBL infection in the urine. The IP stated the facility staff member should be informed of the contact isolation precautions for the residents during the change shift report.<br><br>2. Review of facility's P&P titled Enhanced Barrier Precautions (EBP) revised 6/17/24, showed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Initiation of Enhanced Barrier Precautions: EBP are indicated for residents with any of the following:<br><br>i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers)<br><br>Implementation of Enhanced Barrier Precautions:<br><br>a. Make gowns and gloves available prior to performing task. Note: Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care).<br><br>b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.<br><br>c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room).<br><br>d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.<br><br>e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.<br><br>f. Provide education to residents and visitors.<br><br>g. Do not restrict room placement or out-of-room activities due to enhanced barrier precautions.<br><br>Medical record review for Resident 4 was initiated on 1/31/25. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 4's Order Summary Report showed a physician's order dated 1/13/25, to provide wound treatment to Resident 4's pressure ulcer on the sacrococcyx.<br><br>Review of Resident 4's Skin Check notes dated 1/14/25, showed Resident 4 had an unstageable pressure injury to the coccyx and the pressure injury was acquired in-house. The coccyx pressure injury measured 1.1 cm in length, 0.8 cm in width and 0.1 cm in depth, with 100% slough and serosanguineous exudate present.<br><br>On 1/31/25 at 1010 hours, a wound care treatment observation was conducted with LVN 4, who was assisted by CNA 5.<br><br>On 1/31/25 at 1025 hours, Room B (EBP room) was observed without a trash can inside the residents' room and near the exit for discarding reusable PPE after removal.<br><br>On 1/31/25 at 1026 hours, CNA 5 was observed looking for a facility staff to provide an isolation trash can from the other resident's room.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/31/25 at 1028 hours, an interview was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 stated there should be an isolation trash can in the isolation room to discard the reusable PPE.<br><br>On 1/31/25 at 1138 hours, an interview was conducted with the IP. The IP stated there should be a trash can inside the isolation room and near the exit for discarding the PPE after removal according to the facility's policy. The IP was informed and acknowledged the above findings. The IP further stated she received a physician's order for the EBP for Resident 4 to have the proper isolation set-up in the room.<br><br>On 1/31/25 at 1110 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to be aware of the infection prevention precautions during the change of shift report. The DON stated the licensed nurses who did not work in the nurse's station regularly should be aware of the residents' infection precautions. The DON was informed and acknowledged the above findings. |