STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555141	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town & Country	555 East Memory Lane 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the baseline care plan for one of three sampled residents (Resident 1) was initiated upon admission. * The facility failed to ensure Resident 1's baseline care plan included the necessary information to properly care for the resident with ileostomy (a surgery that lets stool pass from your body without going through your colon or anus) and the necessary nutritional interventions to maintain or prevent weight loss of the resident. This failure had the potential for Resident 1 to not receive the necessary resident-centered care.Findings: Review of the facility's P&P titled admission of a Resident revised on 8/23/23, showed the admission process is intended to obtain all possible information regarding the resident for the development of the comprehensive plan of care, and to assist the resident in becoming comfortable in the facility. The residents are admitted to the facility under orders of the attending physician. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. The information gathered will be placed into the resident's medical record via the facility's means of recordkeeping. A baseline care plan will be developed within 48 hours of a resident's admission. Closed medical record review for Resident 1 was initiated on 7/22/25. Resident was admitted to the facility on [DATE], and was discharged on 7/14/25. Review of Resident 1's H&P examination dated 7/9/25, showed resident had the capacity to understand and make decisions. Review of Resident 1's After Visit Summary from the acute care hospital printed on 7/8/25, included an ostomy care discharge instructions. The discharge instruction showed to drink at least 2 liters of fluid (around 8-10 glasses or 64 oz.) per day to prevent dehydration. Half of this (1 liter) should be water, and the other half (1 liter) should be an electrolyte solution like Gatorade, Vitamin Water, Powerade etc., and to notify the colorectal clinic if the daily output is greater than 1,500 ml or if you begin to experience dry mouth/tongue, dizziness, weakness decreased urine output, cramps in abdomen and/or leg or confusion which may be symptoms of dehydration. Additionally, the discharge instruction form included a chart titled Ostomy Intake/Output Daily Measurement with an example of the documentation. The instruction included to bring the chart to the follow up clinic visit. Review of Resident 1's plan of care failed to show a baseline care plan problem to address the resident's ileostomy care and monitoring. On 7/23/25 at 0953 hours, an interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 verified Resident 1's After Visit Summary showed for an ostomy care section to drink at least 2 liters of fluid per day to prevent dehydration, half of this (1 liter) should be water, and the other half (1 liter) should be an electrolyte solution and, to record fluid intake and ileostomy output daily. LVN 1 verified the resident's intake and output was not monitored. On 7/23/25 at 1026 hours, an interview was conducted with the DON. The DON verified a baseline care plan was not initiated for Resident 1 for the ileostomy care and monitoring of the intake and output. The DON stated the baseline care plan should have been initiated for the resident within 48 hours of admission. Cross reference to F684.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the care plan was developed for one of three sampled residents (Resident 1) who had a change in condition. * The facility failed to develop a care plan when Resident 1 had nausea, vomiting, poor meal intake, and weight loss. This failure had the potential for Resident 1 to not receive the necessary care and services.Findings: Review facility's P&P titled Resident Change of Condition revised on 5/22/24, showed it is the policy of this facility that all changes in resident condition will be communicated to the physician. The nurse in charge is responsible for the notification of the physician prior to end of the assigned shift when a change in a resident's condition is noted. To document the resident change of condition and response in Nursing Progress Notes, on Twenty-Four Hour Report and update resident care plan as indicated. Closed medical record review for Resident 1 was initiated on 7/22/25. Resident was admitted to the facility on [DATE], and was discharged on 7/14/25. Review of Resident 1's H&P examination dated 7/9/25, showed the resident had the capacity to understand and make decisions. Review of Resident 1's System Note dated 7/11/25 at 1336 hours, showed the resident had a change in condition wherein resident complained of nausea. Review of Resident 1's Weights and Vitals Summary showed Resident 1's weights for the following dates:- dated 7/9/25, the resident weighed 197 pounds;- dated 7/12/25, the resident weighed 180 pounds; and- dated 7/13/25, the resident weighed 180 pounds. Further review of Resident 1's plan of care failed to show a care plan problem to address the resident had nausea and weight loss. On 7/23/25 at 0953 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified Resident 1's Weights and Vitals Summary showed a weight loss of 17 pounds in four days. LVN 1 verified Resident 1's plan of care was not initiated for the resident's poor appetite and weight loss. On 7/23/25 at 1026 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified a care plan was not initiated for Resident 1's nausea and weight loss. On 7/24/25 at 0954 hours, an interview and concurrent record review was conducted with the RD. The RD stated resident was at risk for weight loss. The RD verified there was no plan of care initiated for the resident to address resident's poor intake and weight loss. The RD further stated she did not initiate a care plan problem until MDS was completed.

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 three sampled residents (Resident 1) attained and maintained the highest practicable physical well-being. The facility failed to to notify Resident 1's physician regarding the discharge instructions from the acute care hospital to provide specific fluid amount and type to the resident, and to monitor the resident's intake and output. In addition, the facility failed to notify the physician regarding the resident's weight loss of 17 pounds timely. This failure posed the risk for Resident 1 to not receive the necessary care and services timely to maintain the resident's highest physical well-being.Findings: a. Review of the facility's P&P titled admission of a Resident revised on 8/23/23, showed the admission process is intended to obtain all the possible information regarding the resident for the development of the comprehensive plan of care, and to assist the resident in becoming comfortable in the facility. Residents are admitted to the facility under orders of the attending physician. Upon admission, the designated facility staff will obtain information and perform assessments as per their respective departments and as per facility protocol. The information gathered will be placed into the resident's medical record via the facility's means of recordkeeping. Review of the facility's P&P titled admission Orders revised on 8/13/23, showed a physician's order is necessary for an individual to be admitted to a facility. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide written and/or verbal orders for the residents' immediate care and needs. The written and/or verbal orders should include at a minimum: a. Dietary; b. Medication orders if indicated; and c. Routine care orders. The orders should allow facility staff to provide essential care to the residents consistent with the resident's mental and physical status on admission. The orders should provide information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. Closed medical record review for Resident 1 was initiated on 7/22/25. Resident 1 was admitted to the facility on [DATE], and discharged on 7/14/25. Review of Resident 1's After Visit Summary discharge instructions dated 6/24 to 7/8/25, showed to provide the resident at least two liters of fluid (one liter should be water and the other one liter should be an electrolyte solution), and to record how much fluid the resident was drinking and the resident's output from the ostomy everyday. Review of Resident 1's Order Summary Report showed a physician's order dated 7/8/25, to monitor the ileostomy output every shift. However, there was no physician's order to monitor the resident's intake. Further review of Resident 1's medical record failed to show if the Attending Physician was notified regarding Resident 1's discharge instructions from the acute care hospital to monitor the resident's intake and output and provide at least two liters of fluid (one liter should be water and the other one liter should be an electrolyte solution). Review of Resident 1's H&P examination dated 7/9/25, showed the resident had the capacity to understand and make decisions. Review of Resident 1's progress notes dated 7/9/25 at 1050 hours, showed Family Member 1 complained to LVN 2 that the facility was not monitoring the resident's intake and output per the acute care hospital's discharge instructions. On 7/22/25 at 1215 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated the facility refused to monitor the resident's intake and output and provide the fluids as directed in the resident's acute care hospital discharge instructions. Family Member 1 further stated the nurse staff had told her the facility knew how to assess the resident's bowel movement without having to monitor the intake and output. b. Review facility's P&P titled Weight Variance Monitoring revised on 11/17/23, showed unusual or significant weight variance includes the following: a. 3% +/- in one week; b. 5% in 30 days; c. 7.5% in 90 days; and d. 10% in 180 days. Unusual or significant weight losses or gains will be reported by nursing to the physician. When weight loss or gain has been identified as a problem, an entry will be included in the Resident Care Plan and reported to the Providers. Review facility's P&P titled Resident Change of Condition revised on 5/22/24, showed it is the policy of this facility that all changes in resident condition will be communicated to the physician. Routine medical change are all symptoms, and unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life-threatening and weight loss or gain. The nurse in charge is responsible for notification of physician prior to end of assigned shift when a change in a resident's condition is noted. If unable to reach a physician, all call to physicians or exchanges requesting callbacks will be documented on the Nursing Progress Note. If the physician has not returned the call by the end of the shift