STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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 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** 49644 Based on interview and medical record review, the facility failed to provide the necessary services as ordered by the physician for one of eight sampled residents (Resident 6). * The facility failed to ensure the psychiatric evaluation and treatment were provided to Resident 6 as ordered. This failure had the potential for the resident not to receive the necessary care and services. Findings: Medical record review for Resident 6 was initiated on 7/5/24. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P Examination dated 5/13/24, showed Resident 6 did not have a capacity to understand and make decisions. Resident 6's diagnosis included senile dementia with psychosis. The H&P examination further showed Resident 6 needed a psychiatry follow up. Review of Resident 6's MDS dated [DATE], showed Resident 6's cognition was moderately impaired. Review of Resident 6's Order Summary Report showed a physician's order dated 5/10/24, for psychiatric evaluation and treatment with Physician 1. Further review of Resident 6's medical record failed to show documented evidence Resident 6's was scheduled and/or seen for psychiatric evaluation and treatment. On 7/29/24 at 0918 hours, an interview was conducted with Resident 6. Resident 6 was asked if he had seen the psychiatrist, Resident 6 stated, no. On 7/31/24 at 1507 hours, an interview and concurrent medical record review was conducted with LVN 2. When asked if Resident 6 had a follow up with psychiatry, LVN 2 stated no. LVN 2 verified Resident 6 did not follow up with the psychiatrist and further stated the psychiatry consult should have been done. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 1037 hours, an interview and concurrent medical record review was conducted with the DON. The DONacknowledged the physician's order for Resident 6 to have a psychiatric evaluation and treatment with Physician 1 was not done. The DON further stated Resident 6 should have followed-up with the psychiatrist.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the post fall assessments were completed for two of two residents (Residents 4 and 5) reviewed for falls. * Resident 4's post fall neuro check assessment was not done. * Resident 5's post fall neuro check assessment was incomplete. These failures had the potential to delay the identification and response to post fall neurological changes. Findings: Review of the facility's P&P titled Assessing Falls and Their Causes revised March 2018 showed the After a Fall section includes the following: - If a resident had just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities; - Obtain record of vital signs as soon as it is safe to do so; - Observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall, and would document findings in the medical record; and - Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness/consciousness and overall function. Note the presence and absence of significant findings. 1. On 7/26/24 at 1320 hours, a concurrent observation and interview was conducted with Resident 4. Resident 4 was observed being awake and lying on his bed. Bilateral floor mattresses were observed on the floor at the right and left sides of the bed. Resident 4 did not speak English. Medical record review for Resident 4 was initiated on 7/26/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 4/24/24, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's MDS dated [DATE], showed the resident had severe cognitive impairment. The MDS also showed the resident needed partial/moderate assistance with mobility. Review of Resident 4's SBAR Communication Form dated 6/10/24, showed at 2130 hours, the CNA found Resident 4 with his knees and legs on the floor, but the rest of body was on the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 1112 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 4 had unwitnessed falls several times. LVN 2 stated a fall was considered a change of condition. LVN 2 further stated after a resident's fall, they had to perform the neuro check assessment which included to obtain the vital signs for 24 hours. The assessment had to be done every 15 minutes for one hour, then every 30 minutes for the next two hours, and every two hours for the next 24 hours. LVN 2 stated the neuro check assessment was filed in the resident's medical record. Further review of Resident 4's medical record review showed no documented evidence of the neuro check assessments for the fall on 6/10/24. On 8/2/24 at 1200 hours, an interview and concurrent medical record review were conducted with LVN 1. LVN 1 stated Resident 4's fall incident on 6/10/24, was considered unwitnessed fall. LVN 1 stated for unwitnessed fall, they had to do the neuro check assessment because it was unwitnessed and no one knew if the resident's head hit the floor. LVN 1 stated after an unwitnessed fall, they monitored the vital signs and neuro assessment every 15 minutes for one hour, then every 30 minutes for two hours, and every two hours for 24 hours as showed on the Neuro Check Sheet. LVN 1 verified there was no neuro check sheet completed for Resident 4's fall incident on 6/10/24. 2. On 7/30/24 at 0730 hours, an observation was conducted with Resident 5. Resident 5 was observed sleeping and lying on his bed. Bilateral floor mattresses were observed on the floor at the right and left sidesof the bed. On 7/30/24 at 0745 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 5 was a high risk for fall and had several unwitnessed falls in the past. Medical record review for Resident 5 was initiated on 7/30/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 3/10/24, showed Resident 5 did not have the capacity to understand and make decisions. Review of Resident 5's SBAR Communication Form dated 7/5/24, showed at 2140 hours, Resident 5 rolled out of bed onto the floor. Review of Resident 5's Neuro Check Sheet assessment initiated on 7/5/24, showed the neuro checks to be completed every 15 minutes for one hour, then every 30 minutes for two hours, and then every two hours for 24 hours. However, the neuro check assessments for 0930, 1130, and 1330 hours, on 7/6/24, were blank. On 8/2/24 at 1200 hours, an interview and concurrent medical record review wasconducted with LVN 1. LVN 1 reviewed the post fall neurological assessment and verified the missing the assessments for 0930, 1130, and 1330 hours, on 7/6/24. On 8/2/24 at 1600 hours, an interview and concurrent medical record review wasconducted with the DON. The DON stated the neurological assessment including vital signs should be done post fall incident for 24 hours, and the neuro check sheet form should be filed in the resident's medical record since it was not done electronically. The DON was informed of the findings for Residents 4 and 5. The DON acknowledged the above findings.