

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Extended Care Hospital of Westminster		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 properly obtain the informed consents for the use of bed exit alarms from the resident or responsible party for three of three sampled residents (Residents 1, 2, 3). * The facility failed to ensure Residents 1, 2, 3 had informed consent for the use of the bed alarm. This failure posed the risk for the residents and their responsible parties to not be informed of their treatment plan and the potential risks. Findings: Review of the facility's P&P titled Informed Consents revised 04/2024 showed each resident will receive in advance all information that is material to a decision to accept or refuse treatment and the resident has the right to accept or refuse any treatment or procedure. If a resident has a responsible person, that individual is informed and consent will be obtained from them. 1. Medical record review for Resident 1 was initiated on 11/3/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 1's H&P examination dated 1/24/25, showed Resident 1 did not have the capacity to understand and make decisions. Review of Resident 1's Order Summary Report showed a physician's order dated 11/1/25, for the bed alarm to alert staff if attempts to get OOB Ad Lib to prevent falls/injury due to poor safety awareness secondary to diagnosis of dementia and to check the placement every shift. Further review of Resident 1's medical record failed to show the consent for the use of the bed exit alarm for Resident 1. On 11/4/25 at 1150 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 1 had a bed alarm in placed. LVN 1 stated since Resident 1's fall, the bed exit alarm was in placed. 2. Medical record review for Resident 2 was initiated on 11/3/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Medical Visit dated 12/13/24, showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 10/27/25, for bed alarm #1 placed on buttocks and bed alarm #2 placed on torso/back to alert staff if attempts to get OOB unassisted to prevent falls/injury due to poor safety awareness secondary to diagnosis of Dementia and history of recurrent falls, and to check the placement every shift. Further review of Resident 2's medical record failed to show the consent for the use of the bed exit alarm for Resident 2. 3. Medical record review for Resident 3 was initiated on 11/3/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 4/17/25, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed a physician's order dated 9/2/25, for the bed alarm to alert staff if attempts to get OOB unassisted to prevent falls/injury due to unsteady gait secondary to diagnosis of muscle weakness, and to check the placement every shift. Further review of Resident 3's medical record failed to show the consent for the use of the bed exit alarm for Resident 3. On 11/5/25 at 1100 hours, an interview and medical record review was conducted with LVN 4. LVN 4 verified Residents 1, 2 and 3 had bed exit alarms in placed. However, the facility did not obtain informed consent from the residents or responsible party for the use of the bed exit alarms. LVN 4 stated the facility had never obtained informed consents for the bed exit alarms. On 11/5/25 at 1130 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Residents 1, 2 and 3 had bed exit alarms in placed and had no informed consent from the resident or responsible party for the use of the bed exit alarms. The DON stated the facility had never obtained informed consent for the use of the bed exit alarms.</p>		