

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Mainplace Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1835 West LA Veta Avenue Orange, CA 92868	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was informed in advance of their proposed treatments or treatment options to choose the preferable option for the change in services.</p> <p>* The facility failed to ensure Resident 1 was informed and given the right to choose his treatment services when the facility changed his outpatient psychiatry services to inhouse psychiatry services. This failure had the potential to prevent the resident from participating in his treatment decisions.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Resident Rights (undated) showed the resident has the right to be informed in advance by the physician or other practitioner or professional of the risks and benefits of proposed care of treatments and treatment alternative options to choose the alternative or options the resident prefers.</p> <p>Medical record review for Resident 1 was initiated on 5/1/24. Resident 1 was admitted to the facility on [DATE].</p> <p>Review of Resident 1's H&P examination dated 1/31/24, showed Resident 1 had the capacity to make decisions.</p> <p>Review of Resident 1's MDS dated [DATE], showed Resident 1 was cognitively intact.</p> <p>Review of the facility document titled AMHS PACT FULLu dated 2/27/24, showed Resident 1 was seen at the outpatient psychiatric office and had future appointments set with AHMS PACT [NAME] on 3/5 and 3/12/24.</p> <p>Review of Resident 1's Initial Psychiatric Evaluation dated 2/27/24, showed Resident 1 had the initial consultation with the inhouse psychiatrist on 2/27/24.</p> <p>On 5/1/24 at 0838 hours, an interview was conducted with Resident 1. Resident 1 stated he had been seen by a psychiatrist in the facility once a month, but it was not his usual psychiatrist from the outpatient psychiatric office. Resident 1 stated he did not know why his outpatient psychiatric services were changed to the inhouse psychiatry services.</p> <p>(continued on next page)</p>

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>On 5/1/24 at 1538 hours, an interview was conducted with the Case Manager for Resident 1. The Case Manager stated since Resident 1 was living in the facility and the facility provided the inhouse psychiatry and psychology services, there was no reason to send the resident out weekly for his outpatient psychiatry appointments. The Case Manager stated Resident 1 had been receiving inhouse psychiatry and psychology services once a month.</p> <p>On 5/2/24 at 1339 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated Resident 1's psychology and psychiatry services were changed to be done inhouse as of 2/27/24. The SSD verified there was no documentation to show Resident 1 was notified or agreed with the change from the outpatient to inhouse psychiatry services.</p> <p>On 5/3/24 at 1252 hours, a follow-up interview was conducted with Resident 1. Resident 1 stated he was not informed in advance of the change from his weekly outpatient psychiatry services to the monthly inhouse psychiatry services. Resident 1 stated he did not agree with the change. Resident 1 stated he would have preferred the outpatient psychiatry services as the frequency of the visits decreased from weekly outpatient to once a month inhouse visits.</p> <p>On 5/3/24 at 1326 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the above findings.</p>

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the laboratory services for one of three sampled residents (Resident 1).</p> <p>* The facility failed to carry out the physician's order for laboratory testing for Resident 1.</p> <p>* The facility failed to ensure the abnormal laboratory test results for Resident 1 were reported to the physician in a timely manner.</p> <p>These failures had the potential to adversely affect the resident's physical health and well-being.</p> <p>Findings:</p> <p>Medical record review for Resident 1 was initiated on 5/1/24. Resident 1 was admitted to the facility on [DATE].</p> <p>a. Review of the facility's P&P titled Physician's Orders, Telephone Orders, and Recapitulation Process (undated) showed all orders must be specific and complete with all necessary details to carry out the prescribed order without any question.</p> <p>Review of Resident 1's Physician Orders dated 1/31/24, showed a physician's order to complete the CBC, CMP, and HbA1C tests in the AM.</p> <p>However, further review of the medical record failed to show documented evidence the CBC, CMP, and HbA1C tests were completed as per the physician's order.</p> <p>On 5/3/24 at 0812 hours, an interview and concurrent medical record review was conducted with RN 1 for Resident 1. RN 1 verified the above findings and stated the CBC, CMP, and HbA1C tests were completed on 2/8/24, seven days later.</p> <p>b. Review of the facility's P&P titled Change of Condition, Response revised 12/2023 showed the nurses shall use their clinical judgment and contact the physician based on the urgency of the situation. The Medical Director shall be notified in the event that the attending physician or on-call physician cannot be reached.</p> <p>Review of Resident 1's Lab Results Report dated 2/8/24, showed the following blood test results were outside of the clinical reference ranges:</p> <ul style="list-style-type: none"> - BUN level of 97 mg/dL (normal reference range: 7-25 mg/dL) - Creatinine level of 5.2 mg/dL (normal reference range: 0.1-1.3mg/dL) - eGFR low estimate level of 12 (normal reference range >59) <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- eGFR high estimate level of 15 (normal reference range >59)</p> <p>Review of Resident 1's Progress Note dated 2/9/24, showed the licensed nurse received the above laboratory results on 2/9/24, and the physician was notified and waiting for a response.</p> <p>However, further review of Resident 1's medical record failed to show documented evidence the licensed nurse had followed up with the physician to report Resident 1's abnormal laboratory results after 2/9/24. In addition, Resident 1's medical record review failed to show documented evidence the Medical Director was notified of Resident 1's abnormal laboratory results when the primary physician could not be reached.</p> <p>Review of Resident 1's Physician Progress Note dated 2/12/24, showed Resident 1 had acute renal failure (sudden and reversible reduction in the kidney function). In addition, the physician ordered to start the intravenous fluids for hydration and schedule the outpatient nephrology consultation visit.</p> <p>Review of Resident 1's eINTERACT Change in Condition Evaluation dated 2/12/24, showed a recommendation from the primary clinician to use 80 ml/hr intravenously every shift (four liters) for elevated BUN/Creatinine until 2/14/24.</p> <p>Review of Resident 1's plan of care showed a care plan problem initiated on 2/12/24, addressing Resident 1's intravenous hydration therapy secondary to elevated BUN/Creatinine levels on 2/8/24. The intervention included to infuse normal saline (use to manage and treat dehydration) at 80 ml/hr for a total of four liters.</p> <p>On 5/3/24 at 0812 hours, an interview and concurrent medical record review was conducted with RN 1 for Resident 1. RN 1 stated the BUN/Creatinine levels on 2/8/24 were very high and verified only one attempt was documented on 2/9/24, to notify the physician of the abnormal lab results. RN 1 stated several attempts should have been made to notify the physician of the abnormal lab results to ensure there were no new orders. RN 1 stated if the critical lab results were identified and the physician could not be reached, the licensed nurse should continue to call the physician and/or attempt to call the physician's exchange services.</p> <p>On 5/3/24 at 1326 hours, an interview and concurrent medical record review was conducted with the DON for Resident 1. The DON verified the Medical Director was not notified of Resident 1's abnormal laboratory results after the primary physician did not respond. The DON verified there were no assessments conducted following the abnormal laboratory results until 2/12/24.</p>		