

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2026
NAME OF PROVIDER OR SUPPLIER Sun Mar Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 West Orange Avenue Anaheim, CA 92804	
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 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop a care plan timely and implement care plan interventions for one of three sampled residents (Resident 1). * Resident 1 did not have a care plan for constipation. Additionally, Resident 1's care plan for diarrhea and loose stools was not developed in a timely manner. There was no monitoring for Resident1's signs and symptoms of dehydration as identified in the care plan. These failures had the potential risk of not providing appropriate, consistent, and individualized care to the resident. Findings: Review of the facility's P&P titled Comprehensive Care Plan dated October 2022 showed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing and mental and psychological needs that are identified in the comprehensive assessment. Medical record review for Resident 1 was initiated on 2/3/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 3/29/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's Nursing Progress Notes dated 4/2/25, showed Resident 1 had loose stools on 4/2/25. The Progress Notes further showed a physician's order to discontinue the docusate sodium (stool softener), to hold Geri-Kot tablet (laxative), and to give Lactobacillus (probiotics to maintain gut health). Review of Resident 1's Order Summary Report showed the following orders:- dated 4/5/25, discontinue docusate sodium oral tablet one tablet via GT in the morning for bowel movement, hold if loose stool; - dated 4/5/25, hold Geri-Kot tablet 8.6 mg one tablet via g-tube for bowel management, hold if loose stool ordered; and- dated 4/5/25, give Lactobacillus oral tablet one tablet via GT two times a day for supplement. Review of Resident 1's care plan for diarrhea and loose stools initiated on 4/9/26, showed interventions including to monitor, document and report as needed for signs and symptoms of dehydration (dry skin and mucous membranes, poor skin turgor, weight loss, anorexia, malaise, hypotension, increase heart rate, fever, abnormal electrolyte levels). Resident 1's care plan for the diarrhea and loose stools was initiated seven days after the first episode of diarrhea/ loose stools started (on 4/2/25). Review of Resident 1's medical record failed to show a care plan was developed for the resident's constipation, and failed to show the resident was monitored for signs and symptoms of dehydration. Review of Resident 1's Nursing Progress Notes dated 4/16/25, showed the resident's abdomen was non- tender, bowel sounds present, diarrhea noted and complaints of nausea. The physician was notified and an order was initiated for loperamide HCl (medication to treat diarrhea) two mg one tablet via GT every eight hours for loose stool or diarrhea. Review of Resident 1's Nursing Progress Notes dated 4/17/25, showed the resident was transferred to the acute care hospital for abnormal vital signs and was admitted to the ICU. On 1/3/26 at 0946 hours, an interview and concurrent medical record review for Resident 1 was conducted with the MDS Coordinator. The MDS Coordinator stated one of her</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555266
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<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>responsibilities was to coordinate the initiation of care plans. The MDS Coordinator stated the admitting supervisors would initiate the basic care plans, and she would add the diagnosis related care plans and medications. The MDS Coordinator stated the charge nurses working the shift complete the episodic care plans when the episode occurs with a timeframe as soon as it happens. The MDS Coordinator further stated care plans are checked the following day by a charge nurse, MDS coordinators, and the DON. The MDS Coordinator verified Resident 1 did not have a care plan for constipation despite Resident 1 taking a laxative and stool softer every day. The MDS Coordinator also verified Resident 1 had loose stools starting 4/2/25, and the care plan was not initiated until 4/9/25. The MDS Coordinator stated the care plan should have been initiated as soon as the episode of diarrhea occurred. The MDS Coordinator stated the care plans were not done until the change of condition was reported. On 1/3/26 at 1414 hours, an interview and concurrent medical record review for Resident 1 was conducted with the IP. The IP stated she checked and completed the infection related care plans. When asked what happened to Resident 1's care plan to address episodes of loose stools, the IP stated the loose stools were just one time on 4/2/25, thus the care plan was initiated on 4/9/25, when the change of condition was reported and documented. The IP reviewed Resident 1's progress notes showing the resident had loose stools. The IP verified the above findings and stated, I will get back to you.</p>