STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Orange Hills	5017 E. Chapman Avenue Orange, CA 92869

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and facility document review, the facility failed to ensure the resident rights were respected for one nonsampled resident (Resident 35). * CNA 3 was using his personal cell phone while feeding Resident 35. This failure had the potential for Resident 35 to be treated without dignity and respect. Findings: Review of the facility's employee Handbook Section Two: Good to Great signed by CNA 3 on 11/5/24, showed any form of personal electronic communication is prohibited during work hours. This includes the use of personal electronic devices. Medical record review for Resident 325 was initiated on 11/12/24. Resident 325 was readmitted to the facility on [DATE]. Review of Resident 325's IDT-BIMS dated 11/12/24, showed the resident was cognitively intact. On 11/14/24 at 0912 hours, an interview was conducted with Resident 325 at their bedside. Resident 325 stated CNA 3 was feeding Resident 35 and on his cell phone the other day. Resident 325 stated Resident 35 was legally blind and not aware of what the CNA was doing, but it was very disrespectful to be on the personal cell phone while providing care to a resident. Medical record review for Resident 35 was initiated on 11/12/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 9/22/24, showed the resident was legally blind. Review of Resident 35's IDT-BIMS dated 11/6/24, showed the resident was cognitively intact. On 11/14/24 at 1350 hours, an interview was conducted with the DON. The DON stated the staff should not use their personal cell phones while performing resident care and on the unit. (continued on next page)

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

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	On 11/15/24 at 0847 hours, a telephone interview was conducted with CNA 3. CNA 3 stated he had used his cell phone three to four times while feeding Resident 35, and he verified the facility's policy was for no cell phones allowed while working.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs of four of 27 final sampled residents (Residents 96, 108, 775, and 78). * The facility failed to ensure Residents 96, 108, 775, and 78's call lights were within the residents' reach. This failure created the potential to negatively impact the residents' psychosocial well-being or result in a delay to provide care. Findings: Review of the facility's P&P titled Nursing clinical, Subject Call Lights/Bell Revised May 2020 showed to leave the resident comfortable and place the call device within the resident's reach before leaving the room. If the call light/bell is defective, immediately report this information to the unit supervisor. 1. On 11/13/24 at 1554 hours, an observation for Resident 96 and concurrent interview was conducted with LVN 11. Resident 96's call light was observed hanging at the back of the bed which was not within the resident's reach. LVN 11 verified it was at the back of the head of bed hanging close to the wall. LVN 11 removed the call light and placed it close to the resident's right arm. LVN 11 verified the call light was functioning. Medical record review for Resident 96 was initiated on 11/13/24. Medical record showed Resident 96 was admitted to the facility on [DATE]. 2. On 11/13/24 at 1558 hours, an observation for Resident 108 and concurrent interview was conducted with LVN 7. Resident 108's call light was seen at the back of the head underneath the pillow, which was out of Resident 108's reach. LVN 7 verified the findings and stated it should be within reach. Medical review for Resident 108 was initiated on 11/13/24. Medical record for Resident 108 showed initial admitted to facility on 6/04/24, and readmitted on [DATE]. 51352 3. On 11/12/24 at 1219 hours, on observation of Resident 775 was conducted. Resident 775 was observed sitting in the wheelchair at the left side of the bed. Resident 775's call light was observed on the floor and not within the resident's reach. On 11/12/24 at 1446 hours, an observation of Resident 775 was conducted. Resident 775 was observed lying in bed on his back. Resident 775's call light was observed on the floor and not within the resident's reach. Medical record review for Resident 775 was initiated on 11/12/24. Resident 775 was admitted to the facility on [DATE]. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 775's H&P examination dated 11/9/24, showed Resident 775 did not have the capacity to understand and make decisions. On 11/12/14 at 1456, an observation and concurrent interview was conducted with CNA 2. CNA 2 verified Resident's 775's call light was on the floor and not within the resident's reach. CNA 2 stated the call light should always be within the resident's reach. CNA 2 was observed to put the call light within the resident's reach. On 11/15/24 at 1504 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 49644 4. On 11/12/24 at 0919 hours, during the initial tour of the facility, Resident 78's call light was observed on the right shoulder of Resident 78. Medical record review for Resident 78 was initiated on 11/12/24. Resident 78 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 78's H&P examination dated 8/7/24, showed the resident did not have the capacity to understand and make decisions. On 11/12/24 at 0928 hours, a concurrent observation of Resident 78's call light and interview was conducted with LVN 13. LVN 13 verified Resident 78's call light was on Resident 78's right shoulder and not within Resident 78's reach. LVN 13 stated Resident 78 was able to use the call light and had movement on both hands. LVN 13 moved the call light under Resident 78's right hand. On 11/14//24 at 1435 hours, an interview was conducted with the DON. The DON stated most residents in the Subacute Unit used the call light. The DON further stated the staff needed to place the call light where the resident could access it. The DON stated the staff determined what kind of call light to use based on observation and informed the maintenance for the appropriate call light. On 11/15/24 at 1451 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to notify the physician timely of the resident's changes in status for two of 27 final sampled residents (Residents 51 and 56). * Resident 51's physician was not notified timely for a change in swallow status. * Resident 56's physician was not notified of the resident's recent episodes of emesis and of the resident's tube feeding being placed on hold. These failures resulted in a delay of physician notification, intervention and/or implementation of the physicians' orders with the potential for an adverse resident outcomes. Findings: Review of the facility's P&P titled Change of Condition Reporting dated May 2019 showed all changes in the resident's condition will be communicated to the physician. The staff will document the change of condition in the eInteract Change of Condition UDA and in the nursing progress notes. All attempts to notify the physician will be documented in the nursing progress notes. 1. Medical record review for Resident 51 was initiated on 11/12/24. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Order Summary Report dated 11/14/24, showed a physician's order dated 5/24/24, for diet to include thin liquids consistency. Review of Resident 51's Progress Notes showed the Social Services note dated 11/4/24. The note showed the resident's family member informed the SSD that he noticed the resident was having a hard time swallowing liquids. The note showed the SSD notified the nursing staff, and the nursing staff would notify the physician. On 11/13/24, an interview was conducted with the Speech Therapist. The Speech Therapist stated she heard a few days ago that the resident was having difficulty swallowing and just did her screening today and recommended a swallow study. The Speech Therapist stated the resident's family member told her today the resident was having difficulty drinking liquids with a straw and they were using a syringe to give her liquids. Review of Resident 51's Progress Notes showed a Change in Condition note dated 11/13/24 at 1803 hours, showed the resident was having increased difficulty with the use of straw and the physician was notified at 1540 hours. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1404 hours, an interview and concurrent medical record review were conducted with the DON. The DON stated there was a change in condition for Resident 56's difficulty swallowing yesterday. When asked the expectation for reporting a change in condition, the DON stated for swallowing changes with liquids, to address right away since there was an increased risk of injury. The DON stated the nursing communicated to the Director of Rehabilitation and a Speech Therapy screen was done. The DON then reviewed the Social Services note dated 11/4/24, and verified the facility failed to notify the physician timely of a change in condition. 2. Medical record review for resident 56 was initiated on 11/12/24. Resident 56 was readmitted to the facility on [DATE]. Review of Resident 56's Order Summary Report dated 11/14/25, showed a physician order dated 10/21/24, for Vital 1.5, to provide 1900 ml daily at 95 ml/hr for 20 hours; to start at 1500 hours and run until the total volume delivered. On 11/13/24 at 1510 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 stated the resident's tube feeding was held since the resident had episodes of vomiting and constipation since last night. LVN 3 stated they ran the resident's tube feeding and the resident received their tube feeding approximately for two hours during the shift. LVN 3 stated they did not notify the physician of the resident's vomiting or need to hold the resident's tube feed and was unsure if the prior shift, night shift, had notified the physician. When asked how much formula the resident received since yesterday's feeding was started at 1500 hours, LVN 6 went to Resident 56's feeding pump and stated the resident received 612 ml (1288 ml less than the ordered dose) of formula since she hung the current 1000 ml bottle yesterday at 1500 hours. The LVN stated the bottle had approximately 500 ml of formula left. On 11/14/24 at 1328 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated even though Resident 56 had a history of vomiting, since there was no current order for Zofran (an antiemetic) the nurse should have notified the physician. The DON also stated since the resident's weight was already low, the nursing staff should have notified the physician and obtained an order prior to holding the resident's tube feeding. Cross reference to F693.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, and medical record review, the facility failed to provide a safe and comfortable environment for one nonsampled residents (Resident 35). * The staff went through the resident's belongings without the resident's consent. This failure resulted in the resident being upset staff went through her personal belongings, which had the potential to negatively impact the resident's well-being. Findings: Medical record review for Resident 35 was initiated on 11/12/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 9/22/24, showed the resident was legally blind. Review of Resident 35's IDT -BIMS dated 11/6/24, showed the resident was cognitively intact. Medical record review for Resident 325 was initiated on 11/12/24. Resident 325 was readmitted to the facility on [DATE]. Review of Resident 325's IDT -BIMS dated 11/12/24, showed the resident was cognitively intact. On 11/14/24 at 0833 hours, during a medication administration observation with LVN 2 and Resident 35, Resident 35 told the nurse I need state, after informing the resident again I was present, the resident stated early in the morning while she was sleeping, someone came into her room with a flashlight and went through her things while she was sleeping, and to talk to her roommate (Resident 325) who witnessed it. Resident 35 repeated the above two more times during her medication administration, and stated her roommate saw it. On 11/14/24 at 0912 hours, an interview was conducted with Resident 325. Resident 325 stated on 11/13/24 at 0445 hours, she observed two people dressed like staff, entered the room, and went to Resident 35's bedside. Resident 325 stated one staff member had a flashlight and was going through Resident 35's personal belongings on top of their tray table and bedside table, and then looked through items in the drawer. Resident 325 stated Resident 35 was slept through everything. She told the resident later in the morning and Resident 35 was very upset. On 11/14/24 at 1350 hours, an interview was conducted with the DON. The DON stated on 11/12/24, the staff was instructed to check the resident's bedside to ensure proper labeling of items and check the food expiration dates. The DON stated the staff should have gotten permission of the resident's before checking their belongings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview and medical record review, the facility failed to ensure the necessary care and services provided to two of 27 final sampled residents (Residents 33 and 73). * Resident 73's skin and wound consult recommendations were not followed up timely by the facility. * Resident 33 was not monitored every shift for at least 72 hours following the weight loss. These failures resulted in a potential delay of identifying changes in the residents' statuses and/or a delay of implementing the interventions to ensure the quality of care was provided. Findings: 1. Medical record review for Resident 73 was initiated on 11/12/24. Resident 73 readmitted to the facility on [DATE]. Review of Resident 73's skin and wound consult dated 10/30/24, showed the resident was seen for dry scattered rashes. The note showed the resident was already being treated with Triamcinolone 0.1% (a topical cream used for skin conditions) for sever itchiness. The dermatologist's recommendations included the following: - Ensure a daily adequate gentle skin care regimen: daily lukewarm baths, aggressive emollient therapy with either Aquaphor or Vaseline afterwards, with frequent reapplication of emollients two to three times a day. - Switch all personal hygiene products to fragrance-free - Avoid harsh soaps and hot water showers, lukewarm is best. Review of Resident 73's medical record failed to show the physician was notified of the dermatologist's recommendations. On 11/12/24 at 1137 hours, an interview was conducted with Resident 73 at their bedside. Resident 73 stated the skin was so itchy, got a cream to put on which helped a little, but at night, the itching was worse. On 11/14/24 at 1615 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated once a consultant report was received, the protocol was for the nurse to notify the physician of the recommendations, obtain new orders if any, and document everything in the resident's medical record. The DON then reviewed Resident 73's wound and skin consultant report and medical record, and verified Resident 73's medical record failed to show the physician was notified of the consultant's recommendations. 49644 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled Change of Condition Reporting dated 5/2019 showed the licensed nurse responsible for the resident will continue assessment and documentation every shift for at least 72 hours or until condition has stabled. Medical record review for Resident 33 was initiated on 11/12/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's MDS dated [DATE], showed Resident 33 had severe cognitive impairment. Review of Resident 33's eINTERACT (a program to reduce the frequency of transfers to the acute hospital) Change in Condition Evaluation V4.2 dated 11/4/24, showed Resident 33's change of condition was weight loss. Further review of Resident 33's medical record failed to show Resident 33 was continuously monitored every shift for at least 72 hours after a change of condition identified related to Resident 33's weight loss. On 11/14/24 at 1447 hours, a concurrent interview and medical record review was conducted with the ADON. The ADON verified Resident 33 was not monitored on the night shift on 11/5/24, and the day shift on 11/7/24. The ADON stated the licensed nurse should be monitoring and reassessing the resident when there was a change of condition. On 11/15/24 at 0942 hours, a concurrent interview and medical record review was conducted with RN 3. RN 3 verified Resident 33 was not monitored on the night shift of 11/5/24, and day shift on 11/7/24. RN 3 stated the licensed nurses should have checked the residents who were being monitored for 72 hours so they would know if the residents were improving or not. On 11/15/24 at 1531 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, and medical record review, the facility failed to ensure the staff reported and addressed a new pressure ulcer timely for one of three final sampled residents (Resident 51) reviewed for pressure ulcers. This failure had the potential to result in a delay of treatment and interventions being put in place to prevent further decline. Findings: Medical record review for Resident 51 was initiated on 11/12/24. Resident 51 was admitted to the facility on [DATE]. On 11/14/24 at 1024 hours, an observation of Resident 51's being transferred to the wheelchair after her shower and morning ADL care provided by the CNA and RNA. After CNA 1 and the RNA left the resident's bedside, an observation of Resident 51's right heel showed an open area of approximately 2 cm with a minimal depth. Review of Resident 51's medical record showed no documented evidence of a wound located on the resident's right heel. On 11/14/24 at 1409 hours, an interview and medical record review were conducted with Treatment Nurse 1. Treatment Nurse 1 stated Resident 51 had a resolved non-pressure skin issue to their right medial foot, and there was no injury to the right heel. Treatment Nurse 1 reviewed a photograph of Patient 51's right heel taken on 10/14/24 at 1024 hours, and stated they were not aware of that wound. On 11/14/24 at 1432 hours, an interview was conducted with CNA 1 and the DON. CNA 1 stated today was their first time being assigned to Resident 51 and this morning, they observed the wound to Resident 51's right heel during the shower. CNA 1 stated they reported it to Treatment Nurse 2 sometime after lunch. The DON stated the CNA should have notified the treatment nurse timelier, and not wait until after lunch. On 11/15/23 at 0810 hours, an interview was conducted with Treatment Nurse 2. Treatment Nurse 2 stated they were notified about Resident 51's right heel pressure injury by CNA 1 yesterday afternoon. On 11/15/24 at 0817 hours, an interview was conducted with the DON. On 11/15/24 at 1140 hours, a telephone interview was conducted with CNA 2. CNA 2 stated they were assigned to Resident 51 two days earlier in the week and observed a callous to the resident's right heel. CNA 2 stated they did not report it because they did not realize it was a new skin issue, since they had seen the treatment nurse in the resident's room in the past.

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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** 39683 Based on interview and medical record review, the facility failed to implement two staff assistance for ADL care for one of eight final sampled residents (Resident 51) reviewed for accident harzards. This failure resulted in the resident sustaining another fall, which had the potential to negatively impact the resident's well-being. Findings: Medical record review for Resident 51 was initiated on 11/12/24. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Fall Committee IDT note dated 8/23/24 at 2023 hours, showed Resident 51 sustained a fall on 8/19/24. The note showed a CNA rolled the resident in bed to place a mechanical lift sling under the resident, and the resident slid off the bed. The IDT note showed they recommended two-person assistance with ADL care. Review of Resident 51's Fall Committee IDT note dated 10/2/24 at 1459 hours, showed Resident 51 sustained a fall on 9/30/24. The note showed a CNA was providing bedside care and the resident began to slide off the bed. On 11/14/24 at 1427 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for the fall on 9/30/24, the CNA was performing ADL care without assistance and should have two staff assistance with ADL care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services to prevent UTI for one of two final sampled residents (Resident 30) reviewed for indwelling urinary catheter. * Resident 30's urinary drainage bag and tubing were positioned above the bladder. This failure posed the risk for Resident 30 to develop urinary tract infection and other complications from UTI. Findings: Review of the facility's P&P titled Nursing Clinical, Subject Catheter Drainage Bag Revised November 2019 showed under the Standard Drainage Bag procedures, to position the drainage bag below the level of the resident's bladder and the drainage bag should be kept off the floor. On 11/14/24 at 0839 hours, an observation for Resident 30 and concurrent interview was conducted with CNA 6. Resident 30's indwelling urinary catheter drainage bag was observed inside the dignity bag (a bag used to cover and hold the catheter drainage bag so it is not visible) but its position was higher than the bladder, CNA 6 stated the indwelling urinary catheter bag must be lower than the bladder. On 11/14/24 at 0844 hours, another observation for Resident 30 and concurrent interview was conducted with LVN 8. LVN 8 stated the indwelling urinary catheter drainage bag must be below the bladder. LVN 8 verified the catheter drainage bag and tubing were above the bladder. On 11/14/24 at 0912 hours, an interview was conducted with the SAU Manager. The SAU Manager verified the catheter drainage bag was higher than the urinary bladder. The SAU Manager stated it must be lower than the bladder at all times. The SAU Manager repositioned the urine bag to be lower than the bladder at the right side of Resident 30's bed. Medical record review for Resident 30 was initiated on 11/14/24. Medical Record showed Resident 30 was originally admitted on [DATE], and readmitted on [DATE]. On 11/14/24, review of Resident 30's care plan was conducted. Resident 30's care plan showed a care plan problem addressing the use of indwelling urinary catheter for neurogenic bladder initiated on 4/11/24, and revised on 5/17/24. The care plan interventions revised on 4/11/24, included to position the catheter drainage bag and tubing below the level of the bladder and away from the room entrance door.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, and medical record review, the facility failed to ensure the correct enteral formula was administered to one of two final sampled residents (Resident 56) reviewed for tube feeding * Resident 56 had the incorrect strength of tube feeding administered. This failure resulted for a less than the ordered calories to be administered to the resident, which had the potential to negatively impact the resident's well-being. Findings: Medical record review for Resident 56 was initiated on 11/12/24. Resident 56 was readmitted to the facility on [DATE]. Review of Resident 56's Order Summary Report dated 11/14/25, showed a physician order dated 10/21/24, for Vital 1.5, to provide 1900 ml daily at 95 ml/hr for 20 hours, and to start at 1500 hours, and run until the total volume delivered. On 11/13/24 at 1510 hours, an observation, interview, and medical record review was conducted with LVN 1. LVN 1 stated they held the resident's tube feeding due to vomiting and for approximately two hours their shift (0700-1900 hours shift). When asked how much formula the resident had received since yesterday's feeding was started at 1500 hours, LVN 6 went to Resident 56's feeding pump and stated the resident received 612 ml of formula since she hung the current 1000 ml bottle yesterday at 1500 hours. The LVN stated the bottle had approximately 500 ml of formula left. LVN was asked what type of formula was hanging, the LVN replied Vital 1.2 (1.2 calories per ounce), and verified the resident should be receiving Vital 1.5 (1.5 calories per ounce). Cross reference to F580, example #2.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for four of seven residents (two final sampled residents, Residents 65 and 83; and two nonsampled residents, Residents 725 and 726) reviewed for respiratory care. * The facility failed to ensure Residents 83, 725, and 726's oxygen tubing was dated. * The facility failed to ensure Resident 65 received oxygen as ordered by the physician. These failures had the potential to put the residents at risk for adverse effects of the inaccurate administration of oxygen and improper care of oxygen equipment. Findings: Review or the facility's P&P titled Oxygen Administration (mask, cannula, catheter, use of humidifier) revised 12/2023 showed it is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as emergency measure until the order can be obtained. Oxygen tubing is to be replaced every seven days. 1. On 11/12/24 at 0826 hours, an observation for Resident 725 and concurrent interview was conducted with LVN 14. Resident 725 was observed asleep in bed receiving 2.5 liters per minute of oxygen via tracheostomy. LVN 14 verified Resident 725's oxygen tubing was undated. Medical record review for Resident 725 was initiated on 11/12/24. Resident 725 was admitted to the facility on [DATE]. Review of Resident 725's Order Summary Report dated 11/13/24, showed a physician's order dated 11/9/24, to administer humidified oxygen via T-bar/T-mask at two liters per minute to keep oxygen saturation level greater or equal to 92% every shift. On 11/14/24 at 1435 hours, an interview was conducted with the DON. The DON stated the subacute unit's RT had their own weekly schedule. The DON stated the oxygen tubing and humidifier should be dated. 2. On 11/12/24 at 0828 hours, an observation for Resident 726 and concurrent interview was conducted with LVN 14. Resident 726 was observed asleep in bed with oxygen administered via tracheostomy at three liters per minute. LVN 14 verified there was no date observed on Resident 726's oxygen tubing. Medical record review for Resident 726 was initiated on 11/12/24. Resident 726 was admitted to the facility on [DATE]. Review of Resident 726's Order Summary Report dated 11/13/24, showed a physician's order dated 11/12/24, to administer humidified oxygen via T-bar/T-mask at one liter per minute every day and night shift as tolerated, and to place on A/C (assist-control ventilation) if not tolerated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1435 hours, an interview was conducted with the DON. The DON stated the subacute unit's RT had their own weekly schedule. The DON stated the oxygen tubing and humidifier should be dated. 3. On 11/12/24 at 0826 hours, an observation for Resident 83 and concurrent interview was conducted with LVN 14. Resident 83 was observed asleep in bed receiving two liters per minute of oxygen via tracheostomy. LVN 14 verified Resident 83's oxygen tubing was undated. Medical record review for Resident 83 was initiated on 11/12/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report dated 11/13/24, showed a physician's order dated 9/13/24, to administer humidified oxygen via T-bar/T-mask at two liters per minute to keep oxygen saturation level greater or equal to 92% every shift. On 11/12/24 at 0936 hours, an interview was conducted with RRT 1. RRT 1 stated the oxygen tubing was supposed to be dated during the night shift every Saturdays and if needed. RRT 1 stated the humidifier should be changed and dated, and oxygen should be dated if there was no date. On 11/13/24 at 1028 hours, an interview was conducted with LVN 11. LVN 11 stated the RT usually took care of the oxygen tubing. LVN 11 stated she would change the oxygen tubing and put the date if there was no date on the oxygen tubing. On 11/13/24 at 1259 hours, an interview was conducted with LVN 15. LVN 15 stated the RT changed the humidifier and oxygen tubing on the night shift every Saturday. LVN 15 stated according to the policy and the RT director, the humidifier and oxygen tubing should be replaced and dated if there was no date. On 11/14/24 at 1435 hours, an interview was conducted with the DON. The DON stated the subacute unit's RT had their own weekly schedule. The DON stated the oxygen tubing and humidifier should be dated. On 11/15/24 at 1451 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 48332 4. Review of the facility's P&P titled Policy/ Procedure- Nursing Clinical, Subject-Oxygen Administration (Mask, Cannula, Catheter, use of Humidifier) revised 12/2023, showed it is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. Procedure showed obtain appropriate physician's order. Medical record review for Resident 65 was initiated on 11/14/24. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's Order Summary Report showed an order dated 3/7/24, for humidified oxygen via T-bar/ T-mask at 3 liters per minute to keep oxygen saturation level greater or equal to 92% every day and night shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 65's care plan date revised 3/5/24, showed the resident had tracheostomy related to impaired breathing mechanics. The interventions dated 3/5/24, showed to administer oxygen as ordered and give humidified oxygen as prescribed. On 11/14/24 at 0930 hours, an observation was conducted of Resident 65. Resident 65 had a tracheostomy with T-bar connected to oxygen being administered at 4 liters per minute. On 11/14/24 at 1347 hours, a concurrent observation of Resident 65 and interview was conducted with LVN 8. LVN 8 verified Resident 65's oxygen was at 4 liters per minute and did not match the physician's order.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure three of five final sampled residents (Residents 18, 41, and 56) reviewed for side rail use remained free from the accident hazards associated with the use of elevated side rails. * The facility failed to ensure the accurate and complete assessments and evaluations for the side rails use for Resident 18. * The facility failed to ensure documented evidence of the least restrictive measures attempted prior to the side rail use for Resident 41. * Resident 56's siderail order was for an inappropriate use. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Bed Rail Assessment revised on 8/2017 showed the facility to attempt to use appropriate alternatives prior to installing a side rail or bed rail. If a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. 1. On 11/13/24 at 0745 hours, Resident 18 was observed lying in bed with 1/4 (quarter) side rails elevated. Resident 18 was lying in bed and watching the television. Resident 18 stated he used the side rails for positioning. Medical record review for Resident 18 was initiated on 11/12/24. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Order Summary Report showed a physician's order dated 9/9/24, for bilateral 1/4 side rails up for mobility and positioning. Review of Resident 18's MDS dated [DATE], showed Resident 18's cognition was intact. Review of Resident 18's LN-Restraint/Enabling Device/Safety Device Evaluation-V2 dated 9/16/24, did not show the measures or interventions attempted before implementing the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 18's medical record failed to show the least restrictive measures were evaluated if effective. On 11/14/24 at 0855 hours, an observation and concurrent interview was conducted with CNA 8. CNA 8 verified Resident 18's had the bilateral 1/4 side rails. CNA 8 stated Resident 18 was able to use the 1/4 side rails for turning and positioning. On 11/14/24 at 0939 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 18's LN-Restraint/Enabling Device/Safety Device Evaluation-V2 did not show the measures attempted before implementing the side rails and the least restrictive measure was not done. The ADON further stated the licensed nurse would try everything prior to applying the side rails. The ADON stated the licensed nurse forgot to check the box on the measures attempted before implementing the side rails. On 11/15/24 at 1531 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 51352 2. Review of the facility's P&P titled Bedrail assessment dated ,d+[DATE] showed it is the policy of this facility to use appropriate alternatives prior to installing a side or bed rail. The facility should maintain evidence of the alternatives attempted that failed to meet the resident's needs and the alternatives considered but not attempted because they were inappropriate for the resident. Medical record review for Resident 41 was initiated on 11/12/24. Resident 41 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 41's Order Summary Report dated 11/13/24, showed the physician's order dated 10/2/24, for the use of 1/4 side rails for positioning and ease in mobility as an enabler. Review of Resident 41's LN-Restraint/Enabling Device/Safety Device Evaluation- V2 dated 10/2/24, showed Resident 41 had an unsteady gait which contributed to her risk for fall and/or need for a safety/enabling device. The evaluation showed Resident 41 requested the side rails to enhance bed mobility. The evaluation failed to show documented evidence of the least restrictive alternatives implemented before side rails use. On 11/12/24 at 0803 hours, an interview was conducted with Resident 41. Resident 41 was observed lying in bed with the bilateral 1/4 side rails elevated. Resident 41 stated she used the side rails to change positions in the bed. On 11/13/24 at 0937 hours, Resident 41 was observed lying in the bed with the bilateral 1/4 side rails elevated. On 11/13/24 at 1159 hours, a follow-up interview and concurrent observation was conducted with Resident 41. Resident 41 stated she requested the side rails to assist her with position changes while in the bed. Resident 41 stated the side rails on the bed were always elevated. Resident 41 stated the facility did not offer her alternatives for the use of the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 1500 hours, an interview, concurrent medical record review, and facility document review was conducted with the DON and ADON. The DON verified Resident 41's side rail use as per the resident's request. The DON stated the facility would recommend the least restrictive alternatives for the residents prior to the use of the side rails. The DON stated the least restrictive alternatives were documented on the LN-Restraint/Enabling Device/Safety Device Evaluation- V2. However, Resident 41's LN-Restraint/Enabling Device/Safety Device Evaluation- V2 dated 10/2/24, failed to show documented evidence of the least restrictive alternatives implemented before initiating the side rail use. On 11/13/24 at 1621 hours, a follow-up interview and concurrent medical record review was conducted with the DON. The DON verified Resident 41's LN-Restraint/Enabling Device/Safety Device Evaluation- V2 dated 10/2/24, failed to show the least restrictive alternatives implemented before the side rail use. The DON stated the interventions on the evaluation form were not appropriate for Resident 41, and the facility did not implement the least restrictive alternatives before initiating the side rail use. The DON verified the least restrictive alternatives should have been implemented for Resident 41 before initiating side rail use. On 11/13/24 at 1643 hours, a follow-up interview was conducted with the DON. The DON verified the facility should have documented the least restrictive alternatives implemented before initiating side rail use for Resident 41 and/or documented the alternatives were inappropriate for Resident 41 in the LN-Restraint/Enabling Device/Safety Device Evaluation. When asked for documentation of the least restrictive alternatives were implemented prior to Resident 41's use of the side rails, the DON provided Resident 41's Physical Therapy Treatment Encounter Note(s) dated 10/10/24. The Encounter Note for Resident 41 showed the PTA's recommendations included training in rolling, scooting, and partial bridging to facilitate independence in bed mobility. However, the DON verified the side rails were already in use for Resident 41 on the date of the PTA's note and therefore, would not be considered a recommendation for the least restrictive alternatives before initiating the side rail use. On 11/15/24 an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 39683 3. Medical record review for Resident 56 was initiated on 11/12/24. Resident 56 was readmitted to the facility on [DATE]. Review of Resident 56's Order Summary Report dated 11/14/25, showed a physician order dated 9/1/24, for use of the bilateral 1/4 side rails for positioning and ease in mobility. Review of Resident 56's plan of care showed a care plan problem addressing the resident at risk for falls with an intervention for the use of 1/4 side rails for positioning and ease in mobility as an enabler. On 11/12/24 at 1613 hours, Resident 56 was observed lying in bed with the bilateral padded 1/4 side rails up. The resident did not respond to verbal stimulation and was not observed with purposeful movement. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 1510 hours, an interview and concurrent observation was conducted with LVN 1 at Resident 56's bedside. LVN 1 verified Resident 56 had the bilateral padded 1/4 side rails, and stated the resident did not use the side rails for repositioning and had no purposeful movement. On 11/14/24 at 1328 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 56 did not have purposeful movement and was unable to self-position. The DON reviewed the resident's physician's order and verified the order for the bilateral padded 1/4 side rails was an inappropriate use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51352 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services when: * The facility failed to ensure all controlled medications were accounted for and documented for one of three inspected medication carts (Medication Cart A) with controlled medications. * The facility failed to ensure accurate and complete documentation of controlled medication administration for two nonsampled residents (Residents 22 and 94). These failures had the potential for the medications to be administered in errors and opportunities for drug diversion. Findings: Review of the facility's P&P titled Controlled Medications revised 12/2019 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record: - Date and time of the administration. - The amount administered. - Signature of the nurse administering the dose (completed after the medication is administered). At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented on a controlled drug count audit record. 1. On 11/15/24 at 1056 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 3. The form titled Narcotic Count Sheet dated 11/1/24 to 11/15/24, showed the following entries were crossed out with a single line for 11/7/24. - 7 am on column: signature for oncoming 7 am nurse -7 pm off column: signature for off going 7 pm nurse - Count correct column: a check mark - Key exchange column: a check mark When LVN 3 was asked why the above entries were crossed out, LVN 3 stated she filled out the row for 11/7/24 in error and crossed out the entries. LVN 3 verified the Narcotic Count Sheet did not show documentation licensed staff performed the controlled substances count for Medication Cart A on 11/7/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/15/24 at 1113 hours, an inspection of Medication Cart A and concurrent count of the controlled medications, medical record review, and interview was conducted with LVN 3. a. A bubble pack (type of pre-formed, plastic packaging that seal individual tablets until they are taken) of Resident 94's hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg tablets showed a total of 21 tablets remaining. However, the Medication Count Sheet for Resident 94 showed an incomplete entry on row 20. The entry for row 20 showed a date of 11/15/24, and LVN 3's initials. The column titled time for row 20 was blank. LVN 3 stated Resident 94 received the hydrocodone-acetaminophen medication around the clock and she started to fill out the rows for tablet 20 in anticipation of Resident 94's next dose. In addition, LVN 3 stated the Medication Count Sheet should be completed only at the time of the medication administration to ensure correct counts of controlled medications. b. A bubble pack of Resident 22's lorazepam (antianxiety medication) 0.5 mg tablets showed a total of 15 tablets remaining. However, the Medication Count Sheet for Resident 22 showed there were 16 tablets remaining. LVN 3 verified the number of remaining hydrocodone-acetaminophen tablets on the Medication Count Sheet for Resident 22 did not match the number of tablets remaining in the bubble pack. LVN 3 stated the count sheet was incorrect due to the lorazepam 0.5 mg tablet being administered to Resident 22 at 0815 hours on 11/15/24, but not documented on the Medication Count Sheet. Review of Resident 22's MAR for November 2024 showed documentation the lorazepam 0.5 mg was administered at 0815 on 11/15/24. LVN 3 verified the Medication Count Sheet documentation was not done for Resident 22's lorazepam 0.5 mg given at 0815 on 11/15/24, and documentation should be completed at the time the medication was given. LVN 3 stated documenting on the count sheet at the time when the medication was given ensured the correct counts of the controlled substances. LVN 3 verified all the above findings. On 11/15/24 at 1504 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. The DON verified the documentation on the Medication Count Sheet must be completed at the time when the medications were given. The DON verified documentation of controlled substance administration should not be filled out prior to the medication administration to prevent drug diversion. Furthermore, the DON verified the Narcotic Count Sheet for Medication Cart A failed to show documentation a controlled substance count was performed on 11/7/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the orthostatic blood pressure was monitored accurately as ordered by the physician related to the use of an antipsychotic medication for one of five final sampled residents (Resident 42) reviewed for unnecessary medications. This failure had the potential for Resident 42 to have adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dose of the psychotropic medication for Resident 42. Findings: Review of the facility's P&P titled Unnecessary Drugs revised 5/2007 showed it is the policy of the facility that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: 1. In excessive dose (including duplicate therapy); 2. For excessive duration; 3. Without adequate monitoring; 4. Without adequate indications for its use; 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 6. Any combinations of the reasons above. Under the Procedures section, the facility must monitor and track progress towards the therapeutic goal(s) and detect the emergence or presence of any significant adverse consequences for them to be minimized. Review of the facility's P&P titled Postural Hypotension, assessment dated [DATE], showed it is the policy of this facility to assess for postural hypotension if ordered by the physician. Note changes in blood pressure while the resident is lying and either sitting or standing. Allow 5 to 8 minutes between position changes before obtaining blood pressure. Medical record review for Resident 42 was initiated on 11/12/24. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's Order Summary Report dated 11/14/24, showed the following physician's orders: (continued on next page)

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New Orange Hills	5017 E. Chapman Avenue Orange, CA 92869

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/28/24, to administer Zyprexa (antipsychotic medication) 2.5 mg one tablet by mouth in the morning for schizophrenia (chronic mental disorder that affects how people think, perceive reality, and interact with others). - dated 5/28/24, to administer Zyprexa 5 mg one tablet by mouth at bedtime for schizophrenia. - dated 4/14/23, to monitor orthostatic BP while lying one time a day every Monday. - dated 4/14/23, to monitor orthostatic BP while sitting one time a day every Monday. Review of Resident 42's MAR for August through November 2024 showed the following medication was administered to Resident 42: - Zyprexa 2.5 mg tablet daily at 0900 hours, from 8/1 to 11/14/24; and - Zyprexa 5 mg tablet daily at 2100 hours, from 8/1 to 11/14/24. Further review of Resident 42's MAR for August through November 2024 showed the orthostatic BP (lying and sitting) were scheduled to be monitored every Monday. However, the blood pressure readings for both positions were the same as follows: - On 8/5/24, the blood pressure readings were 145/79 mmHg for the lying position and 145/79 mmHg for the sitting position. - On 8/19/24, the blood pressure readings were 137/74 mmHg for the lying position and 137/74 mmHg for the sitting position. - On 9/2/24, the blood pressure readings were 139/73 mmHg for the lying position and 139/73 mmHg for the sitting position. - On 11/11/24, the blood pressure readings were 125/78 mmHg for the lying position and 125/78 mmHg for the sitting position. On 11/14/24 at 1557 hours, an interview and concurrent medical record review for Resident 42 was conducted with the DON. The DON was informed and verified the above findings. The DON verified Resident 42's orthostatic BP was not accurately monitored and stated there should be a difference of the resident's BP readings when the resident was lying and sitting. The DON stated the orthostatic BP readings should not be the same for the sitting and lying position if the procedure for taking the orthostatic BP readings was followed. On 11/15/24 at 0940 hours, an interview and concurrent medical record review for Resident 42 was conducted with LVN 16. When asked about the procedure for taking orthostatic blood pressure readings, LVN 16 stated the BP was taken with the resident lying down. A second BP was taken as soon as the resident was sitting up. LVN 16 stated the orthostatic BPs readings should not be the same for the sitting and lying position. LVN 16 verified the orthostatic BP readings for Resident 42 were the same for the above dates. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 1504 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39683 Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the medication error rate was below 5%. The facility's medication rate was 25% for nine medication errors out of 36 medication administration observations. One nurse (LVN 2) observed administering the medications was found to have errors while administering the medications to one of 27 final sampled residents (Resident 43) and one nonsampled resident (Resident 35). This failure created the risk of the resident developing complications and ineffective therapeutic effects of the medications. Findings: 1. On 11/14/24 at 0800 hours, a medication pass observation was conducted with LVN 2 for Resident 51. LVN 2 was observed administering eight medications to Resident 43. LVN 2 was observed crushing each medication and mixing them with applesauce in the individual cups. After administering the medications to the resident, the LVN went to discard the used medications cups. An observation of all eight medicine cups showed a residual of medication in each cup. LVN 2 verified the findings, resulting in eight medication errors. 2. On 11/14/24 at 0824 hours, a medication pass observation was conducted with LVN 2 for Resident 35. LVN 2 was observed administering dorzolamide (an eye drop medication for glaucoma) 2% drops into the resident's right eye. Review of the pharmacy label showed to administer to both eyes. After the medication administration, LVN 2 stated the order was revised for it only to be administered in the right eye. LVN 2 reviewed Resident 35's physician's orders and verified the order was for both eyes, but stated the resident only liked the drops in the right eye. On 11/14/24 at 0844 hours, an interview was conducted with Resident 35. Resident 35 stated they would like their eye drops in both eyes. This resulted in an additional medication error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51352 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage of medication and disposal of biologicals. * The facility failed ensure one single-use medication was discarded after use in Medication Cart E. * The facility failed to ensure the sublingual medication was not stored with externally administered medications in Medication Cart D. * The facility failed to ensure the contents of the sharp disposal container remained below the full line for Medication Cart A. In addition, the facility failed to ensure oral medications, topical medications, ophthalmic medications (medication to treat conditions of the eye), nasal medications, inhaled medications, and suppositories (a solid, cone-shaped or round object that contains medication and is inserted into a body cavity) were stored separately in Medication Cart A. *T he facility failed to ensure the subcutaneously administered medications (inserted beneath the skin either by injection or infusion) were not stored with the topical medications, and the orally administered medications were not stored with the externally administered medications in Medication Cart C. In addition, the facility failed to ensure the container for the orally administered medication in Medication Cart C was kept in clean condition. * The facility failed to ensure the ophthalmic medication, subcutaneously medications, GT (Gastrostomy tube - a small tube placed through the abdominal wall into the stomach, used to provide feeding formula and/or administer medications) medications, transdermal medications (medication that is absorbed through the skin), inhalant medications, and topical medications were stored separately in Medication Cart B. These failures had the potential to result in unsafe medication administration, cross contamination of medications, and put staff and residents at risk for needlesticks. Findings: Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed the following: - All drugs and biologicals are stored in locked compartments under the proper temperature controls. -Orally administered medications are kept separately from externally used medications e.g., suppositories, liquids, lotions, and tablets. - Eye medications are kept separate from ear medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Contaminated containers, or those that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists. The OSHA (Occupation Safety and Health Administration - a division of the Department of Labor which ensures workers have safe and healthful working conditions) document titled Protecting Yourself When Handling Contaminated Sharps dated 1/2011 defined a needlestick as a cut from a contaminated sharp that can result in a worker being infected with bloodborne pathogens. The document further showed the sharps containers must be emptied or replaced routinely and not be overfilled. 1. On 11/15/24 at 0951 hours, a medication cart inspection for Medication Cart E was conducted with RN 1. The following was observed: - One used 10 ml syringe of 0.9% sodium chloride (saline) was stored with unopened Ultrasite Needle-Free injection sites (a device used to prevent backflow of blood when injecting or infusing fluids or medications). - One tube of hydrocortisone (medication used to treat skin conditions that cause swelling, redness, itching and rashes) cream 1% stored with the 25-gauge safety needles (needle engineered to reduce the risk of accidental needlestick injuries by retracting or shielding the needle after use). RN 1 verified the above findings and stated the 10 ml syringe of 0.9% sodium chloride should have been discarded after use and the hydrocortisone 1% cream should not have been stored with the 25-gauge needles. 2. On 11/15/14 at 1022 hours, a medication cart inspection for Medication Cart D was conducted with RN 1. One bottle of nitroglycerin (medication used to treat chest pain) 0.4 mg sublingual tablets was observed stored with the lubricant jelly. RN 1 stated the nitroglycerin medication should not be stored in Medication Cart D and it should not be stored with the lubricant jelly. RN 1 verified the finding and removed the bottle of the nitroglycerin medication from Medication Cart D. 3. On 11/15/24 at 1056 hours, a medication cart inspection for Medication Cart A was conducted with LVN 3. The following was observed: - The contents of the sharp disposal container were above the full line. - One box of Refresh Celluvisc (eye drops to soothe and treat symptoms of dry eyes) 1% eye gel was stored with one box of orally administered throat lozenges. - One box of Gericare artificial tears (lubricant eye drops) was stored with one bottle of docusate sodium (stool softeners) 250 mg capsules, 30 packets of pantoprazole sodium (medication released in the body slowly over time to treat heartburn symptom) 40 mg delayed release oral suspension, and 60 single-use containers of dorzolamide hydrochloride 2% and timolol maleate (used to treat increased pressure in the eye caused by glaucoma) 0.5% ophthalmic solution. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One box of Polyvinyl alcohol (lubricating eye drops) 1.4% was stored with one tube of Procto-Med HC (used to treat pain, itching, swelling, and discomfort caused by hemorrhoids) 2.5% hydrocortisone cream and one bottle of Pertzye DR (used to treat eye conditions like glaucoma) 8,000 unit capsules. - One box of biscodyl (medication to treat constipation) 10 mg suppositories was stored in the bottom drawer with the BP (blood pressure) cuff and stethoscope. -Three boxes of ipratropium bromide and albuterol sulfate (medication to control symptoms of lung disease and treat air flow blockage) inhalation solution 0.5-3 mg per 3 ml was stored with one bottle of Saline Mist (used to treat sinus congestion) 0.65% nasal spray, one bottle of fluticasone propionate used to treat hay fever, nasal polyps, and other allergic and non-allergic nasal symptoms) 50 mcg nasal spray, 12 tablets of rizatriptan benzoate (used to treat acute migraine headaches) 10 mg oral tablets, one fluticasone furoate/vilanterol (medication to treat and prevent breathing difficulties caused by lung disease) inhalation powder 100 mcg/25 mcg inhaler, three boxes of lidocaine 5% transdermal patches (medication applied to the skin to treat pain), and two vials of intramuscular methylprednisone (given via injection into the muscle to prevent and treat inflammatory conditions such as asthma, allergic reactions, and arthritis) 40 mg. LVN 3 verified the above findings and stated the medications with different routes of administration should not be stored together to prevent cross-contamination. 4. On 11/15/24 at 1141 hours, a medication cart inspection for Medication Cart C was conducted with LVN 5. The following was observed: - One tube of diclofen sodium (medication put on the skin to treat the inflammation and swelling of joints) topical gel 3% was stored with two boxes of pre-filled single dose enoxaparin sodium (medication to prevent blood clots) syringes, and one box of heparin sodium (medication to prevent blood clots) 5,000 units per ml vials. - Lidocaine 5% transdermal patches and scopolamine 1 mg transdermal patches were stored with one bottle of oral liquid Prostat (protein supplement) and fiber protein powder (dietary supplement). The Prostat bottle was observed with sticky beige colored liquid on the top of the container and covered the bottle's label. - One box of biscodyl 10 mg suppositories was stored with orally administered liquid vitamin C 500 mg per 5 ml (supplement) and orally administered docusate sodium (stool softener) 50 mg per ml. LVN 5 verified the findings. 5. On 11/15/24 at 1408 hours, a medication cart inspection of Medication Cart B was conducted with LVN 6 and the ADON. The following was observed: - One unopened box of Refresh Celluvisc lubricant eye gel stored with four boxes of heparin sodium 5,000 units per ml vials. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Testosterone 1.62% topical gel (applied to the skin to increase the levels of testosterone) was stored with one bottle of cephalexin (antibiotic medication) 250 mg per 5 ml suspension liquid was stored with morphine sulfate (pain medication) oral solution 100 mg per 5 ml, one bottle of docusate sodium 100 mg oral capsules. - Two boxes of lidocaine 5% pain patches were stored with albuterol sulfate inhalation solution 0.083%. - Diclofen sodium topical gel 1% was stored with one bottle of Delsym cough syrup, ipratropium bromide and albuterol sulfate inhalation solution, and Pradaxa (blood thinner) 110 mg oral capsules. LVN 6 and the ADON verified the above findings. On 11/15/24 at 1504 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview and medical record review, the facility failed to follow-up with the physician for the abnormal laboratory results for one of five final sampled residents (Resident 70) reviewed for unnecessary medication. This failure had the potential for the resident to have undesirable outcomes. Findings: Medical record review for Resident 70 was initiated on 11/12/24. Resident 70 was readmitted to the facility on [DATE]. Review of Resident 70's Skilled Nursing H&P examination dated 9/9/24, showed the resident had intractable epilepsy (a seizure disorder). Review of Resident 70's Order Summary Report dated 11/14/24, showed a physician's order for divalproex sodium (a compound containing valproic acid and sodium valproate) 500 mg daily for seizure activity. Review of the Consultant Pharmacist's Medication Regimen Review for August 2024 showed a recommendation for Resident 70. The recommendation showed to clarify if the valproic acid was for seizures, and if it was, to obtain a valproic acid level. Review of Resident 70's Laboratory Results Report for the valproic acid dated 9/7/24, showed the resident's valproic acid level was 37 mcg/ml, with a reference range of 50-100 mcg/ml. The report showed a flag code of L. Review of Resident 70's Progress Note showed a nursing note dated 9/7/24 at 1257 hours, the nurse communicated with the physician regarding the valproic acid level results and a recommendation to increase the dose. The note showed they were awaiting a response. Review of Resident 70's medical record failed to show the facility made repeated attempt to notify the resident's physician of the low laboratory results. On 11/15/24 at 1055 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for an abnormal laboratory values, the expectation was to make two to three attempts to notify the physician and if unable to get a hold of the physician, then staff should contact the medical director.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the cutting board was kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the heavy-duty blender used for puree preparation was air dried prior to storing. * The facility failed to ensure the microwave utilized to warm up the food was in sanitary condition and free of food residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 11/15/24, showed 88 of 137 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 11/12/24 at 0804 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Manager. The following were observed and verified by the Dietary Manager: - Two white rubber spatulas with red handles were chipped at the edges and discolored. The Dietary Manager stated it should not be used because it can harbor bacteria inside the groves. - One stainless whisk was observed dirty with dry, crusted orange residue resembles a rust. - Two stainless slotted scoops with black handles were dirty, discolored and had dry paper sticking to it. One of the black handles was partially melted and worn off which resembled burnt mark. 2. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 11/12/24 at 0804 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Manager. The following was observed and verified by the Dietary Manager: - Two stainless slotted scoops with black handles were dirty, discolored and had dry paper sticking to it. - Two stainless spatulas with cream handles were stored wet and dirty. - One stainless scoop with blue handle was dirty, fuzzy with cloudy film. - Two cutting knives with black handle were dirty with dry green residue, fuzzy with cloudy film. 3. Review of the facility's P&P titled Sanitation dated 2023 showed plastic ware, china, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 11/12/24 at 0804 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Manager. One green cutting board was observed fuzzy, heavily marred, discolored, and peeling. 4. Review of the facility's P&P titled Dishwashing dated 2023 showed dishes are to be air dried in racks before stacking and storing. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 11/12/24 at 0804 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Manager. One heavy-duty blender stored on the counter shelf was still wet with visible water inside. 5. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 11/12/24 at 0804 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Manager. The microwave at a countertop table was observed dirty with dry, crusted, clear to pale yellow food residue inside the microwave's glass plate. The Dietary Manager verified the findings and stated he was not sure if the microwave was used to warm food for the residents or staff, he had not seen anyone used the microwave. 6. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Orange Hills	5017 E. Chapman Avenue Orange, CA 92869

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 1458 hours, during the kitchen tour, a concurrent observation and interview was conducted with the Dietary Manager. The kitchen hood had black, grease residue. The Dietary Manager acknowledged the findings and stated the dietary staff cleaned the hood once a week and an outside company performed the service every three months for the kitchen hood and was last maintained or serviced on 9/19/24. 7. Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacturer's recommendations, and the date recorded when cleaned. The Maintenance Supervisor can keep this record, or it can be posted on the ice machine. According to the USDA Food Code 2017, Section 4-601.11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. On 11/12/24 at 0847 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Maintenance Supervisor. The ice machine's interior top portion to the water curtain located directly above the ice bin, was observed with ice buildup. The Maintenance Supervisor acknowledged the findings and stated the ice machine was under the warranty and could not be touch but he will call the outside company for maintenance services. On 11/14/24 at 1619 hours, a follow up interview was conducted with the Dietary Manager. The Dietary Manager acknowledged the above findings and stated the following: - The microwave should be cleaned to ensure it will not harbor any bacteria. - The spatulas should have a smooth surface because it had to be cleanable. - The utensil/kitchenware with greasy residue should be cleaned, washed properly, and air dried. - The utensil/ kitchenware with dents, scratches, and damaged should be discarded. - The cutting board heavily marred was discarded. - The blender should have been placed upside down and properly air dried. - The ice machine should not have an ice buildup because it can damage the ice machine and harbor bacteria. - The hood over the stove should not have a black, greasy residue because it can be a potential fire hazard. On 11/15/24 at 1519 hours, the DON and RD were informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were accurately maintained for four of 27 residents (three final sampled residents, Residents 33, 41, and 105; and one nonsampled resident, Resident 49) reviewed for medical records. * The facility failed to ensure Resident 33's intravenous fluid intake was documented. * The facility failed to ensure the RNA documented Resident 33's refusal to be weighed. * The facility failed to ensure Resident 49's MAR was completed. * The facility failed to ensure Resident 105's hospice visitation log was completed. * The facility failed to ensure Resident 41's updated flu vaccination consent was filed in the appropriate medical records folder. These failures had the potential for the residents' care needs not being met as the medical record was incomplete. Findings: Review of the facility's P&P titled Nutrition Status Management revised 12/2024 showed the following: - Evaluations will include determining ideal body weight range, usual body weight, current diet order, percentage of food eaten, possible dental problems, current illness, resident likes and dislikes, psychosocial needs, and any other change in medical condition that may impact weight gain or loss. - Nutritional assessment may include: weighing and weight changes, oral intakes of food and fluid, IV therapy . Review of the facility's P&P titled Nutrition revised 1/24/24, showed any resident meeting the criteria for weight loss and any resident at risk will be weighed weekly if ordered by the physician with the weight entered into POC (Point of Care)/PCC (PointClickCare). Medical record review for Resident 33 was initiated on 11/12/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's MDS dated [DATE], showed Resident 33 had severe cognitive impairment. 1.a. Review of Resident 33's Order Summary Report showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/18/24, to monitor the resident's Intake and Output every shift for new admit with the indwelling urinary catheter for 30 days. - dated 11/2/24, to administer sodium chloride intravenous solution, use 75 ml/hr intravenously every shift for hydration for 2 liters (0.45% Normal Saline). - dated 11/4/24, to administer sodium chloride intravenous solution, use 100 ml/hr intravenously every shift for hydration for 3 liters until 11/6/24 23:59 (D5 1/2 NS). Further review of Resident 33's medical record failed to show documentation of Resident 33's IV fluid intake every shift. On 11/14/24 at 1001 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified there was no documentation of the IV fluids given to Resident 33 every shift on the fluid intake record. RN 3 stated the IV fluids given should have been documented by the licensed nurses. On 11/15/24 at 1134 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no documentation of the IV fluids given on the fluid intake record for Resident 33. The DON stated the licensed nurse should have assessed the patient for an adequate hydration if the IV fluid intake was not documented. b. Review of Resident 33's Order Summary Report dated 10/16/24, showed for weekly weights for four weeks: every seven days for four weeks. On 11/14/24 at 1629 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 33 was not weighed on 11/11/24. The ADON further stated the RNA was the one who should have weighed the resident and input the weight in PCC. The ADON stated the weight should have been documented to monitor weight gain or weight loss. On 11/15/24 at 0848 hours, an interview and concurrent medical record review was conducted with RNA 1. RNA 1 verified there was no documentation of Resident 33's weight on 11/11/24. RNA 1 stated she weighed the residents and input the residents' weight in PCC. RNA 1 further stated she was taught how to use the PCC but did not knew how to document Resident 33's refusal in PCC. RNA 1 stated she tried to weigh the resident again but the LVN told her the resident was on comfort care and Resident 33 did not want to be weighed. 2. Review of the facility's P&P titled Medication Administration revised 8/2021 showed it is the policy of this facility that medications shall be administered as prescribed by the attending physician. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR) and treatment administration record (TAR) as appropriate. Medical record review for Resident 49 was initiated on 11/12/24. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's Skilled Nursing H&P examination dated 9/5/23, showed Resident 49 was unable to make decisions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 49's MAR dated 11/12/24, showed missing documentations for the following if administered or performed as ordered: - Insulin Lispro (fast acting insulin) Solution Inject subcutaneously in the morning for DM as per sliding scale as follows: If BS 0 - 69 mg/dl = 0 units give 8 oz of OJ (orange juice) then recheck in 15 minutes. If BS remains <70 mg/dl or unresponsive give glucagon, call MD (Doctor of Medicine). BS 70 - 150 mg/dl - 0 units no action; BS 151 - 200 mg/dl = 1 unit BS 201 - 250 mg/dl = 2 units; BS 251 - 300 mg/dl = 3 units; BS 301 - 350 mg/dl = 4 units; BS 351 - 400 mg/dl = 5 units; BS 401+ mg/dl = 6 units, recheck BS In 30 minutes and if BS >400 mg/dl, call MD, - Prevacid (reduces the amount of acid in the stomach) Capsule Delayed Release 30 mg (lansoprazole) one capsule via GT one time a day for GERD (gastroesophageal reflux disease). - Vital signs every shift. - Artificial Tears ophthalmic solution (artificial tear solution) one drop in both eyes four times a day for dry eyes. - Equipment: Use of left-hand mitten to prevent injury from pulling tubes. 1. Remove every two hours to check for skin condition (swelling, ROM (range of motion), circulation) and re-apply. Y = with issues. N = without issues. 2. Monitor for episodes of pulling on vital tubes every shift. Yes = patient pulling tubes. No = patient not pulling tubes. Review of Resident 49's MAR on 11/13/24 showed missing documentations for the following if administered or performed as ordered: - Insulin Lispro Solution Inject subcutaneously in the morning for DM as per sliding scale (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prevacid Capsule Delayed Release 30 mg (lansoprazole) one capsule via G-tube one time a day for GERD. - Artificial Tears Ophthalmic solution (artificial tear solution) one drop in both eyes four times a day for dry eyes. - Equipment: Use of left-hand mitten to prevent injury from pulling tubes. 1. Remove every two hours to check for skin condition (swelling, ROM, circulation) and re-apply. Y = with issues. N = without issues. 2. Monitor for episodes of pulling on vital tubes every shift. Yes = patient pulling tubes. No = patient not pulling tubes. On 11/15/24 at 1111 hours, an interview and concurrent medical record review was conducted with LVN 15. LVN 15 verified the missing documentations on Resident 49's MAR for 11/12 and 11/13/24. LVN 15 stated the staff were supposed to document in the MAR. On 11/15/24 at 1451 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the process of the medication administration included the five rights, pouring the medication, giving the medication, and signing the document. The DON stated the medical records did daily audits to capture any missing documentation and she would be notified if there was recurrent missing documentation. The DON stated the charge nurse had 72 hours to complete their audit. On 11/15/24 at 1451 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 51539 3. Review of the facility's document review titled Hospice Service Agreement dated 11/5/20, showed the SNFs shall also document accurately in the patient chart in the SNF record, according to the policy for the particular SNF. Documentation of services provided shall include copies of any instructions delivered to the patient. All required documentation shall be submitted within 5 days of providing any specific services. Medical record review for Resident 105 was initiated on 11/12/24. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's Certification Statement with Plan of Care Effective date of 10/8/24, showed Resident 105 was to be visited by skilled nurse to visit one time a week and a Hospice Aide two times a week. Review of Resident 105's Order Summary Report showed a physician's order dated 11/11/24, to admit the resident to hospice care under a hospice provider with diagnosis of COPD (Chronic Obstructive Pulmonary Disease). Review of the hospice provider Flow Sheet sign-in log showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 10/24/24, showed one visitation from a skilled nurse and one visitation from a Hospice Aid (missing signature of one visitation from a Hospice Aid). - on11/5/24 -11/9/24 showed one visitation from a skilled nurse and one visitation from a Hospice Aid (missing signature of one visitation from a Hospice Aid). On 11/13/24 at 1454 hours, an interview and concurrent facility documents and medical record review was conducted with the DSD. The DSD was asked if the hospice provider Flow Sheet sign-in log was accurately filled out for the months of October 2024 through November 2024. She verified the sign-in log was missing signatures and dates of when services were provided for Resident 105 by the hospice staff. The DSD stated she contacted the hospice provider to remind them that Resident 105's hospice provider Flow Sheet sign-in log needed to be completed with each visit. 4. Review of facility's P&P titled Record Systems, Organization and Maintenance -Designated Record Set undated showed the facility shall maintain a health record for each resident, which shall include: - Consent forms - Licensed nurse's notes Review of the facility's P&P titled Immunizations-Residents revised 7/2023 showed information related to education provided regarding the benefits and risks of each immunization and the administration or refusal of or medical contraindication to the vaccines will be documented in the resident's medical records. - Document that the resident either received the influenza and/ or pneumococcal and/ or Covid 19 immunization or did not receive the influenza and/ or immunization due to medical contraindications or declination. Medical record review for Resident 41 was initiated on 11/12/24. Resident 41 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 41's Order Summary showed a physician's order dated 10/24/24, for influenza vaccine 0. 5 ml injection IM (intramuscular) annually as prophylaxis for influenza, unless contraindicated one time only for influenza prevention for one day. Further review of Resident 41's medical record did not show a signed consent form for influenza Vaccine. On 11/13/24 at 1557 hours, an interview and concurrent medical record review was conducted with the IP regarding Resident 41. The IP was asked where Resident 41's consent was kept for the Influenza vccine. The IP stated the consent for Resident 41 was stored in her own facility binder for record keeping and not in the resident's medical records. When asked if the consent was a medical record belonging to Resident 41, the IP stated yes. When asked what the proper area for Resident 41's consent to be stored, the IP stated it should have been in the Resident's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 1628 hours, an interview and concurrent medical record review was conducted with the DON regarding Resident 41. The DON was asked where signed consent was kept for the Influenza vaccine given to the residents. The DON stated the signed consent forms for all vaccines were kept in the residents' medical records. When asked if Resident 41's influenza consent should have been stored in the resident's medical record, the DON stated yes, that was where all the records were stored. On 11/15/24 at 1503 hours, an interview with the DON and Administrator was conducted. The DON and Administrator were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infection were implemented as evidenced by: * The facility failed to implement their infection control surveillance program for January 2024 through September 2024. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobials. Residents who were not prescribed antimicrobials were not included in the facility's infection control surveillance program. * The facility failed to implement their infection control surveillance program for July 2024 through September 2024. * The facility failed to ensure infection control practices were implemented for one final sampled resident (Resident 775) * The facility failed to ensure tracheostomy supplies in the respiratory carts were stored properly for use. * The facility failed to ensure one final sampled resident (Resident 43's) urinal was labeled. * The facility failed to ensure the blood glucose meter in Medication Cart A was cleaned after use. These failures posed the risk for not identifying infections and controlling the transmission of communicable disease to other resident through the facility. Findings: Review of the facility's P&P titled Infection Prevention and Control Program undated showed the resident infection cases are monitored by the IP. The IP completes an Infection Surveillance from monthly and reports on a routine basis. Review of the facility's P&P titled Infection Prevention and Control Program - Infection Control dated 6/2021 showed the facility had goals to: - decrease the risk of infection to residents and personal. - Recognize infection control practices while providing care. 1.a. Review of the facility's monthly Infection Prevention and Control Surveillance Log from January 2024 through September 2024 Showed the following surveillance data: - January 2024, total of 45 cases including 16 CAI and 29 HAI, - February 2024, total of 48 cases including 11 CAI and 37 HAI, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- March 2024, total of 41 cases including 10 CAI and 31 HAI, - April 2024, total of 47 cases including 13 CAI and 34 HAI, - May 2024, total of 44 cases including 14 CAI and 30 HAI, - June 2024, total of 49 cases including 16 CAI and 33 HAI, - July 2024, total of 55 cases including 24 CAI and 32 HAI, - August 2024, total of 38 cases including 11 CAI and 27 HAI, and - September 2024, total of 44 cases including 9 CAI and 35 HAI. Review of the facility's monthly Prevention and Control Surveillance log from January 2024 through August 2024 showed documentation of the residents having an HAI or CAI and prescribed with antimicrobial medications. Further review of the facility's monthly Prevention and Control Surveillance Log from January 2024 through September 2024 showed the facility failed to conduct surveillance for all the residents' infections, specific to the residents who had signs and symptoms of infection, met the McGeer's criteria (method used to retrospectively counting true infection), and were not prescribed antimicrobial medications. On 11/12/24, at 1442 hours, an interview was conduction with the IP. When asked if she included the residents with signs and symptoms of infection who met the McGeer's criteria, but were not prescribed antimicrobial medication on the monthly Prevention and Control Surveillance log, the IP stated the residents who developed signs and symptoms, and who were not prescribed antibiotics were not a part of the monthly Prevention and Control Surveillance log. b. Review of the facility's monthly Infection Prevention and Control Surveillance Log and Surveillance Data Collection Forms for July 2024 showed the following residents with antibiotic were not included in the monthly surveillance log, the IP stated she did not include the residents without antibiotics in the log. - dated 7/3/24, Resident 528's Zosyn (antibiotic) 3.375 grams - dated 7/8/24, Resident 80's Doxycycline (antibiotic) 100 mg - dated 7/30/24, Resident 78's Zerbaxa (antibiotic) 3 grams Review of the facility's monthly Infection Prevention and Control Surveillance Log and Surveillance Data Collection Forms for August 2024 showed the following residents with antibiotic were not included in the monthly surveillance log. - dated 8/7/24, Resident 527's Amoxicillin (antibiotic) 875-125 mg - dated 8/7/24, Resident 45's Ceftriaxone (antibiotic) 1 gram (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's monthly Infection Prevention and Control Surveillance Log and Surveillance Data Collection Forms for August 2024 showed the following residents with antibiotic were not included in the monthly surveillance log. -dated 9/6/24, Resident 528's Ceftriaxone (antibiotic) 2 grams -dated 9/5/24, Resident 14's Azithromycin (antibiotic) 500 mg -dated 9/7/24, Resident 100's Zosyn (antibiotic) 3.375 grams -dated 9/27/24, Resident 9's Doxycycline (antibiotic) -dated 9/28/24, Resident 529's Ertapenem (antibiotic) 2. Medical record review for Resident 775 was initiated on 11/12/24. Resident 775 was admitted to the facility on [DATE]. On 11/13/24 at 124 hours, an observation of Resident 775's room including signage of enhanced barrier precautions. On 11/13/24 at 1500 hours, an interview and concurrent medical record review was conducted with the DON. When the DON was asked if Resident 775 had the physician's order for the enhanced barrier precautions, she stated she did not see one. When the DON was asked if Resident 775 had a care plan for the enhanced barrier precautions, she verified the resident did not have any. The DON verified both order and care plan should have been completed for Resident 775 due to his wounds. 3. Review of the facility's P&P titled Medication Access and storage revised on 2/2019 showed that contaminated, or those in containers that are cracked, solid, or without secure closures are immediately removed from stock, disposed of according to procedures for medications destruction and reordered from the pharmacy if a current order exists. On 11/15/24 at 1115 hours, a respiratory cart inspection for Cart 6 in Station one was conducted with the Administrator. The following was observed: - One Spring-loaded T Adapter was found without a secure closure package in the first drawer. - Closed Suction Tracheostomy Catheter parts were found without a secure closure package in the first drawer. On 11/15/24 at 1123 hours, the Administrator was asked if the tracheostomy adaptors should be in the cart without a closure package. The Administrator stated it should not be used and should have been discarded. When asked if parts of the tracheostomy catheter should be stored in the cart without a secure closure package, the Administrator stated it should have been thrown away. On 11/15/24 at 1503 hours, during an interview with the DON and Administrator, the DON and Administrator were informed and acknowledged the above findings. 49644 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the facility's P&P titled Disposable Equipments revised 8/2019 showed it is the policy of this facility to allow multiple usage of disposable equipment for residents' ADL care such as bed bath basins, urinals, and emesis basins. These items will be clearly labelled when initially used and changed. On 11/12/24 at 1138 hours, a urinal inside a urinal holder on the left side of Resident 43's bed was observed unlabeled. Medical record review for Resident 43 was initiated on 11/12/24. Resident 43 was admitted to the facility on [DATE], and readmitted on [DATE] . Review of Resident 43's MDS dated [DATE], showed Resident 43's cognition was intact. On 11/12/24 at 1158 hours, an observation and concurrent interview was conducted with RN 4. RN 4 verified the urinal inside a urinal holder on the left side of Resident 43's bed was unlabeled. RN 4 stated whoever gave the urinal to Resident 43 should have labeled the urinal. On 11/15/24 at 1531 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 51352 5. Review of the facility's P&P titled Glucometer Calibration showed the glucometer (blood glucose meter) will be cleaned and disinfected per the manufacturer's guidelines. Review of the Evencare G2 blood glucose meter user's guide published in 2018 showed the instructions to disinfect the glucose meter include the following: 1. The blood glucose meter should be inspected for blood, debris, dust, or lint. 2. Clean the blood glucose meter with one of the validated disinfecting wipes listed below: - Dispatch Hospital Cleaner Disinfectant Towels with Bleach - Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol - Chlorox Healthcare Bleach and Germicidal and Disinfectant Wipes - Medline Micro-Kill Bleach Germicidal Bleach Wipes Wipe all external areas of the blood glucose meter, including the front and back surfaces, until visibly clean. Allow the surface of the blood glucose meter to remain wet at room temperature for the contact time listed on the wipe's directions before use. Wipe blood glucose meter dry or allow to air dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 1056 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 3. The back side of the Evencare G2 blood glucose meter in Medication Cart A was observed with a red/brown smear. LVN 3 verified the findings and stated the blood glucose meter should be cleaned after use and should not be soiled. LVN 3 was observed to clean the blood glucose meter with Medline Micro-Kill Bleach Germicidal Bleach Wipes (ready to use wipes with a bleach solution, used to clean and disinfect hard and nonporous surfaces). On 11/15/24 at 1504 hours, an interview was conducted with the Administrator and DON. The DON stated the blood glucose meter should be disinfected before and after use and should not be visibly soiled. The Administrator and DON were informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Orange Hills	5017 E. Chapman Avenue Orange, CA 92869

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 51539 Based on interview, facility document review, and facility P&P review, the facility failed to implement their Antibiotic Stewardship Program (ASP) when: * The facility failed to conduct an assessment for the McGeer's criteria to determine the true infection for one nonsampled resident (Resident 525). * The facility failed to use the correct Surveillance Data Collection Form for two final sampled residents (Residents 96 and 108) and four nonsampled residents (Residents 4, 8, 86, and 531). * The facility failed to properly use the Surveillance Data Collection Form criteria to indicate a true infection for one final sampled resident (Resident 83) and three nonsampled residents (Residents 2, 19, and 80). These failures had the potential for inaccurately identifying for true infections and potentially inhibited residents from receiving proper treatment and care. Findings: Review of the facility's P&P titled Infection Prevention- Surveillance of Infection and Reporting undated showed the IP/DNS (Director of Nursing Services)/Designee will trend all validated infections using McGeer's criteria on monthly basis. Action Plans will be written for any identified problems and implemented as soon as possible. 1. On 11/12/24 at 1457 hours, an interview and concurrent facility document reviews were conducted with the IP. When asked to review Residents 525's Surveillance Data Collection Form since Resident 525 was on the Infection Prevention and Control Surveillance Log for July 2024, the IP stated she did not have a Surveillance Data Collection (McGeer's criteria) Form filled out for the resident. When the IP was asked if Resident 525 should have had a Surveillance Collection Form, she stated the resident should have had a form to validate a true infection. 2.a. Review of the facility's monthly Surveillance Data Collection Form for July 2024 showed the following residents did not have the correct IP Surveillance Data Collection Form: - Surveillance Data Collection Form- Other Infections was used for Resident 86 rather than Surveillance Data Collection Form- Respiratory Tract Infections - Surveillance Data Collection Form- Other Infections was used for Resident 108 rather than Surveillance Data Collection Form- Skin/ Soft Tissue, and Mucosal Infection. - Surveillance Data Collection Form- Other Infections was used for Resident 8 rather than Surveillance Data Collection Form- Skin/ Soft Tissue, and Mucosal Infection. b. Review of the facility's monthly Surveillance Data Collection Form for August 2024 showed the following resident did not have the correct IP Surveillance Data Collection Form: (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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Surveillance Data Collection Form- Other Infections was used for Resident 96 rather than Surveillance Data Collection Form- Respiratory Tract Infections. c. Review of the facility's monthly Surveillance Data Collection Form for September 2024 showed the following residents did not have the correct IP Surveillance Data Collection Form: - Surveillance Data Collection Form- Other Infections was used for Resident 4 rather than Surveillance Data Collection Form-Urinary Tract Infections. - Surveillance Data Collection Form- Other Infections was used for Resident 531 rather than Surveillance Data Collection Form- Skin/ Soft Tissue, and Mucosal Infection. On 11/12/24 at 1501 hours an interview and concurrent facility document review were conducted with the IP. When asked about if she should have used a more precise Surveillance Data Collection Form based McGeer's criteria for each resident, the IP verified a more precise Surveillance Data Collection Form should have been used. 3.a. Review of the facility's monthly Surveillance Data Collection Forms for July 2024 showed the following resident did not meet the criteria McGeer's for HAI on the Surveillance Data Collection Form: - Resident 83 was prescribed Bactrim DS (antibiotic) initiated on 7/6/24; however, the Surveillance Data Collection Form- Urinary Tract Infections showed the HAI was checked and not the did not meet two of the McGeer's criteria b. Review of the facility's monthly Surveillance Data Collection Forms for September 2024 showed the following residents did not meet the criteria McGeer's for HAI on the Surveillance Data Collection Form. - Resident 2 was prescribed Bactrim DS (antibiotic) initiated on 9/6/24; however, the Surveillance Data Collection Form- Urinary Tract Infections showed the HAI was checked and not the did not meet two of the McGeer's criteria - Resident 19 was prescribed Ciprofloxacin (antibiotic) 250 mg initiated on 9/19/24; however, the Surveillance Data Collection Form- Urinary Tract Infections for residents with indwelling urinary catheter showed the HAI was checked and not the did not meet two of the McGeer's criteria - Resident 80 was prescribed ertapenem (antibiotic) 1 gram and linezolid (antibiotic) 600 mg initiated on 9/30/24; however, the Surveillance Data Collection Form- Respiratory Tract Infection showed the HAI was checked and not the did not meet two of the McGeer's criteria On 11/12/24 at 1512 hours, an interview and concurrent facility document review of the monthly Surveillance Data Collection logs were conducted with the IP. The IP verified Residents 2, 19, 80, and 83 did not meet the McGeer's criteria on their Surveillance Data Collection Forms and should have been checked. On 11/15/24 at 1503, an interview with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.