STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the dignity was maintained for one nonsampled resident (Resident 298) reviewed for urinary catheter care. * The facility failed to ensure the Resident 298's urinary catheter drainage bag was covered. This failure created the potential to affect the residents' well-being. Findings: Review of the facility's P&P titled Dignity dated 2/2021 showed all the residents should be cared for in a manner that promotes and enhances his or her sense of wellbeing. Facility staff should promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. On 5/12/25 at 0911 hours, Resident 298 was observed in bed with an uncovered urinary catheter drainage bag at the side of the bed. On 5/12/25 at 1038 hours, Resident 298 was observed up in his wheelchair and the uncovered urinary catheter drainage bag was placed under the wheelchair. On 5/13/25 at 0942 hours, Resident 298 was again observed in bed with an uncovered urinary catheter drainage bag at the side of the bed. Medical record review for Resident 298 was initiated on 5/13/25. Resident 298 was admitted to the facility on [DATE]. Review of Resident 298's MDS assessment dated [DATE], showed Resident 298 had mild cognitive impairment. The resident had an indwelling urinary catheter and needed total assistance from the staff for urinary catheter care. Review of Resident 298's Order Summary Report dated 5/13/25, showed a physician's order dated 5/11/25, for a urinary catheter care every shift and to change the urinary catheter bag as needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 298's care plan for urinary retention dated 5/2/25, showed interventions including position the urinary catheter bag and tubing below the level of the bladder and away from the entrance door. However, there no intervention to place the urinary catheter drainage bag in a privacy bag. On 5/13/25 at 1414 hours, an observation and concurrent interview for Resident 298 was conducted with CNA 1. CNA 1 stated Resident 298 had a urinary drainage bag and it needed to be measured for the amount of urine and emptied at the end of her shift. CNA 1 stated she placed the urinary catheter drainage bag under the wheelchair and at the side of the bed. CNA 1 verified Resident 298's urinary catheter drainage bag was not covered with a privacy bag. CNA 1 stated the urinary catheter drainage bag should have been covered with a privacy bag. On 5/13/25 at 1441 hours, an interview and concurrent medical record review for Resident 298 was conducted with LVN 2. LVN 2 verified the physician's order for Resident 298's indwelling urinary catheter connected to the urinary catheter drainage bag. LVN 2 was informed of the observation about Resident 298's urinary catheter drainage bag was not covered with a privacy bag. LVN 2 stated CNA 1 informed her of Resident 298's urinary catheter drainage bag not covered with a privacy bag. LVN 2 further stated she provided CNA 1 with a privacy bag and instructed to place it on Resident 298's urinary catheter drainage bag. On 5/15/25 at 1045 hours, an interview and concurrent medical record review for Resident 298 was conducted with the DON. The DON stated she expected the nurses to provide a privacy bag to the resident's urinary catheter drainage bag to provide dignity to the residents. The DON was informed and verified the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide written information regarding the right to formulate advance healthcare directives for one of 13 final sampled residents (Resident 19) and one nonsampled resident (Resident 298) reviewed for formulation of advance healthcare directives. This failure had the potential for the residents' decisions regarding their healthcare and treatment options not being honored. Findings: Review of the facility's P&P titled Advanced Directives revised September 2022 showed the following: - Prior to admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives. - The resident or representative is provided with written information concerning the right to accept or refuse medical or surgical treatment, and to formulate an advanced directive if he or she choose to do so. - Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative. - If the resident or representative indicates that he or she had not established advance directives, the facility staff will offer assistance in establishing advance directives. - If the resident or the resident representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. 1. Medical record review for Resident 298 was initiated on 5/13/25. Resident 298 was admitted to the facility on [DATE]. Review of Resident 298's H&P examination dated 4/30/25, showed Resident 298 had the capacity to exercise the rights and sign necessary documents. Review of Resident 298's POLST dated 4/30/25, showed under Section D Information and Signatures, Resident 298 had no advance directive. Review of Resident 298's Advance Directive Acknowledgment Form dated 4/29/25, showed the box for I have executed an Advance Directive was checked off. The form showed a signature for the resident/representative; however, there was no facility staff signature. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 298's medical record failed to show documented evidence Resident 298 was provided with the written information regarding advance directives. On 5/15/25 at 0944 hours, an interview and concurrent medical record review for Resident 298 was conducted with the Case Manager. The Case Manager stated she was responsible for the gathering of the advance directives when a resident was admitted to the facility. The Case Manager stated she would ask the resident or resident's family member if they had a copy and if so, requested a copy of the advance directive. The Case Manager stated she assisted the residents or family members to formulate the advance directive and complete the Advance Directive Acknowledgement form if they did not have an advance directive. The Case Manager stated she remembered talking to Resident 298 and his family member about the advance directive and Resident 298's family member informed her that Resident 298 had executed an advance directive. The Case Manager was asked if she requested a copy of Resident 298's advance directive and if she documented the conversation with Resident 298 and his family member. The Case Manager reviewed the progress notes and was unable to show documentation about Resident 298's advance directive. The Case Manager verified and acknowledged the findings. On 5/15/25 at 1045 hours, an interview and concurrent medical record review for Resident 298 was conducted with the DON. The DON stated she expected the case manager would complete the advance directive acknowledgement form for the residents when they admitted to the facility. The DON was informed and verified the findings. 2. Medical record review for Resident 19 was initiated on 5/12/25. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19's BIMS score was zero, indicating severe cognitive impairment. Review of Resident 19's POLST, undated, failed to show the completion of section D for advanced directive. Review of Resident 19's Advance Directive Acknowledgement dated 12/6/24, showed Resident 19 wished to execute an advance directive. On 5/12/25 at 1051 hours, an interview and concurrent medical record review for Resident 19 was conducted with the DSD. The DSD reviewed Resident 19's POLST and verified the incomplete of section D for Advance Directive. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 1104 hours, an interview and concurrent medical record review for Resident 19 was conducted with the SSD. The SSD reviewed Resident 19's POLST and verified it did not show completion of section D for Advance Directive. The SSD stated Resident 19 was not able to execute an advance directive and offered resources to Family Member 2. The SSD verified there was no documentation of resources or follow up provided to Family Member 2. The SSD stated there was no advance directive available in Resident 19's medical record and verified the above findings. The SSD stated the process in executing an advance directive was initiated by the admitting nurse, and the SSD would follow up the next day. If the resident did not have an advance directive, the SSD would offer the resident or responsible party the information on how to obtain conservatorship when the resident was incapable of making medical decisions. Furthermore, the SSD stated the process and resources provided in executing an advance directive to the resident and responsible party must be document in the medical record. The SSD stated if it was not documented, it meant it was not completed. On 5/15/25 at 1505 hours, an interview was conducted with the DON. The DON was asked the facility's process in completing the POLST and obtaining the advance directive. The DON stated upon the resident's admit to the facility, the admitting nurse must complete the POLST. The DON further stated the SSD was responsible to check for completion of the POLST and follow up on the advance directive. Furthermore, the DON stated any follow up with the resident and responsible party must be documented in the medical record. The DON and Administrator 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
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 13 final sampled residents (Resident 34) was free from accident hazards. The facility failed to implement floor mattress as ordered by the physician as a fall risk precaution for Resident 34. This failure had the potential for serious injury to the resident. Findings: Review of the facility's untitled P&P revised 11/29/22, showed bed safety, for the residents who try to get out of the bed unsafely when alone should be evaluated for a low bed and floor mat. On 5/13/25 at 0926 hours, during an observation, Resident 34 was lying in bed and no floor mattress was placed by the bed. Instead, the floor mattress was leaned against the wall. Medical record review for Resident 34 was initiated on 5/12/25. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's care plan report showed a care plan focus dated 10/11/24, to address a high risk for falls related to Alzheimer's and dementia with poor safety awareness. The interventions included the application of floor mattress at bedside for safety. Review of Resident 34's Quarterly MDS assessment dated [DATE], showed Resident 34 had severe cognitive impairment. Section GG of the assessment showed Resident 34 had impairment to both upper and lower extremities. Review of Resident 34's H&P examination dated 4/10/25, showed Resident 34 had no capacity to exercise the rights and sign the necessary documents; therefore, the resident's family member would be informed of the medical condition and/or plan of treatment. Review of Resident 34's Order Summary Report dated 5/12/25, showed a physician's order dated 2/7/25, for floor mattress at the bedside for safety. On 5/13/25 at 1409 hours, an interview was conducted with CNA 7. CNA 7 stated she recalled Resident 34 had attempted to get out of bed and floor mattress was used for safety. On 5/13/25 at 0936 hours, an observation with a concurrent interview was conducted with LVN 2. LVN 2 verified the above findings and stated Resident 34 had a fall incident in the past and the floor mattress should be in placed at all times when the resident was in bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one nonsampled resident (Resident 299). * The facility failed to ensure the PICC line catheter measurements were obtained and documented. In addition, the facility failed to ensure the PICC line plan of care included the measurements of the length of the external catheter and arm circumference. These failures had the potential to delay the identification of IV catheter related complications for Resident 299. Findings: Review of the facility's P&P titled Central Venous Catheter Care and Dressing Changes dated 10/2024 showed the dressing of the central venous catheter is routinely changed at least every seven days or as needed when the dressing becomes damp, loosened or visibly soiled. The licensed nurse would measure the length of the external central vascular access device with each dressing change or if dislodgement is suspected then compare with length documented at insertion. Also to measure the arm circumference and compare to baseline when clinically indicated to assess for possible complications. Medical record review for Resident 299 was initiated on 5/13/25. Resident 299 was admitted to the facility on [DATE]. On 5/12/25 at 0939 hours, an observation and concurrent interview was conducted with Resident 299. Resident 299 was sitting in her wheelchair with a PICC line on her left upper arm. The PICC line had a transparent dressing dated 5/5/25. Resident 299 stated the PICC line was placed in the facility. Review of Resident 299's Order Summary Report dated 5/13/25, showed a physician's order dated 5/6/25, to change the dressing on the central line once a week and as needed. However, further review of the physician's order failed to show documented evidence of a physician's order to measure the length of the PICC line external catheter and the arm circumference. Review of Resident 299's care plan for PICC use dated 5/6/25, failed to include the measurements of the length of the external catheter and the arm circumference of Resident 299. Review of Resident 299's TAR for May 2025 showed on 5/11/25, the PICC line dressing was changed by the licensed nurse. However, there was no documented evidence the licensed nurse obtained the measurements of the length of the external catheter and arm circumference of Resident 299 during the dressing change. On 5/14/25 at 0821 hours, an interview and concurrent medical record review for Resident 299 was conducted with LVN 1. LVN 1 verified Resident 299 had a PICC line on the left upper arm. LVN 1 stated they would make sure the PICC line was clean and there were no signs and symptoms of infection. LVN 1 stated the RNs were responsible for the care and maintenance of the residents' central lines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 0905 hours, an interview and concurrent medical record review for Resident 299 was conducted with RN 1. RN 1 stated the RNs were responsible for the care and maintenance of the central lines including the assessment and administration of the IV medications. RN 1 stated the assessment included the monitoring of the PICC line insertion site for any signs and symptoms of infection and documentation on the IV MAR and TAR. RN 1 stated Resident 299's PICC line on the left upper arm was placed in the facility by the contracted provider for IV antibiotic medication administration. RN 1 stated the dressing change for Resident 299's PICC line was done every seven days. RN 1 was asked if the assessment of the PICC line placement would include the measurements of the length of the external catheter of the PICC line and arm circumference, RN 1 stated yes, during dressing change. RN 1 verified and acknowledged the PICC line assessment did not include the measurements of the length of the external catheter and the arm circumference. Also, RN 1 verified there was no physician's order obtained for Resident 299's PICC line for the measurements of the length of the external catheter and arm circumference and not included in the care plan interventions. On 5/14/25 at 0936 hours, an interview and concurrent medical record review for Resident 299 was conducted with the DON. The DON was informed and verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 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** 2. Review of the facility's P&P titled CPAP/BiPAP Support revised 3/2015 showed to review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure for the machine. Review and follow manufacturer's instruction for CPAP machine setup and oxygen delivery. Under the general guidelines for cleaning showed the following: - Machine cleaning: to wipe the machine with soapy water and rinse at least once a week and as needed. - Humidifier (if used): use clean, distilled water only in the humidifier chamber; to clean the humidifier weekly and air dry; and to disinfect using vinegar-water solution (1:3) in the clean humidifier. To soak for 30 minutes and rinse thoroughly. - Filter cleaning: to rinse the washable filter under running water once a week to remove dust and debris. - Mask and nasal pillows: to wipe with isopropyl alcohol daily after use. - Tubings and headgear (strap): to wash with soapy water, rinse, and air dry weekly. Review of the ResMed AirSence 10 (CPAP machine) user guide (undated) showed under the caring for the device section, to regularly clean the tubing assembly, water tub, and mask to prevent the growth of the germs that can adversely affect the health; and clean the device weekly as directed. On 5/12/25 at 1022 hours, an observation and concurrent interview was conducted with Resident 297. Resident 297 was in bed awake and the CPAP machine was placed on top of the bedside drawer. Resident 297 verified the CPAP machine was her machine, and stated she cleaned and maintained the machine with the assistance of her family member. Resident 297 stated the facility staff did not do anything about the CPAP machine. Resident 297 stated she placed it on herself at night and took it off when she woke up. Medical record review for Resident 297 was initiated on 5/13/25. Resident 297 was admitted to the facility on [DATE]. Review of Resident 297's medical record failed to show documented evidence a physician's order was obtained for the use of CPAP machine, a care plan was formulated, care and maintenance and monitoring of the device was completed. On 5/13/25 at 1412 hours, an interview was conducted with CNA 1. CNA 1 stated she was aware of Resident 297's CPAP machine at the bedside and had not seen Resident 297 using the device. CNA 1 stated she was responsible for making sure the CPAP machine was in a safe place, and the mask and tubing were placed in a clear plastic bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1226 hours, an interview and concurrent medical record review for Resident 297 was conducted with LVN 2. LVN 2 stated the night nurses were responsible for applying the CPAP machine and taking it off from the residents. LVN 2 verified Resident 297's used the CPAP machine. LVN 2 stated the licensed nurses documented the care and maintenance of the CPAP machine in the TAR. LVN 2 reviewed Resident 297's medical record and verified there was no documented evidence of the CPAP machine care and maintenance. LVN 2 verified and acknowledged Resident 297's CPAP machine did not have a physician's order, care plan, and no care or maintenance of the device. On 5/15/25 at 1040 hours, an interview and concurrent medical record review for Resident 297 was conducted with the DON. The DON stated the residents who have a CPAP machine, the licensed nurses would obtain a physician's order for the use, care and maintenance per the manufacturer's guidelines of the device, formulate a care plan, and monitor the residents for the use of the device. The DON was informed and verified the above findings. Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for three of 13 final sampled residents (Residents 19, 40, and 397) and one nonsampled resident (Resident 297) reviewed for oxygen therapy. * The facility failed to ensure Resident 19 was properly receiving oxygen when the nasal cannula delivering oxygen was found on the floor. * The facility failed to ensure Resident 40 was administered oxygen as ordered by the physician. * The facility failed to ensure Resident 297's CPAP machine was cleaned as per the manufacturer's guidelines and failed to obtain a physician's order, formulate a care plan, and monitor for the use of the CPAP machine. These failures had the risk for equipment contamination and respiratory complications, which might adversely affect the health and well-being of Resident 297. * The facility failed to follow the physician's order for Resident 397's oxygen therapy. In addition, the facility failed to ensure Resident 397's oxygen signage was posted on the door. These failures had the potential for the residents to not receive the appropriate care and may negatively impact on the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Oxygen Administration revised date 10/2010 showed to verify if there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration. Place an Oxygen in Use sign on the outside of the room entrance door. Medical record review for Resident 397 was initiated on 5/12/25. Resident 397 was admitted to the facility on [DATE]. Review of Resident 397's H&P examination dated 5/7/25, showed Resident 397 had the capacity to make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 397's Care Plan Report dated 5/12/25, showed a care plan focus addressing the resident's pneumonia. The interventions included to administer the oxygen as needed as ordered for SOB and to keep the oxygen saturation level greater than 92%. Review of Resident 397's Order Summary Report dated 5/14/25, showed a physician's order dated 5/12/25, to administer oxygen at two LPM via nasal cannula every shift to keep the oxygen saturation level greater than 92%. On 5/13/25 at 0901 hours, during an observation, Resident 397 was lying in bed with the oxygen on via nasal cannula which was attached to the oxygen concentrator machine and set at two LPM. In addition, during the observation, the oxygen tubing was labeled and dated; however, there was no oxygen signage posted on the door. On 5/13/25 at 1007 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified there was no oxygen signage on the resident's door and stated there should have been a signage for No Smoking, Oxygen in Use for safety and awareness. On 5/14/25 at 0829 hours, during an observation, Resident 397 was lying in bed with the oxygen on via nasal cannula which was attached to the oxygen concentrator machine and set at one LPM. On 5/14/25 at 0834 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified the above findings and stated she would adjust the oxygen setting to two LPM and the physician's order for the oxygen administration for Resident 397 should have been followed. 3. Medical record review for Resident 19 was initiated on 5/12/25. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19's BIMS score was zero, indicating severe cognitive impairment. Review of Resident 19's Order Summary Report showed the physician's order dated 2/27/25, to administer oxygen at two LPM via nasal cannula to keep oxygen saturation level above 92% as needed for hypoxemia (a condition characterized by abnormally low levels of oxygen in the blood). On 5/13/25 at 0831 hours, an observation of Resident 19 and concurrent interview was conducted with LVN 5. Resident 19 was lying in bed and asleep. Resident 19's oxygen concentrator was turned on and set at two LPM. However, the nasal cannula tubing was on the floor and not on Resident 19. LVN 4 verified the findings, removed the oxygen tubing from the floor, and replaced it with a new nasal cannula. LVN 4 stated the nasal cannula tubing was not supposed to be on the floor. On 5/15/25 at 1505 hours, an interview was conducted with the DON. The DON was asked about the facility's policy of oxygen tubing care and storage. The DON stated the oxygen tubing should not be on the floor and must be kept in the bag if it was not in use or administered on the resident when in use. The DON and Administrator were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Oxygen Administration dated 10/2010 showed the following: - Verify and review the physician's orders for oxygen administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- After completing the oxygen setup or adjustment, the rate of oxygen flow, route, and rationale should be recorded in the medical record. On 5/12/25 at 1007 hours, during the initial tour of the facility, Resident 40 was in bed receiving four LPM of oxygen via nasal cannula. On 5/15/25 at 1104 hours, during an observation, Resident 40 was sitting up in a chair receiving four LPM of oxygen via nasal cannula. Medical record review for Resident 40 was initiated on 5/15/25. Resident 40 was admitted to the facility on [DATE]/25. Review of Resident 40's Order Summary Report dated 5/15/25, showed a physician's order dated 4/10/25, to administer oxygen at two LPM per nasal cannula every shift. On 5/15/25 at 1111 hours, an interview and concurrent medical record review for Resident 40 was conducted with LVN 2. LVN 2 verified Resident 40 was receiving four liters of oxygen. LVN 2 reviewed Resident 40's orders and verified the physician's orders showed an order for the oxygen to be administered at two LPM per nasal cannula. LVN 2 verified there was no order allowing the licensed staff to adjust the oxygen settings. LVN 2 also verified the licensed staff was incorrectly selecting yes when the system prompted them to verify Resident 40 was receiving oxygen at two LPM each shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 5. On 5/12/25 at 1036 hours, during the initial tour of the facility, Resident 15 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 5/13/25 at 0923 hours, Resident 15 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 15 was initiated on 5/12/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Order Summary Report dated 5/13/25, failed to show a physician's order for the use of bilateral half side rails in bed. Review of Resident 15's H&P examination dated 4/11/24, showed Resident 15 had a diagnosis of failure to thrive, T12 compression fracture (a break in the twelfth thoracic vertebra (T12) located in the mid-back), and osteoporosis (a disease that weakens bones, making them more likely to break). Review of Resident 15's Annual MDS assessment dated [DATE], showed a BIMS score of 9 (scores of 8 to 12 suggest moderate cognitive impairment). On 5/14/25 at 1319 hours, an interview and concurrent record review was conducted with RN 3. RN 3 verified the above findings and stated a physician's order should be in place for the used of bilateral half side rails. On 5/15/25 at 0805 hours, an interview and concurrent record review was conducted with RN 1. RN 1 acknowledged the above findings and stated there should be a physician's order, informed consent, entrapment assessment, and bed rail assessment prior to the used of side rails to ensure residents' safety, to prevent injuries and the risk of entrapment. 6. On 5/13/25 at 0926 hours, during an observation, Resident 34 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 5/14/25 at 1359 hours, Resident 34 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 34 was initiated on 5/12/25. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's Order Summary Report dated 5/13/25, failed to show a physician's order for the use of bilateral half side rails in bed. Review of Resident 34's H&P examination dated 4/10/25, showed Resident 34 was a high risk for falls and had no capacity to exercise rights and sign necessary documents; therefore, the family would be informed of medical condition and/or plan of treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 34's Quarterly MDS assessment dated [DATE], showed Resident 34 had severe cognitive impairment. Section GG of the assessment showed Resident 34 had impairment to both upper and lower extremities. On 5/14/25 at 1333 hours, an interview and concurrent record review was conducted with RN 3. RN 3 verified the above findings and stated a physician's order should be in place for the use of bilateral half side rails. On 5/15/25 at 0805 hours, an interview and concurrent record review was conducted with RN 1. RN 1 acknowledged the above findings and stated there should be a physician's order, informed consent, entrapment assessment, and bed rail assessment prior to the used of side rails to ensure the residents' safety and to prevent injuries and the risk of entrapment. 7. On 5/13/25 at 0942 hours, during an observation, Resident 40 was awake in bed with the bilateral half side rails elevated at the head of the bed. Medical record review for Resident 40 was initiated on 5/13/25. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's medical records failed to show the informed consent for the used of bilateral upper side rails. Review of Resident 40's H&P examination dated 4/11/25, showed Resident 40 had fluctuating capacity to make decisions. Review of Resident 40's admission MDS dated [DATE], showed a BIMS score of 10 (scores of 8 to 12 suggest moderate cognitive impairment). Review of Resident 40's Order Summary Report dated 5/13/25, failed to show a physician's order for the use of bilateral half side rails in bed. On 5/14/25 at 1554 hours, an interview and concurrent record review was conducted with LVN 1. LVN 1 verified the above findings and stated there should be a physician's order prior to the used of bilateral half side rails. On 5/15/25 at 0805 hours, an interview and concurrent record review was conducted with RN 1. RN 1 acknowledged the above findings and stated there should be a physician's order, informed consent, entrapment assessment, and bed rail assessment prior to the used of side rails to ensure residents' safety and to prevent injuries and the risk of entrapment. 8. On 5/14/25 at 1127 hours, during a wound care observation, Resident 397 was awake in bed with the bilateral half side rails elevated at the head of the bed. Medical record review for Resident 397 was initiated on 5/12/25. Resident 397 was admitted to the facility on [DATE]. Review of Resident 397's H&P examination dated 5/7/25, showed Resident 397 had the capacity to make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 397's admission MDS dated [DATE], showed a BIMS score of 15 (score of 13-15 suggests intact cognition). Review of Resident 397's Order Summary Report dated 5/13/25, failed to show a physician's order for the use of bilateral half side rails in bed. Review of Resident 397's medical record failed to show the informed consent for the used of bilateral upper side rails. On 5/14/25 at 1347 hours, an interview and concurrent record review was conducted with RN 3. RN 3 verified the above findings and stated a physician's order should be in place for the use of bilateral half side rails. On 5/15/25 at 0805 hours, an interview and concurrent record review was conducted with RN 1. RN 1 acknowledged the above findings and stated there should be a physician's order, informed consent, entrapment assessment, bed rail assessment, and care plan prior to the used of side rails to ensure residents' safety, to prevent injuries and the risk of entrapment. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure nine of nine final sampled residents (Residents 1, 2, 12, 15, 18, 19, 34, 40, and 397) and one nonsampled resident (Resident 16) reviewed for the side rail use remained free from the accident hazards associated with the use of the elevated side rails. * The facility failed to obtain a physician's order and informed consent for the use of the bilateral upper side rails for Residents 1, 2, 16, 19, 40, and 397. In addition, the facility failed to ensure the side rails assessment was completed accurately for Resident 1. * The facility failed to ensure the IDT meeting and determination for side rails was complete. Additionally, the facility failed to have the physician's order for side rails, side rail consent, and evaluation for Residents 12 and 18. * The facility failed to obtain a physician's order for the use of the bilateral upper side rails for Residents 15 and 34. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: The FDA issued a Safety Alert titled Entrapment Hazards with Hospital Bed Side Rails (1995), which showed the 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 Safety and Bed Rails revised on 8/2022 showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent; - If attempted alternatives do not adequately meet the resident's needs, the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes an evaluation of the alternatives to bed rails which were attempted and how these alternatives failed to meet the resident's needs, resident's risk associated with the use of bed rails, input from the resident and/or representative and consultation with the attending physician; and - Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. 1. On 5/12/25 at 0847 hours, during the initial tour, Resident 1 was observed lying in bed awake, was oriented to name and verbally responsive. Resident 1's bed had elevated bilateral side rails. Resident 1 stated she did not use her side rails. On 5/12/25 at 0856 hours, an observation and concurrent interview was conducted with CNA 2. Resident 1 was lying in bed with elevated bilateral upper side rails. CNA 2 stated Resident 1 used the bilateral upper side rails for repositioning while in bed. CNA 2 verified the above findings. Medical record review for Resident 1 was initiated on 5/14/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/15/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's cognitive skills for daily decision-making score was 3, indicating severely impaired. Review of Resident 1's Order Summary Report for 4/2025 failed to show for a physician's order for the bilateral upper side rails. Further review of Resident 1's medical records failed to show for an informed consent for use of bilateral upper side rails. On 5/14/25 at 0909 hours, an interview was conducted with LVN 3. LVN 3 stated Resident 1 currently uses the bilateral upper side rails for turning in bed. LVN 3 was asked about the process prior to applying side rails, the LVN stated there must be a side rail assessment, order, consent and care plan. Furthermore, LVN 3 was asked who completed the entrapment assessment. LVN 3 stated she had not heard or seen an entrapment assessment. On 5/14/25 at 0939 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 1's medical record failed to show the side rails evaluation, entrapment assessments, order, and informed consent. 2. On 5/12/25 at 0902 hours, during the initial tour, Resident 2 was lying in bed asleep. Resident 2's bed had the elevated bilateral side rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/12/25 at 0905 hours, an observation and concurrent interview was conducted with CNA 2. Resident 1 was lying in bed with bilateral upper side rails elevated. CNA 2 stated Resident 2 used the bilateral upper side rails for repositioning while in bed. CNA 2 verified the above findings. On 5/13/25 at 0837 hours, an observation and concurrent interview was conducted with LVN 4. Resident 2 was sitting up in bed and eating her breakfast. Resident 2's bed had the elevated bilateral upper side rails. LVN 4 verified the above findings. Medical record review for Resident 2 was initiated on 5/14/25. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2's cognitive skills for daily decision-making score was 3, indicating severely impaired. Review of Resident 2's Order Summary Report dated 5/14/25, failed to show the physician's order for the bilateral upper side rails. Reviewed Resident 2's Side Rail Evaluation Quarterly dated 3/28/25, showed the Side Rails/Assist bar were not indicated at this time. Review of Resident 2's medical record failed to show the consent was obtained for the use of bilateral upper side rails. On 5/14/25 at 1028 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 2's medical record failed to show there was a physician's order and informed consent from the resident's responsible party for the use of the side rails. 3. Medical record review for Resident 16 was initiated on 5/14/25. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 9/22/23, showed Resident 16 had the capacity to understand and make decisions. Review of Resident 16's MDS assessment dated [DATE], showed Resident 16's BIMS score was 15, indicating cognitively intact. On 5/14/25 at 0900 hours, an observation and concurrent inteview was conducted with Resident 16. Resident 16 was in bed, awake, alert, and verbally responsive. Resident 16's bed had the elevated bilateral upper side rails. Resident 16 stated he used the side rails for bed mobility and during transfers. Review of Resident 16's Order Summary Report dated 5/14/25, failed to show there was a physician's order for the use of the bilateral upper side rails. Further review of Resident 16's medical record failed to show an informed for the use of bilateral upper side rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25 at 0915 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 reviewed the resident's medical record and verified the findings. LVN 3 stated when the resident had the side rails, they should have a physician's order and an informed consent. 4. On 5/12/25 at 0858 hours, an initial tour observation and concurrent interview was conducted with CNA 2. Resident 19 was lying in bed, awake, alert, and eating her breakfast. Resident 19's bed had the elevated bilateral upper side rails. CNA 2 verified the above findings. CNA 2 stated Resident 19 used the bilateral upper side rails to reposition in bed. Medical record review for Resident 19 was initiated on 5/14/25. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19's BIMS score was zero, indicating severe cognitive impairment Reviewed Resident 19's Side Rail Evaluation Quarterly dated 4/23/25, showed the Side Rails/Assist bar were not indicated at this time. Review of Resident 19's Order Summary Report dated 4/2025 failed to show the physician's order to apply the bilateral upper side rails. Review of Resident 19's medical record failed to show an informed consent for the use of bilateral upper side rails. On 5/14/25 at 0939 hours, an interview was conducted with RN 1. RN 1 was asked about the facility's process prior to applying side rails. RN 1 stated the residents must be assessed for the side rails' indication, and they need to obtain physician's order and informed consent from the resident or responsible party. RN 1 stated an entrapment assessment must be included prior to applying the side rails. RN 1 stated the Maintenance Supervisor was responsible for the bed inspection, and the Safety Alarms/Bedrail use/Entrapment Risk Evaluations were completed by the admission nurse and IDT. RN 1 stated the side rails and devices used without appropriate assessments, the order and consent would be considered physical restraint and could cause injury to the residents. On 5/14/25 at 1010 hours, a follow-up interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. On 5/15/25 at 1505 hours, an interview was conducted with the DON and Administrator. The DON was asked for the facility's process prior to side rail use. The DON stated she was responsible for the monthly check of the side rail's assessments and consents completion and accuracy. The DON stated each time a resident needed the side rails, the licensed nurse must assess for appropriateness, obtain the physician's order and consent from the resident or responsible party, develop a care plan, complete the entrapment assessment, and apply the side rails. The DON stated if the side rails were applied to the resident's bed and used by the resident; however, there were no assessments, physician's order, consent, and care plan, then the side rails should not be applied and would be considered a restraint. The DON and Administrator were informed and acknowledged the above findings. 9. On 5/12/25 at 1054 hours and on 5/14/25 at 0835 hours, Resident 12 was observed in bed with elevated bilateral upper side rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 12 was initiated on 5/14/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Safety Alarms/Bedrail Use/And Entrapment Risk Evaluation dated 9/17/24, showed the IDT Determination for bedrails was left blank. Further review of Resident 12's Entrapment Risk Evaluation showed only one signature from the nursing department for the IDT meeting, resulting in an incomplete IDT meeting Review of Resident 12's Informed Consent for Bedrail Use dated 9/19/24, showed no indications were specified for the use of side rails. Review of Resident 12's medical record did not show the Side Rail Evaluation was completed in conjunction with the 9/19/24 consent. Review of Resident 12's Side Rail Evaluation - Quarterly/Annual dated 3/13/25, showed the side rails/assist bar were not indicated at this time; however the facility entered a new Side Rail Evaluation on 5/14/25, which showed the side rails/assist bar were indicated and served as an enabler to promote independence. Review of Resident 12's Order Summary Report dated 5/14/25, did not show a physician's order for the use of the side rails. Further review of the Order Summary Report showed a new order dated 5/14/25, for side rails, quarter. There was no indication listed for the use of side rails. On 5/14/25 at 1401 hours, an interview and concurrent medical record review for Resident 12 was conducted with LVN 3. LVN 3 verified the IDT determination for bedrails section was blank. LVN 3 verified the IDT meeting was incomplete because the IDT meeting should consist of members of the care team like the physician and social worker. LVN 3 was unable to locate the physician's order for side rails prior to 5/14/25. LVN 3 verified the physician's order dated 5/14/25, was incomplete because the orders for the side rails need to have an indication. LVN 3 verified the consent dated 9/19/24, was incomplete because there were no indications for side rails listed and stated indications were necessary because the side rails were considered an assistive device, and could be considered a restraint. LVN 3 was unable to locate an assessment associated with the consent dated 9/19/24. LVN 3 verified the side rails should not have been in use for Resident 12 because the evaluation dated 3/13/25, showed side rails were not indicated. 10. On 5/12/25 at 1045 hours and on 5/14/25 at 0835 hours, Resident 18 was observed in bed with elevated bilateral upper side rails. Medical record review for Resident 18 was initiated on 5/14/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Safety Alarms/Bedrail Use/And Entrapment Risk Evaluation dated 2/5/25, showed the sections for the Bedrail Evaluation Summary and IDT Determination for bedrails were left blank. Further review of Resident 18's Entrapment Risk Evaluation showed only one signature from the nursing department for the IDT meeting, resulting in an incomplete IDT meeting Review of Resident 18's Informed Consent for Bedrail Use dated 3/1/25, showed no indications were specified for the use of side rails. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 18's Side Rail Evaluation dated 3/27/25, showed the side rails/assist bar were not indicated at this time. Review of Resident 18's Order Summary Report dated 5/14/25, did not show an order for side rails. On 5/14/25 at 1401 hours, an interview and concurrent medical record review for Resident 18 was conducted with LVN 3. LVN 3 verified the bedrail evaluation summary and the IDT Determination were incomplete because there was no documentation. LVN 3 verified the IDT meeting was incomplete because the IDT meeting should consist of members of the care team like the physician and the social worker. LVN 3 was unable to locate a physician's order for side rails prior to 5/14/25. LVN 3 verified the consent dated 3/1/25, was incomplete because there were no indications for the side rails listed and stated the indications were necessary because the side rails were considered an assistive device and could be considered as a restraint. LVN 3 verified the side rails should not have been in use for Resident 18 because the evaluation dated 3/27/25, showed the side rails were not indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the facility's P&P titled Medication Administration Subcutaneous dated 2007 showed the licensed nurses to administer medications via the subcutaneous route in a safe, accurate and effective manner. The procedures included the following: - To check the last injection sites and select a new appropriate site for injection. - To document the injection on the MAR along with the site. Medical record review for Resident 597 was initiated on 5/13/25. Resident 597 was admitted to the facility on [DATE]. On 5/14/25 at 1410 hours, an observation and concurrent interview was conducted with Resident 597. Resident 597 was in his wheelchair awake with bluish to greenish discoloration on the posterior right upper arm. Resident 597 stated the nurse gave his injection medication for blood clot on the back of his arm. Review of Resident 597's Order Summary Report dated 5/14/25, showed a physician's order dated 4/29/25, to administer enoxaparin sodium injection 40 mg subcutaneously one time a day for DVT prophylaxis for 21 days. Review of Resident 597's Location of Administration Report for April and May 2025 for Resident 597's enoxaparin injection showed the injection sites were not rotated on the following dates and times: - on 4/26/25 at 0849 hours, the enoxaparin medication was administered to the left rear of the upper arm. - on 4/27/25 at 0943 hours, the enoxaparin medication was administered to the left rear of the upper arm. - on 4/29/25 at 0844 hours, the enoxaparin medication was administered to the left rear of the upper arm. - on 4/30/25 at 0828 hours, the enoxaparin medication was administered to the left rear of the upper arm. - on 5/1/25 at 0925 hours, the enoxaparin medication was administered to the left rear of the upper arm. - on 5/2/25 at 0842 hours, the enoxaparin medication was administered to the left rear of the upper arm. - on 5/11/25 at 1005 hours, the enoxaparin medication was administered to the right rear of the upper arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 5/11/25 at 1010 hours, the enoxaparin medication was administered to the right rear of the upper arm. - on 5/12/25 at 1042 hours, the enoxaparin medication was administered to the right rear of the upper arm. Further review of Resident 597's medical record failed to show documented evidence Resident 597's skin discoloration on the right upper arm was assessed, monitored, and the physician and family representative were notified. On 5/14/25 at 1435 hours, an interview and concurrent medical record review for Resident 597 was conducted with LVN 1. LVN 1 verified Resident 597 was on anticoagulant medication for DVT prophylaxis and monitored for any signs and symptoms for bleeding. LVN 1 was asked if she administered the anticoagulant medication injection to Resident 597's dose for the day. LVN 1 verified and stated she administered the anticoagulant medication injection to Resident 597's left upper arm. LVN 1 was asked if she observed any skin discoloration to Resident 597's right upper arm. LVN 1 denied observation of any skin discoloration of Resident 597. LVN 1 was asked at Resident 597 bedside and assessed the skin discoloration of the resident. LVN 1 verified the skin discoloration on the right upper arm of Resident 597. On 5/15/25 at 0908 hours, an interview and concurrent medical record review for Resident 597 was conducted with RN 1. RN 1 was asked at Resident 597's bedside and verified the skin discoloration on the resident's right upper arm. RN 1 stated she was not aware and did not receive any report about the skin discoloration of Resident 597. RN 1 verified Resident 597 was on anticoagulant medication which was administered via injection subcutaneously. RN 1 was asked how the licensed nurse would know where the last injection sites of the anticoagulant medication was administered. RN 1 stated the licensed nurse documented the injection sites in the MAR under the Location of Administration Report included the date and time of administration of the medication. RN 1 was asked to review the MAR under the Location of Administration Report for the administration of enoxaparin. RN 1 verified and acknowledged the injection sites for enoxaparin injection medication were not rotated on several days when the anticoagulant medication was administered. RN 1 stated the injection sites for the anticoagulant medication should have been rotated to different sites to prevent any adverse effects. On 5/15/25 at 1105 hours, an interview and concurrent medical record review for Resident 597 was conducted with the DON. The DON stated she expected the licensed nurses would follow the facility's P&P on administering medications. The DON was informed of the findings and verified the above findings. Based on observation, interview, medical record review, facility document review, and facility P&P, the facility failed to provide pharmaceutical services to meet the resident's needs for one of 13 final sampled residents (Resident 597). * The facility failed to ensure Resident 597's oxycodone HCl IR (narcotic) was accurately reconciled. Resident 597's oxycodone HCl was documented as administered on the Controlled Drug Record but not on the electronic MAR. This failure had the potential for diversion of controlled medications. * The facility failed to ensure Resident 597's enoxaparin (anticoagulant medication) injection sites were rotated. This failure had the potential for poor health outcome for Resident 597. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: 1. Review of the facility's P&P titled Controlled Substances dated 2007 showed to administer the controlled medication and document the dose administration on the MAR. On 5/12/25 at 1109 hours, a concurrent observation of Station 1's Medication Cart, interview, medical record review for Resident 597 and facility document review was conducted with LVN 1. Review of Resident 597's Controlled Drug Record - Individual Patient's Narcotic Record showed one tablet of oxycodone HCl was removed from the bubble pack on 5/3/25 at 2200 hours. Resident 597's oxycodone HCl bubble pack showed eight tablets remaining, which matched the number of oxycodone HCl tablets in Resident 597's Controlled Drug Record. Review of Resident 597's MAR failed to show the oxycodone HCl medication was administered to the resident on 5/3/25 at 2200 hours. LVN 1 acknowledged and verified the oxycodone HCl medication was removed from the bubble pack on 5/3/25, and documented in Resident 597's Controlled Drug Record but not in the MAR. LVN 1 stated the medication should have been documented in the MAR right after it was administered. Medical record review for Resident 597 was initiated on 5/12/25. Resident 597 was admitted to the facility on [DATE]. Review of Resident 597's H&P examination dated 4/26/25, showed Resident 597 had no capacity to exercise rights and sign necessary documents. Review of Resident 597's Order Summary Report dated 4/30/25, showed a physician's order dated 4/23/25, to administer Oxycodone HCl one tablet by mouth every six hours as needed for moderate pain. On 5/14/25 at 1043 hours, a telephone interview was conducted with RN 1. RN 1 verified she worked in the facility on 5/3/25, during the evening shift. RN 1 stated she administered Resident 597's medications during her shift. RN 1 stated Resident 597 complained of pain, so she gave the oxycodone HCl medication to Resident 597 after popping it out of the bubble pack. RN 1 stated she was not sure what happened and was sure she signed it as administered on the MAR. When asked about the process of administering the controlled medications, RN 1 stated, I signed Resident 597's Controlled Drug Record right after I removed the oxycodone HCl medication and signed the MAR after I administered the medication. RN 1 further stated, I should have double checked if I signed the MAR. On 5/14/25 at 1026 hours, a concurrent medical record review for Resident 597, facility document review, and interview was conducted with the DON. The DON verified the findings. On 5/15/25 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 6.45%. One of two licensed nurses (LVN 1) observed during the medication administration was found to have made errors. * LVN 1 failed to ensure metformin medication (antidiabetic) was administered to Resident 26 with meal as per the physician's orders. * LVN 1 failed to ensure Resident 697 received calcium citrate (supplement) on time following admission to the facility. These failures created the risk for the residents to have potential side effects or complications related to the medications. Findings: 1. Review of the facility's P&P titled Administering Medications dated 4/2019 showed the following: - Medications are administered in accordance with prescriber orders, including any required time frame - Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). On 5/13/25 at 0908 hours, a medication administration observation for Resident 26 was conducted with LVN 1. LVN 1 prepared one tablet of metformin 1000 mg medication. LVN 1 administered the metformin tablet medication to Resident 26 at 0922 hours. Resident 26 stated she ate breakfast at 0800 hours. Medical record review for Resident 26 was initiated on 5/13/25. Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's Order Summary Report showed a physician's order dated 4/8/25, for metformin HCl oral tablet 1000 mg one tablet by mouth two times a day for DM. Take with meals. On 5/13/25 at 1408 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified she did not administer the metformin medication to Resident 26 with her meal. 2. Review of the facility's P&P titled Administering Medications dated 4/2019 showed the following: - Medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate records of medication order and receipt. - New medications, except for emergency or stat medications, are ordered as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If the first dose of medication is scheduled to be given before the next regularly scheduled pharmacy delivery, please telephone or transmit the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery. - Timely delivery of new orders is required so that mediation administration is not delayed. On 5/13/25 at 0853 hours, a medication administration observation for Resident 697 was conducted with LVN 1. LVN 1 was unable to administer the calcium citrate to Resident 697 as the pharmacy had not delivered the medication since admission. Medical record review for Resident 697 was initiated on 5/13/25. Resident 697 was admitted to the facility on [DATE]. Review of Resident 697's Order Summary Report showed a physician's order dated 4/8/25, for calcium citrate oral tablet 950 mg (200 Ca) one tablet by mouth one time a day for supplement. On 5/13/25 at 1000 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 697 was admitted to the facility on [DATE] at 1410 hours. On 5/13/25 at 1402 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated as soon as a resident was admitted , all medication orders were sent to the pharmacy, and the medications were usually delivered within the same day. LVN 1 verified the calcium citrate medication had not yet been delivered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food items were served in appetizing temperatures: * The temperature was not maintained at the acceptable range for cold beverages. This failure posed the risk for not providing palatable and appetizing food for the residents receiving a meal tray from the kitchen. Findings: Review of the facility's Diet Type Report dated 5/12/25, showed 45 of 45 residents consumed the food prepared in the kitchen. Review of the facility's P&P titled Cold Holding and Storage revised date 12/1/22, showed cold TCS (Time/Temperature Control for Safety) food must be held at proper temperatures to prevent harmful bacterial growth and/ or toxin production that can occur if it remains in the temperature danger zone too long. Cold TCS foods must be maintained at 41 degrees Fahrenheit or below during holding, display, service, and transport. On 5/13/25 at 1140 hours, a tray line observation and concurrent interview was conducted with the CDM. The CDM checked and verified the following temperatures: - cranberry juice - 42.6 degrees Fahrenheit; - another cranberry juice - 43.8 degrees Fahrenheit; - orange juice - 42.8 degrees Fahrenheit; and - mixed cranberry and orange juice - 43.6 degrees Fahrenheit. The CDM verified the temperature of the cranberry juice, orange juice, and mixed cranberry juice were not holding the cold beverage temperature. The CDM stated the holding temperatures for the cold beverages should be 41 degrees Fahrenheit and below. The CDM acknowledged the beverage temperatures varying from 42.6 to 43.8 degrees Fahrenheit were above the recommended temperatures for cold food. The pitcher of beverages was placed in bucket of ice to keep beverages cold prior to serving the residents' lunch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 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. 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 sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the heavy-duty blenders used for puree preparation were dried and clean prior to storing. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the food prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 5/12/25, showed 45 of 45 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation and Infection Prevention/ Control, Area and Equipment Cleaning revised date 1/2025 showed the facility's Maintenance Department is scheduled to clean equipment that requires special training and equipment, such as the ice maker, refrigeration coils and exhaust hood. Review of the facility's P&P titled Equipment Condition and Management dated 10/1/22, showed the equipment must be maintained in a state of good repair and condition, in compliance with applicable local, state, and federal, statutes, regulations, and ordinances. 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. On 5/12/25 at 0836 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Aide. The kitchen hood over the stove had black, dirt residue. The Dietary Aide acknowledged the findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Sanitation and Infection Prevention/ Control, Cleaning of Food and Nonfood Contact Surfaces revised date 1/2025 showed discard any food contact surfaces with chips, nicks or broken pieces, such as fryer baskets or skimmers that have damaged, loose or broken wires, strainers, pans, skillets, and knives, which cannot be cleaned properly. Nonfood contact surfaces of utensils and equipment must be made of materials that are safe, corrosion resistant, nonabsorbent, smooth and easily cleanable, and maintained in good condition. Review of the facility's P&P titled Equipment Condition and Management dated 10/1/22, showed the equipment and utensils must be designed and constructed to be safe and to prevent the migration of harmful substances, colors, odor or tastes to food. Also under normal use conditions, materials that are used in the construction of utensils and food-contact surfaces of equipment must be smooth and free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. Durable, corrosion-resistant, and non-absorbent. Finished to have a smooth, easily cleanable surface. Resistant to pitting, chipping, scratching, scoring, distortion, and decomposition. Free of sharp internal angles, corners, and crevices. Finished to have smooth welds and joints. 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. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of the 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 5/12/25 at 0836 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Aide. The following was observed and verified by the Dietary Aide: - One Ninja blender stored at a countertop shelf was old and worn out and cracked at the base of the blender. The lid was cracked and the rubber portion worn out and discolored. - One stainless steel serving spoon with black handle was partially melted. - One stainless steel spatula with black handle was deformed at the edges and handle partially melted. - One plastic black spoon was partially melted at the edges. - Two rubber spatulas with red handle were chipped/cracked at the edges. - One rubber spatula with brown handle was discolored, chipped/cracked at the edges. - One stainless steel serving scoop with a black handle partially melted. - Two stainless steel slotted serving scoops with black handles were partially melted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One stainless steel serving spoon with black handle was partially melted. - One stainless steel spatula with brown handle was chipped at the edges and handle was discolored and partially melted. - One stainless steel ice cream scoop old, worn out, and discolored. - One cutting dough with cream handle was discolored and partially melted. 3. Review of the facility's P&P titled Sanitation and Infection Prevention/ Control, Cleaning of Food and Nonfood Contact Surfaces revised date 1/2025 showed the food contact surfaces are in good condition, made of non-toxic materials and are easily cleanable. The food-contact surfaces of all the cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Review of the facility's P&P titled Equipment Condition and Management dated 10/1/22, showed the equipment and utensils must be designed and constructed to be safe and to prevent the migration of harmful substances, colors, odor or tastes to food. Also under normal use conditions, the materials that are used in the construction of the utensils and food-contact surfaces of the equipment must be durable, corrosion-resistant, and non-absorbent. 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 the equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 5/12/25 at 0836 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Aide. The following was observed and verified by the Dietary Aide: - Robot coupe blender at a countertop shelf with blade had dry, orange residue, rubber portion of the lid was dirty and had yellow discoloration. - Four stainless steel serving scoops with green handles were stored in the clear container for clean spoodles and utensils were dirty with dry fuzzy film, watermarks and crusted residue. - Two stainless steel serving scoops with blue handles were stored in the clear container for clean spoodles and the utensils were dirty with dry watermarks and crusted residue. - Two stainless steel serving scoops with cream handles were stored in the clear container for clean spoodles and the utensils were dirty with dry watermarks and crusted residue. - One stainless steel serving scoop with black handle was stored in the clear container for clean spoodles and the utensil was dirty and had dry crusted residue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Two stainless steel serving spoons with black handles were stored in the clear container for clean spoodles and the utensils were dirty, had dry watermarks and crusted residue. - Two stainless steel serving slotted scoops with black handles were stored in the clear container for clean spoodles and the utensils were dirty, had dry fuzzy film and crusted residue. - One stainless steel slotted serving spoon was stored in the clear container for clean spoodles and the utensil was dirty with crusted residue. - One stainless steel scoop with a blue handle used for food portioning was stored in the clear container for clean spoodles and the utensil was dirty and had crusted residue. - One stainless steel scoop with gray handle used for food portioning was stored in the clear container for clean spoodles and the utensil was dirty and had crusted residue. - One stainless steel serving scoop with black handle was stored in the clear container for clean spoodles and the utensils was dirty and had dry crusted residue. - Two stainless steel slotted serving scoops with black handles were stored in the clear container for clean spoodles and the utensils were dirty and had dry crusted residue. - One stainless steel serving spoon with black handle was stored in the clear container for clean spoodles and the utensil was dirty with dry watermarks. 4. Review of the facility's P&P titled Equipment Condition and Management dated 10/1/22, showed surfaces such as the cutting blocks and boards that are subject to scratching and scoring must be resurfaced if they can no longer be effectively cleaned and sanitized or discarded if they are not capable of being resurfaced. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as the 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 5/12/25 at 0836 hours, an initial tour observation and concurrent interview was conducted with the Dietary Aide. The white, green, and red cutting boards were observed fuzzy, discolored, heavily marred and had deep groves. The Dietary Aide verified the findings, and stated the cutting boards were ordered by the Chef, and was unsure how often. 5. Review of the facility's P&P titled Dish Machine Usage and Testing dated 10/1/22, showed for air dry: place the equipment or utensils onto a clean surface to air dry. Do not dry with a towel or other method. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, the equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, the cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 5/12/25 at 0836 hours, an initial tour observation and concurrent interview was conducted with the Dietary Aide. Two heavy-duty blenders stored at a countertop shelf were still wet with water dripped from the blender lid and visible water inside. The Dietary Aide acknowledged the above findings. The Director of Dining Services was informed and acknowledged all the above findings. The Director of Dining Services stated all the utensils should have been washed properly to prevent bacteria growth and for infection control purposes. The blenders should have been air dried to prevent mold and bacteria growth. The cutting boards should have been replaced for infection control purposes. The hood over the stove should be free from grease or dirt for fire hazard prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment;and 2. A contingency plan for staffing needs. This failure had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, the CMS issued revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. There should also be a contingency plan for staffing needs for events so as not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff members, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment. Additionally, the Facility Assessment did not show resources necessary to care for the residents including a contingency plan for the staffing needs. On 5/15/25 at 1019 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment was dated 3/12/25, and acknowledged she was aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest update from the CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on interview, medical record review and facility P&P review, the facility failed to ensure the medical record for one of 13 final sampled residents (Resident 298) was complete and accurate. This failure had the potential for Resident 298's care needs not being met as the medical record was inaccurate. Findings: Review of the facility's P&P on Output Measuring and Recording dated October 2010 showed the following: - Purpose: to accurately determine the amount of urine a resident excretes in a 24-hour period; - Documentation: the amount of urine output in ml should be recorded in the resident's medical record. Medical record review for Resident 298 was initiated on 5/15/25. Resident 298 was admitted on [DATE]. Review of Resident 298's Order Summary Report dated 5/15/25, showed the following orders: - dated 4/29/25, for intake and output every shift; - dated 5/11/25, for urinary catheter 18 Fr with 10 cc bulb every shift; and - dated 5/11/25, to drain catheter every shift. Review of Resident 298's TAR failed to show the urine output recorded on the following dates and shifts: - 5/3/25, for both day and night shifts. - 5/7/25, for the night shift. - 5/8/25, for the evening shift. - 5/9/25, for the night shift. - 5/11/25, for the evening. On 5/15/25 at 0940 hours, a telephone interview and concurrent medical record review was conducted with RN 1 and the DON. RN 1 confirmed Resident 298 had an indwelling urinary catheter in place. RN 1 verified the incomplete entries and stated the output measured should have been recorded with the actual amount of urine. The DON verified the above findings and stated the nurses were responsible for checking the output and documenting in the TAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/15/25 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 3. Review of the facility's P&P titled Bedpan/ Urinal Offering/ Removing dated 2/2018 showed store the bedpan or urinal as per facility policy. Review of the facility's P&P titled Handwashing/ Hygiene dated 8/2019 showed the use of an alcohol-based hand rub at least 62% alcohol or alternatively, soap (antimicrobial or non- antimicrobial) and water: after handling contaminated equipment. On 5/12/25 at 1242 hours, an observation in Resident 597's room and concurrent interview was conducted with CNA 5. Resident 597's urinal containing urine was observed on top of the overbed table near uncovered cups of water and cranberry juice. CNA 5 entered the room, put on gloves, removed the urinal, and discarded the urine to the toilet, rinsed the urinal, and placed the urinal back to Resident 597's overbed table near the uncovered cups of water and cranberry juice. CNA 5 used the same gloves previously used to discarding the contents of the urinal, to move the overbed table and put on socks to Resident 597's feet. CNA 5 acknowledged the urinal was on top of the over bed table and verified he should not have placed the urinal back to the overbed table. CNA 5 further stated the urinal should be kept away from food or drinks. CNA 5 acknowledged and verified he did not remove the gloves he wore when he discarded the urine from the urinal and continued with what he was doing. CNA 5 was asked if using the same contaminated gloves in moving the table or putting on resident's socks were acceptable, CNA 5 stated No, I should have changed my gloves and washed my hands. On 5/12/25 at 1246 hours, an observation and concurrent interview was conducted with the IP. The IP observed the urinal on top of the overbed table and verified the urinal should not be on top of the overbed table. The IP verified the above findings. On 5/15/25 at 1100 hours, an observation and concurrent interview was conducted with the DON. The DON verified the findings and stated the facility's policy required the urinals be placed in the designated urinal holders at bedside and should not be placed on the over bed table or the nightstand. On 5/15/25 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified all of the above findings. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program designed to help prevent the development and transmission of diseases and infections. * The facility failed to ensure the staff's personal belongings were not stored with the clean linen. * The facility failed to ensure LVN 6 performed hand hygiene when providing wound care treatment to Resident 19. * CNA 5 placed Resident 597's urinal near the cups of beverages and failed to perform hand hygiene after handling a urinal. These failures posed the risk for not identifying infections and controlling the transmission of communicable disease to other residents throughout the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: 1. Review of the facility's P&P titled Laundry Infection Control revised on 11/2023 showed the following: - Clean linen shall be handled, transported, and stored by methods that will ensure its cleanliness. Review of the facility's P&P titled Laundry Supplies Storage revised on 11/2023 showed the supply area must be neat organized and locked at all times. On 5/14/25 at 1115 hours, during the initial tour, the black backpack and jacket were stored with the clean linen in the clean linen room. On 5/14/25 at 1118 hours, an observation and concurrent interview was conducted with the Laundry Aide and the Housekeeping Supervisor. The Laundry Aide and the Housekeeping Supervisor verified the above findings. The Laundry Aide stated the black backpack and jacket stored with the clean linen were his personal belongings. In addition, the Laundry Aide stated his personal belongings were not supposed to be stored with the clean linen. On 5/15/25 at 1505 hours, an interview was conducted with the Administrator. The Administrator was asked about the facility's policy in storing employee's belongings in the laundry clean area. The Administrator stated the employee's personal belongings should not to be stored with the clean linens. Furthermore, the Administrator stated the laundry's clean linen area must be always kept clean. 2. Review of the facility's P&P titled Handwashing and Hand Hygiene revised on 8/2019 showed the following: - All personnel staff follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors; - Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations like when hands are visibly soiled and after contact with a resident with infectious diarrhea including but not limited to infections caused by norovirus (a group of viruses that causes severe vomiting and diarrhea), salmonella (bacteria that causes diarrhea, fever and stomach pains), shigella (are bacteria (germs) that cause diarrhea), and C. difficile (a bacterial infection that can cause diarrhea and other symptoms, including colitis, which is inflammation of the colon); - Use an alcohol-based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations like before and after direct contact with residents, before performing any non-surgical invasive procedures, before handling clean or soiled dressings or gauze, after contact with resident's intact skin and after removing gloves; and - The use of gloves does not replace hand washing or hand hygiene. Integration of glove use along with routine and hygiene is recognized as the best practice for preventing healthcare-associated infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 0936 hours, a wound care observation for Resident 19 and a concurrent interview was conducted with LVN 5. LVN 5 stated Resident 19 had a sacrococcyx pressure injury (localized skin damage caused by prolonged or intense pressure, often over bony prominences). The following was observed: - LVN 5 was performed hand hygiene with an alcohol-based hand rub, then donned clean gloves and explained the procedure to the resident; - LVN 5 touched Resident 19's right thigh after picking up the trash can with the same gloves without performing hand hygiene; - LVN 5 removed the gloves, donned clean gloves, and removed Resident 19's dressing on the sacrococcyx without performing hand hygiene; - LVN 5 cleaned Resident 19's sacrococcyx pressure injury with a gauze soaked with normal saline, patted dry with dry gauze, applied Collagen powder (a topical wound treatment, particularly for promoting healing in stalled or chronic wounds, and can be an effective adjunctive therapy) and calcium alginate (a naturally derived, highly absorbent wound dressing material made from seaweed to treat various wounds), and covered with a foam dressing without changing gloves and performing hand hygiene; and - LVN 5 removed the gloves and washed her hands after the wound care treatment. On 5/13/25 at 0956 hours, a follow-up interview was conducted with LVN 5. When asked about performing a hand hygiene during wound care treatment, LVN 5 stated infection control practices like handwashing and hand hygiene must be performed to prevent the spread of infection to Resident 19 especially after touching a dirty trash receptacle. LVN 5 verified the above findings. Review of Resident 19's Order Summary Report showed physician's order dated 5/12/25, showed to cleanse the sacrococcyx pressure injury with normal saline, pat dry, apply Collagen powder and Calcium alginate then cover with a foam dressing daily and as needed for soiling for 14 days. On 5/15/25 at 1505 hours, an interview was conducted with the DON. The DON was asked about the facility's infection control policy, especially during wound care treatment. The DON stated the licensed nurse or treatment nurse must remove the gloves after touching any dirty surfaces, perform handwashing, and don new gloves to prevent the spread of infection. The DON and Administrator 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
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurately completed for nine of 13 final sampled residents (Residents 1, 2, 12, 15, 18, 19, 34, 40, and 397) and one nonsampled resident (Resident 16). This failure had the potential to negatively impact the residents, resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety and Bed Rails revised date 8/2022 showed the resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. Bed dimensions are appropriate for the resident's size. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. Review of the facility's Bed System Measurement Device Test Results Worksheet (undated) failed to show Zones 6 and 7 were reflected and recorded on the form and assessed for entrapment. For example: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 5/12/25 at 1036 hours, during the initial tour of the facility, Resident 15 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 5/13/25 at 0923 hours, Resident 15 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 15 was initiated on 5/12/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 4/11/24, showed Resident 15 had a diagnosis of failure to thrive, T12 compression fracture (a break in the twelfth thoracic vertebra (T12) located in the mid-back), and osteoporosis (a disease that weakens bones, making them more likely to break). Review of Resident 15's Annual MDS assessment dated [DATE], showed a BIMS score of 9 (scores of 8 to 12 suggest moderate cognitive impairment). Review of Bed System Measurement Device Test Results Worksheet dated 5/1/25, failed to show Zones 6 and 7 were reflected and recorded on the form and assessed for the entrapment. Cross reference to F700, example #5. 2. On 5/13/25 at 0926 hours, during an observation, Resident 34 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 5/14/25 at 1359 hours, Resident 34 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 34 was initiated on 5/12/25. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's Quarterly MDS assessment dated [DATE], showed Resident 34 had severe cognitive impairment. Section GG of the assessment showed Resident 34 had impairment to both the upper and lower extremities. Review of Resident 34's H&P examination dated 4/10/25, showed Resident 34 is high risk for falls and had no capacity to exercise rights and sign necessary documents therefore, family will be informed of medical condition and/ or plan of treatment. Review of Bed System Measurement Device Test Results Worksheet dated 5/1/25, failed to show Zones 6 and 7 were reflected and recorded on the form and assessed for the entrapment. Cross reference to F700, example #6. 3. On 5/13/25 at 0942 hours, during an observation, Resident 40 was awake in bed with the bilateral half side rails elevated at the head of the bed. Medical record review for Resident 40 was initiated on 5/13/25. Resident 40 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 40's H&P examination dated 4/11/25, showed Resident 40 had fluctuating capacity to make decisions. Review of Resident 40's admission MDS assessment dated [DATE], showed a BIMS score of 10 (scores of 8 to 12 suggest moderate cognitive impairment). Review of Bed System Measurement Device Test Results Worksheet dated 5/1/25, failed to show Zones 6 and 7 were reflected and recorded on the form and assessed for the entrapment. Cross reference to F700, example #7. 4. On 5/14/25 at 1127 hours, during a wound care observation, Resident 397 was awake in bed with the bilateral half side rails elevated at the head of the bed. Medical record review for Resident 397 was initiated on 5/12/25. Resident 397 was admitted to the facility on [DATE]. Review of Resident 397's H&P examination dated 5/7/25, showed Resident 397 had the capacity to make decisions. Review of Resident 397's admission MDS assessment dated [DATE], showed a BIMS score of 15 (score of 13-15 suggests intact cognition). Review of Bed System Measurement Device Test Results Worksheet dated 5/1/25, failed to show Zones 6 and 7 were reflected and recorded on the form and assessed for the entrapment. On 5/15/25 at 0945 hours, an interview and concurrent record review for Residents 15, 34, 40, and 397, was conducted with the Maintenance Supervisor. The Maintenance Supervisor acknowledged the above findings and stated Zones 6 and 7 were not reflected on the Bed System Measurement Device Test Results Worksheet form; therefore, the entrapment zones were inaccurately assessed. Cross reference to F700, example #8. 5. On 5/12/25 at 0847 hours, during the initial tour, Resident 1 was lying in bed awake, oriented to name and verbally responsive. Resident 1's bed had elevated bilateral side rails. Resident 1 stated she did not use her side rails. Medical record review for Resident 1 was initiated on 5/14/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/15/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's cognitive skills for daily decision-making score was 3, indicating severely impaired. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/12/25 at 0856 hours, an observation and concurrent interview was conducted with CNA 2. Resident 1 was lying in bed with elevated bilateral upper side rails. CNA 2 stated Resident 1 used the bilateral upper side rails for repositioning while in bed. CNA 2 verified the above findings. Review of Resident 1's Bed System Measurement Device Test Results Worksheet dated 5/1/25, showed the entrapment assessment was completed and passed for Zones 1 to 4, however, there was no documented evidence to show the facility assessed for Zones 6 and 7. Review of Resident 1's medical record failed to show for the informed consent and care plan for the use of the bilateral upper side rails. On 5/14/25 at 0909 hours, an interview was conducted with LVN 3. LVN 3 was asked who completed the entrapment assessment. LVN 3 stated she had not heard or seen an entrapment assessment. Cross reference to F700, example #1. 6. On 5/12/25 at 0902 hours, during the initial tour, Resident 2 was lying in bed asleep. Resident 2's bed had elevated bilateral side rails. Medical record review for Resident 2 was initiated on 5/14/25. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2's cognitive skills for daily decision-making score was 3, indicating severely impaired. Review of Resident 2's Bed System Measurement Device Test Results Worksheet dated 5/1/25, showed the entrapment assessment was completed and passed for Zones 1 to 4, however, there was no documented evidence to show the facility assessed for Zones 6 and 7. On 5/12/25 at 0905 hours, an observation and concurrent interview was conducted with CNA 2. Resident 1 was observed lying in bed with bilateral upper side rails elevated. CNA 2 stated Resident 2 used the bilateral upper side rails for repositioning while in bed. CNA 2 verified the above findings. On 5/13/25 at 0837 hours, an observation and concurrent interview was conducted with LVN 5. Resident 2 was observed sitting up in bed and eating her breakfast. Resident 2's bed had elevated bilateral upper side rails. LVN 5 verified the above findings. Cross reference to F700, example #2. 7. On 5/14/25 at 0900 hours, an observation and concurrent interview was conducted with Resident 16. Resident 16 was in bed, awake, alert, and verbally responsive. Resident 16's bed had elevated bilateral upper side rails. Resident 16 stated he used the side rails for bed mobility and during transfers. Medical record review for Resident 16 was initiated on 5/14/25. Resident 16 was readmitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 16's H&P examination dated 9/22/23, showed Resident 16 had the capacity to understand and make decisions. Review of Resident 16's MDS assessment dated [DATE], showed Resident 16's BIMS score was 15, indicating cognitively intact. Review of Resident 16's Bed System Measurement Device Test Results Worksheet dated 5/1/25, showed the entrapment assessment was completed and passed for Zones 1 to 4; however, there was no documented evidence to show the facility had assessed for Zones 6 and 7. Cross reference to F700, example #3. 8. On 5/12/25 at 0858 hours, an initial tour observation and concurrent interview was conducted with CNA 2. Resident 19 was lying in bed, awake, alert, and eating her breakfast. Resident 19's bed had the elevated bilateral upper side rails. CNA 2 verified the above findings. CNA 2 stated Resident 16 used the bilateral upper side rails to reposition in bed. Medical record review for Resident 19 was initiated on 5/14/25. Resident 19 was readmitted to the facility on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19's BIMS score was zero, indicating severe cognitive impairment. Review of Resident 19's Bed System Measurement Device Test Results Worksheet dated 5/1/25, showed the entrapment assessment was completed and passed for Zones 1 to 4; however, there was no documented evidence to show the facility assessed for Zones 6 and 7. On 5/15/25 at 1009 hours, an interview, and concurrent facility document review for Residents 1, 2, 12, 16, 18, and 19 was conducted with the Maintenance Supervisor. The Maintenance Supervisor was asked about the facility's process of their bed inspection and entrapment assessment. The Maintenance Supervisor stated any maintenance staff could assess for entrapment using a measuring tape and document on the Bed System Measurement Device Test Results Worksheet. Review of the Bed System Measurement Device Test Results Worksheet for Residents 1, 2, 12, 16, 18, and 19 dated 5/1/25, showed the entrapment assessment was completed and passed for Zones 1 to 4; however, there was no documented evidence the facility assessed for Zones 6 and 7. The Maintenance Supervisor verified the above findings. Furthermore, the Maintenance Supervisor stated he would rectify and update the Bed System Measurement Device Test Results Worksheet immediately to show Zones 6 and 7. On 5/15/25 at 1505 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. Cross reference to F700, example #4. 9. On 5/12/25 at 1054 hours and 5/14/25 at 0835 hours, Resident 12 was observed in bed with elevated bilateral upper side rails. Medical record review for Resident 12 was initiated on 5/14/25. Resident 12 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555295	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Point - Windcrest	19191 Harvard Avenue Irvine, CA 92612

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 12's H&P examination dated 9/18/25, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Bed System Measurement Device Test Results Worksheet dated 5/1/25, showed the entrapment assessment was completed and passed for Zones 1 to 4; however, there was no documented evidence to show the facility assessed for Zones 6 and 7. Cross reference to F700, example #9. 10. On 5/12/25 at 1045 hours and on 5/14/25 at 0835 hours, Resident 18 was observed in bed with elevated bilateral upper side rails. Medical record review for Resident 18 was initiated on 5/14/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 2/8/25, showed Resident 18 did not have the capacity to understand and make decisions. On 5/15/25 at 1050 hours, an interview and concurrent observation was conducted with CNA 6. CNA 6 verified Resident 18 used the side rails for mobility but did not always need them. Review of Resident 18's Bed System Measurement Device Test Results Worksheet dated 5/1/25, showed entrapment assessment was completed and passed for Zones 1 to 4; however, there was no documented evidence to show the facility assessed for Zones 6 and 7. Cross reference to F700, example #10