

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on interview, medical record review, and facility document review, the facility failed to ensure the staff implemented two-person assist for transfers one of two final sampled residents (Resident 18) as per the plan of care, resulting the right ankle fracture treated with the right ankle splint. This failure had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Medical record review of Resident 18 was initiated on 10/21/24. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 18's quarterly MDS dated [DATE], showed under section GG (Functional Abilities and Goal), sit to lying, sit to stand, chair/bed to chair transfer was coded as substantial or maximal assistance.</p> <p>Review of Resident 18's care plan dated 9/5/24, showed a problem of activity daily living self-care performance deficits related to impaired mobility as manifested by having generalized weakness/deconditioning/debility. The interventions included to require two persons assist for extensive to total care for transfers.</p> <p>Review of Resident 18's progress note dated 10/2/24, showed the resident care assistant reported the resident's right ankle was slightly swelling. The resident care assistant stated she helped the resident transfer from the shower chair to the bed, and the resident stated she twisted her right ankle during the transfer. Per the resident, I will be okay. My foot always gets caught from the carpet.</p> <p>Review of Resident 18's progress note dated 10/3/24, showed the resident had the right ankle fracture with right ankle splint back from the acute care hospital.</p> <p>On 10/21/24 at 0920 hours, a concurrent observation and interview was conducted with Resident 18. Resident 18 was observed sitting upright in bed with a cast on the right leg. Resident 18 stated when the nurse helped her transfer from the wheelchair to the bed, the resident put her leg under the bed cabinet drawer and her foot got caught under the drawer. Resident 18 stated she did not pay attention to her legs, had weakness in her knee, and twisted her ankle.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/21/24 at 1545 hours, an interview was conducted with CNA 2. CNA 2 was asked what happened on 10/2/24. CNA 2 stated she transferred Resident 18 from the shower chair to bed by herself. Resident 18's leg was caught between the nightstand. CNA 2 stated she was not aware Resident 18 needed a two-person assist. CNA 2 stated she knew other staff were assisting the resident without another person assisting.</p> <p>On 10/22/24 at 0915 hours, a concurrent interview and medical record review for Resident 18 was conducted with the Case Manager. The Case Manager verified Resident 18's quarterly MDS for sitting to stand, sit to stand and transfer for maximal assistance which needed two-person assist. The Case Manager stated he assessed the resident, interviewed staff, and reviewed the rehabilitation notes to develop the care plan for ADL needs. The Case Manager acknowledged the care plan was developed in the beginning of the 2024 and verified Resident 18 needed two-person assist for transfers. The Case Manager verified the findings.</p> <p>On 10/23/24 at 0920 hours, a concurrent interview and medical record review was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated Resident 18 had the right knee osteoarthritis and right knee weakness. The Director of Rehabilitation further stated the resident had decreased tolerance to activity. The Director of Rehabilitation verified Resident 18 needed two-person assist for transfers since admission.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 14 final sampled residents (Resident 22) and one nonsampled resident (Resident 17) reviewed for respiratory care were provided with the appropriate respiratory services.</p> <p>* The facility failed to ensure Resident 17's nasal cannula was stored in a sanitary manner when not in use.</p> <p>*The facility failed to ensure Resident 22's nasal cannula tubing and respiratory storage bag were dated.</p> <p>These failures had the potential to affect the respiratory health and well-being of the residents received respiratory care in the facility.</p> <p>Findings:</p> <p>1. Medical record review for Resident 17 was initiated on 10/21/24. Resident 17 was admitted to the facility on [DATE].</p> <p>Review of Resident 17's Order Summary Report dated 10/24/24, showed a physician's order dated 5/29/24, to administer oxygen two liters per minute via nasal cannula as needed for shortness of breath and oxygen saturation level less than 90%.</p> <p>During an initial tour of the facility on 10/21/24 at 0927 hours, Resident 17's nasal cannula tubing was observed hanging on the concentrator and not stored in a bag when not in the use.</p> <p>On 10/21/24 at 0935 hours, a concurrent observation and interview for Resident 17 was conducted with LVN 3. LVN 3 acknowledged the oxygen tubing was dated 10/21/24, was just hanging on the concentrator and not stored in a Ziploc/set-up bag when not in use. LVN 3 verified the above findings.</p> <p>On 10/24/24 at 1340 hours, the DON was informed and acknowledged the above findings.</p> <p>51539</p> <p>2. Review of the facility's P&P titled Oxygen Administration dated 11/16/23, showed to change and date oxygen tubing, mask, or cannula every Sunday by night shift staff.</p> <p>Medical record review for Resident 22 was initiated on 10/21/24. Resident 22 was admitted to the facility on [DATE].</p> <p>Review of the Order Summary Report dated 9/29/24, showed a physician's order dated 3/19/24, for oxygen at 3 liters per minute via nasal cannula as needed for SOB.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 10/21/24 at 0931 hours, an observation for Resident 22 was conducted. Resident 22 was observed lying in bed watching the television. Resident 22's nasal cannula and respiratory storage bag were observed hanging on the oxygen concentrator undated and unlabeled on the right side of Resident 22's bedside.</p> <p>On 10/21/24 at 1044 hours, an observation and concurrent interview for Resident 22 was conducted with LVN 2 at Resident 22's bedside. LVN 2 verified there was no date on Resident 22's nasal cannula and respiratory storage bag.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>46787</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the main menus were followed for 42 of 42 residents who consumed food prepared in the kitchen. This failure had the potential for the residents to not receive the menus as planned.</p> <p>Findings:</p> <p>Review of the facility's matrix showed 42 residents consumed food prepared in the facility's kitchen.</p> <p>Review of the facility's P&P titled Menu Alternatives dated 2018 showed the Director of Food and Nutrition Services is responsible for supervising meal preparation and service to ensure the menu is followed and served as planned. Residents/patients who do not like the menu entree will be given the menu alternative.</p> <p>Review of the facility's document titled Daily Spreadsheet Tuesday Day 17, showed the following items were to be served for the lunch main menu on 10/22/24:</p> <ul style="list-style-type: none"> - Burgundy Beef Tenderloin Tips - Parslied Noodles - Seasoned Spinach - Choice of Bread - Margarine <p>Review of the facility's document titled Daily Spreadsheet Tuesday Day 17, showed the following items served for lunch alternate menu on 10/22/24:</p> <ul style="list-style-type: none"> - Turkey Pot Pie - Seasoned Spinach - Choice of Bread - Margarine <p>On 10/22/24 at 1130 hours, an observation was conducted of the lunch meal tray line with the DSS. The alternate menu was observed being prepared in the kitchen. The DSS stated the alternate menu was being followed today and not the main menu.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Further review of the facility's documents failed to show evidence the residents were notified of the menu change.</p> <p>On 10/23/24 at 0802 hours, an interview and concurrent facility document review was conducted with the DSS. The DSS acknowledged and verified the main menu was not followed and the residents were not notified of the menu change.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on interview, facility document, and facility P&P review, the facility failed to implement the antibiotic stewardship program.</p> <p>* The facility failed to ensure the appropriate use of antibiotics for one final sampled resident (Resident 25) and two nonsampled residents (Residents 9 and 20). This failure had the potential for inappropriate use and increased risk of drug resistant organisms.</p> <p>Findings:</p> <p>According to the CDC, the antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms.</p> <p>Review of the facility's P&P titled Antibiotic Stewardship Program - Review and Surveillance revised on 11/16/23, showed the IP or designee will review the antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.</p> <p>1. Review of the Infection Surveillance Report for the week of 8/30/24 to 9/5/24, showed Resident 20 was on ciprofloxacin 500 mg (an antibiotic medication) for urinary tract infection for five days.</p> <p>Medical record review for Resident 20 was initiated on 10/23/24. Resident 20 was admitted to the facility on [DATE].</p> <p>Review of Resident 20's Infection Screening Evaluation dated 8/25/24, under the Infection Analysis section, Resident 20 met the McGeer's Criteria for gastroenteritis (an inflammation of the stomach).</p> <p>However, review of Resident 20's medical record did not show documented evidence the physician was informed the resident did not meet the McGeer's Criteria for urinary tract infection.</p> <p>2. Review of the Infection Surveillance Report for the week 9/20/24 to 9/26/24, showed Resident 9 was on Azithromycin 250 mg (an antibiotic medication) for cough for five days.</p> <p>Medical record review for Resident 9 was initiated on 10/23/24. Resident 9 was readmitted to the facility on [DATE].</p> <p>Review of Resident 9's Infection Screening Evaluation dated 9/19/24, under the Infection Analysis section, showed the section for the criteria was not marked to show whether Resident 9's infection met the criteria for true infection or not.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Freedom Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23442 El Toro Road Lake Forest, CA 92630	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Infection Surveillance Report for the week 9/20/24 to 9/26/24, showed Resident 9 was on azithromycin 250 mg (an antibiotic medication) for cough for five days.</p> <p>3. Review of the Infection Surveillance Report for the week 10/4/24 to 10/10/24, showed Resident 25 was on Augmentin 100-125 mg (an antibiotic medication) for pneumonia for seven days.</p> <p>Medical record review for Resident 25 was initiated on 10/23/24. Resident 25 was admitted to the facility on [DATE].</p> <p>Review of Resident 25's Infection Screening Evaluation dated 10/5/24, under the Infection Analysis section, showed Resident 25 met the McGeer's Criteria for gastroenteritis.</p> <p>Furthermore, medical record review for Resident 20 did not show documented evidence the physician was informed that the resident did not meet the McGeer's Criteria for pneumonia.</p> <p>On 10/23/24 at 1356 hours, an interview and concurrent facility document review was conducted with the DSD/IP and RN 1/IP. Both verified the above findings. The DSD/IP stated the facility should have notified the physician if the residents did not meet the criteria or obtain clarification for the use of antibiotics.</p> <p>On 10/24/24 at 1615 hours, the Administrator and DON acknowledged the above findings.</p> <p>Cross reference to F880, examples #1.a, b, and d.</p>		