

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Alta Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13075 Blackbird Street Garden Grove, CA 92843	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**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 provide the necessary services to maintain the resident's highest practicable well-being for three of five sampled residents (Residents 1, 2, and 3). * The facility failed to ensure the transportation services were properly coordinated to and from the dialysis clinic for Resident 2's hemodialysis treatment. Resident 2 was not picked-up from the dialysis clinic on 3/4/25, as a result, Resident 2 took two public buses and walked the remainder of the way back to the facility. In addition, Resident 2 felt fear and anxiety and was prescribed antianxiety medications related to the incident. This failure potentially put Resident 2 in imminent harm and caused mental distress, when the resident was out of the facility for seven to eight hours unsupervised without facility knowledge. * The facility failed to notify the physician, report the incident, document, provide and document an assessment, and monitor Resident 2 when he returned from dialysis approximately seven to eight hours after the dialysis on 3/4/26. In addition, the facility failed to manage interventions for the resident when transportation issues were known to not wait for the resident during outpatient appointments. These failures had the potential for delay in detection of the adverse effect to the resident and the resident to not receive the necessary care and interventions. * The facility failed to provide psychosocial support when Resident 2 reported an incident on his way back to the facility which caused him to feel fear, anxiety, and exhibited crying on 3/4/26. In addition, Resident 2's lorazepam (antianxiety medication) discontinued on 3/3/26, was reinstated on 3/5/26 and administered on 3/6/26 (two days after the reported incident on 3/4/26). These failures had the potential for the resident to not receive the necessary psychosocial support and treatment and potential affect the resident's well-being. * The facility failed to timely administer Resident 2's midodrine (medication to symptomatic orthostatic hypotension (low blood pressure upon standing), by narrowing blood vessels) and failed to notify the physician when Resident 1's medications were not administered timely on 3/4/26. These failures had the potential for the resident to experience adverse consequences when medications were administered late. * The facility failed to ensure transportation services were provided to Resident 1's dermatology appointment on 1/8/26, instead the appointment was rescheduled 49 days later on 2/26/26. This failure had the potential for the resident to not receive the necessary care and treatments timely. * The facility failed to document Residents 2 and 3's departure and arrival times when the residents had outpatient medical appointments. This failure had the potential for the facility to not know the residents' whereabouts and the residents not assessed upon departure and return from their medical appointments. Findings: Review of the facility's P&P titled Emergency Procedure -Missing Resident (undated) showed to document the following: 1. Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety; 2. Staff will implement the protocol for missing resident immediately upon discovering that a resident cannot be located; 3. Notify the family/responsible party and attending physician if the resident is not found in the facility or the grounds; 4. When the resident is found, notify all staff members; examine the resident for injuries; notify the attending physician of the residence status; and contact the family/responsible person in form of his/her status (ensure (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>all the above steps are documented in the nursing notes); and5. Complete an incident report and follow the facilities incident reporting process. Document the incident and events objectively in the resident record, including: circumstances and precipitating factors, interventions utilized to return the resident to the unit, residents response to the interventions, results of reassessment upon the residents return and the condition of the resident, care rendered, notification of police, family, and physician, physicians order following notification, and additional prevention strategies implemented. Review of the facility's P&P titled Appointments (undated) showed transportation to and from the specialty provider is organized as required, to be arranged by Social Services Department and will collaborate with family representative. Licensed nurse to document residents departure and clinical condition on the day of the appointment and when the resident comes back. Any orders and follow-up appointment are documented in the electronic record and to follow up availability of MD progress notes to be included in the resident's medical record. Review of the facility's P&P titled Social Services dated 10/2010 showed the facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable well-being. The P&P further showed the following:1. The social services director is a qualified social worker and is responsible for: program planning, policy development, and priority setting of social services; providing for the social and emotional needs of the resident and family; supervising social services personnel; maintaining records related to social services; conducting or coordinating in-service training classes; and meeting or assisting with the medically related social service needs of residents.2. Medically related social services are provided to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose). Review of the facility's P&P titled Medication Administration Schedule revised 11/2020 showed scheduled medications are administered within one hour of their prescribed time, unless otherwise specified. Review of the facility's P&P titled Dialysis Care dated 8/2021 showed the facility will arrange for dialysis care as ordered by the attending physician. The facility maintains a contract with a dialysis service provider which addresses communications between the facility and provider. The facility will arrange for such residents on a weekly basis and/or as needed. The facility will arrange transportation to and from the dialysis provider as well as for meals (if necessary), medication administration and a method of communication between the dialysis provider and the facility. Review of the facility's P&P titled Acute Condition Changes-Clinical Protocol dated 8/2021 showed the following:1. The physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling catheter who has recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia.2. In addition, the nurse shall assess and document/report the following baseline information: vital signs; neurological status; current level of pain, and any recent changes in pain level; level of consciousness; cognitive and emotional status; residence age and sex; onset, duration, severity; recent labs; history of psychiatric disturbances, mental illness, depression, etc.; all active diagnoses; and all current medications.Cause and Identification: the staff and physician we'll discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, medication regimen, and diagnostic test results. If necessary, the physician will order diagnostic tests and evaluate the patient directly.Treatment/Management: the physician will help identify and authorize appropriate treatments.Monitoring and Follow-up: the staff will monitor and document the resident/patients progress and responses to treatment, and the physician will address treatment accordingly. The physician will help the staff monitor a resident/patient with a recent acute change of condition until the problem or condition has been resolved or stabilized. According to the National Kidney Foundation dated 4/2024 showed that hemodialysis is a life-saving treatment for kidney failure that removes waste and extra fluids from the blood and regulates blood pressure. Hemodialysis does have side effects. Sometimes, it is hard to tell whether a symptom is due to (continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>3/5/26, showed Resident 2's assessment of mild symptoms of anxiety present during interaction. Symptoms such as slightly on edge, nervousness, slight muscle tension, and presenting physically weak. Further review of Resident 2's MAR for March 2026 showed Resident 2 was administered lorazepam as needed from 3/6/26 to 3/10/26. In addition, Resident 2 was administered Vistaril from 3/6/26 to 3/10/26 at 0900 and 1700 hours. Review of Resident 2's medical record failed to show documented evidence the SSD visited or followed up with Resident 2 following the incident on 3/4/26, until 3/5/26 at 1703 hours. On 3/5/26 at 1550 hours, an interview and concurrent medical record review for Resident 2 was conducted with the SSD and Case Manager. The Case Manager stated she had been aware of Resident 2's recent issues with transportation. The SSD stated she saw something in communications this morning. When asked if Resident 2 had been followed up by the SSD, the SSD stated she had not talked to him and was unsure her assistant had. The SSD stated a psychosocial follow up should be done if a resident stated they were fearful. On 3/11/26 at 0850 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DSD. The DSD verified Resident 2 was taking medications for anxiety which had ended on 3/3/26, and was reordered on 3/5/26 to start on 3/6/26. When asked if Resident 2 was administered the lorazepam medication for anxiety on 3/4/26, the DSD stated no. When asked if Resident 2 was having manifestations of crying, if the physician should be notified, the DSD stated the physician should be notified on that day. The DSD verified there was no assessment of resident's clinical condition upon arrival back to the facility and the physician should have been notified. d. Review of Resident 2's Order Summary Report showed a physician's order dated 2/19/26, showed to administer midodrine HCL oral tablet 10 mg, give one tablet by mouth three times a day for hypotension. Give with meals. Hold for systolic blood pressure less than 160 mmHg. Review of Resident 2's MAR for March 2026 showed Resident 2 was administered Midodrine three times a day from 3/1/26 to 3/10/26 at 0700, 1130, and 1700 hours. Review of the facility document titled MAR Admin Audit Report dated 3/4/26, showed Midodrine was administered on 3/4/26 at 2034 hours. On 3/6/26 at 1140 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. When asked when the resident would be considered missing, the DON stated we have the usual times of residents return. The DON stated the process for a missing resident would be to call the clinic, family member, resident if alert and oriented, transportation to find out if the resident was picked up and then call the police for assistance. The DON stated she spoke to Resident 2 on 3/5/26, and he was crying when talking about what had happened last night. The DON verified Resident 2 was affected because of the events which occurred on 3/4/26. On 3/11/26 at 0850 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DSD. The DSD stated the nurses have one hour before and one hour after scheduled times to administer medications. The DSD verified the Midodrine was administered late at 2030 hours (two and a half hours later). The DSD stated the physician should have been notified when medications were administered late. On 3/11/26 at 1430 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON stated the physician should have been notified of incident, and the late medication administration. The DON verified the above findings. 2. Medical record review for Resident 1 was initiated on 3/5/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's eInteract Change in Condition Evaluation dated 11/6/25, showed Resident 1 had a brown scalp lesion, and an appointment was scheduled for a dermatology consultation on 1/8/26 at 1030 hours. Review of Resident 1's Order Listing Report dated 1/6/26, showed a physician order for Dermatology follow up for scalp brown lesion to scalp for 1/8/26 at 1030 hours was discontinued. Review of Resident 1's Nurses Progress Notes dated 1/6/26 at 1605 hours, showed rescheduled appointment for dermatology for 2/26/26 at 0930 hours. Family Member 1 and the SSD aware to set up the transportation. Review of Resident 1's Social Services Progress Notes dated 2/26/26 at 1007 hours, showed the SSD was informed Resident 1's transportation did not arrive. The SSD attempted to get a hold of Transportation 1 regarding estimated time of arrival of transportation. However, was unable to get a hold of a (continued on next page)</p>		

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