

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 02/18/2025
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 0578</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to obtain and/or maintain copies of the advance directives in the medical records for two of eight final sampled residents (Residents 18 and 60) reviewed for advance directives. These failures had the potential for the residents' decisions regarding their healthcare and treatment not being honored.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Advance Directive dated 3/23/22, showed at the time of admission, the Admission Staff or designee would inquire about the existence of an Advance Directive. The facility will honor the resident's Advance Directives and will provide the resident with information related to Advance Directives upon admission. Further review of the facility's P&P showed, if the resident has an Advance Directive, Admission Staff or designee will place a copy or scan of the Advance Directive in the resident's medical record and will notify the Director of Social Services of the existence of the Advance Directive,</p> <p>1. Medical record review for Resident 18 was initiated in 2/10/25. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 18's H&P examination dated 1/18/25, showed Resident 18 had the capacity to understand and make decisions.</p> <p>Review of Resident 18's Social Services assessment dated [DATE], under the Resident Rights/Healthcare Decision Making/Advance Directives section, showed Resident 18 had an advance directive and a copy was in his medical record.</p> <p>Review of Resident 18's medical record showed only page 4 (of four pages) of Resident 18's advance directive was uploaded into the resident's electronic medical record. Further review of the document failed to show Resident 18's health care directives.</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
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<p>F 0578</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 2/13/25 at 0912 hours, an interview and concurrent medical record review for Resident 18 was conducted with the SSA and SSD. The SSA verified the above findings. The SSA stated a copy of Resident 18's advance directive was not in the paper medical record and the uploaded page did not reflect Resident 18's advance healthcare directives. The SSD stated the complete copy of Resident 18's advance directive should be uploaded and available in Resident 18's medical record to ensure his wishes were honored in the event the resident no longer had the capacity.</p> <p>2. Medical record review for Resident 60 was initiated on 2/10/25. Resident 60 was admitted to the facility on [DATE].</p> <p>Review of Resident 60's Physician Orders for Life-Sustaining Treatment (POLST) dated 1/21/25, showed Resident 60's advance directive was available and had been reviewed.</p> <p>Review of Resident 60's Advance Directive Acknowledgement form signed upon admitted d 1/17/25, showed Resident 60 had executed an advance directive.</p> <p>Review of Resident 60's Social Services assessment dated [DATE], under the Resident Rights/Healthcare Decision Making/Advance Directives section, showed Resident 18 had an advance directive and a copy was not in his medical record.</p> <p>Review of Resident 60's medical record failed to showed a copy of Resident 60's advance directive was maintained in the resident's medical record. Further review of Resident 60's medical record failed to show documentation the facility attempted to obtain a copy of Resident 60's advance directive.</p> <p>On 2/13/25 at 0904 hours, an interview and concurrent medical record review for Resident 60 was conducted with the SSA. The SSA verified the above findings and stated the information on Resident 60's POLST was inaccurate.</p> <p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated the purpose of an advance directive was to ensure the facility was aware of the resident's wishes in the event they no longer had the mental capacity to make healthcare decisions. The DON further stated upon admission, the Admissions personnel was responsible for assessing if the resident had an advance directive and the social services department was responsible for obtaining a copy of the advance directive and ensuring a copy was in the resident's medical records. The DON stated if the resident had an advance directive, she expected a complete copy of the resident's advance directive to be in the resident's medical record. The DON further stated the social services department was responsible for obtaining a copy of the advance directive as soon as possible and they should document their attempts of obtaining a copy of the advance directive in the progress notes.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the written information regarding the facility's bed hold policy was provided to the resident/resident's representative at the time of transfer to the acute care hospital for one of three sampled resident (Residents 47) reviewed for hospitalization . This failure had the potential for the resident and/or representative to be unaware of their rights to request a bed hold upon transfer.</p> <p>Findings:</p> <p>Review of the facility's titled Bed-Holds and Returns revised 10/2022 showed the residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All the residents/representatives are provided with written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). For the residents, regardless of the payer source, are provided written notice about these policies at least twice:</p> <ol style="list-style-type: none"> 1. Notice in advance of any transfer (e.g., in the admission packet); and 2. Notice at the time of transfer (or, if the transfer was an emergency, within 24 hours). <p>Medical record review for Resident 47 was initiated on 2/10/25. Resident 47 was admitted on [DATE], and readmitted on [DATE].</p> <p>Review of Residents 47's MDS dated [DATE], showed Resident 47's BIMS score of 15, indicating cognitively intact.</p> <p>Review of Resident 47's Notice of Transfer or discharge date d 2/5 and 2/8/25, showed Resident 47 was transferred to the acute care hospital.</p> <p>Review of Resident 47's Progress Notes dated 2/5 and 2/8/25, showed no documentation the bed hold notification was provided to the resident and/or representative.</p> <p>On 2/18/25 at 1103 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified and acknowledged there was no documentation showing the resident or the resident's representative was informed at the time of transfer in writing regarding the facility's seven day bed hold policy.</p> <p>On 2/18/25 at 1113 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified and acknowledged there was no written documentation of the Bed Hold Notice of Policy and Authorization.</p> <p>On 2/18/25 at 1212 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p>		

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<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** 49644</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accident hazards for one of three final sampled residents (Resident 4) reviewed for accident hazards.</p> <p>* The facility failed to implement the bilateral floor mats as per the plan of care for Resident 4. This failure had the potential risk for injury to Resident 4.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed the care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers.</p> <p>Medical record review for Resident 4 was initiated on 2/11/25. Resident 4 was admitted to the facility on [DATE].</p> <p>Review of Resident 4's plan of care showed a care plan problem dated 7/29/24, addressing Resident 4's risk for falls/injuries. The interventions included may have floor mats to both sides of the bed.</p> <p>Review of Resident 4's MDS quarterly assessment dated [DATE], showed Resident 4 had severe cognitive impairment.</p> <p>On 2/11/25 at 1630 hours, Resident 4 was observed awake and lying position in a low bed. Resident 4's bilateral floor mats were observed leaning against the wall of Resident 4's room instead of both sides of the bed.</p> <p>On 2/11/25 at 1637 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 4's floor mats were leaning against the wall of Resident 4's room instead of on the floor. LVN 4 stated the floor mats were needed because Resident 4 might fall and she was a high risk for fall.</p> <p>On 2/18/25 at 1211 hours, the DON and Interim Administrator were informed and acknowledged the above findings.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services related to the use of the GT for three of three final sampled residents (Residents 55, 58, and 74) reviewed for the GT management.</p> <p>* The facility failed to ensure the licensed staff managed the GT feeding for Resident 55. CNA 14 had resumed the GT feeding after providing incontinent care to Resident 55. In addition, the facility failed to ensure Resident 55's enteral feeding formula was labeled with the time and the Kangaroo (enteral feeding pump machine) water bag was labeled with the time and name of contents inside the bag.</p> <p>* The facility failed to ensure LVN 2 auscultated the resident to check the GT placement prior to the administration of the GT medication for Resident 58. In addition, the facility failed to ensure Resident 58's abdominal binder (compression band around the abdomen used to provide support and safety) was applied as per the care plan.</p> <p>* The facility failed to ensure Resident 74's HOB was elevated at a 30 degree angle or above when Resident 74 was receiving the enteral feeding via the GT.</p> <p>These failures posed the risk for complications related to the use of the GT for Residents 55, 58, and 74.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Enteral Feeding-Close dated 5/26/21, showed enteral feedings will be administered via pump as ordered by the attending physician. The head of the bed should be elevated 30 degrees during feedings. The formula may hang for 24-48 hours, depending on the manufacturer guidelines. To label the formula with the date and the time hung only. To change the feeding formula and tubing every 24-48 hours or as required by manufacturer guidelines.</p> <p>Review of the facility's P&P titled Enteral Tube Medication Administration dated 10/2017 showed to verify the tube placement, use the following procedures:</p> <ol style="list-style-type: none"> a. Insert a small amount of air into the tube with the syringe and listen to the stomach with the stethoscope for the gurgling sounds. b. Aspirate stomach contents with the syringe to check for residual feeding. <p>1. Medical record review for Resident 55 was initiated on 2/10/25. Resident 55 was admitted to the facility on [DATE], and readmitted to the facility on [DATE].</p> <p>Review of Resident 55's MDS dated [DATE], showed Resident 55 had a feeding tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. On 2/10/25 at 0927 hours, Resident 55 was observed lying in bed. An enteral feeding pump was observed with Nepro 1.8 (enteral formula) bottle hanging from the feeding pump pole. The enteral formula bottle was observed not labeled with the date or start time. The Kangaroo brand bag was observed with a clear liquid inside. The label on the bag was observed without the date, time, and name of contents inside the bag.</p> <p>Review of Resident 55's Order Summary Report dated 2/13/25, showed the following orders:</p> <ul style="list-style-type: none"> - dated 1/15/25, to administer water flush at 150 ml every four hours for 20 hours per day, and start the GT feeding at 1200-1300 hours. - dated 1/16/25, to administer Nepro via pump at 50 ml per hour for 20 hours per day, to provide 1000 ml, 1000 kcals, and start at 1200-1300 hours, and continue until the total volume infused. <p>On 2/11/25 at 1155 hours, an interview and concurrent observation was conducted with LVN 2. Resident 55's enteral feeding formula was observed not labeled with the name, date, room, and rate. The Kangaroo bag containing the clear liquid was not labeled with the time and name of contents inside the bag. LVN 2 verified the findings and stated she did not know when the enteral feeding formula was hung and the label on the Kangaroo bag should be labeled with the name of content inside the bag.</p> <p>On 2/12/25 at 1052 hours, an interview was conducted with the DON. The DON stated the enteral feeding formulas and the water bags should be labeled with the resident's name, room, date, time, rate, and name of content inside the bag.</p> <p>b. On 2/12/25 at 0800 hours, Resident 55 was observed in bed and CNA 14 was observed with another CNA providing care to Resident 55. The resident's enteral feeding pump was observed on hold.</p> <p>On 2/12/25 at 0807 hours, an observation and concurrent interview was conducted with CNA 14. Resident 55 was observed in bed, with the enteral feeding pump infusing Nepro 1.8 at 50 ml/hr. When asked, CNA 14 stated he resumed the enteral feeding after he had provided incontinent care to Resident 55. CNA 14 acknowledged there was a potential risk of the GT dislodgment during the turning and repositioning of Resident 55. When asked how CNA 14 was able to verify the GT placement prior to resuming the enteral feeding, CNA 14 stated he did not know.</p> <p>On 2/12/25 at 1052 hours, an interview was conducted with LVN 2. LVN 2 stated only the licensed nurses were responsible for putting the enteral feeding devices on hold and resuming the enteral feedings. LVN 2 stated there was a risk of dislodgment of the GT during care, therefore, the licensed nurses should check the GT placement after the care was rendered and prior to resuming the enteral feeding. LVN 2 further stated the CNAs should not touch the enteral feeding device.</p> <p>On 2/12/25 at 1052 hours, an interview was conducted with the DON. The DON stated the licensed nurses were responsible for holding and/or resuming the enteral feedings. The DON stated the CNAs were not trained to put</p> <p>the enteral feedings on hold or to resume the enteral feedings.</p> <p>2. Medical record review for Resident 58 was initiated on 2/10/25. Resident 58 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 58's MDS dated [DATE], showed Resident 58 had a feeding tube.</p> <p>a. On 2/11/25 at 0918 hours, a medication administration observation for Resident 58 was conducted with LVN 2. LVN 2 failed to check the GT placement via auscultation prior to the administration of the GT medications.</p> <p>On 2/11/25 at 0958 hours, an interview was conducted with LVN 2. LVN 2 verified she did not check the GT placement prior to the administration of the GT medications. LVN 2 further stated she should check the GT placement to ensure for proper placement of the GT prior to administering the GT medications.</p> <p>On 2/12/25 at 1052 hours, an interview was conducted with the DON. The DON stated when administering the medications via the GT, she expected the licensed nurses to check for the GT placement via auscultation and checking for gastric residual.</p> <p>b. Review of Resident 58's plan of care showed a care plan problem dated 10/17/24, addressing Resident 58's requirement for the GT feeding to meet the nutritional and hydration needs. The care plan showed Resident 58 had episodes of pulling out/dislodgment off the GT. The interventions showed to apply the abdominal binder to prevent pulling out the GT.</p> <p>On 2/11/25 at 0945 hours, during a medication administration observation with LVN 2, Resident 58 was observed not wearing an abdominal binder.</p> <p>On 2/12/25 at 1100 hours, an interview, observation, and concurrent medical record review for Resident 58 was conducted with LVN 2. Resident 58 was observed not wearing an abdominal binder. LVN 2 verified Resident 58 was not wearing an abdominal binder and stated Resident 58 had a history of pulling out her GT and was sent to the acute care hospital. LVN 2 verified Resident 58 was not wearing an abdominal binder during the medication administration observation on 2/11/25. LVN 2 reviewed Resident 58's plan of care and verified the above findings. LVN 2 stated the care plan intervention to apply the abdominal binder should be implemented to prevent Resident 58 from pulling out her GT.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>49644</p> <p>3. Medical record review for Resident 74 was initiated on 2/11/25. Resident 74 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 74's MDS dated [DATE], showed Resident 74 had moderately impaired cognitive skills for daily decision making.</p> <p>Review of Resident 74's Order Summary Report dated 2/11/25, showed a physician's order dated 1/15/25, to administer Glucerna (enteral feeding) 1.5 calorie continuous via pump at 55 ml/hr for 20 hours per day; and to start the infusion at 1400 hours, and continue until the total volume is infused.</p> <p>On 2/12/25 at 1555 hours, Resident 74 was observed lying in bed and receiving the enteral tube feeding with the HOB elevated less than 30 degrees .</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/12/25 at 1600 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 74's HOB was elevated less than 30 degrees while the resident was receiving the enteral tube feeding. LVN 1 stated Resident 74's HOB should have been elevated at 30 degrees to prevent aspiration (inhaling food, liquid or other material into the lungs).</p> <p>On 2/18/25 at 0831 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated when the resident was receiving the GT feeding, the HOB should be at least 30 to 45 degrees to prevent aspiration pneumonia (lung infection when food, liquid or other material are inhaled into the lungs).</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</p> <p>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 accesses for six of six final sampled residents (Residents 60, 83, 110, 716, 816, and 818) reviewed for IV care.</p> <p>* The facility failed to ensure the initial PICC line external catheter measurements were documented in the medical record and confirmed the baseline measurements of the PICC line external catheters and arm circumferences prior to the administration of IV antibiotics for Resident 83. In addition, the facility failed to ensure Resident 83's PICC dressing was labeled with the date and a care plan was developed for the use of Resident 83's right upper arm PICC.</p> <p>* The facility failed to ensure accurate documentation of the monitoring and documentation of Resident 60's right arm midline. In addition, the facility failed to develop a care plan for the use of Resident 60's right upper arm midline.</p> <p>* The facility failed to ensure the midline dressing for Resident 716 was changed.</p> <p>* The facility failed to ensure Resident 110's PIV site was dated and labeled.</p> <p>* The facility failed to ensure Resident 816's PIV site was labeled with the date and the licensed nurse's initials to show when it was inserted.</p> <p>* The facility failed to ensure Resident 818's midline external catheter and arm circumference measurements were performed and documented in the medical record upon admission to the facility.</p> <p>These failures had the potential to delay the identification of catheter related complications for the residents.</p> <p>Findings:</p> <p>Review of the facility's P&P titled PICC Dressing Change dated 3/2023 showed the length of the external catheter is obtained upon admission, during dressing changes, and if signs or symptoms of complications are present. To measure the external catheter length (from the insertion site to the hub). To label the dressing with the date and time, and the nurse's initials. Further review of the facility's P&P showed documentation in the medical record includes, but is not limited to:</p> <ul style="list-style-type: none"> - date and time; - site assessment; - length of external catheter; - Resident response to procedure and/or medication; and - Resident teaching. <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's P&P titled Midline Catheter Dressing Change dated 3/2023 showed the dressing changes using the transparent dressings are performed: upon admission (if not dated or site is not visible for assessment), at least weekly, and if the integrity of the dressing has been compromised (wet, loose, or soiled). To measure the upper arm circumference: upon admission and when clinically indicated to assess the presence of edema and possible deep vein thrombosis (DVT, condition where a blood clot forms in a deep vein). Further review of the facility's P&P showed documentation in the medical record includes, but is not limited to:</p> <ul style="list-style-type: none"> - date and time; - site assessment; - length of external catheter; - upper arm circumference; - Resident response to procedure and/or medication; and - Resident teaching. <p>1. On 2/10/25 at 0915 hours, Resident 83 was observed in bed with a PICC line with a two-port external catheter to the right upper arm . A transparent dressing was observed undated on the PICC line site.</p> <p>Medical record review for Resident 83 was initiated on 2/10/25. Resident 83 was admitted to the facility on [DATE].</p> <p>Review of Resident 83's MDS dated [DATE], showed Resident 83 was admitted from an acute care hospital and received the antibiotic medications and IV medications at the facility.</p> <p>Review of Resident 83's Nursing Documentation - V11 dated 1/2/25, showed Resident 83 was admitted for IV therapy, management of diabetes (body has trouble controlling the blood sugar), and wound care. Further review of the admission documentation failed to show any documentation of the measurements for Resident 83's arm circumference and external catheter length of right upper arm PICC line.</p> <p>Review of Resident 83's Order Summary Report dated 2/13/25, showed a physician's order dated 1/3/25, to administer ceftriaxone (antibiotic) 2 gm intravenous every 24 hours until 2/10/25, for cellulitis (bacterial infection of the skin and underlying tissues).</p> <p>Review of Resident 83's Intravenous Therapy Medication Record for January and February 2025 showed Resident 83 was administered ceftriaxone 2 gm intravenous on the following dates and times:</p> <ul style="list-style-type: none"> - on 1/3/25 at 2000 hours, - on 1/4/25 at 2030 hours, - on 1/5/25 at 2000 hours, and <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- from 1/6/25 to 2/10/25 at 1800 hours.</p> <p>Further review of Resident 83's Intravenous Therapy Medication Record for January 2025 showed Resident 83's PICC dressing was changed on 1/4/25, with the external catheter length measurement of 1.5 cm. However, there was no documentation of Resident 83's baseline arm circumference and external catheter length upon admission to the facility on [DATE].</p> <p>Review of Resident 83's medical record failed to show documented evidence of Resident 83's baseline arm circumference and external length of the PICC line measurements upon admission to the facility. In addition, Resident 83's medical record failed to show the licensed nurse had confirmed the baseline measurements of Resident 83's arm circumference and PICC line external length measurements prior to the use of the PICC line.</p> <p>Review of Resident 83's plan of care failed to show a care plan problem to address the use of Resident 83's right upper arm PICC line.</p> <p>On 2/11/25 at 1136 hours, Resident 83 was observed in bed. Resident 83's right upper arm PICC dressing was observed with a transparent dressing dated 2/9/25.</p> <p>On 2/11/25 at 1440 hours, an interview was conducted with RN 2. RN 2 verified on 2/10/25, Resident 83's right upper arm PICC dressing was not dated. RN 2 stated on 2/10/25, he noted the dressing was not labeled so he checked the Intravenous Therapy Medication Record and documentation showing the PICC dressing was changed on 2/9/25, so he dated Resident 83's PICC dressing for 2/9/25, even though he did not perform the dressing change. RN 2 stated the licensed nurse who changed the dressing should date the dressing.</p> <p>On 2/13/25 at 1310 hours, a follow-up interview and concurrent medical record review for Resident 83 was conducted with RN 2. RN 2 stated for the residents admitted to the facility with a PICC line, the RN was responsible for verifying the placement of the PICC line by measuring the arm circumference and external catheter length of the PICC and verifying/comparing the measurements with the reports from the acute care hospital, prior to the use of the PICC line. RN 2 further stated the nurse should document the baseline measurements and verification in the resident's progress notes. RN 2 reviewed Resident 83's medical record and verified the above findings.</p> <p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated the PICC dressings were changed every seven days and as needed, and the dressing should be labeled with the date. The DON stated on admission, there should be the baseline measurements of the arm circumference and external catheter of the PICC line catheter. In addition, the DON stated she expected the licensed nurse to review the resident's medical record from the acute care hospital to verify the baseline measurements. The DON further stated the licensed nurse should verify and document the verification of the baseline measurements in the resident's progress notes before the use of the PICC.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>2. On 2/10/25 at 1131 hours, Resident 60 was observed in bed with the right upper arm midline (a small, thin tube that is inserted into a vein in the upper arm).</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medical record review for Resident 60 was initiated on 2/10/25. Resident 60 was admitted to the facility on [DATE].</p> <p>Review of Resident 60's MDS dated [DATE], showed Resident 60 was admitted from an acute care hospital and received the antibiotic medications and IV medications while a resident at the facility.</p> <p>Review of Resident 60's Midline Insertion Record dated 1/27/25, showed a midline catheter was inserted in Resident 60's right basilic vessel. The record showed the internal length was 14 cm, external length was 0 cm, and arm circumference was 31 cm.</p> <p>Review of Resident 60's Intravenous Therapy Medication Record for January and February 2025 showed Resident 60's right arm midline dressing was changed on the following dates with the external catheter length measurements:</p> <ul style="list-style-type: none"> - on 1/27/25, 0 cm. - on 2/3/25, 2 cm. - on 2/9/25, 2 cm. <p>Further review of Resident 60's Intravenous Therapy Medication Record for February 2025 showed the current IV site was the right upper arm midline, inserted on 1/27/25. The internal and external midline length were left blank.</p> <p>Review of Resident 60's Progress Notes showed the following nursing documentations:</p> <ul style="list-style-type: none"> - dated 1/27/25 at 1518 hours, the resident's midline was replaced and the new IV site was on the left arm. - dated 1/28/25 at 0400 hours, and 1/29/25 at 0640 hours, the licensed nurse monitored for the new midline on the resident's left arm and observed the site intact with no signs of infiltration/infection. <p>Review of Resident 60's plan of care failed to show a care plan problem was developed to address the use of Resident 60's right upper arm midline.</p> <p>On 2/13/25 at 1248 hours, an interview and concurrent medical record review for Resident 60 was conducted with RN 2. RN 2 stated Resident 60 had a midline inserted on 1/27/25, in the right arm. RN 2 stated the dressing changes were done weekly and as needed, and the external catheter length was measured and documented with each dressing change. RN 2 reviewed Resident 60's medical record and verified the above findings. RN 2 stated the documented external catheter length measurements of 2 cm were inaccurate, and the documentation of the monitoring for Resident 60's IV access should be for the right arm.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated the purpose of measuring the external catheter length was to determine any dislodgment of the catheter. The DON stated if there were any discrepancies in the external catheter length measurements, the RN should address the discrepancy and inform the physician. The DON further stated the residents should have a care plan developed for the use of a PICC or midline IV catheter.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>50953</p> <p>3. Review of the facility's P&P titled Peripheral Venous Catheter Insertion dated 3/2023 showed to write the date, time and initials on the dressing label.</p> <p>Medical record review for Resident 716 was initiated on 2/10/25. Resident 716 was admitted to the facility on [DATE].</p> <p>Review of Resident 716's Physician Order for Infusion Therapy dated 2/4/25, showed for the RUA midline, to change all the central line, PICC, and midline transparent dressings per sterile technique upon admission (if not dated or site not visible for assessment), every seven days and PRN if wet, loose, or soiled.</p> <p>Review of Residents 716's MDS dated [DATE], showed the resident had a BIMS score of 15 (meaning cognitively intact).</p> <p>On 2/10/25 at 0938 hours, Resident 716 was observed awake and lying in bed with a midline with one lumen (channel or tube within a catheter) to the right upper arm and the midline dressing dated 2/2.</p> <p>On 2/10/25 at 1021 hours, an observation and concurrent interview was conducted with RN 2 for Resident 716. RN 2 verified and acknowledged the midline dressing for Resident 716 was dated 2/2. RN 2 stated Resident 716's RUA midline dressing should have been done on 2/9/25.</p> <p>4. Medical record review for Resident 110 was initiated on 2/10/25. Resident 110 was admitted to the facility on [DATE].</p> <p>Review of Resident 110's Order Summary Report dated 2/13/25, showed a physician's order to administer metronidazole (antibiotic medication) 500 mg IVPB every eight hours for cerebral abscess (collection of pus in the brain tissue).</p> <p>Review of Residents 110's MDS dated [DATE], showed the resident had a BIMS score of 14 (meaning cognitively intact).</p> <p>On 2/10/25 at 0907 hours, Resident 110 was observed awake and lying in bed with a single-lumen PIV line to the right hand, not labeled with the date, time and initial of the facility staff.</p> <p>On 2/10/25 at 1014 hours, an observation and concurrent interview was conducted with RN 2 for Resident 110. RN 2 verified Resident 110's right hand PIV was not labeled with the date, time, and initial of the facility staff.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/18/25 at 1212 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON was informed and acknowledged the above findings.</p> <p>47476</p> <p>5. Medical record review for Resident 816 was initiated on 2/10/25. Resident 816 was admitted to the facility on [DATE].</p> <p>Review of Resident 816's eINTERACT SBAR Summary for Providers dated 2/8/25, showed the resident's change in condition related to decreased appetite and fluid intake. The provider recommendation included to administer one liter of IV fluids 0.9% normal saline at 50 ml/hr for hydration. The document showed a 24 gauge PIV was inserted into Resident 816's right hand.</p> <p>Review of Resident 816's Physician Orders for Infusion Therapy dated 2/8/25, showed a physician's order to place a PIV, if there was no venous access.</p> <p>On 2/10/25 at 1057 hours, an observation of Resident 816 was conducted in the resident's room. Resident 816 was observed with a single-lumen PIV line to the right hand with undated and unlabeled dressing.</p> <p>On 2/10/25 at 1115 hours, a concurrent observation and interview was conducted with the IP. The IP verified Resident 816's PIV line dressing was not dated or labeled. The IP stated the PIV line dressing should be labeled with the date it was started and initialed by whoever started the PIV.</p> <p>On 2/11/25 at 0906 hours, an observation of Resident 816 was conducted in the resident's room. Resident 816 was observed with a single-lumen PIV line to the right hand with an undated and unlabeled dressing.</p> <p>On 2/10/25 at 0949 hours, an observation and concurrent interview was conducted with RN 2. RN 2 verified Resident 816's PIV line dressing was not dated or labeled. RN 2 stated the PIV line dressing should be labeled with the date when the PIV line was inserted.</p> <p>6. Medical record review for Resident 818 was initiated on 2/10/25. Resident 818 was admitted to the facility on [DATE].</p> <p>Review of Resident 818's Physician Orders for Infusion Therapy dated 1/24/25, showed a physician's order for the following:</p> <ul style="list-style-type: none"> - Zosyn (antibiotic medication) 3.375 gm every eight hours for 28 days for right foot cellulitis (skin infection). - To provide midline care for the right upper arm midline; to measure the external catheter length of the PICC and midlines upon admission and with each dressing change; and include the arm circumference for the midlines upon admission. <p>Further review of Resident 818's medical record failed to show documented evidence the measurement of the external catheter length or arm circumference for Resident 818's right upper arm midline was obtained upon admission to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/12/25 at 1426 hours, an interview and concurrent medical record review was conducted with RNs 1 and 2. RN 1 verified the RN was responsible for the maintenance of the IV in the facility. RNs 1 and 2 verified Resident 818's medical record did not show the midline external catheter and arm circumference measurements were obtained upon admission as per the facility's P&P and physician's orders.</p> <p>On 2/18/25 at 1140 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON acknowledged the above findings.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 47476</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the safe respiratory care to the meet the needs for two of two final sampled residents (Residents 55 and 816) reviewed for respiratory care.</p> <p>* The facility failed to administer the oxygen as per the physician's order to Resident 816.</p> <p>* The facility failed to ensure Resident 55's sterile water for the humidifier was labeled with an opened date.</p> <p>These failures had the potential to affect the respiratory health and well-being of the residents in the facility.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed under the preparation section, to verify there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration.</p> <p>During the initial tour of the facility on 2/10/25 at 1057 hours, an observation was conducted in Resident 816's room. Resident 816 was observed lying in bed receiving oxygen by nasal cannula at three liters per minute. Resident 816 stated she had a hard time breathing.</p> <p>On 2/10/25 at 1115 hours, an observation and concurrent interview was conducted with the IP in Resident 816's room. The IP verified Resident 816 was receiving an oxygen at three liters per minute. Resident 816 stated she was short of breath and needed her oxygen saturation level to be between 95 - 97%.</p> <p>On 2/10/25 at 1123 hours, Resident 816 was observed to press her call light.</p> <p>On 2/10/25 at 1125 hours, an observation was conducted with LVN 8 in Resident 816's room. LVN 8 was observed to check Resident 816's oxygen saturation level with a vital signs monitor. The monitor showed Resident 816's oxygen saturation level was at 92%. LVN 8 verified Resident 816 was on oxygen at three liters per minute and would increase it. LVN 8 stated the physician's order was for up to six liters per minute. LVN 8 stated she would need to switch to a different oxygen machine because the one Resident 816 was using could only delivered five liters per minute.</p> <p>Medical record review for Resident 816 was initiated on 2/10/25. Resident 816 was admitted to the facility on [DATE].</p> <p>Review of Resident 816's Nursing Documentation Note dated 2/7/25, showed Resident 816 was on six liters per minute of oxygen with an oxygen saturation level at 97%.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 816's Nursing Documentation Notes dated 2/8 and 2/9/25, showed Resident 816 was breathing with oxygen at six liters per minute via nasal cannula. The resident's respirations were even/unlabored, with no shortness of breath, cough, congestion, or complaints of pain/discomfort when asked.</p> <p>Further review of Resident 816's medical record failed to show a rationale for Resident 816 to have the administration of the oxygen decreased to three liters per minute.</p> <p>Review of Resident 816's Order Summary Report dated 2/10/25, showed a physician's order dated:</p> <ul style="list-style-type: none"> - 2/8/25 at 0309 hours, for oxygen at six liters per minute via nasal cannula continuously to keep the oxygen saturation level greater than 92%. - 2/10/25 at 1600 hours, for oxygen at three liters per minute via nasal cannula continuously to keep the oxygen saturation level greater than 92% as per the family request. <p>Review of Resident 816's General Note dated 2/10/25, showed Resident 816 was complaining of difficulty breathing and the CNA called the LVN. The LVN went to Resident 816's room and checked the resident's oxygen, and the oxygen saturation level was at 93% at three liters per minute with nasal cannula. The LVN increased the oxygen to six liters per minute with nasal cannula and the oxygen saturation level was at 95 - 96%.</p> <p>On 2/12/25 at 0936 hours, a concurrent interview and medical record review was conducted with the DON. The DON acknowledged the above findings and stated the staff should be following the physician's order for the oxygen administration.</p> <p>48882</p> <p>2. Review of the facility's P&P titled Respiratory Care; Equipment Care and Handling updated 11/2018 showed the respiratory equipment is handled in a manner that maintains good working order and promotes proper infection control. The P&P also showed to use only sterile medications, diluents, and solutions that have been dispensed aseptically and to date medication containers when opened and refrigerate as necessary per the manufacturer's recommendations.</p> <p>Medical record review for Resident 55 was initiated on 2/10/25. Resident 55 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 55's Order Summary Report dated 2/13/25, showed a physician's order dated 1/16/25, to administer the oxygen at three liters per minute via nasal cannula, may titrate up to 10 liters per minute as needed for shortness of breath, comfort, or if the oxygen saturation level less than 90%.</p> <p>On 2/10/25 at 0927 hours, Resident 55 was observed lying in bed and receiving oxygen via nasal cannula between two and three liters per minute. The nasal cannula was observed connected to the oxygen concentrator with a bottle of sterile water used for humidification. The sterile water was not observed with an opened date.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 1145 hours, an interview and concurrent observation was conducted with LVN 2. LVN 2 stated Resident 55 was currently on continuous oxygen at three liters per minute via nasal cannula. LVN 2 verified the above findings and stated the sterile water should be dated with the opened date when opened.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to offer or provide adequate and appropriate pain management for one of two final sampled residents (Resident 818) reviewed for pain management. The facility failed to ensure Resident 818 was administered pain medication as per the physician's order. Additionally, the facility failed to consistently provide the NPI for pain prior to the administration of a narcotic pain medication to Resident 818. These failures had the potential for not effectively managing the resident's pain.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Pain Management revised 10/2022 showed the staff will continually observe and monitor the residents for comfort and presence of pain and will implement strategies in accordance with professional standards of practice, the patient-centered plan of care, and the patient's choices related to pain management. The nurse will notify the physician as appropriate and obtain treatment orders as indicated. The residents receiving interventions for pain will be monitored for the effectiveness and/or side effects/adverse drug reactions. To document non-pharmacological interventions and effectiveness.</p> <p>Medical record review for Resident 818 was initiated on 2/10/25. Resident 818 was admitted to the facility on [DATE].</p> <p>Review of Resident 818's MDS dated [DATE], showed Resident 818 was cognitively intact.</p> <p>Review of Resident 818's plan of care showed a care plan focus initiated on 1/25/25, to address Resident 818's actual pain and discomfort related to status post open reduction and internal fixation (ORIF, an orthopedic surgical procedure used to repair a broken bone) with external fixation (an external device used to keep the bone stabilized) to the right foot and right heel infection. The interventions included to offer non-pharmacologic interventions prior to PRN pain medication.</p> <p>Review of Resident 818's MAR for January 2025 showed a physician's order dated 1/24/25, to administer morphine (narcotic pain medication) 15 mg one tablet by mouth every four hours as needed for severe pain (pain level of 8-10, on a 0-10 pain scale with 0=no pain and 10=worst pain). Resident 818 was administered the morphine medication as follows:</p> <ul style="list-style-type: none"> - on 1/25/25 at 0720 hours, for a pain level of 10; at 1120 hours, for a pain level of 10; at 1530 hours, for a pain of level 8; and at 2000 hours, for a pain of level 8; - on 1/26/25 at 0035 hours, for a pain of level 8; at 0635 hours, for a pain of level 8; and at 1500 hours, for a pain of level 8; - on 1/27/25 at 0100 hours, for a pain of level 8; at 0500 hours, for a pain of level 8; 1600 hours, for a pain of level 7; and at 2000 hours, for a pain of level 7; <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 1/28/25 at 0000 hours, for a pain of level 8; at 0500 hours, for a pain of level 8; at 1230 hours, for a pain of level 8; at 1742 hours, for a pain of level 6; and at 2143 hours, for a pain of level 6;</p> <p>- on 1/29/25 at 0500 hours, for a pain of level 0; at 1000 hours, for a pain of level 8; at 1724 hours, for a pain of level 6; and at 2130 hours, for a pain of level 6;</p> <p>- on 1/30/25 at 0130 hours, for a pain of level 8; at 0830 hours, for a pain of level 8; at 1250 hours, for a pain of level 8; and at 1810 hours, for a pain of level 9; and</p> <p>- on 1/31/25 at 0715 hours, for a pain of level 10 and at 1430 hours, for a pain of level 8.</p> <p>Review of Resident 818's MAR for January 2025 showed a physician's order dated 1/24/25, to administer hydrocodone-acetaminophen (narcotic pain medication) 10-325 mg one tablet by mouth every four hours as needed for moderate pain (a pain level of 5 - 7). The MAR further showed the PRN hydrocodone-acetaminophen medication was not administered to the resident.</p> <p>Review of Resident 818's MAR for January 2025 showed documentation for the physician's order dated 1/24/25, for the NPI used before the administration of the PRN pain medication every six hours as needed:</p> <p>- on 1/25/25, no administrations;</p> <p>- on 1/26/25, no administrations;</p> <p>- on 1/27/25 at 0044 hours, with 1,6,7 NPI provided, at 0436 hours, with NA NPI provided; and at 2340 hours, with 1,6,7 NPI provided;</p> <p>- on 1/28/25 at 0449 hours, with 6,7 NPI provided;</p> <p>- on 1/29/25 at 0704 hours, with NA NPI provided and at 0930 hours, with 1,6,7 NPI provided;</p> <p>- on 1/30/25 at 0110 hours, with 6,7 NPI provided; at 0800 hours, with 6,7 NPI provided; and at 1220 hours, with 6,7 NPI provided; and</p> <p>- on 1/31/25 at 1400 hours, with 1,2,3,4 NPI provided.</p> <p>The MAR failed to show a legend on what 1, 2, 3, 4, 6, 7, and NA meant.</p> <p>Further review Resident 818's MAR for January 2025 showed a physician's order dated 1/24/25, to document the NPI, which were coded as follows: A. Heat; B. Repositioning; C. Relaxation breathing; D. Food/fluid; E. Massage; F. Exercise; G. Immobilization of joint; and H. Other - write in progress note as needed:</p> <p>- on 1/24/25 at 2000 hours, with B, C, D provided;</p> <p>- on 1/25/25 at 1500 hours, with A, B, D provided;</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 1/26/25 at 1430 hours, with A, B, C, D provided; and</p> <p>- on 1/27/25 at 1900 hours, with B, C, H provided.</p> <p>However, the MAR failed to show documented evidence the NPI were provided prior to the administration of the PRN morphine 15 mg on the following dates and times:</p> <p>- on 1/25/25 at 0720, 1120, and 2000 hours;</p> <p>- on 1/26/25 at 0035 and 0635 hours;</p> <p>- on 1/27/25 at 0100, 0500, and 1600 hours;</p> <p>- on 1/28/25 at 0000, 0500, 1230, 1742, and 2143 hours;</p> <p>- on 1/29/25 at 0500, 1000, 1724, and 2130 hours;</p> <p>- on 1/30/25 at 0130, 0830, 1250, and 1810 hours; and</p> <p>- on 1/31/25 at 0715 and 1430 hours.</p> <p>Further review of Resident 818's medical record failed to show documented evidence the NPI were provided with each of the PRN pain medication administration listed above.</p> <p>On 2/11/25 at 0902 hours, an interview was conducted with Resident 818. Resident 818 stated she had agonizing pain after her surgery. Resident 818 stated she took the morphine 15 mg medication every four hours for the pain.</p> <p>On 2/18/25 at 0841 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the facility's process for pain medications was to asses for pain and the licensed nurse would give the pain medication based on the pain scale. RN 1 verified the morphine 15 mg was administered to Resident 818 outside of the pain scale parameter on multiple occasions. RN 1 stated the NPI were offered for the PRN pain medication and verified the NPI were not provided to Resident 818 prior to the pain medication administration listed above.</p> <p>On 2/18/25 at 1106 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON verified the morphine 15 mg medication PRN order was administered outside of the pain scale and verified the medication should have been offered based on the pain scale. The DON stated for the PRN pain medications, the licensed nurse assessed the level of pain and offered the NPI and if the NPI did not work, then the licensed nurse would give the prescribed PRN pain medication.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of two final sampled residents (Resident 21) reviewed for dialysis care.</p> <p>* The facility failed to ensure Resident 21's scheduled medications on the dialysis days were held as per the physician's order. In addition, the facility failed to ensure Resident 21's AV shunt was assessed after the dialysis treatment and fluid restriction was monitored . These failures had the potential to negatively affect Resident 21's physical well-being, which potentially would result in the resident having an excess of fluid which could lead to negative health consequences.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Hemodialysis Care and assessment dated ,d+[DATE] showed the process for documentation for residents receiving dialysis services should include the following:</p> <p>a. The licensed nurse completes the pre-dialysis form prior to the resident leaving for dialysis.</p> <p>b. Upon return, the pos-dialysis assessment portion of the form is completed and attached to the resident's medical record.</p> <p>c. If no documentation or new order is received from the dialysis center, no new orders will be implemented. If a post dialysis weight is not received from the dialysis center, a weight is obtained in the center and documented on the form.</p> <p>Residents who require hemodialysis are provided ongoing assessment and monitoring of the resident's condition before and after dialysis treatments including monitoring for complications and interventions as part of nursing standards of practice. Issues are documented, as noted, by the licensed nurse and medical providers are notified.</p> <p>Medical record review for Resident 21 was initiated on 2/10/25. Resident 21 readmitted to the facility on [DATE].</p> <p>Review of Resident 21's H&P examination dated 5/27/24, showed Resident 21 had the capacity to make and understand decisions.</p> <p>Review of Resident 21's Order Summary Report dated 2/18/25, showed the following physician's orders:</p> <p>- dated 7/2/24, for hemodialysis every Tuesday, Wednesday, Thursday, and Saturday;</p> <p>- dated 7/2/24, to auscultate for bruit and palpate for thrill; and notify the physician for the absence of bruit/thrill;</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 7/2/24, to administer hydralazine Hcl (medication to treat high blood pressure 50 mg one tablet by mouth every eight hours for hypertension, and to hold if the SBP less than 110 mmHg;</p> <p>- dated 7/2/24, to administer nifedipine (medication to treat high blood pressure) ER 20 mg one tablet by mouth every 24 hours for hypertension; and to hold if the SBP less than 110 mmHg,</p> <p>- dated 7/2/24, for fluid restriction of 1200 ml per day as follows: nursing department: 0700-1500 hours shift = 120 ml, 1500-2300 hours shift = 120 ml, and 2300-0700 hours shift = 120 ml; and dietary department: breakfast tray = 360 ml, lunch tray = 120 ml, and dinner tray = 60 ml.</p> <p>- dated 9/8/24, to assess the AV fistula site for infection, edema, bleeding upon return from dialysis; and</p> <p>- dated 12/12/24, to hold hypertension medications (used to treat blood pressure greater than 140/90 mmHg) prior to dialysis.</p> <p>Review of Resident 21's Hemodialysis Communication Record for January and February 2025 showed Resident 21 had received dialysis treatment on 1/2, 1/4, 1/7, 1/8, 1/9, 1/11, 1/14, 1/15, 1/16, 1/18, 1/21, 1/22, 1/23, 1/25, 1/28, 1/29, 1/30, 2/1, 2/4, 2/5, 2/6, and 2/8/25.</p> <p>Review of Resident 21's Hemodialysis Communication Record dated 1/8/25, failed to show documented evidence Resident 21's AV shunt was assessed by the facility staff after the dialysis treatment.</p> <p>Review of Resident 21's Hemodialysis Communication Record dated 1/14/25, showed the recommendation by the dialysis center for fluid restriction less than 2000 ml per day between dialysis treatments. Additionally, the communication record showed 3.8 liters of IDWG was removed from Resident 21 during dialysis treatment.</p> <p>Review of Resident 21's Hemodialysis Communication Record dated 1/18/25, showed Resident 21 had a BP of 107/43 mmHg upon arrival to the dialysis center. The dialysis center was unable to remove the IDWG due to Resident 21's low BP. Additionally, the communication record showed the dialysis center's recommendation was to limit Resident 21's fluid intake and monitor the resident for signs and symptoms of fluid overload over the weekend.</p> <p>Further review of Resident 21's medical record failed to show documented evidence the physician was notified of the new recommendations from the dialysis center and/or when the resident had significant status changes on the above dates.</p> <p>Review of Resident 21's MAR for January and February 2025 showed the following:</p> <p>- hydralazine hcl 50 mg tablet was administered at 0600 hours, on 1/1 to 1/17, 1/19 to 1/27, 1/30, 1/31, and 2/1 to 2/10/25, which included the dialysis days.</p> <p>- nifedipine ER 30 mg tablet was administered at 0900 hours, on 1/14, 2/1, 2/3, 2/6, and 2/9/25, which included the dialysis days.</p> <p>- there was no documentation of the total amount of the resident's daily fluid intake.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 21's medical record failed to show documented evidence the physician was notified when Resident 21 received the hydralazine hcl and nifedipine medications on the dialysis days.</p> <p>On 2/13/25 at 1320 hours, an interview and concurrent medical record review was conducted with LVN 11 for Resident 21. When asked about the process when a resident returned from a dialysis treatment, LVN 11 stated the AV shunt should be assessed for bruit, thrill, bleeding, and signs and symptoms of infection; and the assessment should be documented on the resident's Hemodialysis Communication Record. LVN 11 stated if the Hemodialysis Communication Record showed any orders and/or recommendations from the dialysis center or resident status changes, the LVN was expected to notify the resident's physician. LVN 11 verified there was no documented evidence of the assessment of Resident 21's AV shunt after dialysis treatment on 1/8/25. Additionally, LVN 11 verified there was no documented evidence Resident 21's physician was notified of the new recommendations and/or when the resident had significant status changes on 1/14 and 1/18/25. When asked about Resident 21's fluid restriction, LVN 11 stated the LVNs were responsible for monitoring Resident 21's fluid intake during meals and medication administrations and documenting in the MAR. LVN 11 verified there was no documentation to show the total amount of Resident 21's fluid intake each shift.</p> <p>On 2/18/25 at 0945 hours, an interview and concurrent medical record review was conducted with RN 1 for Resident 21. When asked about Resident 21's hydralazine hcl and nifedipine ER medications, RN 1 verified there was a physician's order to hold Resident 21's hydralazine hcl and nifedipine ER medications on the days of the dialysis treatment. RN 1 verified the hypertension medications were not held as ordered on the above dates. RN 1 verified there was no documented evidence the physician was notified when Resident 21 was routinely administered the hypertension medications on the days of the dialysis treatment.</p> <p>On 2/18/25 at 1534 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs of two final sampled residents (Residents 50 and 58).</p> <p>* The facility failed to ensure the physician's orders for Resident 58 were accurate. The medication route was ordered to be oral instead of GT. This failure had the potential for the medications to be administered in error.</p> <p>* One of five licensed nurses (LVN 2) who was observed during the medication administration was found to have an error. LVN 2 failed to administer the complete dose of one of Resident 58's medications when significant residual of the multivitamin (supplement) medication was observed in the medication cup after administering the medication via GT to Resident 58.</p> <p>* The facility failed to ensure LVN 1 documented the administration of the sodium chloride (supplement) medication to Resident 50 in the electronic MAR and/or in the resident's progress notes.</p> <p>These failures had the potential to negatively affect the residents' health conditions and posed the risk for possible complications or delay in interventions.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration- General Guidelines dated 10/2017 showed medications are administered as prescribed in accordance with good nursing principles and practices and only by the persons legally authorized to do so. Prior to the administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines. If a resident is tube-fed, medications are crushed finely to prevent clogging the tube. Further review of the facility's P&P showed medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or conditions, the nurse calls the pharmacy provider for clarification prior to the administration of the medication or if necessary, contacts the prescriber for clarification. The interaction with the pharmacy and/or the prescriber and the resulting order clarification is documented in the nursing notes and elsewhere in the medical record as appropriate. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure the necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1.a. On 2/11/25 at 0918 hours, a medication administration observation for Resident 58 was conducted with LVN 2. LVN 2 was observed administering all the medications via the GT to Resident 58.</p> <p>Medical record review for Resident 58 was initiated on 2/10/25. Resident 58 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 58's MDS dated [DATE], showed Resident 58 had an enteral feeding tube.</p> <p>Review of Resident 58's Order Summary Report dated 2/11/25, showed the following physician's orders dated 1/28/25:</p> <ul style="list-style-type: none"> - to administer polyethylene glycol (laxative) 3350 powder, 17 gm by mouth daily for constipation in four to eight ounces of fluid if the resident has not had a bowel movement in the past 72 hours and hold for loose stool. - to administer multiple vitamins-mineral (supplement) one tablet by mouth daily for supplement. <p>On 2/11/25 at 0958 hours, an interview and concurrent medical record review for Resident 58 was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated Resident 58 had a GT, and all of the resident's medications should be administered via GT. LVN 2 further stated the ordered route for the above medications should be changed to accurately reflect the care that the resident was receiving.</p> <p>On 2/13/25 at 1441 hours, an interview and concurrent medical record review for Resident 58 was conducted with the DON. The DON stated the licensed nurses who responsible for putting the physician's orders into the resident's medical record and carrying out the physician's orders. The DON further stated if there were any discrepancies in the physician's orders, the licensed nurses were responsible for clarifying the discrepancies. The DON reviewed Resident 58's medical record and verified the above findings. The DON stated the licensed nurse should have clarified the physician's order to accurately reflect the medication route.</p> <p>b. On 2/11/25 at 0918 hours, a medication administration observation for Resident 58 was conducted with LVN 2. LVN 2 prepared and administered Resident 58's medications which included the following:</p> <ul style="list-style-type: none"> - one tablet of aspirin (antiplatelet) 81 mg, - one tablet of memantine (dementia medication, used to treat symptoms of Alzheimer's disease, a brain disease that slowly destroys the memory and the ability to think, learn, communicate and handle daily activities) 5 mg, - one tablet of metoprolol tartrate (antihypertensive) 25 mg, - one tablet of multivitamin with mineral, and - 17 gm of polyethylene glycol 3350 in five ounces of water. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>LVN 2 was observed administering the above medications to Resident 58 via the GT. After administering the medication, one medication cup was observed with a significant amount of yellow-colored medication residue.</p> <p>On 2/11/25 at 0955 hours, an interview and concurrent observation was conducted with LVN 2. LVN 2 verified the above findings and identified the medication cup contained the multivitamin with mineral medication. LVN 2 stated when there was significant residue in the medication cup she should add more water, stir the contents, and administer the complete dose of the medication to the resident.</p> <p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated during the administration of the medications, the licensed nurses were expected to ensure the medications were administered as per the physician's orders, including the correct route and complete dose. The DON stated when there are medication residue in the medication cup, the licensed nurses were expected to add water, mix the contents, and administer the complete dose as ordered by the physician.</p> <p>2. On 2/12/25 at 0857 hours, a medication administration observation for Resident 50 was conducted with LVN 1. LVN 1 prepared and administered Resident 50's medications. LVN 1 stated Resident 50 had a physician's order for sodium chloride (supplement) 1 gm orally scheduled at 0900 hours; however, she could not administer the medication as it was not available in her medication cart.</p> <p>On 2/12/25 at 1005 hours, an interview was conducted with LVN 1. LVN 1 stated when the medication was not available in the medication cart, she would check the central supply for the medication. If the medication was not in the central supply stock, she would call the pharmacy and order the medication. LVN 1 was asked and stated she had not checked the central supply for sodium chloride medications. LVN 1 further stated she would attempt to obtain and administer the medication to Resident 50 as soon as possible.</p> <p>On 2/12/25 at 1058 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated she had obtained the sodium chloride medication from the central supply and planned to administer the sodium chloride medication to Resident 50.</p> <p>Review of Resident 50's MAR for February 2025 showed the sodium chloride 1 gm tablet was held on 2/12/25 at 0900 hours.</p> <p>Review of Resident 50's Progress Notes failed to show the licensed nurse's documentation on 2/12/25, for the reason the sodium chloride 1 gm tablet was held and failed to show the documentation LVN 1 administered the sodium 1 gm tablet on 2/12/25.</p> <p>On 2/18/25 at 0907 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated she had administered the sodium chloride 1 gm tablet medication to Resident 50 on 2/12/25. LVN 1 verified she did not document the administration of the medication in Resident 50's MAR or the progress notes.</p> <p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated during the administration of medications, if the medication was not available in the medication cart, the licensed nurses were expected to follow up with the central supply/pharmacy to obtain the medication and administer the medication as soon as possible. The DON further stated if the medication was held, she expected the licensed nurse to inform the physician and document in the progress notes the reason the medication was held.</p> <p>(continued on next page)</p>		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953</p> <p>Based on interview and medical record review, the facility failed to ensure two of five final sampled residents (Residents 60 and 110) reviewed for unnecessary medication were properly monitored for the signs and symptoms of bleeding related to the use anticoagulant (prevents blood clots) medication.</p> <p>* The facility failed to ensure Resident 110 was monitored for the signs and symptoms of bleeding for the use of enoxaparin (anticoagulant medication) medication.</p> <p>* The facility failed to monitor for signs and symptoms of bleeding related to Resident 60's use of the apixaban (anticoagulant medication) medication.</p> <p>These failures had the potential for the residents to develop significant side effect of bleeding and negatively affect the resident's health condition and well-being.</p> <p>Findings:</p> <p>According to DailyMed, the enoxaparin medication's most common adverse effect was the increased risk of bleeding.</p> <p>1. Medical record review for Resident 110 was initiated on 2/10/25. Resident 110 was admitted to the facility on [DATE].</p> <p>Review of Resident 110's H&P examination dated 1/25/25, showed Resident 110 had the capacity to understand and make decisions.</p> <p>Review of Resident 110's Order Summary Report dated 2/13/25, showed a physician's order dated 1/15/25, to administer enoxaparin 40 mg/0.4 ml injection subcutaneously one time a day to prevent clotting.</p> <p>Review of Resident 110's plan of care showed a care plan problem dated 1/15/25, addressing the resident's potential for easy bruising, skin tears, ecchymosis and bleeding related to adverse reaction of the enoxaparin medication. The care plan interventions included to monitor for the signs and symptoms of bleeding: discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, nose bleeds; and to notify the physician for any changes in the condition.</p> <p>Review of Resident 110's medical record did not show documented evidence Resident 110 was monitored for the signs and symptom of bleeding.</p> <p>On 2/13/25 at 1307 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 verified there was no monitoring documented to show Resident 110 was assessed for the adverse effects related to the use of the enopaxarin medication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Alta Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13075 Blackbird Street Garden Grove, CA 92843	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/18/25 at 1212 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>48882</p> <p>2. According to the Lexicomp, an online reference for clinical drug information, showed apixaban was an anticoagulant and may increase the risk of bleeding (hemorrhage), including severe and potential fatal major bleeding.</p> <p>Medical record review for Resident 60 was initiated on 2/10/25. Resident 60 was admitted to the facility on [DATE].</p> <p>Review of Resident 60's Order Summary Report dated 2/13/25, showed a physician's order dated 1/17/25, to administer apixaban 5 mg one tablet by mouth two times a day for the treatment/prevention of blood clots. The physician's orders for the apixaban medication did not include the monitoring for the side effects.</p> <p>Review of Resident 60's MAR for February 2025 showed Resident 60 was administered the apixaban medication by mouth two times a day from 2/1/25 to 2/12/25 at 0900 and 1700 hours, except on 2/6/25 at 0900 hours.</p> <p>Further review of Resident 60's MAR for February 2025 failed to show documentation Resident 60 was being monitored for the signs and symptoms of bleeding related to the use of the apixaban medication.</p> <p>Review of Resident 60's plan of care showed a care plan problem dated 1/22/25, addressing Resident 60's potential for easy bruising, skin tears, ecchymosis and bleeding related to the adverse reaction of the apixaban medication. The interventions included to monitor for the signs and symptoms of bleeding: discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, muscle joint pain, diarrhea, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath or nose bleeds; and to notify the physician for any changes in condition.</p> <p>On 2/13/25 at 1024 hours, an interview and concurrent medical record review for Resident 60 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated for the use of the anticoagulant medication, there should be the monitoring for the signs and symptoms of bleeding and bruising every shift.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352</p> <p>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the monitoring for the use of the antipsychotic medications (medications that affect brain activities associated with mental process and behavior) for three of five sampled residents (Residents 4, 41, and 60) reviewed for unnecessary medications were completed when:</p> <p>* The facility failed to ensure Resident 41 was monitored accurately for orthostatic hypotension as ordered by the physician for the use of Seroquel (antipsychotic medication). In addition, the facility failed to ensure Resident 41's informed consent for the use of the Seroquel medication included the indication for its use and the date for the Seroquel medication to be stopped.</p> <p>* The facility failed to ensure Resident 60's informed consent had documentation of the frequency and behavior manifestations for the use of the Risperdal (antipsychotic) medication and to monitor Resident 60 for orthostatic hypotension for the use of the Risperdal medication. In addition, the facility failed to ensure the physician documented the justification for the continued daily use and no-stop date for the PRN use of the Risperdal medication for Resident 60.</p> <p>* The facility failed to ensure Resident 4 was monitored for orthostatic hypotension as ordered by the physician for the use of Seroquel medication.</p> <p>These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of psychotropic medication.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Blood Pressure, Measuring Assessments and Care Planning (undated) showed orthostatic (postural) hypotension is defined as a 20 mmHg or greater decline in systolic blood pressure (the blood pressure during the contraction of the heart) or a 10 mmHg or greater decline in diastolic blood pressure (the pressure in the arteries when the heart rests between beats) upon standing.</p> <p>1. a. Medical record review for Resident 41 was initiated on 2/10/25. Resident 41 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 41's H&P examination dated 5/7/24, showed the resident had no capacity to understand and make decisions. Further review of Resident 41's H&P examination showed the resident had a diagnosis of unspecified psychosis.</p> <p>Review of Resident 41's Order Summary Report dated 2/18/25, showed the following physician's orders:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - dated 3/21/22, to monitor for significant side effects from the Seroquel medication usage including postural hypotension; - dated 3/31/22, to monitor for orthostatic hypotension while sitting one time a day every Saturday; - dated 3/31/22, to monitor for orthostatic hypotension while lying one time a day every Saturday; - dated 3/31/22, to monitor for orthostatic hypotension while standing one time a day every Saturday; and - dated 8/23/24, to administer Seroquel 25 mg one-half tablet of by mouth twice a day for psychosis manifested by increased yelling/screaming. <p>Review of Resident 41's MAR for January through 2/12/25, showed the following medications were administered to Resident 41:</p> <ul style="list-style-type: none"> - Seroquel 25 mg, half of a tablet daily at 0900 hours, from 1/1 to 2/12/25; and - Seroquel 25 mg, half of a tablet daily at 1700 hours, from 1/1 to 2/11/25. <p>Further review of Resident 41's MAR for January through 2/12/25, showed the orthostatic BP (lying, sitting, and standing) were scheduled to be monitored every Saturday. However, the blood pressure readings for the three positions were the same as follows:</p> <ul style="list-style-type: none"> - On 1/4/25, the blood pressure readings was 98/74 mmHg for the lying, sitting, and standing position. - On 1/11/25, the blood pressure readings was 132/79 mmHg for the lying, sitting position, and 132, and standing position. - On 1/18/25, the blood pressure readings was 110/54 mmHg for the sitting position, lying position, and standing position. - On 1/25/25, the blood pressure readings was 128/67 mmHg for the sitting position, lying, and standing position. - On 2/1/25, the blood pressure readings was 120/68 mmHg for the lying position and standing position. - On 2/8/25, the blood pressure readings was 124/70 mmHg for the lying position and sitting position. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/12/25 at 1014 hours, an interview and concurrent medical record review for Resident 41 was conducted with LVN 1. When asked about the procedure for taking the orthostatic blood pressure readings, LVN 1 stated the BP was taken while the resident was sitting or lying down. A second BP reading was taken a few minutes after changing the resident's position to sitting or standing. LVN 1 stated the orthostatic BP readings should not be the same for the lying, sitting, and standing position. LVN 1 stated Resident 41 could be at risk for the low blood pressure not being identified if the orthostatic BP readings were not taken using the proper procedure. LVN 1 verified the orthostatic BP readings for Resident 41 were the same for the above dates.</p> <p>On 2/13/25 at 1041 hours, an interview and concurrent medical record review for Resident 41 was conducted with RN 1. RN 1 verified Resident 41 had a physician's order to monitor for orthostatic hypotension as a side effect of the Seroquel medication administration. RN 1 stated the blood pressure readings should not be the same for the lying, sitting, and standing position. RN 1 stated Resident 41 was at risk for injury and adverse consequences because of the inaccurate monitoring of the orthostatic hypotension. RN 1 verified the orthostatic BP readings for Resident 41 were the same for the above dates.</p> <p>b. Review of the facility's P&P titled Consent for Psychotropic Drugs revised 9/2017 showed when the physician had ordered the use of antipsychotic, antidepressant, antianxiety, and/or hypnotic drug, the Center obtains, per Federal and State Regulations and Center policy, informed consent from the resident or resident representative. An informed consent is obtained before the drug prescribed is administered.</p> <p>The Procedure was described as follows:</p> <ol style="list-style-type: none"> 1. The licensed nurse reviews/completes the following with the resident and/or responsible party: <ol style="list-style-type: none"> a. The drug, dosage, and frequency. b. Discuss the rationale/benefits for the orders as directed by the physician. c. Discuss the potential risk factors (side effects/symptoms) of taking the prescribed drug. d. Review the content with them and obtain their signature if they agree to take the prescribed drug. <p>Review of Resident 41's Psychotropic Medication Administration Informed Consent dated 8/23/24, showed to increase the Seroquel medication dosage to 12.5 mg by mouth twice a day. However, the consent did not show the documentation of the behavioral indications for the recommended increase of the Seroquel medication dosage.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/25 at 1041 hours, an interview and concurrent medical record review was conducted with RN 1 for Resident 41. When asked about the procedure for obtaining the informed consent prior to the administration of psychotropic medications, RN 1 stated the written consent form should include the name of the medication, dosage, frequency, indications for the medication (behavioral manifestations), and date for the medication to be stopped. Resident 41's Psychotropic Medication Administration Informed Consent dated 8/23/24, was reviewed with RN 1. RN 1 verified Resident 41's consent form did not show the documentation of the behavioral indications for the recommended increase of the Seroquel medication or the date for the medication to be stopped.</p> <p>On 2/18/25 at 1534 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>48882</p> <p>2. Review of the facility's P&P titled Antipsychotic Medication Use revised 7/2022 showed antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. PRN orders for the antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. The duration of the PRN order will be indicated in the order. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: b. cardiovascular: orthostatic hypotension, arrhythmias.</p> <p>Review of the facility's P&P titled Medication Redimen Review (Monthly Report) dated 6/2021 showed recommendations are acted upon and documented by the facility staff and or the prescriber. The physician accepts or acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.</p> <p>Medical record review for Resident 60 was initiated on 2/10/25. Resident 60 was admitted to the facility on [DATE].</p> <p>Review of Resident 60's MDS dated [DATE], showed Resident 60 had modified independence (some difficulty in new situations) in cognitive skills for the daily decision making. Further review of Resident 60's MDS showed Resident 60 had the diagnosis of PTSD and was on an antipsychotic medication.</p> <p>Review of Resident 60's Order Summary Report dated 2/13/25, showed the following physician's orders:</p> <p>- dated 1/18/25, to report to the physician if any side effects were present: sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, postural hypotension, sweating, loss of appetite, tardive dyskinesia (facial, tongue movement), cognitive behavior (decreased mental status), akathisia (inability to sit still), Parkinsonism (tremors, drooling from the mouth, muscle rigidity), every shift,</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 1/21/25, to administer Risperdal 2 mg 1/2 (half) tablet by mouth two times a day for PTSD manifested by restlessness as evidenced by irritability towards others, and</p> <p>- dated 1/21/25, to administer Risperdal 2 mg 1/2 (half) tablet by mouth every four hours as needed for PTSD manifested by restlessness as evidenced by irritability towards others. No stop date per the physician.</p> <p>Review of Resident 60's MAR for February 2025 showed the following:</p> <p>- Resident 60 was administered Risperdal 2 mg 1/2 tablet by mouth two times a day from 2/1 to 2/12/25 at 0900 and 2100 hours,</p> <p>- Resident 60 was administered Risperdal 2 mg 1/2 tablet by mouth every four hours as needed on 2/12/25 at 0557 hours, and</p> <p>- Resident 60 was monitored for: free of significant side effects from Risperdal medication usage, to report to the physician if any side effects are present: sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, postural hypotension, sweating, loss of appetite, tardive dyskinesia , cognitive behavior (decreased mental status), akathisia (inability to sit still), Parkinsonism. The MAR showed a check mark from 2/1 to 2/12/25 for the day, evening, and night shifts.</p> <p>Further review of Resident 60's MAR failed to show Resident 60 was monitored for the orthostatic hypotension related to the use of the Risperdal medication.</p> <p>Review of Resident 60's plan of care showed a care plan problem dated 1/22/25, addressing Resident 60's antipsychotic drug use of the Risperdal medication for PTSD manifested by restlessness as evidenced by irritability towards others. The interventions showed to monitor for the side effects and consult the physician and/or pharmacist as needed.</p> <p>Review of Resident 60's Psychotropic Medication Administration Informed Consent dated 1/20/25, showed a consent was obtained for Risperdal 1 mg PO tablet. The consent failed to indicate the frequency or manifestations for the use of the Risperdal medication.</p> <p>Review of the facility's documents for Resident 60's pharmacy recommendation dated 1/28/25, showed the following:</p> <ol style="list-style-type: none"> 1. Resident 60 was admitted with orders for the Risperdal medication and to ensure the physician (or Psych physician) documentation was available to support the continued use of the current psychotropic. The section for Physician/Prescriber Response showed the physician selected AGREE and documented per Psych. 2. The Pharmacist noted Resident 60 had an order for the the use of the Risperdal medication PRN. The Pharmacist documented Per the new CMS regulations, PRN psychotropic orders are limited to 14 days. If longer duration of this PRN antipsychotic order was required, please include the documentation in the clinical record. The facility document showed the physician selected No stop date. Update the current PRN order to include no stop date per MD. The section for Physician/Prescriber Response showed the physician selected AGREE and documented per Psych. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's document titled Consultant Pharmacist's Medication Regimen Review for the recommendations created between 1/1 and 1/28/25, for Resident 60 showed the following:</p> <ul style="list-style-type: none"> - The Pharmacist recommended (for Resident 60's Risperdal medication) to ensure the physician documentation was available to support the continued use of the current psychotropic. The section for Follow-Through showed, note written to the secondary physician. - The Pharmacist recommended (for Resident 60's Risperdal PRN medication) the PRN psychotropic orders are limited to 14 days. If longer duration of this PRN antipsychotic order was required, please include the documentation in the clinical record. The section for Follow-Through showed, note written to physician. <p>Review of Resident 60's Physician's Progress Notes dated 1/21/25, failed to show documentation to support the continued use of the Risperdal medication for Resident 60.</p> <p>Further review of Resident 60's medical record failed to show any progress notes by the physician to support Resident 60's continued use of the Risperdal medication and the documentation for Resident 60 to have the Risperdal PRN medication for more than 14 days.</p> <p>On 2/13/25 at 1024 hours, an interview and concurrent medical record review for Resident 60 was conducted with RN 1. RN 1 stated an informed consent must be obtained for the use of antipsychotic medication. RN 1 further stated the informed consent for the use of antipsychotic should include the name of the medication, dose, route, frequency, and indications for the use of the medication. RN 1 stated for the residents on antipsychotics, the monitoring of behaviors was conducted every shift, as well as the monitoring for the potential side effects related to the use of the antipsychotic medication. RN 1 stated the monitoring of the side effects for the use of the antipsychotic medications was documented in the MAR. RN 1 reviewed Resident 60's informed consent for the use of the Risperdal medication and verified the consent was missing the frequency and indication of the medication. RN 1 further reviewed Resident 60's medical record and verified there was no documentation the licensed nurses were monitoring Resident 60 for orthostatic hypotension.</p> <p>On 2/13/25 at 1555 hours, an interview and concurrent medical record review for Resident 60 was conducted with the DON. The DON stated she designated two licensed nurses to be responsible for the recommendations made by the Pharmacist on the monthly drug regimen reviews. The DON stated the recommendations by the Pharmacist should be addressed as soon as possible. The DON reviewed the Pharmacist's recommendations for Resident 60's Risperdal medication use and stated there were no documentation by the physician in Resident 60's medical record to indicate the continued use of the Risperdal medication and the justification for the PRN Risperdal medication with no stop date. The DON stated the Pharmacist's recommendations for Resident 60 were not followed-up and should have been followed up timely.</p> <p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated she expected the Pharmacist's recommendations for the drug regimen review to be addressed as soon as possible. The DON further stated, if the recommendations were addressed with the physician or were not resolved, then she expected the licensed nurses to document in the resident's progress notes.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49644</p> <p>3. Medical record review for Resident 4 was initiated on 2/11/25. Resident 4 was admitted to the facility on [DATE].</p> <p>Review of Resident 4's MDS quarterly assessment dated [DATE], showed Resident 4 had severe cognitive impairment.</p> <p>Review of Resident 4's Order Summary Report dated 2/11/25, showed the physician's order dated 7/25/24, to take the orthostatic blood pressure. Direction for orthostatic BP: Enter BPs in Weights and Vitals tab directly. Take the BP while lying, then take BP while standing every seven days. Evaluate both recording for potential orthostatic hypotension indicated if the systolic drops by 20 units or diastolic drops by 10 units. Document occurrence and action taken in the Progress Note.</p> <p>Further review of Resident 4's medical record did not show documentation of Resident 4's orthostatic BP readings.</p> <p>On 2/14/25 at 1010 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified the orthostatic BP was not done for Resident 4 as ordered by the physician. RN 3 stated the LVN should have taken Resident 4's BP. RN 3 further stated Resident 4's BP might drop when the resident stood up or sat up too quickly. RN 3 stated Resident 4's BP should be monitored for the psychotropic and BP medications.</p> <p>On 2/14/25 at 1135 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the orthostatic BP for Resident 4 was not done as ordered by the physician. LVN 3 stated she did not read Resident 4's physician's order clearly. LVN 3 further stated the licensed nurse usually entered the orthostatic BP in the MAR. LVN 3 stated the physician's order for the monitoring of Resident 4's orthostatic BP was documented differently from the usual physician's order. LVN 3 stated the orthostatic BP should have been done so the licensed nurse could monitor the side effect of the Seroquel medication to Resident 4.</p> <p>On 2/18/25 at 0826 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the orthostatic BP should have been done by the licensed nurse because the Seroquel medication might induce orthostatic hypotension associated with dizziness.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48882</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 11.54%. Three of five licensed nurses (LVNs 1, 2, and 10) were found to have made errors during the medication administration observations.</p> <p>* Resident 50 had a physician's order for zinc (supplement) for wound healing. LVN 1 failed to administer the zinc medication as ordered due to the unavailability of the medication.</p> <p>* LVN 2 failed to check Resident 58's last bowel movement and if Resident 58 had loose stool prior to administering the polyethylene glycol 3350 (laxative medication) medication.</p> <p>* LVN 10 failed to check whether Resident 109 had a bowel movement in the last 72 hours prior to administering the polyethylene glycol medication.</p> <p>These failures had the potential to negatively affect the residents' health.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration-General Guidelines dated 10/2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with the written orders of the attending physician.</p> <p>1. On 2/12/25 at 0857 hours, a medication administration observation for Resident 50 was conducted with LVN 1. LVN 1 prepared and administered Resident 50's medications. LVN 1 stated Resident 50 had a physician's order for zinc (supplement) 220 mg orally scheduled at 0900 hours, however she could not administer the medication as it was not available in her medication cart.</p> <p>On 2/12/25 at 1005 hours, an interview was conducted with LVN 1. LVN 1 stated when the zinc medication was not available in the medication cart, she would check the central supply for the medications. If the medication was not in the central supply stock, she would call the pharmacy and order the medication. LVN 1 was asked and stated she had not checked the central supply for the zinc. LVN 1 further stated she would attempt to obtain and administer the medication to Resident 50 as soon as possible.</p> <p>On 2/12/25 at 1058 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated the central supply did not have the zinc medication and she had placed an order for the zinc medication with the pharmacy.</p> <p>Review of Resident 50's Order Summary Report dated 2/13/25, showed a physician's order dated 2/10/25, to administer zinc 220 mg orally once a day for wound healing.</p> <p>Review of Resident 50's MAR for February 2025 showed the zinc 220 mg tablet was held on 2/12/25 at 0900 hours.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated during the administration of medications, if the medication was not available in the medication cart, the licensed nurses were expected to follow up with the central supply/pharmacy to obtain the medication and administer the medication as soon as possible. The DON further stated if the medication was held, she expected the licensed nurse to inform the physician and document in the progress notes the reason the medication was held.</p> <p>2. On 2/11/25 at 0918 hours, a medication administration observation for Resident 58 was conducted with LVN 2. LVN 2 administered five medications to Resident 58, including the polyethylene glycol 3350 powder 17gm in five ounces of water via the GT.</p> <p>Review of Resident 58's Order Summary Report dated 2/11/25, showed a physician's order dated 1/28/25, to administer polyethylene glycol 3350 17 gm by mouth daily for constipation, in four to eight ounces of fluid, if the resident had no bowel movement in the past 72 hours; and to hold for loose stools.</p> <p>On 2/11/25 at 0958 hours, an interview and concurrent medical record review for Resident 58 was conducted with LVN 2. LVN 2 reviewed Resident 58's medical record and stated Resident 58 had a GT, thus the ordered route for the polyethylene glycol 3350 medication was incorrect. Additionally, LVN 2 stated the physician's order for the polyethylene glycol 3350 medication was to administer to Resident 58, if the resident had no bowel movement in the last 72 hours and to hold the medication for loose stools. LVN 2 stated she did not check Resident 58's last bowel movement and consistency prior to the administration of the polyethylene glycol 3350 medication. LVN 2 reviewed Resident 58's medical record and stated Resident 58's last bowel movement was on 2/10/25 at 0330 hours (less than 72 hours) and the consistency of the bowel movement was documented as loose stools. LVN 2 stated she should not have administered the polyethylene glycol 3350 medication.</p> <p>3. On 2/11/25 at 0856 hours, a medication administration observation for Resident 109 was conducted with LVN 10. LVN 10 administered two medications orally to Resident 109, including the polyethylene glycol 3350 powder 17gm in five ounces of water.</p> <p>Review of Resident 109's Order Summary Report dated 2/11/25, showed a physician's order dated 1/13/25, to administer polyethylene glycol 3350 17 gm by mouth daily for constipation, in four to eight ounces of fluid, if the resident had no bowel movement in the past 72 hours.</p> <p>On 2/11/25 at 0912 hours, an interview and concurrent medical record review for Resident 109 was conducted with LVN 10. LVN 10 verified the physician's order was to administer the polyethylene glycol 3350 medication if the resident had no bowel movement in the past 72 hours. LVN 10 reviewed Resident 109's medical record and stated Resident 109 had a bowel movement on 2/9/25 at 2200 (less than 72 hours). LVN 10 further stated she should not have administered the polyethylene glycol 3350 medication.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p>		

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<p>F 0761</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45064</p> <p>Based on observation, interview and facility P&P review, the facility failed to ensure the expired medications were removed for one of four Medication Carts (Medication Cart B). This failure had the potential for the medication to lose the stability and effectiveness.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Storage In The Facility effective date 4/2008 showed outdated medications are immediately remove from the stock, and disposed of according to the procedures for medication disposal.</p> <p>On 2/13/25 at 1350 hours, a medication cart inspection for Medication Cart B was conducted with RN 1. The following was observed:</p> <ul style="list-style-type: none"> - 14 packets of Vitamin A & D (skin protectant) ointment with an expiration date of 10/2023. <p>RN 1 verified the above findings. RN 1 stated the expired medications should be removed and discarded from the medication cart.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>47476</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the kitchen staff had the appropriate skill set to safely perform the daily operation of the Food and Nutrition Services Department.</p> <p>* Dietary Aide 1 was unable to correctly demonstrate how to test the chemical concentration of the sanitizing solution used to sanitize the food contact surfaces.</p> <p>* Dietary Aides 1 and 2 were unable to correctly describe how to manually wash the dishes.</p> <p>These failures had the potential to lead to foodborne illnesses in a highly susceptible population of the residents who received food prepared in the kitchen.</p> <p>Findings:</p> <p>Review of the facility's Diet Type Report dated 2/12/25, showed 107 of the 111 residents residing in the facility as of 2/12/25, received foods prepared in the kitchen. On 2/12/25 at 1050 hours, the CDM stated she was unable to provide the Diet Type Report for 2/10/25.</p> <p>Review of the facility's P&P titled Environment revised 9/2017 showed the Dining Services Director will ensure that all the employees are knowledgeable in the proper procedures for cleaning and sanitizing of all the food service equipment and surfaces.</p> <p>Review of the Ecolab Oasis 146 Multi-Quat Sanitizer manufacturer's instructions dated 2015 showed the directions for sanitation range testing. The instructions stated to withdraw and tear off approximately two inches of test paper from the dispenser. Dip test paper for 10 seconds in test solution. Don't shake. Under the section showing the direction for use, showed to expose all surfaces of equipment, ware, or utensils to the sanitizing solution for a period of not less than one minute.</p> <p>1. According to the USDA Food Code 2022, 4-501.116, Warewashing Equipment, Determining Chemical Sanitizer Concentration showed the effectiveness of chemical sanitizers is determined primarily by the concentration and pH of the sanitizer solution. Therefore, a test kit is necessary to accurately determine the concentration of the chemical sanitizer solution.</p> <p>On 2/10/25 at 0810 hours, an observation and interview was conducted with Dietary Aide 1 and the CDM who provided the translation. Dietary Aide 1 was asked to demonstrate how to check the sanitizing solution in the sanitation bucket. Dietary Aide 1 was observed to use a quaternary test strip and dipped and swishes the strip for four seconds into a red bucket filled with sanitizer. The testing strip color changed. When asked how long she dipped the test strip in the sanitizer for, the Dietary Aide stated one or two seconds. The CDM and Dietary Aide 1 verified she should have dipped the test strip in the sanitizer for 10 seconds per the guideline. Dietary Aide 1 stated the color changes too much.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. According to the USDA Food Code 2022, 4-703.11 Hot Water and Chemical showed efficacious sanitation depends on the warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning.</p> <p>Review of the facility's document titled Manual Warewashing undated showed the dishwashing - two-sink method for pots, pans and cooking utensils. For sink one, showed to wash in a clean detergent solution and rinse with clean water in sink one. For sink two, showed to sanitize using hot water or chemical sanitizer. To sanitize with hot water, dishes must be immersed in hot water of not less than 171 degrees F for 30 seconds and to sanitize using chemical sanitizers, a chemical sanitizing solution used according to manufacturer's instructions.</p> <p>a. On 2/12/25 at 0821 hours, a concurrent interview and observation was conducted with Dietary Aide 2. Dietary Aide 2 was asked for the procedure for manual dishwashing in their two-compartment sink. Dietary Aide 2 stated they washed the dishes at 110 degrees F, rinsed, and then sanitized. Dietary Aide 2 stated to sanitize, she would mix the sanitizer and water in the second sink. Dietary Aide 2 stated she would leave the items in the solution with the chemicals at 171 degrees F for 30 seconds.</p> <p>b. Dietary Aide 1 was summoned and asked the procedure for manual dishwashing with Dietary Aide 2 who was translating. Dietary Aide 1 stated she would scrub the dishes in another sink away from the two-compartment sink, then would sanitize and leave the dishes for three to five seconds in the sanitizer, then would put the items in the wash, then air dry.</p> <p>The CDM was informed the two staff members were unable to verbalize the correct process for manual dishwashing. The CDM acknowledged the findings and stated they would need to be re-educated.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual 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>47476</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menus were followed as evidenced by:</p> <ul style="list-style-type: none"> * Residents were served the yellow cake instead of the carrot cake with cream cheese frosting as shown on the posted menu. * Residents 97 and 466 were not served the chocolate ice cream as per the menu. * Resident 66 who was on a renal diet was not provided a renal diet per the menu. In addition, Resident 66 was not served a double portion of the protein per the diet order. <p>These failures had the potential for the residents to not receive an adequate nutrition and appropriate servings to meet the residents' individual needs.</p> <p>Findings:</p> <p>Review of the facility's Diet Type Report dated 2/12/25, showed 107 of 111 residents residing in the facility received foods prepared in the kitchen. On 2/12/25 at 1050 hours, the CDM stated she was unable to provide the Diet Type Report for 2/10/25.</p> <p>Review of the facility's P&P titled Menus revised 10/2022 showed the menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. Menus will be posted in the Dining Services department, dining rooms, and resident/patient care areas.</p> <p>Review of the facility's P&P titled Substitutions revised 4/2007 showed all the substitutions are noted on the menu and filed in accordance with established dietary policies.</p> <p>1. Review of the facility's Diet Guide Sheet printed 2/12/25, showed for Week 2: Monday lunch menu, the residents were to be served with the carrot cake with cream cheese frosting.</p> <p>However, during the lunch observation, the residents were not served the carrot care with cream cheese frosting as per the diet guide and menu. For example:</p> <p>a. On 2/10/25 at 1214 hours, an observation was conducted for Resident 51. Resident 51's meal ticket showed there resident was to receive a regular dysphagia advanced diet.</p> <p>Review of the facility's Diet Guide Sheet for 2/10/25, showed Resident 51 was to receive one square of carrot cake with cream cheese frosting on her meal tray; however, Resident 51 was served one square of the yellow cake.</p> <p>b. On 2/10/25 at 1222 hours, an observation was conducted for Resident 43. Resident 43's meal ticket showed the resident was to receive a carbohydrate controlled - dysphagia advanced diet.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Diet Guide Sheet for 2/10/25, showed Resident 43 was to receive one-half square of the carrot cake with cream cheese frosting on his meal tray; however, Resident 43 was served one square of the yellow cake.</p> <p>c. On 2/10/25 at 1221 hours, an observation was conducted for Resident 76. Resident 76's meal ticket showed the resident was to receive a regular - dysphagia advanced diet.</p> <p>Review of the facility's Diet Guide Sheet for 2/10/25, showed Resident 76 was to receive one square of the carrot cake with cream cheese frosting on his meal tray; however, Resident 76 was served one square of the yellow cake.</p> <p>On 2/10/25 at 1228 hours, the CDM and DSS. The CDM stated they did not have the carrot cake so they substituted with the yellow cake and provided the document titled Menu Substitution Log noting the substitution. When asked if the menu was changed and if the residents were notified of the change, the CDM stated they would have to change the menu outside and that was how the residents would know of the change. The CDM stated they failed to change the menu to show the substitution and verified the residents were not notified of the change in the menu.</p> <p>2. Review of the facility's Diet Guide Sheet printed 2/12/25, showed for Week 2: Tuesday, the residents were to be served one chocolate ice cream.</p> <p>a. On 2/11/25 at 1220 hours, during the trayline observation, Resident 466's meal ticket showed the resident was to receive a regular - dysphagia pureed diet. There were no restrictions on the texture of the liquids consistency. Resident 466's tray was observed to have a vanilla pudding on the tray and no chocolate ice cream. The meal cart which contained Resident 466's tray was sent out of the kitchen.</p> <p>b. On 2/11/25 at 1252 hours, an observation was conducted for Resident 97. Resident 97's meal ticket showed the resident was to receive a regular - dysphagia puree diet. There were no restrictions on the texture of the liquids consistency. Resident 97's tray was observed to have a vanilla pudding on the tray and no chocolate ice cream.</p> <p>On 2/12/25 at 1050 hours, an interview was conducted with the CDM, DSS, and Regional Dietician. The CDM verified the above findings.</p> <p>3. Review of the facility's Diet Guide Sheet printed 2/12/25, showed for Week 2: Tuesday, the residents on a carbohydrate controlled renal diet were to be served with pork carnitas, marinated cucumber salad, mashed potatoes or black beans, and one sugar cookie.</p> <p>On 2/11/25 at 1254 hours, an observation was conducted for Resident 66. Resident 66's meal ticket showed the resident was to receive a renal - dysphagia puree and honey-thick liquids diet. The meal ticket also showed Resident 66 was to receive a double portion of protein, fish and chicken only. Resident 66's tray was observed to have one portion of pureed protein, pureed green beans, pureed black beans, and pureed starch.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/11/25 at 1258 hours, a concurrent observation of Resident 66's meal tray and interview was conducted with the CDM and [NAME] 2. [NAME] 2 verified Resident 66 did not receive a double portion. The CDM verified the cucumber salad was not prepared. The Regional Dietician and CDM verified Resident 66 did not receive the renal diet as per the menu.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47476</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen as evidenced by:</p> <ul style="list-style-type: none"> * The facility failed to ensure the labeling and dating of the food items in the freezer used for the residents food. * The facility failed to ensure the maintenance tools were stored properly. <p>These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen.</p> <p>Findings:</p> <p>Review of the facility's Diet Type Report dated 2/12/25, showed 107 of the 111 residents residing in the facility as of 2/12/25 received foods prepared in the kitchen. On 2/12/25 at 1050 hours, the CDM stated she was unable to provide the Diet Type Report for 2/10/25.</p> <p>1. Review of the facility's P&P titled Food Receiving and Storage undated showed all the foods stored in the refrigerator or freezer are covered, labeled, and dated.</p> <p>During the initial tour of the kitchen conducted with the CDM on 2/10/25 at 0754 hours, the following was observed:</p> <ul style="list-style-type: none"> - an opened bag of veggie vegan patties observed unlabeled and undated; - one opened package of French toast unlabeled and undated; and - one bag of hamburger buns unlabeled and undated. <p>The CDM verified the above findings.</p> <p>2. According to the USDA Food Code 2022 Section 6-501.113, .Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be (B)Stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools.</p> <p>On 2/12/25 at 0832 hours, a concurrent observation and interview was conducted with the CDM. The CDM stated their cleaning materials were kept outside of the kitchen. There were three brooms observed to be stored on the ground outside of the kitchen. The CDM verified the cleaning materials should be kept hanging on the wall.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47476</p> <p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>Based on interview and facility P&P review, the facility failed to ensure the education was provided to the staff on safe food handling of outside food. This failure had the potential to cause foodborne illnesses to the medically vulnerable residents population who consumed food brought from the outside sources.</p> <p>Findings:</p> <p>Review of CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further shows the facility has the responsibility under the food safety regulation to help the visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit.</p> <p>Review of the facility's P&P titled Food Brought in by Family or Visitors revised 3/2024 showed the residents' family members will be educated to inform nursing staff of their desire to bring food into the facility. Family/visitors are asked to prepare and transport food using safe food handling practices. The responsible facility staff member will be responsible for reheating foods in the unit microwave.</p> <p>On 2/9/25 at 0825 hours, an interview was conducted with the IP. The IP stated the residents sometimes had food brought in from the outside and did not let the residents to have leftovers. The IP stated they did not have a resident refrigerator due to infection control issues. The IP stated she would tell the family members to take the leftovers home. The IP stated they would reheat food in a microwave in the employee lounge labeled for the resident's family to use only. The IP then went to the employees lounge and verified there was no microwave labeled for family use only.</p> <p>On 2/10/25 at 1016 hours, a concurrent observation and interview was conducted with Family Member 1 in Resident 46's room. There were several unlabeled containers of food on Resident 46's bedside tables. Family Member 1 stated he would bring Resident 46 food from home and if the food was cold, he would ask the staff to heat it up.</p> <p>On 2/11/25 at 1417 hours, an interview was conducted with CNA 3. CNA 3 stated Family Member 1 would bring Resident 46 food from home and would ask him to heat up the food. CNA 3 stated Family Member 1 told him how long to warm the food for. When asked if he received safe food handling education, CNA 3 stated he had to make sure Resident 46 was able to eat and swallow the food before it was provided to the resident.</p> <p>On 2/12/25 at 0852 hours, an interview was conducted with LVN 2. LVN 2 was asked if she received education regarding safe food handling. LVN 2 was unable to recall if she received the education.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/12/25 at 0907 hours, an interview was conducted with the DSD. The DSD stated she had not provided education to the staff on safe food handling. When asked what education would be provided, the DSD stated how to assist the resident during meals, how to handle the food, prepare the residents, hand hygiene, and a microwave was available and would remind the staff the food heated should not be very hot. The DSD provided the past in-service titled Food-Handling given to staff on 9/17/24, however, the DSD was unable to provide the lesson plan and verified she did not know what education was provided. The DSD verified the in-service was only provided to the CNAs.</p> <p>On 2/12/25 at 1050 hours, an interview was conducted with the CDM, DSS, and Regional Dietitian. The CDM verified they were not responsible for providing safe food handling education to the facility staff not working in the kitchen.</p> <p>On 2/13/25 at 0847 hours, an interview was conducted with CNAs 4 and 6. CNA 6 assisted with the translation of the questions that were asked. When asked about the food brought in by the visitors, CNA 4 stated the resident's family would ask to reheat the food for one minute and she would cover the food and put it in the microwave. CNA 4 stated she made sure the food was not too hot for the residents. CNAs 4 and 6 were asked what temperature the food should be to safely reheat it. The CNAs were unable to answer. CNAs 4 and 6 stated they had not received any education on safe food handling.</p> <p>On 2/18/25 at 1140 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON acknowledged the above findings.</p>		

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NAME OF PROVIDER OR SUPPLIER Alta Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13075 Blackbird Street Garden Grove, CA 92843	

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>47476</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in one of six garbage dumpsters. This failure had the potential to attract pests/rodents that carried diseases.</p> <p>Findings:</p> <p>According to the FDA Food Code 2022, 5-501.113, Covering Receptacles, receptacle and waste handling units for refuse, recyclables, and returnables shall be kept covered with tight-fitting lids or doors if kept outside the food establishment.</p> <p>On 2/10/25 at 0729 hours, and 2/11/25 at 0724 hours, one of six garbage dumpsters located outside of the facility was observed propped open.</p> <p>On 2/11/25 at 1430 hours, the Maintenance Assistant was informed and verified the above findings. The Maintenance Assistant stated he was responsible to maintaining the garbage dumpsters. The Maintenance Assistant stated the lids should be closed for infection control.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide the safe and sanitary environment were implemented as evidenced by:</p> <ul style="list-style-type: none"> * The facility failed to record all the residents with infection on the facility's infection surveillance tool. The facility's infection surveillance tool did not include all the residents identified with infections. The facility only documented on the surveillance log the residents who were prescribed with antibiotics were identified as having infection. * The facility failed to ensure the staff used proper PPE upon entering the resident's room for one nonsampled resident (Resident 88) who had Covid. * The facility failed to ensure LVN 7 donned the proper PPE during high-contact care for Resident 616 who was on enhanced barrier precautions. * The facility failed to ensure Resident 55's nasal cannula tubing was not touching the ground and under the trash can. <p>These failures posed a risk for transmission of disease-causing microorganisms and infections.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Infection Prevention and Control Program Description revised 11/15/20, showed the IPCP is a comprehensive process that addresses preventing, identifying, reporting, investigating, and controlling of infections and communicable diseases for patients, staff, volunteers, visitors, and other individuals providing services under a contractual agreement. The major activities of the program are:</p> <ul style="list-style-type: none"> * Surveillance of Infections which includes ongoing monitoring to identify possible communicable diseases or infections before they can spread to others in the Center and to whom they should be reported. * Process Surveillance to review infection prevention and control practices directly related to patient care. * Implementation of Control Measures and Precautions which includes basics such as hand hygiene, Standard and Transmission Based Precautions (including the use of PPE), cleaning/disinfecting equipment and measures to protect persons (as listed above) from communicable diseases or infections. <p>1. Review of the facility's Infection Prevention and Control Surveillance Log did not show a record of all the residents with infection. The surveillance log showed only the residents who were prescribed with the antibiotics.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/12/25 at 0953 hours, an interview and record review was conducted with the IP. The IP stated she was responsible for the infection control surveillance in the facility. When asked if the facility included on their infection surveillance log all the residents with signs and symptoms of infections but were not prescribed antibiotic, the IP stated they were only tracking the residents who were prescribed with antibiotic on the surveillance log. The IP acknowledged the infection surveillance log did not include all the residents identified with infection, and only the residents who were prescribed with antibiotic were listed on the infection surveillance form. The IP stated she did not have a surveillance log for the residents with signs and symptoms of infection but they addressed the residents' change of condition.</p> <p>On 2/18/25 at 0752 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the IP should have tracked also the residents who have signs and symptoms of infection but were not prescribed antibiotic to make sure they would be able to know if the residents were really infected.</p> <p>On 2/18/25 at 1211 hours, the Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>50953</p> <p>2. Review of the facility's P&P titled Covid-19 Management, Infection Control (undated) showed to provide a safe environment and to prevent the development and transmission of Covid- 19; Covid-19 transmission-based precautions the staff will use the following PPE: N95 respirator, gloves, gown, and eye protection.</p> <p>On 2/10/25 at 1004 hours, during the initial tour of the facility, Room A showed a sign outside the door stop, Novel Respiratory Precaution to clean hands-on room entry, wear gown on room entry, wear a N-95 and face shield or goggles, wear gloves on room entry and clean hands when exiting.</p> <p>On 2/11/25 at 0816 hours, CNA 15 was observed donning PPE gown, N-95, and gloves, then went inside the room and remove a breakfast tray, don off PPE gloves, gown, and N-95 mask. CNA 15 was observed with no face shield nor goggles.</p> <p>On 2/12/25 at 0759 hours, CNA 15 was observed answering the call light in Room A, sanitized the hands, and don on PPE, gown, N-95 and gloves. The CNA was observed with no face shield nor goggles.</p> <p>On 2/12/25 at 1342 hours, an interview was conducted with CNA 15. The CNA 15 verified no face shield or goggles was used during the care with Resident 88.</p> <p>On 2/13/25 at 0929 hours, an interview was conducted with the IP. The IP verified Resident 88 was a Covid positive and while doing resident care for the staff to don proper PPE consist of wearing gown, N-95 and face shield or goggle and gloves. The IP was informed and acknowledged CNA 15 did not use the goggle or face shield during care with Resident 88.</p> <p>On 2/18/25 at 1212 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON was informed and acknowledged the above findings.</p> <p>48882</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24, and effective 4/1/24, showed, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed the EBP recommendations now included the use of EBP for the residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. The indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.</p> <p>Medical record review for Resident 616 was initiated on 2/12/25. Resident 616 was admitted to the facility on [DATE].</p> <p>Review of Resident 616's Order Summary Report showed a physician's order dated 2/5/25, for enhanced barrier precautions for Resident 616's right knee surgical wound.</p> <p>On 2/12/25 at 0831 hours, a medication administration observation for Resident 616 was conducted with LVN 4. A sign outside of Resident 616's room showed the providers and staff must wear a gown and gloves with high contact care activities. A yellow sticker was indicated next to Resident 616's name on the door. LVN 4 was observed entering Resident 616's room to administer Resident 616's medications. LVN 4 was not observed donning a gown. LVN 4 was observed touching Resident 616's arm to check her identification band. LVN 4 was then observed administering enoxaparin (anticoagulant) 30 mg subcutaneously into Resident 616's right lower abdomen.</p> <p>On 2/12/25 at 0841 hours, an interview was conducted with LVN 4. LVN 4 stated the yellow sticker next to the resident's name indicated the resident was under enhanced barrier precautions. LVN 4 stated the enhanced barrier precautions meant the staff should wear the gown and gloves when making contact with the resident to prevent the transmission organism. LVN 4 stated Resident 616 was on enhanced barrier precautions for her wound. LVN 4 verified she did not wear a gown during the medication administration and stated she should have worn a gown.</p> <p>On 2/18/25 at 1428 hours, an interview was conducted with the DON. The DON stated for the residents with wounds and on enhanced barrier precautions, the staff were expected to don appropriate PPEs consisting of gown and gloves when entering the room to administer medications or provide care.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p> <p>4. Medical record review for Resident 55 was initiated on 2/10/25. Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident 55's MDS dated [DATE], showed Resident 55 had severe cognitive impairment.</p> <p>Review of Resident 55's Order Summary Report dated 2/13/25, showed a physician's order dated 1/16/25, to administer oxygen at three liters per minute via nasal cannula, may titrate up to 10 liters per minute as needed for shortness of breath, comfort, or if the oxygen saturation level less than 90%.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/11/25 at 1145 hours, an interview and concurrent observation of Resident 55 was conducted with LVN 2. Resident 55 was observed lying in bed, receiving continuous oxygen via nasal canula at three liters per minute. Resident 55's nasal canula tubing connected to the oxygen concentrator was observed touching the ground, and the trash can was observed on top of the nasal canula tubing. LVN 2 verified the above findings. LVN 4 stated the tubing should not touch the ground due to infection control risks. LVN 4 was then observed fixing the nasal canula tubing and stated she the tubing should be changed.</p> <p>On 2/18/25 at 1505 hours, an interview was conducted with the Interim Administrator and DON. The Interim Administrator and DON were informed and acknowledged the above findings.</p>		