

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Park Vista at Morningside		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Brea Blvd. Fullerton, CA 92835	

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 0554</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 17 final sampled residents (Resident 507) was assessed to determine if it was safe to self-administer their medications. In addition, the facility failed to ensure Resident 507 had the physician's order and care plan developed prior to self-administering their medications. These failures had the potential for the unsafe medication administration and negatively impact the resident's physiological well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Self Administration of Medications revised 11/28/16, showed the facility should comply with facility policy, applicable law, and the state operations manual with respect to the resident self-administration of the medications. The facility in conjunction with the IDT, should assess and determine, with respect to each of the resident, whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. The facility should ensure that orders for self-administration list the specific medication(s) the resident may self-administer. The facility should document the self-administration of medications in the resident's care plan.</p> <p>Medical record review for Resident 507 was initiated on 12/2/24. Resident 507 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 507's H&P examination dated 11/28/24, showed Resident 507 had the capacity to understand and make decisions.</p> <p>Review of Resident 507's Order Summary Report dated 12/3/24, showed a physician's order dated 11/28/24, to administer carboxymethylcellulose sodium ophthalmic solution 0.5% (medication used to relieve dry eyes) eye drops.</p> <p>On 12/2/24 at 0930 hours, a white bottle of carboxymethylcellulose sodium ophthalmic solution 0.5% eye drops was observed on Resident 507's bedside table. Resident 507 stated she administered the eye drops to both of her eyes when she had dry eyes.</p> <p>Further review of Resident 507's medical record failed to show a physician's order was obtained or a care plan problem was developed addressing Resident 507's self-administration of the medication.</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 0554</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 12/2/24 at 0943 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified the above findings and stated there were no residents in the facility who were able to self-administer the medications.</p>		

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<p>F 0558</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the call light was within reach for one nonsampled resident (Resident 307). This failure had the potential for Resident 307 not being able to summon help if needed and not receiving the care timely.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Answering the Call Lights dated October 2010 showed when the resident is in bed or confined to a chair in the room, be sure the call light is within easy reach of the resident.</p> <p>On 11/18/24 at 0900 hours, Resident 307 was observed awake and sitting up in a wheelchair. Resident 307's call light was observed on the floor.</p> <p>Medical record review of Resident 307 was initiated on 12/2/24. Resident 307 was admitted to the facility on [DATE].</p> <p>Review of Resident 307's plan of care showed a care plan problem dated 11/26/24, addressing the resident's risk for bowel incontinence related to immobility and cognitive impairment. The interventions included assisting the resident to the toilet as needed.</p> <p>Review of Resident 307's plan of care showed a care plan problem dated 11/26/24, addressing the resident's deficits in the daily living self-care performance. The interventions included to assist the resident with toileting hygiene, toilet transfers, and sitting to lying repositioning as the resident was dependent on the staff for assistance.</p> <p>On 11/18/24 at 1005 hours, the MDS Coordinator was summoned to the room. The MDS Coordinator verified the call light was out of Resident 307's reach. The MDS Coordinator was asked if Resident 307 could press the call light. Resident 307 was observed pressing the call light. The MDS Coordinator verified the findings.</p>

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<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** 46787</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide and document in the medical record the information on how to formulate an advance directive for one of two final residents (Resident 508) reviewed for an advance directives.</p> <p>* Resident 508's responsible party had not been provided the information regarding their rights to formulate an advance directive. This failure had the potential for the facility to provide treatment and services against the resident's wishes.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Advance Directives revised 6/24/15, showed it is the policy to provide written information to the resident and their responsible party regarding their rights to formulate an advance directive. If the resident indicates that he or she has not established advance directives, the facility will offer assistance in establishing advance directives.</p> <p>Medical record review for Resident 508 was initiated on 12/2/24. Resident 508 was admitted to the facility on [DATE].</p> <p>Review of Resident 508's Social Services Evaluation dated 11/21/24, showed Resident 508 did not have an advance directive.</p> <p>Review of Resident 508's POLST dated 11/19/24, showed the resident had a legally recognized decision-maker.</p> <p>Further review of Resident 508's medical record failed to show whether Resident 508 and/or the responsible party were informed of their rights to formulate an advance directive.</p> <p>On 12/3/24 at 1549 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD acknowledged Resident 508 and/or the responsible party were not informed of their rights to formulate an advance directive.</p>		

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<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on interview and facility document review, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 for one of three residents (nonsample resident, Resident 44) reviewed for beneficiary notices. This failure had the potential to not allow Resident 44's responsible party to make an informed decision regarding their Medicare services.</p> <p>Findings:</p> <p>Review of the facility's document titled Beneficiary Notice Guidelines dated 11/2024 showed the SNF ABN Form CMS-10055 is provided to residents or their responsible parties when the SNF determines the beneficiary no longer required daily skilled services and the resident remains in the facility regardless of payer type.</p> <p>Medical record review for Resident 44 was initiated on 12/2/24. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 44's medical record showed Resident 44's Medicare Part A skilled services benefits exhausted on 5/17/24.</p> <p>On 12/3/24 at 1558 hours, an interview and concurrent facility document review was conducted with the SSD. The SSD verified Resident 44's Medicare Part A skilled services benefits exhausted on 5/17/24. The SSD acknowledged Resident 44's responsible party was not provided with the SNF ABN Form CMS-10055 but should have been.</p>		

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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on interview, medical record review, and facility document review, the facility failed to ensure the MDS for discharge was completed and transmitted to CMS for two nonsampled residents (Residents 42 and 46) reviewed for resident assessments. This failure had the potential to affect the provision of care or services for the residents.</p> <p>Findings:</p> <p>Review of the facility's guidelines titled CMS RAI Manual Version 3.0 Chapter 2: Assessments for the RAI revised October 2024 showed under the section Discharge Assessment-Return Not Anticipated, assessments must be completed within 14 days after the discharge date and must be submitted within 14 days after the MDS completion date.</p> <p>1. Closed medical record review for Resident 42 was initiated on 12/5/24. Resident 42 was admitted to the facility on [DATE], and was discharged from the facility on 7/3/24.</p> <p>Review of Resident 42's medical record failed to show a discharge MDS assessment was completed and transmitted.</p> <p>2. Closed medical record review for Resident 46 was initiated on 12/5/24. Resident 42 was admitted to the facility on [DATE] and was discharged from the facility on 7/5/24.</p> <p>Review of Resident 46's medical record failed to show a discharge MDS assessment was completed and transmitted.</p> <p>On 12/5/24 at 0759 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated she completed the MDS assessments based on the CMS RAI Manual. The MDS Coordinator acknowledged and verified the above findings.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the RD evaluations and interventions related to weight loss were conducted timely for one of one final sampled residents (Resident 18) reviewed for nutrition. This failure had the potential for further weight loss and not meeting the nutrition needs for the resident.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Weight Management Guidelines revised 12/2023 showed the residents with significant weight variance should be identified and appropriate intervention implemented. Suggested parameters for evaluating significance of unplanned and undesired weight loss/gain are:</p> <ul style="list-style-type: none"> a. 1 (one) week - 2-3% is significant; greater than 3% is severe. b. 1 (one) month - 5% is significant; greater than 5% is severe. c. 3 (three) months - 7.5% is significant; greater than 7.5% is severe. <p>Further review of the P&P showed to follow best practice guidelines for interventions. Obtain residents preferences regarding interventions and individualize. Try food first. If weight loss continues and intake is consistently less than or equal to 50%, recommend an appetite stimulant for 30 days. When additional weight loss occurs, recommend a three day calorie count and check the advance directives.</p> <p>Medical record review for Resident 18 was initiated on 12/2/24. Resident 18 was readmitted to the facility on [DATE].</p> <p>Review of Resident 18's Mini Nutritional assessment dated [DATE], showed Resident 18 was at risk for malnutrition (condition in which the body does not get enough nutrients).</p> <p>Review of the facility's document titled Weights and Vitals Summary showed Resident 18's weights were documented as follows:</p> <ul style="list-style-type: none"> - 143.2 lbs on 6/30/24; - 136.2 lbs on 7/7/24 (a loss of 7 lbs/4.9% in one week); - 138.2 lbs on 7/14/24; - 130.4 lbs on 7/21/24 (a loss of 7.8 lbs/5.6% in one week from 7/14/24 to 7/21/24); - 131.6 lbs on 7/28/24; (a loss of 11.6 lbs/8.1% in one month); - 128.4 lbs on 8/4/24 (a loss of 3.2 lbs/2.4% in one week from 7/28/24 to 8/4/24); <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 124.8 lbs on 8/12/24 (a loss of 3.6 lbs/2.5% in one week from 8/4/24 to 8/12/24);</p> <p>- 119.8 lbs on 8/18/24 (a loss of 23.4 lbs/16.34% in seven weeks)</p> <p>Review of the facility's document titled Documentation Survey Reports for June, July, and August 2024 showed Resident 18's oral intakes for the following months:</p> <p>- For June 2024, 94.6% of the 37 meals recorded had intakes less than or equal to 50% intake.</p> <p>- For July 2024, 80% of the 92 meals recorded had intakes less than or equal to 50% intake.</p> <p>- For August 2024, 68.8% of the 93 meals recorded had intakes less than or equal to 50% intake.</p> <p>Review of Resident 18's Nutritional Services Notes showed the following:</p> <p>- dated 6/21/24, Resident 18 was evaluated to have an increased risk for weight loss related to edema and suboptimal PO intake. Resident 18's skin was intact and she had edema. Recommend liberalized diet to regular SB6 NAS diet with mildly thick liquids and fruit instead of dessert. Recommend add Glucerna one container at 10 AM for 180 calories and 10 grams of protein per day.</p> <p>- dated 7/2/24, showed Resident 18 disliked Glucerna and other nutritional supplements. Resident 18's intake was 25% which did not meet the established assessed needs of 58-71% PO for nutrition and hydration. Resident 18's skin was intact and edema was resolved. Recommend to add special nutrition program with all meals and gelato of Magic Cup (frozen dessert) with lunch for an additional approximate 1100 calories and 48 grams of protein. Recommend to discontinue Glucerna one container at 10 AM.</p> <p>- dated 7/16/24, Resident 18's weight was consistent with previous weight of 135-140 lbs. Resident 18's intake was 25-75% which met established assessed needs of 58-71% PO for nutrition and hydration. No recommendations at this time.</p> <p>- dated 7/25/24, all nutritional interventions have been used. Will recommend to communicate with MD that all nutritional interventions had been exhausted by weight loss persists. Continue plan of care and monitor weights and skin for significant changes.</p> <p>- dated 8/15/24, Resident 18's intake was 50%, which did not meet the established assessed needs of 58-71 % PO for nutrition and hydration. All the nutritional interventions had been used. Recommend Glucerna between meals to provide 360 kcal and 20 grams of protein. Continue the plan of care and to monitor the weights and skin for significant changes.</p> <p>- dated 8/21/24, Resident 18's intake was 35-50%, which did not meet the established assessed needs of 58-71 % PO for the nutrition and hydration. Recommend speech therapy evaluation to approve thin liquids and/or ice cream to improve PO intake. Discontinue Glucerna, resident disliked.</p> <p>Review of Resident 18's Physician's Progress Note dated 7/11/24, failed to address Resident 18's weight loss. Under the plan for frailty syndrome, it showed the RD was to assess the resident's adequate caloric intake for weight loss prevention.</p> <p>(continued on next page)</p>		

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<p>F 0692</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 Dietary Recommendations dated 7/25/24, showed Resident 18 had nutritional concerns of a 7.8 lbs weight loss in one week. The recommendation showed to communicate to the MD that all nutritional interventions have been exhausted, but the resident's weight loss persisted. Under the section for follow up, the date was blank.</p> <p>Review of Resident's Physician's Progress Note dated 8/9/24, showed Resident 18 was slowly improving since coming back from the acute care hospital for sepsis. Weights were stable and her PO intake was fair. Under the plan for frailty syndrome showed the RD to assess regarding adequate caloric intake for weight loss prevention.</p> <p>Further review of Resident 18's medical record failed to show the resident's physician was notified of the RD recommendation on 7/25/24. There was no documented evidence of evaluation or recommendation from the physician or RD to address Resident 18's continued weight loss from 7/25/24 through 8/15/24. Additionally, there was no documented evidence of the recommendation for an appetite stimulant per the facility's P&P.</p> <p>On 12/4/24 at 1119 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated the RD would write down their dietary recommendations on the form titled Dietary Recommendations, give the forms to the nurses, then the nursing staff would follow up. RN 2 reviewed the RD recommendation on 7/25/24, for Resident 18 and verified there was no documented evidence the physician was notified of the RD recommendations.</p> <p>On 12/4/24 at 1552 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 18 had weight loss but had maintained her weight range since August 2024. The DON stated the facility first identified Resident 18's weight loss on 6/30/24 and had conducted weekly weights at that time. The DON stated the resident would have significant weight loss if they lost three pounds in one week or five pounds in one month. The DON reviewed the RD recommendation on 7/25/24 and verified there was no documented evidence the physician was notified per the RD recommendation. The DON stated the nursing staff should carry out the RD recommendations in a timely fashion, ideally the next day.</p> <p>On 12/5/24 at 0926 hours, an interview and concurrent medical record review was conducted with the RD. The RD stated the facility had a written communication form he would fill out and provide to the nurses to follow up. The RD stated he started working at the facility on 8/15/24 and saw Resident 18 on 8/15/24. When asked about his recommendations to give Glucerna even when it was documented Resident 18 disliked Glucerna, the RD stated he talked to Resident 18 and she told him she would try. The RD verified there was no documented evidence of follow up from the RD regarding Resident 18's weight loss from 7/25/24 until 8/15/24.</p> <p>On 12/5/24 at 1200 hours, a follow-up interview was conducted with the DON. The 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** 32179</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of four final sampled residents (Residents 31, 32, 36, and 18) reviewed for respiratory care were provided with the appropriate respiratory care.</p> <p>* The facility failed to ensure Resident 36's oxygen was administered as ordered. In addition, the facility failed to change the humidifier and the oxygen nasal cannula (flexible tube to deliver oxygen into the nose) timely.</p> <p>* The facility failed to ensure Resident 32's oxygen nasal cannula was stored in a sanitary manner when not in use.</p> <p>* The facility failed to ensure Resident 31's oxygen nasal cannula was stored in a sanitary manner and changed timely.</p> <p>* The facility failed to ensure Resident 18's oxygen nasal cannula was stored in a sanitary manner.</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. Medical record review for Resident 36 was initiated on 12/2/24. Resident 36 was admitted to the facility on [DATE].</p> <p>Review of the facility's P&P titled Oxygen Management dated 9/10/24, showed the humidifiers should be dated, timed, and initialed when used. The nasal cannulas, masks, and tubing should be changed every seven days, timed, and initialed.</p> <p>Review of Resident 36's Order Summary Report dated 12/2/24, showed a physician's order dated 12/21/11, to administer the oxygen at two to three liters per minute via nasal cannula continuously to keep the oxygen saturation level above 92%.</p> <p>On 12/2/24 at 0800 hours, Resident 36 was observed with an oxygen at four liters per minute via nasal cannula. The humidifier was empty, and the oxygen nasal cannula and storage bag were dated 11/20/24.</p> <p>On 12/2/24 at 0900 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 36 was receiving oxygen at four liters per minute. LVN 1 stated he was not sure what the physician's order was for Resident 36's oxygen and would check it. LVN 1 verified the oxygen nasal cannula was undated and the storage bag was dated 11/20/24. LVN 1 acknowledged the humidifier was empty.</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 12/2/24 at 1030 hours, an observation, interview, and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 36 had an oxygen orders for three liters per minute; however, the resident was observed receiving four liters per minute of oxygen.</p> <p>2. Medical record review for Resident 32 was initiated on 12/2/24. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 32's Order Summary Report dated 12/3/24, showed a physician's order dated 10/26/24, to administer the oxygen at two to four liters per minute via nasal cannula as needed for shortness of breath or oxygen saturation level less than 92%.</p> <p>On 12/2/24 at 0810 hours, Resident 32 was observed lying in bed, with the nasal cannula placed on top of the oxygen concentrator and not inside the storage bag when not in use. The nasal cannula was undated, and the storage bag was dated 11/20/24.</p> <p>On 12/2/24 at 0915 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated the nasal cannula should be stored inside the storage bag when not in use. LVN 1 verified the nasal cannula was undated and the storage bag was dated 11/20/24.</p> <p>3. Medical record review of Resident 31 was initiated on 12/2/24. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 31's Order Summary Report dated 12/3/24, showed a physician's order dated 11/19/24, to administer the oxygen at two to four liters per minute via nasal cannula as needed for shortness of breath or oxygen saturation levels less than 92% and to administer the oxygen at two to four liters per minute via nasal cannula at night to keep the resident's oxygen saturation levels above 92% during the evening and night shifts.</p> <p>On 12/2/24 at 0815 hours, Resident 31 was observed sitting upright in bed with the nasal cannula on the right side of his bed. The oxygen nasal cannula was connected to the oxygen concentrator at two liters per minute. The nasal cannula was undated, and the storage bag was dated 11/20/24. When asked if he had taken off his oxygen, Resident 31 stated no.</p> <p>On 12/2/24 at 0920 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the nasal cannula should be placed in the resident's nostrils or stored inside the storage bag when not in use. LVN 1 verified the oxygen nasal cannula was undated and the storage bag was dated 11/20/24. LVN 1 stated the storage bag should be changed weekly.</p> <p>47476</p> <p>4. During the initial tour of the facility on 12/2/24 at 1034 hours, Resident 18's oxygen concentrator was observed not in use. The oxygen nasal cannula was observed on the floor under the chair next to the concentrator. The humidifier bottle and nasal cannula were observed unlabeled.</p> <p>On 12/2/24 at 1041 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated Resident 18 used the oxygen as needed intermittently. LVN 1 verified the above findings and stated the nasal cannula should be in a bag and changed every Wednesday or as needed.</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>Medical record review for Resident 18 was initiated on 12/2/24. Resident 18 was readmitted to the facility on [DATE].</p> <p>Review of Resident 18's Order Summary Report dated 12/2/24, showed a physician's order dated 6/18/24, to provide the oxygen at two to four liters via nasal cannula as needed for shortness of breath or oxygen saturation less than 92%.</p> <p>On 12/5/24, an interview was conducted with the DON and Administrator. The DON and Administrator 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** 32179</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services necessary to ensure the accurate reconciliation and disposal of medications.</p> <p>* The facility failed to ensure one of 17 final sampled residents (Resident 25) medications were not left at the resident's bedside. In addition, the facility failed to ensure the pharmaceutical services were provided to meet the needs of one nonsampled resident (Resident 2).</p> <p>* The facility failed to ensure the count performed for all controlled medications in the Omnicell (automatic drug delivery system) was accurate as per the facility's P&P. This failure posed the risk of medication diversion.</p> <p>* The facility failed to ensure Resident 2's routine medication was available. This failure had the potential to result in poor health outcomes to the resident.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Automated Drug Delivery System (ADDS) dated 2022 showed the pharmacy and facility staff shall comply with complaint, medication error, or omission reporting procedures for incidents that result from the use of the ADDS and/or system software. The pharmacy and facility shall follow the policies set forth by their respective organizations, which may include, but are not limited to: notifying the prescriber, documenting the facts of the incident, identifying the individuals involved, performing a root cause analysis, and developing a corrective action plan.</p> <p>Review of the facility document titled Pharmacy Discrepancy Report dated from 9/1/24 through 12/3/24, showed the following medications were listed:</p> <ul style="list-style-type: none"> - On 11/18/24 at 0737 hours, for the zolpidem tartrate (sleep aide medication) 5 mg tablet, the bin quantity before was five tablets, one tablet taken out, and the bin quantity after was 4 tablets. - On 11/19/24 at 0558 hours, for the zolpidem tartrate 5 mg tablet, the bin quantity before was four tablets, one tablet was added, and the bin quantity after was five tablets. - On 11/28/24 at 0537 hours, for the hydralazine (blood pressure medication) 10 mg tablet, the bin quantity before was 17 tablets, seven tablets were taken out, and the bin quantity after was 10 tablets. - On 11/28/24 at 0537 hours, for the hydralazine 10 mg tablet, the bin quantity before was 10 tablets, one tablet was taken out (corrected), and the bin quantity after was nine tablets. - On 10/21/24 at 0418 hours, for the tramadol hydrochloride (controlled pain medication) 50 mg tablet, the bin quantity before was 10 tablets, two tablets were taken out, and the bin quantity after was eight tablets. <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>- On 10/21/24 at 0524 hours, for the tramadol hydrochloride 50 mg tablet, the bin quantity before was 62018 (bar code) tablets. The transaction quantity showed 760212 (bar code). There was no specific actions documented and the bin quantity after was six tablets.</p> <p>- On 10/21/24 at 1216 hours, for the tramadol hydrochloride 50 mg tablet, the bin quantity before was seven tablets. However, the transaction quantity showed 760212 (bar code). There was no specific actions documented and the bin quantity after was 760219.</p> <p>- On 10/22/24 at 0707 hours, for the tramadol hydrochloride 50 mg tablet, the bin quantity before was eight tablets, two tablets were added, and the bin quantity after was 10 tablets.</p> <p>- On 11/23/24 at 0814 hours, for the levofloxacin (antibiotic medication) 250 mg, the bin quantity was five tablets, one tablet was removed, and the bin quantity after was four tablets.</p> <p>- On 11/24/24 at 0948 hours, for the levofloxacin 250 mg tablet, the bin quantity before was four tablets, two tablets were added, and the bin quantity after was 6 tablets.</p> <p>On 12/4/24 at 1340 hours, an interview and concurrent facility document was conducted with the DON, Pharmacy Staff 1, and 2. The review of the facility document titled Pharmacy Discrepancy Report dated from 9/1/24 through 12/3/24 was conducted with the DON regarding the Omnicell. When the DON was asked how the medications in the Omnicell were accounted for, the DON stated the night shift nurses were counting the controlled medications, antibiotics, and other medications. Pharmacy Staff 1 and 2 stated if there was a discrepancy when the medications were checked, the Omnicell would generate the discrepancy report automatically and email it to the DON.</p> <p>When Pharmacy Staff 1 and 2, and the DON were asked how the zolpidem medication was added back into the Omnicell on 11/19/24, almost 24 hours after it was removed. The DON stated the nurse added it back, however, the DON and Pharmacy Staff 1 and 2 were unable to explain where the nurse got the zolpidem tablet from to change the bin quantity back to five tablets. The DON and Pharmacy Staff 1 and 2 were asked about the seven tablets of hydralazine medication removed from the Omnicell on 11/28/24, the DON stated it was a discrepancy and the nurse should have taken only one tablet. The DON verified when after the nurse corrected the count for the hydralazine medication on 11/28/24, after removing only one tablet, and the ending count was nine tablets. However, when the DON and Pharmacy Staff 1 and 2 were asked why the ending count for the hydralazine medication was nine tablets and not 16 tablets, they were unable to provide an explanation. When the DON and Pharmacy Staff 1 and 2 were asked how the count for the tramadol medication remained at 10 tablets on 10/22/24, even after two tablets were removed on 10/21/24 at 0418 hours, and the bin quantity was six tablets on 10/21/24 at 0524 hours, the DON and Pharmacy Staff 1 and 2 were unable to provide an explanation. In addition, when the DON was asked about the discrepancy report for the tramadol medication for 10/21/24 at 0524 hours and 10/21/24 at 1216 hours, which did not show the specific actions taken by the staff (taken out or added), the DON stated the nurse scanned the bar code of the medication, instead of inputting the number of tablet(s) removed when the Omnicell system asked for the quantity and the system accepted and recorded it. Lastly, when the DON, Pharmacy Staff 1 and 2 were asked why and how the nurse added two tablets to the levofloxacin count on 11/24/24, the DON and Pharmacy Staff 1, 2 were unable to provide an explanation but they stated the nurse must have miscounted.</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>On 12/4/24 at 1500 hours, an interview was conducted with the DON. The DON acknowledged the discrepancy in counting the of the controlled medications and other medications in the Omnicell. The DON acknowledged the count for the hydralazine medication after the correction was made on 11/28/24, should have been 16 tablets, and not nine tablets as shown. The DON acknowledged there was a potential for the actual count of the controlled medications and other medications to not be accurate. The DON verified the above findings.</p> <p>2. Medical record review of Resident 2 was initiated on 12/2/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the facility's P&P titled Receipt of Interim/Stat/Emergency Deliveries dated 1/1/13, showed if a necessary medication is not contained within the Facility's interim/stat/emergency supply, and facility determines that an interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery as required or for delivery by contract courier.</p> <p>Review of the facility's P&P titled Reordering, Changing and Discontinuing Reorder dated 1/1/13, showed facility staff should reorder medications using an electronic list of residents and medications due or by use of barcode technology. Facility staff should review the transmitted reorders for status and potential issues and Pharmacy response.</p> <p>Review of Resident 2's Order Summary Report dated 12/9/24, showed a physician's order dated 11/19/24, to administer Eliquis (blood thinner) 2.5 mg orally one tablet by mouth twice a day for deep vein thrombosis (blood clot in a deep vein) prophylaxis. Additionally, there was a physician's order dated 11/23/24, to administer zinc sulfate (supplement) 220 mg one capsule by mouth once a day for 14 days for wound care.</p> <p>On 12/4/24 at 0900 hours, a medication administration observation was conducted with LVN 2 for Resident 2. LVN 2 stated the bubble pack for the routine Eliquis and zinc sulfate medications had run out of supply. LVN 2 stated she had faxed and called the pharmacy several times regarding the routine Eliquis and zinc sulfate medications, but the pharmacy had not sent either medications.</p> <p>Review of the facility's document titled Refill Reorder Form dated 11/28/24, showed the Eliquis 2.5 mg was ordered. The form also indicated the communication with the pharmacist regarding the refill for the Eliquis medication took place on 12/2/24 via phone, followed by a fax request on 12/3/24. There was no documentation to show why the pharmacy never sent the medications.</p> <p>On 12/4/24 at 1130 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 was observed receiving the medication delivery for Resident 2 from the pharmacy. LVN 2 administered the zinc sulfate and Eliquis medications to Resident 2.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 17 final sampled residents (Resident 25) was free of significant medication errors.</p> <p>* The facility failed to ensure Resident 25 was administered the piperacillin sodium tazobactam medication (antibiotic) as ordered by the physician. This failure had the potential to negatively impact the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Administering Medications dated 2001 showed the medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one hour of their prescribed time, unless, otherwise specified.</p> <p>Medical record review for Resident 25 was initiated on 12/2/24. Resident 25 was admitted to the facility on [DATE].</p> <p>Review of Resident 25's H&P examination dated 11/5/24, showed Resident 25 had the capacity to understand and make decisions.</p> <p>Review of Resident 25's Order Summary Report dated active as of 12/3/24, showed a physician's order dated 11/29/24, to administer piperacillin sodium tazobactam solution reconstituted 3.375 g intravenously every six hours for UTI for seven days.</p> <p>On 12/2/24 at 1102 hours, an interview was conducted with Resident 25. Resident 25 stated she was not administered her 0600 hours antibiotic dose during the previous night shift.</p> <p>Review of Resident 25's Infusion Medication Administration Record for December 2024 failed to show the dose of the piperacillin sodium tazobactam medication due on 12/2/24 at 0600 hours was administered to Resident 25.</p> <p>On 12/3/24 at 1406 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 acknowledged and verified the above findings.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed ensure proper storage and label of medications in one of two medication storage rooms (Medication room [ROOM NUMBER]) and two of three medication carts (Medication Carts A and C) when:</p> <ul style="list-style-type: none"> * An opened tuberculin (medication used to help diagnose tuberculosis) vial was stored in the refrigerator inside Medication room [ROOM NUMBER] without an open date. An opened box of instant food thickener was stored in Medication room [ROOM NUMBER] and contained multiple expired packets of food thickener. In addition, a bag of the home medications without a resident's name was stored in Medication room [ROOM NUMBER]. * Temperature log for Medication room [ROOM NUMBER] had multiple missing entries on multiple dates. * Three packets of Non-Adhesive Pad was stored in Medication Cart A and had expired on ,d+[DATE]. * Residents 14 and 40's topical medications in Medication Cart C was not labeled with an open date as per the facility's policy. <p>These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles revised on [DATE], showed the following:</p> <ul style="list-style-type: none"> - Facility staff should record the date opened on the medication container has a shortened expired date once opened. - Facility should ensure that medications and biologicals for expired or discharged residents are stored separately, away from use, until destroyed. <p>Review of the facility's P&P titled Temperature of Medications dated ,d+[DATE] showed the drugs required to be stored at a room temperature shall be stored at a temperature between 59-to-86-degree Fahrenheit, recommend a temperature log for daily documentation, saving records for a minimum of one year.</p> <p>Review of the facility's P&P Medication Labeling and Storage revision dated [DATE], showed to distinguish the house items from the resident supplies, non-prescription drugs belong to an individual resident shall bear the resident's name.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On [DATE] at 0938 hours, an observation and concurrent inspection of Medication room [ROOM NUMBER] was conducted with RN 1. The following was observed:</p> <ul style="list-style-type: none"> - An opened tuberculin vial inside the refrigerator was observed without an open date. - An opened box of EasyMix (instant food thickener) with multiple packets was stored in the cabinet and was expired on [DATE]. - A bag of home medications without a resident's name was observed on the counter. <p>RN 1 verified the above findings.</p> <p>2. On [DATE] at 1030 hours, an interview and concurrent facility document review was conducted with the DON for Medication room [ROOM NUMBER]'s Temperature Logs for the month of October through [DATE]. Review of Medication room [ROOM NUMBER]'s Temperature Logs showed missing entries for the following dates: ,d+[DATE], ,d+[DATE] through ,d+[DATE], ,d+[DATE] through ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE]. The DON verified the findings.</p> <p>3. On [DATE] at 1130 hours, a medication cart inspection for Medication Cart A was conducted with LVN 4. The following was observed:</p> <ul style="list-style-type: none"> - Three packets of Polymem Non-Adhesive Pad were observed inside the medication cart and were expired on ,d+[DATE]. LVN 4 verified the findings. <p>4. On [DATE] at 1211 hours, a medication cart inspection for Medication Cart C was conducted with LVN 1. The following was observed:</p> <ul style="list-style-type: none"> - One opened tube of diclofenac sodium (used for pain relief) topical gel for Resident 14 was observed without an open date. - One opened tube of diclofenac sodium topical gel for Resident 40 was observed without an open date. <p>LVN 1 verified the findings.</p> <p>a. Medical record review was initiated for Resident 12 on [DATE]. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 12's Order Summary Report dated [DATE], showed a physician's order to administer diclofenac sodium external topical gel 1% to the left shoulder every eight hours as needed for pain management.</p> <p>b. Medical record review was initiated for Resident 40 dated [DATE]. Resident 40 was admitted to the facility on [DATE].</p> <p>Review of Resident 40's Order Summary Report dated [DATE], showed a physician's order to administer Voltaren External Gel 1% (diclofenac sodium) to the right hip and right knee topically as needed for pain every eight hours for pain management.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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, and facility document review, the facility failed to ensure the menu was followed for three of 50 residents who received food from the kitchen.</p> <p>* Residents 22, 40, and 43 were not provided with the garlic breadstick as per the lunch menu on 12/2/24. This failure had the potential for the residents not receiving adequate nutrition and not receiving the menu as planned.</p> <p>Findings:</p> <p>Review of the facility's document titled Diet Count by Diet dated 12/2/24, showed 50 of 54 residents received food prepared in the kitchen.</p> <p>Review of the facility's document titled Daily Spreadsheet - Monday dated 12/2/24, showed the following menu for lunch:</p> <ul style="list-style-type: none"> - regular/NAS (no added salt) diet included a serving of a garlic breadstick and butter; - easy to chew diet included a soft and buttered garlic breadstick; and - soft and bite sized diet and pureed diet included a serving of pureed garlic breadstick and butter. <p>a. On 12/2/24 at 1200 hours, LVN 1 was observed checking the meals in a meal cart. LVN 1 stated he checked if the diet matched the texture on the meal tray.</p> <p>On 12/2/24 at 1210 hours, during the dining observation, Resident 43 was observed in her room with her lunch tray in front of her. Resident 43's meal ticket showed she would receive a pureed garlic breadstick and butter. Resident 43's meal tray was observed without a pureed garlic breadstick and butter. CNA 3 verified there was no pureed garlic breadstick and butter on Resident 43's meal tray and verified the resident should have received the pureed garlic breadstick according to Resident 43's meal ticket.</p> <p>On 12/2/24 at 1227 hours, the CDM verified the above findings.</p> <p>b. On 12/2/24 at 1218 hours, during the dining observation, Resident 40 was observed in the dining room. Resident 40's meal ticket showed she would receive a soft and buttered garlic breadstick with butter. Resident 40's meal tray was observed without the garlic breadstick. RNA 1 verified Resident 40's meal tray did not have a garlic breadstick according to the resident's meal ticket and proceeded to go to the kitchen to get Resident 40 the breadstick.</p> <p>On 12/2/24 at 1223 hours, the CDM verified the above findings.</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 - Few</p>	<p>c. On 12/2/24 at 1222 hours, during the dining observation, Resident 22 was observed in the dining room. Resident 22's meal ticket showed he would receive a pureed garlic breadstick and butter. Resident 22's meal tray was observed without a pureed garlic breadstick and butter.</p> <p>On 12/2/24 at 1223 hours, the CDM verified the findings.</p> <p>On 12/2/24 at 1230 hours, an interview was conducted with the CDM and Chef de Cuisine. The Chef de Cuisine stated the staff who was responsible for serving the pureed bread missed the garlic breadstick for the first few trays and forgot to put it on the first few orders. The CDM stated they had a third server on the line who checked the trays and then the nursing staff would check the meal trays one final time before entering the room. The CDM stated in the dining room the third server would check the meal tray on the trayline and then the RNA in the dining room would check the resident's meal tray.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen.</p> <ul style="list-style-type: none"> * The facility failed to ensure proper labeling and dating of foods in the kitchen. * The facility failed to ensure proper labeling and dating of foods in the refrigerator used for residents' food brought in by visitors and expired foods were discarded. * The facility failed to ensure the foods were stored off the floor. * The facility failed to ensure the plate lowerator (adjustable heated plate dispenser), can opener, kitchen microwave, oven, and warmer were clean. * The facility failed to ensure the egg salad was not stored on the shelf containing raw meats. <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 document titled Diet Count by Diet dated [DATE], showed 50 of 54 residents received food prepared in the kitchen.</p> <p>1. Review of the facility P&P titled Food Storage revised ,d+[DATE] showed the food items should be stored, thawed, and prepared in accordance with good sanitary practice. All the products should be inspected for safety and quality and be dated upon receipt, when opened, and when prepared. Use use-by dates on all the food stored in refrigerators. Any expired or outdated food products should be discarded. Under the section titled Frozen Vegetables showed the frozen vegetables should be stored as purchased.</p> <p>Review of the facility's P&P titled Labeling and Dating for Safe Storage of Food revised ,d+[DATE] showed when the food is taken out of an original container write the name of the food being stored on the container, the placed date, and the use-by date.</p> <p>On [DATE] at 0802 hours, an initial tour was conducted in the kitchen with the [NAME] and the following were observed:</p> <ul style="list-style-type: none"> a. In Refrigerator 1, the following was observed prepared but not labeled per the facility policy: <ul style="list-style-type: none"> - a pan of tilapia filets; - a pan of cleaned chicken; <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Park Vista at Morningside		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Brea Blvd. Fullerton, CA 92835	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - a container of mushrooms; - a container of egg salad; - two containers of chopped onions; and - a container of tomato wedges. <p>Additionally, the following expired items were observed:</p> <ul style="list-style-type: none"> - one box of pork chops with a use-by date of [DATE]; - one container of mushrooms with a use-by date of [DATE]; - one container of marinated vegetables with a use-by date of [DATE]; - one container of chopped tomatoes with a use by date of [DATE]; and - one container of Tuscan Caesar dressing with a use by date of [DATE]. <p>b. In Freezer 1, the following was observed not labeled per the facility policy:</p> <ul style="list-style-type: none"> - one opened and unsealed bag of pearl onions; - one bag of assorted pastries; and - brown rice packets. <p>c. In the pantry area, the following was observed not labeled per the facility policy:</p> <ul style="list-style-type: none"> - one bottle of breakfast syrup; and - one bag of a dry mixture. <p>d. In Refrigerator 2, the following was observed not labeled per the facility policy:</p> <ul style="list-style-type: none"> - one uncovered pan of dessert; and - one container of opened lemon meringue pie. <p>e. In the Freezer 2, the following was observed not labeled per the facility policy:</p> <ul style="list-style-type: none"> - two containers of Thrifty ice cream. <p>The [NAME] verified the above findings.</p> <p>2. Review of the facility's P&P titled Food from Outside Sources revised ,d+[DATE] showed perishable food should be sealed and dated with a use-by date and placed in refrigeration.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 0852 hours, an observation of Refrigerator 3 was conducted with the Activities Assistant. The following were observed:</p> <ul style="list-style-type: none"> - one container of whipped cream cheese spread, unlabeled and undated; - one container of veggie spread, unlabeled and undated; - one bottle of ranch dressing, unlabeled and undated; - one container with a croissant sandwich, unlabeled and undated; - one container with a bagel with spread, labeled with resident's name, however, undated; - a bag of tomatoes, labeled with the resident's name and dated ,d+[DATE]; - two disposable cups filled with food, unlabeled and undated; - one Silk soy milk carton, expired on [DATE], unlabeled; - two opened tubs of ice cream, unlabeled and undated; and - a bag of tamales, labeled with resident's name, however, the bag was undated. <p>The Activities Assistant verified the above findings. The Activities Assistant stated the food items should be dated and have the resident's name on it and would be thrown out after three days.</p> <p>On [DATE] at 1542 hours, an interview was conducted with the CDM. The CDM was asked how often the resident refrigerators were checked and cleared out. The CDM stated the dietary staff would do the refrigerator checks daily.</p> <p>On [DATE] at 1308 hours, the CDM, Food and Nutrition Manager, and Chef de Cuisine were informed and acknowledged the above findings.</p> <p>3. According to the USDA Food Code 2022, Section ,d+[DATE].11, foods should be stored six inches above the floor.</p> <p>On [DATE] at 0802 hours, an initial tour was conducted in the kitchen with the Cook. In Freezer 1, a box of salmon filets was observed on the floor with another box of chicken pot pie stacked on top of it. Additionally, a box of petite peas was observed on the floor with boxes of ice cream cups, chicken wing sections, and deep dish pie shells observed stacked on top of it. The [NAME] verified the findings.</p> <p>4. According to the USDA Food Code 2022, ,d+[DATE].11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils, the food- contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the USDA Food Code 2022, ,d+[DATE].13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.</p> <p>On [DATE] at 0802 hours, an initial tour was conducted in the kitchen with the Cook, the following were observed:</p> <ul style="list-style-type: none"> a. The can opener was observed with black and yellow substance on the blade. b. The base of the blender was observed with brown dried residues. c. There was a brown substance observed on the inside top and a white residue on the walls of the microwave. d. The oven door and inside base were observed with dried brown and white substances. e. The plate lowerator was observed with plates. The plate lowerator was observed with a brownish and yellow substance on the bottom warming plate. <p>The [NAME] verified the above findings.</p> <p>On [DATE] at 1308 hours, the CDM, Food and Nutrition Manager, and Chef de Cuisine were informed and acknowledged the above findings. The CDM stated they got a new can opener and cleaned the above mentioned.</p> <p>5. According to the USDA Food Code 2022, ,d+[DATE].11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation, food shall be protected from cross contamination by separating raw animal foods during storage, preparation, holding and display from cooked ready-to-eat food.</p> <p>On [DATE] at 0802 hours, an initial tour was conducted in the kitchen with the Cook. In Refrigerator 1, there was a container of the egg salad labeled ,d+[DATE] stored on top of an unopened box of lamb loin chops and next to a box of sliced bacon. There was a box containing roasted bacon on the shelf above. The [NAME] stated the egg salad should not have been stored on the shelf because the shelf was only used to store meats.</p>

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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 three of five 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>Review of the facility's P&P titled Health Center Trash Removal dated 1/2015 showed the environmental services staff is responsible for all trash removal from the health center. When trash is transferred, it must be moved in trash bins that are covered. This is for infection control reasons.</p> <p>On 12/3/24 at 0920 hours, an observation and concurrent interview was conducted with the Maintenance Director. Three garbage dumpsters located outside of the facility were observed with trash overfilled, causing the lids to not be able to fully close.</p> <p>On 12/3/24 at 0925 hours, an interview was conducted with the EVS Director. The EVS Director stated the garbage dumpster lids should always be covered. The EVS Director was informed and acknowledged the above findings.</p> <p>On 12/4/24 at 1308 hours, the CDM, Food and Nutrition Manager, and Chef de Cuisine were informed and acknowledged the above findings.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure one of 17 final sampled residents (Resident 30) had accurate and complete medical record.</p> <p>* The facility also failed to ensure the monitoring of behavior for the psychotropic medication on Resident 2's MAR was completed. This failure had the potential for the resident's care needs not being met as the medical record was incomplete and inaccurate.</p> <p>Findings:</p> <p>Medical record review of Resident 30 was initiated on 12/2/24. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 30's Order Summary Report dated 12/3/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 3/26/24, to monitor behavior for poor meal intake (less than 50 percent) for Remeron (antidepressant medication). - dated 8/2/23, to monitor behavior for verbalization of feeling anxious every shift for buspirone (antidepressant medication). - dated 6/25/24, to monitor behavior of anxiety manifested by biting nails and scratching for Ativan (antianxiety medication) every shift. - dated 10/10/24, to monitor behavior for hyperventilation for lorazepam (Ativan) every shift. <p>Review of Resident 30's behavior monitoring for anxiety manifested by biting nails and scratching at skin every shift for Ativan showed the following missing documentation in Resident 30's MAR:</p> <ul style="list-style-type: none"> - On 10/12 (night shift), 10/19 (night shift), 10/24 (evening shift), 10/25 (morning shift), and 10/26/24 (night shift). - On 11/4 (night shift), 11/9 (night shift), 11/21 (evening shift), 11/22 (night shift), and 11/29/24 (night shift). <p>Review of Resident 30's behavior monitoring for hyperventilation every shift for lorazepam showed the following missing documentation in Resident 30's MAR:</p> <ul style="list-style-type: none"> - On 10/12 (night shift), 10/19 (night shift), 10/24 (evening shift), 10/25 (morning shift), and 10/26/24 (night shift). - On 11/4 (night shift), 11/9 (night shift), 11/21 (evening shift), 11/22 (night shift), and 11/29/24 (night shift). <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 30's behavior monitoring for the resident's poor meal intake (less than 50 percent) every shift showed the following missing documentation in Resident 30's MAR:</p> <ul style="list-style-type: none"> - On 10/19 at 1800 hours, 10/24 at 1800 hours, 10/25 at 0900 hours, 10/25 at 1300 hours, 10/27 at 0900 hours, and 10/27/24 at 13:00 hours. - On 11/7 at 0900 hours, 11/7 at 1300 hours, 11/12 at 1300 hours, and 11/21/24 at 1800 hours. <p>Review of Resident 30's behavior monitoring for verbalization of feeling anxious every shift for buspirone showed the following missing documentation in Resident 30's MAR:</p> <ul style="list-style-type: none"> - On 10/12 (night shift), 10/19 (night shift), 10/24 (evening shift), 10/25 (morning shift), and 10/26/24 (night shift). - On 11/4 (night shift), 11/9 (night shift), 11/21 (evening shift), 11/22 (night shift), and 11/29/24 (night shift). <p>On 12/4/24 at 1025 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated the nursing staff should have completed the documentation if they were monitoring Resident 30's above behaviors. The MDS Coordinator stated if the nursing staff were unable to do so, the reason would be documented in the progress notes. The MDS Coordinator verified the findings.</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** 32179</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the safe and sanitary environment to help prevent the development and transmission of infections to two of 17 final sample residents (Residents 26 and 31) and one nonsampled resident (Resident 2) when:</p> <ul style="list-style-type: none"> * The facility failed to ensure LVN 3 donned the appropriate PPE when administering medications through the GT tube for Resident 26 who was on the EBP precautions. In addition, Resident 26's isolation cart was touching the trash inside the resident's room. *The facility failed to ensure LVN 2 donned the appropriate PPE when administering medications to one nonsampled resident (Resident 2) on the EBP precautions. * A stack of incontinence briefs was observed on top of the isolation cart inside the Room A. In addition, the isolation cart was observed touching the trash bin. * Resident 31's incontinence briefs were stored on the floor at the right side of the bed. In addition, the isolation cart inside Room B was touching the trash bin. <p>These failures posed a risk of transmitting disease-causing microorganisms.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Enhanced Standard Precautions (ESP) Guidelines dated 1/24/24, showed Enhanced Standard Precaution primary includes the expansion of barriers such as gowns and gloves for specific high contact care activities, based on the resident's characteristics that are associated with a high [NAME] of Multi-drug Resistant Organism (MDRO) colonization and transmission , the following might be considered for implementation of ESP: Presence of indwelling devices (e.g urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters), wound presence of pressure injury, functional disability and total dependence on others for assistance with activities of daily living.</p> <p>Medical record review of Resident 26 was initiated on 12/2/24. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 26's Order Summary Report dated 12/3/24, showed a physician's order dated 5/16/24, for the enhanced precautions due to the presence of a gastrostomy tube.</p> <p>On 12/3/24 at 0805 hours, LVN 3 was observed taking Resident 26's blood pressure and pulse using a stethoscope without donning an isolation gown. In addition, the isolation cart for the enhanced precautions was inside the room, was touching the trash.</p> <p>On 12/3/24 at 0850 hours, LVN 3 was observed checking the GT placement and residual, and administering Resident 26's medication through the GT tube. LVN 3 was observed without an isolation gown.</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 12/3/24 at 0910 hours, LVN 3 was observed administering two types of eye medications to Resident 26 and did not don an isolation gown.</p> <p>On 12/3/24 at 0920 hours, LVN 3 was observed suctioning Resident 26 and then administering ipratropium albuterol (medication to help open up breathing airways) solution through a nebulizer mask. LVN 3 did not don an isolation gown.</p> <p>On 12/3/24 at 1000 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 acknowledged she was not aware Resident 26 was on enhanced barrier precautions. LVN 3 was informed she was observed not donning on an isolation gown when she took Resident 26's blood pressure and pulse, suctioned the resident, checked the GT placement and residual, and administered Resident 26's medication through the GT tube. LVN 3 was also informed the isolation cart was touching the trash bin. LVN 3 acknowledged and verified these findings</p> <p>2. Medical Record review of Resident 2 was initiated on 12/2/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's Order Summary Report dated 12/3/24, showed a physician's order for the enhanced precautions due to a wound.</p> <p>On 12/4/24 at 0900 hours, LVN 2 was observed giving Resident 2 water and administering the medication without donning on an isolation gown. The isolation cart for the enhanced precautions was inside the resident's room.</p> <p>On 12/4/24 at 0930 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated she was not aware Resident 2 was on enhanced barrier precautions. LVN 2 acknowledged Resident 2 required enhanced barrier precautions for a wound and verified the above findings.</p> <p>3. Medical record review for Resident 36 was initiated on 12/2/24. Resident 36 was admitted to the facility on [DATE].</p> <p>On 12/2/24 at 0800 hours, a stack of incontinence briefs were stored on top of the isolation cart inside Room A. In addition, the isolation cart was observed touching the trash bin.</p> <p>On 12/2/24 at 0900 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 acknowledged the incontinence briefs should not be stored on top of the isolation cart and the isolation cart should not be touching the trash bin as it had the potential to spread infection. LVN 1 verified the findings.</p> <p>4. Medical record review of Resident 31 was initiated on 12/2/24. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 31's Order Summary Report dated 12/3/24, showed a physician's order dated 9/20/24, for the enhanced based precautions due to the indwelling urinary Foley catheter (flexible tube used to drain uring from the bladder into a collection bag) use.</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 12/2/24 at 0805 hours, two stacks of Resident 31's incontinence briefs were stored on the floor next to the right side of Resident 31's bed. In addition, the isolation cart was observed touching the trash bin.</p> <p>On 12/2/24 at 0920 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 acknowledged the incontinence briefs should not be stored on the floor and the isolation cart should not be touching the trash bin as it had the potential to spread infection. LVN 1 verified the findings.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure four of five final sampled residents (Residents 12, 21, 25, and 507) and one nonsampled resident (Resident 24) reviewed for immunizations were educated and offered the influenza and pneumococcal vaccinations as evidenced by:</p> <p>* The facility failed to offer the educational materials for the risks and benefits for the pneumococcal and influenza vaccines to Residents 12, 21, 24, 25, and 507 as per the facility's P&P. In addition, the facility failed to indicate which pneumococcal vaccine was offered for Residents 12, 21, 24, 25, and 507. These failures put the residents at risk for infection and transmission of pneumococcal and influenza infections.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Pnemococcal Vaccine Guidelines dated 1/3/24, showed all the residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine.</p> <p>Review of the facility's P&P titled Influenza Vaccine Guidelines dated 1/3/24, showed all the residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents or residents' representatives. Prior to the vaccination the resident or resident's legal representative will be provided information and education regarding the benefits and potential side effects of the influenza vaccine.</p> <p>1. Medical record review for Resident 12 was initiated on 12/2/24. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident 12's medical record failed to show the following was offered to the resident:</p> <ul style="list-style-type: none"> - the educational materials of the risks and benefits for the pneumococcal and influenza vaccines; and - the type of pneumococcal vaccine offered. <p>2. Medical record review for Resident 21 was initiated on 12/2/24. Resident 21 was admitted to the facility on [DATE], and readmitted to the facility on [DATE].</p> <p>Review of Resident 21's medical record failed to show the following was offered to the resident:</p> <ul style="list-style-type: none"> - the educational materials of the risks and benefits for the pneumococcal and influenza vaccines; and <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- the type of pneumococcal vaccine offered.</p> <p>3. Medical record review for Resident 24 was initiated on 12/2/24. Resident 24 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 24's medical record failed to show the following was offered to the resident:</p> <ul style="list-style-type: none"> - the educational materials of the risks and benefits for the pneumococcal and influenza vaccines; and - the type of pneumococcal vaccine offered. <p>4. Medical record review for Resident 25 was initiated on 12/2/24. Resident 25 was admitted to the facility on [DATE].</p> <p>Review of Resident 25's medical record failed to show the following was offered to the resident:</p> <ul style="list-style-type: none"> - the educational materials of the risks and benefits for the pneumococcal and influenza vaccines; and - the type of pneumococcal vaccine offered. <p>5. Medical record review for Resident 507 was initiated on 12/2/24. Resident 507 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 507's medical record failed to show the following was offered to the resident:</p> <ul style="list-style-type: none"> - the educational materials of the risks and benefits for the pneumococcal and influenza vaccines; and - the type of pneumococcal vaccine offered. <p>On 12/4/24 at 0923 hours, an interview and concurrent medical record review for Residents 12, 21, 24, 25, and 507 was conducted with the IP. The IP acknowledged and verified the above findings.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Park Vista at Morningside		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Brea Blvd. Fullerton, CA 92835	
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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>47476</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the essential kitchen equipment was maintained in safe operation condition when the ice machine manufacturer cleaning and sanitizing instructions were not followed for two of three ice machines (Ice Machines 1 and 2) in the facility. This failure had the potential to result in the equipment to not function in the way it was intended which could affect the health status of the residents.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Ice Machine revised 10/2018 under the section titled Frequency: Two Times per Year -Internal Components, showed per the Food Code, the internal components must be cleaned and sanitized per manufacturer guidelines, county or state regulations and not less than two times per year.</p> <p>Review of the ice machine instruction manual for the Hoshizaki ice machine undated, showed the appliance must be maintained in accordance with the instruction manual and labels provided. Failure to install, operate, and maintain the equipment in accordance with this manual will adversely affect safety, performance, component life, and warranty coverage.</p> <p>Under the section titled Maintenance Schedule, showed the following schedule for every six months:</p> <p>-Icemaker and ice storage bin: clean and sanitize per the cleaning and sanitizing instructions provided in this manual.</p> <p>-Dispense drain pan and gear motor drain pan: wipe down with a clean cloth and warm water. Slowly pour one cup of sanitizing solution (prepare as outlined in the sanitizing instructions in this manual) into the dispense drain pan and gear motor drain pan. Be careful not to overflow the dispense or gear motor drain pan. Repeat with a cup of clean water to rinse.</p> <p>Under the section titled Cleaning and Sanitizing Instructions, showed the following:</p> <p>-Cleaning solution: dilute 9.6 fluid ounces of Hoshizaki Scale Away with 1.6 gallons of warm water.</p> <p>-Sanitizing solution: dilute 0.82 fluid ounces of 5.25% sodium hypochlorite solution (chlorine bleach) with 1.6 gallons of warm water.</p> <p>-Cleaning and sanitizing procedures for the icemaker and ice storage bin and the dispense drain pan and gear motor drain pan.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/3/24 at 0911 hours, an observation of Ice Machines 1 and 2 and concurrent interview was conducted with the Maintenance Director. The Maintenance Director stated Ice Machine 1 was eight months old and Ice Machine 2 was one year old. The Maintenance Director was asked about the cleaning procedures for the two ice machines. The Maintenance Director stated Ice Machines 1 and 2 were closed units and did not use any chemicals in the ice machines. The Maintenance Director stated the facility cleaned the filters weekly and cleaned the inside every three months. The Maintenance Director verified he did not clean the icemaker or ice storage bin for Ice Machines 1 and 2. There was an orange residue observed on Ice Machine 2's ice machine spout. The Maintenance Director verified the finding and stated he would put it on their system to be cleaned once a week.</p> <p>On 12/3/24 at 0943 hours, a concurrent interview and facility document review was conducted with the Maintenance Director. The Maintenance Director verified Ice Machines 1 and 2 were not cleaned per the manufacturer's guidelines.</p> <p>On 12/4/24 at 1308 hours, the CDM, Food and Nutrition Manager, and Chef de Cuisine were informed and acknowledged the above findings.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete; and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of bed side rails for three of three final sampled residents (Residents 507, 30, and 38) reviewed for the entrapment risk. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.</p> <p>Findings:</p> <p>According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are:</p> <ul style="list-style-type: none"> - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. <p>Review of the facility's P&P titled Proper Use of Side Rails Guidelines revised 7/10/19, showed the purposes of the guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit use of side rails as restraints unless necessary to treat a resident's medical symptoms. An assessment will be made by the IDT to determine the resident's symptoms, risk of entrapment and reason for using the side rails. When side rail use is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment.</p> <p>1. On 12/2/24 at 0921 hours, Resident 507's bed was observed with bilateral one-fourth side rails elevated. Resident 507 stated she used the side rails to reposition herself while in bed.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review for Resident 507 was initiated on 12/2/24. Resident 507 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 507's H&P examination dated 11/28/24, showed Resident 507 had the capacity to understand and make decisions.</p> <p>Review of 507's Order Summary Report dated 12/2/24, showed a physician's order dated 12/2/24, for high/low bed with one-fourth side rails as enabler for turning and repositioning.</p> <p>Review of Resident 507's Entrapment Risk Evaluation dated 12/2/24, showed the IDT determined the bilateral one-fourth siderails were indicated to serve as an enabler to promote independence and safety concerns both general and unique to Resident 507.</p> <p>Review of Resident 507's Bed System Measurement Device Test Results Worksheet dated 12/2/24, showed Zones 2, 3, and 4 were checked and P was circled for Pass. However, the worksheet did not show if Zones 1, 5, 6, and 7 were assessed for the entrapment risk.</p> <p>2. On 12/2/24 at 0938 hours, Resident 30's bed was observed with bilateral one-fourth side rails elevated.</p> <p>Medical record review for Resident 30 was initiated on 12/2/24. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 30's H&P examination dated 11/18/24, showed Resident 30 had no capacity to understand and make decisions.</p> <p>Review of 30's Order Summary Report dated 12/2/24, showed a physician's order dated 12/2/24, for high/low bed with one-fourth side rails as enabler for turning and repositioning.</p> <p>Review of Resident 30's Entrapment Risk Evaluation dated 11/23/24, showed the IDT determined the bilateral one-fourth siderails were indicated to serve as an enabler to promote independence and safety concerns both general and unique to Resident 38 had been considered.</p> <p>Review of Resident 30's Bed System Measurement Device Test Results Worksheet dated 2/21/23, showed Zones 2, 3, and 4 were checked and P was circled for Pass. However, the worksheet did not show if Zones 1, 5, 6, and 7 were assessed for the entrapment risk.</p> <p>On 12/4/24 at 1054 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director verified he only assessed for the entrapment Zones 2, 3, and 4 and did not assess for Zones 1, 5, 6, and 7.</p> <p>47476</p> <p>3. On 12/2/24 at 1028 hours, Resident 38's bed was observed with bilateral one-fourth side rails elevated. Resident 38 stated she held onto the side rails when she turned while in bed.</p> <p>Medical record review for Resident 38 was initiated on 12/2/24. Resident 38 was readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 38's H&P examination dated 4/30/24, showed Resident 38 had the capacity to understand and make decisions.</p> <p>Review of Resident 38's Order Summary Report dated 12/2/24, showed a physician's order dated 12/2/24, for high/low bariatric bed with one-fourth side rails as enabler for turning and repositioning.</p> <p>Review of Resident 38's Entrapment Risk Evaluation for Bedrails dated 12/2/24, showed the IDT determined the bilateral one-fourth siderails were indicated to serve as an enabler to promote independence and safety concerns both general and unique to Resident 38 had been considered.</p> <p>Review of Resident 38's Bed System Measurement Device Test Results Worksheet dated 11/1/24, showed Zones 2 and 3 were checked and P was circled for Pass. However, the worksheet did not show if Zones 1, 4, 6, and 7 were assessed for the entrapment risk.</p> <p>On 12/4/24 at 1413 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated he checked the beds daily and when it was reported a bed was not working. The Maintenance Director verified he measured the beds for safety. The Maintenance Director reviewed Resident 38's Bed System Measurement Device Test Results Worksheet. The Maintenance Director verified he only assessed for the entrapment Zones 2 and 3 and did not assess for Zones 1, 4, 6, and 7.</p> <p>On 12/4/24 at 1530 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 38 needed two people to assist her with mobility and she would grab the side rails when the resident turned in bed.</p> <p>On 12/5/24 at 1116 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.</p>