

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555709	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Chapman Global Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 East Chapman Avenue Orange, CA 92869	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide necessary care and services to ensure the residents maintained their highest physical well-being for five of five sampled residents (Residents 1, 2, 3, 4, and 5). * Resident 1 had fracture of the right upper arm. There was no monitoring for pain, redness, swelling and warmth of extremities. * The facility failed to follow the physician's order for PT and OT treatment for Resident 1 and OT treatment for Resident 4. * The facility failed to follow the physician's order for daily RNA services for Residents 1, 2, 3, and 5. These failures had the potential for delayed medical interventions and could negatively impact the residents well-being. Findings: 1. Medical record review for Resident 1 was initiated on 10/1/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed a BIMS score of 00 (severe cognitive impairment). Review of Resident 1's Care Plans initiated 7/28/25, showed the following:- risk for pain, redness, swelling and warmth of extremity/ies; interventions included monitoring for pain, warmth, redness and swelling of affected extremity/ies, document and report to MD any signs and symptoms of pain, warmth and redness.- risk for fracture/spontaneous fracture; interventions included monitoring for signs and symptoms of fracture and notify MD as soon as possible. Also to monitor signs and symptoms of pain and discomfort and refer to MD.- risk for pain/altered comfort; interventions included assessment for non-verbal signs and symptoms of pain: grimaces, irritability, crying and posturing. Review of Resident 1's PT/OT Treatment record dated 9/16/25, showed the resident was grimacing when there was repositioning of the head/body/bilateral lower extremities. Review of Resident 1's medical record failed to show documented evidence the PT had reported the resident with grimacing during the repositioning. Review of Resident 1's Flowsheets - All Others dated 9/17/25, failed to show documentation of the following: - no documentation of the limited range of motion in upper and lower extremity joints and for no joint tenderness/swelling under the Musculoskeletal Assessment - no CNA documentation for the 0700 to 1730 hours shift. Further review of Resident 1's Flowsheets - All Others dated 9/17/25, showed RN 3 was notified Resident 1's right arm was swollen, warm to touch, and with bruises at 2130 hours. Resident 1 was unable to move arm, and nodded when asked if there was pain when the right arm was touched. Review of Resident 1's x-ray report for the right shoulder dated 9/17/25, showed a fractured humerus. On 10/2/25 at 1244 hours, a telephone interview was conducted with LVN 4. LVN 4 stated Resident 1 was not checked for signs and symptoms of swelling or redness. Furthermore, LVN 4 stated a head-to-toe assessment was not completed. Resident 1 looked fine. On 10/3/25 at 0919 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the RNs should monitor the residents every four hours, the LVNs every two hours, as well as the CNAs. Skin monitoring should be included. The DON verified there was no CNA documentation for the 0700 to 0730 hours on 9/17/25. Furthermore, the DON verified there was no documentation to show the PT had reported the resident had grimacing during the treatment on 9/16/25. On 10/3/25 at 1646 hours, a telephone interview was conducted with LVN 2. LVN 2 stated Resident 1 was uncomfortable when the right arm was touched. The swelling and bruise would not be visible unless the sleeves of the hospital gown was pulled up. 2. a. Medical record review for Resident 1 was initiated on 10/1/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the following orders: - dated 8/20/25, for PT treatment once a day for two days per week times two weeks for therapeutic activity, functional mobility, neuromuscular (network of nerves and muscles) re-education, therapeutic exercise and patient/family education.- dated 8/26/25, for OT to continue treatment two times a week for four weeks for ADL retraining, functional mobility for ADLs, neuromuscular re-education, therapeutic activities, therapeutic exercise for ADLs, resident/family education. Review of Resident 1's PT/OT Treatment Record for August to September 2025 showed only one PT treatment for the week 8/25 to 8/29/25, and no PT treatment for the week 9/1 to 9/5/25. Further review of the document failed to show Resident 1 had OT treatment from 9/1 to 9/16/25. b. Medical record review for Resident 4 was initiated on 10/2/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed a BIMS score of 2 (severe cognitive impairment). Review of Resident 4's Order Summary Report showed an order dated 8/5/25, for OT to continue one time a week for four weeks for ADL retraining, functional mobility for ADLs, neuromuscular re-education, patient/family education, therapeutic activities and therapeutic exercise for ADLs. Review of Resident 4's medical record failed to show documentation Resident 4 had OT treatment for the week 9/1 to</p>		