STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555709	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Global Medical Center D/P Snf	2601 East Chapman Avenue Orange, CA 92869

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the resident's protected health information was utilized in a confidential manner for one of 12 final sampled residents (Resident 10). * Resident 10's protected health information was displayed on a staff computer screen located in the residents' hallway. The facility staff left the computer unattended on two occasions, while Resident 10's protected health information was displayed. This failure had the potential to violate the resident's right to protected health information privacy. Findings: Review of the facility's P&P titled Confidentiality of Medical Records revised 12/2022 showed the information contained within the medical record belongs to the resident and will be kept confidential. Employees and medical staff are expected to exercise due care in any discussion, use, or disclosure of the protected health information. Medical record review for Resident 10 was initiated on 2/10/25. Resident 10 was admitted to the facility on [DATE]. On 2/12/25 at 1520 hours, a computer was observed in the hallway adjacent to the residents' rooms. The computer screen displayed Resident 10's personal health information which included the resident's name and scheduled medications. The hallway was utilized by the residents' family members and visitors. On 2/12/25 at 1525 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 was observed in the nursing station and asked to come to the residents' hallway to observe the unattended staff computer. LVN 2 verified the staff computer located in the residents' hallway was unattended and displayed Resident 10's personal health information. LVN 2 stated this computer was utilized by the Respiratory Therapist. LVN 2 stated when the Respiratory Therapist left the computer unattended, he should have either logged out of the computer or utilized the paper attached to the computer screen (which functioned to cover the computer screen when staff were not present) to ensure Resident 10's personal health information confidentiality. (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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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	On 2/12/25 at 1549 hours, a follow-up observation and concurrent interview was conducted with LVN 2. The same computer in the hallway adjacent to the residents' rooms was again observed unattended, and the computer screen was observed with Resident 10's personal health information displayed (Resident 10's name and scheduled medications). LVN 2 verified the findings.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37726 Based on observation and interview, the facility failed to maintain a homelike environment for four of 12 final sampled residents (Residents 10, 14, 18, and 23). * Resident 23 resided in Room A and Residents 10, 14, and 18 resided in Room B. The walls behind the residents' beds were observed in disrepair as evidenced by holes, scratches, unfinished patchwork, and/or peeled paint. This failure had the potential to negatively impact the residents' well-being. Findings: On 2/13/25 at 1438 hours, an observation was conducted of Resident 23. Resident 23 was observed lying in his bed in Room A. The wall behind Resident 23's bed was observed with a hole, scratches, and unfinished patch work. On 2/13/25 at 1440 hours, an observation was conducted of Room B. Residents 10, 14, and 18 resided in Room B. The residents were observed lying in their beds. The wall behind the residents' beds was observed in disrepair as evidenced by holes, scratches, unfinished patchwork, and peeled paint. The residents who resided in Rooms A and B were not interviewable, as the residents were cognitively impaired. On 2/13/25 at 1519 hours, an interview was conducted with the CNO. The CNO was shown the photos of the walls with holes, scratches, unfinished patchwork, and/or peeled paint behind Residents 10, 14, 18, and 23's beds. The CNO verified the findings and acknowleged Rooms A and B needed to be repaired.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to promote healing of the pressure injuries for one of two final sampled residents (Resident 18) reviewed for pressure injuries. * The facility failed to ensure Resident 18's air mattress was set at the alternate mode (setting where mattress inflates and deflates with air cyclically to redistribute pressure on the body) as ordered by the physician. This failure had the potential to inhibit the pressure injury healing. Findings: Medical record review for Resident 18 was initiated on 2/10/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Interventional Wound Care Management Progress Note dated 2/5/25, showed Resident 18 had several wounds which included a Stage 3 pressure injury to the sacrum and Stage 4 pressure injuries to the left and right hips and right ankle. On 2/12/25 at 0830 hours, an observation and concurrent interview was conducted with LVN 4. Resident 18 was observed lying on an air mattress. The air mattress was observed with a setting of the static mode (setting where the mattress remains inflated with air at a constant pressure). LVN 4 was asked if the static mode setting was the correct setting for Resident 18's air mattress. LVN 4 stated yes, the static mode setting for Resident 18's air mattress was the correct setting. On 2/12/25 at 1236 hours, a follow-up interview and concurrent medical record review was conducted with LVN 4. Review of Resident 18's physician's order dated 2/13/24, for an air mattress to be set at the alternate mode with a cycle of five minutes. LVN 4 verified Resident 18's physician had ordered for Resident 18's air mattress to be set at the alternate mode and not the static mode.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, facility document review, and facility P&P review, the facility failed to ensure two of two final sampled residents (Residents 9 and 11) reviewed for RNA services received the RNA services as ordered. * The facility failed to ensure Residents 9 and 11 received the RNA services daily as ordered by the physician. This failure had the potential for the residents to have a decline in ROM function, which could lead to worsening of contractures or muscle weakness. Findings: Review of the facility's P&P titled Restorative Nursing Program revised 11/2021 showed for the RNA to ensure that all the residents are assessed on admission and ongoing for their restorative/rehabilitative needs and abilities. All the residents will be assessed by rehabilitative services within 48 hours of admission and ongoing for their restorative/rehabilitative needs and abilities. A plan of care will be developed specifically designed to promote and improve functional levels and enhance the quality of life. The RNA program is provided seven days a week based on the resident's individual needs and delivered per the physician order. The P&P further showed the RNA will carry out the treatment programs per the physician order and to document daily in the Restorative Nursing Documentation Record and complete a weekly summary for each of the resident in the program. 1. Medical record review for Resident 9 was initiated on 2/11/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 11/4/24, showed Resident 9 had history of contractures and quadriplegia. Review of Resident 9's Care Plan titled ADLs Functional Status/Rehabilitation Potential dated 3/27/12, showed Resident 9 was limited in physical mobility related to the risk for decline with the ROM related to contractures and risk for further decline and limitation with BUE/BLE. The care plan interventions included to provide assistance for repositioning/transferring, bed mobility, and locomotion and RNA as ordered. Review of Resident 9's Patient Orders for February 2025 showed a physician's orders dated 5/17/23, for RNA to do the following: - to apply the right and left elbow extension splints after ROM exercises for four hours daily for seven days, and skin check as needed; - to provide passive ROM exercises to all four extremities daily; - to apply bilateral PRAFOs after ROM exercises times four hours daily; and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- to apply right and left WHFOs after PROM exercises for four hours daily, and skin check as needed. Review of Resident 9's RNA Flowsheet for February 2025 showed no documented evidence the RNA services were provided as ordered by the physician on 2/1, 2/2, and 2/5/25. 2. Medical record review for Resident 11 was initiated on 2/11/25. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's H&P examination dated 9/16/24, showed Resident 11 had history of contractures and quadriplegia. The H&P examination further showed the plan for Resident 11 included the ROM exercises. Review of Resident 11's Care Plan titled Respiratory dated 12/8/15, showed an approach included ROM exercises on all extremities during the care and activities. Review of Resident 11's Care Plan titled Alteration in Cardiac Function dated 12/8/25, showed to provide assistance for repositioning/transferring, bed mobility, and locomotion. Review of Resident 11's Patient Orders for February 2025, showed a physician's orders dated 5/17/23, for RNA to do the following: - to apply the bilateral PRAFOs/ankle contracture boots to bilateral ankles for two hours on, and one hour off daily, and monitor for redness; - to apply the bilateral knee extension brace daily for four hours after the ROM exercises and check skin for breakdown; - to provide PROM exercises of the bilateral upper and lower extremities once daily, seven days per week; and - to place a hand/towel rolls in bilateral hands after ROM exercises and self care when resting; and may remove for ADL care. Review of Resident 11's RNA Flowsheet for February 2025 showed no documented evidence the RNA services were provided as ordered by the physician on 2/1, 2/2, 2/4, 2/5, and 2/8/25. On 2/13/25 at 1038 hours, a concurrent interview and medical record review was conducted with RNA 1. RNA 1 stated Residents 9 and 11 required total care, including staff assistance with turning, repositioning, and cleaning. RNA 1 verified the above missing RNA documentations for Residents 9 and 11. RNA 1 stated the RNAs were supposed to sign off on the RNA Flowsheet when the RNA services were completed. RNA 1 stated not performing the RNA services as ordered by the physician could lead to resident's extremity contractures and stiffness. RNA 1 further stated the RNA services would help prevent resident's extremity contractures and stiffness from occurring. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 1052 hours, a concurrent interview and record review was conducted with RN 1. RN 1 verified the above findings for Residents 9 and 11. RN 1 stated the signatures on the RNA Flowsheet indicated the RNA tasks were completed. RN 1 stated if the RNA did not sign the RNA Flowsheet, then it meant RNA services were not provided or the RNA forgot to sign. RN 1 further stated missing several days of RNA services could affect the residents' muscles and lead to contractures. On 2/13/25 at 1403 hours, a concurrent interview and record review was conducted with the CNO. The CNO verified Residents 9 and 11 had missing RNA signatures in the RNA Flow Sheets for February 2025. The CNO stated her expectations were for the RNAs to work on the RNA services as ordered to prevent the risk of further contractures.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for three of 12 final sampled residents (Residents 12, 13, and 21). * The facility failed to ensure the low air loss mattress pump of Residents 13 and 21 was placed in a safe area as per the manufacturer's recommendation. * The facility failed to implement the floor mats to both sides of Resident 12's bed for safety, in accordance with the physician's order. These failures put the residents at high risk of serious injury. Findings: Review of the facility's P&P titled Pressure Ulcer Prevention, Management Protocol and Treatment dated 10/2024 showed the residents will be assessed for pressure ulcer to prevent the occurrence and/or progression of a pressure ulcer. The interventions for prevention of pressure ulcer includes the use of pressure relief/low air loss mattress/egg crate/overlay. 1. Review of Resident 13's low air loss mattress user manual for Power Pro Elite Mattress System, (undated), showed the important safety warnings instructions to reduce the risk of injury to person included to avoid dropping or putting any heavy objects on the pump. The product installation guide showed to position the pump by its elastic hanger brackets over the footboard of the bed. On 2/10/25 at 1058 hours, and 2/11/25 at 1423 hours, Resident 13 was observed in bed on a low air loss mattress and the pump was observed on the floor under the bed. Medical record review for Resident 13 was initiated on 2/11/25. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Patient Orders showed a physician's order dated 2/13/24, to place an air mattress in bed for wound healing. Review of Resident 13's Plan of Care dated 6/3/21, showed a care plan problem was developed addressing Resident 13's risk of skin breakdown problem and pressure ulcer. The interventions included the use of low air loss mattress for skin management. On 2/11/25 at 1423 hours, an observation and concurrent interview for Resident 13 was conducted with LVN 1. LVN 1 was asked about Resident 13's low air loss mattress pump observed under the bed and on the floor. LVN 1 verified the low air loss pump was placed under the resident bed and stated the pump was not supposed to be under the bed. LVN 1 stated the low air loss pump should be placed and hanged on the footboard of the bed and should be off the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident 21's low air loss mattress operations/maintenance manual for [NAME] Air II Low Air Loss Therapy Mattress dated 5/2009 showed under the set-up guide, a caution to not place the control unit on the floor and should hang the control unit on the foot of the bed facing away from the bed. Failure to do so could result in a personal injury. On 2/10/25 at 0929 hours, and 2/11/25 at 0930 hours, Resident 21 was observed in bed on a low air loss mattress and the control unit was observed on the floor under the bed. Medical record review for Resident 21 was initiated on 2/11/25. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Patient Orders showed a physician's order dated 5/29/24, to place a low air loss mattress in bed for wound healing. Review of Resident 21's Plan of Care dated 5/30/24, showed a care plan problem was developed addressing Resident 21's risk of skin breakdown problem. The interventions included the use of pressure relieving mattress for skin management. On 2/11/25 at 1533 hours, an observation and concurrent interview for Resident 21 was conducted with RN 2. RN 2 was asked about Resident 21's low air loss mattress control unit observed under the bed and on the floor. RN 2 verified the low air loss control unit was placed under Resident 21's bed and stated the low air loss control unit hook did not fit the foot board of the bed and unable to hang where the machine was supposed to be. RN 2 acknowledged the low air loss control unit was placed under Resident 21's bed and it was not safe. On 2/13/25 at 1350 hours, an interview and concurrent medical record review for Residents 13 and 21 was conducted with the CNO. The CNO was informed of the findings and acknowledged the above findings. 37726 3. Medical record review for Resident 12 was initiated on 2/10/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's MDS dated [DATE], showed Resident 12 had severely impaired cognition and was dependent on staff for self-care and mobility. Review of Resident 12's Rounding Notes dated 6/7/23 at 0745 hours, showed Resident 12 sustained a fall in the facility. Review of Resident 12's physician's order dated 5/17/23, for floor mats to both sides of Resident 12's bed for safety. On 2/11/25 at 0935 hours, and 2/11/25 at 1045 hours, an observation was conducted of Resident 12. Resident 12 was observed lying in bed. Resident 12's bed was observed with a floor mat in place on one side of Resident 12's bed. The opposite side of Resident 12's bed was observed without a floor mat in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 1450 hours, an observation, interview, and concurrent medical record review was conducted with LVN 5. Resident 12 was observed lying in bed. Resident 12's bed was observed with a floor mat in place on one side of Resident 12's bed. The opposite side of Resident 12's bed was observed without a floor mat in place. LVN 5 verified the findings. LVN 5 stated Resident 12 was at risk for falls, and she would immediately implement the second fall mat, in accordance with the physician's order to have the floor mats to both sides of the bed for safety.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services for the use of GT were provided for two of 12 final sampled residents (Residents 3 and 13). * The facility failed to ensure Resident 3's HOB was elevated at a 30 degree angle or higher when Resident 3 was receiving the enteral feeding via GT. * The facility failed to ensure Resident 13's HOB was elevated at a 30 degree angle or higher when Resident 13 was receiving the enteral feeding via GT. These failures posed the risk for complications related to use of the GT for Residents 3 and 13. Findings: Review of the facility's P&P titled Enteral Feeding dated 10/2024 showed during the enteral feeding, keep the resident's head of the bed at a 30 to 45 degree angle as per the physician's order. 1. Medical record review for Resident 3 was initiated on 2/12/25. Resident 3 was admitted to the facility on [DATE]. On 2/10/25 at 0923 hours, and 2/12/25 at 0835 hours, Resident 3 was observed in bed with the head of the bed not elevated at a 30 degree angle or higher while the GT feeding was infusing. Review of Resident 3's MDS dated [DATE], showed Resident 3 had severe cognitive impairment, difficulty of swallowing, and on tube feeding. Review of Resident 3's Patient Orders showed the following physician's orders: - dated 5/22/23, to always elevate HOB at 30 to 45 degrees while feeding is administered and for one hour after the GT feeding. - dated 10/1/24, to administer Glucerna 1.2 (enteral feeding formula) via GT at 50 ml/hr. On 2/12/25 at 1101 hours, an observation and concurrent interview for Resident 3 was conducted with LVN 2 at bedside. LVN 2 verified the HOB for Residents 3 was not elevated at 30 degrees angle and the GT feeding was infusing. LVN 2 was asked on how she would determine if the head of bed was elevated properly as per the physician's order. LVN 2 stated there was a device on the bed to show the degree angle of the HOB elevation. LVN 2 verified Residents 3's bed had no device to determine the proper elevation of the HOB. LVN 2 verified Residents 3's HOB was not elevated at 30 degree angle and should have been elevated as per the physician's order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 1044 hours, an observation and concurrent interview for Resident 3 was conducted with CNA 1 at the resident's bedside. CNA 1 verified Resident 3 needed total assistance from the staff on all ADL care. CNA 1 verified the HOB was elevated for Resident 3. However, CNA 1 stated she did not know if the HOB was high enough for the resident. On 2/12/24 at 1423 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 2. RN 2 stated the resident's HOB should be elevated as per the physician's order or at least 30 degree angle to prevent aspiration. RN 2 verified Resident 3's physician's order to elevate the HOB 30 to 45 degrees angle while the enteral feeding was infusing. RN 2 was informed of the findings and stated all the nurses should ensure the HOB was elevated as per the physician's order. 2. Medical record review for Resident 13 was initiated on 2/11/25. Resident 13 was admitted to the facility on [DATE]. On 2/10/25 at 1058 hours, and 2/11/25 at 1423 hours, Resident 13 was observed in bed with the HOB not elevated at a 30 degree angle or higher while the GT feeding was infusing. Review of Resident 13's MDS dated [DATE], showed Resident 13 had difficulty of swallowing, and on tube feeding. Review of Resident 13's Patient Orders showed the following physician's order: - dated 11/26/24, to administer Glucerna Nepro (enteral feeding formula) via GT at 40 ml/hr. - dated 7/3/23, to always elevate the HOB at 30 to 45 degrees while feeding is administered and for one hour after the GT feeding. Review of Resident 13's Plan of Care showed a care plan problem was developed on 6/10/21, addressing Resident 13's risk of nutritional deficit. The interventions included for the HOB elevated 30 to 45 degrees while the GT feeding was administered. On 2/12/25 at 1044 hours, an observation and concurrent interview for Resident 13 was conducted with CNA 1 at bedside. CNA 1 verified Resident 13 needed total assistance from the nurses on all ADL care. CNA 1 verified the HOB was elevated for Resident 13. However, CNA 1 stated she did not know if the HOB was high enough for the resident. On 2/12/25 at 1348 hours, an interview and concurrent medical record review for Resident 13 was conducted with LVN 3. LVN 3 was asked about Resident 13's HOB. LVN 3 stated Resident 13's HOB was elevated at 15 degree angle. LVN 3 verified Resident 13's physician's order was to elevate the HOB at 30 to 45 degree angle. LVN 3 was asked how they would know if the HOB was elevated within the physician's order, LVN 3 stated she would base it on an observation the HOB position. LVN 3 was asked if there was a device on the bed that would measure the exact elevation of the HOB. LVN 3 verified and acknowledged there was no device on the bed to show the exact elevation of the HOB. LVN 3 stated the HOB should have been elevated to 30 degree angle to prevent aspiration of the resident. On 2/13/25 at 1345 hours, an interview and concurrent medical record review for Resident 3 and 13 was conducted with the CNO. The CNO was informed and acknowledged the above findings.

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Chapman Global Medical Center D/P Snf	2601 East Chapman Avenue Orange, CA 92869

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one of 12 final sampled residents (Resident 21). * The facility failed to obtain a physician's order for the care and maintenance of the IV access and develop a plan of care for Resident 21's IV access to the lower extremity. These failures had the potential to delay identification of intravenous access to lower extremity related complications for the resident. Findings: On 2/10/25 at 0929 hours, Resident 21 was observed in bed with an IVF infusing at 70 ml per hour via IV machine. Resident 21's IV access was unable to locate due to the cover in bed. Medical record review for Resident 21 was initiated on 2/11/25. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's MDS dated [DATE], showed Resident 21 had moderately impaired cognitive skills. On 2/11/25 at 1533 hours, an observation and concurrent interview was conducted with RN 2 at Resident 21's bedside. RN 2 was asked about Resident 21's IV access. RN 2 stated Resident 21's IV access was located on Resident 21's lower extremity. RN 2 showed Resident 21's IV access was on the right foot and the IV access was observed with a dry transparent dressing dated 2/10/25. RN 2 stated Resident 21 was on the IV for hydration due to the abnormal laboratory results. Review of Resident 21's physician's order dated 2/10/25, to start a peripheral IV line on the lower extremity due to the difficulty finding a good access on the upper extremities. Further review of the physician's order showed no documented evidence a physician order was obtained for the IV access assessment, dressing change, and how often the peripheral IV access site should be changed. Review of Resident 21's Plan of Care failed to show a care plan problem was developed to address Resident 21's use of the IV including the care and maintenance of the IV access site on Resident 21's lower extremities. On 2/12/25 at 1503 hours, a follow-up interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 21's physician's order for the IV access to the lower extremity due to the poor IV access on the upper extremities. RN 2 was asked for Resident 21's physician's order for the IV access assessment, dressing change, and how often the peripheral IV access site should be changed. RN 2 stated they changed the IV access every four days and they would call the physician to ask for the extension of the order. RN 2 verified there was no physician's order for the IV access assessment, dressing change, and how often the peripheral IV access site should be changed. Furthermore, RN 2 verified there was no care plan developed for Resident 21's IV use. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 1350 hours, an interview and concurrent medical record review was conducted with the CNO. The CNO was informed and verified the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to dispose the unused medication in accordance with the facility's P&P. * LVN 4 disposed Resident 18's unused half tablet fludrocortisone (corticosteroid medication) in a sharps container (container used for the disposal of sharp medical equipment) instead of the pharmaceutical waste container as per the facility's P&P. This failure posed the risk for improper management of pharmaceutical waste. Findings: Review of the facility's P&P titled Pharmaceutical Waste dated 10/2022 showed the pharmaceutical waste includes all the unusable medications. All unusable pharmaceutical waste shall be disposed of in the pharmaceutical waste containers (white with blue lids) including the partially used medications including tablets. Medical record review for Resident 18 was initiated on 2/10/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's the physician's order dated 10/25/23, showed an order to give fludrocortisone 0.05 mg daily via GT for hypotension (low blood pressure). On 2/12/25 at 0835 hours, a medication administration observation for Resident 18 was conducted with LVN 4. LVN 4 prepared and administered Resident 18's medications. During the medication administration observation for Resident 18, LVN 4 was observed disposing a portion of the fludrocortisone medication in the sharps container. LVN 4 stated she obtained a fludrocortisone 0.1 mg tablet from the facility's Pyxis. LVN 4 stated she cut the fludrocortisone 0.1 mg tablet in half and administered a half tablet (0.05 mg) of fludrocortisone to Resident 18. LVN 4 further stated she disposed of the unused half tablet of fludrocortisone in the sharps container attached to the medication cart.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Pharmacy Consultant's recommendations from the MRR were acted upon for one of five final sampled residents (Resident 13) reviewed for the unnecessary medications. * The Pharmacy Consultant's recommendation to discontinue the chlorhexidine (antiseptic medication) and perform a hemoglobin A1c level (a blood test that measures the average blood sugar level over the past two or three months) for Resident 13 were not acted upon. These failures had the potential to put the residents at risk for adverse consequences related to the medications. Findings: Review of the facility's P&P titled Skilled Nursing Facility - Drug Regimen Review dated 09/2022 showed the pharmacist review the drug regimen of the resident monthly and make appropriate recommendations. The pharmacist will report in writing the irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the administrator and to the director of nursing services. The identified irregularity from the review should change request to residents' drug regimen should be conducted in a timely manner. Medication order recommendations or actions in response to the irregularities should be performed, unless specified otherwise or sooner if deemed clinically significant. Medical record review for Resident 13 was initiated on 2/11/25. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's MRR dated 12/31/24, showed the pharmacist's recommendation to discontinue the chlorhexidine medication for the medication was not recommended for the residents on a ventilator. Another pharmacist's recommendation dated 1/28/25, showed to draw a hemoglobin A1c level with the next laboratory test. The MRR was signed by the physician; however, there was no response from the physician if the pharmacist's recommendations were approved or not. Review of Resident 13's physician's order dated 3/28/24, to administer chlorhexidine 0.12 % 10 ml oral rinse twice a day. The medication was an active order and had not been discontinued. Further review of the physician's order failed to show documented evidence the laboratory order for hemoglobin A1c level was obtained from the physician. On 2/13/25 at 0959 hours, an interview and concurrent medical record review was conducted with the Director of Pharmacy. The Director of Pharmacy verified the MRR for Resident 13. The Director of Pharmacy stated the physician did not want the chlorhexidine medication to be discontinued and the physician should put the reason as to why the medication should not be discontinued. The Director of Pharmacy verified the recommendation for Resident 13's laboratory of hemoglobin A1c level was due to the diagnosis of diabetes. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 1031 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated when they received the MRR from the pharmacist, they would inform the physician and follow up for any orders. RN 1 was informed of the MRR of Resident 13 with recommendations from the pharmacist. RN 1 reviewed Resident 13's MRR and verified the charge nurses failed to follow up with the physician about Resident 13's MMR recommendations from the pharmacist. On 2/13/25 at 1340 hours, an interview and concurrent medical record review for Resident 13 was conducted with the CNO. The CNO was informed and verified the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8%. * The facility failed to administer Resident 18's lactulose (laxative) and clonidine (antihypertensive) medications as ordered by the physician. These failures had the potential to negatively affect the resident's health. Findings: Review of the facility's P&P titled Medication Administration revised 7/2013 showed prior to administering a medication, the healthcare professional shall: verify that the medication selected for the administration is correct based on the medication order and product label. Review of the facility's P&P titled Medication Administration Schedule revised 5/2023 showed a scheduled medication maybe administered 30 minutes before or after the scheduled time. Actual time of medication administration must be documented on the Medication Administration Record. Medical record review for Resident 18 was initiated on 2/10/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Patient Orders showed the folloiwng physician's orders: - dated 12/12/23, to administer lactulose 30 grams via GT daily (at 0900 hours) for elevated ammonia. - dated 9/11/24, to administer clonidine 0.3 mg/24 hours transdermal patch once a week on Wednesday (at 0900 hours) for muscle spasticity. On 2/12/25 at 0835 hours, a medication administration observation for Resident 18 was conducted with LVN 4. LVN 4 prepared and administered Resident 18's medications via GT which included the following: - Norco (narcotic pain medication) 5/325 mg one tablet; - Eliquis (a blood thinner medication) 5 mg one tablet; - levetiracetam (antiseizure medication) 500 mg two tablets; - folic acid (supplement) 1 mg one tablet; - Fludrocortisone Acetate (a medication used to reduce inflammation) 0.1 mg, half a tablet; - levalbuterol inhalation solution (breathing treatment) 1.25 mg/ml; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- ferrous sulfate oral solution (iron supplement) 300 mg/5 ml; - valproic acid oral solution (antiseizure medication) 250 mg/5 ml, administered 750 mg/15 ml; - lactulose solution 20 gm (30 ml); - Allegra (anti-allergy medication) 180 mg one tablet; and - chlorhexidine 0.12% oral rinse. During the medication administration for Resident 18, LVN 4 was observed having administered the lactulose solution 20 grams/30 ml medication via Resident 18's GT. Additionally, LVN 4 was not observed applying Resident 18's clonidine 0.3 mg/24 hours transdermal patch. On 2/12/25 at 1108 hours, after having administered Resident 18's scheduled medications, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 reviewed Resident 18's active medication orders. LVN 4 verified Resident 18's physician's order showed to administer lactulose 30 grams (45 mls) via GT daily for elevated ammonia. LVN 4 acknowledged she only administered 20 grams (30 ml) of lactulose instead of 30 grams as ordered by the physician to Resident 18. Additionally, LVN 4 verified she failed to administer (apply) Resident 18's clonidine 0.3 mg/24 hours transdermal patch as ordered by the physician, which was scheduled to be applied at 0900 hours.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48332 Based on observation, interview and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling and disposal of the medications for two of four medication carts (Medication Carts A and B). This failure posed the risk for the occurrence of errors in medication administration. Findings: Review of the facility's P&P titled Medication Storage and Security, Pharmacy Manual dated 9/2023, under the Policy section, showed all the medications shall be stored in appropriately segregated and secure conditions to minimize the potential for medication errors and theft or diversion. The external use medications in liquid, tablet, capsule, or powder form shall be segregated from the medications intended for internal use. The aerosol products shall be stored separately from other topical products. 1. On 2/11/25 at 1155 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 5. The following was observed: - inside the first drawer, one bottle of loperamide liquid (medication to treat loose bowel movement/diarrhea), one bottle of Carboxymethylcellulose 0.5% eye drops (medication used to relieve dry, irritated eyes), and one Albuterol Sulfate inhaler (medication that treats and prevent breathing problems like shortness of breath) were stored in one tray with no partition. - inside the second drawer, one vial of Insulin Lantus 100 units/ml (medication to treat high blood sugar level) and one bottle of Calcitonin Sodium Nasal spray (medication to treat bone loss sprayed thru the nose) were stored in one tray with no partition. LVN 5 verified the above findings and placed a separator on each medication. LVN 5 acknowledged the above medications should have been stored separately. 2. On 2/11/25 at 1205 hours, an observation of Medication Cart B and concurrent interview was conducted with LVN 6. The third drawer of the medication cart was observed with one vial of Insulin Lantus 100 units/ml and one bottle of Carboxymethylcellulose 0.5% eye drops stored in one tray with no partition. LVN 6 verified the above findings and stated the medications should have been stored separately with partitions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure the food preparation utensils and equipment were in good, sanitary, and cleanable working conditions. * The facility failed to ensure the staff's personal food items were not placed in the kitchen refrigerator. * The facility failed to ensure the kitchen staff wore hair restraint. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's census on 2/10/25, showed two of 23 residents received food prepared from the facility's kitchen. 1. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Sanitation reviewed 8/2024 showed to prevent food borne illness in patients and customers, separate cutting boards are provided for meat, fish, and poultry (red), and raw fruits and vegetables. Cooked foods must not be placed on the same cutting boards as raw foods. Cutting boards are cleaned and sanitized in between each use. On 2/11/25 at 0930 hours, during the initial tour, a concurrent observation and interview with the RD was conducted. The following was observed: - one spatula with brown discoloration and heavily worn, - two scoops with melted handles and heavily worn, and - three white cutting boards with heavily marred with black discoloration. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD verified the above findings. The RD stated the above kitchen equipment would need to be replaced. 2. On 2/11/25 at 0913 hours, a concurrent observation and interview with Dietary Aide 1 and the RD was conducted in front of the reach-in Refrigerator 2. A black container was noted with green food substance. Dietary Aide 1 verified the above item was her personal salad brought from home. Dietary Aide 1 stated she stored her personal food in the kitchen reach-in Refrigerator 2. The RD stated the staff's personal food items should not be kept in the kitchen refrigerator. 3. According to the USDA Food Code 2022, Section 2-402.11, Hair Restraints - Effectiveness showed consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. The food employees may contaminate their hands when they touch their hair. A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. The USDA Food Code 2022 further showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep hear from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Review of the facility's P&P titled Food Preparation/Production revised 8/2024 showed the hair nets, hats or caps must be worn, and beard guards where indicated, when working in the kitchen and dish room. On 2/12/25 at 0901 hours, a concurrent observation and interview with [NAME] 1 was conducted in the kitchen. [NAME] 1 was observed with sideburns and a mustache with no beard restraint. [NAME] 1 verified the findings and stated he would wear a beard restraint. The RD was present and verified the observation. The RD acknowledged the beard restraints should be worn in the kitchen. On 2/13/25 at 1325 hours, an interview with the RD and Dietary Supervisor was conducted. All of the above findings were acknowledged and verified. On 2/13/25 at 1403 hours, an interview with the CNO was conducted. The CNO verified the staff's personal food items should not be kept in the kitchen refrigerator. The CNO acknowledged all of the above findings.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the facility's garbage and refuse was properly disposed as evidence by: * The facility failed to ensure two of eight waste dumpsters were properly closed and not overfilled with trash. This failure had the potential to cause unsafe sanitary conditions and potential to harbor pests and rodents. Findings: According to the USDA Food Code 2022, Section 5-501.11 Storing Refuse, Recyclables, and Returnables showed refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. According to the USDA Food Code 2022, Section 5-501.113 Covering Receptacles: Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered. (A) Inside the food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use (2) After they are filled; and (B) With tight-fitting or doors if kept outside the food establishment. Review of the facility's P&P titled Sanitation dated 8/2024 showed to prevent food borne illness in residents and customers, food waste is kept in leakproof, nonabsorbent, tightly closed containers and disposed of as frequently as necessary to prevent nuisance or unsightliness. On 2/11/25 at 0942 hours, a concurrent observation and interview with the RD was conducted. Two waste dumpster were observed overflowing with trash. The RD verified the findings and stated waste dumpster lids should be closed to prevent attracting pests and rodents. On 2/13/25 at 1325 hours, an interview with the RD and Dietary Supervisor was conducted. All of the above findings were acknowledged and verified. On 2/13/25 at 1403 hours, an interview with the CNO was conducted. The CNO acknowledged all of the above findings.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. Resources necessary to care for residents including weekends; 3. Include a plan to maximize recruitment and retention of direct care staff; and 4. Include a contingency plan for staffing needs. This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and includes the active involvement of direct care staff in developing the Facility Assessment. Also includes the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 2/13/25 at 1342 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the CNO. The CNO verified the Facility Assessment was dated 1/11/24, and acknowledged she was not aware of the new update of the Facility Assessment from the CMS. The CNO verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The CNO further verified there were no resources necessary to care for the residents including weekends, and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. The CNO verified and acknowledged the Facility Assessment was not updated based on the latest update from the CMS.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51920 Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices were implemented. * The facility's infection control committee did not meet for one quarter in 2024 to discuss infection control within the subacute unit. This failure posed the risk for transmission of diseases-causing microorganisms and resulted in the committee not being able to discuss quarterly infection control statistics within the subacute unit. Findings: Review of the facility's P&P titled Medical Staff Bylaws, undated, showed the Medical Executive/Quality Improvement Committee shall meet as often as necessary, but at least quarterly and shall maintain a record of its proceedings and actions. On 2/12/25 at 1337 hours, a concurrent interview and document review was conducted with the Director of Infection Prevention/Acting IP. Review of the Infection Control Pharmacy and Therapeutics meeting logs showed no quarterly meeting was held after 8/20/24. When asked about the last infection control committee meeting, the Director of Infection Prevention/Acting IP stated the last infection control meeting was held on 8/20/24. The Director of Infection Prevention/Acting IP verified the infection control committee did not meet in November 2024 due to the Medical Doctor who also served as the Infection Control Chair, being out of the country until 1/30/25. The Director of Infection Prevention/Acting IP verified the infection control committee was supposed to meet quarterly and missed the November 2024 quarterly infection control meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555709	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Global Medical Center D/P Snf	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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48332 Based on interview and facility document review, facility failed to have a full-time, dedicated IP. This failure had the potential for the Infection Prevention and Control Program not being implemented without proper oversight. Findings: Review of the Organizational Chart of the facility updated February 2025 showed the position for Infection Control Supervisor/Infection control was vacant. Review of the QSO-22-19 dated 6/29/22, showed the SNFs are required to have an IP who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program. On 2/12/25 at 1105 hours, an interview was conducted with the Director of Infection Prevention/Acting IP. The Director of Infection Prevention/Acting IP stated she was being stationed and stayed most of the time at the acute care unit of the facility. The Director of Infection Prevention/Acting IP stated she was currently helping the facility on their infection control and would stay in the building for only one to two hours including her work in the acute unit of the facility. The Director of Infection Prevention/Acting IP verified there was no dedicated IP personnel in the facility since January 2024 and they had been hiring and interviewing applicants. The Director of Infection Prevention/Acting IP verified no other facility staff was taking the responsibilities of a dedicated IP. On 2/13/25 at 0840 hours, an interview was conducted with the CNO. The CNO stated the facility shared an IP personnel with the acute care unit of the facility. The CNO verified the facility did not have a full time, dedicated IP, and was actively doing interviews and have full intention to fill the position.