

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35346</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure one nonsampled resident (Resident 12) was assisted with her meals in a timely manner. This failure had the potential for Resident 12 not enjoying her meals at an appetizing temperature.</p> <p>Findings:</p> <p>On 2/19/25 at 0800 hours, Resident 12's breakfast tray was observed to be delivered to Resident 12.</p> <p>On 2/19/25 at 0940 hours, Resident 12's breakfast tray was observed on the overbed table still covered. The overbed table was observed about one foot away from the foot of Resident 12's bed.</p> <p>On 2/19/25 at 1000 hours, an observation was conducted with CNA 1. CNA 1 was observed standing over Resident 12 and placing a spoon of oatmeal into Resident 12's mouth.</p> <p>On 2/19/25 at 1146 hours, an observation was conducted with CNA 1. CNA 1 was observed placing Resident 12's meal tray on Resident 12's overbed table. CNA 1 was then observed walking out of Resident 12's room and down the hallway.</p> <p>On 2/19/25 at 1205 hours, Resident 12's lunch meal tray was observed still covered on Resident 12's overbed table.</p> <p>On 2/19/25 at 1230 hours, an observation was conducted with CNA 1. CNA 1 was observed walking into Resident 12's room and asking Family Member 2 if the family member wanted to assist the resident with her lunch.</p> <p>On 2/19/25 at 1240 hours, an interview was conducted with CNA 1. CNA 1 verified the above findings. CNA 1 was unable to explain the delay in assisting Resident 12 with eating her meals shortly after the meal trays were delivered.</p> <p>Medical record review for Resident 12 was initiated on 2/19/25. Resident 12 was admitted to the facility on [DATE].</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 12's H&amp;P examination dated 12/6/23, showed Resident 12's diagnoses included severe brain injury, multiple back fractures, rib fractures, chronic lung disease, and difficulty swallowing.</p> <p>Review of Resident 12's February 2025 Order Recap Report showed a physician's order dated 2/18/25, for soft and bite-sized texture diet. The order further showed the resident was to be fed by the CNAs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>48332</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to provide a safe, clean, homelike environment for one of 12 final sampled residents (Resident 8).</p> <p>* Resident 8 was residing in Room A. Room A had a supply cabinet drawer that was difficult to pull open and with thin wood material coming out from the face of the drawer. In addition, the wall near the call light system had chipped off blue paint. These failures had the potential to negatively impact the resident's quality of life.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Maintenance Service revised 4/2024 showed the maintenance services shall be provided to all areas of the building, grounds, and equipment. The P&amp;P also showed maintaining the building in good repair and free from hazards, providing routinely scheduled maintenance service to all areas.</p> <p>On 2/19/25 at 1426 hours, an observation was conducted on Room A. Resident 8 was observed lying in her bed in Room A. Room A was observed with a supply cabinet drawer that was difficult to pull open and with thin wood material coming out from the face of the drawer. When the supply cabinet drawer was pulled out to open, the drawer rails were observed not aligned. In addition, the wall near the call light system had chipped off blue paint.</p> <p>On 2/20/25 at 0815 hours, a follow-up observation and concurrent interview was conducted with LVN 5. LVN 5 verified the above findings and stated he did not know how long it had been since the blue paint had chipped off the wall and when the supply cabinet drawer became difficult to open. LVN 5 stated he would follow up with the maintenance staff.</p> <p>On 2/20/25 at 1240 hours, a telephone interview was conducted with Family Member 3. Family Member 3 was asked what she noticed inside the room of Resident 8. Family Member 3 stated other than the oxygen and toys, she noticed the supply cabinet drawer on the right side of Room A upon entry did not open properly and thought it would fall if it was pulled opened. Family Member 3 stated she did not use the supply cabinet to put Resident 8's stuff in because it was broken. Family Member 3 stated the blue wall was peeling off, and also the face of the drawer. Family Member 3 stated it could be better if the drawer was working and fixed.</p> <p>On 2/24/25 at 1505 hours, an interview was conducted with the CEO. The CEO acknowledged the above findings. The CEO stated a job order was sent to the maintenance department for repair.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35346</p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to implement their abuse P&amp;P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150 B of the Social Security Act for one nonsampled resident (Resident 12) as evidenced by:</p> <p>* The facility failed to ensure the reporting of Resident 12's sexual abuse allegation to the local State and Federal agencies in a timely manner. This failure posed the risk for the abuse allegation going unreported and uninvestigated.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Abuse revised 11/2024 showed the facility was required to complete the contact information sheet for state/local reporting agencies. Further review of the P&amp;P showed the facility was to fax a written report to the local state survey agency.</p> <p>On 2/20/25 at 1400 hours, an interview was conducted with Family Member 1. Family Member 1 stated the facility was trying to discharge Resident 12 too soon. Family Member 1 stated the facility was doing this in response to Family Member 1 reporting Resident 12 was sexually abused by CNA 2. Family Member 1 stated she had reported the abuse allegation to the CEO in April 2024.</p> <p>Review of Resident 12's progress note dated 4/24/24, showed Family Member 1 had reported Resident 12 was afraid of CNA 2.</p> <p>On 2/21/25 at 0830 hours, an interview and concurrent medical record review was conducted with the CEO. When asked about a sexual abuse allegation of Resident 12, the CEO verified she was aware of Resident 12's sexual abuse allegation. The CEO stated she received information about the abuse allegation in May 2024 from the local police department. When asked about reporting the abuse allegation to the local State agency, the CEO stated she hand delivered the report to the local State agency but did not keep a copy of the documents submitted to the local State agency. When asked about a progress note dated 4/24/24, showing Family Member 1 reported Resident 12 was afraid of CNA 2, the CEO stated she was not notified of the sexual abuse allegation until May 2024. When asked if she had any documented evidence related to the reporting the abuse allegation to the local State agency or any other documents related to the abuse investigation, the CEO stated she did investigate the allegation and it was unsubstantiated; however, she did not make or keep a copy of the documents related to the abuse allegation investigation.</p> <p>Cross reference to F610.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35346</p> <p>Based on interview, medical record review, and the facility P&amp;P review, the facility failed to implement their abuse P&amp;P related to the investigation of sexual abuse for one nonsampled resident (Resident 12). This failure had the potential for not taking all the necessary corrective actions to protect Resident 12 and other residents from abuse.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Abuse revised 11/2024 showed the facility is to:</p> <ul style="list-style-type: none"> <li>* document all allegations of abuse;</li> <li>* the licensed nurse is to assess the individual and document injury assessment;</li> <li>* interview family members, visitors, and other residents as applicable; and</li> <li>* interview staff from different shifts.</li> </ul> <p>On 2/20/25 at 1400 hours, an interview was conducted with Family Member 1. Family Member 1 stated the facility was trying to discharge Resident 12 too soon. Family Member 1 stated the facility was doing this in response to Family Member 1 reporting Resident 12 was sexually abused by CNA 2. Family Member 1 stated she observed Resident 12 scream and agitated when Resident 12 heard CNA 2's voice. Family Member 1 stated Resident 12 had communicated to her that CNA 2 touched her breasts and vaginal area. Family Member 1 stated she reported Resident 12 was afraid of CNA 2 to the CEO in April 2024.</p> <p>Medical record review for Resident 12 was initiated on 2/21/25. Resident 12 was admitted to the facility on [DATE].</p> <p>Review of Resident 12's H&amp;P examination dated 12/6/23, showed Resident 12's diagnoses included severe brain injury, multiple back fractures, and rib fractures post status fall.</p> <p>Review of Resident 12's medical record failed to show a body assessment was completed in reference to the alleged sexual abuse.</p> <p>Review of Resident 12's progress notes dated 4/24/24, showed Family Member 1 reported Resident 12 was afraid of CNA 2.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 0830 hours, an interview and concurrent medical record review was conducted with the CEO. When asked about a sexual abuse allegation regarding Resident 12, the CEO verified she was aware of Resident 12's alleged sexual abuse allegation. The CEO stated she received information about the sexual abuse allegation in May 2024 from the local police department. When asked about the investigation of this allegation, the CEO stated she interviewed all night shift staff. The CEO stated she did not have documented evidence to show the facility staff statements or a list of the facility staff she had interviewed. In addition, the CEO stated she did not interview Resident 12's family members or visitors about the sexual abuse allegation. The CEO stated the allegation was unsubstantiated; however, she did not keep the copy of the investigation she did.</p> <p>The facility failed to provide any documented evidence to show the sexual abuse allegation was thoroughly investigated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51920</p> <p>Based on interview and medical record review, the facility failed to ensure a copy of the Notice of Transfer/Discharge was sent to the LTC Ombudsman for one of one final sampled resident (Resident 19) reviewed for hospitalization . This failure posed the risk of the LTC Ombudsman not being aware of the circumstances should an appeal be filed by the resident or their representative regarding the transfer/discharge and the risk of the residents or their representative not being aware of their rights prior to the transfer/discharge from the facility.</p> <p>Findings:</p> <p>Medical record review for Resident 19 was initiated on 2/19/25. Resident 19 was admitted to the facility on [DATE].</p> <p>Review of Resident 19's H&amp;P examination dated 1/10/25, showed Resident 19 had no capacity to understand and make decisions. The H&amp;P examination showed Resident 19 was transferred to an acute care facility on 12/13/25, for a higher level of care.</p> <p>Further review of Resident 19's medical record did not show the Notice of Transfer/Discharge was completed and a copy of the notice was sent to the LTC Ombudsman upon Resident 19's transfer to the acute care facility.</p> <p>On 2/24/25 at 0957, an interview was conducted with the Case Manager. The Case Manager verified the above findings. The Case Manager stated the Notice of Transfer/Discharge was not sent to the Ombudsman due to the short amount of time Resident 19 was in the facility. The Case Manager stated she now knew this procedure was not correct and the Notice of Transfer/Discharge needed to be sent regardless the length of time that the resident was in the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51920</p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to develop and implement the individualized care plans for two of 12 sampled residents (Residents 4 and 19) and one nonsampled resident (Resident 12).</p> <p>* The facility failed to develop a care plan problem to address the resident's family member education regarding the use of gown and glove during high-contact interactions with the resident. This failure posed the risk for Resident 4 to be infected and spread the infection.</p> <p>* The facility failed to ensure the care plan problem for the use of the mechanical lift was implemented when Resident 12 was transferred by one staff using the mechanical lift instead of two staff assistance. This failure posed the risk of Resident 12 for injury or fall.</p> <p>* The facility failed to develop a care plan problem for Resident 19 to address the use of anticoagulant and antibiotic medications. This failure posed the risk for Resident 19 to develop complications associated with the use of anticoagulant and antibiotic medications.</p> <p>Findings:</p> <p>1. Medical record review for Resident 19 was initiated on 2/21/25 at 0811 hours. Resident 19 was readmitted to the facility on [DATE].</p> <p>Review of Resident 19's H&amp;P examination dated 1/10/25, showed Resident 19 had no capacity to understand and make decisions.</p> <p>Review of Resident 19's Order Summary Report dated 2/19/25, showed a physician's order dated 1/10/25, for enoxaparin sodium (blood thinner medication) injection solution prefilled syringe 30 mg/0.3 ml, inject 30 mg subcutaneously two times a day for deep vein thrombosis (DVT) prophylaxis. Another physician's order dated 1/13/25, showed an order for amoxicillin (antibiotic medication) oral tablet 500 mg via J-tube two times a day for asplenia.</p> <p>Further review of Resident 19's medical record failed to show a care plan problem was developed for the use of anticoagulant and the antibiotics medications.</p> <p>On 2/21/25 at 0845 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified Resident 19 had the orders for an anticoagulant and antibiotic medications. RN 3 acknowledged the care plan problems should be developed for the anticoagulant medication to indicate what to monitor for a resident taking an anticoagulant, and for the infection associated with the antibiotic use. RN 3 was unable to locate the care plan problems in Resident 19's medical record for the anticoagulant and antibiotic use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 0855 hours, an interview was conducted with RN 2. RN 2 stated she was responsible for entering the physician's orders and initiating the appropriate care plans. RN 2 stated there should be a care plan problem initiated when a resident was prescribed for an anticoagulant or antibiotic. RN 2 stated the nursing team did a weekly care plan check to verify the appropriate care plans have been initiated. RN 2 verified Resident 19 did not have a care plan for the anticoagulant or antibiotic and it was a mistake.</p> <p>32179</p> <p>2. Medical Record review of Resident 4 was initiated on 2/19/25. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the facility's P&amp;P titled Enhanced Based Precaution dated 8/2024 showed once a resident is placed on EBP, the staff members will promptly communicated the purposed of EBP to the family members/next of kin. Continue following barrier precaution including hand hygiene, the use of gown, gloves, mask or eye shields when contact with mosit bodily fluid is likely; injection safety practices, respiratory hygiene/cough etiquette, recomended enviromental infection control practices in all care settings for all residents.</p> <p>Review of the Order Summary Report dated 2/20/25, showed a physician's order dated 9/6/24, to place in EBP for infection prevention.</p> <p>On 2/19/24 at 0815 hours, Resident 4's family member was observed entering the room without donning gloves and gowns, and had suctioned the resident a few times. In front of the room, a sign was posted indicating enhanced-based precautions. There was no staff member observed providing education to Resident 4's family member.</p> <p>On 2/19/24 at 1000 hours, an observation and concurrent interview for Resident 4 was conducted with LVN 1. LVN 1 was asked if the resident's family member was aware of donning gowns and gloves. LVN 1 stated in the past, she had informed Resident 12's family member. LVN 1 stated she did not educate the family member this morning.</p> <p>On 2/19/24 at 1015 hours, a concurrent interview and medical record review was conducted with RN 5. RN 5 were asked if there was a care plan problem to address the resident's family member education about wearing gowns and gloves during high-contact interactions with the resident. RN 5 was unable to provide documentation. RN 5 verified the findings.</p> <p>35346</p> <p>3. Review of the facility's P&amp;P titled Hydro-Lift instructions dated 5/4/21, showed to always use two people when moving the lift with a resident.</p> <p>On 02/20/25 at 1600 hours, CNA 1 was observed transferring Resident 12 from the resident's bed to a wheelchair, using a mechanical lift.</p> <p>On 2/20/25 at 1630 hours, an interview was conducted with CNA 1. When asked about transferring residents using a mechanical lift, CNA 1 stated there should be two-person transfer assist when using a mechanical lift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 12's plan of care showed a care plan problem addressing Resident 12's transfers. One of the interventions was the resident required a mechanical lift with assistance from two staff members.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35346</p> <p>Based on observation, interview, and medical record review, the facility failed to revise the care plan for one of 12 final sampled residents (Resident 17) and one nonsampled resident (Resident 12).</p> <p>* Resident 12's plan of care was not revised to reflect an abuse allegation reported.</p> <p>* Resident 17's plan of care was not revised to reflect the resident's use of bilateral afo to lower extremity.</p> <p>These failures posed the risk of the residents to not receive the appropriate care.</p> <p>Findings:</p> <p>1. On 2/20/25 at 1400 hours, an interview was conducted with Family Member 1. Family Member 1 stated Resident 12 communicated that the resident was sexually abused by CNA 2. Family Member 1 stated she reported this allegation to the Administrator in April 2024.</p> <p>On 2/21/25 at 0830 hours, an interview was conducted with the Administrator. The Administrator verified she was aware of Resident 12's abuse allegation. When asked about a care plan problem addressing Resident 12's abuse report, the Administrator stated she would look for the care plan. The resident's plan of care was not revised to address Resident 12's abuse allegation.</p> <p>On 2/19/25, medical record review for Resident 12 was initiated.</p> <p>Review of Resident 12's plan of care failed to show Resident 12's plan of care was revised to reflect a care plan problem addressing Resident 12's abuse allegation.</p> <p>Cross references to F609 and F610</p> <p>32179</p> <p>2. Medical Record review of Resident 17 was initiated on 2/19/25. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the Order Summary Report dated 2/20/25, showed a physician's order dated 11/15/24, for the resident to wear the bilateral AFOs two hours on and two hours off from 0800 to 2200 hours as tolerated; maintain the ankle alignment and PROM exercises and prevent further contractures; check for skin integrity prior to and after the application; and inform the rehabilitation staff, nursing staff, or MD of any redness that not disappear within 30 minutes.</p> <p>On 2/20/25 at 1445 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 was asked if there was any care plan to address the use of bilateral AFOs. RN 1 was unable to provide the documentation. RN 1 acknowledged the plan of care would need to be revised. RN 1 verified the findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51920</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of 12 final sampled residents (Resident 1) received the appropriate treatment and services to prevent the occurrences of complications from the GT feeding.</p> <p>* The facility failed to ensure Resident 1's head of bed was positioned safely at 30 to 45 degrees during the GT feeding to reduce the risk of aspiration. In addition, the facility failed to ensure Resident 1's tube feeding formula was properly labeled. These failures posed the risk for developing complications related to GT feedings, which had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Medical record review for Resident 1 was initiated on 2/20/25. Resident 1 was admitted to the facility on [DATE].</p> <p>Review of Resident 1's H&amp;P examination dated 3/6/21, showed Resident 1 had no capacity to understand and make decisions.</p> <p>a. Review of the facility's P&amp;P titled Enteral Tube Feeding via Continuous Pump dated 3/2022 showed to position the head of the bed at 30 - 45 (semi-Fowler's position) for feeding unless medically contraindicated.</p> <p>On 2/19/24 at 0830 hours, an initial observation was conducted for Resident 1. Resident 1 was observed to have the tracheostomy, ventilator, and a GT feeding setup.</p> <p>On 2/20/25 at 0832 hours, an interview was conducted with RT 1. RT 1 verified the HOB for the residents who had a tracheostomy, on ventilators or tube feedings should be at least 30 to reduce the risk of aspiration and [NAME]. RT 1 stated it was the responsibility of all the staff to ensure the HOB was at the correct elevation.</p> <p>On 2/20/25 at 0844 hours, an observation of Resident 1 and concurrent interview with RN 2 was conducted. The HOB for Resident 1 was confirmed to be only 20 with an angle measurement tool. RN 2 stated she thought the HOB for the residents on GT feedings should be above 45 , but it was ultimately the responsibility of the resident's nurse. RN 2 verified 20 was the incorrect setting for Resident 1 as she had a tracheostomy, ventilator, and was on periodic tube feedings.</p> <p>On 2/20/25 at 0956 hours, an interview was conducted with LVN 1. LVN 1 verified the HOB for Resident 1 should be at least 30 to keep the secretions away so she would not aspirate.</p> <p>On 2/20/25 at 1013 hours, an interview was conducted with CNA 2. CNA 2 verified the HOB should be 30 . CNA 2 stated she knew of the need for the resident to be positioned to 30 degrees from in-service trainings at the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/20/25 at 1028 hours, an interview was conducted with LVN 4. LVN 4 verified the HOB for Resident 1 should be at 30 - 45 as per the facility P&amp;P.</p> <p>On 2/2025 at 1332 hours, an observation was conducted of Resident 1. Resident 1 was observed in bed. The HOB for Resident 1 was confirmed to be only 20 with an angle measurement tool. Resident 1 was observed with an ongoing enteral GT feeding. RN 2 entered the resident's room and verified the HOB was too low. The measurement of 20 was verified by RN 2 and she adjusted the HOB to the correct height.</p> <p>b. Review of the facility's P&amp;P titled Enteral Tube Feeding via Continuous Pump issued on 3/2022 showed for the enteral feeding formula label, to document the initials, date and time the formula was hung/administered, and initial that the label was checked against the order.</p> <p>Review of Resident 1's Medication Administration Record showed an enteral feeding physician's order dated 10/19/24, for Boost Kids Essentials with fiber 1.5 three times a day at 195 ml to run over one hour at 0900, 1300, and 1700 hours; and give 75 ml of water flush before and after the feeding.</p> <p>On 2/19/25 at 0830 hours, an initial observation was conducted for Resident 1. Resident 1 was observed to have the tracheostomy, ventilator, and GT feeding setup. The feeding formula and water flush bags were observed with the label showing the date of 2/19/25, and time of 0600 hours.</p> <p>On 2/20/25 at 1028 hours, an interview was conducted with LVN 4. LVN 4 stated the night shift was in charge of changing the water flush and GT feeding bags every 24 hours so the date and time on the empty bags was the date and time when the bags were changed. LVN 4 stated there was no way to know when the GT feeding formula was added to the GT feeding bag without looking in the computer. LVN 4 verified the staff did not put the date, time, or initial the GT feeding and flush bags when the feeding formula and water were added to the bags.</p> <p>On 2/2025 at 1332 hours, an observation was conducted of Resident 1. Resident 1 was observed in bed with an on going GT feeding. The date and time on the GT feeding and flush bags were noted as 2/20/25 at 0600 hours. RN 2 entered the room and stated the date and time on the bags referred to when the GT feeding and flush bags were changed. RN 2 verified the facility had no system for labeling the GT feeding bags with the date and time when the GT feeding formula was added to the bag.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332</b></p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to provide the necessary respiratory care and services for two of 12 final sampled residents (Residents 7 and 9).</p> <p>* The facility failed to ensure Resident 7's cool aerosol therapy (treatment that uses mist of medicine to help relieve upper airway issues by loosening phlegm) plastic bag was dated as per the facility's P&amp;P.</p> <p>* The facility failed to ensure Resident 9's suction canister (bottle connected to suction machine to collect the secretions like phlegm, mucous during suctioning ) was dated when it was installed and hooked to the suction machine (medical device that removes obstructions from a patient's airway by clearing from secretions).</p> <p>These failures had the potential for increased risk of infection.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Changing Respiratory Equipment revised 1/2025 showed the purpose of the P&amp;P is to provide guidelines for changing respiratory therapy equipment. Continuous aerosol therapy equipment will be changed every seven days and PRN. All equipment will be dated including the tracheostomy collar. Aerosols will be issued sterile prefilled water and that is to be changed when empty or up to 48 hours of use. Suction canisters will be changed by nursing weekly and as needed. All disposable equipment will be dated when changed.</p> <p>1. During the initial tour of the facility on 2/19/25 at 1605 hours, Resident 7 was observed lying in bed and connecting to a cool aerosol via T-piece (a device used for delivering oxygen through the trachea - tube like structure that connects the voice box to the lungs). The plastic bag labeled Cool Aerosol was dated 2/6/25.</p> <p>On 2/20/25 at 0845 hours, a follow-up observation with concurrent interview with RT 3 for Resident 7 was conducted. The plastic bag labeled Cool Aerosol was still dated 2/6/25. RT 3 was asked when they changed the set-up bag for the Cool Aerosol. RT 3 stated it was changed every week. RT 3 verified it was dated 2/6/25, and should have been changed last week which was on 2/13/25.</p> <p>Medical record review for Resident 7 was initiated on 2/20/25. Resident 7 was initially admitted to facility on 9/19/22, and readmitted on [DATE].</p> <p>Review of Resident 7's medical record showed the resident's diagnoses included chronic respiratory failure (condition in which lungs are unable to adequately exchange oxygen and carbon dioxide over an extended period of time leading to low oxygen level), tracheostomy status, and multiple congenital heart malformations (heart defects that are present at birth).</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 2/19/25 at 1615 hours, an observation and concurrent interview with LVN 5 for Resident 9 was conducted. Resident 9 was lying in her bed. Resident 9's suction canister was observed with 60 -70 ml of whitish secretions connected to the suction machine which was not dated. LVN 5 verified the above findings stated it should be dated because all the suction canisters must be dated once it was installed and connected to the suction machine.</p> <p>Medical record review for Resident 9 was initiated on 2/20/25. Resident 9 was initially admitted to facility on 2/1/23, and was readmitted on [DATE].</p> <p>Review of Resident 9's medical record showed the resident's diagnoses included acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), tracheostomy status, and dependence on ventilator (machine that moves air in and out of the lungs) status.</p> <p>On 2/24/25 at 1510 hours, the CEO was made aware and acknowledged the above findings.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32179</p> <p>Based on observation, interview, medical record review, and facility's P&amp;P review, the facility failed to ensure one of 12 final sampled residents (Resident 273) were free from the unnecessary psychotropic medications.</p> <p>* The facility failed to monitor the episodes of OMS as one of the behavior manifestations and side effect monitoring for alprazolam (anxiety medication) and sertraline (antidepressant medication) medications for Resident 273. In addition, both medications had the same indication. This failure had the potential for inaccurate behavior and side effects monitoring, which might cause the physician for not having the necessary information to determine the effectiveness of the medications for Resident 273.</p> <p>Findings:</p> <p>Medical review of Resident 273 was initiated on 2/19/25. Resident 273 was admitted to the facility on [DATE].</p> <p>Review of the Order summary Report dated 2/21/25, showed a physician's order dated 2/19/25, to administer alprazolam oral tablet 0.25 mg via GT two times a day for OMS for 30 Days. The summary report also showed a physician's order dated 2/20/25, to administer sertraline hydrochloride 50 mg by mouth one time a day for OMS for five days, then give 75 mg by mouth one time a day.</p> <p>On 2/24/25 at 1000 hours, an interview and concurrent medical record review for Resident 273 was conducted with RN 4. RN 4 stated there was no monitoring of the behavior for the use of sertraline medication. RN 4 acknowledged the behavior monitoring for the alprazolam medication was not accurate in the physician's order and the order was not specific. RN 4 acknowledged both medications had the same indication for use and it would be difficult to monitor the effectiveness of the medication. RN 4 stated there was no side effect monitoring for the two medications. RN 4 verified the above findings.</p> <p>On 2/24/25 at 1100 hours, an interview and concurrent medical record review with LVN 6 was conducted. LVN 6 was asked which behaviors they were monitoring for the use of alprazolam and sertraline medications. LVN 6 stated it was for OMS. LVN 6 was not sure what specific behaviors to monitor for the use of the two medications. After reviewing the TAR, LVN 6 stated they monitored for 'call out' behavior for alprazolam medication. LVN 6 acknowledged the physician's order did not specify the behaviors monitoring for the use of the alprazolam and sertraline medications. LVN 6 verified the findings.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32179</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure the residents' medications and biologicals were properly stored and labeled for two of 12 final sampled residents (Residents 4 and 273). In addition, the facility failed to ensure three of six medication carts had no expired supplies and medication.</p> <p>* Resident 4 had a six ounce tube of Triad hydrophilic wound dressing (used to provide a moist wound healing environment) with CMC (cellulose gum) at the bedside table.</p> <p>* Resident 273 had a 22-gram tube of mupirocin (used to treat skin infections) 2% ointment and a 60-gram tube of Venelex wound dressing (used to cover wounds) on the bedside table.</p> <p>* Medication Cart 2 had eight packets of SurePrep protective wipe (skin protectant) with an expiration date of [DATE].</p> <p>* Medication Cart 4 had an AG Cuffill pressure manometer (used for measuring and regulating intra-cuff pressure) with an expiration date of [DATE].</p> <p>* Medication Cart 6 had a GT feeding tube extension sets with Enfit (enteral feeding connection) connectors with an expiration date of [DATE], and 42 packets of SurePrep protective wipe with an expiration date of [DATE].</p> <p>These failures had the potential for the unsecured medications be accessible to other residents and visitors, and the residents receiving expired or contaminated biologicals or medications.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Medication Storage in the Facility dated ,d+[DATE] showed the medications and biologicals are stored safely, securely and properly, following manufactures' recommendations or those of the supplier. Medications will not be kept on hand after the expiration date on the label (and no contaminated or deteriorated medications shall be available).</p> <p>1. Medical review for Resident 273 was initiated on [DATE]. Resident 273 was admitted to the facility on [DATE].</p> <p>On [DATE] at 0830 hours, Resident 273 was observed with a 22-gram tube of mupirocin 2% ointment and a 60-gram tube of Venelex wound dressing on the bedside table.</p> <p>On [DATE] at 1440 hours, an observation and concurrent interview was conducted with RN 4. RN 4 was asked about the two tubes of medications on the resident's bedside table. RN 4 stated the medications were brought in with Resident 273 since the resident was admitted to the facility. RN 4 stated the medications should be locked or stored in the medication treatment cart. RN 4 verified the above findings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Medical Record review of Resident 4 was initiated on [DATE]. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>On [DATE] at 0815 hours, Resident 4 was observed with a six ounce tube of Triad hydrophilic wound dressing with CMC at the bedside table.</p> <p>On [DATE] at 1430 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated the wound dressing medication was brought in with Resident 4 since the resident was admitted to the facility. LVN 1 stated the wound dressing medication should be stored in medication treatment cart. LVN 1 verified the above findings.</p> <p>45064</p> <p>3. On [DATE] at 0813 hours, an inspection of Medication Cart 2 was conducted with RN 1. Medication Cart 2 was observed with eight packets of SurePrep protective wipe with an expiration date of [DATE]. RN 1 stated the expired supplies should be removed from the treatment cart immediately. RN 1 stated the SurePrep wipe was used to clean the skin to ensure the wound dressing would adhere better. RN 1 stated the expired supplies could be less effective. RN 1 verified the findings.</p> <p>4. On [DATE] at 0845 hours, an inspection of Medication Cart 4 was conducted with RT 1. Medication Cart 4 was observed with an AG Cuffill pressure manometer with an expiration date of [DATE]. RT 1 stated the expired supplies needed to be remove from medication cart immediately. RT 1 verified the findings.</p> <p>5. On [DATE] at 0824 hours, an inspection of Medication Cart 6 was conducted with LVN 3. Medication Cart 6 was observed with a GT feeding tube extension sets with Enfit connectors with an expiration date of [DATE], and 42 packets of SurePrep protective wipe with an expiration date of [DATE]. LVN 3 stated the expired supplies should be removed from the medication immediately. LVN 3 stated the expired supplies could be less effective when used. LVN 3 verified the findings.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>45064</p> <p>Based on interview and facility document review, the facility failed to submit the complete and accurate direct care staffing information to CMS. This failure posed the risk of inaccurate auditable data reporting.</p> <p>Findings:</p> <p>Review of the CMS CASPER reports showed the facility triggered a One-Star Staffing Rating due to the failure to submit data for the quarter from 7/1/24 to 9/20/24.</p> <p>Review the Pediatric Monthly Subacute Staffing Report showed the following:</p> <ul style="list-style-type: none"> <li>- For September 2024, the RN and LVN hours were within the requirement. However, there were 17 days that the CNA hours were below the minimum, for a total of 167.66 hours below the minimum.</li> <li>- For October 2024, the RN and LVN hours were within the requirement. However, there were nine days that the CNA hours were below the minimum, for a total of 76.68 hours below the minimum.</li> <li>- For November 2024, the RN and LVN hours were within the requirement. However, there were five days that the CNA hours were below the minimum, for a total of 30.10 hours below the minimum.</li> <li>- For December 2024, the RN and LVN hours were within the requirement. However, there were five days that the CNA hours were below the minimum, for a total of 37.99 hours below the minimum.</li> <li>- For January 2025, the RN and LVN hours were within the requirement. However, there were 16 days that the CNA hours were below the minimum, for the a total of 100.31 hours below the minimum.</li> </ul> <p>There were negative variances of the CNA hours for the months mentioned above; however, there were excess nursing hours; therefore, the nursing staff assisted the residents with resident care.</p> <p>On 2/21/25 at 1109 hours, an interview and concurrent facility document review was conducted with the CEO. When asked about the data submitted to CMS related to the payroll and reports generated triggering extremely low staffing on weekends, the CEO stated she submitted the PBJ electronically in October 2024 but did not submit it in the required XML format. The CEO stated the submitted PBJ was rejected, but she did not notice the rejection initially. The CEO stated when she found out it was rejected, she tried to resubmit the PBJ but was not able to. The CEO stated the October 2024 PBJ was submitted on 10/25/24 (Friday), and the facility tried resubmitting on 10/28/24 (Monday); however, there was no option to resubmit the PBJ. The CEO stated the facility was unable to contact CMS to obtain the information on how to resubmit the PBJ because there was no contact information available. When asked to provide the documentation of the October 2024 PBJ rejection notice, the CEO was unable to show or provide the copy. The CEO stated when she went back to the CMS PBJ website, she was unable to print the notice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2025
NAME OF PROVIDER OR SUPPLIER  Healthbridge Children's Hospital - Orange D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 393 S Tustin St Orange, CA 92866	
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35346</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to ensure the resident care equipment was kept in safe operating condition as evidenced by:</p> <ul style="list-style-type: none"> <li>* The facility's mechanical lift stopped working during the transfer for one nonsampled resident (Resident 12).</li> <li>* The ice buildup was observed in the enteral feeding refrigerator.</li> </ul> <p>These failures posed the risk for equipment hazards or unsafe practices which could affect the residents' well-being in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's P&amp;P titled Hydro-Lift Instructions for Use dated [DATE], showed the lift was to be charged daily, with minimum charging time of eight hours.</li> </ol> <p>On [DATE] at 1600 hours, an observation was conducted with CNA 1. CNA 1 was observed transferring Resident 12 from the resident's bed to a wheelchair using a mechanical lift. When lifting Resident 12 approximately one and a half feet above her wheelchair, the mechanical lift stopped working. CNA 1 stated the mechanical lift's battery had died. CNA 1 was then observed manually pushing the mechanical lift and placing Resident 12 back to her bed. CNA 1 then stated she would get a charged battery for the mechanical lift.</p> <p>On [DATE] at 1645 hours, an interview was conducted with the Maintenance Director/Plants Operations. The Maintenance Director/Plants Operations was informed of the mechanical lift stopped working during a resident transfer. The Maintenance Director/Plants Operations stated the facility staff were expected to replace the mechanical lift's battery with a charged battery after each use.</p> <ol style="list-style-type: none"> <li>2. On [DATE] at 0955 hours, an observation and concurrent interview was conducted with RN 4. When RN 4 asked where the food items brought from outside of the facility could be stored, RN 4 showed a refrigerator labeled hospital nutrition only. The prepared enteral feedings used for the residents were observed stored inside the refrigerator with ice build up along the back side of the refrigerator. RN 4 verified the above findings.</li> </ol>		