

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER Bayshire Yorba Linda Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 17803 Imperial Highway Yorba Linda, CA 92886	

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 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>32179</p> <p>Based on observations, interview, and facility document review, the facility failed to ensure the most recent Recertification Survey's plan of correction was readily accessible to the residents and public. This failure posed the risk for the residents, their families, and visitors to not be aware of the facility's plan of correction for the last Recertification Survey as the documents were not available to review.</p> <p>Findings:</p> <p>On 4/2/25 at 1107 hours, during the residents' group meeting, five of nine residents stated they did not know where the latest survey results were located and were unaware of their rights to review the survey results.</p> <p>On 4/7/25 at 1000 hours, an interview and concurrent facility document review was conducted with the Administrator. A white binder containing the survey results was observed in the lobby area. The binder included the CMS 2567 from the last recertification survey conducted on 1/26/24. However, the binder did not contain the a copy of the Plan of Correction. The Administrator verified and acknowledged the findings and stated someone might have removed the Plan of Correction from the binder.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787</p> <p>Based on observation, interview, and medical record review, the facility failed to develop the plan of care to reflect the individual care needs for one of 13 final sampled residents (Resident 25).</p> <p>* The facility failed to develop a care plan problem to address Resident 25's spinal precautions and use of LSO brace while out of bed. This failure posed the risk of not providing appropriate, consistent, or individualized care to the resident.</p> <p>Findings:</p> <p>Medical record review of Resident 25 was initiated on 4/2/25. Resident 25 was admitted to the facility on [DATE].</p> <p>Review of Resident 25's H&P examination dated 3/31/25, showed one of Resident 25's diagnosis was S/P lumbar fusion.</p> <p>Review of Resident 25's PT and OT Evaluation and Treatment notes dated 4/1/25, showed the section for Precaution/Contraindication showing to provide spinal precautions and LSO brace when out of bed.</p> <p>Review of Resident 25's Order Summary Report showed a physician's order dated 4/1/25, for the LSO brace when out of bed.</p> <p>Review of Resident 25's Nursing Progress Note dated 4/1/25, showed a documentation by RN 1 included the following admitting diagnoses: spinal stenosis, lumbar region with neurogenic claudication, encounter for Orthopedic Care, and fusion of the spine, and lumbar region.</p> <p>Review of Resident 25's Care Plan Report for ADL care, Pain, PT, and OT did not include the interventions to provide Resident 25 the spinal precautions, and/or use the use of LSO brace when out of bed.</p> <p>On 4/3/25 at 1055 hours, an interview and concurrent medical record review was conducted with the OT and PT staff regarding Resident 25's plan of care. The OT and PT staff verified Resident 25 had a lumbar fusion, should be on the spinal precautions, and to use the LSO brace when out of bed. The OT and PT staff verified and acknowledged Resident 25's care plan did not include the interventions to provide spinal precaution and/or the used of the LSO brace when out of bed.</p> <p>On 4/4/25 at 957 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 stated Resident 25 used the back brace when getting out of bed and no other precautions were needed or instructed during the transfers or in bed mobility of the resident.</p> <p>On 4/4/25 at 1002 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 was in Resident 25's room and observed transferring Resident 25 from the bed to the chair weighing scale. CNA 4 was asked if he had to do any precautions during Resident 25's transfers, CNA 4 stated, no, the resident is a lot better than before.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 1330 hours, an interview was conducted with the DON and Administrator. The DON and Administrator was made aware and acknowledged the above findings.</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on interview and medical record review, the facility failed to revise the residents' comprehensive care plans to address the use of side rails for three of four final sampled residents (Residents 16, 17, and 339) reviewed for the side rail use.</p> <p>* The facility failed to ensure the plan of care for Residents 16, 17, and 339 addressing the use of the side rails were revised to show the accurate least restrictive interventions prior to the use of side rails. The residents' plan of care showed the grab rails and quarter-sized rails were used as the least restrictive interventions prior to the use of the side rails. These failures posed the risk of not providing an individualized care for Residents 16, 17, and 339 related to the use of the side rails.</p> <p>Findings:</p> <p>1. Medical record review for Resident 16 was initiated on 4/1/25. Resident 16 was readmitted to the facility on [DATE].</p> <p>Review of Resident 13's Order Summary Report showed a physician's order dated 3/13/25, for the bilateral deluxe assist bed handles up while in bed for turning and repositioning.</p> <p>Review of Resident 13's Skilled Nursing - Admission Initial Eval - V13 dated 3/13/25, under the Side/Bed Rail Evaluation section, showed the alternative attempted and/or considered was an adjustable bed (low-mid height).</p> <p>Review of Resident 13's plan of care showed a care plan problem dated 3/14/25, addressing the use of the grab bars for the resident's mobility. The interventions/tasks included for the grab bars to both sides of the bed, and the side/bed rails quarter size were used as the least restrictive devices for the bed mobility, turning, positioning and transfers to reduce the functional decline.</p> <p>2. Medical record review for Resident 17 was initiated on 4/1/25. Resident 17 was readmitted to the facility on [DATE].</p> <p>Review of Resident 17's Order Summary Report showed a physician's order dated 2/17/25, for the bilateral deluxe assist bed handles up while in bed for turning and repositioning.</p> <p>Review of Resident 17's Skilled Nursing - Admission Initial Eval - V13 dated 2/17/25, under the Side/Bed Rail Evaluation section, showed the alternative attempted and/or considered was the use of the bedside mats.</p> <p>Review of Resident 17's plan of care showed a care plan problem dated 2/17/25, addressing the use of the grab bars for mobility. The interventions/tasks included for the grab bars to both sides of the bed, and the quarter size side/bed rails were used as the least restrictive devices for the bed mobility, turning, positioning and transfers to reduce the functional decline.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Medical record review for Resident 339 was initiated on 4/1/25. Resident 339 was admitted to the facility on [DATE].</p> <p>Review of Resident 339's Order Summary Report showed a physician's order dated 3/31/25, for the bilateral deluxe assist bed handles up while in bed for turning and repositioning.</p> <p>Review of Resident 339's Skilled Nursing - Admission Initial Eval - V13 dated 3/31/25, under the Side/Bed Rail Evaluation section, showed the alternative attempted and/or considered was the bedside mats.</p> <p>Review of Resident 339's plan of care showed a care plan problem dated 4/1/25, addressing the use of the grab bars for mobility. The interventions tasks included for the grab bars to both sides of the bed, and the quarter size side/bed rails were used as the least restrictive devices for the bed mobility, turning, positioning and transfers to reduce the functional decline.</p> <p>On 4/7/25 at 1005 hours, an interview and concurrent medical record review for Residents 16, 17, and 339 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the admitting nurse initiated the care plan for Residents 16, 17, and 339 related to the use of the side rails. RN 1 was not sure why the interventions related to the use of the grab rails were the same for Residents 16, 17, and 339, and why the grab rails and side/bed rails were documented in the care plan as the least restrictive devices for bed mobility, turning, positioning and transfers.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary respiratory care and services were provided to three of 13 final sampled residents (Residents 1, 2, and 19) reviewed for the respiratory care.</p> <p>* The facility failed to ensure Resident 19 received the oxygen as per the physician's order.</p> <p>* The facility failed to ensure Residents 1 and 2 were provided with the No Smoking/Oxygen in Use sign indicating the oxygen use continuously.</p> <p>These failures had the potential to negatively affect the residents' well-being and posed the risk for safety due to the residents' use of the oxygen continuously.</p> <p>Findings:</p> <p>1. Medical record review for Resident 19 was initiated on 4/1/25. Resident 19 was admitted to the facility on [DATE].</p> <p>Review of Resident 19's H&P examination dated 1/10/25, showed Resident 19 had the capacity to understand and make decisions.</p> <p>Review of Resident 19's Order Summary Report dated 4/2/25, showed a physician's order dated 1/14/25, to administer oxygen therapy continuously at 2 liters per minute via nasal cannula and may titrate the oxygen up to 5 liters per minute to maintain the oxygen saturation levels greater than 90% every shift for shortness of breath.</p> <p>On 4/1/25 at 0830 hours, an observation was conducted for Resident 19. Resident 19 was observed receiving the oxygen therapy at 1.5 liters per minute continuously via nasal cannula.</p> <p>On 4/1/25 at 1000 hours, an observation and concurrent interview was conducted with RN 2. RN 2 was summoned to Resident 19's room. Resident 19 was observed receiving the oxygen therapy at 1.5 liters per minute continuously via nasal cannula. RN 2 verified the findings.</p> <p>On 4/1/25 at 1010 hours, a follow-up interview and concurrent medical record review was conducted with RN 2. RN 2 stated Resident 19 should have been receiving the oxygen therapy at 2 to 5 liters per minute via nasal cannula continuously.</p> <p>2. Review of the facility's P&P titled Oxygen Administration revised October 2010 showed the purpose of this procedure is to provide guidance for the safe oxygen administration. The section for Equipment and Supplies necessary when performing this procedure included the No Smoking/Oxygen in Use sign and the Steps in the Procedure showed to place an Oxygen in Use sign on the outside of the resident's room entrance door, and close the door.</p> <p>Medical record review for Resident 2 was initiated on 4/1/25. Resident 2 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's Order Summary report dated 4/3/25, showed a physician's order dated 3/17/25, to administer oxygen therapy continuously at 2 liters per minute via nasal cannula and may titrate the oxygen up to 5 liters per minute to maintain the oxygen saturation levels greater than 90% every shift for shortness of breath.</p> <p>On 4/1/25 at 0800 hours, an observation was conducted for Resident 2. Resident 2 was observed receiving the oxygen therapy at 3 liters per minute continuously via nasal cannula. There was no No Smoking/Oxygen in Use sign placed on the outside of the room entrance.</p> <p>On 4/1/25 at 1010 hours, an observation and concurrent interview was conducted with RN 2. RN 2 was summoned to Resident 2's room. Resident 2 was observed receiving the oxygen therapy at 3 liters per minute continuously via nasal cannula. There was no signage of No Smoking/Oxygen in Use present. RN 2 stated there should have been a signage indicating the oxygen use as Resident 2 used the oxygen continuously. RN 2 verified the findings.</p> <p>48332</p> <p>3. On 4/1/25 at 0844 hours, during the initial tour of the facility, Resident 1 was observed eating breakfast while on bed with head of bed upright position receiving oxygen via nasal canula at 2 liters per minute via oxygen concentrator. There was no No Smoking/Oxygen in Use sign placed on the entrance door of the resident's room.</p> <p>Medical record review for Resident 1 was initiated on 4/2/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident 1's medical diagnoses included COPD and other specified symptoms involving the circulatory and respiratory systems.</p> <p>Review of Resident 1's Order Summary Report dated 4/2/25, showed a physician's order dated 3/21/25, for oxygen therapy continuously at 2 liters per minute via nasal canula and may titrate the oxygen up to 5 liters per minute to maintain the oxygen saturation levels greater than 90% every shift for shortness of breath.</p> <p>On 4/1/25 at 1028 hours, a follow up observation and concurrent interview was conducted with RN 2 for Resident 1. There was no No Smoking/ Oxygen in Use sign observed at the entrance of Resident 1's door. RN 2 verified Resident 1 was on continuous use of oxygen and there was no No Smoking/Oxygen in Use sign placed on the entrance of the door. RN 2 stated all residents on oxygen therapy should have a sign on the entrance of the door.</p> <p>On 4/1/25 at 1040 hours, another follow-up observation and concurrent interview was conducted with the DON for Resident 1. The DON verified the findings and stated there should be a No Smoking/Oxygen in Use signage in the resident's room for all the residents using the oxygen.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787</p> <p>Based on interview, facility record review, and facility P&P review, the facility failed to ensure the necessary pharmacy services were provided to one of 13 final sampled residents (Resident 25) and the proper accounting and safeguarding was performed to prevent loss, or diversion of the controlled medications.</p> <p>* The facility failed to provide the insulin medication (medication used to lower the blood sugar) to Resident 25 as ordered by the physician.</p> <p>* The facility failed to ensure the Narcotic Shift Count sheets were completely signed by the incoming and outgoing licensed nurses assigned to Medication Cart 1.</p> <p>These failures posed the risk to negatively affect the resident's well-being and loss or diversion of the controlled medications.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Administering Medications revised 4/2019 showed the individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medications.</p> <p>Medical record review for Resident 25 was initiated on 4/4/25. Resident 25 was admitted to the facility on [DATE].</p> <p>Review of Resident 25's Order Summary Report dated 4/2/25, showed a physician's order dated 3/31/25, for Humulin R Injection Solution (used to lower blood sugar) inject subcutaneously before meals as per the following blood sugar levels results:</p> <ul style="list-style-type: none"> - 71- 150 mg/dl = give 0 unit; - 151-200 mg/dl = give 1 unit; - 201-250 mg/dl = give 3 units; - 251-300 mg/dl = give 4 units; - 301-350 mg/dl = give 5 units; - 351-400 mg/dl = give 7 units; and - 401-999 mg/dl = give 8 units and notify the MD. <p>Review of Resident 25's MAR for April 2025 showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 4/1/25 at 0730 hours, the blood sugar level result was 176 mg/dl, with a documented code of 13 (meaning no insulin required), and</p> <p>- on 4/3/25 at 1630 hours, the blood sugar level result was 186 mg/dl, with a documented code of 13.</p> <p>On 4/4/25 at 1053 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 acknowledged and verified the findings. LVN 3 stated she should have administered the insulin medication because Resident 25's fingerstick blood sugar level result was more than 150 mg/dl.</p> <p>On 4/4/25 at 1111 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified and acknowledged the findings and stated, the insulin coverage of 1 unit should have been administered.</p> <p>On 4/7/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were made aware and acknowledged the above findings.</p> <p>48332</p> <p>2. Review of the facility's P&P titled Controlled Substances revised April 2019 showed the facility complies with all the laws, regulations and other requirements related to the handling, storage, disposal, and documentation of the controlled medications. The controlled substances are reconciled upon the receipt, administration, disposition, and at the end of each shift. The controlled medications are counted at the end of each shift. The nurses coming on duty and the nurses going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately. The P&Ps for monitoring of the controlled medications to prevent the loss, diversion or accidental exposure are periodically reviewed and updated by the director of nursing services and the consultant pharmacist.</p> <p>On 4/2/25 at 1212 hours, a medication cart inspection for Medication Cart 1 was conducted with LVN 1. The Narcotic Binder was reviewed and showed the Narcotic Shift Count sheets had multiple missing nurses' signatures for the incoming and/or outgoing nurses for the following shifts and dates:</p> <p>a. For January 2025:</p> <ul style="list-style-type: none"> - during the morning shifts on 1/10, 1/12, and 1/14 - 1/19/25; - during the afternoon shifts on 1/15 - 1/16/25, and 1/18 - 1/19/25; and - during the night shifts on 1/1, 1/10, 1/14 - 1/15/25, and 1/19 - 1/20/25. <p>b. For February 2025:</p> <ul style="list-style-type: none"> - during the morning shifts on 2/4, 2/6, 2/10, 2/18, 2/20, and 2/26/25; - during the afternoon shifts on 2/4, 2/18, 2/26 - 2/27/25; and - during the night shifts on 2/2, 2/6, 2/10, 2/17 - 2/19/25, 2/24, and 2/26/25. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. for March 2025:</p> <ul style="list-style-type: none"> - during the morning shifts on 3/1, 3/12, 3/14 - 3/15/25, 3/21 - 3/22/25, 3/27, 3/29, and 3/31/25; - during the afternoon shifts on 3/4, 3/10, 3/12, 3/14, 3/15, 3/22, 3/27, 3/29, and 3/31/25; and - during the night shifts on 3/1, 3/22, 3/27, and 3/28/25. <p>LVN 1 verified there were multiple days and shifts in the Narcotic Shift Count sheet with no licensed nurses' signatures from the outgoing and incoming shifts. LVN 1 stated this posed the potential risk of medication errors and drug diversion.</p> <p>On 4/3/25 at 0840 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the above findings. The DON stated it was important that the controlled drugs were counted and the Narcotic Shift Count sheets were signed to prevent the possible loss and diversion of the controlled drugs.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 22.58%. Two of two licensed nurses (LVNs 1 and 2) were observed to have made the errors during the medication administration.</p> <p>* LVN 2 failed to ensure the correct medications were administered to Resident 591 as per the physician's orders.</p> <p>* LVN 1 failed to ensure the education provided for not chewing the extended release medications for Residents 19 and 29. Additionally, LVN 1 failed to assess or ask Residents 19 and 29 if they had any signs or symptoms of bleeding or bruise.</p> <p>These failures had the potential to negatively affect the residents' health conditions.</p> <p>Findings:</p> <p>1. On 4/2/25 at 0809 hours, during the medication administration observation, LVN 2 administered the following medications to Resident 591 orally:</p> <ul style="list-style-type: none"> - Metformin (antidiabetic) 1000 mg one tablet - Oyster Calcium (supplement) 500 mg with Vitamin D 10 mcg one tablet - B complex with B12 (supplement) one tablet - DOK docusate sodium (stool softener) 100 mg one soft gel - multivitamins with minerals one tablet - acidophilus probiotic one tablet - LiquaCel concentrate liquid protein 16 grams/2.5 grams of arginine sugar free 30 ml - magnesium oxide (mineral) 400 mg - MiraLAX polyethylene glycol (laxative) 3350 - Multi Vitamins one tablet - GeriKot (stool softener) 8.6 mg one tablet - Zinc (mineral) 50 mg one capsule - Vitamin C 500 mg one tablet <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Bayshire Yorba Linda Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 17803 Imperial Highway Yorba Linda, CA 92886	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review was initiated on 4/2/25 on Resident 591. Resident 591 was admitted on [DATE].</p> <p>Review of Resident 591's H&P examination dated 3/24/25, showed a list of medications including the following medications:</p> <ul style="list-style-type: none"> - Emergen-C Blue oral packet (multiple vitamins with minerals) one packet by mouth one time a day for supplement - Caltrate 600 + D3 (vitamin) oral tablet 600-20 mg-mcg one tablet by mouth two times a day for supplement <p>Review of Resident 591's Order Summary Report dated 4/2/25, showed the following medications were scheduled for 0900 hours:</p> <ul style="list-style-type: none"> - cyanocobalamin tablet (vitamin) 1000 mcg one tablet by mouth one time a day - Emergen C- Blue oral packet (multivitamins with minerals) one packet by mouth one time a day - lactobacillus (probiotic) oral tablet one tablet by mouth one time a day - LiquaCel oral liquid (amino acids) 30 ml by mouth one time a day - magnesium oxide oral tablet 400 mg one tablet one time a day - MiraLax powder 17 gm/scoop (polyethylene glycol 3350) one scoop by mouth as needed, to mix with six to eight ounces of fluids. - multivitamin adult oral tablet (multiple vitamin) one tablet by mouth one time a day - Senna Lax oral tablet 8.6 mg one tablet by mouth one time a day - vitamin C oral tablet 500 mg (ascorbic acid) one tablet by mouth one time a day - zinc sulfate capsule 220 mg one capsule by mouth one time a day - Caltrate 600 + D3 (calcium carbonate - cholecalciferol) oral tablet 600-20 mg-mcg one tablet by mouth two times a day - docusate sodium oral tablet 100 mg one tablet by mouth two times a day - metformin HCl oral tablet 1000 mg two times a day <p>On 4/2/25 at 1207 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 591 received multivitamin with minerals in a tablet form instead of packet form as per the physician's order. LVN 2 stated they ran out of multivitamin with minerals in the packet form. LVN 2 further verified the wrong dosage of oyster calcium was given to the resident. LVN 2 acknowledged and verified the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/25 at 1217 hours, an interview was conducted with the Central Supply staff. The Central Supply staff stated when the stock was low for the OTC (over the counter) medications, the nurses would write down what OTC medications were needed and the Central Supply staff would reorder. The Central Supply staff further stated if the medication delivery was delayed, the Central Supply staff would go to a local pharmacy to purchase as instructed by the DON.</p> <p>On 4/2/25 at 1445 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed the above medication errors and verified the findings. RN 1 stated from the time of resident admission, the clarification should have been done with the physician's orders.</p> <p>On 4/7/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.</p> <p>32179</p> <p>2. According to National Library of Medicine dated 10/15/17, showed not to split, chew or crush extended release tablets.</p> <p>a. Medical record review for Resident 19 was initiated on 4/1/25. Resident 19 was admitted to the facility on [DATE].</p> <p>Review of Resident 19's Order Summary Report dated 4/2/25, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 1/11/25: to administer nifedipine (calcium channel blocker) ER tablet 60 mg one tablet by mouth once daily for hypertension, hold if systolic blood pressure less than 105 mmHg. - dated 1/28/25: to administer potassium chloride (mineral) ER tablet 10 meq one tablet by mouth once daily as a supplement in conjunction with Lasix. - dated 3/1/25: to administer apixaban (anticoagulant) 2.5 mg tablet by mouth twice daily for atrial fibrillation. - dated 1/9/25, to monitor for signs/symptoms of anticoagulant complications: blood tinged or blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, severe bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs <p>On 4/2/25 at 0820 hours, during the medication observation, LVN 1 administered one tablet of nifedipine 60 mg tablet ER and one tablet of Potassium Chloride 10 meq ER to Resident 19. However, LVN 1 did not instruct Resident 19 to avoid chewing the medications. Resident 19 was observed making munching movements with their mouth.</p> <p>On 4/2/25 at 0825 hours, LVN 1 was observed administering one tablet of apixaban to Resident 19. However, LVN 1 did not assess or inquire whether Resident 19 exhibited any signs or symptoms of bleeding or bruising.</p> <p>b. Medical record review for Resident 29 was initiated on 4/1/25. Resident 29 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 29's Order Summary Report dated 4/2/25, showed the following physician orders:</p> <ul style="list-style-type: none"> - dated 2/14/25, to monitor for signs/symptoms of anticoagulant complications: blood tinged or blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, severe bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Report abnormal to physician and/or practitioner every shift. - dated 2/15/25: to administer apixaban 2.5 mg tablet by mouth twice daily for deep vein thrombosis prophylaxis. - dated 2/27/25: to administer metoprolol succinate (antihypertensive) 25 mg Extended Release tablet one-half tablet by mouth once daily for hypertension; and hold if SBP <105 mmHg or heart rate (HR) <60 bpm. <p>Review of Resident 29's bubble pack of apixaban 2.5 mg tablets showed a label indicating the medication increases the risk of gastrointestinal bleeding and to report any bruising or bleeding to a physician.</p> <p>On 4/2/25 at 0900 hours, during an observation, LVN 1 administered one tablet of apixaban to Resident 29. However, LVN 1 did not assess whether Resident 29 had any signs or symptoms of bleeding or bruising.</p> <p>On 4/2/25 at 0910 hours, during an observation, LVN 1 administered one tablet of metoprolol 25 mg XL to Resident 29. However, LVN 1 did not instruct Resident 29 to avoid chewing the medication.</p> <p>On 4/2/25 at 0935 hours, during an interview, LVN 1 was asked about providing patient education regarding extended-release medications. LVN 1 stated the extended release medications should not be chewed and acknowledged not instructing Residents 19 and 29 to avoid chewing the medicine. LVN 1 verified he did not assess or asked questions for any signs or symptoms of bleeding or bruising to both of the residents before administering the apixaban medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48332</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were stored in a safe and secure manner.</p> <p>* The facility failed to the medications were properly stored in the location where they could not be accessible by the non-licensed staff.</p> <p>* The facility failed to ensure Medication Cart 1 was locked when not in use.</p> <p>These failures had the potential for unauthorized persons to have access to locked medications.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Storage of Medications, revised 11/2020 showed the facility stores all the drugs and biologicals in a safe, secure and orderly manner. The drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only the person authorized to prepare and administer medications have access to locked medications. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators , carts and boxes) containing drugs and biologicals are locked when not in use.</p> <p>1. On 4/02/25 at 1355 hours, an interview and concurrent observation of the central supply room was conducted with the DON and CNA 4. CNA 4 stated he was the central supply room designee and had the key to the central supply room. An open metal shelf was observed with the following medications:</p> <ul style="list-style-type: none"> - six bottles of Thera Antifungal Body Powder, - two boxes of Hydrocortisone Cream 1% tube Itch Relief, - four boxes of Zinc Oxide ointment Skin Protectant tubes, and - one box of sachet containing Triple antibiotic Ointments. <p>CNA 4 was asked how these medications were dispensed to the nurses. CNA 4 stated he gave the medications to the nurses when they asked for it. The DON verified the findings and stated these medications should not be in the central supply room where non-licensed staff could access it. The DON further stated the medications should have been placed inside an enclosed locked cabinet that only the licensed nurses could access.</p> <p>39453</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 4/2/25 at 1402 hours, Medication Cart 1 was observed parked in the hallway facing the entrance lobby near the nurses' station. The nurses at the nurses' station were observed using the computer, and not attending to Medication Cart 1. Medication Cart 1 was observed unlocked and unattended. The residents, visitors, and staff were observed passing by the medication cart.</p> <p>On 4/2/25 at 1404 hours, an observation of Medication Cart 1 and concurrent interview was conducted with LVN 1. Medication Cart 1 was observed unlocked and unattended. LVN 1 verified the above findings. LVN 1 stated he forgot to lock Medication Cart 1 because he had to check a resident. LVN 1 stated Medication Cart 1 should be locked at all times.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by:</p> <ul style="list-style-type: none"> * The facility failed to ensure the proper labeling and dating of the food items and expired food items were discarded in the satellite kitchen. * The facility failed to ensure the proper labeling and dating of the foods in the refrigerator was in place for the residents' food brought in by the visitors. * The facility failed to ensure the bins, scoops, spoons, peeler, can opener, and microwave were clean. * The facility failed to air dry the scoops before storing in the storage bin. * The facility failed to ensure the cutting boards were kept in a sanitary condition. <p>These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared from the kitchen.</p> <p>Findings:</p> <p>Review of the facility's Diet Type Report dated [DATE], showed 42 of 43 residents residing in the facility received foods prepared in the kitchen.</p> <p>1. Review of the facility's P&P titled Labeling and Dating for Safe Storage of Food revised [DATE], showed the following;</p> <ul style="list-style-type: none"> - All products should be dated upon receipt; - All products should be dated when opened; - Use use-by dates on all food once opened and stored under refrigeration; and - When food is taken out of an original container, write the name of the food being stored on the container, the placed date, and the use-by date. <p>On [DATE] at 0821 hours, an initial tour of the satellite kitchen and concurrent interview was conducted with the Dietary Aide. The following was observed:</p> <ol style="list-style-type: none"> a. Two bags of cheese were not labeled and dated inside Refrigerator 1 b. The following was observed in Refrigerator 2: <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - A container of Thick and Easy water with lemon flavor was not labeled and dated; - A container of Thick and Easy water with apple flavor was not labeled and dated; - A container of Thick and Easy water with strawberry flavor was not labeled and dated; and - A container of Thirster prune juice was labeled with a use-by date of [DATE]. <p>c. An unlabeled container with brown granules was observed on the kitchen shelf.</p> <p>The Dietary Aide verified the above findings. The Dietary Aide stated the brown granules inside a container was coffee. The Dietary Aide stated the bags of cheese and container of thickened juices were just opened but she forgot to label the food items with the opened date.</p> <p>2. Review of the facility's P&P titled Food from Outside Sources revised [DATE], showed if the food is brought in by visitors, friends, family members or resident's guests, the facility should help them understand safe food handling practices.</p> <p>On [DATE] at 1133 hours, an inspection of the refrigerator used for residents' food brought in from visitors, and concurrent interview was conducted with RN 1. A facility document (untitled) posted on the refrigerator door showed the following:</p> <ul style="list-style-type: none"> - All food items brought in by family must be labeled with the name, date and room number; - If not labeled, it will be immediately discarded; and - Perishable foods will be tossed out after three days. <p>The following food items were observed inside the refrigerator:</p> <ul style="list-style-type: none"> - A small container of ice cream was not labeled with resident name, room and date received; - A container of wheat sprout spread was labeled with resident name, and dated [DATE]; and - A container of dark chocolate mousse was labeled with resident name, but undated. <p>RN 1 verified the above findings. RN 1 stated the food items were supposed to be labeled with the resident name, room number and date when the food items were received. RN 1 stated if the food item was from the restaurant and/or from home, the facility staff encouraged them to finish the food purchased from outside. When asked how long should the food from outside source be stored inside the refrigerator, RN 1 answered it should be 24 hours because they were not sure of how the food item was prepared and transported, and also because the refrigerator used to store food items from outside source was small.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. According to the 2022 FDA Food Code, ,d+[DATE].11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>According to the 2022 FDA Food Code, ,d+[DATE].13, Non-Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.</p> <p>a. On [DATE] at 0942 hours, an inspection of the ice machine in the main kitchen and conducted interview and facility document review was conducted with the Director of Maintenance. The ice machine was observed with black particles on the ice machine deflector and on the groove in front of deflector when wiped with a white paper towel. The Director of Maintenance verified the above findings. The Director of Maintenance stated an outside vendor provided cleaning service to the ice machine quarterly. The Director of Maintenance also stated the dietary staff was responsible for cleaning the exterior of the ice machine, and the bin of the ice machine. The Director of Maintenance stated the dietary staff used a food-grade multi-quat sanitizing solution to clean the bin of the ice machine.</p> <p>Cross-reference to F908 #2.</p> <p>b. On [DATE] at 0821 hours, during the initial tour of the satellite kitchen and concurrent interview was conducted with the Dietary Aide. The following was observed:</p> <ul style="list-style-type: none"> - A ice cream scoop was observed chipped and corroded; - A gray scoop was observed with food debris; - The can opener and peeler were observed with rust; - The white scoop, black serving spoon, and red adaptive spoon were observed with white stain; and - The storage bins for the scoops was observed with white stain. <p>The Dietary Aide verified the findings.</p> <p>c. On [DATE] at 1044 hours, during the inspection of the main kitchen, five cupcake pans were observed with brownish discoloration. The Culinary Director verified the findings.</p> <p>d. On [DATE] at 0925 hours, the microwave used to warm the residents' food in the satellite kitchen was observed with a brownish discoloration and food debris. The CDM verified the findings.</p> <p>4. According to the 2022 FDA Food Code, ,d+[DATE].11, Equipment and Utensils, Air- Drying Required, showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 0821 hours, during the initial tour of the satellite kitchen, six scoops were stored wet inside a storage bin. The Dietary Aide verified the findings.</p> <p>5. According to the 2022 FDA Food Code, Section ,d+[DATE].12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces.</p> <p>On [DATE] at 0821 hours, a red cutting board was observed to be heavily marred with knife marks. The Dietary Aide verified the findings.</p>

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<p>F 0813</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179</p> <p>Based on observation, interview, and facility P&P review, the facility failed to implement the P&P to ensure proper storage of food brought in by family members.</p> <p>* An unlabeled and undated bag of cereal was observed on Resident 29's bedside table. This failure had the potential to result in foodborne illnesses in a highly susceptible resident population.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Foods Brought by Family or Visitors dated 3/2022 showed the food brought by family or visitors and left with the resident to consume later must be labeled and stored in a manner that clearly distinguishes it from facility-prepared food. Non-perishable foods must be stored in resealable containers with tightly fitting lids.</p> <p>Medical record review for Resident 29 was initiated on 4/1/25. Resident 29 was admitted to the facility on [DATE].</p> <p>On 4/2/25 at 0900 hours, an observation and concurrent interview was conducted with LVN 1. There was an undated and unlabeled resealable, transparent plastic bag of dry cereal stored on Resident 29's bedside table. LVN 1 stated they only labeled the wet food, not dry food.</p> <p>On 4/2/25 at 1032 hours, an interview with the DON. The DON stated the bag of dry cereal should have been labeled and dated. The DON verified the findings.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' medical records were complete and accurate for six of 13 final sampled residents (Residents 16, 17, 25, 28, 29, and 339) and two nonsampled residents (Residents 640 and 641).</p> <p>* The facility failed to ensure the signatures on the informed consent for the buspirone (antianxiety medication) medication for Resident 16 matched the printed names on the consent form. Additionally, Resident 16's MAR entries failed to show the job designation of the staff signing.</p> <p>* The facility failed to ensure the MAR entries showed the job designation of the staff signing the MAR for Residents 17, and 339.</p> <p>* The facility failed to ensure Resident 28's medication administrations, treatments, and monitorings were documented in the MAR after it was administered or provided. Additionally, the consent to treat and consent for the use lorazepam (antianxiety medication) was incomplete.</p> <p>* The facility failed to ensure Resident 25's consent for the use of the buspar medication (antianxiety) was complete.</p> <p>* Resident 2's advance directive was not available in active medical record.</p> <p>* The facility failed to document the physician's name, date and time when the physician was notified and name of the nurse who notified the physician when Residents 29, 640, and 641 did not meet the McGeer's criteria but received the antibiotic treatments.</p> <p>These failures posed the risk for the resident care needs not being met as their medical record information were inaccurate and incomplete.</p> <p>Findings:</p> <p>Review of the Health and Human Services Agency, California Department of Public Health AFL (All Facilities Letter) 24-07 showed under the examination and signatures: before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain the informed written consent signed by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. If the resident or resident's representative cannot sign the form, a licensed nurse can sign the form and document the name of the person who gave consent and the date.</p> <p>1. Medical record review for Resident 16 was initiated on 4/1/25. Resident 16 was readmitted to the facility on [DATE].</p> <p>* Review of Resident 16's Order Summary Report showed a physician's order dated 3/18/25, to administer buspirone 5 mg one tablet two times a day, to start on 3/25/25.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 16's Skilled Nursing - Psychotropic Consent - V1 dated 3/24/25, showed a verbal consent was obtained from Resident 16. The consent form, under the Verbal Consent section, showed the names of RN 1 and the DON printed as the healthcare professional/ facility staff. Further review of the consent form did not show the signatures of RN 1 and the DON, and there was no signature of the physician.</p> <p>On 4/3/25 at 1337 hours, an interview and medical record review was conducted with the Medical Records Director. The Medical Records Director stated the informed consent forms were kept in an accordion file folder in her office, and the informed consent forms and all other medical records were uploaded to the resident's electronic health records as soon as the physician had signed it, and all the information on the medical record forms was completed. When asked about Resident 16's informed consents, the Medical Records Director stated, everything has been uploaded to PCC.</p> <p>On 4/3/25 at 1350 hours, an interview and medical record review was conducted with the DON. When asked about Resident 16's informed consent for buspirone medication, the DON verified the form in the resident's electronic health record did not show the signatures of RN 1 and the DON.</p> <p>On 4/3/25 at 1520 hours, the Medical Records Director gave a copy of Resident 16's Skilled Nursing - Psychotropic Consent - V1 dated 3/24/25, for the buspirone medication. The consent form showed the names of RN 1 and the DON printed as the healthcare professional/ facility staff, with signatures below their printed name, and also a signature of the physician.</p> <p>On 4/4/25 at 1045 hours, a follow-up interview and concurrent medical record review was conducted with the DON. Review of Resident 16's Skilled Nursing - Psychotropic Consent - V1 dated 3/24/25, for buspirone medication showed the names of RN 1 and the DON printed as the healthcare professional/ facility staff, with signatures below their printed name, and a signature of the physician. When asked about the signatures on the consent form, the DON stated the MDS Coordinator and another LVN signed the consent form. The DON acknowledged the signatures were not signed by the healthcare professional/ facility staff who actually verified the resident's informed consent for the buspirone medication.</p> <p>On 4/4/25 at 1100 hours, an interview and medical record review was conducted with the MDS Coordinator. When asked about the residents' informed consent. The MDS Coordinator stated the informed consents for psychotropic medications were obtained by the nurses, and if missed, she would follow up with the resident. When asked about the informed consent for buspirone medication for Resident 16, the MDS Coordinator stated RN 1 and the DON already spoke to the resident about the buspirone medication, and she did not speak to Resident 16 about the buspirone medication, but she acknowledged she signed the consent form.</p> <p>On 4/4/25 at 1110 hours, an interview and medical record review was conducted with LVN 1. When asked about the informed consent for buspirone medication for Resident 16, LVN 1 stated he did not speak with Resident 16 about the buspirone medication, but he acknowledged he signed the consent form.</p> <p>* Review of Resident 16's MAR for March 2025, under the Staff Administration Legend section, did not show the professional titles for seven of 10 staff who signed the MAR.</p> <p>Review of Patient 16's MAR for April 2025, under the Staff Administration Legend section, did not show the professional titles for two of four staff who signed the MAR.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 1027 hours, an interview and concurrent medical record review for Patient 16 was conducted with the DON. The DON verified the above findings.</p> <p>2. Medical record review for Resident 17 was initiated on 4/1/25. Resident 17 was readmitted to the facility on [DATE].</p> <p>Review of Resident 17's MAR for March 2025, under the Staff Administration Legend section, did not show the professional titles for 12 of 14 staff who signed the MAR.</p> <p>Review of Patient 17's MAR for April 2025, under the Staff Administration Legend section, did not show the professional titles for four out of four staff who signed the MAR.</p> <p>On 4/7/25 at 1027 hours, an interview and concurrent medical record review for Patient 16 was conducted with the DON. The DON verified the above findings.</p> <p>3. Medical record review for Resident 339 was initiated on 4/1/25. Resident 339 was readmitted to the facility on [DATE].</p> <p>Review of Resident 339's MAR for March 2025, under the Staff Administration Legend section, did not show the professional titles for one of two staff who signed the MAR.</p> <p>Review of Patient 339's MAR for April 2025, under the Staff Administration Legend section, did not show the professional titles for three of three staff who signed the MAR.</p> <p>On 4/7/25 at 1027 hours, an interview and concurrent medical record review for Patient 16 was conducted with the DON. The DON verified the above findings.</p> <p>50787</p> <p>4. Medical record review for Resident 28 was initiated on 4/3/25. Resident 28 was admitted on [DATE].</p> <p>a. Review of Resident 28's Skilled Nursing - Psychotropic Consent dated 2/24/25, for the use of the lorazepam medication every 12 hours showed the provider's signature. However, the form failed to show the date when the provider had signed the consent for the lorazepam medication.</p> <p>Review of Resident 28's H&P examination dated 2/26/25 showed Resident 28 has the capacity to understand and make decisions. The H&P further showed Resident 28 was on the lorazepam 1 mg tablet, give one tablet by mouth two times daily for 14 days.</p> <p>On 4/7/25 at 900 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified and acknowledged the consents for Resident 28 were incomplete. RN 1 stated, this is not good, all consents should have been completed.</p> <p>b. Review of the facility's P&P titled Administering Medications revision date April 2019 showed the individual administering the medication, initials the resident's MAR on the appropriate line after giving each medication, before administering the next one.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 28's MAR for March 2025 showed a blank documentation during the morning shift on 3/5/25, for the following medications, treatments, and monitoring:</p> <ul style="list-style-type: none"> - the covid 19 monitoring; - the documentation for the number of times of the urine output; - the enhanced barrier precaution; - the lactobacillus oral capsule (a probiotic medication); - the lactulose oral solution (bowel management) medication; - the resident ' s intake in ml provided by nursing during each shift; - the observation for the central venous catheter site for signs and symptoms of infiltration /extravasation, redness, swelling or pain every shift; - the monitoring for the presence of pain every shift; - the pain non-pharmacological intervention provided every shift; - the snacks being provided three times a day; - the Voltaren (arthritis pain relief) external gel 1%, applied to left and right shoulder topically three times daily; - the respiratory order for incentive spirometer four times a day; and - the vancomycin HCL oral suspension (antibiotics) 50 mg/ml by mouth four times a day. <p>Review of Resident 28's MAR for April 2025 showed a missing or inaccurate documentation for</p> <p>the monitoring for the signs/symptoms of the anticoagulant (blood thinner medication) complications during the day and night shift on 4/1/25. The MAR showed documentation 60 for the section to document if the resident with signs and symptoms from the use of the anticoagulant complications.</p> <p>On 4/7/25 at 0908 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked regarding Resident 28's inaccurate documentation of the monitoring for the signs/symptoms of the anti-coagulant complications during the night shift on 4/1/25. RN 1 stated, I don't know why it was document as 60, it should have been a positive or negative sign.</p> <p>On 4/7/25 at 1502 hours, an interview and concurrent medical review was conducted with LVN 4. LVN 4 stated, yes, I remember I gave the medications and did all of the treatment left and may have forgotten to click them (to save) after I did. LVN 4 further stated I should have clicked saved after I administered the medications and monitored Resident 28, then rechecked for the completion at the end of the shift.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. Medical record review for Resident 25 was initiated on 4/4/25. Resident 25 was admitted to the facility on [DATE].</p> <p>Review of Resident 25's Skilled Nursing- Psychotropic Consent dated 3/13/25, failed to show the physician's signature and date.</p> <p>Review of Resident 25's Physician's Progress Note dated 3/31/25, showed Resident 25's mental status was alert, interactive, and cooperative.</p> <p>Review of Resident 25's Order Summary Report dated 4/2/25, showed a physician's order dated 3/31/24, for bupropion HCl (medication to treat depression) tablet extended release 150 mg one tablet by mouth one time a day for depression.</p> <p>On 4/4/25 at 1359 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 stated she would follow up any incomplete consents after a resident's admission. LVN 4 stated she would check the physician's progress notes if the resident or family was notified of the medication, consented or declined to give the consent. LVN 4 further stated if there was no documentation, she would follow up with the physician and the resident's family member then would complete the consent form. LVN 4 verified and acknowledged Resident 25's informed consent for the buspirone medication was incomplete.</p> <p>On 4/7/25 at 0900 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified and acknowledged the consent for Residents 25 was incomplete. RN 1 stated, this is not good, all consents should have been completed.</p> <p>On 4/7/25 at 1330 hours, an interview was conducted with the DON and Administrator for Residents 25, 26, and 28. The DON and Administrator were made aware and acknowledged the above findings.</p> <p>32179</p> <p>6. Medical Record review for Resident 2 was initiated on 4/1/25. Resident 2 was admitted to the facility on [DATE].</p> <p>Review of Resident 2's H&P examination dated 3/18/25, showed Resident 2 had the capacity to understand and make decision.</p> <p>Review of Resident 2's POLST dated 3/17/25, under section D for the advance directive, showed no documented evidence whether the advance directive had been discussed, if unavailable, or not applicable.</p> <p>On 4/2/25 at 1450 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD was asked whether Resident 2 had been offered an advance directive and to provide documentation of it. The SSD stated Resident 2 had the capacity but was unable to provide documentation of the resident's advance directive. The SSD further stated upon admission, the admission coordinator should have uploaded the advance directive to Resident 2's medical record. The SSD verified the above findings.</p> <p>51920</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. Review of the facility's P&P titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcome revised December 2016 showed the IP or designee will review the antibiotic utilization as a part of the antibiotic stewardship program and identify the specific situations that are not consistent with the appropriate use of antibiotic. The P&P further showed at the conclusion of the review, the provider to be notified of the review findings.</p> <p>Review of the facility's document titled Infection Surveillance Monthly Report for February 2025 showed Residents 29, 640, and 641 were prescribed with the antibiotics in February but did not meet the McGeer's Criteria. Further review of the Infection Surveillance Monthly Report for February 2025 showed the column for Comments with the following information:</p> <ul style="list-style-type: none"> - for Resident 29, per MD continue IV antibiotic, - for Resident 640, per MD complete antibiotic course, and - for Resident 641, MD notified still wants to complete course. <p>Review of Residents 29, 640, and 641's medical records failed to show the name of the physician, date, and time when the physician was notified; and name of the nurse who notified the physician and received the order and the justification or reason to continue the antibiotic medication use when the residents did not meet the McGeer's Criteria.</p> <p>On 4/3/25 at 1323 hours, an interview and concurrent medical record review was conducted with the IP. When asked when and who notified the physician, the IP was unable to locate the documentation in the Infection Surveillance Monthly Report or in Residents 29, 640, or 641's medical record to show the name of the physician, date and time when the physician was notified, and name of the nurse who notified the physician and received the order and justification to continue the antibiotic treatments for the residents who did not meet the McGeer's Criteria.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920</p> <p>Based on interview, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were maintained.</p> <p>* The facility failed to accurately classify which residents met the McGeer's Criteria in the infection control surveillance. This failure posed the risk of inaccurately identifying if the residents met the criteria for true infections and appropriate antibiotic use.</p> <p>* The facility failed to implement the neutropenic precautions for Resident 17. Fresh flowers were observed at bedside, the door was not kept closed, and the IP was observed entering the room without a mask.</p> <p>* The facility failed to ensure the enhanced barrier precautions for Resident 591 were observed.</p> <p>* The sink in Medication Room A was not clean.</p> <p>These failures posed the risk of potential transmission of communicable diseases to other residents in the facility.</p> <p>Findings:</p> <p>1. According to the CDC, unnecessary antibiotic use promotes development of antibiotic-resistant bacteria. Every time a person takes antibiotics, sensitive bacteria are killed, but resistant germs may be left to grow and multiply. Repeated and improper use of antibiotics is the primary cause of the increase in drug-resistant bacteria.</p> <p>Review of the facility's P&P titled Antibiotic Stewardship-Order for Antibiotics dated 12/2016 showed the appropriate use of antibiotic included criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).</p> <p>Review of the facility's P&P titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcome revised 12/2016 showed the IP or designee will review antibiotic utilization as a part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotic. The P&P further showed at the conclusion of the review, the provider to be notified of the review findings.</p> <p>On 4/7/25 at 1019 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the Infection Surveillance Monthly Reports were the tool the facility to use to track the infections. Review of the December 2024 and January 2025 Infection Surveillance Monthly Reports failed to show the tracking for the residents who did not meet the McGeer's Criteria. The IP verified the above information and was unable to provide alternate documentation to show for the tracking of the resident's McGeer's criteria.</p> <p>39453</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the facility's P&P titled Isolation - Categories of Transmission-Based Precautions revised 9/2022, under the Neutropenic Precautions (Reverse Isolations) section, showed the following:</p> <ul style="list-style-type: none"> - Neutropenic precautions, also known as reverse isolation, are implemented to protect immunocompromised residents from potential sources of infection. These residents are at increased risk for acquiring infections from other individuals or the environment due to weakened immune systems; - The resident is placed in a private room with strict attention to cleanliness and infection control practices; - Masks may be worn by staff and visitors, especially if there is a known risk of respiratory infection; and - Fresh flowers, plants, and fruits/vegetables that are not fully cooked or washed are typically restricted due to potential sources of pathogen. <p>Review of the facility's document titled Neutropenic Precautions showed the following:</p> <ul style="list-style-type: none"> - For the visitors to report to the nurses' station before entering the room; - Private room with closed door; - Handwashing is required upon entering the room; - No fresh fruits, vegetables or flowers maybe taken into the room; and - No visitors or staff with infections illnesses may enter the room. <p>On 4/1/25 at 0935 hours, during the initial tour of the facility, a sign was observed outside Resident 17's room by the door, notifying the staff and visitors that the resident was on neutropenic precautions. A sign showing the sequence for putting on PPE was also posted outside Resident 17's room by the door. The door was observed open and Resident 17 was observed in bed. Two vases with fresh flowers were observed at bedside.</p> <p>Medical record review was initiated on 4/1/25. Resident 17 was readmitted to the facility on [DATE].</p> <p>Review of Resident 17's Order Summary Report showed a physician's order dated 2/18/25, for neutropenic precautions related to cancer post chemo treatment.</p> <p>On 4/1/25 at 1130 and 1604 hours, on 4/2/25 at 0848 and 1406 hours, a neutropenic isolation sign was observed posted outside the resident's door. The door was observed open.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/25 at 1409 hours, an observation for Resident 17 and concurrent interview was conducted with the IP. A neutropenic isolation sign was observed posted outside the resident's door. The door was observed open. Resident 17 was observed in bed and asked for assistance with repositioning her arm. Two vases with fresh flowers were observed at bedside. The IP was observed going into the room with gown and gloves but without a mask on. The IP was observed assisting Resident 17. The IP verified she did not wear a mask when she entered the room and had assisted Resident 17. The IP also verified the door was open, and there were two vases with fresh flowers at the resident's bedside. The IP stated the mask, gloves, and gown should be worn when entering the room on neutropenic precaution and the door should be closed at all times.</p> <p>50787</p> <p>3. On 4/7/25 at 832 hours, Resident 591 was observed being transferred by CNA 2 from the bed to the wheelchair inside her room. CNA 2 was observed not wearing a gown during the transfer. A signage was observed outside Resident 591's room for the Enhanced Barrier Precautions and the instructions included the donning of the PPE.</p> <p>On 4/7/25 at 0837 hours, interview was conducted with CNA 2. When asked what PPE to use during the care of Resident 591, CNA 2 stated, I wear a gown and gloves when I am changing her and not during transfers. CNA 2 was shown the signage outside the room regarding the Enhanced Barrier Precautions which included dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting care, device care or use including urinary catheter and wound care.</p> <p>Medical record review for Resident 591 was initiated on 4/7/25. Resident 591 was admitted to the facility on [DATE].</p> <p>Review of Resident 591's Order Summary Report showed a physician's order dated 3/22/25, for the Enhanced Barrier Precautions secondary to the presence of the indwelling medical device.</p> <p>On 4/7/25 at 0844 hours, an interview was conducted with LVN 2. LVN 2 was asked regarding Resident 591's enhanced barrier precaution order. LVN 2 stated, we have to wear a PPE when taking care of Resident 591. LVN 2 was made aware that CNA 2 did not wear a gown during Resident 591's transfer from the bed to the wheelchair. LVN 2 stated CNA 2 should have worn a gown.</p> <p>On 4/7/25 at 1315 hours, an interview was conducted with the IP. The IP stated a gown must be worn when taking care of a resident on an enhanced barrier precautions including the transfers. The IP acknowledged the above findings.</p> <p>On 4/7/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was made aware and acknowledged the above findings.</p> <p>48332</p> <p>4. Review of the facility's P&P titled Storage of Medications revised 11/2020 showed the facility stores all the drugs and biologicals in a safe, secure, and orderly manner. The nursing staff is responsible for maintaining the medication storage and preparation areas in a clean, safe and sanitary manner.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/25 at 0910 hours, an interview and concurrent observation of Medication Room A was conducted with RN 1. RN 1 verified the sink in Medication Room A was dirty, the sink strainer had brown color discoloration, the circular portion surrounding the drainage had bluish discoloration measuring approximately 5 cm x 7 cm in its widest diameter, and the elongated dirt materials were soaked in water at the base of the strainer. There was also whitish streak discoloration at the top of the sink on the right side of the faucet. RN 1 stated the water was leaking from the faucet and sink was stained blue. RN 1 verified the sink needed maintenance and needed to be cleaned.</p> <p>On 4/2/25 at 0920 hours, an interview and concurrent observation of Medication Room A's sink was conducted with the DON. The DON verified the findings and stated it should be clean all the time.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>48332</p> <p>Based on observation, interview and facility P&P review, the facility failed to ensure the equipment was maintained in a safe and operable manner.</p> <ul style="list-style-type: none"> * The sink faucet in Medication Room A was leaking. * The facility failed to ensure the ice machine in the main kitchen was cleaned and sanitized as per the manufacturer's specifications. * The facility failed to ensure there was no ice build-up in the walk-in freezer in the main kitchen, the freezer in the satellite kitchen, and the freezer of the refrigerator used for residents' food brought from outside source. * The facility failed to ensure the thermometer used in the satellite kitchen was calibrated properly. <p>These failures had the potential for the equipment to not function in the way it was intended.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Maintenance Service revised 12/2009 showed the maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds and equipment are maintained in a safe and operable manner.</p> <p>On 4/2/25 at 0910 hours, an interview and concurrent observation of Medication Room A was conducted with RN 1. RN 1 verified the sink faucet in Medication Room A was leaking, the sink strainer had brown color discoloration, the circular portion surrounding the drainage had bluish discoloration measuring approximately 5 cm x 7 cm in the widest diameter, and the base of the strainer was soaked with water. RN 1 verified water was leaking from the faucet and the sink was stained blue. RN 1 stated maintenance should have fixed the leakage, and nurses should have reported when they found the leakage.</p> <p>On 4/2/25 at 0920 hours, an interview and concurrent observation of Medication Room A sink was conducted with the DON. The DON verified the leaking faucet from the sink. The DON stated they would discuss with the Administrator and maintenance staff to fix it.</p> <p>On 4/2/25 at 1005 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance verified the leaking faucet and stated it could have been fixed if the nurses had reported the leakage.</p> <p>39453</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. According to the FDA Food Code 2022 Section 4-501.11 showed equipment shall be maintained in good repair and proper adjustment. Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed.</p> <p>Review of the facility's P&P titled Ice Machines and Ice Storage Chests revised 1/2012 showed the facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions.</p> <p>Review of the Manitowoc Indigo NXT Ice Machines Installation, Operation and Maintenance Manual dated 5/11/18, under Maintenance section showed the following:</p> <ul style="list-style-type: none"> - Clean and sanitize the ice machine every six months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment. An extremely dirty ice machine must be taken apart for cleaning and sanitizing; - Manitowoc Ice Machine Cleaner and Sanitizer are the only products approved for use in Manitowoc ice machines; - For exterior cleaning, clean the area around the ice machine as often as necessary to maintain cleanliness and efficient operation. Wipe surface with a damp cloth rinsed in water to remove dust and dirt from the outside of the ice machine. If a greasy residue persists, use a damp cloth rinsed in a mild dish soap and water solution, and wipe dry with a clean, soft cloth; and - The cleaning and sanitizing procedure must be performed a minimum of once every six months. The ice machine and bin must be disassembled, cleaned and sanitized. <p>Review of the facility's document titled Invoice from the facility's outside vendor showed a preventative maintenance cleaning and sanitizing was performed on the ice machine in the main kitchen on 2/20/25.</p> <p>Review of the facility's document titled Ice Machine Cleaning Log showed the ice machine in the main kitchen was cleaned on 3/8/25.</p> <p>On 4/2/25 at 0942 hours, an inspection of the ice machine in the main kitchen, interview and concurrent facility document review was conducted with the Director of Maintenance. The ice machine was observed with black particles on the ice machine deflector and on the groove in front of deflector when wiped with a white paper towel. The Director of Maintenance verified the above findings. The Director of Maintenance stated an outside vendor provided cleaning service to the ice machine quarterly. The Director of Maintenance also stated the dietary staff was responsible for cleaning the exterior of the ice machine, and the bin of the ice machine. The Director of Maintenance stated the dietary staff used a food-grade multi-quat sanitizing solution to clean the bin of the ice machine. The Director of Maintenance verified the dietary staff was not using the Manitowoc Ice Machine Cleaner and Sanitizer solution as indicated in the manufacturer's manual to clean the ice storage bin of the ice machine in the main kitchen nor the exterior of the ice machine.</p> <p>Cross-reference to F812, example #3.a.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. a. On 4/1/25 at 0850 hours, an observation of the main kitchen and concurrent interview was conducted with the Culinary Director. There was no thermometer observed inside the walk-in freezer. The walk-in freezer was observed with a thick ice build-up from floor to the ceiling on the interior part of the freezer near the door. There were several food items in the freezer that were covered with ice. The Culinary Director verified the above findings. The Culinary Director stated there was something wrong with the freezer door and a new freezer door had been ordered.</p> <p>On 4/3/25 at 0949 hours, an interview and concurrent facility document review was conducted with the Director of Maintenance. The Director of Maintenance stated there was an ice build-up because the needed to be replaced and stated a there was a lead time of four to six weeks when the freezer door will be delivered. When asked when the freezer door was inspected and the walk-in freezer cleaned, the Director of Maintenance stated they removed the ice build-up and cleaned the walk in area a couple of days ago.</p> <p>Review of the facility's document titled Freezer Door Cleaning Log showed it was signed off on 3/3, 3/10, 3/17, 3/24, and 3/31/25.</p> <p>b. On 4/1/25 at 0821 hours, during the initial tour of the satellite kitchen, ice build-up was observed inside the freezer. The Dietary Aide verified the above findings.</p> <p>c. On 4/1/25 at 1133 hours, an inspection of the refrigerator used for the residents' food brought from outside and concurrent interview was conducted with RN 1. An ice-build up was observed inside the freezer and a brownish discoloration was observed on the shelves of the refrigerator used for the residents' food brought from the outside source. RN 1 verified the above findings.</p> <p>On 4/3/25 at 0949 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance stated the housekeeping staff was responsible for the weekly cleaning of the refrigerator used for the residents' food brought from the outside sources, which was usually on Mondays.</p> <p>On 4/3/25 at 1016 hours, an interview was conducted with the CDM. The CDM stated the dietary staff was responsible for the weekly cleaning of the refrigerator used for residents' food brought from outside sources.</p> <p>4. According to the FDA Food Code 2022, section 4-502.11, showed food temperature measuring devices shall be calibrated in accordance with manufacturer's specifications as necessary to ensure their accuracy.</p> <p>Review of the Lonicera Thermometer User Instruction (undated) showed to calibrate, take a cup of water and insert the probe into the ice water to touch the ice. When the final temperature is reached, hold down the CAL button for five seconds. After five seconds, the display will flash CAL on the screen, then the digit will flash, then press the C/F button to increase the digit or the HOLD button to decrease the digit until 0C or 32 F is reached.</p> <p>Review of the facility's P&P titled How to Calibrate Thermometers: Bi-Metallic Stem and Digital revised 12/12/19, showed calibration of thermometers is a must in order to assure the temperature displayed on the thermometer is accurate. The method of calibration for bi-metallic stem and digital thermometers includes the following:</p> <p>(continued on next page)</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Fill a medium size glass with clean ice; - Add 1/2 cup clean water to the ice and wait for two minutes; - Using the case as a handle, place the thermometers in the middle of the ice water and wait for three minutes while stirring the water occasionally. The thermometer must be two inches deep in the water and ice in order for the sensing area to be covered completely; - If the temperature reading is 32 degrees F, the thermometer is calibrated accurately. If the thermometer does not record 32 degrees F, then an adjustment is needed. For digital thermometer, leave it in ice water. Press the reset button. If it does not read 32 degrees F, add a battery and recheck or replace the thermometer. <p>On 4/2/25 at 1117 hours, a thermometer calibration observation and concurrent interview was conducted with the Dietary Aide, and the CDM was present. The Lonicera thermometer was observed in a cup with ice and water. The Dietary Aide stated to calibrate the thermometer, the C/F button needed to be pressed and then wait for the temperature to go down to 32 degrees F. The Dietary Aide was observed pressing the C/F button. Then, the Dietary Aide was observed repeatedly pressing the C/F and HOLD buttons. The thermometer showed 33.4 degrees F temperature. The Dietary Aide was observed using the thermometer to check the food temperature. The CDM verified the above findings.</p> <p>On 4/3/25 at 1016 hours, an interview was conducted with the CDM and RD. The CDM verified the Dietary Aide did not calibrate the thermometer correctly. The CDM stated the Dietary Aide was supposed to push the calibrate button for five seconds, and let the thermometer sit in the cup with water and ice, then lift the thermometer up and pushed the button more to get the temperature down to 32 degrees F.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' beds were inspected and the entrapment assessments were conducted when identifying areas of possible entrapment with the use of bed rails for two of four final sampled residents (Residents 26 and 339) investigated related to the use of side rails. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.</p> <p>Findings:</p> <p>1. According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are:</p> <ul style="list-style-type: none"> - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. <p>Review of the facility's P&P titled Bed Safety revised 12/2007 showed to try to prevent deaths/ injuries from the beds and related equipment including the frame, mattress, side rails, headboard, footboard, and bed accessories, the facility shall promote the following approaches:</p> <ul style="list-style-type: none"> - Inspection by the maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; - Review that gaps within the bed system are within the dimensions established by the FDA. The review shall consider situations that could be caused by the resident's weight, movement or bed position; and <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Identify additional safety measures for residents who have been identified as higher than usual risk for injury including entrapment such as altered mental status, restlessness, etc.</p> <p>On 4/1/25 at 0904 hours, 4/3/25 at 1412 hours, 4/4/25 at 1030 hours, and 4/7/25 at 0942 hours, Resident 339 was observed lying in bed with the bilateral grab rails elevated.</p> <p>Medical record review for Resident 339 was initiated on 4/1/25. Resident 339 was admitted to the facility on [DATE].</p> <p>Review of Resident 339's Order Summary Report showed a physician's order dated 3/31/25, for the bilateral deluxe assist bed handles while in bed for turning and positioning.</p> <p>Review of Resident 339's Skilled Nursing - Admission Initial Eval - V 13 dated 3/31/25, showed the following:</p> <ul style="list-style-type: none"> - The Cognition/ Mental Status section showed Resident 339 was alert and oriented; - The Functional GG section showed Resident 339 required supervision from the facility staff for mobility and transfers; and - The Side/ Bed Rail Evaluation, Evaluation of Entrapment Risk section showed there were gaps between the resident's mattress and side/ bed rail, headboard and footboard. <p>On 4/7/25 at 1027 hours, an interview and concurrent medical record for Resident 339 was conducted with the DON. The DON verified the initial evaluation for Resident 17 showed there were gaps between the resident's mattress and side/bed rail, headboard, and footboard.</p> <p>On 1/24/25 at 1225 hours, a concurrent interview and facility document review for Resident 339 was conducted with the Director of Maintenance. The Director of Maintenance stated the maintenance department was responsible for the yearly bed inspection of all the beds in the facility, including the Entrapments Zones 1 to 4. When asked if he inspected the bed when there was a change of bed or mattress or a new resident to determine if any areas of possible entrapment are present based on the change of the bed, or mattress, or user, the Director of Maintenance stated he did not go back to check, not unless the resident had a low air loss mattress. The Director of Maintenance also stated they would only check the bed frame when the nurses reported to have it repaired. When asked to show documentation of his bed inspection, the Director of Maintenance showed and verified the following documents:</p> <ul style="list-style-type: none"> - The facility document titled Bed Safety Action Grid dated 6/1/18, showed Entrapment Zones 1 to 4 were encircled. - The facility document titled Bed Rail Inspection dated 1/25/25, showed Resident 339's bed passed. - The facility document titled Entrapment Measurements for Resident 339's bed dated 1/25/25, showed Zones 1 to 4 were marked P. The areas to show entrapment measurements between the mattress and the headboard and footboard were left blank. <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Maintenance verified the above findings. When asked if the nurses reported the initial evaluation on 3/31/25, for Resident 17 showing there were gaps between the resident's mattress and side/bed rail, headboard, and footboard and if he conducted a bed inspection and entrapment assessment for Resident 17, the Director of Maintenance answered no. The Director of Maintenance stated he only conducted the bed inspection with the entrapment assessments on 1/25/25, for all the beds in the facility.</p> <p>50787</p> <p>2. On 4/1/25 at 1048 hours, during the initial tour of the facility, Resident 26's bed was observed to have the bilateral enablers.</p> <p>Medical record review for Resident 26 was conducted on 4/7/25. Resident 26 was admitted to the facility on [DATE].</p> <p>Reviewed Resident 26's Order Summary Report dated 4/7/25, showed a physican's order dated 3/3/25, for deluxe assist bed handles up times two while in bed for turning and positioning.</p> <p>Review of Resident 26's Skilled Nursing - Admission Initial Evaluation dated 3/3/25, the section for Side/Bed Rail Evaluation - Evaluation of Entrapment Risk, showed, yes to all the questions if the side rails had gaps between mattress, and side/bed rail, headboard or footboard.</p> <p>On 4/7/25 at 1307 hours, a concurrent observation, interview and facility document review was conducted with the Director of Maintenance. The Director of Maintenance stated the side rails were being inspected annually and as needed when a low air pressure mattress was used. When asked for the bed entrapment measurement documentation for Resident 26, the Director of Maintenance stated he performed the assessment on all the beds on 1/25/25. However, the Director of Maintenance was unable to provide the documentation of the bed entrapment measurements for Resident 26. Resident 26's Evaluation of Entrapment Risk dated 3/3/25, was reviewed with the Director of Maintenance. The Director of Maintenance stated he was not aware of any reported gaps between the mattress, and side/bed rail, headboard or footboard.</p> <p>On 4/7/25 at 1330 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was made aware and acknowledged the above findings.</p>		