STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555859	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to meet the professional standards of care for one of three sampled resident (Resident 1) reviewed for change of condition. * RT 1 failed to follow the professional standards of care when he attended Resident 1's change of condition. This failure posed the risk of not providing the appropriate and necessary care and services to the resident during a change of condition.Findings: Review of the facility's P&P titled Quality of Care released on 10/2022 showed the Subacute Unit (SAU) identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care, and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs and ensure each resident receives necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. According to the American Association for Respiratory Care (AARC) Statement of Ethics and Professional Conduct revised on 10/2021 showed in the conduct of professional activities, the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapist shall:- perform only those procedures or functions in which they are individually competent, and which are within their scope of accepted and responsible practice. Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's BIMS score was zero, indicating severe cognitive impairment. Review of Resident 1's progress note dated [DATE], documented by RN 1 showed at 1145 hours, Resident 1's pulse oximeter machine was alarming and checked by RT 1. RT 1 was unable to obtain the resident's oxygen saturation. RT 1 suctioned Resident 1 and did not obtain any tracheal secretions and/or a gag reflex (a natural, involuntary protective response that prevents foreign objects from entering the airway). However, there was no documentation written by RT 1 regarding the actions and interventions provided to Resident 1. On [DATE] at 1352 hours, a telephone interview was conducted with RT 1. RT 1 stated he attended Resident 1's alarming pulse oximeter on [DATE]. RT 1 was asked to explain in detail to describe Resident 1's condition and what had occurred after he entered Resident 1's room on [DATE]. RT 1 stated on [DATE], he was covering for the assigned RT's lunch break when the licensed nurse asked him to check Resident 1's alarming pulse oximeter. RT 1 stated he went to the RT 1's room right away and a male family member was present at the bedside. The resident's pulse oximeter machine was alarming without any numbers showing on the machine. RT 1 stated he observed Resident 1 lying on the bed, with his eyes closed and appearing to be jaundice (a yellow discoloration of the body tissue) on his face, and lethargic (a state of feeling sluggish, tired, and lacking energy). RT 1 stated he introduced himself to the family member and explained he would check the pulse oximeter. RT 1 stated he was trouble shooting the pulse oximeter when he observed Resident 1's hand was wet and proceeded to apply a new pulse oximeter on a different finger. Meanwhile, RT 1 stated Resident 1 still appeared lethargic. In addition, RT 1 stated after changing the pulse oximeter and placing the pulse oximeter on a different finger, the pulse oximeter machine was alarming and not showing the pulse oximeter reading. RT 1 stated Resident 1's family member attempted to wake Resident 1; however, Resident 1 did not respond. RT 1 stated he tapped Resident 1 to wake him up and decided to suction Resident 1 since it usually induced a gag reflex. Prior to RT 1 suctioning Resident 1, RT 1 stated he observed Resident 1 with the same jaundice color on the face, lethargic, not gasping for air, or congested. RT 1 stated after he suctioned Resident 1 twice via the closed inline suction (a medical technique that uses a sterile, closed-loop system to remove secretions from a tracheostomy tube or endotracheal tube while the patient remains connected to a ventilator), there was no gag reflex observed. RT 1 then provided 100% oxygenation and grabbed the portable pulse oximeter from the cart located outside Resident 1's door. RT 1 checked Resident 1's oxygen saturation, however the pulse oximeter did not show the resident's oxygen saturation level and heart rate. RT 1 stated he proceeded to check Resident 1's pulse for the first time on the resident's right radial (smaller bone in the forearm) for 10-15 seconds and noted the resident had no pulse. RT 1 stated Resident 1 was observed to be unresponsive, so he pressed the blue button by the wall for emergency assistance. RT 1 stated after he pressed the blue button, he quickly went out of Resident 1's room to the nurse's station to ask the licensed nurse for Resident 1's code status. RT 1 stated Resident 1 was full code (a healthcare directive indicating that all life-saving measures, such as CPR, should be used if a resident's

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for one of five sampled residents (Resident 1). * The facility failed to obtain the physician's orders and informed consents prior to the beside debridement (the medical removal of dead, damage, or infected tissue to improve the healing potential of the remaining tissue) for Resident 1's scrotal and perineal/perianal wounds. In addition, the facility failed to ensure the wound assessments were completed after the bedside debridement. These failures had the potential for Resident 1 to not receive the necessary care and services to maintain the resident's highest physical well-being.Findings: Review of the facility's P&P titled CORE: Conservative Sharp Wound Debridement released 6/2021 showed conservative sharp wound debridement:a. May require more than one session (serial based on the needs of the patient and the characteristics of the wound).c. Each debridement requires a new and separate consent. (Example: physician orders a serial session of four debridement. Four separate consents should be attained, one before each debridement.) Further review of the facility's P&P showed to photograph, measure the wound, apply appropriate topical treatment and document the wound assessment procedure performed in the weekly wound documentation pathway. Closed medical record review for Resident 1 was initiated on 9/2/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/5/25. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had severely impaired cognitive skills for daily decision making. a. Review of Resident 1's Informed Consent for Surgical and Special Procedures dated 6/21/25, showed a consent was obtained for: incision, drainage, and debridement of perineal abscess. Review of Resident 1's Wound Consultant Physician's Operative/Procedure Report dated 6/21/25, showed the following procedure was performed: incision drainage, and debridement of perineal, bilateral perianal, and scrotal abscess. Further review of the Operative Report showed the open wound was subsequently packed and dressed with Betadine (an antiseptic product that contains the active ingredient povidone-iodine) soaked Kerlix (a brand of pre-washed, 100% woven cotton gauze bandage rolls). Review of Resident 1's Wound Consultant Physician's Operative/Procedure Report dated 6/27/25, showed the following procedure was performed: excisional (to surgically remove) debridement of open wound of scrotum and perineum, with excision of devitalized (having been deprived of life, vigor, or effectiveness), necrotic (dead or dying cells and tissue resulting from necrosis, a pathological process where cells in living tissue die due to injury or lack of blood supply) skin and subcutaneous fat. However, review of Resident 1's Physician Order Sheet for June 2025 failed to show the physician's order for the procedures on 6/21 and 6/27/25. Further review of Resident 1's closed medical record failed to show an informed consent was obtained and signed for the excisional debridement of the open wound of the scrotum and perineum, with excision of devitalized, necrotic skin and subcutaneous fat on 6/27/25. On 9/7/25 at 1500 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON stated there should be a physician's order for any planned procedure including the order to obtain the consent for the procedure. The DON stated the procedure written on the informed consent should match the physician's order. The DON stated if the consent did not match the procedure to be performed, the licensed nurse needed to obtain a new consent to match the procedure to be performed. The DON stated per the facility's P&P, there should be one informed consent obtained for each procedure to be performed. The DON reviewed Resident 1's medical record and verified the above findings. The DON further verified the documented procedure on Resident 1's consent for 6/21/25, did not match the procedure documented on the Wound Consultant Physician's Operative/Procedure Report. b. Review of Resident 1's Wound Consultant Physician's Operative/Procedure Report dated 6/21/25, showed the following procedure was performed: incision, drainage, and debridement of perineal, bilateral perianal, and scrotal abscess. Further review of the Operative Report showed the wound was measured following the completion of the procedure and the measurements were documented accordingly. The open wound was subsequently packed and dressed with betadine soaked Kerlix. Review of Resident 1's Wound Consultant Physician's Operative/Procedure Report dated 6/27/25, showed the following procedure was performed: Excisional debridement of open wound of scrotum and perineum, with excision of devitalized, necrotic skin and subcutaneous fat. Further review of the Operative/Procedure Report showed the wound was measured following the completion of the procedure and the measurements were documented accordingly. The open wound was subsequently packed and dressed with Kerlix soaked in

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services related to pressure injuries (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore to promote wound healing) were provided to three of three sampled residents (Residents 1, 2, and 3) reviewed for wound management. * The facility failed to ensure the physician was informed and a change of condition was initiated when there was an increase in the wound size and necrotic tissue for Resident 1's sacrococcyx (fused bone at the very end of the spine) pressure injury. * The facility failed to ensure the LAL mattress setting was consistent with Residents 2 and 3's weight. These failures posed the risk for complications and delayed wound healing.Findings: Review of the facility's P&P titled CORE: Clinical Guidelines for Pressure Injury released 6/2022 showed each resident should have an individualized plan of care created around the identified risk level. Principles of wound healing: (d.) identify the type and volume of wound drainage, (e.) document the injury size, depth, and location per wound care team/designee, f. identify tissue type (necrotic, pink, yellow, etc.). Standard interventions for all patients can include but are not limited to: (a.) high specification support surface, (b.) skin and wound assessment, (c.) repositioning orders, (d). wound care consult. Review of the facility's P&P titled Prevention and Treatment of Pressure Injury and Other Skin Alterations released 11/2022 showed based upon the assessment and the resident's clinical condition, choices and identified needs, basic or routine care could include, but is not limited to, interventions to: (a.) redistribute pressure; (c.) provide appropriate, pressure-redistributing, support surfaces. When assessing the pressure injury itself, it is important that documentation addresses:a. the type of injury because interventions may vary depending on the specific type of injury.b. the pressure injury's stage.c. a description of the pressure injury's characteristics.d. the progress towards healing and identification of potential complications.e. if an infection is present. Further review of the P&P showed with each dressing change or at least weekly (and more often when indicted by wound complications or changes in wound characteristics), an evaluation of the pressure injury should be documented. 1. Closed medical record review for Resident 1 was initiated on 9/2/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/5/25. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had severely impaired cognitive skills for daily decision making. The MDS further showed Resident 1 was at risk for pressure injuries and had an unhealed Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer present upon admission. Review of Resident 1's plan of care showed a care plan problem (undated) addressing Resident 1's potential for further pressure injury development, skin breakdown and skin discoloration related to the Stage 4 sacrococcyx pressure injury. The care plan interventions included to consult the Wound Care Physician as ordered. Review of Resident 1's Wound Assessments for the sacrococcyx wound showed the following documentation:- on 5/31/25, the wound measured 5.0 cm (length) x 5.5 cm (width) x UTD (unable to determine) depth, and the wound bed had 20% granulation, 60% slough, and 20% necrotic tissue.- on 6/11/25, the wound measured 5.0 cm x 5.0 cm x UTD, and the wound bed with 30% granulation, 60% slough, and 10% necrotic tissue.- on 6/18/25, the wound measured 6.5 cm x 6.5 cm x 2.5 cm, and the wound bed with 100% necrotic tissue. The licensed nurse documented the wound was to be debrided on Sunday.- on 6/25/25, the wound measured 8.0 cm x 7.0 cm x 3.0 cm, and the wound bed with 100% necrotic tissue. The licensed nurse documented the wound was noted to be declining. Further review of Resident 1's closed medical record failed to show the documentation the Wound Care Physician was informed of the increase in the wound size and necrotic tissue of Resident 1's Stage 4 sacrococcyx pressure ulcer on 6/18/25, and the increase in the wound size on 6/25/25. On 9/17/25 at 1030 hours, an interview was conducted with LVN 3. LVN 3 stated for the residents with wounds, the weekly skin assessments were completed weekly and as needed when there were any changes noted to the wound, for example if the wound was noted to be declining, deteriorating, or increasing in size. LVN 3 stated when conducting the weekly wound assessment, if the wound was noted with an increase in the size, drainage, or the presence of an odor, the treatment nurse should document the findings in the progress notes and notify the Wound Consultant Physician. LVN 3 verified on 6/18 and 6/25/25, she conducted the weekly wound assessment for Resident 1. LVN 3 reviewed Resident 1's closed medical record and verified the above findings. LVN 3 stated the Wound Care Physician should have been notified and the notification should have been