

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/07/2025
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NAME OF PROVIDER OR SUPPLIER  MAINPLACE POST ACUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1835 WEST LA VETA AVENUE ORANGE, CA 92868
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F 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Number: CA00953053.</p> <p>The survey team entered the facility on 4/3/25 at 1100 hours.</p> <p>The facility identified the census as 151.</p> <p>The survey sample size was 4</p> <p>Inspection was limited to the complaint investigated and did not represent the findings of a full inspection of the facility.</p> <p>* FOR COMPLAINT NUMBER: CA00953053, DEFICIENCIES WERE IDENTIFIED AND CITED AT F760.</p> <p>GLOSSARY AND DEFINITIONS:</p> <p>Corticosteroid - a medicine that works by calming down the body's immune response to reduce pain, itching and swelling. It can also be used as hormone replacement for people who do not have enough of the natural stress hormone, cortisol</p> <p>DON - Director of Nursing</p> <p>H&amp;P - History and Physical</p> <p>MDS - Minimum Data Sheet (a standardized assessment tool that measures health status in nursing home residents)</p> <p>mg - milligram(s)</p>	F 000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provision of Health and safety Code Please accept the plan of correction as our allegation of compliance.</p> <p>F 760</p> <p>How corrective action will be accomplished for those residents affected by the deficient practice.</p> <p>The Facility was made aware of the incident . MD was notified and transcribed the missing Hydrocortisone</p>	4/21/25
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DON

(Commented) 4/30/25

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.

ACCEPTED 4/30/25

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F 000	Continued From page 1  NP - Nurse Practitioner  P&P - Policy and Procedure  Pituitary adenoma - a benign tumor located in the pituitary gland.  Pituitary gland - known as the "master gland " , a small pea-sized gland located in the base of the brain which regulates cortisol production. Surgery on the pituitary gland can lead to insufficient cortisol levels, causing symptoms like fatigue, weakness, and nausea.  RN - Registered Nurse  Steroid tapering - the process of slowly decreasing a steroid dosage over time.	F 000	order. MD was notified of the incident/ conducted investigation and completed an incident report. Initiated monitoring for resident 1. Resident remains in stable and no negative effects were noted on resident 1.	4/21/25	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of four sampled residents (Resident 1) was free from the significant medication errors.  * The facility failed to administer Resident 1's Cortef (generic name: hydrocortisone, a corticosteroid) as ordered by Resident 1's neurosurgeon. This failure posed the risk for Resident 1 to have an increased pain, swelling, fatigue, weakness, and nausea.	F 760	<ul style="list-style-type: none"> <li>How the facility will identify other resident having the potential to have been affected by the deficient practice and corrective action taken: The Medical Records Director/ Designee conducted audits on all admissions on April 4,7,8,9 2025 and ensure that orders from the Hospital are carried out promptly. The DON conducted inervice to the Licensed nurses on 4-4-25 regarding admission process to ensure that discharge orders from</li> </ul>		

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F 760	Continued From page 2  Findings:  Review of the facility's P&P titled Administration of Medications dated 10/2021 showed the medications shall be administered as prescribed by the resident's physician.  Medical record review for Resident 1 was initiated on 4/3/25. Resident 1 was admitted to the facility on 3/10/25.  Review of Resident 1's H&P examination dated 3/12/25, showed Resident 1 did not have the capacity to understand and make medical decisions. Resident 1 had a diagnosis of a pituitary adenoma and was readmitted to the facility following a pituitary tumor removal.  Review of Resident 1's discharge orders from Hospital 1 dated 3/10/25, showed the following physician's orders:  - dated 3/10/25 at 2100 hours, to administer one dose of Cortef tablet 25 mg, then  - Administer Cortef tablet 20 mg every morning for two doses. The first dose to be given on 3/11/25 at 0900 hours, and the last dose to be administered on 3/12/25 at 0900 hours  - Administer Cortef tablet 10 mg every afternoon for two doses. The first dose to be given on 3/11/25 at 1400 hours, and the last dose to be administered on 3/12/25 at 1400 hours.  - Administer Cortef tablet 5 mg, every afternoon starting on 3/13/25 at 1400 hours, until discontinued.	F 760	the Hospital are being carried out correctly. The Admission nurse who failed to transcribe the Hydrocortisone was given 1:1 inservice and training on admission process on 03-20-25 and guided on verification/ comparing of hospital discharge order/ and ensure that each order is double checked for accuracy and completeness.  • What measures will be put into place to ensure that the deficient practice does not recur: The Admission nurse will verify Admission orders from the Hospital, will review with the Attending Physician for accuracy and will transcribe to resident's admission records. The RN Supervisor of next shift will compare admission orders from the Hospital versus the one on resident's record. If noted with discrepancy the MD will be notified for order clarification and will carry out the orders promptly.	4/21/25	

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F 760	<p>Continued From page 3</p> <p>Review of the facility's Physician Order Summary Report for Resident 1 dated 3/11/25, did not show an order for the Cortef medication.</p> <p>Review of Resident 1's MDS assessment dated 3/14/25, showed the resident had severe cognitive impairment.</p> <p>Review of Resident 1's Progress Note from the NP dated 3/20/25 at 1729 hours, showed Resident 1 was discharged from Hospital 1 to the facility on 3/10/25, with an order for the hydrocortisone dose to taper; however, the order was not carried out. The NP personally reviewed the transfer orders from Hospital 1 and the order was in fact documented in the discharge transfer orders, but for an unknown reason, it was missed or not started.</p> <p>On 4/3/25 at 1545 hours, an interview was conducted with RN 1. RN 1 stated when a resident arrived at the facility, the admission nurse was responsible to review the discharge orders from the acute care hospital. RN 1 stated the admission nurse then transcribed the medication orders from the paper format, into the electronic medical record. RN 1 stated the electronic version of the medication orders were faxed to the physician for the physician to review. RN 1 stated the night shift RN supervisor was responsible for double checking the orders to ensure the electronic version of the orders were transcribed from the paper records correctly.</p> <p>On 4/7/25 at 1005 hours, an interview and concurrent medical record review was conducted with UM 1. Review of Resident 1's discharge orders from the acute care hospital dated</p>	F 760		4/21/25	

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F 760	<p>Continued From page 4</p> <p>3/10/25, and the facility's physician order summary dated 3/11/25, showed the Cortef medication was not transcribed from Hospital 1's discharge paperwork into the electronic record. Review of Resident 1's discharge records also showed Resident 1 had received two 50 mg doses of the Cortef medication at Hospital 1. The documents showed the first dose was administered on 3/8/25 at 2011 hours, and the second dose was administered on 3/9/25 at 0900hours. UM 1 stated the night RN supervisor was responsible to do a recapitulation, which was the process of checking the order summary against the original orders. Further review of the discharge paperwork did not indicate the RN supervisor had done a double check of the orders from the acute care hospital. UM 1 stated the orders should have been checked off, but nothing indicated the orders had been double checked or signed.</p> <p>On 4/7/25 at 1538 hours, an interview was conducted with the Pharmacy Consultant. The Pharmacy Consultant stated the purpose of a hydrocortisone taper was to allow for the body to slowly adjust to the effects of the steroids. The Pharmacy Consultant stated if the steroids were stopped suddenly, it can be rough. The Pharmacy Consultant stated if a steroid was stopped suddenly, it can cause a resident to feel agitated or uneasy from the changes in the blood sugar.</p> <p>On 4/7/25 at 1620 hours, an interview and concurrent medical record review was conducted with the DON. The DON confirmed the above findings.</p>	F 760	<p>/Designee will check again the next day if orders were carried out correctly by comparing orders and will sign the sheet to verified it was checked for accuracy The DON / Designee will be notified of the findings for follow up.</p> <ul style="list-style-type: none"> <li>How the facility plans to monitor its performance to make sure solutions are sustained: The facility will utilize QA tool " Medication Management" every month x 3 months and Quarterly thereafter. Result of the findings to be forwarded to the QA Committee monthly for follow up and recommendation.</li> </ul> <p>Completion date 04-21-25</p>	4/21/25