STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055330	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to protect the residents' (Residents 2 and 4) rights to be free from the sexual abuse by another resident (Resident 3). * The facility failed to monitor and provide Resident 3 with the 1:1 (one staff to one resident) supervision as per the care plan after an incident of Resident 3 grabbing Resident 2's breasts on 9/6/24, resulting in Resident 3 continuing to fondle Resident 4's breasts during the activities in the dining room on 9/8/24. This failure resulted in Resident 3 continuing to sexually abuse other residents. Findings: Review of the facility's P&P titled Abuse Prevention Program revised 4/2021 showed the residents have the right to be free from abuse, neglect, misappropriate of resident property, and exploitation, which included freedom from sexual abuse. The residents are protected from abuse by anyone including other residents. In addition to protecting residents from any further harm during investigations. Review of the facility's P&P titled Abuse, Neglect, Exploitation, or Misappropriation Reporting and Investigation revised 4/2024 showed upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Review of the facility's P&P titled Care Plans, Comprehensive Person Centered revised 12/2016 showed, identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship the resident's problem areas and their causes, and relevant clinical decision making. On 9/7/24 at 1408 hours, the CDPH, L&C Program received an SOC 341 from the facility showing Resident 2 reported to the charge nurse alleging Resident 3 had grabbed her right breast on 9/6/24 at 2345 hours. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/10/24 at 1715 hours, the CDPH, L&C Program received an SOC 341 from the facility showing Resident 3 had fondled Resident 4's breasts in the dining room on 9/8/24. 1. Medical record review for Resident 2 was initiated on 9/10/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 6/3/24, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's MDS dated [DATE], showed Resident 2 was cognitively intact with a BIMS score of 15. Review of Resident 2's SBAR Communication Form dated 9/7/24, showed Resident 2 reported to staff another resident (Resident 3) grabbed her right-side breast on 9/6/24 at 2345 hours, at the smoking patio. The form further showed Resident 2 felt upset. On 9/10/24 at 1036 hours, an interview was conducted with Resident 2. Resident 2 stated on 9/6/24 at 2345 hours, while she was coming in from the smoking patio, Resident 3 stated, oh boobies, then grabbed her both breasts. Resident 2 stated Resident 3 squeezed so hard that hurt her right breast. Resident 2 further stated the following day when she walked by Resident 3 who again stated oh boobies in front of other people and families. On 9/11/24 at 0835 hours, a follow-up interview was conducted with Resident 2. Resident 2 stated she felt violated and embarrassed and stated that was the first man to ever touch her ever since her husband passed away in 2011. 2. Medical record review for Resident 4 was initiated on 9/10/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS dated [DATE], showed Resident 4 was moderately impaired with a BIMS score of 11. Review of Resident 4's SBAR Communication Form dated 9/8/24, showed Resident 4 reported her breast was fondled by another resident (Resident 3) while they were in the activity room. On 9/10/24 at 1129 hours, an interview with the DON was conducted. The DON verified Resident 3 grazed his hands over Resident 4's chest which was witnessed by the Activities Assistant. On 9/10/24 at 1346 hours, an interview was conducted with Resident 4. Resident 4 stated while sitting in the activities room, Resident 3 had reached over, touched her breasts, and laughed and kept doing it. Resident 4 further stated she told Resident 3 to stop, then she got up and moved. When asked if anyone else saw the incident, Resident 4 stated the Activities Assistant saw and told Resident 3 to stop. On 9/10/24 at 1401 hours, an interview was conducted with the Activities Assistant. The Activities Assistant stated on 9/8/24 at 1015 hours, Resident 4 was sitting next to Resident 3 in the dining room for activities when Resident 3 kept reaching his hand over Resident 4 and touching Resident 4's breasts with an open palm. When asked if she witnessed the incident, Activities Assistant stated yes. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Closed medical record review for Resident 3 was initiated on 9/10/24. Resident 3 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 3's SBAR Communication Form dated 9/7/24, showed a report was received Resident 3 grabbed a resident's right breast on 9/6/24 at 2345 hours, in the smoking patio. Review of Resident 3's SBAR Communication Form dated 9/8/24, showed Resident 3 was brought to the dining room for the activity time, and Resident 3 kept trying to fondle a female resident's chest even after multiple warnings by the female resident telling Resident 3 to stop. Review of Resident 3's MDS dated [DATE], showed the Section GG for Functional Limitation in Range of Motion for the upper extremity (shoulder, elbow, wrist, hand) indicated 0 (no impairment). Review of Resident 3's Plan of Care showed a care plan problem initiated on 9/7/24, addressing the report of Resident 3 grabbed a resident's right breast at the smoking patio. The care plan goal showed no grabbing other breast behavior on next review date. The care plan interventions included to conduct the frequent visual checks and provide the 1:1 sitter. Review of the facility's Daily Assignment Sheets for 9/7 and 9/8/24, showed the LVNs and CNAs were assigned to multiple residents per shift. Further review of the assignment sheets failed to show documented evidence a staff was assigned to conduct the 1:1 sitter for Resident 3. On 9/11/24 at 1014 hours, an interview was conducted with RN 1. RN 1 stated the 1:1 sitter would consist of one nurse or one CNA to one resident, and the staff would be with the resident at all times to ensure the resident's whereabouts. RN 1 verified there was no documented evidence Resident had the 1:1 sitter after the first incident on 9/6/24, with Resident 3 as per the care plan initiated on 9/7/24, until after the second abuse allegation with Resident 4 on 9/8/24. On 9/12/24 at 1340 hours, an interview was conducted with LVN 5. LVN 5 verified Resident 3 did not have the 1:1 sitter on 9/7 - 9/8/24, prior to the second allegation due to short of staff. LVN 5 stated if Resident 3 was provided a sitter, the 1:1 sitter would also accompany the Resident 3 during the activity time. On 9/13/24 at 1024 hours, a follow-up interview was conducted with the Activities Assistant. The Activities Assistant stated there were no other staff members in the room during the activities on 9/8/24. The Activities Assistant verified Resident 3 did not have the 1:1 sitter in the dining room. On 9/17/24 at 1349 hours, an interview was conducted with CNA 4. CNA 4 verified she was assigned to Resident 3 on 9/8/24. When asked what her role was with Resident 3, CNA 4 stated I needed to monitor him. When asked how many other residents she had on 9/8/24, CNA 4 stated she had eight or nine residents. When asked who was monitoring Resident 3, CNA 4 stated, me I guess. When asked how Resident 3 got into the activities room, CNA 4 stated she assisted Resident 3 to get dressed and Resident 3 self-propelled himself in his wheelchair into activities. When asked if anyone accompanied Resident 3 in the activities room, CNA 4 stated no. When asked if anyone was watching Resident 3 during activities, CNA 4 stated, not that I'm aware. When asked if Resident 3 was being monitored prior to the second abuse allegation with Resident 4, CNA 4 stated, not that I'm aware. (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/17/24 at 1450 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the P&P to ensure the reporting of a reasonable suspicion of a crime in accordance with section 1150B for one of four sampled residents (Resident 4) as evidenced by: * The facility failed to ensure Resident 4's sexual abuse allegation by Resident 3 was reported timely to the CDPH L&C Program and local law enforcement agency. This failure had the potential for abuse and injury of unknown origin allegations to go unreported and uninvestigated timely. Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating revised 4/2024 showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Medical record review for Resident 4 was initiated on 9/10/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS dated [DATE], showed Resident 4 was moderately impaired with a BIMS score of 11. Review of Resident 4's SBAR Communication Form dated 9/8/24, showed Resident 4 reported her breast was fondled by another resident while they were in the activity room. Review of Resident 4's medical record failed to show documented evidence Resident 4's abuse allegation was reported. On 9/10/24 at 1129 hours, an interview with the DON was conducted. The DON verified Resident 3 grazed his hands over Resident 4's chest which was witnessed by the Activities Assistant. On 9/10/24 at 1401 hours, an interview was conducted with the Activities Assistant. The Activities Assistant stated, on 9/8/24 at 1015 hours, when Resident 4 was sitting next to Resident 3 in the dining room for activities, Resident 3 kept reaching his hand over to Resident 4 and touching Resident 4's breasts with an open palm. When asked if she witnessed the incident, Activities Assistant stated yes. On 9/10/24 at 1605 hours, an interview with the SSD was conducted for Resident 4. The SSD stated Resident 4's allegation of sexual abuse should have been reported to the CDPH L&C Program and local law enforcement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 1259 hours, a follow-up interview with the DON was conducted. The DON acknowledged Resident 4's abuse allegation was not reported to the CDPH L&C Program and local law enforcement reported timely.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for three of four sampled residents (Residents 1, 2, and 4). * The facility failed to ensure the nursing staff reported and documented the unwitnessed fall for Resident 1 on 8/28/24. Furthermore, the 72-hours neurological and post fall risk assessments were not completed following Resident 1's unwitnessed fall. * The facility failed to monitor the psychosocial harm for Residents 2 and 4 post abuse allegations. This failure had the potential to negatively affect the residents' health and well-being. Findings: 1. Review of the facility's P&P titled Neurological Assessment revised 10/2010 showed the general guidelines for neurological assessments are indicated following an unwitnessed fall. Review of the facility's P&P titled Falls and Fall Risk Managing revised 3/2018 showed a fall is defined as: unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Review of the facility's P&P titled Assessing Falls and Their Causes revised 3/2018 showed the residents must be assessed upon admission and regularly afterward for potential risk of falls. Observed for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. Review of the facility's P&P titled Falls Clinical Protocol revised 3/2018 showed the staff and physician will monitor and document the individual's response to interventions intended to reduce falling or consequences of falling. Medical record review for Resident 1 was initiated on 9/5/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's SOC 341 submitted to the CDPH, L&C Program on 9/6/24, showed Resident 1 complained of right arm pain, swelling of the right arm was noted, and Resident 1 was unable to do range of motion on 8/28/24. The form further showed Resident 1's x-ray result showed fracture to the right arm. Review of the facility's investigation file for Resident 1's right arm fracture conducted on 9/5/24, showed CNA 2 and LVN 3 stated Resident 1 was found sitting on the floor on 8/28/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of Resident 1's medical record failed to show documented evidence a COC was completed, the physician and family was notified, the resident was monitored, and the post fall assessment was completed. On 9/12/24 at 0956 hours, CNA 2 stated on the morning of 8/28/24, Resident 1 was found sitting on the floor outside his room. On 9/12/24 at 1020 hours, LVN 3 stated during his shift on 8/27 to 8/28/24 at 2300 - 0700 hours, he saw Resident 1 sitting on the floor. When asked if it was documented that Resident 1 was found sitting on the floor, LVN 3 stated no. LVN 3 further stated he informed Resident 1's charge nurse, and she was supposed to document. On 9/12/24 at 1401 hours, an interview was conducted with the DSD. The DSD verified there were no neuro checks documented for Resident 1's unwitnessed fall that occurred on 8/28/24. The DSD stated the process for an unwitnessed fall would include assessing the resident, notifying the physician, and family or responsible party, monitor for 72 hours, and care plan. On 9/12/24 at 1630 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated when resident had a fall, the fall should be reported, and the COC should be initiated including the notification of the physician and family. The DON verified Resident 1's medical record failed to show the documentation of Resident 1's unwitnessed fall. On 9/17/24 at 1426 hours, a follow-up interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified there were no post fall risk assessments done for Resident 1's unwitnessed fall on 8/28/24. 2. Medical record review for Resident 2 was initiated on 9/10/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's SBAR Communication Form dated 9/7/24, showed Resident 2 reported to staff that another resident grabbed her right-side breast on 9/6/24 at 2345 hours, at the smoking patio. Review of Resident 2's Care Plan initiated on 9/7/24, showed a care plan problem addressing the abuse allegation when Resident 2' breast was grabbed by another resident. The interventions included frequently visual check, monitor vital signs, and provide support as needed. Review of Resident 2's Progress Notes for September 2024 did not show documented evidence Resident 2 was monitored post abuse allegation. On 9/10/24 at 1605 hours, an interview was conducted with the SSD. The SSD stated she was not aware of Resident 2's abuse allegation and should have been notified so she could check on Resident 2. 3. Medical record review for Resident 4 was initiated on 9/10/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's SBAR Communication Form dated 9/8/24, showed Resident 4 reported that her breast was fondled by another resident while they were in the activity room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's Care Plan initiated on 9/8/24, showed a care plan problem addressing the abuse allegation when Resident 4's breast was fondled by another resident. The interventions included to provide frequent visual check, monitor for signs and symptoms of emotional distress, and provide emotional support. Review of Resident 4's Progress Notes for September 2024 did not show documented evidence Resident 4 was monitored post abuse allegation. On 9/11/24 at 1259 hours, an interview and concurrent medical record review for Residents 2 and 4 was conducted with the DON. The DON stated after a COC, there should be frequent monitoring every two hours per shift. The DON verified there were no post COC monitoring for Residents 2 and 4.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent or minimize injuries of a fall for one of four sampled residents (Resident 1). * Resident 1 had a history of falls; however, the floor mats were not provided as per the resident care plan and the fall risk assessment was inaccurate. This failure had the potential to place the resident at risk for further serious injury. Findings: Review of the facility's P&P titled Neurological Assessment revised 10/2010 showed the general guidelines for neurological assessments are indicated following an unwitnessed fall. Review of the facility's P&P titled Falls and Fall Risk Managing revised 3/2018 showed a fall is defined as: unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Review of the facility's P&P titled Assessing Falls and Their Causes revised 3/2018 showed the residents must be assessed upon admission and regularly afterward for potential risk of falls. Observed for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. Review of the facility's P&P titled Falls Clinical Protocol revised 3/2018 showed the staff and physician will monitor and document the individual's response to interventions intended to reduce falling or consequences of falling. Medical record review for Resident 1 was initiated on 9/5/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's SBAR Communication Form dated 7/28/24, showed Resident 1 had a fall. Resident 1 was found on the floor by the CNA. Review of Resident 1's Fall Risk Assessment form dated 7/28/24, showed Resident 1's fall risk score was 8. The document indicated Total score of 10 or above represents High Risk. The form further showed Resident 1 was alert and had no falls in the past three months. Review of Resident 1's IDT Progress Notes dated 7/29/24, showed Resident 1 had a fall on 7/28/24. The IDT recommendations included to provide Resident 1 with mats on floor. Further review of the medical record showed the resident also had an unwitnessed fall on 8/28/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/24 at 1329 hours, a concurrent observation and interview was conducted with RN 1. Resident 1 was observed in bed and the floor mats were against the wall. RN 1 acknowledged Resident 1's floor mats should be placed on the floor beside Resident 1's bed. On 9/17/24 at 1015 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 stated the Fall Risk Assessment form was to be completed upon admission and when a resident had a fall. RN 2 verified the Fall Risk Assessment form for Resident 1 dated 7/28/24, was inaccurate as the resident had a fall on 7/28/24, and Resident 1 had intermittent confusion. RN 2 acknowledged Resident 1's Fall Risk Assessment score should have been higher putting Resident 1 to be a high risk for fall. On 9/17/24 at 1450 hours, the DON acknowledged the above findings.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to offer or provide the adequate and appropriate pain management for one of four sampled residents (Resident 1). * The facility failed to offer and provide Resident 1 pain medication when Resident 1 complained of pain on 8/28/24. This failure had the potential to negatively affect Resident 1's well-being. Findings: Review of the facility's P&P titled Pain revised 3/2018 showed the physician and staff will identify individuals who have pain or who at risk for having pain, which includes a review for any treatment that the resident currently is receiving for pain, including complementary and non-pharmacologic treatments. Review of the facility's Change in Resident's Condition or Status revised 7/2024, showed the nurse will notify the resident's attending physician or physician on call when there has been a (an): need to alter the resident's medical treatment significantly. Review of Resident 1's Care Plan dated 8/29/24, showed to monitor for pain per shift and administer medications as ordered. Medical record review for Resident 1 was initiated on 9/5/24. Resident 1 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 1's H&P evaluation dated 8/20/24, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's SBAR Communication Form dated 8/28/24, showed Resident 1's right wrist was swollen with purplish discoloration, and the resident was unable to do range of motion (ROM), and the hand was immobilized by the supervisor. Review of Resident 1's Progress Notes dated 8/28/24, showed at 0801 hours, Resident 1 complained of pain to the right hand/wrist. Upon the assessment, Resident 1 was noted with swelling, and pain present when performing the ROM. The progress note further showed the nurse was unable to give pain medication due to Resident 1 was NPO. Review of Resident 1's Physicians Order Summary showed a physician's order dated 8/19/24, to administer acetaminophen (pain medication) rectal suppository 650 mg insert one capsule rectally every four hours as needed for mild pain, levels 1-3 (NPO). Review of Resident 1's MAR for August 2024 did not show documented evidence the acetaminophen suppository was administered to Resident 1 when Resident 1 complained of pain on 8/28/24. There was no documentation showing Resident 1 was offered or provided any pain relief. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055330	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab Center of Tustin	2210 E. First Street Santa Ana, CA 92705

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/24 at 1512 hours, an interview was conducted with Resident 1. Resident 1 stated he fell and hurt his right wrist. When asked if Resident 1 has pain in right wrist, Resident 1 stated oh yeah, it still hurts now. On 9/13/24 at 1050 hours, an interview and concurrent medical record review was conducted with RN 1. When asked if Resident 1 complained of pain on 8/28/24, RN 1 stated the Resident 1 verbalized dolor (means pain in Spanish). When asked what level of pain that Resident 1 had, RN 1 stated 5 out of 10 (on a 0 to 10 pain scale with 0 = no pain and 10 = the worst pain). When asked if Resident 1 was administered pain medication, RN 1 stated Resident 1 was NPO, so Resident 1 did not receive any pain medication. When asked if the physician was contacted regarding other pain medications for Resident 1 due to NPO, RN 1 stated no. RN 1 verified Resident 1 had an order for acetaminophen suppository (for mild pain), then RN 1 stated, I forgot about the suppository. When asked if Resident 1 was offered any pain medication, RN 1 verified there was no documentation Resident 1 was offered or provided any pain relief on 8/28/24. On 9/17/24 at 1450 hours, the DON acknowledged the above findings.