STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 12 final sampled residents (Resident 21) was free from the physical restraints. * The facility failed to conduct an assessment and implement the least restrictive measures prior to applying a mitten (mitten which look like boxing gloves with a Velcro or tie at the wrist to hold them in place and immobilize the resident's fingers) to Resident 21's hand and abdominal binder. In addition, the facility failed to obtain an informed consent from the responsible party for the use of hand mitten and abdominal binder. These failures posed the risk of compromising the residents' independence and psychosocial well-being. Findings: Review of the facility's P&P titled Restraints dated 1/2024 showed the restraints will be used only with a written order from a physician and should be obtained prior to the application of restraints, ensure the least restrictive alternatives were determined inadequate to protect the safety of the resident, initial assessment of the resident mental, behavioral, and physical status of the resident must be done and informed consent was obtained. All restraints use is documented in the resident's electronic medical record. On 3/11/24 at 1231 hours, Resident 21 was observed lying in bed and the hand mitten was on top of the bedside drawer. Medical record review for Resident 21 was initiated on 3/13/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's MDS dated [DATE], showed Resident 21's cognitive skills for daily decision making was severely impaired. Review of Resident 21's Order Summary Report dated 3/13/24, showed a physician's order dated 11/25/23, to apply abdominal binder around the GT (a small tube placed through the abdominal wall into the stomach, used to provide feeding formula and/or administer medications) site every shift. Another physician's order dated 11/25/24, was for Resident 21 to wear the mittens as needed, check skin and circulation every one hour during use. (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
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's medical record failed to show documentation of the informed consent, assessment, and least restrictive measures completed prior to implementing the hand mittens and abdominal binder. Review of Resident 21's Treatment Administration Record for the month of March 2024 showed the mittens were used on 3/7/24. Further review of Resident 21's medical record failed to show documented evidence as to when the mittens were released and no skin assessment for circulation every one hour during the use of the mittens. On 3/13/24 at 1047 hours, an observation and concurrent interview for Resident 21 was conducted with LVN 1. LVN 1 stated Resident 21 wore the mittens at times due to pulling out of the GT and tracheostomy tube (breathing tube inserted through the neck into the airway to maintain an open airway). LVN 1 further stated Resident 21 wore an abdominal binder for pulling out the GT. On 3/13/24 at 1100 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified Resident 21 used the mittens and abdominal binder. RN 1 also verified there were no consent, no assessment, and no monitoring for the use of the abdominal binder and hand mittens restraints. On 3/14/24 at 1524 hours, a concurrent interview and medical record review for Resident 21 was conducted with the CEO. The CEO was informed and verified the above findings.

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	555753	A. Building B. Wing	03/14/2024

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview and medical record review, the facility failed to ensure for an accurate assessment was completed for one nonsampled resident (Resident 14). * The staff failed to complete the comprehensive assessment for discharge. This failure had the potential for a follow-up change in the resident's care needs not being identified. Findings: Medical record review of Resident 14 was initiated on 3/14/24. Resident 14 was admitted to the facility on [DATE], and discharge on 11/13/23. Review of the discharge summary for Resident 14 dated 11/13/24, showed the resident was discharged to another facility. On 3/14/24 at 1530 hours, an interview and concurrent medical record review was conducted with the CEO. The CEO was asked if the resident had a comprehensive assessment MDS for discharge since the resident was discharged on [DATE]. The CEO stated the MDS was not completed. The CEO verified the 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to develop the comprehensive person-focused care plans for four of 12 final sampled residents (Residents 1, 8, 10, and 21). * The facility failed to develop a care plan problem for Resident 1's use of lap tray (a removable stable surface which can be attached to the wheelchair designed to lean on for support, provide activity, and feeding surfaces) while in the wheelchair for positioning. * The facility failed to develop a care plan problem for Resident 8's use of tobramycin (antibiotic) medication. * The facility failed to develop a care plan problem for Resident 10's use of side rail in bed. * The facility failed to develop a care plan problem Resident 21's use of the mittens and abdominal binder restraints. These failures posed the risk of not providing the appropriate, consistent, and individualized care of the residents. Findings: 1. On 3/14/23, Resident 1 was observed sitting in the wheelchair. A lap tray was observed attached to the wheelchair. Medical record review for Resident 1 was initiated on 3/11/24. Resident 1 was admitted to the facility on [DATE]. Review of the Order Summary Report showed a physician's order dated 5/20/22, to provide a lap tray on when sitting up in wheelchair for assistance with proper positioning of upper extremities as tolerated. Review of Resident 1's plan of care failed to show a care plan problem was developed to address Resident 1's use of lap tray for positioning. On 3/14/24 at 1043 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 4. RN 4 verified Resident 1's use of lap tray while in the wheelchair. RN 4 verified there was no care plan developed for the use of the lap tray while in the wheelchair. 2. Medical record review for Resident 8 was initiated on 3/11/24. Resident 8 was readmitted to the facility on [DATE]. (continued on next page)

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	555753	A. Building B. Wing	03/14/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Summary Report showed a physician's order dated 4/21/23, to administer tobramycin inhalation nebulization solution 300 mg/5 ml via tracheostomy two times a day every month starting on the first for 14 days. Review of Resident 8's plan of care failed to show a care plan problem was developed to address Resident 8's use of the tobramycin medication. On 3/14/24 at 1113 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 4. RN 4 verified Resident 8's use of the tobramycin medication. RN 4 verified there was no care plan developed for the use of tobramycin medication. 39670 3. On 3/11/24 at 1013 hours and 3/12/24 at 1057 hours, Resident 10 was observed in bed asleep with all four side rails elevated. Medical record review for Resident 10 was initiated on 3/12/24. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's Order Summary Report dated 3/14/24, showed a physician's order dated 1/25/24, for Resident 10's to have one side rail up to secure the ventilator tubing due to position sensitivity every shift for airway/ventilation protection. Further review of the medical record showed no documented evidence the resident's care plan addressed the use of side rail in bed for protection. On 3/14/24 at 1110 hours, an interview and concurrent medical record review for Resident 10 was conducted with RN 2. RN 2 verified Resident 10's use of side rail in bed. RN 2 verified there was no care plan formulated for the use of side rail in bed. 4. On 3/13/24 at 0904 hours, during the medication administration observation and concurrent interview for Resident 21 was conducted with LVN 2. Resident 21 was observed with an abdominal binder in placed on the abdomen. LVN 2 stated Resident 21 had episodes of pulling out his GT when he was awake. Medical record review for Resident 21 was initiated on 3/13/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Order Summary Report dated 3/13/24, showed a physician's order dated 11/25/23, to apply abdominal binder around the GT site every shift. The physician's order dated 11/25/24, showed an order for Resident 21 to wear mittens as needed, check skin and circulation every one hour during use. Further review of the medical record showed no documented evidence the resident's care plan addressed the use of mittens and abdominal binder. (continued on next page)

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	555753	A. Building B. Wing	03/14/2024

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Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/24 at 1318 hours, an interview and concurrent medical record review for Resident 21 was conducted with RN 1. RN 1 verified Resident 21's use of the mittens as needed and abdominal binder. RN 1 verified there was no care plan developed for the use of the mittens and abdominal binder. On 3/14/24 at 1524 hours, an interview and concurrent medical record review for Residents 10 and 21 was conducted with the CEO. The CEO was informed and verified the above findings.

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 12 final sampled residents (Resident 21) was revised to reflect the resident's current care needs and interventions. * Resident 21's plan of care was not revised to address Resident 21's padded side rails use. This failure posed the risk for not providing Resident 21 with individualized and person-centered care. Findings: Review of the facility's P&P titled Care Plan dated 5/2023 showed the plan of care should be individualized based on the diagnosis, assessment, and personal goals of the residents. The planning of care, treatment, and services includes the regularly reviewing, and revising the plan of care. The plan of care should be updated daily with revisions reflecting the reassessment of the needs of the resident. On 3/13/24 at 1007 hours, Resident 21 was observed in bed asleep. The side rails were elevated with the pads in place. Medical record review for Resident 21 was initiated on 3/13/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Order Summary Report dated 3/13/24, showed a physician's order dated 11/25/23, for the use of padded side rails for seizure/safety precaution every shift. Review of Resident 21's plan of care showed a care plan problem dated 11/23/23, addressing Resident 21's seizure disorder. However, the care plan problem was not revised to reflect Resident 21's continuous use of the padded side rails as per the physician's order. On 3/13/24 at 1318 hours, an interview and concurrent medical record review for Resident 21 was conducted with RN 1. RN 1 verified Resident 21's use of the padded side rails in bed for safety. RN 1 verified Resident 21's had a care plan problem for the seizure activity. RN 1 verified the care plan interventions were not included the padded side rails in bed for safety. RN 1 stated the care plan should have been formulated on the change on the status of the resident and updated if there was a new physician's order. On 3/14/24 at 1524 hours, an interview and concurrent medical record review was conducted with the CEO. The CEO was informed and verified the above findings.

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	555753	A. Building B. Wing	03/14/2024

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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 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** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for four of 12 final sampled residents (Residents 4, 7, 11, and 22). * The facility failed to ensure Resident 11's vital signs were taken, and neurological assessment was completed after a fall incident on 2/20/24, to which a care plan problem was only initiated on 2/29/24. In addition, the medical record did not show the facility addressed the causative factors of the fall and consulted the pharmacist and the physical therapist as per the care plan. Furthermore, the medical record did not show an IDT review was conducted as per the facility's P&P on falls. * The facility failed to ensure Resident 4's stroller was strapped while the resident was in the stroller as per the physician's order. In addition, the facility failed to show documentation Resident 4 was monitored while on the stroller. Furthermore, the facility failed to develop a care plan problem related to the use of stroller. * The facility failed to ensure Resident 7 was provided with full padded side rails as per the physician's order and resident's care plan. * The facility failed to ensure the resident's side rail paddings were properly placed as per the physician's order and residents' care plan intervention for Resident 22. These failures had the potential for the residents to sustain injuries and additional falls. Findings: 1. Review of the facility's P&P titled Fall Risk Assessment Identification dated 8/28/14, showed the section for In the Event if the Occurrence of a Fall showing to ensure patient safety, conduct a physical examination, measure and document vital signs; and commence neurological observation if the resident's head was the first point of impact, and the Documentation of Fall Event section showed the following: - Record the incident in the resident's clinical record, including the description of event, location, activity occurring, time, who was present, assessment, findings, interventions and patient outcomes/condition, notification of the incident; - What additional protected/ preventive measures have been out in place; - Licensed nurse assigned to the resident should complete a fall assessment in patient's clinical record and a care plan; - Licensed nurse assigned to the resident should notify physical therapist of the fall incident for assessment and evaluation of patient's condition and recommendations based on her assessment and should documented in the resident's clinical records; and (continued on next page)

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	555753	A. Building B. Wing	03/14/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The IDT review the physical therapist recommendations and the IDT will document the plan of care on monitoring the patient based on the recommendation of physical therapist and the IDT will have to sign on the IDT progress notes as evidence it was reviewed for implementation. Medical record review for Resident 11 was initiated on 3/11/24. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Progress Notes showed a nursing progress note dated 2/20/24, showed Resident 11 was seen off a stroller and on the floor by the EVS (environmental services) staff. The nursing progress note also showed Resident 11 was immediately placed on the bed and assessed. Review of Resident 11's incident report for an unwitnessed fall dated 2/20/24, under the Other Information section showed, the stroller straps noted to be broken, and patient was highly active and attempted to climb out of stroller. Review of Resident 11' plan of care showed a care plan problem initiated on 2/29/24, addressing Resident 11's actual fall incident with no injury on 2/20/24. The interventions/tasks included the following: for no apparent acute injury, determine and address the causative factors of the fall, pharmacy consult to evaluate medications, provide activities that promote exercise and strength building where possible, physical therapy consult for strength and mobility, take vital signs every shift, and take blood pressure while lying, sitting, and standing one time in the first 24 hours. Further review of Resident 11's medical record did not show Resident 11's vital signs were taken, and neurological assessment was completed after the fall. In addition, the medical record did not show the facility addressed the causative factors of the fall and consulted the pharmacist and the physical therapist as per the care plan. Furthermore, the medical record did not show an IDT review was conducted for a fall as per the facility's P&P. On 3/14/24 at 1128 hours, an interview and concurrent medical record and facility document review for Resident 11 was conducted with RN 4. RN 4 verified Resident 11 had a fall incident on 2/20/24, and verified the care plan problem to address the actual fall incident was only initiated on 2/29/24. RN 4 also verified there was no neurological evaluation and fall assessment following the fall incident. On 3/14/24 at 1501 hours, an interview and concurrent medical record and facility document review for Resident 11 was conducted with the CEO. The CEO verified the above findings. The CEO verified the facility failed to conduct a neurological assessment, IDT review, follow-up documentation and investigation regarding Resident 11's fall incident. 2. On 3/12/24 at 1000 hours, and 3/13/24 at 1057 hours, Resident 4 was observed in a stroller, by the door. Resident 4 was observed swinging his body and legs while on the stroller. The stroller was not observed strapped to the crib. Medical record review for Resident 4 was initiated on 3/11/24. Resident 4 was admitted to the facility on [DATE]. (continued on next page)

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	555753	A. Building B. Wing	03/14/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's Order Summary Report showed a physician's order dated 8/23/23, for the resident to be up in a stroller daily for up to two hours at a time as tolerated. The stroller back/handles must be braced and/or strapped to crib to prevent stroller from tipping over. Review of Resident 4's plan of care failed to show a care plan problem was developed to address Resident 4's use of stroller and the need for the stroller to be strapped to the crib. On 3/13/24 at 1008 hours, an observation, interview, and concurrent medical record review for Resident 4 was conducted with LVN 3. LVN 3 stated Resident 4 was usually placed in the stroller. When asked to show documentation for the monitoring of Resident 4 while he was in the stroller, LVN 3 could not find any documentation. LVN 3 also verified there was no care plan to address Resident 4's use of stroller and the need for the stroller to be strapped to the crib. On 3/13/24 at 1104 hours, a follow-up interview for Resident 4 was conducted with LVN 3. LVN 3 verified Resident 4 was in the stroller, and the stroller was not strapped to the crib. LVN 3 verified the physician's order to strap the resident's stroller to the crib. LVN 3 stated the stroller had weights on to prevent it from tipping over. On 3/13/24 at 1447 hours, an interview and concurrent medical record review for Resident 4 was conducted with the CEO. The CEO verified the above findings. The CEO verified there was no documentation of monitoring Resident 4 while in the stroller. The CEO stated if Resident 4's stroller was not strapped to the crib, a staff was needed to be with him, and Resident 4 should be watched the most. 3. On 3/11/24 at 0901 hours, 3/12/24 at 0944 and 1412 hours, and 3/13/24 at 0932 hours, Resident 7 was observed in bed with four side rails elevated. There were no paddings on the side rails in place. Medical record review for Resident 7 was initiated on 3/11/24. Resident 7 was readmitted to the facility 12/26/22. Review of Resident 7's Order Summary Report showed a physician's order dated 6/23/23, to apply padded side rails every shift for seizure precautions. Review of Resident 7's Safety Device assessment dated [DATE], showed the type of safety device used was side rails. The assessment form did not show the box for padded side rails was checked and did not show the reason for the device used. Review of Resident 7's plan of care showed a care plan problem revised on 8/7/23, addressing the resident's impaired physical mobility. The interventions included the use of full padded side rails as per the physician's order for safety during care provisions. Review of the Task form for side rails showed checkmarks daily from 2/13 to 3/13/24, for side rails applied per order task. The form did not show if the paddings on the side rails were in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/24 at 1029 hours, an observation, interview, and concurrent medical record review for Resident 7 was conducted with LVN 3. LVN 3 verified Resident 7 was observed in bed with four side rails elevated, and there were no paddings on the side rails in place. LVN 3 stated Resident 7's family member would usually take the paddings off the side rails. When asked for a documentation when Resident 7's family member had taken out the paddings off the side rails, and facility's education to the resident's family member, LVN 3 could not find any documentation. On 3/13/24 at 1356 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 3. RN 3 verified there was a physician's order for padded side rails and a care plan intervention for padded side rails for safety and seizure precautions. RN 3 verified the assessment form was inaccurate and incomplete as it did not show padded side rails were used, and the reason for the device was left blank. RN 3 also stated Resident 7's family member would use pillows on the side rails instead of the paddings. When asked for a documentation when Resident 7's family member had taken out the paddings off the side rails, and facility's education to the resident's family member, RN 3 could not find any documentation. On 3/14/24 at 1432 hours, an interview and concurrent medical record review for Resident 7 was conducted with the CEO. The CEO was informed and verified the above findings. 39670 4. On 3/11/24 at 1032 hours and 3/12/24 at 1042 hours, Resident 22 was observed in bed with the bilateral side rails elevated and there were no paddings on the side rails in place. Medical record review for Resident 22 was initiated on 3/13/24. Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 22's Order Summary Report dated 3/13/24, showed a physician's order dated 3/8/24, to apply bilateral padded side rails every shift for seizure precautions. Review of Resident 22's Safety Device assessment dated [DATE], showed the use of padded side rails due to history of seizure. Review of Resident 22's plan of care showed a care plan problem dated 1/26/24, addressing the seizure disorder. The interventions included to full padded side rails as per the physician's order for safety and seizure precautions. On 3/13/24 at 1342 hours, an interview for Resident 22 was conducted with CNA 1. CNA 1 verified the side rails were elevated when the resident was in bed. CNA 1 stated Resident 22 was able to hold on the side rail when assisting in turning and repositioning in bed. CNA 1 verified there was only one padded side rail in the bed. On 3/13/24 at 1452 hours, an interview and concurrent medical record review for Resident 22 was conducted with RN 3. RN 3 verified the use of side rail in bed for Resident 22. RN 3 verified there was a physician's order and care plan intervention for padded side rails for safety and seizure precautions. RN 3 was informed of Resident 22's use of the side rails and no pads in place. RN 3 stated there should have been a pad in place to the bed side rails because there was a physician's order for safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 1444 hours, an interview and concurrent medical record review for Resident 22 was conducted with the CEO. The CEO was informed and verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one of 12 final sampled residents (Resident 21). * The facility failed to ensure the CVAD (Central Venous Access Device - a type of intravenous catheter) line external catheter measurements were completed and documented in the medical record for Resident 21. In addition, the facility failed to develop a plan of care for the use of CVAD. These failures had the potential to delay the identification of catheter related complications for the resident. Findings: Review of the facility's P&P titled Central Venous Catheter Care and Dressing Changes dated 9/2023 showed to measure the length of the external central vascular access device with each dressing change or if the catheter dislodgement is suspected and compare with the length documented at insertion. Observe the central line catheters insertion site and surrounding areas for complications. Medical record review for Resident 21 was initiated on 3/13/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's History and Physical examination dated 11/22/23, showed Central/PICC line daily evaluations. However, the medical record failed to show the information of the measurement and assessment of the CVAD line was documented. Review of Resident 21's Order Summary Report dated 3/13/24, showed a physician's order dated 1/10/24, to change the PICC line dressing every Wednesday and as needed if soiled. However, the medical record failed to show a physician's order for the care and services for the CVAD. Further review of the medical record failed to show documented evidence the measurement of the length of the CVAD line catheter above the insertion site was obtained upon admission and during the dressing change weekly. Review of Resident 21's plan of care failed to show documented evidence a care plan problem was developed to address the use of CVAD line. On 3/13/24 at 1047 hours, an observation and concurrent interview for Residents 21 was conducted with RN 1 at Resident 21's room. RN 1 stated Resident 1 had a PICC line tunneled on the right upper chest and was able to locate the CVAD with a dry dressing, two lumen catheters, and with a label of the date of the dressing was changed. RN 1 stated the dressing change for the CVAD was performed once a week and as needed. RN 1 verified Residents 21's medical record did not show the Central/PICC line external catheter measurements. In addition, RN 1 verified there was no specific care plan developed for the use of Central/PICC line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 1524 hours, an interview and concurrent medical record review for Resident 21 was conducted with the CEO. The CEO was informed and verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the mechanical ventilation tubing setup bag for one of 12 final sampled residents (Resident 9) was labeled in accordance with the facility's P&P. This failure posed the risk for the resident's equipment to be contaminated which had the potential for increased risk of infection. Findings: Review of the facility's P&P titled Changing Respiratory Equipment revised 4/2023 showed the following: - Bacterial growth in the ventilator circuit will be minimized by changing the ventilation circuit at a routine time interval; - All closed system suction catheters will be changed every Monday, Wednesday, and Friday; - Respiratory disposable treatment equipment will be changed weekly (such as hand-held nebulizer equipment, cough assist circuits, aero chambers, etc), and - All disposable equipment will be dated when changed. On 3/11/24 at 0823 hours, 3/12/24 at 0848 hours, and 3/13/24 at 0927 hours, Resident 9 was observed in bed with a tracheostomy tube (breathing tube inserted through the neck into the airway to maintain an open airway) in place and connected to a mechanical ventilator (a machine that takes over the work of breathing when a person is not able to breathe enough on their own). An unlabeled and undated set-up bag was observed hanging on the ventilator machine. Medical record review for Resident 9 was initiated on 3/11/24. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's Order Summary Report showed the following physician's orders dated: - 9/29/22, for mechanical ventilation with the ventilation settings, and do vent check every four hours; and - 3/6/24, to administer dornase alfa (a synthetic protein used to improve lung function in people with cystic fibrosis by thinning pulmonary secretions and reducing the risk of respiratory tract infections) inhalation solution 2.5 mg/2.5 ml via trach two times a day for increased secretions. On 3/13/24 at 0912 hours, an observation and concurrent interview for Resident 9 was conducted with RT 1. RT 1 verified Resident 9's tracheostomy set-up bag was unlabeled and undated. RT 1 stated the set-up bag was for the mechanical ventilation tubing and should be changed weekly every Wednesday. RT 1 stated the set-up bag for the mechanical ventilation tubing was supposed to be labeled with the resident's initials and room number, and dated when it was changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/23/23 at 1419 hours, an interview and concurrent medical record review for Resident 9 was conducted with the RT Director. The RT Director stated the [NAME] close suction system (a protected suction tube or catheter inside a sterile plastic sleeve) was supposed to be changed three times a week, every Monday, Wednesday and Friday, and as needed. The RT Director stated the respiratory set-up bags should be labeled with the resident's initials and should be dated when it was changed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the least restrictive alternatives were attempted prior to the use of side rails for one of 12 final sampled residents (Resident 9). This failure had the potential to put the resident at risk for entrapment and serious injury. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. On 3/11/24 at 0823 hours, 3/12/24 at 0848 hours, 3/13/24 at 0927 and 1116 hours, and 3/14/24 at 0759 hours, Resident 9 was observed lying in bed with bilateral full padded side rails elevated. Medical record review for Resident 9 was initiated on 3/11/24. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's Order Summary Report showed a physician's order dated 4/11/23, to apply the padded side rails every shift for seizure and safety precautions. Review of Resident 9's Side Rail Use Assessment Form dated 1/18/22, showed the area for the less restrictive measures attempted was left blank. Further review of Resident 9's medical record did not show the least restrictive alternatives were attempted prior to the use of side rails. On 3/13/24 at 1447 hours, an observation, interview, and concurrent medical record review for Resident 9 was conducted with LVN 3. LVN 3 verified Resident 9 was in bed with the bilateral full padded side rails elevated. LVN 3 verified Resident 9's medical record did not show the least restrictive alternatives were attempted prior to the use of side rails. On 3/14/24 at 0819 hours, a concurrent interview and medical record review for Resident 9 was conducted with RN 2. RN 2 stated the side rail assessment form was the only form used to show the least restrictive measures prior to the use of side rails. RN 2 verified the side rail assessment form for Resident 9 did not show the least restrictive alternatives were attempted prior to the use of side rails as it was left blank. Cross reference to F909, example #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Pharmacy Consultant's recommendations from the drug regimen review were acted upon for two of 12 final sampled residents (Residents 4 and 11). * The Pharmacy Consultant's recommendation to add blood pressure monitoring to the Diuril (diuretic) medication order in the MAR for Resident 11 was not acted upon. * The Pharmacy Consultant's recommendation to discuss with the primary physician to evaluate the need for the continuation of the Culturelle (supplement) medication, and to add the word for chronic use to the medication order if it was for chronic use was not acted upon for Resident 4. These failures had the potential to put the residents at risk for adverse consequences related to the medications. Findings: Review of the facility's P&P titled Medication Regimen Review revised 5/2022 showed the goal of the MRR (Medication Regimen Review) is to promote positive outcomes while minimizing consequences and potential risks associated with medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication-related problems, medication errors and irregularities. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice, is not supported by medical evidence, and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences. 1. Medical record review for Resident 11 was initiated on 3/11/24. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed a physician's orders dated 2/16/24, to administer Diuril 150 mg via GT two times a day for hypertension, and to hold the ordered medication for systolic blood pressure (the first or upper number, which measures the pressure in the arteries when the heart beats) less than 90 mmHg or diastolic blood pressure (the second or lower number, which measures the pressure in the arteries when the heart rests between beats) less than 55 mmHg. Review of the MRR to Nursing form dated 2/28/24, showed the pharmacy consultant recommendation to add blood pressure monitoring to the Diuril medication order on the MAR to document prior to dose administration. Review of Resident 11's MAR showed the resident was administered the Diuril medication from 3/1 to 3/13/24, at 0900 and 2100 hours, and on 3/14/24 at 0900 hours. The MAR did not show the blood pressure was monitored and documented on the MAR prior to the medication administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 11's medical record showed no documented evidence the pharmacy consultant's recommendations were addressed. 2. Medical record review for Resident 4 was initiated on 3/11/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's orders dated 12/1/23, to administer Culturelle kids oral packet via GT two times a day. The physician's order did not show the Culturelle medication was for chronic use. Review of the MRR to Nursing form dated 2/28/24, showed the pharmacy consultant's recommendation to discuss with the primary care physician to evaluate the need for the continuation of the Culturelle medication, and to add the word for chronic use to the medication order if it was for chronic use for Resident 4. Further review of Resident 4's medical record showed no documented evidence the Culturelle medication was discussed with the primary care physician to evaluate the need for continuation of the medication, and to add the word for chronic use if the medication was for chronic use. On 3/14/24 at 1447 hours, an interview and concurrent medical record review for Residents 4 and 11 was conducted with the CEO. When asked about the pharmacy consultant's recommendations, the CEO stated the MRR to Nursing form was usually given to the DON and the nursing staff had two days to complete the recommendations. The CEO verified the pharmacy consultant's recommendations for Residents 4 and 11 were not addressed.

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	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 12 final sampled residents (Resident 9) were free from unnecessary psychotropic (any drug that affects brain activity) medications. * The facility failed to monitor episodes of crying inconsolably as one of the behavior manifestations for Risperdal (antipsychotic) medication for Resident 9. The facility failed to ensure Resident 9's monthly behavior summary and monthly summary of the side effects monitoring were accurate related to the use of Risperdal medication. In addition, the facility failed to document the implementation of the non-pharmacological interventions prior to the use of the Risperdal medication. Furthermore, the facility failed to ensure there was a monthly summary of the side effects monitoring related to the use of the diazepam (sedative) medication. These failures had the potential for inaccurate behavior and side effects monitoring, and the physician not having the necessary information to determine the effectiveness of the medication for Resident 9. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 5/2022 showed the following: - Resident of the facility who are prescribed a psychotropic medication; - The resident's need for the psychotropic medication shall be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued; - Residents who are prescribed antipsychotic medication shall receive gradual dose reductions and behavioral interventions unless clinically contraindicated, in an effort to discontinue these drugs; - Behavioral interventions are individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving and/ or accommodating a resident's distressed behavior; and - Licensed nurses shall be aware of potential side effects of psychotropic medications and report any side effects to the resident's attending physician. Medical record review for Resident 9 was initiated on 3/11/24. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's Order Summary Report showed the following physician's orders dated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/1/24, to administer diazepam 2 mg via GT three times a day for OMS (Opsoclonus-Myoclonus Syndrome, an inflammatory neurological disorder affecting the eye and muscles, and causes other disturbances) as evidenced by flailing or moaning. To chart non-pharmacological interventions (1) change and reposition, (2) dimming of lights, (3) calming music, (4) therapeutic touch, (5) distractions, and (6) other, specify. To chart side-effects: (0) none, (1) sedation, and (3) ataxia; - 2/4/23, for diazepam behavior manifestation count every shift (1) document number of times patient has episodes of flailing, and (2) document the number of times the resident has episodes of moaning. - 2/4/23, for diazepam behavior manifestation count in the evening starting on the first and ending on the second of every month for monthly behavior summary. Document number of times in the previous month the resident has moaning episodes; - 3/22/23, for diazepam side effect monitoring every shift for OMS. Please indicate the number of times in the shift the resident (1) had respiratory rate less than 16 breaths per minute, and (2) the resident appeared drowsy; - 3/22/23, for diazepam side effect monitoring every shift monitoring starting on the first and ending on the first of every month. Please indicate the number of times in the last 30 days the resident (1) had respiratory rate less than 16 breaths per minute, and (2) the resident appeared drowsy; and - 11/17/23, to administer Risperdal 0.5 mg via GT every 12 hours for OMS as evidenced by emotional lability and crying inconsolably. - 1/15/24, for Risperdal behavior manifestation count every shift: to document number of times the resident has increased emotional lability episodes; - 1/15/24, for Risperdal behavior manifestation count in the evening starting on the first and ending on the second of every month for monthly behavior summary. Document number of episodes in the previous month the resident had increased emotional lability; - 12/14/23, for Risperdal side effect monitoring every shift for OMS. Please tally number of times in your shift the resident was noted to (1) appear drowsy; (2) have urinary retention; or (3) appear agitated; - 12/14/23, for Risperdal side effect monitoring one time a day starting on the first and ending on the first of every month. Please tally number of times in the last 30 days the resident (1) appear drowsy; (2) have urinary retention; or (3) appear agitated. Review of Resident 9's MAR for January 2024 showed the following: - Resident 9 was administered diazepam medication with the non-pharmacological interventions and zero side effects from 1/1 to 1/31/24 at 0800, 1500, and 2200 hours; and - Resident 9 was administered Risperdal medication from 1/1 to 1/31/24, at 0900 and 2100 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's MAR for February 2024 showed the following: - Resident 9 was administered Risperdal medication from 2/1 to 2/29/24, at 0900 and 2100 hours; and - Resident 9 was administered diazepam medication with the non-pharmacological interventions and zero side effects from 2/1 to 2/29/24 at 0800, 1500, and 2200 hours. Review of Resident 9's MAR for March 2024 showed the following: - Resident 9 was administered Risperdal medication from 3/1 to 3/12/24 at 0900 and 2100 hours, and on 3/13/24 at 0900 hours. - Resident 9 was administered diazepam medication with non-pharmacological interventions and zero side effects from 3/1 to 3/12/24 at 0800, 1500, and 2200 hours; and on 3/13/24 at 0800 hours. Review of Resident 9's TAR for January 2024 showed the following: - The diazepam behavior manifestation count from 1/1 to 1/31/24, showed a total of 15 episodes of [NAME] (moaning) for day and night shifts, and zero episodes of flail (flailing) for day and night shifts; - The Risperdal behavior manifestation count from 1/1 to 1/31/24, showed a total of 22 episodes of EL (emotional lability) for day and night shifts, and zero episode of TON (toning) for day and night shifts; -There was no monitoring for episodes of crying inconsolably related to the use of Risperdal medication; and - The Risperdal side effect monitoring count from 1/1 to 1/31/24, showed a total of nine episodes of (1) appearing drowsy, zero episode of (2) having urinary retention, and two episodes of (3) agitated on day and night shifts. Review of Resident 9's TAR for February 2024 showed the following: - The diazepam monthly behavior summary for Janurary 2024 showed zero episode of flail (flailing) on 2/1/24, and 15 episodes of [NAME] (moaning) on 2/1/24, and another 15 episodes of moaning on 2/2/24; -There was no monthly summary for side effect monitoring for diazepam medication. -The diazepam behavior manifestation count from 2/1 to 2/29/24, showed a total of nine episodes of [NAME] (moaning) for day and night shifts, and zero episodes of flail (flailing) for day and night shifts; - The Risperdal monthly behavior summary for Janurary 2024 showed 22 episodes of 'ton (toning) on 2/1/24, and another two episodes of toning on 2/2/24 (while the TAR in January 2024 showed zero episodes of toning). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There was no monthly summary to show the total number of episodes of EL (emotional lability) for January 2024 related to the use of the Risperdal medication. - The Risperdal monthly side effect monitoring summary for January 2024 showed zero episodes (while the TAR in January 2024 showed nine episodes of drowsiness, and two episodes of agitation). - The Risperdal behavior manifestation count from 2/1 to 2/29/24, showed a total of 22 episodes of EL (emotional lability) for day and night shifts, and zero episode of TON (toning) for day and night shifts; -There was no monitoring for episodes of crying inconsolably related to the use of Risperdal medication; and - The Risperdal side effect monitoring count from 2/1 to 2/29/24, showed a total of two episodes of (1) appearing drowsy, and zero episodes of (2) having urinary retention, and (3) agitated on day and night shift. Review of Resident 9's TAR for March 2024 showed the following: - The diazepam monthly behavior summary for February 2024 showed zero episode of flail (flailing) on 3/1/24, and nine episodes of [NAME] (moaning) on 3/1/24, and another zero episode of moaning on 3/2/24; - There was no monthly summary for side effect monitoring for diazepam medication. - The diazepam behavior manifestation count from 3/1 to 3/12/24, showed a total of zero episodes of [NAME] (moaning) for day and night shifts, and zero episodes of flail (flailing) for day and night shifts; - The Risperdal monthly behavior summary for February 2024 showed zero episode of 'ton (toning) on 3/1/24, and zero episodes of toning on 3/2/24; - There was no monthly summary to show the total number of episodes of EL (emotional lability) for February 2024 related to the use of the Risperdal medication; - The Risperdal side effect monitoring for February 2024 showed zero episodes (while the TAR in February 2024 showed two episodes of drowsiness); - The Risperdal behavior manifestation count from 3/1 to 3/13/24, showed a total of three episodes of EL (emotional lability) for day and night shifts, and zero episode of TON (toning) for day and night shifts; -There was no monitoring for episodes of crying inconsolably related to the use of Risperdal medication; and - The Risperdal side effect monitoring count from 3/1 to 3/13/24, showed a total of seven episodes of (1) appearing drowsy, and zero episodes of (2) having urinary retention, and (3) agitated on day and night shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 9's medical record showed no documentation of the non-pharmacological interventions prior to the use of Risperdal medication, no monitoring for episodes of crying inconsolably, and no monthly behavior summary of the episodes of emotional lability; and the monthly summary for the side effects monitoring related to the use of Risperdal medication was inaccurate. In addition, there was no monthly summary for the side effects monitoring related to the use of diazepam medication. On 3/14/24 at 0819 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated Resident 9 should have been monitored for emotional lability and crying inconsolably, instead of emotional lability and toning for Risperdal use. RN 2 also stated the monthly behavior summary for toning should have been documented under emotional lability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the staff implemented the proper storage, labeling, and disposal of medications in a safe manner. * The facility failed to dispose of the discontinued medications in Medication Room A. * The facility failed to ensure the medications administered orally were stored separately from the externally used medications inside Medication Cart A. These failures had the potential to result in the unsafe medication administration and cross-contamination of the medications. Findings: Review of the facility's P&P titled Medication Storage revised 5/2023 showed it is the policy of the facility to uphold all local, state and federal laws pertaining to the storage and destruction of medications used in this facility. Discontinued medication may be stored in the medication room for up to 90 days or expiration date should be reordered. 1. On 3/12/24 at 0952 hours, an inspection of Medication Room A was conducted with RN 5 and the following was observed: - a Ziplock bag containing several foil packets of Tobramycin (antibiotic) medication for Resident 21 was observed inside the medication refrigerator. RN 5 verified the above findings. RN 5 stated the RTs administered the medication, and the licensed nurses only let the RTs get the medication from the medication room. Medical record review for Resident 21 was initiated on 3/12/24. Resident 21 was admitted to the facility on [DATE]. Review of a physician's order dated 11/21/24, showed an order to discontinue Tobramycin (antibiotic) inhalation nebulization solution 300 mg every 12 hours for chronic lung disease. On 3/12/24 at 1440 hours, an inspection of Medication Room A and concurrent interview and medical record review was conducted with RT 2, with RN 5 present. A Ziplock bag containing several foil packets of Tobramycin medication for Resident 21 was observed inside the medication refrigerator. RT 2 verified the findings. RT 2 stated discontinued medications should be taken out of the refrigerator and given to the RT Director. 2. On 3/12/24 at 1048 hours, an inspection of Medication Cart A was conducted with LVN 4 and the following was observed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a bottle of fluticasone (corticosteroid) nasal spray was stored next to a bottle of trihexyphenidyl (antispasmodic) medication, a bottle of glycopyrrolate (anticholinergic) medication, a box of scopolamine (anticholinergic) patch, a bottle of Gavilax (laxative) medication, a bottle of polyethylene glycol (laxative) medication, and a bottle of vitamin D3 liquid (supplement) medication; - a bottle of Genteal tears (eye drops) was stored with two bottles of chlorhexidine (antiseptic/ disinfectant), a bottle of levetiracetam (antiseizure) medication, and a bottle of vitamin D3 liquid (supplement) medication; - a box of glycerin suppositories (laxative), and a box of bisacodyl suppositories (laxative) were stored with bubble packs of ondasentron (antiemetic) medication, gerikot (laxative), ibuprofen (nonsteroidal anti-inflammatory drug), and bottles of acetaminophen (analgesic) medication - a bottle of Systane (eye drops) was stored with packets of HealthyLax (laxative) solution, a container of NanoVM (supplement) powder, box of simethicone (antiflatulent) tablets; - foil packets of glycerin suppositories and a bottle of saline enema (laxative) were stored with a bottle of acetaminophen (analgesic), a bottle of diphenhydramine (antihistamine) medication, a bottle of ibuprofen, and a bubble pack of sodium bicarbonate (alkalinizing agents); - a box of glycerin suppositories and a bottle of saline enema were stored with a bottle of ibuprofen, a bottle of Benadryl (antihistamine) medication, and a bottle of ondasentron solution; and - a box of glycerin suppositories and two bottles of saline enema were stored with a bottle of acetaminophen, a bottle of ibuprofen, and simethicone drops. LVN 4 verified the above findings. On 3/14/24 at 1504 medication, an interview was conducted with the CEO. The CEO verified the above findings. The CEO stated the discontinued medications should be taken out of the refrigerator. The CEO stated the dividers should be used to ensure the medications administered orally were stored separately from the externally used medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 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: * The facility failed to ensure the expired and moldy food items in the refrigerator were discarded. * The facility failed to remove a bag of beef patties with freezer burns. * The facility failed to store a bag of sausage patties properly. * The facility failed to air-dry four cutting boards. * The facility failed to ensure the cutting boards were in sanitary condition. These failures had the potential for food broone illness. Findings: Review of the Diet Type Report dated [DATE], showed two of 19 residents in the facility received food prepared in the kitchen. 1. According to USDA Food Code 2022, Section ,d+[DATE].17, Ready to Eat, Time/ Temperature Control for Safety Food, Date Marking, showed refrigerated, ready-to-eat, time/ temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations, and the day or date marked by the food establishment may not exceed a manufacturer's use-by-date if the manufacturer determined the use-by date based on food safety. On [DATE] at 0749 hours, an initial tour of the kitchen was conducted with the CDM, and the following was observed: - A container of mozzarella cheese was observed labeled with a preparation date of [DATE], and a use-by date of [DATE]; - A container of strawberries labeled with a use-by date of [DATE], was observed with molds; - A bag of beef patties was observed with freezer burns; and - A bag of sausage patties was observed open, and not fully closed. The CDM verified the above findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. According to the USDA Food Code 2022, Section ,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 prevents them from drying and may allow an environment where microorganism can begin to grow. On [DATE] at 0825 hours, four cutting boards were observed on the shelves and wet. The CDM stated the cutting boards on the shelves were ready to use. The CDM verified the cutting boards were stored wet. 3. According to the USDA Food Code 2022, Section ,d+[DATE].12, Cutting Surfaces, showed surfaces such as cutting blocks that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. Review of the facility's P&P titled Sanitation revised ,d+[DATE] showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. On [DATE] at 0825 hours, two cutting boards were observed to be heavily marred with knife marks. The CDM verified the cutting boards with knife marks and needed to be replaced.

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	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32179 Based on interview, facility documemt review, and facility P&P review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to ensure the water management program was established and implemented to include an assessment of the facility water systems to identify where Legionella (a bacterium commonly found in natural and man-made aquatic environments, warm stagnant water) and other opportunistic pathogens can grow and spread; implementation of measures to prevent the growth of Legionella and other opportunistic pathogens; and a way to monitor the measures they have in place. This failure increased the risk for the spread of infection. Findings: Review of the facility's P&P titled Waterborne Pathogen and Water Management Plan dated January 2024 showed to conduct facility risk assessment to identify where legionaella and other opportunistic waterborne pathogens (e.g pseudomonas, burkhholderia, Stenotrophomonas, nonturbeculosis mycobacteria and fungi) could grow and spread in the facility water system. The facility will create a flow diagram of the building water system and identify areas and any devices that are in use that could pose a risk for harboring Legionella or other waterborne pathogens. The flow diagram will include the following areas: i. receiving, ii. cold water distribution, iii. heating, iv. hot water distribution waste. Specify testing proctocols and acceptable ranges for control measures and document the result and corrective action takes when control limits are not maintained. On 3/14/24 at 1130 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to show their water management program. The Infection Control Preventionist was unable to provide the documentation for flow diagram of the building, on how the water flows through the building, not identified any areas in the building where the water may stagnate, and for an ongoing monitoring of the water testing. The IP verified the findings. On 3/14/24 at 1200 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance stated he checked the temperature for the residents' comfort or prevent scalding from the hot water and not as a control measure as part of the water management plan. On 3/14/24 at 1515 hours, an interview was conducted with CNA 1. CNA 1 stated the water was used for all the residents for shower or handwashing.

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	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement an accurate antibiotic stewardship program. The facility failed to include the residents on long-term antibiotic in the surveillance listing for two of 21 final sampled residents (Residents 1 and 8). This failure posed the risk of inaccurately identifying residents met the indication of antibiotic use, and inappropriate antibiotic use. Findings: 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. Review of the facility's P&P titled Antibiotic Stewardship Program revised 1/2022 showed the following: - The IP will be responsible for infection surveillance and MDRO (multi-drug resistance organism) tracking; - The IP will collect and review data such as: the type of antibiotic ordered, route of administration, antibiotic costs; and - The Pharmacy will review and report antibiotic usage data including numbers of antibiotic prescribed (e.g. days of therapy) and the number of residents treated each month; and - The IP and/or other members of the ASP (Antimicrobial Stewardship Program) team will review and report findings to facility staff and to QA (Quality Assurance) Committee, who will then provide feedback to facility staff. 1. Medical record review for Resident 1 was initiated on 3/11/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the following physician's orders dated: -7/28/23, to administer gentamicin sulfate (antibiotic) 40 mg/ml via irrigation one time a day for infection prophylaxis. Mix 80 mg/2 ml gentamicin to 50 ml normal saline for a total of 52 ml, then flush med to port, clamp, then unclamp after 60 minutes; and -4/21/23, to administer Tobramycin (antibiotic) 300 mg via tracheostomy every 12 hours every two months starting on the first for 28 days for pneumonia (an infection that inflames the air sacs in one or both lungs) prophylaxis. 2. Medical record review for Resident 8 was initiated on 3/11/24. Resident 8 was readmitted to the facility on [DATE]. (continued on next page)

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	555753	A. Building B. Wing	03/14/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's Order Summary Report showed a physician's order dated 4/21/23, to administer Tobramycin inhalation nebulization solution 300 mg/5 ml via tracheostomy two times a day every month on the first day for 14 days for pneumonia (prophylaxis). Review of the facility's document titled Subacute Surveillance Line Listing for December 2023, January and February 2024, showed a list of the residents on antibiotic, infection type and site, organism, isolation precaution and etiology. The line listing form did not show Resident 1 who was on gentamicin and Tobramycin therapy and Resident 8 who was on Tobramycin therapy. On 1/14/19 at 1032 hours, an interview and concurrent medical record and facility document review was conducted with the IP. The IP verified the above findings. The IP stated she did not include Residents 1 and 8 in the surveillance line listing because they were on long-term antibiotic therapy. When asked about infection control monthly report, the IP stated she reported the number of the residents on antibiotics, any antibiotic orders reviewed by the pharmacist for appropriateness and order accuracy, and any antibiotic stewardship education by the physician. The IP stated these were documented in the Quality Assurance and Performance Improvement (QAPI) Committee Meeting report. Review of the Quality Assurance and Performance Improvement Committee Meeting report for December 2023 and January 2024, under Antibiotic Stewardship section, showed the following: - There were three out of four antibiotic time-outs in December 2023; and - There was no antibiotic use in January 2024. The IP verified the above findings. The IP stated the QAPI report on the Antibiotic Stewardship section was based on the surveillance line listing, and it only included the residents on short-term antibiotic therapy and did not include the residents on long-term antibiotic therapy. The IP verified she did not review the duration of the antibiotic therapy, the pharmacist did not review the antibiotic usage data including the duration or the days of the antibiotic therapy, and the IP did not report an accurate number of the residents prescribed with antibiotics.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the residents' entrapment assessments were complete and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for six of 12 final sampled residents (Residents 1, 7, 9, 10, 17, and 22). These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: 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: - 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. A concurrent observation, medical record review, and facility document review for Residents 1, 7, 9, 10, 17, and 22 showed the residents' bed entrapment assessments were not completed or the bed inspection gap measurements for Zones 5, 6, and 7 were recorded. For example: 1. On 3/11/24 at 0823 hours, 3/12/24 at 0848 hours, 3/13/24 at 0927 and 1116 hours, and 3/14/24 at 0759 hours, Resident 9 was observed lying in bed with bilateral full padded side rails elevated. Medical record review for Resident 9 was initiated on 3/11/24. Resident 9 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 9's Order Summary Report showed a physician's order dated 4/11/23, to apply the padded side rails every shift for seizure and safety precautions. Review of Resident 9's Side Rail Use Assessment Form dated 1/18/22, showed Resident 9 currently used the side rails for positioning or support, and bilateral side rails were recommended. Review of Resident 9's Bed System Measurement Device Test Results Worksheet dated 4/22/23, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of the entrapment for Zones 6 and 7. On 3/13/24 at 1447 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 3. LVN 3 verified Resident 9's use of the side rails in bed. 2. On 3/11/24 at 0901 hours, on 3/12/24 at 0944 hours, on 3/13/24 at 0932 hours, and 3/14/24 at 0813 hours, Resident 7 was observed lying in bed with four side rails elevated. Medical record review for Resident 7 was initiated on 3/11/24. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's Order Summary Report showed a physician's order dated 6/23/23, to have padded side rails up for seizures and safety precautions every shift. Review of Resident 7's Side Rail Use Assessment Form dated 2/7/23, showed Resident 7 used side rails for positioning or support, and bilateral side rails were recommended. Review of Resident 7's Bed System Measurement Device Test Results Worksheet dated 4/25/23, showed the measurements for each entrapment zones of the bed. However, the document failed to show the assessments of the entrapment for Zones 5, 6, and 7. On 3/13/24 at 1029 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 3. LVN 3 verified Resident 7's use of the side rails in bed. LVN 3 stated the entrapment assessment was done by the Maintenance Director. 3. On 3/11/24 at 0937 hours, and 3/12/24 at 0927 and 1031 hours, Resident 1 was observed lying in bed with bilateral full padded side rails elevated. Medical record review for Resident 1 was initiated on 3/11/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 6/23/23, to have the bilateral side rails up while in bed per the resident and family's preferences for comfort every shift. Review of Resident 1's Side Rail Use Assessment Form dated 5/20/2019, showed Resident 1 used the side rails for positioning or support, and bilateral side rails were recommended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 1's Bed System Measurement Device Test Results Worksheet dated 4/27/23, showed the measurements on each entrapment zones of the bed. However, the document failed to show the assessments of the entrapment for Zones 6 and 7. On 3/13/24 at 1029 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 4. RN 4 verified Resident 1's use of the side rails in bed. On 3/14/24 at 0952 hours, an interview and concurrent facility record review for Residents 1, 7, and 9 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the bed inspection including the entrapment assessment of all the beds in the facility. The Maintenance Director stated he used the Bionix safety measuring device to measure the entrapment zones on each of the bed, and documented the results in the worksheet form, to which he showed the Bed System Measurement Device Test Results Worksheet for each of the resident's bed in the facility. When asked about the assessments of the entrapment for Zones 5, 6, and 7 of the bed, the Maintenance Director verified the bed entrapment assessments were incomplete. 39670 4. On 3/11/24 at 1013 hours and 3/12/24 at 1057 hours, Resident 10 was observed in bed asleep with all four side rails elevated. Medical record review for Resident 10 was initiated on 3/12/24. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's Order Summary Report dated 3/14/24, showed a physician's order dated 1/25/24, for Resident 10 to have one side rail up to secure ventilator tubing due to position sensitivity every shift for airway/ventilation protection. Review of Resident 10's Side Rail Use Assessment Form dated 12/13/23, showed the use of left side rail for airway/ventilation protection. Review of Resident 10's Bed System Measurement Device Test Results Worksheet dated 1/25/24, showed the measurements for each entrapment zone of the bed. However, the document failed to show the assessments of the entrapment for Zones 5, 6, and 7. On 3/14/24 at 0942 hours, an interview and concurrent medical record review for Resident 10 was conducted with RN 2. RN 2 verified Resident 10's use of the side rails in bed. RN 2 stated the entrapment assessment was done by the Maintenance Director. 5. On 3/11/24 at 0920 hours, and 3/12/24 at 0959 hours, Resident 17 was observed in bed asleep with all four side rails in bed elevated with pads in place. Medical record review for Resident 17 was initiated on 3/12/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report dated 3/14/24, showed a physician's order dated 6/23/23, to apply the padded side rails for seizure precautions every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 17's Side Rail Use Assessment Form dated 3/21/23, showed the use of side rails in bed for safety and seizure precaution. Review of Resident 17's Bed System Measurement Device Test Results Worksheet dated 3/20/23, showed the measurements for each entrapment zone of the bed. However, the document failed to show the assessments of the entrapment for Zones 5, 6, and 7. On 3/13/24 at 1353 hours, an interview for Resident 17 was conducted with CNA 1. CNA 1 verified Resident 17's use of the side rails in bed. CNA 1 stated Resident 17 was not able to hold the side rail while in bed. On 3/14/24 at 0912 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 2. RN 2 verified Resident 17's use of the side rails in bed. RN 2 stated the entrapment assessment was done by the Maintenance Director. 6. On 3/11/24 at 1032 hours, and 3/12/24 at 1042 hours, Resident 22 was observed in bed with both side rails were elevated. Medical record review for Resident 22 was initiated on 3/13/24. Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 22's Order Summary Report dated 3/13/24, showed a physician's order dated 3/8/24, to apply the bilateral padded side rails every shift for seizure precautions. Review of Resident 22's Side Rail Use Assessment Form dated 1/24/24, showed the use of side rails in bed for safety and seizure precaution. Review of Resident 22's Bed System Measurement Device Test Results Worksheet dated 1/24/24, showed the measurements for each entrapment zone of the bed. However, the document failed to show the assessments of the entrapment for Zones 5, 6, and 7. On 3/13/24 at 1252 hours, an interview and concurrent medical record review for Resident 22 was conducted with RN 3. RN 3 verified the use of side rails in bed for Resident 22. RN 3 stated Resident 22 was able to move in bed. On 3/14/24 at 0951 hours, an interview and concurrent facility record review for Residents 10, 17, and 22 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the entrapment assessment of all the beds in the facility. The Maintenance Director stated he used a device to assess the entrapment zones on each of the bed. The Maintenance Director was able to show the Bed System Measurement Device Test Results Worksheet for each of the resident's bed in the facility. The Maintenance Director was asked about the assessment of the entrapment for Zones 5, 6, and 7 of the bed, the Maintenance Director verified the bed entrapment assessments were incomplete. On 3/14/24 at 1444 hours, an interview and concurrent facility document review for Residents 10, 17, and 22 was conducted with the CEO. The CEO was informed and verified the above findings.