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

PRINTED: 05/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRENCH PARK CARE CENTER	600 E WASHINGTON AVENUE SANTA ANA, CA 92701

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED survey for COMPLAINT No. CA00730562. Inspection was limited to the specific compliant investigated and did not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 37726, HFEN. FOR COMPLAINT NO. CA00730562: THE DEPARTMENT WAS ABLE TO PARTIALLY SUBSTANTIATE THE COMPLAINT ALLEGATION(S). FINDINGS WERE CITED AT F684 FOR RESIDENT 1. GLOSSARY OF ABBREVIATIONS AND BRIEF DEFINITIONS: P&P - policy and procedure LVN - Licensed Vocational Nurse	F 000	**F000** Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.	6/20/21
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and	F 684	**F 684 Quality of Care** **Corrective action for residents found to have been affected by this deficiency:** Resident 1 has not returned to the facility. **How the facility will identify other residents having the potential to be affected by the deficient practice:** On 5/25/21. Medical Records Personnel conducted a change	6/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/28/21

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

ACCEPTED 6/1/21 #37726

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F 684	Continued From page 1 facility P&P review, the facility failed to conduct the status post change of condition assessments for one of two sampled residents (Resident 1) as per the facility's P&P. * Resident 1 had a change of condition involving an episode of oxygen desaturation (a decrease in oxygen concentration in the blood resulting from any condition that affects the exchange of carbon dioxide and oxygen [74% on room air]). The facility failed to conduct an assessment related to the resident's change of condition on the shift preceding Resident 1's emergent transfer to the acute care hospital. Resident 1 then sustained another change of condition (altered level of consciousness and shortness of breath) which required an emergent transfer to the acute care hospital. These failures posed the risk for changes in Resident 1's medical condition not being identified, potentially delaying necessary care and treatment, which posed the risk for negative health outcomes to the resident. Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised 1/2012 showed the nurse will notify the attending physician when there has been a significant change in the resident's physical condition. The nurse will record in the medical record information relative to the change in the resident's medical status. Assessments related to the change in condition will be documented for 72 hours. Medical record review for Resident 1 was initiated on 3/29/21. Resident 1 was admitted to the facility on 11/15/19, and readmitted on 2/3/20.	F 684	in condition q shift documentation audit. 3 out of 14 change in condition have missing documentation. On 5/27/21, the 3 residents with incomplete documentation were assessed by the Assistant Director of Nursing with no noted negative outcome. The residents remain stable. **Measures that will be put into place and systemic changes made to ensure that this deficiency does not recur:** Medical Records Personnel will conduct a change in condition audit 2x per week. Missing q shift licensed nurse documentation will be reported to the Director of Nursing for review follow-up. Director of Nursing will in-service the Licensed Nurses on Change in Condition policy and procedure to be completed by 6/20/21.	

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F 684	Continued From page 2 Review of Resident 1's Change of Condition Interact Assessment Form dated 2/25/21 at 0800 hours, showed Resident 1 had a change of condition which resulted in Resident 1 having an episode of oxygen desaturation. Resident 1 was assessed with increased mucous production and her oxygen saturation level (the amount of oxygen in blood) was measured at 74% on room air. Resident 1's physician was notified of Resident 1's change of condition. Supplemental oxygen therapy was then administered to Resident 1. Review of the Order Summary Report showed a physician's order dated 5/21/20, to administer oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath in order to maintain the oxygen saturation level greater than 92%. Review of Resident 1's medical record showed Resident 1 remained on continuous supplemental oxygen at 2 liters per minute via nasal cannula, status post Resident 1's change of condition (desaturation on 2/25/21 at 0800 hours). Resident 1's oxygen saturation level remained above 92% when received the supplemental oxygen therapy as ordered. Review of Resident 1's Nurses Notes dated 2/26/21 (7-3 shift), showed Resident 1's oxygen therapy was removed on one occasion in order to determine Resident 1's oxygen saturation level on room air. Resident 1's oxygen saturation level on room air was measured at 80%. Review of Resident 1's Nurses Notes dated 2/28/21 at 0920 hours, showed Resident 1	F 684	**How the facility plans to monitor its performance to make sure that solutions are sustained:** Medical Records Director will report the outcome of the Change In Condition audits to the Continuous Quality Improvement Committee. Findings and trends shall be monitored monthly beginning June 2021 x 3 months or until substantial compliance is sustained.	

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F 684	Continued From page 3 exhibited shortness of breath and had an altered level of consciousness. Emergency services were activated and Resident 1 was subsequently transferred to the acute care hospital via 911. Review of Resident 1's medical record failed to show the assessment related to Resident 1's initial change of condition (on 2/25/21) was conducted during the 2300-0700 hours shift immediately preceding Resident 1's transfer to the acute care hospital for shortness of breath and altered level of consciousness. On 5/6/21 at 1123 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 was assigned to care for Resident 1 from 2/27/21 2300 hours to 2/28/21 0700 hours (the shift prior to Resident 1's emergent transfer to the acute care hospital). LVN 1 was asked to describe the facility's P&P for the resident assessment status post change of condition. LVN 1 stated when the resident had a change of physical condition, the licensed nurse should conduct an assessment related to the resident's change in condition every shift for 72 hours, and document the assessment in the nursing progress notes. LVN 1 verified she was assigned to care for Resident 1 during the shift prior to Resident 1's emergent transfer to the acute care hospital. LVN 1 verified Resident 1 had a change of condition on 2/25/21 at 0800 hours, in which Resident 1 had an episode of oxygen desaturation (74% on room air). LVN 1 stated the facility's licensed nurses were required to conduct the assessments after Resident 1's change of condition on 2/28/21 0800 hours, every shift for	F 684		

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F 684	Continued From page 4 72 hours. LVN 1 verified Resident 1's medical record failed to show documentation she had conducted the assessment of Resident 1 during her shift on 2/27/21 (the shift prior to Resident 1 being transferred to the acute care hospital for altered level of consciousness and shortness of breath). LVN 1 was asked if she remembered conducting the assessment of Resident 1, to which she replied she could not remember; it was several months ago and when working on the night shift, she was responsible for caring up to 50 residents.	F 684		