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

PRINTED: 05/09/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
					С			
555093				B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			04/27/2023	
NAME OF I	PROVIDER OR SUPPLIER				1			
ST EDNA	A SUBACUTE AND RE	HABILITATION CENTER				929 N. FAIRVIEW STREET ANTA ANA, CA 92706		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	California Departme ABBREVIATED sur CA00836059. Inspection was limit investigated and did a full inspection of t Representing the C Health: Surveyor 36 FOR COMPLAINT I DEPARTMENT WA THE COMPLAINT A WERE CITED AT F GLOSSARY OF AB DEFINITION: DON - Director of N P&P - policy and pro Notify of Changes (I CFR(s): 483.10(g)(14) Notif (i) A facility must immonsult with the resi consistent with his or representative(s) wh (A) An accident involves in injury and physician interventic (B) A significant cha mental, or psychosol	ets the findings of the ent of Public Health during vey for COMPLAINT No. ed to the specific complair I not represent the findings he facility. alifornia Department of Pu 872, HFEN. No. CA00836059: THE S ABLE TO SUBSTANTIA ALLEGATION(S). FINDING 580 FOR RESIDENT 1. BREVIATIONS AND BRIE ursing cedure njury/Decline/Room, etc.) 14)(i)-(iv)(15) fication of Changes. mediately inform the resided dent's physician; and notify in her authority, the resident here is- living the resident which has the potential for requires	of blic TESS	F 5	0000	This Plan of Correction constitutes the Facility's credible allegation of compliance. St. Edna Subacute and Rehab., hereinafter referred to as STESR, makes its best et to operate in full compliant with both Federal and Stalaws. Nothing, included in Plan of Correction is an admission otherwise. STE has submitted this Plan of Correction in order to contwith its regulatory obligations and does not waive any objections to the merits of form of any allegations contained herein. Please note that STESR contest the merits and/or of any of the deficiency findings alleged below.	nce ate a this ESR f nply on r	<u>\$</u>
1000:000	DIRECTORIC OR DOCUMENT	ER/SUPPLIER REPRESENTATIVE'S	SIGN	IATURE		, TITLE		(X6) DATE
AROKATORY	DIKECTOK'S OK PROVIDE	THE REPRESENTATIVE S	JOH	IN OIL		DIN		(-117/202

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:

5/18/23 at 1055 hours, spoke to DON, POC accepted by HFEN 36872.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WAQC11

Facility ID: CA060000145

If continuation sheet Page 1 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM 555093		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		555093	B. WING	S	10		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	IP CODE	27/2023	
ST EDNA SUBACUTE AND REHABILITATION CENTER			1929 N. FAIRVIEW STREET SANTA ANA, CA 92706				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF IX (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From page	ge 1	F!	580			
	F 580 Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment) t	Corrective Action Residents Identifi been affected by deficiency: Resident 1 was id have been affected deficiency No immediate cor action can be take Resident 1 was di from the facility or	ed to have this lentified to ed by this rective en as ischarged		
Í		ent rights under Federal or		Identification of o			
	(e)(10) of this section (iv) The facility must i	record and periodically mailing and email) and		Residents having potential to be aff this deficiency: On 5/1/2023, a fa	ected by		
The second secon	that is a composite die §483.5) must disclose ts physical configurat ocations that compris part, and must specify	osite distinct part. A facility stinct part (as defined in e in its admission agreement ion, including the various the composite distinct to the policies that apply to en its different locations		reviewed all 23 fa previous 60 days documented notif Resident's Respo representative of incident.	Ils in the for timely ication to ensible party		
T b	This REQUIREMENT by:	is not met as evidenced nedical record review, and		There were no ad deficient findings.	ONDERS COMPANION AND ADMINISTRATION AND ADMINISTRAT		

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(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DAT	E SURVEY
								С
555093				B. WING			04/27/2023	
NAME OF PROVIDER OR SUPPLIER					1 6	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST EDNA SUBACUTE AND REHABILITATION CENTER						929 N. FAIRVIEW STREET SANTA ANA, CA 92706		
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE
	the family for one of (Resident 1) was not (Resident 1) was not fall. This failure had family to not be able decisions for the card. Findings: Review of the facility Management dated physicians and resp promptly notified of residents. Closed medical recoinitiated on 4/27/23, the facility on 3/13/2. Review-of-Residentate 2319 hours, show unwitnessed fall. The 2342 hours. However, evidence the facility family when the residentate 4/8/23 at 0800 hours fall incident last night	the facility failed to ensurative sampled residents of the potential for the resident the potential for the resident of the potential for the resident of the appropriate reand treatment of Resident 10/2017 showed the onsible parties will be the incidents involving the parties of the incident 1 was admitted 3, and discharged on 4/9/10/10/10/10/10/10/10/10/10/10/10/10/10/	was to 23.	F 5	580		the not	
	4/8/23 at 1200 hours was at the facility and physician had not ca	1's Progress notes dated , showed Resident 1's fan d was informed that the lled back. ours, an interview and	nily		and or resignate growing scripts (in the case of separate persons or separate property separate contents			

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NAME OF PROVIDER OR SUPPLIER ST EDNA SUBACUTE AND REHABILITATION CENTER			to the state of th	STREET ADDRESS, CITY, STATE, ZIP CODE 1929 N. FAIRVIEW STREET SANTA ANA, CA 92706				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	Continued From page 3 concurrent closed medical record review was conducted with the DON. The DON stated it w important to notify the resident's family if there was a change in condition. The DON acknowledged the family was not informed.		vas	F 58	The DON and/or his or her designee will review and audit all Resident's fall incident reports within 24 hours to ensure timely notification and documentation of notification to the Resident's responsible party/representative of the fall incident and document findings on the Quality Improvement Audit Tool x 2 months. The documented results will be forwarded to the QA&A Committee monthly x 2 month for further review		7/17-0	
					and action planning as indicated or until QA&A Committee determines compliance	neterness and particular territories		