STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055252	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORANGE HEALTHCARE & WELLNESS CENTRE, LLC	920 WEST LA VETA STREET ORANGE, CA 92868

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide services to attain or maintain the highest practicable level of well-being for one of three sampled residents (Resident 3). The facility failed to follow the physician's orders [REDACTED]. These failures contributed to the facility not taking the immediate interventions and Resident 3 being transferred to the acute care hospital emergency department. Findings: Closed medical record review for Resident 3 was initiated on 8/18/2020. Resident 3 was admitted to the facility on [DATE]. Review of the SNF (skilled nursing facility) initial history and physical examination [REDACTED]. Review of the admission orders [REDACTED]. Review of the laboratory report showed the BMP was performed on 7/19/2020 at 1748 hours, and the following test results were received on 7/20/2020: - BUN level (blood, urea, nitrogen, indicator of kidney and liver function) was 56 mg/dl, which was high (normal range: 7 to 25 mg/dl). - Creatinine level (indicator of kidney function) was 2.30 mg/dl, which was high (normal range: 0.70 to 1.30 mg/dl). - Sodium (a type of electrolyte in the blood, abnormally high sodium could be a sign of dehydration) 150 mEq/L,which was high (normal range: 135 to 145 mEq/L). Review of the physician's telephone orders dated 7/20/2020 at 1200 hours, showed the following orders: - To administer D5W ([MEDICATION NAME] in 5% water) at 60 ml per hour for 10 hours. - To check the resident's BMP in the morning. - To hold [MEDICATION NAME] for one dose in the morning. Review of Resident 3's medical record failed to show documentation the physician's orders [REDACTED]. There was no documentation Resident 3's physician was informed of the BMP laboratory test not done as ordered. In addition, review of the Resident 3's Medication Sheet for July 2020 showed the [MEDICATION NAME] 40 mg tablet section was signed as administered daily at 0900 hours on 7/21, 7/22, and 7/23/2020. The medication was not held on 7/21/2020, as ordered by the physician. Review of the physician's telephone orders dated 7/23/2020 at 1430 hours, showed an order to perform a STAT (immediate) BMP test. Review of the laboratory report collected on 7/23/2020 at 1613 hours, showed the following results received on 7/23/2020 at 2126 hours: - BUN level was 92 mg/dl. This result was critically high (the report showed this test was repeated and verified). - Creatinine level was 5 mg/dl. This result was reported to be high. - Sodium level was 170 mEq/L. This result was reported as critically high. Review of the Nurse's Notes showed no documentation between 7/19 to 7/22/2020. The nursing entry on 7/23/2020 at 1937 hours, showed the licensed nurse was notified by the CNA that Resident 3 was unresponsive. Upon assessment by the RN Supervisor, Resident 3 was found to be lethargic, moaning, and would not open his eyes. Resident 3's blood pressure level was 52/31 mmHg and the oxygen saturation level (the amount of oxygen in the blood) of 72% on room air. The documentation showed Resident 3 had an episode of full body tremors and stiff extremities [MEDICATION NAME] for two minutes. Resident 3's physician was notified and ordered to transfer Resident 3 to the emergency department via 911. The documentation further showed when 911 arrived, Resident 3 had two more episodes of full body tremors [MEDICATION NAME] 45 seconds each. On 8/25/2020 at 1425 hours, a telephone interview and concurrent closed medical record review for Resident 3 was conducted with LVN 2. LVN 2 stated she was assigned to Resident 3 when he was transferred to the emergency department via 911 on 7/23/2020. LVN 2 stated the CNA notified her Resident 3 was not responding. LVN 2 stated Resident 3 was in his room and did not respond to the tactile stimulation or questions. Resident 3's blood pressure was 52/31 mmHg and the oxygen saturation level was 72% on room air. LVN 2 verified the physician's orders [REDACTED]. LVN 1 stated the physician wanted the medication ([MEDICATION NAME]) held until they could see what the laboratory results showed. On 8/26/2020 at 0934 hours, a telephone interview and concurrent closed medical record review for Resident 3 was conducted with the DSD. The DSD verified the above findings and stated the [MEDICATION NAME] medication should have been held and the blood work should be performed as ordered. The DSD verified the physician was not notified the orders to hold the [MEDICATION NAME] and perform the BMP laboratory tests were not carried out. Review of the acute care hospital's emergency department record for Resident 3 dated 7/23/2020, showed Resident 3 arrived to the emergency department unconscious and exhibited some shaking of the left leg and right arm. Resident 3's [DIAGNOSES REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the needs for one of three sampled residents (Resident 1). Resident 1 was not administered the medications as ordered by the physician due to the medication being unavailable. This failure had the potential to negatively impact the resident's health. Findings: Review of the facility's P&P titled Medication Ordering and Receiving (undated) showed the medications that are not automatically refilled by the pharmacy shall be reordered three days in advance of need to assure an adequate supply is on hand. On 7/29/2020 at 1311 hours, an interview was conducted with Resident 1. Resident 1 stated she was not getting her medications in the correct dose or time. Resident 1 stated she was told this was due to the fact that the facility only filled the prescriptions once a month. Resident 1 stated it made her concerned for her health and caused her to wonder what would happen to her if she did not get the medications when she needed them. Medical record review for Resident 1 was initiated on 7/29/2020. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Medical Sheets for July and August 2020 showed numerous dates when Resident 1 did not receive her medications as ordered by the physician. For example: * On 7/1/2020, Resident 3 did not receive the [MEDICATION NAME] inhalation (asthma medication) scheduled to be administered at 0900 hours and Montelukast (medication for asthma) tablet scheduled to be administered at 2100 hours due to the medications being unavailable. * On 7/19/2020, Resident 3 did not receive the [MEDICATION NAME] (antidiabetic medication) tablet 5 mg scheduled to be administered at 0900 hours due to the medication being unavailable. * On 8/31/2020, Resident 3 did not receive the Montelukast tablet scheduled to be administered at 2100 hours due to the medication being unavailable. * Further review of the Medications Sheets showed the physician's orders [REDACTED]. On 7/3/2020, the [MEDICATION NAME] 250 mcg injection was scheduled to be administered at 0900 hours. The licensed nurse documented administering [MEDICATION NAME] 100 mcg injection to the left lower quadrant of the abdomen, and the pharmacy was called to deliver the remaining [MEDICATION NAME] 150 mcg to make up for the physician's orders [REDACTED]. On 9/3/2020 at 1530 hours, a telephone interview and concurrent medical record review for Resident 1 was conducted with the DSD. The DSD verified the above findings and stated the licensed nurses were supposed to refill the medication three days prior to running out to ensure they would get the medication on time. The DSD verified the physician was not notified of the missed doses and should have been.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.