

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/14/2025
NAME OF PROVIDER OR SUPPLIER  Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  501 South Beach Blvd. Anaheim, CA 92804	

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)
<p>F 0550</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50953</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure one nonsampled resident (Resident 173) was provided with the necessary care in the manner that promoted dignity and respect.</p> <p>* The facility failed to provide the meal tray to Resident 173 at the same time with other residents during lunch in the dining room. This failure had the potential to not treat the resident with respect.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Promoting/Maintaining Resident Dignity During Mealtime revised 12/19/22, showed it is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhanced his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident.</p> <p>Medical record review for Resident 173 was initiated on 4/7/25. Resident 173 was admitted to the facility on [DATE].</p> <p>Review of Resident 173's H&amp;P examination dated 3/25/25, showed Resident 173 had a fluctuating capacity to understand and make decisions.</p> <p>On 4/7/25 at 1205 hours, an observation was conducted in the dining room during lunchtime. Residents 3, 97, and 173 were observed sitting at the same table. Residents 3 and 97 were observed with their meal tray and eating, but Resident 173 had no meal tray yet. Resident 97 stated everyone was eating and Resident 173 did not have her lunch tray yet.</p> <p>On 4/7/25 at 1207 hours, an observation and concurrent interview was conducted with the DSD. The DSD verified Resident 173 was not served with her lunch tray at the same time with Residents 3 and 97.</p>

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
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39683</p> <p>Based on interview, record review, and facility P&amp;P review, the facility failed to ensure the accurate and complete consents were obtained for three of 35 final sampled residents (Residents 11, 76, and 117) and two nonsampled residents (Residents 75 and 193).</p> <p>* Residents 75, 117, and 193's consents were not signed appropriately as per the facility's P&amp;P.</p> <p>* Residents 11 and 76's informed consents were not completed to include the date and signature of the person who placed the call; date when the eligible provider or clinician signature signed; date and name/signature of witness; and date and signature of the resident/POA, the name of the two licensed nurses who signed on the consents and the resident/resident's representative name and signature and date. This failure had the potential for violating the residents' rights of not being fully informed of the medications and treatments.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Informed Consent reviewed/revised 12/19/22, showed the following:</p> <ul style="list-style-type: none"> <li>- When the resident does not have capacity to make their own medical decisions and has no legal surrogate, the facility's IDT may make medical decisions that require informed consent. The IDT must include a resident representative who is unaffiliated with the facility.</li> <li>- Prior to the administration of a psychotherapeutic medication, licensed nursing staff shall verify with the resident or surrogate decision maker that informed consent was obtained, and the nurse will complete the Verification of Informed Consent Form.</li> </ul> <p>1. Medical record review for Resident 117 was initiated on 4/7/25. Resident 117 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 117's H&amp;P examinations dated 12/4/24 and 12/13/24, showed the resident could make their needs known but can not make medical decisions.</p> <p>Review of Resident 117's Order List Report showed a physician's order dated 12/2/24, for Abilify (an antipsychotic medication) 15 mg by mouth at bedtime for depression manifested by verbalization of sadness, and sertraline HCl (an antidepressant medication) 150 mg by mouth daily for depression manifested by verbalization of sadness.</p> <p>Review of Resident 117's Physician Document of Informed Consent dated 12/4/24, for sertraline HCl 150 mg daily and Abilify 15 mg at bedtime showed the consent was obtained from Resident 117.</p> <p>Review of Resident 117's Consent For Treatment dated 12/11/24, showed the form was signed by the two facility representatives, and the section for the resident's legal representative giving consent was left blank.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 117's Physician Document of Informed Consent dated 12/12/24, for sertraline HCl 150 mg daily and Abilify 15 mg at bedtime failed to show who gave the consent.</p> <p>On 4/10/25 at 0947 hours, an interview was conducted with the Administrator. The Administrator stated for the resident who had no capacity to make their own medical decision and had no responsible party, the Bioethics Committee/IDT would meet and become the resident's responsible party and make decisions about the resident's plan of care. The Administrator stated the committee included the Ombudsman as well as the IDT. The Administrator stated the Ombudsman was not part of Resident 117's Bioethics Committee/IDT meeting when determining the resident's plan of care and consents.</p> <p>On 4/10/25 at 1030 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated they had not been a part of any Bioethics Committee for any of the residents in the facility for over a year.</p> <p>On 4/11/25 at 1400 hours, an interview and concurrent record review was conducted with the DON. The DON stated the facility's IDT was the resident's representative, and the Administrator would sign as the responsible party on behalf of the IDT. The DON reviewed Resident 117's consents and verified the Administrator should have signed the consents for the treatment and psychotropic medications.</p> <p>Cross reference to F842, example #1.</p> <p>2. Medical record review for Resident 75 was initiated on 4/7/25. Resident 75 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 75's H&amp;P examination dated 9/14/24, showed the resident did not have the capacity to understand and make decisions.</p> <p>Review of Resident 75's Order Listing Report dated 4/11/25, showed the following orders:</p> <ul style="list-style-type: none"> <li>- dated 10/8/24, to administer Seroquel (an antipsychotic medication) 75 mg via GT every 12 hours and</li> <li>- dated 10/22/24, to administer risperidone (an antipsychotic medication) 2 mg via GT every 12 hours and mirtazapine (an antidepressant medication) 15 mg via GT at bedtime.</li> </ul> <p>Review of Resident 75's Consent for Treatment forms dated 9/13/24, 11/6/24, and 1/10/25, were signed by the two facility staff; however, all three forms showed the section for the resident's legal representative giving consent was left blank.</p> <p>Review of Resident 75's Physician Document of Informed Consent form for risperidone 2 mg every 12 hours dated 9/16/24, failed to show who obtained the consent.</p> <p>Review of Resident 75's Physician Document of Informed Consent form for Seroquel 75 mg dated 9/16/24, failed to show who obtained the consent.</p> <p>Review of Resident 75's Physician Document of Informed Consent form for the use of an abdominal binder dated 9/16/24, failed to show who obtained the consent.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 75's Physician Document of Informed Consent form for mirtazapine 15 mg at bedtime and risperidone 2 mg every 12 hours dated 11/22/24, failed to show who obtained the consent.</p> <p>Review of Resident 75's Physician Document of Informed Consent form for mirtazapine 15 mg at bedtime and risperidone 2 mg every 12 hours dated 1/13/25, failed to show who obtained the consent.</p> <p>On 4/10/25 at 0947 hours, an interview was conducted with the Administrator. The Administrator stated for the resident who had no capacity to make their own medical decision and had no responsible party, the Bioethics Committee/IDT would meet and become the resident's responsible party and make decisions about the resident's plan of care. The Administrator stated the committee included the Ombudsman as well as the IDT.</p> <p>On 4/10/25 at 1030, a telephone interview was conducted with the Ombudsman. The Ombudsman stated they had not been a part of any Bioethics Committee for any of the residents in the facility for over a year.</p> <p>On 4/11/25 at 1400 hours, an interview and concurrent record review was conducted with the DON. The DON stated the facility's IDT was the resident's representative, and the Administrator would sign as the responsible party on behalf of the IDT. The DON reviewed Resident 75's consents and verified the Administrator should have signed the consents for the treatment and psychotropic medications.</p> <p>Cross reference to F842, example #2.</p> <p>3. Medical record review for Resident 193 was initiated on 4/7/25. Resident 193 was admitted to the facility on [DATE].</p> <p>Review of Resident 193's H&amp;P examination dated 11/30/24, showed the resident did not have the capacity to understand and make decisions.</p> <p>Review of Resident 193's General Consent for Care, Treatment, and Procedures dated 12/5/25, the section for the signature of the resident or POA (responsible party) had an IDT team written on it. The form had no signature, and the signature line was undated.</p> <p>Review of Resident 193's Authorization Consent for Advanced Wound Care Services dated 3/19/25, showed the consent was obtained from the resident.</p> <p>On 4/10/25 at 0947 hours, an interview was conducted with the Administrator. The Administrator stated for the resident who had no capacity to make their own medical decision and had no responsible party, the Bioethics Committee/IDT would meet and become the resident's responsible party and make decisions about the resident's plan of care. The Administrator stated the committee included the Ombudsman as well as the IDT.</p> <p>On 4/10/25 at 1030 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated they had not been a part of any Bioethics Committee for any of the residents in the facility for over a year.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/11/25 at 1400 hours, an interview and concurrent record review was conducted with the DON. The DON stated the facility's IDT was the resident's representative and the Administrator would sign as the responsible party on behalf of the IDT. The DON reviewed Resident 193's consents and verified the resident was unable to give consent and the Administrator should have signed the consents for the treatment and psychotropic medications instead of an IDT being written on it.</p> <p>Cross reference to F842, example #3.</p> <p>49324</p> <p>4. Medical record review for Resident 11 was initiated on 4/7/25. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 11's H&amp;P examination dated 8/6/24, showed the resident could make needs known but could not make medical decisions.</p> <p>On 4/9/25 at 0834 hours, an interview and concurrent medical record review was conducted with LVN 9. Resident 11's General Consent for Care, Treatment and Procedures form showed the document contained Resident 11's family member phone number; however, there were missing information as follows:</p> <ul style="list-style-type: none"> <li>- the date and signature of the person who placed the call,</li> <li>- date when the eligible provider or clinician signature signed,</li> <li>- date and name/signature of witness, and</li> <li>- date and signature of the resident/ POA.</li> </ul> <p>Further review of Resident 11's medical record showed the resident had another Consent for Treatment form. The form had Resident 11's signature and date. However, there were no date and signature of agent/legal representative on the form.</p> <p>The Consent for the Treatment also showed the instructions at the lower part of the form as white - chart and yellow form - Resident. LVN 9 was asked what the instruction white- chart and yellow- resident meant, LVN 9 stated the white form was the first page that should be stored in the physical chart and the yellow form which was the second page should be handed to the resident's legal representative. LVN 9 further added the yellow form should have been given to Resident 11's legal representative and all of the above missing information should have been completed.</p> <p>5. Medical record review for Resident 76 was initiated on 4/7/25. Resident 76 was admitted to the facility 3/3/25.</p> <p>Review of Resident 76's H&amp;P examination dated 3/4/25, showed the resident had the capacity to understand and make decisions.</p> <p>On 4/10/25 at 1455 hours, an interview and concurrent medical record review was conducted with LVN 9. Review of Resident 76's informed consents showed the consents for the following medications:</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- divalproex ER 500 mg 24 hr tablet two times a day for mood disorder manifested by mood swings</li> <li>- Lexapro (antidepressant) 10 mg PO Q HS for depression manifested crying out</li> <li>- Zyprexa (antipsychotic) 10 mg PO Q HS for Bipolar disorder manifested by mood swings.</li> </ul> <p>Resident 76's Facility Verification of Informed Consent forms also showed the consents were obtained via telephone and the facility verified with the resident or surrogate decision maker that he/she had given informed consent for the proposed psychotherapeutic medication or physical restraint or device to the prescriber, and with two licensed nurses' signature and date. However, the forms showed the following missing information:</p> <ul style="list-style-type: none"> <li>- the name of the two licensed nurses who signed the consents and;</li> <li>- the resident/resident's representative name and signature and date.</li> </ul> <p>LVN 9 verified all the above findings and stated the inform consents should have been signed and dated.</p> <p>On 4/11/25 at 0915 hours, an interview was conducted with the DON. The DON verified the above findings.</p>

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<p>F 0583</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>47474</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to ensure the privacy was provided for one of two nonsampled residents (Resident 179) with GT during the medication administration observation.</p> <p>* The privacy curtain was not pulled completely in Resident 179's room when the licensed nurse administered the medications via GT. This failure had the potential to negatively affect the dignity of the resident and violate the resident's rights to privacy.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Medication Administration via Enteral Tube revised 12/2022 showed it is the policy of the facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines. The P&amp;P further showed under the section for the Procedures, to provide privacy by pulling the privacy curtain or closing the door to a private room.</p> <p>On 4/8/25 at 0853 hours, during the medication administration observation, LVN 5 was observed going inside Resident 179's room to administer the medications via GT. LVN 5 did not completely pull the privacy curtain close when he administered the medications to Resident 179. The room door was observed open and Resident 179 was exposed to the hallway when LVN 5 was checking for the GT placement and residual and administering the resident's medications via GT. Resident 179 was exposed to the facility staff, residents, and visitors who walked past her room. When LVN 5 was asked if the privacy curtains should be drawn closed during the medication administration, LVN 5 verified it should be. LVN 5 then ensured the privacy curtains were drawn closed before continuing with Resident 179's medication administration via GT.</p> <p>On 4/8/25 at 0918 hours, an interview was conducted with LVN 5. LVN 5 verified Resident 179 was not provided with complete privacy during the medication administration. LVN 5 stated the privacy curtains should have been drawn closed to ensure the resident's privacy was protected during the medication administration.</p> <p>On 4/14/25 at 1139 hours, an interview was conducted with the DON . The DON was informed and acknowledged the above findings.</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726</b></p> <p>Based on observation and interview, the facility failed to maintain a homelike environment for one nonsampled resident (Resident 72).</p> <p>* Resident 72 resided in Room A. Room A closet drawer was observed in disrepair as evidenced by chipped paint and unpainted areas. This failure had the potential to negatively impact the resident's quality of life.</p> <p>Findings:</p> <p>Medical record review for Resident 72 was initiated on 4/7/25. Resident 72 was admitted to the facility on [DATE].</p> <p>On 4/10/25 at 1002 hours, an observation and concurrent interview was conducted with Resident 72. Resident 72 was observed in his room (Room A). The closet drawer was observed in disrepair as evidenced by chipped paint and unpainted areas. Resident 72 stated he utilized his closet drawer and would like for his closet drawer to be repaired.</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39683</p> <p>Based on interview and medical record review, the facility failed to ensure the MDS was coded accurately for one of one nonsampled resident (Resident 70) reviewed for respiratory care.</p> <p>* Resident 70's MDS was inaccurately coded to reflect the resident's oxygen use. This failure had the potential for the resident to not receive individualized plans of care to address their individual care needs and inaccurate data for quality measures.</p> <p>Findings:</p> <p>Medical record review for Resident 70 was initiated on 4/7/25. Resident 70 was readmitted to the facility on [DATE].</p> <p>On 4/7/25 at 1052 hours, Resident 70 was observed with an oxygen being administered via nasal cannula.</p> <p>Review of Resident 70's Order Summary Report dated 4/11/25, showed a physician's order dated 11/5/23, to administer oxygen at 4 LPM.</p> <p>Review of Resident 70's Monitor Record for November 2024 showed the supplemental oxygen was administered daily.</p> <p>Review of Resident 70's MDS dated [DATE], showed for the 14-day look-back period, the resident did not receive oxygen therapy.</p> <p>Review of Resident 70's Monitor Record for February 2025 showed the supplemental oxygen was administered daily.</p> <p>Review of Resident 70's MDS dated [DATE], showed for the 14-day look-back period, the resident did not receive oxygen therapy.</p> <p>On 4/11/25 at 1206 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 70's medical record, and stated the resident received continuous supplemental oxygen in November 2024 and February 2025. The MDS Coordinator verified the MDS assessments for 11/26/24 and 2/26/25, were coded inaccurately to reflect Resident 70's oxygen use.</p>		

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<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39683</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to develop and implement the comprehensive care plans for one of 35 final sampled residents (Resident 120).</p> <p>* The facility failed to develop a care plan problem to address Resident 120's indwelling urinary catheter use. This failure had the potential for the resident to not be provided with the appropriate, consistent, and individualized care.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Comprehensive Care Plan revised 12/19/22, showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be describe, at a minimum, the following: the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>Medical record review for Resident 120 was initiated on 4/7/25. Resident 120 was readmitted to the facility on [DATE].</p> <p>On 4/9/25 at 0808 hours, Resident 120 was observed in his wheelchair. Resident 120 was observed with the urinary catheter drainage bag.</p> <p>Review of Resident 120's Order Summary Report dated 4/8/25, showed a physician's order dated 2/23/25, for an indwelling urinary catheter with a drainage bag.</p> <p>Review of Resident 120's Care Plan Report failed to show a care plan problem was developed to address the resident's indwelling urinary catheter use.</p> <p>On 4/9/25 at 1430 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified Resident 120 had an indwelling urinary catheter and the resident plan of care failed to show a care plan for the indwelling urinary catheter use.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726</b></p> <p>Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plan was revised for one of 35 final sampled residents (Resident 80).</p> <p>* The facility failed to ensure Resident 80's comprehensive care plan was revised to reflect a physician's order for one-to-one feeding assistance for aspiration precautions. This failure placed the resident at risk for not being provided appropriate, consistent, and individualized care.</p> <p>Findings:</p> <p>Medical record review for Resident 80 was initiated on 4/7/25. Resident 80 was admitted to the facility on [DATE].</p> <p>On 4/7/25 at 1236 hours, an observation was conducted of Resident 80. Resident 80 was observed in his room eating lunch independently (without the facility staff present and outside of the facility staff view). Resident 80 was observed eating soup and drinking juice and a Boost (nutrition supplement drink). Resident 80 was observed coughing intermittently when swallowing.</p> <p>Review of Resident 80's physician's order dated 3/27/25, showed an order for one-to-one feeding assistance for aspiration precautions.</p> <p>On 4/9/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 80's physician's order dated 3/27/25, for one-to-one feeding assistance for aspiration precautions. The DON then reviewed Resident 80's active care plans and verified Resident 80's care plans addressing nutrition was not revised to include the intervention for one-to-one feeding assistance for aspiration precautions, in accordance with Resident 80's physician's order.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/14/2025
NAME OF PROVIDER OR SUPPLIER  Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  501 South Beach Blvd. Anaheim, CA 92804	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39683</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure necessary care and services were provided to five of 35 final sampled residents (Residents 44, 59, 79, 117, and 197).</p> <p>* Resident 117's monitoring for orthostatic hypotension (a sudden drop in blood pressure when a person stands up from a seated or lying position. This drop in blood pressure can cause symptoms like dizziness, lightheadedness, blurred vision, or even fainting.) was not being conducted correctly, and the physician's order did not have parameters for when to notify the physician.</p> <p>* Resident 44's physician's order for monitoring the orthostatic hypotension did not have parameters for when to notify the physician.</p> <p>* The facility failed to follow Resident 197 physician's order to provide one-to-one feeding assistance during meals. This failure had the potential to place the resident at risk for serious injury and negative health outcomes.</p> <p>* The facility failed to ensure Residents 59 and 79's blood pressure site was accurately documented in the resident's medical record.</p> <p>These failures had the potential for poor health outcomes to these residents.</p> <p>Findings:</p> <p>1. Medical record review for Resident 117 was initiated on 4/7/25. Resident 117 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 117's Order Summary Report dated 4/8/25, showed the following physician's orders:</p> <ul style="list-style-type: none"> <li>- dated 12/12/24, to monitor for orthostatic hypotension ever week on Monday, with BP lying.</li> <li>- dated 12/12/24, to monitor for orthostatic hypotension ever week on Tuesday, with BP sitting.</li> </ul> <p>On 4/9/25 at 1033, an interview was conducted with Resident 117 standing in the hallway outside their room. Resident 117 stated she needed a walker because sometimes she got dizzy. Resident 117 was observed currently not using an assistive device.</p> <p>On 4/9/25 at 1046 hours, an interview was conducted with LVN 2. LVN 2 stated they checked Resident 117 when monitoring for orthostatic hypotension. LVN 2 stated she checked the resident's blood pressure when the resident walked by her, then had the resident go into her room to sit and took another blood pressure while the resident was sitting. LVN 2 stated the resident sometimes has a low BP but it was usually stable. LVN 2 was unsure why there was an order to monitor for the orthostatic hypotension.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/9/25 at 1055 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated there was no facility P&amp;P for taking the resident's BP to monitor for the orthostatic hypotension. The DON stated the process for monitoring for the orthostatic hypotension was as follows: the nurse should first take the blood pressure with the resident lying down, then sitting after a few minutes, and standing after a few minutes. When asked what the parameters for notifying the physician of the BP changes, the DON was unsure and stated the physician's order should specify when to notify the physician for the resident's BP changes between position changes, and it did not. The DON verified the record showed the BP monitoring for orthostatic hypotension from lying to sitting was not done on the same day and should be done minutes apart. The DON also stated the resident was ambulatory and the resident's orthostatic hypotension monitoring should also show the BP was checked while standing too, which the record did not show. The DON stated she was unsure specifically why the resident had an order for the orthostatic hypotension monitoring.</p> <p>2. Medical record review for Resident 44 was initiated on 4/7/25. Resident 44 was readmitted to the facility on [DATE].</p> <p>Review of Resident 44's Order Summary Report dated 4/8/25, showed the following:</p> <ul style="list-style-type: none"> <li>- A physician's order dated 12/11/24, to monitor for orthostatic hypotension every Wednesday day shift with BP in a lying position.</li> <li>- A physician's order dated 12/11/24, to monitor for orthostatic hypotension every Wednesday day shift with BP in a sitting position.</li> </ul> <p>On 4/9/25 at 1055 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated there was no facility P&amp;P for taking BP to monitor for orthostatic hypotension. The DON stated the process for monitoring for the orthostatic hypotension was as follows: the nurse should first take the blood pressure with the resident lying down, then sitting after a few minutes, and standing (if able) after a few minutes. When asked what the parameters for notifying the physician of the BP changes, the DON was unsure and stated the physician's order should specify when to notify the physician for the BP changes between position changes, and verified it did not. The DON was unsure why there was a physician's order for monitoring the resident's orthostatic hypotension.</p> <p>On 4/9/25 at 1119 hours, an interview was conducted with LVN 2. LVN 2 was asked when she should notify the physician for the BP changes when monitoring for the orthostatic hypotension. LVN 2 stated she was unsure because the order did not specify when to notify the physician. When asked if the facility had any resources for her to use in determining the accepted BP fluctuations when monitoring for the orthostatic hypotension, LVN 2 replied not that she was aware of.</p> <p>50953</p> <p>3. Review of the facility's P&amp;P titled Meal Supervision and Assistance dated 2022 showed the resident will be prepared for a well-balanced meal in a calm environment with adequate supervision and assistance to prevent accidents. This includes identifying hazards and risks and implementing interventions to reduce hazards and risks.</p> <p>Medical record review for Resident 197 was initiated on 4/7/25. Resident 197 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 197's H&amp;P examination dated 11/29/24, showed Resident 197 had the capacity to understand and make decisions.</p> <p>Review of Resident 197's Order Summary Report dated 4/8/25, showed a physician's order dated 1/22/25, to provide a regular diet with regular texture and thin liquid consistency, one-on-one feeding assist, and aspiration precautions.</p> <p>Review of Resident 197's plan of care showed a care plan problem dated 1/22/25, addressing the resident's updated diet texture. The interventions included to provide one-on-one feeding assistance for aspiration precautions.</p> <p>Review of Resident 197's MDS assessment dated [DATE], showed the resident had a swallowing disorder and held food in the mouth/cheeks or residual food in the mouth.</p> <p>On 4/10/25 at 0752 hours, an observation and concurrent interview for Resident 197 was conducted with CNA 4. Resident 197 was observed sitting on his bed and eating breakfast. CNA 4 verified Resident 197 ate by himself and did not need any feeding assistance during meals.</p> <p>On 4/10/25 at 0845 hours, an interview and concurrent medical record review for Resident 197 was conducted with LVN 1. LVN 1 verified Resident 197 had a physician's order for one-on-one feeding assistance with meals for aspiration precautions but was not implemented by the facility staff.</p> <p>On 4/14/25 at 0925 hours, an interview and concurrent medical record review for Resident 197 was conducted with the DON. The DON was informed, acknowledged, and verified the above findings.</p> <p>4. Review of the facility's P&amp;P titled Hemodialysis Access Care revised 9/2/22, showed the resident will not receive blood pressure or laboratory sticks on the arm where the dialysis access device is located.</p> <p>Medical record review for Resident 59 was initiated on 4/7/25. Resident 59 was admitted to the facility on [DATE].</p> <p>Review of Resident 59's Order Summary Report for April 2025 showed an order dated 11/2/23, no blood pressure, blood draws. or IV on the left arm.</p> <p>Review of Residents 59's MDS assessment dated [DATE], showed a BIMS score of 14 (meaning cognitively intact).</p> <p>Review of Resident 59's care plan dated 9/14/23, showed the resident needed hemodialysis related to end stage renal disease. The care plan interventions included to not draw blood, do an intramuscular (in the muscle) injection or take blood pressure in the left upper arm with graft.</p> <p>Review of Resident 59's Weights and Vitals Summary showed the following BP readings were obtained from the left arm. For example:</p> <p>-On 4/3/25 at 1757 hours, a BP reading of 126/70 mmHg on the left arm</p> <p>-On 4/5/25 at 2115 hours, a BP reading of 136/78 mmHg on the left arm</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 4/6/25 at 1432 hours, a BP reading of 122/70 mmHg on the left arm</p> <p>-On 4/6/25 at 1433 hours, a BP reading of 110/64 mmHg on the left arm</p> <p>-On 4/6/25 at 1657 hours, a BP reading of 146/68 mmHg on the left arm</p> <p>-On 4/8/25 at 0143 hours, a BP reading of 124/76 mmHg on the left arm</p> <p>-On 4/8/25 at 0146 hours, a BP reading of 126/72 mmHg on the left arm</p> <p>On 4/9/25 at 0918 hours, an interview and concurrent medical record review for Resident 59 was conducted with LVN 1. LVN 1 verified the licensed nurses' documentation of BP showed Resident 59's blood pressure readings were obtained from the resident's left upper extremity.</p> <p>5. Medical record review for Resident 79 was initiated on 4/7/25. Resident 79 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 79's H&amp;P examination dated 12/10/24, showed Resident 79 had the capacity to understand and make decisions.</p> <p>Review of Resident 79's Order Summary Report for April 2025 showed an order dated 12/29/24, for no blood pressure check, no blood draw, no IV start, no intramuscular or restraint on the left arm due to AV shunt.</p> <p>Review of Resident 79's Blood Pressure Summary showed documentation showing the B/P reading was obtained from the left arm. For example:</p> <ul style="list-style-type: none"> <li>- On 4/6/25 at 1406 hours, a BP reading of 122/70 mmHg on the left arm</li> <li>- On 4/8/25 at 0224 hours, a BP reading of 126/76 mmHg on the left arm</li> <li>- On 4/8/25 at 0822 hours, a BP reading of 128/66 mmHg on the left arm</li> <li>- On 4/9/25 at 1743 hours, a BP reading of 126/70 mmHg on the left arm</li> <li>- On 4/9/25 at 2148 hours, a BP reading of 118/70 mmHg on the left arm</li> <li>- On 4/11/25 at 1550 hours, a BP reading of 122/66 mmHg on the left arm</li> <li>- On 4/11/25 at 2156 hours, a BP reading of 136/70 mmHg on the left arm</li> <li>- On 4/12/25 at 0059 hours, a BP reading of 126/76 mmHg on the left arm</li> <li>- On 4/12/25 at 0546 hours, a BP reading of 175/89 mmHg on the left arm</li> <li>- On 4/13/25 at 0053 hours, a BP reading of 122/70 mmHg on the left arm</li> <li>- On 4/13/25 at 0633 hours, a BP reading of 116/70 mmHg on the left arm</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/14/25 at 0757 hours, an interview and concurrent medical record review for Resident 79 was conducted with LVN 1. LVN 1 verified the licensed nurses' documentation of the BP showed Resident 79's blood pressure readings were obtained from the resident's left upper extremity.</p> <p>On 4/14/25 at 0925 hours, an interview and concurrent medical record review for Residents 59 and 79 was conducted with the DON. The DON verified the above findings and stated the blood pressure should not have been taken on the left upper arm of Residents 59 and 79.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37726</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of 35 final sampled residents (Resident 80) remained free from accident hazards.</p> <p>* The facility failed to provide one-to-one feeding assistance for aspiration precautions during lunch for Resident 80 as per the physician's order. Resident 80 was observed consuming lunch independently, without the facility staff present and outside of the facility staff view.</p> <p>This failure had the potential to place the resident at risk for serious injury and negative health outcomes.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Meal Supervision and Assistance dated 2022 showed the resident will be prepared for a well-balanced meal in a calm environment with adequate supervision and assistance to prevent accidents. This includes identifying hazards and risks and implementing interventions to reduce hazards and risks.</p> <p>Medical record review for Resident 80 was initiated on 4/7/25. Resident 80 was admitted to the facility on [DATE].</p> <p>Review of Resident 80's MDS dated [DATE], showed Resident 80 exhibited coughing or choking during the meals or when swallowing the medications. Resident 80 complained of difficulty or pain with swallowing.</p> <p>Review of Resident 80's Care Plan Report showed a care plan problem initiated 3/24/25, with a focus on Resident 80's potential nutritional problem related to dysphagia and Alzheimer's disease. The interventions included to monitor Resident 80 for any signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in his mouth, and several attempts at swallowing.</p> <p>Review of Resident 80's physician's order dated 3/27/25, showed an order for one-to-one feeding assistance for aspiration precautions.</p> <p>On 4/7/25 at 1236 hours, an observation was conducted of Resident 80. Resident 80 was observed in his room eating lunch independently (without the facility staff present and outside of the facility staff view). Resident 80 was observed eating soup and drinking juice and a Boost (nutritional drink). Resident 80 was observed coughing intermittently when swallowing. Resident 80's diet slip was observed on his lunch tray. The diet slip failed to show the physician's order dated 3/27/25, for one-to-one feeding assistance for aspiration precautions.</p> <p>On 4/7/25 at 1245 hours, an observation and concurrent interview was conducted with CNA 5. CNA 5 was assigned to care for Resident 80. CNA 5 was asked how Resident 80 consumed his meals and if he required supervision. CNA 5 stated Resident 80 ate his meals independently and was not at risk for aspiration.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 1300 hours, a follow-up interview and concurrent medical record review was conducted with CNA 5. CNA 5 verified Resident 80's physician's order dated 3/27/25, showing an order for one-to-one feeding assistance for aspiration precautions. CNA 5 stated she was unaware of the physician's order for one-to-one feeding assistance for aspiration precautions. CNA 5 stated in accordance with the physician's order, she should not have left Resident 80 alone while he was eating.</p> <p>On 4/7/25 at 1305 hours, an interview and concurrent medical record review was conducted with LVN 15. LVN 15 verified Resident 80's active physician's order for one-to-one feeding assistance for aspiration precautions. LVN 15 stated in accordance with the physician's order, the facility staff should always maintain a visual of Resident 15 while he was eating.</p> <p>On 4/8/25 at 1430 hours, an interview was conducted with the DM. The DM reviewed Resident 80's lunch diet slip dated 4/7/25 (for the meal Resident 80 was observed eating independently), and verified it did not contain Resident 80's physician's order dated 3/27/25, for one-to-one feeding assistance for aspiration precautions. The DM stated Resident 80's diet slips should contain the physician's order for one-to-one feeding assistance for aspiration precautions.</p> <p>On 4/9/25 at 0845 hours, an interview and concurrent medical record review was conducted with the DOR. The DOR verified Resident 80's physician's order dated 3/27/25, for one-to-one feeding assistance for aspiration precautions. The DOR stated in accordance with the physician's order, the facility staff needed to maintain a visual of Resident 80 during meals to ensure Resident 80 did not aspirate.</p> <p>Cross reference to F657.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</b></p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure the respiratory care and services were provided for three of three final sampled residents (Residents 74, 81, and 83) and one nonsampled resident (Resident 70) reviewed for respiratory care.</p> <p>* The facility failed to ensure Resident 74's nebulization mask, tubing, and canister were labeled.</p> <p>* The facility failed to ensure the suction canister with tubing and Yankauer suction tip (an oral suctioning tool) at Resident 81's bedside were labeled and stored in a set-up bag. The facility failed to ensure the physician's order for the oxygen therapy was followed for Resident 81. In addition, there was no documentation of the oxygen administration.</p> <p>* Resident 83 received oxygen therapy without a physician's order.</p> <p>* The facility failed to ensure the oxygen humidifier was labeled for Resident 70.</p> <p>These failures had the potential for these residents to not receive appropriate respiratory care and increase risks of the infection.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Oxygen Administration revised dated 6/2023 showed the oxygen is administered under the orders of a physician, except in case of an emergency. In such case, oxygen is administered and the orders for oxygen are obtained as soon as practicable when the situation is under control. The facility's P&amp;P further showed other infection control measures include to change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. If applicable, change nebulizer tubing and delivery devices every 72 hours, per the manufacturer's recommendation or per facility policy and as needed if they become soiled or contaminated, and keep delivery devices covered in plastic bag when not in use.</p> <p>Review of the facility's P&amp;P titled Changing Suction Canisters revised 7/8/24, showed to minimize the risk of infection to the resident, the resident's suction canister and tubing shall be changed once a week and as needed.</p> <p>1. On 4/7/25 at 0911 hours, during an observation, Resident 74 was observed lying in bed. The nebulizer tubing, mask, and canister were observed in a set up bag on the left side of Resident 74's bed with no label indicating when the nebulization tubing, canister, and mask were last changed.</p> <p>Medical record review for Resident 74 was initiated on 4/7/25. Resident 74 was admitted to the facility on [DATE].</p> <p>Review of Resident 74's Order Summary Report showed an order dated 1/21/25, to administer ipratropium-albuterol inhalation solution (to treat and prevent symptoms of wheezing and shortness of breath) 3 ml inhale orally every four hours as needed for chest congestion/shortness of breath/wheezing.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 0917 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified the above observation. LVN 4 stated Resident 74's nebulizer tubing, mask, and canister should have been dated and should be changed every week and as needed.</p> <p>2.a. On 4/7/25 at 0914 hours, during an observation, Resident 81 was observed lying in the bed. A suction tubing with a Yankauer suction tip connected to the suction canister and machine was observed stored in the second drawer of the nightstand located at the left side of the resident's bed. The suction canister was observed with half full light-yellow liquid. The suction canister, tubing, and Yankauer were not dated. In addition, the suction tubing and Yankauer suction tip were not stored in a set up bag. A set up bag was observed hanging on the nightstand with the date of 3/9/25.</p> <p>Medical Record review for Resident 81 was initiated on 4/7/25. Resident 81 was admitted to the facility on [DATE].</p> <p>Review of Resident 81's Order Summary Report showed an order dated 3/6/25, to assess for pulmonary hygiene every two hours and as needed for suctioning.</p> <p>On 4/7/25 at 0917 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 stated the suction canister, tubing, and Yankauer suction tip should be labeled and changed every week. In addition, LVN 4 stated the suction tubing and Yankauer suction tip should be stored in a set up bag. LVN 4 verified the above observation and stated the suction canister, tubing, and Yankauer suction tip for Resident 81 should have been labeled and changed every week. LVN 4 stated the suction tubing and Yankauer suction tip for Resident 81 should have been stored in a set up bag.</p> <p>b. On 4/7/25 at 0914 hours, on 4/8/25 at 1434 hours and on 4/9/25 at 0840 hours, Resident 81 was observed lying in the bed and receiving an oxygen at 3.5 LPM via nasal cannula.</p> <p>Review of Resident 81's Order Summary Report dated 2/26/25, showed to administer the oxygen via nasal cannula at one to two liters per minute to maintain the oxygen saturation level greater or equal to 92% as needed.</p> <p>Further review of Resident 81's medical record failed to show documented evidence of the oxygen administration at at 3.5 LPM and the reason why.</p> <p>On 4/9/25 at 0904 hours, an observation, interview, and concurrent medical record review for Resident 81 was conducted with RN 1. RN 1 stated the administration of the oxygen should be documented, and the reason for the PRN administration of the oxygen should also be documented. RN 1 verified Resident 81 was receiving oxygen at 3.5 liters per minutes via nasal cannula. RN 1 stated she was not able to find the documentation of the oxygen administration and reason for the PRN administration of the oxygen for Resident 81.</p> <p>3. On 4/7/25 at 0842 hours, Resident 83 was observed lying in bed, and oxygen was observed at 3.5 liters per minute connected to a nasal cannula. The nasal cannula was observed hanging on Resident 83's right ear and was not in Resident 83's nose. The DSD was called in to the room of Resident 83, the DSD verified the observation, and the DSD was observed putting the nasal cannula into Resident 83's nose. The DSD was then observed checking for the resident's oxygen saturation level which showed 95%.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 0856 hours, the DSD was observed entering Resident 83's room. The DSD stated Resident 83 did not have the physician's order for the oxygen. The DSD was observed removing the nasal cannula from the Resident 83's nose and turned off the oxygen. The DSD was observed checking for the oxygen saturation level of Resident 83 without the oxygen which showed 95%.</p> <p>Medical record review for Resident 83 was initiated on 4/7/25. Resident 83 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 83's H&amp;P examination dated 1/30/25, showed Resident 83 had no capacity to understand and make decisions.</p> <p>Review of Resident 83's Order Summary Report did not show a physician's order for oxygen.</p> <p>Further review of Resident 83's medical record failed to show documentation and the reason for the oxygen administration.</p> <p>On 4/7/25 0858 hours, an interview and concurrent medical record review for Resident 83 was conducted with LVN 10. LVN 10 stated administration of the oxygen required a physician's order and in case of emergency for administration of the oxygen, the physician order should be obtained as soon as possible. LVN 10 was informed of the above observation, LVN 10 stated she did know how long Resident 83 had been receiving oxygen. LVN 10 verified Resident 83 did not have the order for the oxygen. LVN 10 further stated she was not able to find documentation and the reason for the oxygen administration to Resident 83.</p> <p>On 4/9/25 at 1128 hours, an interview and concurrent medical record review for Residents 74, 81, and 83 was conducted with the DON. The DON verified and acknowledged the above findings.</p> <p>39683</p> <p>4. Medical record review for Resident 70 was initiated on 4/7/25. Resident 70 was readmitted to the facility on [DATE].</p> <p>On 4/7/25 at 1052 hours, Resident 70 was observed with oxygen administered via nasal cannula. The oxygen humidifier bottle was undated.</p> <p>Review of Resident 70's Order Summary Report dated 4/11/25, showed the following:</p> <ul style="list-style-type: none"> <li>- A physician's order dated 11/5/23, to administer oxygen at 4 LPM, may titrate oxygen to maintain oxygen saturation level greater than or equal to 92%.</li> <li>- A physician's order dated 11/1/23, to change the oxygen humidifier every Sunday at night shift.</li> </ul> <p>On 4/7/25 at 1100 hours, an interview and observation were conducted with LVN 3. LVN 3 verified Resident 70's oxygen humidifier bottle was not dated when it was last changed, and should have been.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474</b></p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure pharmaceutical services were provided to meet the needs for one final sampled resident (Resident 59) and two nonsampled residents (Residents 118 and 574) reviewed.</p> <p>* The facility failed to ensure the narcotic medication for Resident 118 was accurately signed out, documented and disposed of per the facility's P&amp;P.</p> <p>* The facility failed to ensure Resident 574's order for docusate sodium (bowel movement medication) was followed as ordered by the physician.</p> <p>* The facility failed to ensure Resident 59's hypertension medication was held when the SBP below 130 mmHg.</p> <p>These failures had the potential to result in medication diversion (the illegal use or distribution of a prescription medication that was not originally intended by the prescriber), unsafe handling of the narcotic medications, and the risk for negative health outcomes to the residents.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Controlled Substance Administration and Accountability revised on 6/2023 showed it is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. The P&amp;P further showed the Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient-specific narcotic dispensed from the pharmacy. Moreover, the P&amp;P showed two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record, Controlled Drug Record, or via the automated dispensing system.</p> <p>1. Medical record review for Resident 118 was initiated on 4/9/25. Resident 118 was admitted to the facility on [DATE].</p> <p>Review of Resident 118's H&amp;P examination dated 12/23/24, showed Resident 118 had the capacity to understand and make decisions.</p> <p>Review of Resident 118's MAR for January 2025 showed a physician's order dated 1/2/25, for tramadol 50 mg one tablet by mouth every six hours for pain management. The MAR showed the order was discontinued on 1/21/25.</p> <p>Further review of the MAR for January 2025 showed no documented evidence Resident 118 received the routine tramadol on 1/5/25 at 0600 hours; however, review of Resident 118's Antibiotic or Controlled Drug Record showed Resident 118 had received tramadol on 1/5/25 at 0600 hours.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 118's Antibiotic or Controlled Drug Record initiated on 1/3/25, showed the license nurses' signatures on the number of tramadol remaining at numbers four to six were crossed off.</p> <p>Review of Resident 118's Order Summary Report for March 2025 showed a physician's order dated 1/21/25, for tramadol 50 mg one tablet by mouth every six hours as needed for pain management.</p> <p>Review of Resident 118's tramadol narcotic bubble packet showed there were remaining four tablets of tramadol 50 mg tablets. Further observation showed an unidentified, undated, and unlabeled round, white tablet in a clear pouch attached to the tramadol narcotic bubble packet.</p> <p>On 4/9/25 at 1048 hours, an inspection of the Controlled Drug Records at Medication Cart I were conducted with LVN 7. LVN 7 verified the above findings. LVN 7 stated if a resident refused the narcotic, the narcotic medication was wasted and should be documented. LVN 7 further stated when administering a narcotic medication, the narcotic medication was removed from the bubble packet and both the controlled drug record sheet and the MAR were signed.</p> <p>On 4/9/25 at 1133 hours, a concurrent interview and medical record review for Resident 118 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated when wasting narcotic medications, two license nurses' signatures were documented on the controlled drug record sheet to indicate the narcotic medication was wasted and the narcotic medication was then disposed. RN 1 stated the MAR and Controlled Drug Record sheet should match to prevent medication errors. RN 1 further stated the round, white tablet in a clear pouch attached to the tramadol narcotic bubble packet should have been properly labeled and dated to identify the medication; however, RN 1 stated the unidentified round, white tablet should have been properly disposed.</p> <p>On 4/11/25 at 1433 hours, a concurrent interview and medical record review for Resident 118 was conducted with the DON. The DON verified all the above findings. The DON stated the unidentified round, white tablet attached to the Controlled Drug Record sheet was a wasted tramadol that should have been dated and labeled to indicate the medication and dose. The DON acknowledged the license nurse did not properly dispose of the wasted narcotic as there were no documented evidence of two license nurses' signatures on Resident 118's controlled drug record sheet and a line crossed off on the number six slot of the narcotic count. For the number five slot of the narcotic count of Resident 118's controlled drug record sheet which showed it was crossed off, the DON stated a license nurse signed the number five slot; however, did not administer tramadol or document the error. The DON also acknowledged the license nurse who signed out the number four slot for the tramadol should have signed at the number five slot and stated the signing out of the narcotic were not accurate. The DON stated the license nurse signed on the wrong line. The DON further verified there was no documented evidence the routine tramadol 50 mg was signed on Resident 118's MAR on 1/5/25 at 0600 hours; however, the tramadol was signed on the resident's controlled drug record sheet. The DON stated the MAR and controlled drug record sheet should match, the narcotics should be accurately signed off, and wasted narcotics should be properly disposed to avoid diversion with narcotics.</p> <p>On 4/14/25 at 1139 hours, a concurrent interview and medical record review for Resident 118 was conducted with the DON. The DON verified and acknowledged the above findings.</p> <p>2. Medical record review for Resident 574 was initiated on 4/8/25. Resident 574 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 574's H&amp;P examination dated 3/31/25, showed Resident 574 had history of developmental disorder and was nonverbal.</p> <p>Review of Resident 574's Order Summary Report for April 2025 showed a physician's order dated 4/7/25, for docusate sodium 10 ml via GT every 12 hours for bowel management; and to hold for loose stool.</p> <p>Review of Resident 574's POC Response History document dated 4/8/25, showed Resident 574's bowel movement consistency on 4/8/25 at 0659 hours, was loose/diarrhea (loose, water stool and increased frequency of bowel movements).</p> <p>On 4/8/25 at 0939 hours, during the medication administration observation, LVN 6 was observed going inside Resident 574's room to administer the medications via GT. LVN 6 administered docusate sodium 10 ml via GT. LVN 6 was not observed assessing if Resident 574 had loose stool prior to the medication administration.</p> <p>On 4/8/25 at 1038 hours, a concurrent interview and medical record review for Resident 574 was conducted with LVN 6. LVN 6 verified she did not assess Resident 574 for loose stool and verified the docusate sodium order indicated to hold the medication for loose stool. Further review of Resident 574's POC Response History of the bowel movement consistency showed Resident 574 had history of loose stool/diarrhea on 4/8/25 at 0659 hours. LVN 6 stated she should have checked for current episodes of loose stool or diarrhea prior to administering the docusate sodium.</p> <p>On 4/14/25 at 1139 hours, a concurrent interview and medical record review for Resident 574 was conducted with the DON. Review of Resident 574's POC Response History of the bowel movement consistency dated 4/14/25, showed Resident 574 had history of loose stool/diarrhea on 4/9/25 at 1459 and 2233 hours. The DON stated if the resident had loose stool, the docusate sodium medication should have been held as per the physician's order to hold for loose stool. The DON verified and acknowledged the above findings.</p> <p>50953</p> <p>3. Review of the facility's P&amp;P titled Medication Administration revised 12/19/22, showed the medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standards of practice, in a manner to prevent contamination or infection. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameter.</p> <p>Medical record review for Resident 59 was initiated on 4/7/25. Resident was admitted to the facility on [DATE].</p> <p>Review of Resident 59's Order Summary Report showed an order dated 7/11/24, for losartan potassium (medication to treat high blood pressure) 25 mg one tablet one time a day to hold the medication if the SBP below 130 mmHg, and hold the medication prior to the dialysis on Tuesday, Thursday and Saturday.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Residents 59's MDS assessment dated [DATE], showed a BIMS score of 14 (meaning cognitively intact).</p> <p>Review of Resident 59's Medication Administration Record for April 2025 showed the Chart Codes/Follow Up Codes including a check mark as given. The MAR showed the following was coded with check mark for the medication losartan:</p> <ul style="list-style-type: none"> <li>- On 4/6/25, a B/P reading of 122/70 mmHg</li> <li>- On 4/7/25, a B/P reading of 122/70 mmHg</li> <li>- On 4/8/25, a B/P reading of 126/78 mmHg</li> <li>- On 4/9/25, a B/P reading of 128/72 mmHg</li> </ul> <p>On 4/9/25 at 0918 hours, an interview and concurrent medical record review for Resident 59 was conducted with LVN 1. LVN 1 verified the licensed nurses' documentation on the MAR showing the losartan medication was given to the resident when there was an order to hold the medication when the SBP was below 130 mmHg.</p> <p>On 4/14/25 at 0925 hours, an interview and concurrent medical record review was conducted for Resident 59 with the DON. The DON verified the above findings and stated the losartan medication should be held when the systolic blood pressure below 130 mmHg.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474</b></p> <p>Based on observation, interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage and disposal of the medications as evidence by the following:</p> <ul style="list-style-type: none"> <li>* The facility failed to ensure the arformoterol (medication used to treat chronic obstructive pulmonary disease) medication found in Medication Cart E and Medication Cart F were stored as per the manufacture's storage instructions.</li> <li>* The facility failed to ensure the medical supplies/items that were expired in Medication Carts G and H, and Medication Storage Room B were discarded and/or properly disposed.</li> <li>* The facility failed to ensure Medication Carts B and C was maintained in clean sanitary condition.</li> </ul> <p>These failures had the potential to negatively impact the residents' well-being and the potential for the medications to lose the stability and effectiveness.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Medication Storage revised on ,d+[DATE] showed it is the policy of the facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacture's recommendation and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The P&amp;P further showed for the refrigerated products, all the medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. For unused medications, the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with facility policy.</p> <p>1.a. On [DATE] at 1503 hours, an inspection of Medication Cart E and concurrent interview was conducted with LVN 5. A total of 30 unit dose vials (20 unit dose vials unopened and 10 unit dose vials opened) of arformoterol were observed in the medication cart. Instructions on the medication package showed to store unopened pouched unit dose vials in a refrigerator (36 F to 46 F) and unopened pouched unit dose vials can also be stored at room temperature (at 68 F to 77 F) for up to six weeks. LVN 5 verified the findings and stated the medications should be stored in the refrigerator as shown on the packaging.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. On [DATE] at 1047 hours, an inspection of Medication Cart F and concurrent interview was conducted with LVN 2. A total of 25 unit dose vials (15 unit dose vials unopened and 10 unit dose vials opened) of arformoterol were observed in the medication cart. Instructions on the medication package showed to store unopened pouched unit dose vials in a refrigerator (36 F to 46 F) and unopened pouched unit dose vials can also be stored at room temperature (at 68 F to 77 F) for up to six weeks. LVN 2 verified the findings and stated the facility did not check the temperatures of the medication carts and did not know if the temperature of the medication carts were between 68 F to 77 F as per the manufacture's storage instructions.</p> <p>On [DATE] at 0933 hours, a telephone interview was conducted with the Pharmacist. The Pharmacist stated arformoterol was ideally stored in the refrigerator. The Pharmacist also stated unopened and opened arformoterol could be kept at room temperature from 68 F to 77 F; however, outside of that specific room temperature range was not recommended.</p> <p>2. On [DATE] at 1030 hours, an inspection of Medication Cart G and concurrent interview was conducted with RN 2. One small bore extension set was observed and showed the expired date of [DATE]. RN 2 verified the findings and stated she would discard the expired medical supply.</p> <p>3. On [DATE] at 1106 hours, an inspection of Medication Cart H and concurrent interview was conducted with LVN 8. Fourteen povidone-iodine (antiseptic medication) swab sticks were observed and expired on , d+[DATE]. LVN 8 verified the findings and stated the expired treatment supplies should be discarded since the ingredients in the medications may not be activated or the quality of the medication may not be the same if were used after the expiration date.</p> <p>On [DATE] at 1139 hours, an interview was conducted with the DON regarding the above findings. The DON stated since the facility did not check the temperatures in the medication carts, the arformoterol medication should have been stored in the refrigerator as per the manufacture's storage instructions. The DON was informed and acknowledged the above findings.</p> <p>49324</p> <p>4. On [DATE] at 0915 hours, an inspection of Medication Storage Room B and concurrent interview was conducted with RN 2. A bottle of Peroxigard One Step Disinfectant with expiration date of ,d+[DATE] was observed to be stored in the middle cabinet and 13 OHC (Osang Healthcare) Healthcare Covid 19 Antigen Self test kits with extended used by [DATE], was found in the right lower cabinet. RN 2 verified the expired bottle of disinfectant and the expired Covid 19 Antigen Self test kits should have been disposed. RN 2 also checked the expiration date of the OHC Covid 19 Antigen Self test's website that showed printed use by date of [DATE], and the extended use by date [DATE]. RN 2 also stated the facility licensed staff never used the kits, was even labeled from outer box with [DATE], however the expired kits should have been properly disposed.</p> <p>5.a. On [DATE] at 1008 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 2. The top drawer was observed to be with a moist sticky residue and a bottle of Povidone Iodine Prep Solution (a medication used to disinfect wounds, cuts, scrapes) was with dried medication residue on the upper portion of the bottle.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. On [DATE] at 1008 hours, an inspection of Medication Cart C and concurrent interview was conducted with RN 2. A bottle of Pro-Stat ( a concentrated liquid protein supplement) was not kept clean with sticky medication residue on the top portion of the bottle. RN 2 verified Medication Carts B and C should have maintained clean for infection control.</p> <p>On [DATE] at 0915 hours, an interview was conducted with the DON. The DON verified all of the above findings.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49324</p> <p>Based on observation, interview, facility document review, and facility P&amp;P review, the facility failed to ensure the facility's posted meal Week at A Glance menus met Resident 17's needs.</p> <p>* The facility failed to follow Resident 17's item request of tuna melt during lunch meal was served. This failure placed Resident 17 at risk of not receiving the meal as planned.</p> <p>Findings:</p> <p>Review of the facility's Diet Count by Modification dated 4/10/25, showed 196 of 216 residents residing in the facility received food prepared in the kitchen.</p> <p>Review of the facility's P&amp;P titled Initial Resident Visitation/ Nutritional Screening dated 9/2021 showed to obtain food preferences, allergies, or intolerances and note on Dietary interview/Pre-screen (form 101) or other designated form and tray card.</p> <p>Review of the facility's posted meal spreadsheet titled Week at a Glance Long Term Care Regular Diet dated between 4/6/25 to 4/12/25, showed the lunch on a date of 4/7/25, included a meal of braised pork shoulder, pork and beans, zucchini and yellow squash bread, or roll with butter, pound cake with fresh strawberries and choice of beverage.</p> <p>Medical record review for Resident 17 was initiated on 4/7/25. Resident 17 was admitted to the facility on [DATE] and was readmitted on [DATE].</p> <p>Review of Resident 17's special request form in replacement of the Posted Meal Entree dated 4/7/25, showed a request that included tuna melt.</p> <p>Review of Resident 17's H&amp;P examination dated 3/12/24, showed Resident 17 had the capacity to make decisions.</p> <p>On 4/7/25 at 1218 hours, a dining room observation and concurrent interview was conducted with Resident 17 and LVN 12. Resident 17 was observed comfortably seated in her wheelchair in the dining room and had received a lunch tray that consisted of cranberry juice, beans, bread, cake with strawberries and pork. Resident 17 was asked if she was served with the meal she wanted, Resident 17 stated she did not get what she wanted, did not get the tuna melt, and Resident 17 further stated it did not often happen. LVN 12 was asked if Resident 17 received the meal she wanted, LVN 12 stated the licensed staff should make sure Resident 17 would have the meal she wanted, and verified the meal requested was not followed.</p> <p>On 4/7/25 at 1448 hours, an interview was conducted with the Dietary Supervisor. The Dietary Supervisor was asked about Resident 17's lunch tray that did not contain the tuna melt as requested by Resident 17. The Dietary Supervisor verified the tuna melt replacement of the posted meal entree was missed.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/11/25 at 0915 hours, an interview was conducted with the DON. The DON verified the above findings.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50953</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure the food preference was honored for one nonsampled resident (Resident 173). This failure had the potential for poor meal intake and negatively impact Resident 173's psychosocial well being</p> <p>Findings:</p> <p>Review of the facility's Diet Count by Modification dated 4/10/25, showed 196 of 216 residents residing in the facility received food prepared in the kitchen.</p> <p>Review of the facility's P&amp;P titled Promoting/Maintaining Resident Dignity During Mealtime revised 12/19/22, showed it is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhanced his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. Resident request will be honored during meals to the extent possible.</p> <p>Medical record review for Resident 173 was initiated on 4/7/25. Resident 173 was admitted to the facility on [DATE].</p> <p>Review of Resident 173's H&amp;P examination dated 3/25/25, showed Resident 173 had a fluctuating capacity to understand and make decisions.</p> <p>Review of Resident 173's Plan of Care showed a care plan problem dated 11/5/24, addressing the resident had nutritional problem with the interventions including to honor the resident's food preferences with diet parameter and to offer the substitutes if the meal was taken below 50%.</p> <p>Review of Resident 173's Diet slip dated 4/7/25, showed for soft and bite-size, Vietnamese menu chopped meat, vegetable, noodles, and bread.</p> <p>On 4/7/25 at 1226 hours, an observation and concurrent interview for Resident 173 was conducted with the DSD. The DSD was observed feeding Resident 173 with ice cream. Resident 173 was asking for Vietnamese food. The DSD verified Resident 173 was not served with Vietnamese menu.</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726</b></p> <p>Based on observation, interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure the lunch meals were provided to the residents at the scheduled mealtime for 196 of 216 residents residing in the facility, who received food prepared in the kitchen. This failure led to the residents experiencing hunger, frustration, and aggravation; and had the potential to affect the medications scheduled to be administered in accordance with food consumption, which posed the risk for negative health outcomes.</p> <p>Findings:</p> <p>Review of the facility's Diet Count by Modification dated 4/10/25, showed 196 of 216 residents residing in the facility received food prepared in the kitchen.</p> <p>Review of the facility's P&amp;P titled Meal Hours revised 7/2/18, showed three meals a day are offered at regularly scheduled times. Resident lunch hour was at 1130 hours.</p> <p>Review of the facility's Mealtimes document posted in the resident's dining room showed lunch time was from 1130 to 1230 hours.</p> <p>On 4/10/25 at 1130 hours, a tray line observation and concurrent interview was conducted with the DM. The DM was asked to describe the facility's practice for the lunch preparation for the residents who resided in the facility. The DM stated the kitchen staff normally started plating (arranging the residents ordered food on plates) the residents lunches at 1130 hours. The DM stated the residents' lunch plates were then placed on a tray and the tray was subsequently placed into the portable carts. The portable carts were then delivered (between 1130 and 1230 hours) to the facility hallways adjacent to the residents' rooms, at which time the nursing staff would distribute the lunch trays to the residents.</p> <p>The DM stated all the resident lunches prepared in the kitchen today would not be provided to the residents at the scheduled mealtime. The DM stated the kitchen oven thermostat and igniter were not functioning properly this morning. The DM stated as a result of the oven malfunctioning, the kitchen staff began plating an hour late (at 1230 hours) and the first portable cart containing the resident lunch trays left the kitchen at 1257 hours. The DM stated the scheduled lunch time was between 1130 and 1230 hours. The DM stated all the residents who received lunches prepared in the kitchen (196 residents) would not receive their lunch within the scheduled lunch hour. The DM stated ensuring the residents received their lunch at the scheduled mealtime was important, as some resident medications were administered in accordance with meals. The DM stated for example, a diabetic resident who received insulin and the residents with prescribed medications to be taken with meals and/or before and after meals.</p> <p>Several observations and interviews were conducted with the residents who did not receive their lunch at the scheduled time:</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Medical record review for Resident 48 was initiated on 4/7/25. Resident 48 was admitted to the facility on [DATE].</p> <p>On 4/10/25 at 1320 hours, an observation and concurrent interview was conducted with Resident 48. Resident 48 stated she received six units of insulin at 1130 hours, and had not received her lunch tray. Resident 48 stated the lunch was supposed to arrive around 1130 to 1200 hours. Resident 48 stated she was frustrated and aggravated because she was hungry. Resident 48 stated she felt sweaty because she had not eaten. Resident 48 then requested juice from the facility staff. LVN 5 then brought Resident 48 some cranberry juice and a snack.</p> <p>Review of Resident 48's Nurses Progress Note dated 4/10/25 1355 hours, showed due to serving late lunch, Resident 48's blood sugar level was rechecked at 1345 hours, with a result of 145 mg/dl. Resident 48 asked for something to eat and the charge nurse provided Resident 48 with a plate of fruit and cranberry juice.</p> <p>2. Medical record review for Resident 37 was initiated on 4/7/25. Resident 37 was admitted to the facility on [DATE].</p> <p>On 4/10/25 at 1400 hours, an observation and concurrent interview was conducted with Resident 37. Resident 37 was observed in her room. Resident 37 stated lunch at the facility was usually served at 1200 hours, however, she had yet to receive her lunch today. Resident 37 stated she was not informed by the facility staff that her lunch would be late. Resident 37 stated on a scale from 1 to 10, her hunger was rated at a nine, and she wanted her lunch.</p> <p>3. Medical record review for Resident 147 was initiated on 4/7/25. Resident 147 was admitted to the facility on [DATE].</p> <p>On 4/10/25 at 1410 hours, an observation and concurrent interview was conducted with Resident 147. Resident 147 was observed in his room. Resident 147 stated his normal lunch time was between 1130 and 1200 hours. Resident 147 stated he had not eaten since breakfast, and he was very hungry. Resident 147 stated he was not informed by the facility staff that his lunch would be late.</p> <p>4. Medical record review for Resident 163 was initiated on 4/7/25. Resident 163 was admitted to the facility on [DATE].</p> <p>On 4/10/25 at 1411 hours, an observation and concurrent interview was conducted with Resident 163. Resident 163 was observed in his room. Resident 163 stated he normally ate lunch around 1130 hours. Resident 163 stated the facility staff did not inform him that his lunch would be late today. Resident 163 had yet to receive his lunch and stated, I'm starving.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37726</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to ensure the food safety requirements were met in the kitchen as evidenced by:</p> <ul style="list-style-type: none"> <li>* Defrosted meat stored in the walk-in refrigerator was not labeled with a pull date or use by date.</li> <li>* Several veggie sausage patties were stored in the walk-in refrigerator past the use by date.</li> <li>* The walk-in refrigerator wall and floor were observed with dirt.</li> <li>* Food debris was observed on the bottom of the facility's dairy refrigerator.</li> <li>* Unlabeled food items were observed in the facility's snack refrigerator.</li> <li>* The facility failed to store a plastic rice scoop in a sanitary manner.</li> </ul> <p>These failures had the potential to cause food borne illnesses in a medically vulnerable population of residents who consumed food from the kitchen.</p> <p>Findings:</p> <p>Review of the facility's Diet Count by Modification dated 4/10/25, showed 196 of 216 residents residing in the facility received food prepared in the kitchen.</p> <p>According to the 2022 FDA Food Code, food equipment is used for storage of packaged and unpackaged food such as a reach-in-refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues.</p> <p>Review of the facility's P&amp;P titled Meat Cookery and Storage revised 3/27/24, showed the food and nutrition or dining services department should ensure that meat shall be prepared in a manner to preserve quality, maximize nutrient retention, and to obtain maximum yield of product. Meat which needs defrosting should be pulled three days prior to service and defrosted in a dry, cool area at 41 degrees Fahrenheit or less. Date the meat when pulled (from freezer) for defrosting.</p> <p>Review of the facility's P&amp;P titled Nourishment Refrigerator revised 5/18/23, showed all the food items must be dated with a placed date. All the items out of their original packaging should be discarded no greater than 3 days after placing. If the use by date is unknown or in question, discard the item.</p> <p>Review of the facility's P&amp;P titled Refrigerated Storage Chart revised 12/28/20, showed the recommended proper storage times for the following items: Grapes for three to five days and Chicken for two days.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/7/25 at 0809 hours, an initial tour of the kitchen was conducted with the DM. The DM stated as of 4/7/25, 199 of 220 residents residing in the facility received food prepared in the kitchen.</p> <p>The following observations were made during the initial tour of the kitchen:</p> <p>a. The following items were identified inside of the facility's walk-in refrigerator:</p> <p>* A plastic bin labeled Defrosting Meat: (Meat item veggie sausage, pull on 4/1/25, to be used by 4/4/25) contained several veggie sausage patties. The DM stated in accordance with the facility's P&amp;P and labeling of the veggie sausage patties, the sausage patties were past the use by date and should have been discarded for food safety.</p> <p>* An unlabeled plastic bin contained meat. The DM verified the findings and stated she believed the meat was chicken. The DM stated in accordance with the facility's P&amp;P, specific to defrosting of meat, the meat should have been labeled with the type of meat, the pull date (date obtained from freezer and placed in refrigerator for defrosting), and the used by date. The DM stated this information was required to ensure the residents would not be served with spoiled meat</p> <p>* The walk-in refrigerator wall and floor were observed with dirt (as described by DM). The DM stated the staff deep cleaned the refrigerator once per week and as needed. The DM stated the refrigerator should be maintained in a clean manner to prevent food contamination.</p> <p>b. The following was identified in the facility's Dairy Refrigerator:</p> <p>* Food debris was observed on the bottom of the refrigerator. The food items contained in the refrigerator included Jello, milk, and cottage cheese. The DM verified the findings and stated the refrigerator was cleaned twice a week on delivery days (Monday and Thursday) and as needed. The DM stated the refrigerator should be maintained in a clean condition to avoid contamination of food.</p> <p>c. The following was identified in the facility's Snack Refrigerator:</p> <p>* Three bags of unlabeled grapes observed inside of a plastic bin. The DM verified the findings and stated the grapes should have been labeled with the date received. The DM stated the received date would then be utilized to determine the safe storage time for the grapes.</p> <p>d. The following was identified in the facility's dry storage room:</p> <p>* [NAME] rice was observed stored inside of a plastic bin. A plastic rice scoop was observed lying on top of the plastic bin. A clean bag was observed attached to the front of the plastic bin. The DM stated the rice scoop should be stored inside of the clean bag and not on top of the plastic bin to prevent contamination.</p>		

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>37726</p> <p>Based on observation and interview, the facility failed to ensure the garbage was properly stored in the facility's six garbage dumpsters. This failure had the potential to attract pests/rodents that carried a disease.</p> <p>Findings:</p> <p>According to the 2022 FDA Food Code, outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.</p> <p>On 4/7/25 at 0908 hours, an observation of the facility's garbage dumpsters was conducted. Five of six dumpsters were observed with the lids open and garbage inside. The dumpsters were observed with the lids propped open by garbage, preventing the lids from fully closing.</p> <p>On 4/8/25 at 1648 hours, an observation of the facility's garbage dumpsters was conducted. One of six dumpsters was observed with a missing lid and garbage inside.</p> <p>On 4/14/25 at 0750 hours, an observation of the facility's six garbage dumpsters was conducted. One dumpster was observed with the lid propped open by garbage, preventing the lid from fully closing. Another dumpster was observed without a lid in place and garbage inside.</p> <p>On 4/14/25 at 0840 hours, an interview was conducted with the Administrator. The Administrator verified the findings (via photographs taken of the findings). Additionally, the Administrator stated she had notified the trash company of the missing dumpster lid.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39683</p> <p>Based on interview, medical record review and facility P&amp;P review, the facility failed to ensure the complete and accurate medical records for five of 35 final sampled residents (Residents 50, 106, 117, 574, and 674) and two nonsampled residents (Residents 75 and 193).</p> <p>* Residents 75, 117, and 193's H&amp;P examinations showed the residents had no capacity to make medical decisions; however, their face sheets showed they were self-responsible.</p> <p>* Resident 117's Physician Progress Note showed the resident's cognitive level was reevaluated and showed they had capacity, and to update the H&amp;P examination. However, the H&amp;P examination was not updated.</p> <p>* The facility failed to ensure the hold parameters of Resident 574's metoprolol tartrate (blood pressure medication) were accurate.</p> <p>* The facility failed to ensure the urine output was documented post removal of a indwelling urinary catheter for Residents 106 and 674.</p> <p>* Resident 50's Advance Directive Acknowledgment showed Resident 50 had not executed a POLST; however, Resident 50 had executed a POLST.</p> <p>These failures had the potential for the resident's care needs not being met as their medical information was inaccurate.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Documentation in Medical Record reviewed/ revised 12/19/22, showed documentation shall be factual, accurate and complete, containing sufficient details about the resident's care and/or responses to cares.</p> <p>1. Medical record review for Resident 117 was initiated on 4/7/25. Resident 117 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 117 Admission Records dated 12/6/24 and 1/19/25, failed to show the facility's Bioethics Committee/IDT was the resident's responsible party.</p> <p>Review of Resident 117's H&amp;P examinations dated 12/4/24 and 12/13/24, showed the resident could make their needs known but could not make medical decisions.</p> <p>Review of Resident 117's Physician Progress Note dated 3/26/25 at 1540 hours, showed the physician had reassessed the resident's cognitive function and capacity to make decisions independently and the resident's H&amp;P examination may be updated to able to make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/11/25 at 1400 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated prior to 3/26/25, Resident 117 could not make medical decisions and the facility's Bioethics Committee/IDT was the resident's responsible party. The DON stated Resident 117's Admission Records prior to 3/26/25, failed to show the facility's Bioethics Committee/IDT was the resident's responsible party.</p> <p>Cross reference to F552, example #1.</p> <p>2. Medical record review for Resident 75 was initiated on 4/7/25. Resident 75 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 75's H&amp;P examination dated 9/14/24, showed the resident had no capacity to understand and make decisions.</p> <p>Review of Resident 75's Admission Record dated 4/10/25, showed the resident was self-responsible and his own responsible party.</p> <p>On 4/11/25 at 1400 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 75 had no capacity to make their own decisions and the facility's Bioethics Committee/IDT was the resident's responsible party. The DON stated Resident 75's Admission Record incorrectly showed the resident as their own responsible party.</p> <p>Cross reference to F552, example #2.</p> <p>3. Medical record review for Resident 193 was initiated on 4/7/25. Resident 193 was admitted to the facility on [DATE].</p> <p>Review of Resident 193's H&amp;P examination dated 11/30/24, showed the resident had no capacity to understand and make decisions.</p> <p>Review of Resident 193's Admission Record dated 4/10/25, showed the resident was self-responsible and own responsible party.</p> <p>On 4/11/25 at 1400 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 193 had no capacity to make their own decisions and the facility's Bioethics Committee/IDT was the resident's responsible party. The DON stated Resident 193's Admission Record incorrectly showed the resident was the responsible party.</p> <p>Cross reference to F552, example #3.</p> <p>47474</p> <p>4. Medical record review for Resident 574 was initiated on 4/8/25. Resident 574 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].</p> <p>Review of Resident 574's H&amp;P examination dated 3/31/25, showed Resident 574 had history of developmental disorder and was nonverbal.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 574's Admission Record showed Resident 574 had a diagnosis of GT.</p> <p>Review of Resident 574's Order Summary Report for April 2025 showed a physician's order dated 3/28/25, for metoprolol tartrate 50 mg one tablet via GT every 12 hours for hypertension and hold for SBP less than 1101 or heart rate less than 60 bpm.</p> <p>On 4/11/25 at 0952 hours, a concurrent interview and medical record review for Resident 574 was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated the hold parameters for SBP was not accurate. LVN 6 further stated it should be to hold the administration of the medication for SBP less than 110 mmHg and not 1101 mmHg.</p> <p>On 4/14/25 at 1139 hours, an interview was conducted with the DON . The DON was informed and acknowledged the above findings.</p> <p>49324</p> <p>5.a. Review of facility's P&amp;P titled Indwelling Catheter Use and Removal dated 12/19/22, showed it is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice. Additional care practice include: c. Monitoring for excessive post void residual, after removing a catheter that was inserted for obstruction or overflow incontinence. Removal of indwelling catheter. Assess for first voiding post-catheter removal.</p> <p>Review of the facility's Attendant Prodigy Bladder Scanner Manual (undated) showed the indication of use: the attendant prodigy bladder scanner projects ultrasound energy through the lower abdomen of the resident or patient to obtain an image of the bladder, which is used to calculate bladder volume non-invasively.</p> <p>Medical record review for Resident 674 was initiated on 4/7/25. Resident 674 was admitted to the facility on [DATE], with diagnoses including unspecified obstructive and reflux uropathy.</p> <p>Review of Resident 674's H&amp;P examination dated 3/28/25, showed Resident 674 had no capacity to make decisions.</p> <p>Review of Resident 674's Order Summary Report showed an order with a start date of 3/27/25, to an end date of 3/31/25, to monitor for urinary retention post removal of the indwelling urinary catheter every shift for three days.</p> <p>Review of Resident 674's MDS Section H - Bladder and Bowel dated 4/2/25, showed Resident 674 was frequently incontinent.</p> <p>b. Medical record review for Resident 106 was initiated on 4/7/25. Resident 106 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 106's H&amp;P examination dated 4/5/25, showed the resident had no capacity to make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 106 's Order Summary Report showed an order with a start date of 2/18/25, to an end date of 2/21/25, to monitor for urinary retention post removal of the indwelling urinary catheter every shift for three days.</p> <p>Review of 106's MDS Section H - Bladder and Bowel dated 3/6/25, showed Resident 106 was always incontinent.</p> <p>On 4/9/25 at 0825 hours, an interview and concurrent medical record review for Residents 106 and 674 was conducted with LVN 9. LVN 9 stated the monitoring should be done for urinary retention post removal of a urinary indwelling urinary catheter and the amount needed to be documented. LVN 9 was asked if the facility had a bladder scanner to monitor for post void residuals. LVN 9 stated the facility had a bladder scanner. LVN 9 was asked if there was any documentation of the urine output after Residents 106 and 674's removal of the indwelling urinary catheters. LVN 9 was only able to show a check mark for each shift under Residents 106 and 674's TARs. LVN 9 verified there should be an accurate measurements for the urine output or the bladder scanner should have been used for accuracy of the measurement of retained urine.</p> <p>On 4/11/25 at 0915 hours, an interview was conducted with the DON. The DON verified the above findings.</p> <p>37726</p> <p>6. Medical record review for Resident 50 was initiated on 4/7/25. Resident 50 was admitted to the facility on [DATE].</p> <p>On 4/9/25 at 1044 hours, an interview and concurrent medical record review was conducted with the SSD. Review of Resident 50's POLST dated 2/2/24, showed Resident 50 had a POLST, consistent with Resident 50's medical condition and preferences. However, review of Resident 50's Advance Directive Acknowledgment form dated 2/6/24, showed Resident 50 had not executed a POLST. The SSD verified the findings.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39683</p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure the arbitration agreement was explained and agreed with the appropriate IDT members for three of three residents reviewed for arbitration agreements (nonsampled residents, Residents 75 and 193; and final sampled resident, Resident 117). This failure posed the risk for the resident to not have the right to file an appeal if there was any issue of medical malpractice.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Binding Arbitration Agreement reviewed/revised 12/19/22, showed when explaining the arbitration agreement to the resident or their representative, the facility shall explain the form in a manner that he or she understands, and ensure they understand, and that it is their right not to sign the agreement.</p> <p>Review of the facility's P&amp;P titled Bioethics Committee reviewed/revised 12/19/22, showed the Bioethics Committee is composed of the Administrator, DON, Medical Director, resident's Primary Care Physician, Social Services, and Ombudsman.</p> <p>1. Medical record review for Resident 117 was initiated on 4/7/25. Resident 117 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 117 Admission Records dated 12/6/24 and 1/19/25, failed to show the facility's Bioethics Committee/IDT was the resident responsible party.</p> <p>Review of Resident 117's H&amp;P examinations dated 12/4/24 and 12/13/24, showed the resident could make their needs known but could not make medical decisions.</p> <p>Review of Resident 117's Arbitration Agreement dated 12/13/24, showed the form was signed by the Administrator as the resident's legal representative. The agreement showed by signing the agreement, the resident was giving up the right to dispute allegations of medical malpractice in the court of law, and must use arbitration (where disputing parties use a third party to make a final decision about their dispute). The agreement also showed it was binding for all the parties including the resident, their representative, executors, family members, successors, and their heirs.</p> <p>Review of the Arbitration Agreement's declaration dated 12/13/24, showed the Administrator signed the Arbitration on behalf of the IDT, as the resident's responsible party.</p> <p>Review of Resident 117's the Physician Progress Note dated 3/26/25 at 1540 hours, showed the physician reassessed the resident's cognitive function and the resident was determined had the capacity to make decisions independently.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/10/25 at 0947 hours, an interview was conducted with the Administrator. The Administrator stated for the residents who had no capacity to make medical decisions and had no responsible party, the Bioethics Committee would meet, and the IDT would become the resident's responsible party and be able to make decisions about the resident's medical decisions and plan of care. The Administrator stated in addition to the facility staff, the Ombudsman was also part of the Bioethics Committee. When asked if the Ombudsman was part of Resident 117's Bioethics Committee and the IDT meeting prior to signing the Arbitration Agreement, the Administrator stated she was not. The Administrator stated they signed Resident 117's Arbitration Agreement on behalf of the IDT being the resident's responsible party.</p> <p>On 4/10/25 at 1030 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated she had not been to any Bioethics Committee meetings or any meeting regarding the facility signing an Arbitration Agreement as a residents' representative in over a year.</p> <p>Cross reference to F842, example #1.</p> <p>2. Medical record review for Resident 75 was initiated on 4/7/25. Resident 75 was initially admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 75's H&amp;P examination dated 9/14/24, showed the resident had no capacity to understand and make decisions.</p> <p>Review of Resident 75's Arbitration Agreement dated 12/4/24, showed the form was signed by the Administrator as the resident's legal representative. The agreement showed by signing the agreement, the resident was giving up their right to dispute allegations of medical malpractice in the court of law, and must use arbitration (where disputing parties use a third party to make a final decision about their dispute). The agreement also showed it was binding for all the parties including the resident, their representative, executors, family members, successors, and their heirs.</p> <p>Review of the Arbitration Agreement's declaration dated 12/4/24, showed the Administrator signed the Arbitration on behalf of the IDT, as the resident's responsible party.</p> <p>On 4/10/25 at 0929 hours, an interview was conducted with the SSD. The SSD stated the facility's IDT was the responsible party for Resident 75.</p> <p>On 4/10/25 at 0947 hours, an interview was conducted with the Administrator. The Administrator stated for the residents who had no capacity to make medical decisions and had no responsible party, the Bioethics Committee would meet, and the IDT would become the resident's responsible party and be able to make decisions about the resident's medical decisions and plan of care. The Administrator stated in addition to the facility staff, the Ombudsman was also part of the Bioethics Committee.</p> <p>On 4/10/25 at 1030 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated she had not been to any Bioethics Committee meetings or any meeting regarding the facility signing an Arbitration Agreement as a residents' representative in over a year.</p> <p>On 4/11/25 at 1159 hours, an interview was conducted with the Administrator. The Administrator stated they signed Resident 75's Arbitration Agreement and the Ombudsman was not part of the Bioethics Committee or IDT meeting prior to signing the Arbitration Agreement.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52251</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to implement their infection control program in accordance with the facility's P&amp;P and accepted standards of care.</p> <p>* LVN 11 and CNA 1 failed to follow proper infection control when entering and leaving resident rooms under contact/droplet precautions.</p> <p>* There was a piece of paper trash and staff personal item observed in the clean linen area.</p> <p>* The facility's infection control surveillance did not include residents with signs/symptoms of infection.</p> <p>* The facility failed to ensure the staff wore proper PPE for a COVID-19 isolation room.</p> <p>* The facility failed to ensure the staff wore proper PPE when administering medications via GT.</p> <p>* The facility failed to ensure the staff sanitized the stethoscope after use.</p> <p>* The facility failed to ensure Resident 676's urinal was properly stored.</p> <p>* The facility failed to ensure the urinal observed in Room C's restroom shared by Residents 170 and 674 was properly labeled and stored.</p> <p>* The facility failed to ensure the finished lunch meal tray of Resident 677 was properly stored.</p> <p>These failures put the residents at risk for infection.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Infection Prevention and Control Program revised 12/2022 showed guidelines to ensure that the facility provides a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections per accepted national standards and guidelines.</p> <p>1. a. On 4/9/25 at 1152 hours, during an observation, LVN 11 entered Room D. Room D was a COVID positive designated room on contact/droplet isolation precautions. There was a contact/droplet isolation sign on the door, and a PPE cart at the doorway. LVN 11 did not perform hand hygiene upon entering the room.</p> <p>b. On 4/9/25 at 1206 hours, during an observation, CNA 1 left Room E. Room E was a COVID positive designated room on contact/droplet isolation precautions. There was a contact/droplet isolation sign on the wall next to the door. CNA 1 left Room E ungowned and wearing gloves. CNA 1 did not perform hand hygiene, carried two tray covers, and placed them on top of a clean meal cart with three clean meal trays inside.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. a. On 4/10/25 at 1104 hours, an observation and concurrent interview was conducted with the Laundry Staff. A piece of crumpled paper trash was observed in the clean linen sort area. The Laundry Staff verified the finding.</p> <p>b. On 4/10/25 at 1104 hours, an observation and concurrent interview was conducted with the Laundry Staff. A container of lotion verified for personal use by Laundry Staff was observed in the clean linen sort area. The Laundry Staff verified the finding.</p> <p>3. On 4/11/25 at 1012 hours, a review of the facility's infection control surveillance and concurrent interview was conducted with the IP. There was no documentation the surveillance included the residents with signs/symptoms of infection. The IP verified the findings.</p> <p>47474</p> <p>4. Review of the facility's P&amp;P titled Coronavirus Prevention and Response revised on 12/2022 showed the health care provider who enter the room of a resident with suspected or confirmed COVID-19 infection should adhere to standard precautions and use NIOSH-approved particulate respiratory with N95 filters or higher, gown, gloves, and eye protections.</p> <p>On 4/9/25 at 1540 hours, a concurrent observation and interview was conducted with RN 3 in front of Room D. Room D's door was observed with a sign showing Red Room - Please Keep Door Closed at All Times and Required PPE included Face Shield, N95 mask, Gown, and Gloves. RN 3 was observed standing at the entrance of room [ROOM NUMBER]'s room with the door open, sticking her head inside the room while talking to the residents without wearing her N95 mask. RN 3 verified the findings and verified room [ROOM NUMBER] was a COVID-19 positive room. RN 3 stated she should have worn her N95 mask when talking to the COVID-19 positive residents at the doorway. RN 3 further stated she should have worn her N95 mask to ensure infection control was maintained.</p> <p>On 4/14/25 at 1139 hours, an interview was conducted with the DON. The DON verified the facility had a COVID-19 outbreak with multiple residents testing positive for COVID-19. The DON stated she expected her staff to wear the proper PPE when working with the residents on COVID-19 isolation precautions. The DON stated the PPE included wearing a face shield, N95 mask, gown, and gloves. The DON further stated the staff should have properly worn the N95 mask when communicating with the COVID-19 positive residents at the doorway to ensure infection control was maintained.</p> <p>5. Review of the facility's P&amp;P titled EBP revised on 6/2024 showed it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The P&amp;P further showed the EBP are indicated for the residents including those with indwelling medical devices like central lines, hemodialysis catheters, urinary catheters, and feeding tubes.</p> <p>Medical record review for Resident 179 was initiated on 4/8/25. Resident 179 was admitted to the facility on [DATE].</p> <p>Review of Resident 179's H&amp;P examination dated 1/18/25, showed Resident 179 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 179's Admission Record showed Resident 179 had a diagnosis of GT.</p> <p>Review of Resident 179's Order Summary Report for April 2025 showed a physician's order dated 4/7/25, for EBP for indwelling urinary catheter and PEG tube (GT) use every shift.</p> <p>On 4/8/25 at 0853 hours, during the medication administration observation, LVN 5 was observed going inside Resident 179's room to administer the medications via GT without wearing the proper PPE for the resident on EBP. LVN 5 was observed checking Resident 179's GT placement, residual, and administering the resident's medications via GT without wearing a gown. When LVN 5 was asked if he should have on PPE when administering medications via GT for Resident 179, LVN 5 verified he should. LVN 5 then donned on the proper PPE before continuing with Resident 179's medication administration via GT.</p> <p>On 4/8/25 at 0918 hours, an interview was conducted with LVN 5. LVN 5 verified Resident 179 had a GT and was on the EBP. LVN 5 further verified he did not wear the gown during the medication administration via GT. LVN 5 stated he should wear the proper PPE to protect himself and the other residents for the infection control.</p> <p>6. On 4/8/25 at 0853 hours, during the medication administration observation, LVN 5 was observed going inside Resident 179's room to administer the medications via GT. LVN 5 was observed using the stethoscope to check Resident 179's GT placement and residual. At the completion of the medication administration, LVN 5 was not observed sanitizing the stethoscope.</p> <p>On 4/8/25 at 0918 hours, an interview was conducted with LVN 5. LVN 5 verified using the stethoscope on Resident 179 to check for the placement and residual. LVN 5 further verified he did not sanitize the stethoscope after use. LVN 5 stated he forgot to sanitize the stethoscope. LVN 5 stated he should have sanitized the stethoscope since he had used it for Resident 179 and to maintain infection control.</p> <p>On 4/14/25 at 1139 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>49324</p> <p>7. On 4/7/25 at 0833 hours, during an initial tour observation, Resident 676 was asleep on his bed. Resident 676's urinal filled with urine was observed placed beside his breakfast meal tray on the bedside table.</p> <p>On 4/7/25 at 1030 hours, an observation of Resident 676 and concurrent interview was conducted with LVN 9. Resident 676's urinal was still observed placed on top of the bedside table next to the water pitcher, plastic cup, and another liquid container. LVN 9 verified Resident 676's urinal should be placed on a urinal holder under the bedside table after cleaning and stated it should not be placed beside a meal tray or drinking liquids for infection prevention and control.</p> <p>8. On 4/7/25 at 0838 hours, during an initial tour observation, Room C had a shared restroom for Residents 170 and 674. Room C's restroom had an unlabeled urinal hanging on the waste bin.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 1050 hours, an observation of Room C's restroom and a concurrent interview was conducted with LVN 9. LVN 9 verified the urinal should be labeled and stored on a urinal holder under the residents' bedside table.</p> <p>9. On 4/7/25 at 1304 hours, during an observation, an empty lunch tray was placed on top of a PPE cart containing face shields and gowns. The PPE cart was located beside Room B's door with posted signage the room was on isolation precautions.</p> <p>On 4/7/25 at 1311 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified she placed the finished meal tray on top of the PPE cart and verified she should not have for infection prevention and control.</p> <p>On 4/7/25 at 1422 hours, an interview was conducted with LVN 9. LVN 9 stated meal trays should be placed on a meal cart used for collecting finished meal trays by residents. LVN 9 verified CNA 3 should have not placed the finished lunch meal tray on top of the PPE cart for infection prevention and control.</p> <p>On 4/11/25 at 0915 hours, an interview was conducted with the DON. The DON verified all of the above findings.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 52251</p> <p>Based on interview, facility document review, and facility P&amp;P review, the facility failed to maintain the accurate and complete antibiotic stewardship program designed to reduce the use of unnecessary antibiotics.</p> <p>* The facility failed to properly assess and document signs and symptoms of infection in their infection screening evaluation component of their antibiotic stewardship review. The infection screening evaluation component of antibiotic stewardship also lacked clear guidelines as to how many criteria must be met to be considered true infection and escalate those instances where true infection may be undiagnosed or showing no clinical improvement. This failure has the potential to impair the physiological well being of the residents in the facility.</p> <p>* The facility failed to ensure the Resident 81's prescribed antibiotic for the hepatic encephalopathy specified the duration of the antibiotic therapy as per the facility's antibiotic stewardship program. This failure posed the risk of the residents' continued use of inappropriate antibiotics and developing antibiotic-resistant organisms.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Antibiotic Stewardship Program revised 12/2022 showed the purpose of the program is to optimize the treatment of infections while reducing the adverse effects of the antibiotics. The P&amp;P further showed it was the policy of the facility to implement an antibiotic stewardship program as part of the facilities overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse event associated with antibiotic use. Under the section antibiotic use protocols showed all prescriptions for antibiotics shall specify the dose, duration and indication for use.</p> <p>1. On 4/11/25 at 1012 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the facility's antibiotic stewardship program consisted of reviewing the residents' prescribed antibiotics and determining whether they had met the McGeer's criteria. Review of the infection screening evaluation component failed to show guidelines to be met to be considered a true infection and failed to show an evaluation option for no criteria met. The IP stated the infection screening evaluation component of the antibiotic stewardship review did not specify how many criteria must be met to be considered a true infection, and verified there was no option to check if no criteria was met.</p> <p>On 4/14/25 at 0937 hours, an interview and concurrent facility document review was conducted with the DON. The DON stated the facility's antibiotic stewardship program consisted of reviewing the residents' prescribed antibiotics and determining whether they had met the McGeer's criteria. Review of the infection screening evaluation component failed to show guidelines to be met to be considered a true infection and failed to show an evaluation option for no criteria met. The DON stated the infection screening evaluation component of the antibiotic stewardship review did not specify how many criteria must be met to be considered a true infection and confirmed there was no option to check if no criteria were met. The DON verified the infection screening was based on what the IP sees.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/14/2025
NAME OF PROVIDER OR SUPPLIER  Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  501 South Beach Blvd. Anaheim, CA 92804	

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44175</p> <p>2. 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.</p> <p>Medical record review for Resident 81 was initiated on 4/7/25. Resident 81 was admitted to the facility on [DATE].</p> <p>Review of Resident 81's Order Summary Report Showed a physician's order dated 3/3/25, for rifaximin (antibiotic) oral tablet 550 mg via GT two times a day for hepatic encephalopathy. Further review of the Order Summary Report did not show information specifying the duration of the rifaximin medication.</p> <p>Review of Resident 81's Antibiotic Time Out dated 3/3/25, showed Resident 81 was receiving rifaximin oral tablet 400 mg via GT three times a day. There was no entry or information under the section to verify the total length of the antibiotic treatment (including doses already given).</p> <p>Further review of Resident 81's medical record failed to show documentation specifying the duration of the rifaximin medication.</p> <p>On 4/8/25 at 1339 hours, an interview and concurrent medical record review for Resident 81 was conducted with the IP. The IP verified the above findings. The IP stated Resident 81 was in long term antibiotic therapy for hepatic encephalopathy; however, the IP was not able to show the documented evidence specifying duration of the rifaximin medication for Resident 81.</p> <p>On 4/9/25 at 1128 hours, an interview and concurrent medical record review for Resident 81 was conducted with the DON. The DON verified and acknowledged the above findings.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52251</b></p> <p>Based on interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure two of five final sampled residents (Residents 127 and 160) reviewed for Influenza and pneumococcal immunizations were administered with the vaccine.</p> <p>* The facility facility did not administered the pneumococcal vaccine (a vaccine to protect against infection by pneumococcal bacteria) to Resident 127)</p> <p>* The facility facility did not administered the influenza vaccine to Resident 160.</p> <p>These failures posed the risk for the residents of contracting pneumococcal disease and influenza.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Pneumococcal Vaccination revised 9/2022 showed guidelines to ensure that all eligible residents receive the pneumococcal vaccine in a timely manner, all the residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections, and pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per facility's physician's approved pneumococcal vaccination protocol.</p> <p>1. Medical record review for Resident 127 was initiated on 4/9/25. Resident 127 was admitted to the facility on [DATE].</p> <p>Review of Resident 127's medical record showed Pneumovax 23 was refused, and the resident's Pneumococcal Vaccine Consent/Declination Form was undated.</p> <p>Review of Resident 127's Immunization Records did not show documentation of any additional attempts to offer the administration of the pneumococcal vaccine.</p> <p>On 4/11/25 at 1012 hours, an interview and concurrent medical record review was conducted with the IP. The IP reviewed the form and verified Resident 127's Pneumococcal Vaccine Consent/Declination Form was undated and the PCC record showed no date when the resident had refused when the vaccine was offered. The IP verified Resident 127's medical record did not show any additional attempts to offer the administration of the pneumococcal vaccine.</p> <p>2. Medical record review for Resident 160 was initiated on 4/9/25. Resident 160 was admitted to the facility on [DATE].</p> <p>Review of Resident 160's Immunization Records show documentation the influenza vaccine was refused by Resident 160; however, there was no date when the resident had refused the vaccination.</p> <p>Reviewed Resident 160's vaccine consent/declination form dated 9/20/24, showed the influenza consent was given by the resident's responsible party.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/11/25 at 1012 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified Resident 160's medical record did not show documented evidence the influenza vaccine was administered.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52251</b></p> <p>Based on interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure the COVID vaccine was administered to one of five final sampled residents (Resident 160) reviewed for immunization.</p> <p>* The facility failed to ensure COVID -19 vaccine was administered to Resident 160. This failure had the potential to put the resident and staff at risk for increased infection and transmission of COVID-19 infection.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled COVID Vaccination revised 12/2022 showed the guidelines to ensure that all eligible patients receive the COVID vaccine in a timely manner, all the residents will be offered COVID vaccines to aid in preventing COVID-19 infections, and COVID vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per facility's physician's approved COVID vaccination protocol.</p> <p>Medical record review for Resident 160 was initiated on 4/9/25. Resident 160 was admitted to the facility on [DATE].</p> <p>Review of Resident 160's Immunization Records show no documentation the COVID vaccine was administered to the resident. Review of Resident 160's Vaccine Consent/Declination form dated 9/20/24, showed the COVID consent for vaccine administration was given by the resident's responsible party. However, further review of the resident's medical record failed to show documented evidence the COVID vaccine was administered to Resident 160.</p> <p>On 4/11/25 at 1012 hours, an interview and concurrent medical record review was conducted with the IP. The IP was shown Resident 160's COVID vaccine consent/declination form dated 9/20/24. The IP verified Resident 160's responsible party gave permission for the vaccine to be administered. The IP verified Resident 160's medical record did not show the COVID vaccine was administered after the consent was given 9/20/24.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>49324</p> <p>Based on observation and interview, the facility failed to ensure the accuracy of documentation on the Blood Glucose Monitoring System Quality Control Record for Medication Cart C. This failure had the potential risk of inaccuracy for the glucose test results.</p> <p>Findings:</p> <p>On 4/9/25 at 1011 hours, an inspection of Medication Cart C, review of the blood glucose quality control record, and concurrent interview was conducted with RN 2. Review of the Assure Platinum Meter Serial Number of the Blood Glucose Monitoring System Quality Control Record was observed blank. RN 2 was asked if the form should have been completed. RN 2 verified it should have been with the documentation of the serial number of the meter and completed for accuracy.</p> <p>On 4/11/25 at 0915 hours, an interview was conducted with the DON. The DON verified the above findings.</p>