

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER LA Palma Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 LA Palma Ave Anaheim, CA 92801	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 28) was provided with the necessary care in the manner that promoted dignity and respect.</p> <p>* The facility failed to ensure an effective communication with Resident 28 in a language understood by the resident. This failure had the potential to negatively impact the resident's emotional well-being, and risk for not providing the appropriate treatment of Resident 28.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Translation or Interpretation Services dated 9/2014 showed the following:</p> <ul style="list-style-type: none"> - To ensure those residents with limited English proficiency and those residents who have hearing issues have access to facility services. - The facility provides assistance to resident with limited English proficiency and those resident with hearing deficiencies, through translation and interpretation. <p>Medical record review for Resident 28 was initiated on 8/27/24. Resident 28 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 28's H&P examination dated 10/16/23, showed Resident 28 had no capacity to understand and make decision.</p> <p>Review of Resident 28's plan of care showed a care plan problem dated 6/19/24, addressing Resident 28's language barrier. Resident 28 spoke and understood the Gujarati language (language spoken in [NAME]). The interventions included to make use of translation tools, word and picture pages, and posters for better communication.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/24 at 0928 hours, an observation for Resident 28 and concurrent interview with CNA 3 was conducted. Resident 28 was observed sitting in a wheelchair interacting and talking with CNA 3. Resident 28 was observed pointing at her bed and speaking in the Gujarati language. When asked if Resident 28 understood English, Resident 28 shook her head side to side, indicating no. CNA 3 was observed talking to Resident 28 in English. When asked if CNA 3 understood what Resident 28 was saying, CNA 3 stated sometimes she understood what the resident was saying because she was familiar with Resident 28's daily routine. However, CNA 3 stated sometimes she was just guessing what the resident was saying in her language. There was no communication board observed at the bedside.</p> <p>On 8/28/24 at 0811 hours, an observation for Resident 28 and concurrent interview with CNAs 2 and 9 was conducted. Resident 28 was observed speaking in her primary language. CNA 2 then came in and started talking with Resident 28 in English. When ask if CNA 2 understood Resident 28's language, CNA 2 stated Resident 28 spoke a different language and did not understand Resident 28. CNAs 2 and 9 both stated they did not use a communication board at bedside to communicate with the resident.</p> <p>On 8/28/24 at 0831 hours, an observation and concurrent interview with the DON was conducted. The DON stated the facility had a translation device inside the medication cart for the staff to use. The DON verified Resident 28 did not have a communication board at the bedside. The DON stated she did not understand Resident 28's language. The DON stated the staff would usually call the family to translate.</p> <p>On 8/28/24 at 0844 hours, an observation and interview with CNA 9 and the DSD was conducted. CNA 9 stated she did not use the translation device when communicating with Resident 28 and was not trained by the facility on how to use the device. The DSD showed the translation device, however, the DSD was unable to show the Gujarati language on the translation device. The DSD verified there was no communication board at Resident 28's bedside.</p> <p>On 8/29/24 at 1441 hours, an interview with the Administrator and MDS Coordinator was conducted. The Administrator and MDS Coordinator were informed and acknowledge the above findings.</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>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the psychotropic medication informed consent for one of 16 final sampled residents (Resident 366) was signed by the physician. This failure posed the risk for Resident 366 to not be informed of their care and treatment for the psychotropic medication use.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Informed Consent Policy revised on 4/2024 showed the attending physician, PA (Physician Assistant) or NP (Nurse Practitioner) must obtain the informed consent of the resident or their responsible party for purposes of prescribing, ordering, or increasing an order for a psychotherapeutic medication. The facility shall verify that informed consent has been obtained prior to the administration of psychotherapeutic medication, use of siderails as a restraint, enabler, or assistive device of the use of anything attached to a normal bed, wheelchair, or Geri chair. The P&P further showed it is the responsibility of the physician, PA or NP who orders psychotherapeutic medications to obtain the resident or the resident's responsible party's informed consent prior to the initiation of therapy.</p> <p>Medical record review for Resident 366 was initiated on 8/27/24. Resident 366 was admitted to the facility on [DATE].</p> <p>Review of Resident 366's H&P examination dated 8/12/24, showed Resident 366 had the capacity to understand and make decisions.</p> <p>Review of Resident 366's Order Summary Report dated August 2024 showed a physician's order dated 8/13/24, for trazadone (antidepressant medication, also use to treat inability to sleep) 50 mg give one tablet by mouth at bedtime for insomnia M/B inability to sleep.</p> <p>Review of Resident 366's informed consent for the use of trazadone medication showed no documented evidence the physician signed the consent form.</p> <p>On 8/28/24 at 1033 hours, a concurrent interview and facility document review with LVN 4 was conducted. LVN 4 verified Resident 366's informed consent for the trazadone medication did not have a physician's signature. LVN 4 stated a physician's signature was needed on an informed consent for the trazadone medication to indicate the physician reviewed the medication with the resident and approved of the order.</p> <p>On 8/29/24 at 1340 hours, an interview was conducted with the DON. The DON stated the informed consent had to be signed by the physician. The DON stated the informed consent allowed the facility to administer the medication as ordered. The DON acknowledged the above findings.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787</p> <p>Based on observation, interview, medical record, and facility P&P review, the facility failed to determine if it was safe for one of 16 final sampled residents (Resident 316) to safely self-administer the medications. This failure had the potential for Resident 316 to administer the medications inaccurately.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication: Self- Administration revised 1/2017 showed the facility supports the residents right to self-administer medications if the Interdisciplinary Team (IDT) determines this practice is clinically appropriate. The policy also showed on admission or shortly thereafter, each resident will be assessed to determine if they want to self- administer their medications.</p> <p>On 8/27/24 at 0900 hours, during the initial tour of the facility, Resident 316 was observed with the following medications at the bedside:</p> <ul style="list-style-type: none"> - one bottle of Synthroid (thyroid hormone replacement to treat a condition called hypothyroidism- enlarged thyroid gland and thyroid cancer) 125 mcg tablets; - one bottle of Equate Gas Relief (medication to relieve bloating, pressure, and fullness in the stomach) 125 mg tablets; - one bottle of Tylenol (pain reliever) Extra Strength Time Release gel capsules; and - one bottle of Neuriva Brain Health Plus (dietary supplement intended to support brain health) tablets. <p>Resident 316 stated she self- administered the Synthroid medication.</p> <p>On 8/27/24 at 0918 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 stated Resident 316 was a new resident at the facility. CNA 3 verified the above medications were at Resident 316's bedside.</p> <p>On 8/27/24 at 0920 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the above medications were at Resident 316's bedside. When LVN 1 was asked if she was aware of the medications at Resident 316's bedside, LVN 1 stated the physician was aware and addressed it in her plan of care.</p> <p>Medical record review for Resident 316 was initiated on 8/27/24. Resident 316 was admitted to the facility on [DATE].</p> <p>Review of Resident 316's quarterly MDS dated [DATE], showed Resident 316 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 316's H&P examination dated 8/16/24, showed Resident 316 had the capacity to understand and make decisions. The H&P examination also showed Resident 316 kept all of her medications.</p> <p>Review of Resident 316's Order Summary Report dated 8/28/24, failed to show physician's orders for Resident 316 to self-administer medications and/or to store the medications at bedside.</p> <p>Review of Resident 316's plan of care failed to show a care plan problem to address Resident 316's self-administration of the medications.</p> <p>Review of Resident 316's Self-Administration of Medication assessment dated [DATE], showed Resident 316 did not want to self-administer medications and preferred the licensed nurse to administer her medications.</p> <p>On 8/28/24 at 0841 hours, a follow-up interview was conducted with Resident 316. Resident 316 stated the licensed nurses were aware she was self-administering the above medications. Resident 316 stated she tried to let the facility know that the facility's medication supply strength was not the same as her supply.</p> <p>On 8/28/24 at 1050 hours, an observation, interview and concurrent medical record review was conducted with the DON. The DON verified the above medications were at Resident 316's bedside. The DON verified Resident 316's current assessment for self-administration of medications dated 8/16/24, showed Resident 316 did not want to self-administer medication. When asked if Resident 316 was reassessed to determine if she was safe to self-administer medications, the DON stated no.</p> <p>On 8/29/24 at 1441 hours, an interview was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and acknowledged the above findings.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodation to meet the needs of one nonsampled resident (Resident 60).</p> <p>* The facility failed to ensure the call light button was within Resident 60's reach. This failure had the potential to hinder Resident 60's ability to communicate with facility staff.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Call Lights dated 1/2017 showed when the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident.</p> <p>On 8/27/24 at 0805 hours, during the initial tour of the facility, Resident 60 was observed lying in bed. Resident 60's call light was observed on the floor and not within the resident's reach.</p> <p>Medical record review for Resident 60 was initiated on 8/27/24. Resident 60 was admitted to the facility on [DATE].</p> <p>Review of Resident 60's MDS dated [DATE], showed Resident 60's cognition was intact.</p> <p>On 8/27/24 at 0907 hours, a concurrent observation of Resident 60's call light and interview with CNA 4 was conducted. CNA 4 verified Resident 60's call light was on the floor and not within Resident 60's reach. CNA 4 stated the call light should have been within Resident 60's reach. CNA 4 further stated she would clean the call light and place it within the resident's reach.</p> <p>On 8/29/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled residents (Resident 43) had copy of her advance directive in her medical record. This failure had the potential for the resident's decisions regarding her healthcare and treatment options to not be honored.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Advance Directives revised 4/2017 showed the resident or their responsible party will be asked if the resident has completed an advance directive, and to provide a copy of the document for the resident's clinical record.</p> <p>Medical record review for Resident 43 was initiated on 8/27/24. Resident 43 was admitted to the facility on [DATE].</p> <p>Review of Resident 43's H&P examination dated 2/21/24, showed Resident 43 had no capacity to understand and make decisions.</p> <p>Review of the Quarterly MDS assessment dated [DATE], showed Resident 43 had moderately impaired cognition.</p> <p>Review of the Physician Orders for Life Sustaining Treatment (POLST) form prepared on 2/19/24, showed Resident 43 had an advance directive, but it was not available in her medical record.</p> <p>On 8/28/24 at 1636 hours, an interview was conducted with the Health Information Director. The Health Information Director verified Resident 43 did not have a copy of advance directive in her medical record.</p> <p>On 8/28/24 at 1645 hours, an interview with concurrent record review was conducted with LVN 9. LVN 9 stated the resident's POLST dated 2/19/24, showed Resident 43 had an advance directive but no copy of advance directive found in the resident's medical record. LVN 9 stated a copy of Resident 43's advance directive should be in the resident's medical record because it dictated the resident's medical needs.</p> <p>On 8/28/24 at 1653 hours, an interview was conducted with the SSD. The SSD acknowledged Resident 43 had an advance directive but there was no copy found in the resident's medical record. The SSD stated a copy of the advance directive for Resident 43 should be in her medical record because it showed who the appointed responsible party was and served as a medical guide for the resident's care and wishes.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the recommendations from the Preadmission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level II determination was followed up and incorporated into the resident care for one of one final sampled resident (Resident 44) reviewed for PASARR. This failure had the potential for Resident 44 not receiving the adequate care and services that were recommended by PASARR Level II determination and evaluation report assessed by a appropriate state-designated authority.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Comprehensive Care Planning revised 1/17 showed a comprehensive care plan would be developed for each resident. The comprehensive care plan would provide specific information to include resident strengths, goals, life history and preferences, discharge planning and would be completed within seven days of the Care Area Assessment completion. The facility's P&P further showed there would be coordination of the assessment with the Preadmission Screening and Resident Review (PASARR).</p> <p>Medical record review for Resident 44 was initiated on 8/27/24. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of anxiety disorder (a type of mental health condition) and schizoaffective disorder (chronic mental illness that causes people to experience both schizophrenia and a mood disorder at the same time).</p> <p>Review of the letter sent to Resident 44 by the Department of Health Care Services dated 3/10/23, showed the PASARR Level II Evaluation was conducted on 3/10/23. The letter further showed the facility staff would receive the copy of the determination report and discuss the result with Resident 44 and would incorporate the recommendations into Resident 44's care plan.</p> <p>Review of Resident 44's PASARR Individualized Determination Report dated 3/10/23, showed Resident 44 required nursing facility services due to a medical and/or mental health condition. The PASARR Individualized Determination Report further showed special services were recommended. The report showed the Determination Report was based on a review of Resident 44's medical and social history which showed a significant medical condition with mental stressors that require nursing care.</p> <p>Review of Resident 44's annual MDS dated [DATE], showed Resident 44 was not considered by the State level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition.</p> <p>Review of Resident 44's H&P examination dated 3/21/24, showed Resident 44 had the capacity to understand and make decisions.</p> <p>Review of the Resident 44's medical record did not show the recommendations from the PASARR Individualized Determination Report was followed up.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Resident 44's plan of care failed to show a care plan problem addressing the recommendations from the PASARR Individualized Determination Report.</p> <p>On 8/28/24 at 1640 hours, an interview and concurrent record review for Resident 44 was conducted with the DON. The DON verified the above findings and stated there were no documentation in Resident 44's medical record to show the recommendations from the PASARR Level II determination were followed up. The DON stated the recommendations indicated on Resident 44's PASARR Level II determination report should have been addressed timely and there was a potential risk of Resident 44 not receiving the adequate care and services.</p> <p>On 8/29/24 at 1249 hours, an interview and concurrent medical record review for Resident 44 was conducted with the MDS Coordinator. The MDS Coordinator stated when the Level I Screening was positive, the Department of Health Care Services would contact the facility to conduct a Level II Determination. The MDS Coordinator stated once the determination was complete, the results would be uploaded into the system, and the facility would be able to view the determination results and coordinate the recommended care and services. The MDS Coordinator stated she did not have a system to alert her to view the Level II determination results in the system; that she was only prompted to check the PASARR results when she conducted the annual MDS reviews. The MDS Coordinator further stated she coded Resident 44's annual MDS dated [DATE], incorrectly when she selected no when asked if Resident 44 was considered by the state Level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition.</p> <p>On 8/29/24 at 1425 hours, the DON was informed and acknowledged the above findings.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plans were developed to reflect the individual care needs for 13 of 16 final sampled residents (Residents 15, 17, 20, 32, 33, 34, 35, 40, 44, 45, 48, 59, and 366).</p> <p>* The facility failed to ensure the comprehensive person-centered care plans for the use of grab bars were in place for Residents 15, 17, 20, 32, 33, 34, 35, 40, 44, 45, 48, 59, and 366. This failure had the potential for residents to not be provided with appropriate, consistent, and individualized care.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Comprehensive Care Planning dated on 1/2017 showed the facility developed a comprehensive care plan for each resident. The plan of care must include measurable objectives and time frames and describe services that are to be furnished to attain or maintain the resident's practicable level of well-being.</p> <p>During a concurrent observation, interview, medical record review, and facility document review for Residents 15, 17, 20, 32, 33, 34, 35, 40, 44, 45, 48, 59, and 366 showed the facility did not create a comprehensive care plan for the use of grab bars. For example:</p> <p>1. On 8/28/24 at 0900 hours, Resident 32 was observed lying in bed with bilateral grab bars elevated. Resident 32 was awake alert and verbally responsive. CNA 3 verified the bilateral grab bars were elevated. CNA 3 stated Resident 32 used the grab bars when getting up from bed and turning during the care.</p> <p>Medical record review for Resident 32 was initiated on 8/29/24. Resident 32 was admitted to the facility on [DATE].</p> <p>Review of Resident 32's H&P examination dated 8/2/24, showed Resident 32 had capacity to understand and make decisions.</p> <p>Review of Resident 32's Order Summary Report showed a physician's order dated 8/1/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 32's care plan dated 8/2/24, did not show a comprehensive care plan was developed for the use of the grab bars which include interventions to provide possible least restrictive approaches prior to applying grab bars and assessment of the entrapment.</p> <p>2. On 8/29/24 at 1040 hours, Resident 35's bed was observed with the bilateral grab bars elevated. LVN 3 stated Resident 35 used the grab bars when turning during care. LVN 3 attempted to move the grab bars down; however, they were locked in place and kept elevated.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medical record review for Resident 35 was initiated on 8/29/24. Resident 35 was admitted to the facility on [DATE].</p> <p>Review of Resident 35's H&P examination dated 8/26/24, showed Resident 35 had capacity to understand and make decisions.</p> <p>Review of Resident 35's Order Summary Report showed a physician's order dated 8/9/23, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 35's care plan dated 5/23/23, did not show a comprehensive care plan was developed for the use of the grab bars which include interventions to provide possible least restrictive approaches prior to applying grab bars and assessment of the entrapment.</p> <p>3. On 8/28/24 at 0905 hours, Resident 40 was observed lying in bed with the bilateral grab bars elevated. CNA 3 verified the bilateral grab bars were elevated. CNA 3 stated Resident 40 used the grab bars when turning during the care.</p> <p>Medical record review for Resident 40 was initiated on 8/28/24. Resident 40 was admitted to the facility on [DATE].</p> <p>Review of Resident 40's H&P examination dated 2/24/24, showed Resident 40 had no capacity to understand and make decisions. Resident 40's family member was the responsible party and decision maker.</p> <p>Review of Resident 40's Order Summary Report showed a physician's order dated 3/8/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 40's care plan dated 5/24/24, did not show a comprehensive care plan was developed for the use of the grab bars, which to include interventions to provide possible least restrictive approaches prior to applying grab bars and assessment of the entrapment.</p> <p>4. On 8/29/24 at 1037 hours, Resident 45 was observed lying in bed asleep with bilateral grab bars elevated. RNA 1 verified the bilateral grab bars were elevated. RNA 1 stated Resident 45 used the grab bars when turning during care and during transfer from bed to wheelchair.</p> <p>Medical record review for Resident 45 was initiated on 8/29/24. Resident 45 was admitted to the facility on [DATE].</p> <p>Review of Resident 45's H&P examination dated 8/2/24, showed Resident 45 had capacity to understand and make decisions.</p> <p>Review of Resident 45's Order Summary Report showed a physician's order dated 7/8/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 45's care plan dated 7/9/24, did not show a comprehensive care plan was developed for the use of the grab bars, which to include interventions to provide possible least restrictive approaches prior to applying grab bars and assessment of entrapment.</p> <p>On 8/29/24 at 1045 hours, an interview and concurrent medical record review was conducted with the</p> <p><i>(continued on next page)</i></p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>DON. The DON verified there were no individualized care plan for the use of the grab bars. The DON agreed there must be a care plan for each resident who used the grab bars with interventions to provide possible least restrictive approaches prior to applying grab bars and assessment of the entrapment.</p> <p>On 8/29/24 at 1441 hours, an interview was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and acknowledged the above findings.</p> <p>47474</p> <p>5. Medical record review for Resident 20 was initiated on 8/27/24. Resident 20 was admitted to the facility on [DATE].</p> <p>Review of Resident 20's H&P examination dated 6/6/24, showed Resident 20 had no capacity to understand and make decisions.</p> <p>Review of Resident 20's Order Summary Report dated August 2024 showed a physician's order dated 6/4/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>However, there was no care plan developed to address the use of bilateral grab bars.</p> <p>6. Medical record review for Resident 366 was initiated on 8/27/24. Resident 366 was admitted to the facility on [DATE].</p> <p>Review of Resident 366's H&P examination dated 8/12/24, showed Resident 366 had the capacity to understand and make decisions.</p> <p>Review of Resident 366's Order Summary Report dated August 2024 showed a physician's order dated 8/10/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>However, there was no care plan developed to address the use of bilateral grab bars.</p> <p>On 8/29/24 at 0805 hours, medical record review and concurrent interview with LVN 7 was conducted. LVN 7 verified Residents 20 and 366 did not have a care plan for the use of grab bars and risk for entrapment. LVN 7 stated the care plans were a guide used for the plan of care specifically for that resident and includes the problems, goals, and interventions.</p> <p>On 8/29/24 at 1340 hours, an interview was conducted with the DON. The DON acknowledged the above findings.</p> <p>48882</p> <p>7. On 8/28/24 at 0827 hours, and 8/29/24 at 0738 hours, Resident 44 was observed in bed with bilateral grab bars elevated.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medical record review for Resident 44 was initiated on 8/27/24. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 44's H&P examination dated 3/21/24, showed Resident 44 had the capacity to understand and make decisions.</p> <p>Review of Resident 44's Order Summary Report dated 8/28/24, showed a physician's order dated 2/28/23, to apply bilateral grab bars as enablers to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 44's plan of care failed to show documented evidence a care plan problem was initiated to address Resident 44's use of the bilateral grab bars.</p> <p>On 8/28/24 at 0858 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 44 used the grab bars for positioning in bed.</p> <p>On 8/29/24 at 0805 hours, an interview and concurrent medical record review for Resident 44 was conducted with LVN 7. LVN 7 verified the above findings.</p> <p>On 8/29/24 at 1425 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>8. On 8/27/24 at 0948 hours and on 8/29/24 at 0738 hours, Resident 59 was observed in bed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 59 was initiated 8/27/24. Resident 59 was admitted to the facility on [DATE].</p> <p>Review of Resident 59's H&P examination dated 4/18/24, showed Resident 59 did not have the capacity to understand and make decisions.</p> <p>Review of Resident 59's Order Summary Report dated 8/28/24, showed a physician's order dated 4/16/24, to apply bilateral grab bars as enablers to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 59's plan of care failed to show documented evidence a care plan problem was initiated to address Resident 59's use of the bilateral grab bars.</p> <p>On 8/28/24 at 0851 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 59 used the grab bars for positioning in bed.</p> <p>On 8/29/24 at 0805 hours, an interview and concurrent medical record review for Resident 59 was conducted with LVN 7. LVN 7 verified the above findings.</p> <p>On 8/29/24 at 1425 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>39670</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. On 8/27/24 at 0939 hours and 8/28/24 at 0812 hours, an observation and concurrent interview with Resident 33 was conducted. Resident 33 was observed in bed with both upper grab bars were elevated. Resident 33 stated she used the grab bars while in bed.</p> <p>Medical record review for Resident 33 was initiated on 8/27/24. Resident 33 was admitted to the facility on [DATE].</p> <p>Review of Resident 33's Order Summary Report dated 8/28/24, showed a physician's order dated 7/13/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfer.</p> <p>Review of Resident 33's plan of care failed to show a care plan was developed to address Resident 33's use of grab bars in bed.</p> <p>On 08/28/24 at 1412 hours, an interview for Resident 33 was conducted with CNA 10. CNA 10 verified Resident 33's use of the grab bars. CNA 10 stated Resident 33 was able to turn and reposition in bed independently using the grab bars.</p> <p>On 08/29/24 at 1051 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 4. LVN 4 verified Resident 33's use of the grab bars in bed with a physician's order. LVN 4 was asked about the care plan for the grab bar. LVN 4 reviewed the plan of care and was unable to locate the care plan for the use of the grab bars. LVN 4 stated there should be a specific care plan for the grab bars use in bed.</p> <p>Cross reference to F700, example # 9.</p> <p>10. On 8/27/24 at 1005 hours and 8/28/24 at 0929 hours, Resident 34 was observed in bed with both upper grab bars were elevated.</p> <p>Medical record review for Resident 34 was initiated on 8/27/24. Resident 34 was admitted to the facility on [DATE].</p> <p>Review of Resident 34's Order Summary Report dated 8/28/24, showed a physician's order dated 4/29/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 34's plan of care failed to show a care plan addressing Resident 34's use of grab bars in bed.</p> <p>On 8/28/24 at 1146 hours, an interview for Resident 34 was conducted with CNA 11. CNA 11 stated Resident 34 was able to use the grab bars in bed when turning and reposition in bed. CNA 11 verified Resident 34's use of the grab bars in bed.</p> <p>On 8/28/24 at 1228 hours, an interview and concurrent medical record review for Resident 34 was conducted with LVN 4. LVN 4 verified Resident 34's use of the grab bars in bed. LVN 4 was asked about the care plan for the use of grab bar in bed. LVN 4 reviewed the plan of care and was unable to locate the care plan for the use of the grab bars in bed. LVN 4 stated there should be a specific care plan for the grab bars use in bed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/29/24 at 1453 hours, an interview and concurrent medical record review for Residents 33 and 34 was conducted with the MDS Coordinator. The MDS Coordinator was informed and verified the findings.</p> <p>49644</p> <p>11. Medical record review for Resident 48 was initiated on 8/27/24. Resident 48 was admitted to the facility on [DATE].</p> <p>Review of Resident 48's Order Summary Report showed a physician's order dated 7/5/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 48's plan of care failed to show a care plan was developed to address Resident 48's bilateral grab bars use.</p> <p>On 8/28/24 at 1208 hours, an observation of Resident 48 and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 48's bilateral grab bars were elevated.</p> <p>On 8/29/24 at 0909 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no care plan developed for Resident 48's bilateral grab bars use. RN 1 stated Resident 48's care plan should have been developed by a licensed nurse.</p> <p>On 8/29/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>50787</p> <p>12. On 08/29/24 at 0914 hours, Resident 17 was observed lying in bed with upper bilateral grab bars. Resident 17 nodded her head when asked if she used the grab bars. Resident 17's use of the bilateral grab bars as enablers was verified with the Director of Staff Development .</p> <p>Medical record review initiated for Resident 17 on 8/29/24. Resident 17 was admitted to the facility on [DATE].</p> <p>Review of Resident 17's quarterly MDS dated [DATE], showed Resident 17's BIMS score was 15 (means cognitively intact).</p> <p>Review of Resident 17's Order Summary Report dated 8/28/24, showed physician's order dated 2/3/19, for the use of the bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfer.</p> <p>Review of Resident 17's medical record failed to show a care plan was developed to address the grab bar use to include goals, interventions, and use of less restrictive devices.</p> <p>On 8/29/24 at 1302 hours, medical record review and concurrent interview was conducted with the DON. The DON was informed and verified the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/29/24 at 1441 hours, an interview was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and acknowledged the above findings.</p> <p>50953</p> <p>13. Medical Record Review for Resident 15 was initiated on 8/28/24. Resident 15 was admitted to the facility on [DATE].</p> <p>Review of the physician's order dated 5/20/24, showed an order for the bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfer.</p> <p>On 8/27/24 at 0850 hours, observation and interview with Resident 15 was conducted. Resident 15 was observed in bed with the bilateral grab bars elevated. The resident stated the grab bars were used for turning.</p> <p>On 8/28/24 at 0802 hours, an observation was conducted with CNA 1 for Resident 15. Resident 15 was observed in bed with the grab bars elevated. CNA 1 verified Resident 15 used the grab bars for turning.</p> <p>On 8/28/24 at 1116 hours, LVN 1 verified Resident 15 had the grab bars elevated and used for turning.</p> <p>Review of Resident's 15 plan of care failed to show a care plan was developed to address the use of the grab bars.</p> <p>On 8/29/24 at 937 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator acknowledged the finding.</p> <p>Cross references to F700 and F909.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care for three of 16 final sampled residents (Residents 15, 34, and 59) and one nonsampled resident (Resident 55).</p> <p>* The facility failed to ensure Resident 55 was administered the oxygen as per the physician's order. This failure posed the risk to negatively affect Resident 55's medical condition.</p> <p>* The facility failed to ensure Resident 15's oxygen tubing was dated.</p> <p>* The facility failed to ensure the oxygen tubing was placed in a clear plastic bag when not in use and the nebulizer tubing were not touching the floor for Resident 34.</p> <p>* The facility failed to ensure accurate documentation of the monitoring of Resident 59's oxygen saturation level on room air.</p> <p>These failures had the potential to put the residents at risk for adverse effects of the inaccurate administration of oxygen and improper care of oxygen equipment.</p> <p>Findings:</p> <p>1. On 8/28/24 at 0920 hours, Resident 55 was observed lying in bed and receiving three liters per minute of oxygen via nasal cannula.</p> <p>On 8/28/24 at 0923 hours, a concurrent observation for Resident 55, interview and medical record review was conducted with LVN 3. Resident 55 was observed lying in bed and receiving three liters per minute of oxygen via nasal cannula. LVN 3 verified Resident 55 was receiving three liters per minute of oxygen via nasal cannula. LVN 3 stated Resident 55 was sometimes administered with three liters per minute of oxygen by the night shift nurse because the resident had difficulty of breathing at night.</p> <p>Medical record review for Resident 55 was initiated on 8/27/24. Resident 55 was admitted to the facility on [DATE].</p> <p>Review of Resident 55's Order Summary Report dated 8/28/24, showed a physician's order dated 2/29/24, to administer oxygen at one to two liters per minute via nasal cannula continuously to keep oxygen saturation level above 92%.</p> <p>Further review of Resident 55's medical record did not show the resident had difficulty breathing at night and the physician was informed to increase the oxygen setting to three liters per minute.</p> <p>LVN 3 verified the above findings.</p> <p>50953</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>2. Medical Record Review for Resident 15 was initiated on 8/28/24. Resident 15 was admitted to the facility on [DATE].</p> <p>Review of Resident 15's Order Summary Report showed an order dated 8/21/24, for oxygen at two to four liters per minute via mask/nasal cannula continuous to keep oxygen saturation level above 92%.</p> <p>On 8/27/24 at 0850 hours, Resident 15 was observed in bed with oxygen administered via nasal cannula at two liters per minute. There was a humidifier attached to the oxygen concentrator next to the resident 's bed. There was no date observed on the oxygen tubing (nasal cannula), and the humidifier was dated 8/11/24.</p> <p>On 8/28/24 at 1226 hours, observation and concurrent interview with LVN 3 was conducted. LVN 3 was asked about the process of oxygen tubing change for the residents in the facility. LVN 3 stated the oxygen tubing and humidifier bottle were changed every Sunday morning shift by the license nurse and should be dated. LVN 3 verified the tubing from the humidifier to concentrator was dated 8/11/24, and the oxygen tubing was not dated. LVN 3 was unable to answer when the oxygen tubing was last changed.</p> <p>39670</p> <p>3. On 8/27/24 at 1005 hours, and 8/28/24 at 0929 hours, Resident 34's nebulizer machine was at the bedside with the part of the nebulizer tubing touching the floor.</p> <p>Medical record review for Resident 34 was initiated on 8/28/24. Resident 34 was admitted to the facility on [DATE].</p> <p>Review of Resident 34's Order Summary Report dated 8/28/24, showed a physician's order dated 4/30/24, to administer oxygen at two liters per minute via nasal cannula continuously to keep the oxygen saturation level above 92%. Another physician's order dated 4/29/24, to administer Ipratropium-Albuterol Solution (medication used to treat asthma) 0.5 to 2.5 (3) mg/ml one vial inhalation orally every four hours as needed for shortness of breath.</p> <p>On 8/28/24 at 1228 hours, an observation and concurrent interview was conducted with LVN 5 at Resident 34's bedside. Resident 34's nasal cannula oxygen tubing was placed on the wheelchair connected to the portable oxygen tank. LVN 5 verified the oxygen tubing nasal cannula was not placed on the plastic bag when not in use and the nebulizer tubing was touching the floor. LVN 5 stated the nebulizer tubing should not be touching the floor and the oxygen tubing should have been placed on plastic bag when not in use.</p> <p>On 8/29/24 at 1453 hours, an interview and concurrent medical record review for Resident 34 was conducted with the MDS Coordinator. The MDS Coordinator was informed and verified the above findings.</p> <p>48882</p> <p>4. On 8/27/24 at 0948 hours, Resident 59 was observed lying in bed and receiving three liters per minute of oxygen via nasal cannula.</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>Medical record review for Resident 59 was initiated 8/27/24. Resident 59 was admitted to the facility on [DATE] with a diagnosis of pneumonia (infection of the lungs).</p> <p>Review of Resident 59's H&P examination dated 4/18/24, showed Resident 59 had no capacity to understand and make decisions.</p> <p>Review of Resident 59's Order Summary Report dated 8/28/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 4/16/24, to monitor Resident 59's oxygen saturation level on room air every shift for the diagnosis of shortness of breath. - dated 8/24/24, to administer oxygen at two to three liters per minute via nasal cannula continuously to keep oxygen saturation level above 92%, for shortness of breath and pneumonia. <p>Review of Resident 59's MAR for August 2024 showed the monitoring of Resident 59's oxygen saturation level on room air was documented as check marks for the following days and shifts:</p> <ul style="list-style-type: none"> - from 8/1 to 8/17/24, and 8/25 to 8/27/24: for the day, evening, and night shifts, - on 8/18/24, for the day and evening shifts; - on 8/24/24, for the evening and night shifts; and - on 8/28/24, for the day shift. <p>Further review of Resident 59's MAR for August 2024 failed to show documentation of Resident 59's oxygen saturation level on room air for the above shifts.</p> <p>Review of Resident 59's plan of care showed a care plan problem initiated on 4/17/24, addressing Resident 59's risk for altered breathing [NAME] related to pneumonia. The interventions showed to monitor Resident 59's oxygen saturation level on room air every shift.</p> <p>On 8/28/24 at 1411 hours, an interview and concurrent medical record review for Resident 59 was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated the purpose of monitoring Resident 59's oxygen saturation level on room air was to see if Resident 59 would tolerate being on room air without supplemental oxygen, and to determine the potential for weaning. LVN 5 stated the oxygen saturation level on room air should have been documented in the MAR.</p> <p>On 8/29/24 at 1425 hours, an interview and concurrent medical record review for Resident 59 was conducted with the DON. The DON stated when monitoring the resident's oxygen saturation level on room air, the staff should document the oxygen saturation level in the medical record. The DON was informed and acknowledged the above findings. The DON stated without documentation of Resident 59's oxygen saturation level on room air, the facility would be unable to determine if the resident would be weaned off of from the oxygen or unable to tolerate room air.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure 13 of 16 final sampled residents reviewed for side rail use (Residents 15, 17, 20, 32, 33, 34, 35, 40, 44, 45, 48, 59, and 366) remained free from the accident hazards associated with the use of elevated side rails.</p> <p>* The facility failed to ensure the accurate and complete assessments and evaluations for the grab bars use for Residents 15, 20, 32, 33, 34, 35, 40, 44, 45, 48, 59, and 366. This failure had the potential to put the residents at risk for entrapment and serious injuries.</p> <p>Findings:</p> <p>The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment.</p> <p>Review of the facility's P&P titled Proper Use of Bed Rails dated on 8/2018 showed the facility to assess a resident's risk for entrapment prior to the installation of siderails or bedrails to ensure that the bed's dimensions are appropriate for the resident's size and weight. The facility will assess the resident's risk for entrapment for the use of a grab bar using the facility's grab bar assessment. This policy to reduce entrapment with the use of siderails has been developed utilizing the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.</p> <p>1. On 8/28/24 at 0900 hours, Resident 32 was observed lying in bed with bilateral grab bars elevated. Resident 32 was awake alert and verbally responsive. CNA 3 verified the bilateral grab bars were elevated. CNA 3 stated Resident 32 used the grab bars when getting up from bed and when turning during care.</p> <p>Medical record review for Resident 32 was initiated on 8/29/24. Resident 32 was admitted to the facility on [DATE].</p> <p>Review of Resident 32's H&P examination dated 8/2/24, showed Resident 32 had capacity to understand and make decisions.</p> <p>Review of Resident 32's Order Summary Report showed a physician's order dated 8/1/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 32's Restraint and Other Devices Assessment and Reduction Management Program dated 8/1/24, showed the grab bars were selected under possible approaches in reducing restraints. However, the assessment failed to show the possible approaches identified in the assement were effective or ineffective prior to the use of the bilateral grab bars.</p> <p>2. On 8/29/24 at 1040 hours, Resident 35's bed had bilateral grab bars elevated. LVN 3 stated Resident 35 used the grab bars when turning during care. LVN 3 attempted to move the grab bars down; however, they were locked in place and kept elevated.</p> <p>Medical record review for Resident 35 was initiated on 8/29/24. Resident 35 was admitted to the facility on [DATE].</p> <p>Review of Resident 35's H&P examination dated 8/26/24, showed Resident 35 had capacity to understand and make decisions.</p> <p>Review of Resident 35's Order Summary Report showed a physician's order dated 8/9/23, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 35's Restraint and Other Devices Assessment and Reduction Management Program dated 8/9/23, showed the grab bars were selected under possible approaches in reducing restraints. However, the assessment failed to show the possible approaches identified in the assessment were effective or ineffective prior to the use of the bilateral grab bars.</p> <p>3. On 8/28/24 at 0905 hours, Resident 40 was observed lying in bed with bilateral grab bars elevated. CNA 3 verified the findings. CNA 3 stated Resident 32 used the grab bars when turning during care.</p> <p>Medical record review for Resident 40 was initiated on 8/28/24. Resident 40 was admitted to the facility on [DATE].</p> <p>Review of Resident 40's H&P examination dated 2/24/24, showed Resident 40 had no capacity to understand and make decisions. Resident 40's niece was the responsible party and decision maker.</p> <p>Review of Resident 40's Order Summary Report showed a physician's order dated 3/8/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 40's Restraint and Other Devices Assessment and Reduction Management Program dated 2/23/24, showed the grab bars were selected under possible approaches in reducing restraints and the Least Restrictive Measures Attempted/In Place section was not completed. However, the assessment failed to show possible approaches were effective or ineffective prior to the use of bilateral grab bars.</p> <p>4. On 8/29/24 at 1037 hours, Resident 45 was observed lying in bed asleep with bilateral grab bars elevated. RNA 1 verified the bilateral grab bars were elevated. RNA 1 stated Resident 45 used the grab bars when turning during care and during transfer from bed to wheelchair.</p> <p>Medical record review for Resident 45 was initiated on 8/29/24. Resident 45 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 45's H&P examination dated 8/2/24, showed Resident 45 had capacity to understand and make decisions.</p> <p>Review of Resident 45's Order Summary Report showed a physician's order dated 7/8/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 45's Restraint and Other Devices Assessment and Reduction Management Program dated 7/8/24, showed the grab bars were selected under possible approaches in reducing restraints. However, the assessment failed to show the possible approaches identified in the assessment were effective or ineffective prior to the use of the bilateral grab bars.</p> <p>On 8/29/24 at 1312 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the grab bars were selected under possible approaches in the Restraint and Other Devices Assessment and Reduction Management Program form. The DON acknowledged proper assessment must be completed and least restrictive approaches should be tried prior to the use of bilateral grab bars.</p> <p>On 8/29/24 at 1441 hours, an interview was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and acknowledged the above findings.</p> <p>47474</p> <p>5. Medical record review for Resident 20 was initiated on 8/27/24. Resident 20 was admitted to the facility on [DATE].</p> <p>Review of Resident 20's H&P examination dated 6/6/24, showed Resident 20 had no capacity to understand and make decisions.</p> <p>Review of Resident 20's Order Summary Report dated August 2024 showed a physician's order dated 6/4/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 20's Restraint and Other Devices Assessment and Reduction Management Program dated 6/4/24, showed possible approaches used included the following:</p> <ul style="list-style-type: none"> - Demonstrated ability to use device(s) - Pillows - Device used as enabler - Bed on a low position - Grab bar(s) - Used for comfort <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Restrain and Other Devices Assessment and Reducing Management Program did not show documented evidence the least restrictive measures were assessed as to whether they were effectiveness or ineffectiveness prior to the use of the grab bars.</p> <p>6. Medical record review for Resident 366 was initiated on 8/27/24. Resident 366 was admitted to the facility on [DATE].</p> <p>Review of Resident 366's H&P examination dated 8/12/24, showed Resident 366 had the capacity to understand and make decisions.</p> <p>Review of Resident 366's Order Summary Report dated August 2024 showed a physician's order dated 8/10/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 366's assessment titled Restraint and Other Devices Assessment and Reduction Management Program dated 8/10/24, showed possible approaches used included the following:</p> <ul style="list-style-type: none"> - Demonstrated ability to use device(s) - Pillows - Device used as enabler - Grab bar(s) <p>The Restrain and Other Devices Assessment and Reducing Management Program did not show documented evidence the least restrictive measures were assessed for effectiveness or ineffectiveness prior to the use of the grab bars.</p> <p>On 8/29/24 at 1316 hours, medical record review and concurrent interview with RN 1 was conducted. RN 1 verified the above findings for Residents 20 and 366. RN 1 also verified there were no documented evidence the effectiveness of the least restrictive measures were assessed. RN 1 stated the least restrictive measures were not attempted prior to the use of the grab bars.</p> <p>On 8/29/24 at 1340 hours, medical record review and concurrent interview with the DON was conducted. The DON verified Residents 20 and 366's Restraint and Other Devices Assessment and Reducing Management Program did not show documented evidence the least restrictive measures effectiveness or ineffectiveness were assessed prior to the use of the grab bars. The DON verified and acknowledged the above findings.</p> <p>48882</p> <p>7. On 8/28/24 at 0827 hours and on 8/29/24 at 0738 hours, Resident 44 was observed in bed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 44 was initiated on 8/27/24. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 44's H&P examination dated 3/21/24, showed Resident 44 had the capacity to understand and make decisions.</p> <p>Review of Resident 44's Order Summary Report dated 8/28/24, showed a physician's order dated 2/28/23, to apply bilateral grab bars as enablers to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 44's Restraint and Other Devices Assessment and Reduction Management Program dated 2/28/23, failed to show documentation of the use of least restrictive measures prior to implementation of the bilateral grab bars.</p> <p>Review of Resident 44's Restraint and Other Devices Assessment and Reduction Management Program, quarterly review dated 7/25/24, under the section least restrictive measures attempted/in place, failed to show documentation of the measures that were attempted.</p> <p>On 8/28/24 at 0858 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 44 used the grab bars for positioning in bed.</p> <p>8. On 8/27/24 at 0948 hours and 8/29/24 at 0738 hours, Resident 59 was observed in bed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 59 was initiated on 8/27/24. Resident 59 was admitted to the facility on [DATE].</p> <p>Review of Resident 59's H&P examination dated 4/18/24, showed Resident 59 had no capacity to understand and make decisions.</p> <p>Review of Resident 59's Order Summary Report dated 8/28/24, showed a physician's order dated 4/16/24, to apply bilateral grab bars as enablers to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 59's Restraint and Other Devices Assessment and Reduction Management Program dated 4/16/24, showed the following approaches were selected: bed on a low position, frequent rest periods, frequent toileting, and grab bars. The assessment showed Resident 59 demonstrated the ability to use devices, and the device was used as an enabler. However, further review of the assessment failed to show documentation for the ineffectiveness of the other approaches.</p> <p>Review of Resident 59's Restraint and Other Devices Assessment and Reduction Management Program quarterly review dated 7/22/24, under the section least restrictive measures attempted/in place failed to show documentation of the measures that were attempted.</p> <p>On 8/28/24 at 0851 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 59 used the grab bars during care for turning and repositioning.</p> <p>On 8/29/24 at 1027 hours, an interview and concurrent record review for Resident 59 was conducted with LVN 8. LVN 8 verified Resident 59 had the bilateral grab bars and stated Resident 59 used the bilateral grab bars as enablers during his care.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/29/24 at 1312 hours, an interview and concurrent medical record review for Residents 44 and 59 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings. The MDS Coordinator stated she assumed if the least restrictive approaches were done during the initial assessment, then the least restrictive approaches did not need to be attempted during the quarterly reviews. The MDS Coordinator further stated upon quarterly review, she did not reevaluate Residents 44 and 59 for the least restrictive measures attempted/in place so she left that section blank. When asked, the MDS Coordinator stated all the sections of the assessment should be filled out completely and the least restrictive measures should be attempted with documentation of the effectiveness or ineffectiveness of each approach.</p> <p>On 8/29/24 at 1425 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>39670</p> <p>9. On 08/27/24 at 0939 hours and 08/28/24 at 0812 hours, an observation and concurrent interview with Resident 33 was conducted. Resident 33 was observed in bed with both upper grab bars were elevated. Resident 33 stated she used the grab bars while in bed.</p> <p>Medical record review for Resident 33 was initiated on 8/27/24. Resident 33 was admitted to the facility on [DATE].</p> <p>Review of Resident 33's H&P examination dated 7/15/24, showed Resident 33 had the capacity to understand and make decisions.</p> <p>Review of Resident 33's MDS dated [DATE], showed Resident 33 required moderate assistance of one staff for bed mobility and transfer.</p> <p>Review of Resident 33's Order Summary Report dated 8/28/24, showed a physician's order dated 7/13/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfer.</p> <p>Review of Resident 33's Restraint and Other Devices Assessment and Reduction Management Program form dated 7/13/24, showed the use of the bilateral grab bars as an enabler. However, the least restrictive interventions were left blank and not attempted prior to use of the grab bars in bed.</p> <p>On 8/29/24 at 1051 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 4. LVN 4 verified Resident 33's use of grab bars in bed with a physician's order. LVN 4 was asked about the least restrictive intervention attempted prior to use of the grab bars. LVN 4 verified the grab bars assessment was incomplete and there were no least restrictive interventions attempted prior to use of the grab bars.</p> <p>10. On 08/27/24 at 1005 hours and 08/28/24 at 0929 hours, Resident 34 was observed in bed with both upper grab bars were elevated.</p> <p>Medical record review for Resident 34 was initiated on 8/27/24. Resident 34 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 34's Order Summary Report dated 8/28/24, showed a physician's order dated 4/29/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 34's Restraint and Other Devices Assessment and Reduction Management Program form dated 4/29/24, showed the use of the bilateral grab bars as an enabler. The least restrictive interventions included the use of grab bars. In addition, there were no documented evidence for the least restrictive interventions were evaluated if they were effective or ineffective.</p> <p>On 8/28/24 at 1228 hours, an interview and concurrent medical record review for Resident 34 was conducted with LVN 4. LVN 4 verified Resident 34's used of the grab bars in bed. LVN 4 was asked about the least restrictive interventions for the use of grab bars in bed. LVN 4 verified there was no documentation if the least restrictive measures were effective or not.</p> <p>On 8/29/24 at 1453 hours, an interview and concurrent medical record review for Residents 33 and 34 was conducted with the MDS Coordinator. The MDS Coordinator was informed and verified the above findings.</p> <p>49644</p> <p>11. On 8/27/24 at 0850 hours, during the initial tour of the facility, Resident 48 was observed lying in bed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 48 was initiated on 8/27/24. Resident 48 was admitted to the facility on [DATE].</p> <p>Review of Resident 48's MDS dated [DATE], showed Resident 48's cognition was intact.</p> <p>Review of Resident 48's Order Summary Report showed a physician's order dated 7/5/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 48's Restraint and Other Devices Assessment and Reduction Management Program form dated 7/5/24, showed an incomplete form. The history of restraint use was not answered. Further review of the assessment showed the section for the possible approaches included grab bars.</p> <p>Review of Resident 48's Restraint and Other Devices Updates, undated, showed the form was not completed.</p> <p>Further review of Resident 48's medical record failed to show the least restrictive measures were evaluated if effective.</p> <p>On 8/28/24 at 1208 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 48's had the bilateral grab bars. LVN 5 stated Resident 48 was able to use the grab bar for turning and during the physical therapy.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/29/24 at 0844 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the history of restraint use was not answered, and the possible approaches included were pillows and grab bars. RN 1 stated the grab bars should not be included on the least restrictive possible approaches.</p> <p>On 8/29/24 at 1313 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the pillow and grab bars were included in the possible approaches section of Resident 48's Restraint and Other Devices Assessment and Reduction Management form. The DON stated the grab bars should not be included on the choices for the least restrictive possible approaches. The DON verified the section for the least restrictive measures attempted and in place was not completed on Resident 48's Restraint and Other Devices Updates form. The DON verified the question if the current measures effective on Resident 48's Restraint and Other Devices Updates form was not answered. The DON stated there should be a documentation if the least restrictive measure was effective or ineffective for Resident 48.</p> <p>50787</p> <p>12. On 8/27/24 0847 hours, Resident 17 was observed lying in bed with bilateral grab bars elevated.</p> <p>Medical record review for Resident 17 was initiated on 8/27/24. Resident 17 was admitted to the facility on [DATE].</p> <p>Review of Resident 17's quarterly MDS dated [DATE], showed Resident 17's BIMS score was 15 (means cognitively intact).</p> <p>Review of Resident 17's Order Summary Report dated 8/28/24, showed the physician's order dated 2/3/19, for the use of bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfer.</p> <p>Review of the Restraint and Other Devices Updates quarterly assessment dated [DATE], showed the bilateral grab bars were used as enabler for turning/ repositioning/transfers.</p> <p>Review of the ADL Functional/Rehabilitation Potential Care Plan did not show interventions/tasks to assess the risk for entrapment, the gaps between the mattress, bed fame and the reevaluation for the effectiveness of the grab bars use.</p> <p>On 8/29/24 at 1441 hours, the Administrator and MDS Coordinator were informed of the above findings.</p> <p>50953</p> <p>13. Medical record review for Resident 15 was initiated on 8/28/24. Resident 15 was admitted to the facility on [DATE].</p> <p>Review of Resident's 15 Order Summary Report showed a physician's order dated 5/20/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfer.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Quarterly Restraint and Other Devices Assessment and Reduction Management Program dated 8/21/24, showed an incomplete assessment of the least restrictive measure attempted in place.</p> <p>On 8/27/24 at 0850 hours, observation and interview was conducted with Resident 15. Resident 15 was observed in bed with the bilateral grab bars elevated. The resident stated the grab bars were for used turning.</p> <p>On 8/28/24 at 0802 hours, Resident 15 was observed in bed with the bilateral grab bars elevated. CNA 1 verified the findings and stated the grab bars helped Resident 15 with turning and repositioning.</p> <p>On 8/29/24 at 0937 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator verified and acknowledged the above findings.</p> <p>Cross references to F656 and F909.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>47474</p> <p>Based on observation, interview, and facility document review, the facility failed to ensure the DHPPD nurse staffing forms were accurately posted as per AFL (All Facility Letter) 18-27. This failure had the potential to result in inaccurate staffing information provided to the public.</p> <p>Findings:</p> <p>Review of the AFL 18-27 dated 6/29/18, showed beginning 7/1/2018, the facility shall either create a census and DHPPD form or use the Census and Direct Care Service Hours per Patient Day (CDPH 612 and instructions) to report daily DHPPD. The DON or designee must sign the form verifying the information is true and accurate. The census and DHPPD form must be typed or printed legible.</p> <p>If the facility chooses to create a form, it must contain substantially similar information to the attached CDPH 612 and instructions. The form must include:</p> <ol style="list-style-type: none"> 1. Facility name, address, and license number 2. Patient day date and the patient day start time 3. Total licensed SNF beds 4. Name of administrator and the DON or designee 5. Patient census at start of patient day 6. Scheduled nursing hours and the scheduled DHPPD 7. For the designated census periods: <ol style="list-style-type: none"> a. Beginning census b. Admissions c. Transfers in d. Other intakes that occurred e. Discharges f. Transfers out g. Deaths, and h. Other decreases that occurred <p>(continued on next page)</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. Total actual/final nursing hours at the end of each census period</p> <p>9. Average census</p> <p>10. The actual/final total nursing hours</p> <p>11. Actual/Final DHPPD</p> <p>12. An attestation statement signed by the DON or designee verifying they have reviewed the patient census and nursing hours information and acknowledge the information is true and correct.</p> <p>Review of the facility's document titled Daily Staff from 8/19 to 8/21/24 and 8/28/24, failed to show documented evidence of the facility's license number, total licensed bed capacity, name of the administrator and the DON or designee, designated census periods, actual nursing hours worked, actual DHPPD hours, or the DON or designee's signature to acknowledge the information posted are accurate and true.</p> <p>Review of the facility's document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 8/19 to 8/21/24, showed no documented evidence the DON or assigned designee signed the document.</p> <p>On 8/28/24 at 1434 hours, a facility document review and concurrent interview with the DSD was conducted. The DSD verified the above findings and stated the facility's document titled Daily Staff was incomplete. The DSD stated the Daily Staff document posted the projected nursing hours and denied the actual nursing hours were included on the document.</p> <p>On 8/28/24 at 1441 hours, a facility document review and concurrent interview with the Payroll Director was conducted. The Payroll Director stated she completed the DHPPD form and recorded the actual nursing hours, transfers, discharges, and admissions. Review of the DHPPD form dated 8/19 to 8/21/24, showed no documented evidence the DON or designee had signed the document. The Payroll Director stated the DON did not sign the DHPPD form daily but signed the form twice a month after the close of each pay period. The Payroll Director further verified the Daily Staff documents dated 8/19 to 8/21/24, were incomplete as per the ALF 18-27 guidelines.</p> <p>On 8/29/24 at 0904 hours, a facility document review and concurrent interview with the DON was conducted. The DON verified the facility document titled Daily Staff did not accurately reflect the information as per AFL 18-27 guidelines. The DON further verified she did not sign the DHPPD daily but signed the DHPPD on the 15th of the month and again at the end of the month. The DON stated the DHPPD should be signed daily to acknowledge staffing was accurately coordinated based on the census. The DON further stated if the census was high, the facility would have to increase the staffing to ensure the residents received proper care.</p> <p>On 8/29/24 at 1340 hours, an interview was conducted with the DON. The DON acknowledged the above findings.</p>

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NAME OF PROVIDER OR SUPPLIER LA Palma Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 LA Palma Ave Anaheim, CA 92801	
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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure accurate reconciliation, and disposal of medications.</p> <p>* The facility failed to ensure administration of the controlled medication for Resident 66 was documented in the controlled drug record and MAR.</p> <p>* The facility failed to ensure non-controlled medications were discarded by two licensed nurses.</p> <p>These failures posed the risk for diversion of medications.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Preparation and General Guidelines dated 8/2014, under the Controlled Medications section, showed when a controlled medication is administered, the license nurse administering the medication immediately enters the following information on the accountability record and the MAR:</p> <ul style="list-style-type: none"> - Date and time of administration; - Amount administered; - Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply; and - Initial of the nurse administering the dose on the MAR after the medication is administered. <p>On 8/28/24 at 1411 hours, an inspection of Medication Cart A and concurrent interview and medical record review with LVN 3 was conducted. Upon inspection of Medication Cart A, a bubble pack of clonazepam (antianxiety) medication for Resident 66 was observed with 25 tablets.</p> <p>Review of Resident 66's Antibiotic or Controlled Drug Record for the clonazepam medication showed one tablet of clonazepam medication was removed on 8/27/24 at 1700 hours, and the last count was 26 tablets of clonazepam medication.</p> <p>Medical record review for Resident 66 was initiated on 8/28/24. Resident 66 was admitted to the facility on [DATE].</p> <p>Review of Resident 66's Order Summary Report dated 8/28/24, showed a physician's order dated 8/9/24, to administer clonazepam 0.5 mg one tablet by mouth two times a day for anxiety manifested by verbalization of feeling anxious.</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 66's MAR for August 2024 did not show the clonazepam medication was administered after 8/27/24.</p> <p>Further review of Resident 66's medical record failed to show documented evidence the clonazepam medication was administered to Resident 66 after 8/27/24.</p> <p>LVN 3 verified the above findings. LVN 3 stated she administered the clonazepam medication to Resident 66 today (8/28/24) at 0900 hours. LVN 3 acknowledged she did not document on the controlled drug record when she removed the clonazepam medication and she did not document on the MAR when she administered the clonazepam medication to Resident 66.</p> <p>On 8/28/24 at 1612 hours, an interview and concurrent facility document review was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>2. Review of the facility's P&P titled Medical Waste Management revised 3/2017 showed pharmaceutical waste which consists of hazardous and non-hazardous prescription drugs will be collected for disposal and two nurses will dispose of non-narcotic medications.</p> <p>On 8/28/24 at 0816 hours, an interview and concurrent facility document review was conducted with RN 1. When asked about the disposal of the non-controlled medications, RN 1 stated two licensed nurses removed the sticker from the bubble packs, placed them in the drug disposition record, recorded the quantity of the medication to be disposed and then discarded the medications into a bin. RN 1 stated the drug disposition record should be signed by two licensed nurses.</p> <p>Review of the Medication Disposition Record/Pass Log showed non-controlled medications were disposed on 8/25/24, but were only signed by one licensed nurse.</p> <p>RN 1 verified the above findings.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure three of five residents reviewed for unnecessary medications (Residents 15, 36, and 44) were free from the unnecessary psychotropic medications.</p> <p>* The facility failed to ensure a specific behavior manifestation was identified for Resident 15 related to the use of divalproex (antipsychotic medication). The facility failed to ensure accurate monitoring for Resident 15's orthostatic blood pressure (measurement of the blood pressure while laying down and sitting) as ordered by the physician related to the use of an antipsychotic medication, when the blood pressure readings for Resident 15 had the same results for sitting and lying. In addition, the facility failed to ensure accurate monitoring for Resident 15's meal intake related to the use of mirtazapine (antidepressant) medication. Resident 15's meal intake monitoring documented in the MAR by the licensed nurses did not match the meal intake monitoring documented in the POC (Point of Care) Legend Report by the CNAs. Furthermore, the monthly behavior summary for Resident 15's poor intake did not match Resident 15's meal intake monitoring in the MAR nor the POC Legend Report.</p> <p>* The facility failed to ensure accurate monitoring for Resident 36's meal intake related to the use of mirtazapine medication. Resident 36's meal intake monitoring documented in the MAR by the licensed nurses did not match the meal intake monitoring documented in the POC (Point of Care) Legend Report by the CNAs.</p> <p>* The facility failed to ensure accurate monitoring for orthostatic hypotension (measurement of the blood pressure reading while laying down and sitting) as ordered by the physician for the use of an antipsychotic medication for Resident 44.</p> <p>These failures had the potential for residents to develop significant adverse effects from the medications and had the potential to negatively impact the residents' well-being.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Psychotropic Drug Treatment revised 9/2017, under the Additional Criteria for Use of Antipsychotic Medication for BPSD (behavioral or Psychological Symptoms of Dementia) section, showed before initiating or increasing an antipsychotic medication, the target behavior must be clearly and specifically identified and documented. The monitoring must ensure that the behavioral symptoms are not due to a medical condition or problem such as pain, fluid or electrolyte imbalance, infection, side effects of medication, etc., that can be expected to improve or resolve by treating the underlying condition, and not due to an environmental stressors that can be addressed to improve the symptoms, and not due to psychological stressors alone that can be addressed to improve or resolve the symptoms and persistent.</p> <p>Medical record review for Resident 15 was initiated on 8/27/24. Resident 15 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 15's Order Summary Report dated 8/30/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 5/21/24, to administer divalproex 250 mg one tablet by mouth three times a times for bipolar disorder manifested by mood swings; - dated 5/21/24, to monitor BP (blood pressure) when lying once a week every Sunday on the 0700 to 1500 shift; - dated 5/21/24, to monitor BP when sitting once a week every Sunday on the 0700 to 1500 shift; - dated 5/21/24, to monitor meal percentage less than 50%; - dated 6/21/24, to administer mirtazapine 7.5 mg one tablet by mouth at bedtime for depression manifested by poor appetite; and -dated 7/26/24, to administer risperidone (antipsychotic medication) 0.5 mg one tablet by mouth two times a day for psychosis manifested by sudden angry outburst towards staff. <p>a. Review of Resident 15's medical record failed to show documentation of the specific behavior manifestation or failed to specify what behavior was considered mood swing to justify Resident 15's use of the divalproex medication.</p> <p>Review of Resident 15's MAR for July and August 2024 showed the following:</p> <ul style="list-style-type: none"> - Resident 15 was administered divalproex 250 mg on 7/1 to 8/28/24 at 0900, 1300, and 1700 hours, and on 8/29/24 at 0900 hours; - Resident 15 was administered mirtazapine 7.5 mg on 7/1 to 8/28/24 at 2100 hours; and - Resident 15 was administered risperidone 0.5 mg on 7/26 at 1700 hours, on 7/27 to 8/28/24 at 0900 and 1700 hours, and on 8/29/24 at 0900 hours. <p>b. Further review of Resident's MAR for July and August 2024 showed orthostatic hypotension (lying and sitting) were scheduled to be monitored every Sunday. However, Resident 15's orthostatic blood pressure was checked almost daily, and the blood pressure readings for both positions (lying and sitting) were the same as follows:</p> <ul style="list-style-type: none"> - On 7/1/24, the blood pressure readings were 108/69 mmHg for sitting position and 108/69 mmHg for the lying position. - On 7/3/24, the blood pressure readings were 128/76 mmHg for sitting position and 128/76 mmHg for the lying position. - On 7/4/24, the blood pressure readings were 126/74 mmHg for sitting position and 126/74 mmHg for the lying position. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - On 7/6/24, the blood pressure readings were 130/65 mmHg for sitting position and 118/70 mmHg for the lying position. - On 7/7/24, the blood pressure readings were 134/70 mmHg for sitting position and 134/70 mmHg for the lying position. - On 7/9/24, the blood pressure readings were 98/62 mmHg for sitting position and 98/62 mmHg for the lying position. - On 7/12/24 the blood pressure readings were 128/70 mmHg for sitting position and 128/70 mmHg for the lying position. - On 7/13/24, the blood pressure readings were 132/70 mmHg for sitting position and 132/70 mmHg for the lying position. - On 7/18/24, the blood pressure readings were 133/64 mmHg for sitting position and 133/64 mmHg for the lying position. - On 7/20/24, the blood pressure readings were 128/65 mmHg for sitting position and 128/65 mmHg for the lying position. - On 7/21/24, the blood pressure readings were 128/70 mmHg for sitting position and 128/70 mmHg for the lying position. - On 7/22/24, the blood pressure readings were 98/66 mmHg for sitting position and 98/66 mmHg for the lying position. - On 7/25/24, the blood pressure readings were 125/72 mmHg for sitting position and 125/72 mmHg for the lying position. - On 7/26/24, the blood pressure readings were 122/68 mmHg for sitting position and 122/68 mmHg for the lying position. - On 7/27/24, the blood pressure readings were 122/70 mmHg for sitting position and 122/70 mmHg for the lying position. - On 7/28/24, the blood pressure readings were 126/70 mmHg for sitting position and 126/70 mmHg for the lying position. - On 7/31/24, the blood pressure readings were 101/68 mmHg for sitting position and 101/68 mmHg for the lying position. - On 8/1/24, the blood pressure readings were 112/70 mmHg for sitting position and 112/70 mmHg for the lying position. - On 8/4/24, the blood pressure readings were 119/70 mmHg for sitting position and 119/70 mmHg for the lying position. <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 8/8/24, the blood pressure readings were 124/70 mmHg for sitting position and 124/70 mmHg for the lying position.</p> <p>- On 8/9/24, the blood pressure readings were 124/67 mmHg for sitting position and 124/67 mmHg for the lying position.</p> <p>- On 8/11/24, the blood pressure readings were 110/76 mmHg for sitting position and 110/76 mmHg for the lying position.</p> <p>- On 8/14/24, the blood pressure readings were 119/64 mmHg for sitting position and 119/76 mmHg for the lying position.</p> <p>- On 8/16/24, the blood pressure readings were 130/65 mmHg for sitting position and 130/65 mmHg for the lying position.</p> <p>- On 8/21/24, the blood pressure readings were 115/56 mmHg for sitting position and 115/56 mmHg for the lying position.</p> <p>- On 8/25/24, the blood pressure readings were 128/70 mmHg for sitting position and 128/70 mmHg for the lying position.</p> <p>- On 11/29/23, the blood pressure readings were 118/70 mmHg for sitting position and 118/70 mmHg for the lying position.</p> <p>c. In addition, review of the MAR for July and August 2024 showed Resident 15's meal percentage less than 50% was being monitored as follows:</p> <p>- on 7/7 and 8/7/24, Resident 15 consumed 20% for breakfast on 7/24/24, and consumed 50% for breakfast;</p> <p>- on 7/7, 7/22, 7/24, and 7/25/24, Resident 15 consumed 50% for lunch; and</p> <p>- on 7/18 and 8/21/24, the resident refused dinner and on 7/28/24, Resident 15 consumed 30% for dinner.</p> <p>However, Resident 15's meal intake documentation as shown in the MAR for July and August did not match the CNA documentation of Resident 15's meal intake documentation. For example, review of the POC (Point of Care) Legend Report for July and August 2024 showed the following:</p> <p>- on 7/1/24, Resident 15 consumed 0 to 25% for lunch,</p> <p>- on 7/5 and 7/6/24, Resident 15 consumed 0 to 25% for breakfast .</p> <p>- on 7/5, 7/6, 7/13, 7/18, 7/27, 7/30, 8/5, 8/6, 8/20, and 8/24/24, the resident consumed 26 to 50% for dinner;</p> <p>- on 7/7, 7/11, 7/23, 7/24, 7/28, 7/31, 8/2, 8/7, 8/14, 8/15, 8/16, 8/15, 8/16, 8/20, 8/21, 8/24, and 8/26/24, Resident 15 consumed 26 to 50% for breakfast;</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 7/7, 7/12, 7/16, 7/23, 7/24, 8/1, 8/3, 8/8, 8/9, 8/13, 8/14, 8/15,8/18, 8/20, 8/22, 8/24, 8/25, and 8/27/24, the resident consumed 26 to 50% for lunch;</p> <p>- on 7/12 and 8/21/24, Resident 15 consumed 0 to 25% for dinner; and</p> <p>- on 8/21/24, Resident 15 refused lunch.</p> <p>d. Furthermore, review of the Psychotherapeutic Drug Summary Sheet for poor intake behavior manifestation failed to show the number of behavior episodes were accurately monitored. For example, for July 2024, a total of two behavior episodes were documented. This did not match the documentation of Resident 15's meal intake of less than 50% as documented in the MAR by the licensed nurses, or in the POC Legend Report by the CNAs.</p> <p>On 8/29/24 at 0908 hours, an observation for Resident 15 and concurrent interview was conducted with CNA 2. Resident 15 was observed awake in bed, touching and scratching her forehead. When asked about Resident 15's behavior, CNA 2 stated Resident 15 was confused but was not aggressive, and had not seen Resident 15 become angry. CNA 2 stated Resident 15 did not refuse care, and the resident would often say do whatever you want when asked to assist her with ADL care. When asked about Resident 15's meal intake, CNA 2 stated Resident 15 did not eat a lot and ate mostly less than 50%. CNA 2 stated when Resident 15 ate less than 50%, she offered health shake to Resident 15 and informed the charge nurse.</p> <p>On 8/29/24 at 0916 hours, an interview for Resident 15 was conducted with LVN 3. LVN 3 stated Resident 15 was alert but confused. LVN 3 verified Resident 15 was taking divalproex medication for bipolar disorder manifested by mood swings. When asked what they monitored regarding the mood swings, LVN 3 stated Resident 15 had mood swings when one day she was really happy, and then the next day, she did not want to take two of her medications, or in the afternoon shift, she had mood changes when she became verbally aggressive to the staff. When asked about Resident 15's meal intake, LVN 3 stated Resident 15 ate pretty well, around 50 to 75% of the meal served.</p> <p>On 8/29/24 at 0955 hours, an interview and concurrent interview for Resident 15 was conducted with the DON. The DON was informed and verified the above findings. When asked about the Resident 15's mood swings related to the use of divalproex medication, the DON stated Resident 15's mood swings were related to Resident 15's angry outburst. The DON acknowledged Resident 15 was also taking risperidone medication related to the resident's sudden angry outburst towards staff. The DON verified the target behavior of mood swings related to the use divalproex medication was not specific. The DON verified the orthostatic BP monitoring was not accurately monitored and stated that there should be a difference of the resident's BP when the resident was sitting and lying. The DON also stated the orthostatic BP should only be monitored every Sunday per the physician's order. When asked about the monthly behavior summary on Resident 15's poor meal intake related to the use of mirtazapine medication, the DON stated the licensed nurse tallied the behavior and the adverse reactions from documentation in the MAR. The DON verified the behavior summary sheet did not match the MAR. The DON stated she would find a way for the licensed nurse documentation match the CNAs' documentation of Resident 15's meal intake.</p> <p>2. Medical record review for Resident 36 was initiated on 8/27/24. Resident 36 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 36's Order Summary Report dated 8/29/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 2/19/24, to administer mirtazapine 15 mg one tablet by mouth at bedtime for depression manifested by poor appetite; and - dated 7/26/24, to monitor meal percentage less than 50%. <p>Review of Resident 36's MAR for July and August 2024 showed the following:</p> <ul style="list-style-type: none"> - on 7/1 to 8/28/24 at 2100 hours, Resident 36 was administered mirtazapine 15 mg tablet; - on 7/1, 7/3, 7/9, 7/10, 7/14, 7/15, 7/17, 7/23 and 8/23/24, Resident 36 consumed 0% for breakfast; - on 7/1, 7/2, 7/3, 7/8, 7/9, 7/10, 7/15, 7/17, 7/23, and 7/24/24, Resident 36 consumed 0% for lunch; - on 7/1, 7/15, 7/17, 7/23, 7/25, and 7/28/24, Resident 36 consumed 50% for dinner; - on 7/2, 7/8, 7/16, 7/24, 7/25, 7/26, 7/29 and 8/21/24, consumed 50% for breakfast; - on 7/2/24, Resident 36 consumed 0% for dinner; - on 7/6, 7/7, and 7/24/24, Resident 36 consumed 25% for dinner; - on 7/7/24, the resident consumed 25% for breakfast; - on 7/7/24, Resident 36 consumed 25% for lunch; - on 7/18/24, Resident 36 refused dinner; and - on 7/25/24, Resident 36 consumed 50% for lunch. <p>a. However, Resident 36's meal intake documentation as shown in the MAR for July and August 2024 did not match the CNA documentation of Resident 36's meal intake. For example, review of the POC Legend Report for July and August 2024 showed the following:</p> <ul style="list-style-type: none"> - on 7/1, 7/4, 7/5, 7/6, 7/10, 7/13, 7/18, 7/19, 7/24, 7/25, 7/26, 7/27, 7/30, 7/31, 8/6, 8/9, and 8/10/24, Resident 36 consumed 26 to 50% for dinner; - on 7/3, 7/4, 7/7, 7/14, 7/22, 7/27, 7/29, 8/15, 8/18, 8/24, 8/25, 8/26, and 8/28/24, Resident 36 consumed 26 to 50% for lunch; - on 7/14, 7/16, 7/30, 8/1, 8/3, 8/8, 8/11, 8/17, 8/22, 8/23, 8/24, and 8/25/24, Resident 36 consumed 26 to 50% for breakfast; and - on 7/30/24, Resident 36 consumed 0 to 25% for lunch. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. In addition, review of the Psychotherapeutic Drug Summary Sheet for poor appetite behavior manifestation failed to show the number of behavior episodes was accurately monitored. For example, for July 2024, a total of 19 behavior episodes were documented. This did not match the documentation of Resident 36's meal intake of less than 50% as documented in the MAR by the licensed nurses, or in the POC Legend Report by the CNAs.</p> <p>On 8/29/24 at 0901 hours, an observation of Resident 36 and concurrent interview was conducted with CNA 2. Resident 36 was observed awake, and sitting in the wheelchair in front of her room. When asked about Resident 36's meal intake, CNA 2 stated Resident 36 did not eat a lot, on liquid diet and ate mostly less than 50%. CNA 2 stated when Resident 36 ate less than 50% she offered a health shake to Resident 36 and informed the charge nurse.</p> <p>On 8/29/24 at 0913 hours, an interview for Resident 36 was conducted with LVN 3. When asked about Resident 36's meal intake, LVN 3 stated Resident 36 ate about 75% of her meals. LVN 3 stated the charge nurses checked the trays before and after resident meals, then documented the meal intake in the MAR.</p> <p>On 8/29/24 at 0955 hours, an interview and concurrent interview for Resident 36 was conducted with the DON. The DON was informed and verified the above findings. When asked about the monthly behavior summary on Resident 36's poor meal intake related to the use of mirtazapine medication, the DON verified the behavior summary sheet did not match the MAR. The DON stated the licensed nurses and CNAs should coordinate regarding the residents' meal intake monitoring.</p> <p>48882</p> <p>3. Medical record review for Resident 44 was initiated on 8/27/24. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 44's H&P examination dated 3/21/24, showed Resident 44 had the capacity to understand and make decisions.</p> <p>Review of Resident 44's Order Summary Report dated 8/28/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 1/17/24, for Risperdal (antipsychotic medication) to administer 1 mg tablet by mouth two times a day for schizoaffective disorder (a chronic mental illness that causes people to experience both schizophrenia and a mood disorder at the same time), manifested by episodes of sudden angry outburst toward staff, - dated 3/2/24, to monitor the BP in the lying position for orthostatic hypotension, every Sunday during the 0700 to 1500 hour shift, and - dated 3/2/24, to monitor the BP in the sitting position for orthostatic hypotension, every Sunday during the 0700 to 1500 hour shift. <p>Review of Resident 44's MAR for August 2024 showed orthostatic BP (lying and sitting) readings were scheduled to be monitored every Sunday. However, the BP readings for both positions (lying and sitting) were the same as follows:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 8/11/24, the BP readings were 132/82 mmHg for the sitting position and 132/82 mmHg for the lying position.</p> <p>- On 8/25/24, the BP readings were 128/70 mmHg for the sitting position and 128/70 mmHg for the lying position.</p> <p>On 8/28/24 at 1402 hours, an interview and concurrent medical record review for Resident 44 was conducted with LVN 5. LVN 5 reviewed the medical record for Resident 44 and verified the above findings. LVN 5 stated the BP readings for the lying and sitting positions should be different.</p> <p>On 8/29/24 at 1425 hours, an interview and concurrent medical record review for Resident 44 was conducted with the DON. The DON stated the expectation of staff when monitoring orthostatic hypotension was to check the resident's BP in two different positions, and to compare the two BPs to see if the resident's BP was affected by the position change. The DON reviewed Resident 44's medical record and stated the BP readings should not be the same and staff were not monitoring for orthostatic hypotension accurately. The DON was informed and acknowledged the above findings.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.14%. One of two licensed nurses (LVN 5) who were observed during the medication administration was found to have made errors.</p> <p>* LVN 5 failed to administer the metoprolol (antihypertensive medication) and diltiazem (antihypertensive medication) as per the physician's order when LVN 5 failed to ensure Resident 16's heart rate was taken prior to administering the medications. This failure had the potential for Resident 16 to develop significant side effects from the medications and affect Resident 16's health condition.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Preparation and General Guidelines dated 10/2017, under the Medication Administration- General Guidelines section, showed the medications are administered in accordance with written orders of the attending physician.</p> <p>On 8/28/24 at 0943 hours, a medication administration observation for Resident 16 was conducted with LVN 5. LVN 5 was observed checking Resident 16's BP. Then, LVN 5 prepared the following medications for Resident 16:</p> <ul style="list-style-type: none"> - one tablet of famotidine (antacid) 20 mg; - one tablet of clopidogrel (anticoagulant) 75 mg; - one tablet of cranberry (supplement) 450 mg; - one tablet of vitamin B12 (supplement) 1000 mcg; - one capsule of diltiazem (antihypertensive medication) 120 mg; - one softgel of docusate sodium (stool softener) 250 mg; - one tablet of metoprolol (antihypertensive medication) 25 mg; - one tablet of multivitamins with minerals (supplement) - two tablets of Geri-kot (stool softener) 8.6 mg; - one capsule of tamsulosin (alpha blocker, used to relax the smooth muscles on the prostate and bladder) 0.4 mg; and - one tablet of vitamin C (supplement) 500 mg. <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review for Resident 16 was initiated on 8/27/24. Resident 16 was admitted to the facility on [DATE].</p> <p>Review of Resident 16's Order Summary Report showed the following physician's orders dated 9/20/21:</p> <ul style="list-style-type: none"> - To administer diltiazem 120 mg one capsule by mouth one time a day for hypertension; hold the medication if the SBP (systolic blood pressure) less than 110 mmHg, or heart rate less than 60 beats per minute; and check BP and heart rate prior to giving medication; and - To administer metoprolol 25 mg one tablet by mouth two times a day for hypertension; hold the medication if SBP less than 110 mmHg, or heart rate less than 60 beats per minute; and check BP and heart rate prior to giving medication. <p>On 8/28/24 at 0958 hours, LVN 5 was observed bringing the prepared medications to Resident 16. When LVN was asked what Resident 16's heart rate was, before administering Resident 16's BP medications, LVN 5 stated she did not check Resident 16's heart rate but only checked the resident's BP. LVN 5 proceeded to administer the medications to Resident 16.</p> <p>On 8/29/24 at 1044 hours, an interview and concurrent medical record review for Resident 16 was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the medications should be administered as ordered by the physician. The DON stated she expected the licensed nurses to check the heart rate and BP, and follow the parameters as ordered for the medication administration.</p> <p>Cross reference to F760.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453</p> <p>Based on observation, interview, medical record review, and facility P&P review the facility failed to ensure one nonsampled resident (Resident 16) was free from the significant medication error.</p> <p>* The facility failed to ensure Resident 16's heart rate was taken prior to administering the metoprolol (antihypertensive medication) and diltiazem (antihypertensive medication) medications. This failure had the potential to cause Resident 16 to have abnormally slow heart rate and negatively affect the resident's health.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Preparation and General Guidelines dated 10/2017 under the Medication Administration- General Guidelines section, showed medications are administered in accordance with written orders of the attending physician.</p> <p>On 8/28/24 at 0943 hours, a medication administration observation for Resident 16 was conducted with LVN 5. LVN 5 prepared and administered Resident 16's medications including one tablet of metoprolol 25 mg and one capsule of diltiazem 120 mg. LVN 6 was observed not obtaining Resident 16's heart rate prior to administering the metoprolol and diltiazem medications.</p> <p>Medical record review for Resident 16 was initiated on 8/27/24. Resident 16 was admitted to the facility on [DATE].</p> <p>Review of Resident 16's Order Summary Report showed the following physician's orders dated 9/20/21:</p> <ul style="list-style-type: none"> - To administer diltiazem 120 mg one capsule by mouth one time a day for hypertension; hold the medication if the SBP less than 110 mmHg, or the heart rate less than 60 beats per minute; and check the BP and heart rate prior to giving medication; and - To administer metoprolol 25 mg one tablet by mouth two times a day for hypertension; hold the medication if the SBP less than 110 mmHg, or the heart rate less than 60 beats per minute; and check the BP and heart rate prior to giving medication. <p>On 8/28/24 at 0958 hours, LVN 5 an interview was conducted with LVN 5. LVN 5 stated she forgot to check Resident 16's heart rate. LVN 5 verified she did not check Resident 16's heart rate prior to administering the metoprolol and diltiazem medications to the resident.</p> <p>On 8/29/24 at 1044 hours, the DON was informed and acknowledged the above findings.</p> <p>Cross reference to F759.</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>39453</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of medications.</p> <p>* The facility failed to ensure the medications for Residents 22 and 53 who were discharged to home, Resident 2 who was transferred out of the facility, and Resident 63 who had expired was removed from the current medication supply in Medication Room A and Medication Cart A.</p> <p>* The facility failed to ensure the expired medications had been removed from the current medication supply in Medication Cart B.</p> <p>* The facility failed to ensure the opened foil pouches of inhalation solution medications for Residents 5, 15, and 40 in Medication Cart A were labeled with an opened date.</p> <p>* The facility failed to ensure the bubble packs (a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil to take the medication) containing medication tablets for Residents 2, 16, 37, and 45 remained intact and free from tears.</p> <p>* The facility failed to ensure the orally administered medications were stored separate from externally used medications.</p> <p>* The facility failed to ensure Resident 55's inhalation solution medication was not left unattended on top of the medication cart.</p> <p>* The facility failed to ensure Resident 37's insulin pen was not left unattended on the resident's bedside table.</p> <p>These failures had the potential to negatively impact the residents' well-being, the potential for the medications to lose the stability and effectiveness; and the potential for the residents, staff, and visitors to have access to the medications.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Storage in the Facility dated 4/2008 under the Storage of Medications section, showed the following:</p> <ul style="list-style-type: none"> - Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions; and - Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. <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>Review of the drug label information for budesonide inhalation suspension (bronchodilator) revised 8/2024 showed budesonide inhalation suspension ampules can be stored for two weeks after opening the protective aluminum foil envelope. Throw away budesonide suspension ampules if not used within two weeks of opening the protective aluminum foil envelope.</p> <p>Review of the drug label information for albuterol sulfate inhalation solution dated 6/26/24, showed to store the unit-dose vials in the protective foil pouch at all times. Once removed from the foil pouch, to use the vial(s) within two weeks.</p> <p>Review of the drug label information for ipratropium bromide and albuterol sulfate (bronchodilator) inhalation solution revised 6/2024 showed unit dose vials should remained stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week.</p> <p>1. On 8/28/24 at 0816 hours, an inspection of Medication Room A and concurrent interview and medical record review was conducted with RN 1. The following was observed:</p> <p>a. A box containing promethegan (antiemetic medication) 25 mg rectal suppository for Resident 63 was observed inside the refrigerator used for medications.</p> <p>Closed medical record review for Resident 63 was initiated on 8/28/24.</p> <p>Review of Resident 63's medical record showed physician's order dated 8/13/24, to release body to mortician per family's request.</p> <p>b. Two gallons of colon electrolyte lavage (a solution used to cleanse the bowel before certain medical tests) for Resident 53 was observed inside the medication refill cabinet.</p> <p>Closed medical record review for Resident 53 was initiated on 8/28/24.</p> <p>Review of Resident 53's medical record showed physician's order dated 7/31/24, to discharge to home.</p> <p>c. A bubble pack of famotidine (antacid medication) 40 mg tablets for Resident 22 was also observed inside the medication refill cabinet.</p> <p>Closed medical record review for Resident 22 was initiated on 8/28/24.</p> <p>Review of Resident 22's medical record showed physician's order dated 8/22/24, to discharge to home with remaining medication.</p> <p>d. Several bubble packs containing oral medications were observed stored with boxes of ipratropium bromide and albuterol sulfate (bronchodilator medication) inhalation units, and diclofenac (NSAID, non-steroidal anti-inflammatory drug) topical cream.</p> <p>RN 1 verified the above findings.</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>2. On 8/28/24 at 1411 hours, an inspection of Medication Cart A, and concurrent interview and medical record review was conducted with LVN 3. The following was observed:</p> <p>a. A bubble pack containing metoprolol (antihypertensive) 10 mg tablet for Resident 45 was observed with a tear on one of the foil blister packs, and the back of the blister pack was taped with a directions changed refer to chart sticker.</p> <p>Medical record review for Resident 45 was initiated on 8/27/24.</p> <p>Review of Resident 45's Order Summary Report showed a physician's order dated 7/8/24, to administer metoprolol 50 mg one tablet by mouth two times a day.</p> <p>b. A bottle of Velphoro (phosphate binder medication used to control serum phosphorus levels), and a bottle of chewable calcium carbonate (supplement) tablet were stored with a box of estradiol (hormone) vaginal cream.</p> <p>c. A bottle of lactulose (laxative medication), a bottle of gerilax (laxative medication), and a bottle of elder tonic multivitamin (supplement) were stored with a box of containing fluticasone (corticosteroid) nasal spray.</p> <p>d. A box containing an opened foil pouch with budesonide (corticosteroid) inhalation units for Resident 40 was observed without an opened date.</p> <p>Medical record review for Resident 40 was initiated on 8/27/24.</p> <p>Review of Resident 40's Order Summary Report showed a physician's order dated 4/26/24, to administer budesonide inhalation suspension 0.5 mg/2 ml via nebulizer every 12 hours.</p> <p>e. A box containing an opened foil pouch with albuterol sulfate inhalation units for Resident 15 was observed without an opened date.</p> <p>Medical record review for Resident 15 was initiated on 8/27/24.</p> <p>Review of Resident 15's Order Summary Report showed a physician's order dated 8/21/24, to administer albuterol solution 2.5 mg/3 ml via nebulizer every four hours as needed.</p> <p>f. A box containing an opened foil pouch with ipratropium bromide and albuterol sulfate inhalation units for Resident 5 was observed without an opened date.</p> <p>Medical record review for Resident 5 was initiated on 8/27/24.</p> <p>Review of Resident 5's Order Summary Report showed a physician's order dated 4/10/24, to administer ipratropium-albuterol solution 0.5-2.5 mg/3 ml via nebulizer every four hours.</p> <p>g. A bubble pack containing hydrocodone/APAP (opioid narcotic medication used to relieve severe pain) 10-325 mg for Resident 2 was observed with a tear on one of the foil blister packs. In addition, the bubble pack of hydrocodone/APAP was observed stored with the current narcotic medications.</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>Closed medical record review for Resident 2 was initiated on 8/27/24.</p> <p>Review of Resident 2's medical record showed a physician's order dated 8/26/24, to transfer the resident to the acute care hospital.</p> <p>LVN 3 verified the above findings.</p> <p>3. On 8/28/24 at 1447 hours, an inspection of Medication Cart B (IV medication cart), interview, and concurrent medical record review was conducted with RN 1. The following was observed:</p> <ul style="list-style-type: none"> - Five pieces of povidone iodine (antiseptic) 0.6 ml/1% topical solution swabs had expired on 2/2023; - Eight pieces of povidone iodine 0.6 ml/1% topical solution swabs had expired on 5/2023: and - 34 pieces of povidone iodine topical solution swabsticks had expired on 7/20/24. <p>RN 1 verified the above findings.</p> <p>4. On 8/28/24 at 0943 hours, a medication administration observation for Resident 16 was conducted with LVN 5. The bubble pack containing famotidine 20 mg for Resident 16 was observed with a tear on one of the foil blister packs. LVN 5 verified the above findings.</p> <p>5. On 8/28/24 at 1007 hours, a medication administration observation for Resident 37 was conducted with LVN 3. The bubble pack containing icosapent ethyl (antilipemic medication used to decrease high fat levels) one gram for Resident 37 was observed with a tear on one of the foil blister packs. LVN 3 verified the above findings.</p> <p>6. On 8/28/24 at 0916 hours, a medication administration observation for Resident 55 was conducted with LVN 3. After preparing Resident 55's medications including ipratropium-albuterol medication, LVN 3 was observed leaving the ipratropium-albuterol inhalation unit dose on top of the medication cart and proceeded to enter Resident 55's room. LVN 3 was also observed going to the resident's bathroom and washed her hands. The medication was out of LVN 3's reach and sight. Several staff were observed passing by the medication cart with the ipratropium-albuterol medication on top of the medication cart. LVN 3 verified the above findings.</p> <p>7. On 8/28/24 at 1007 hours, a medication administration observation for Resident 37 was conducted with LVN 3. After preparing Resident 37's medications including Lantus (long-acting insulin, use for diabetic) insulin pen. LVN 3 was observed leaving the Lantus insulin pen unit dose on top of Resident 37's bedside table. LVN 3 was also observed going to the resident's bathroom and washed her hands. The medication was out of LVN 3's reach and sight. LVN 3 verified the above findings.</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>43119</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by:</p> <ul style="list-style-type: none"> * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the scoops used for food portioning were air dried and clean prior to storing. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good conditions. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the heavy-duty blenders used for puree preparation, the clear measuring containers, and the pink plastic drinking cups were air dried prior to storing. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the microwave utilized to warm up the residents' food was in sanitary condition and free of food residue. * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. <p>These failures had the potential to cause foodborne illnesses for the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's matrix showed 60 of 62 residents consumed food prepared in the kitchen.</p> <p>1. Review of the facility's P&P titled Sanitation and Infection Control dated 2011 showed cutting boards will be cleaned and sanitized after each use. Wash in hot soapy water, rinse, sanitize and air dry. May also be sanitized in the dish machine if dishware safe.</p> <p>According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces.</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 8/27/24 at 0817 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. One white, one blue, and two green cutting boards were observed with deep grooves, heavily marred, discolored, and fuzzy. The Dietary Director acknowledged the findings and stated new cutting boards were ordered.</p> <p>2. Review of the facility's P&P titled Sanitation and Infection Control dated 2011 showed all kitchen ware equipment and surfaces which come in contact with food will be cleaned and sanitized after each use.</p> <p>According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food.</p> <p>According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying.</p> <p>On 8/27/24 at 0830 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. Five scoops with green, white, and gray handles used for food portioning were observed stored inside the counter drawer still wet, with visible water inside and had dry, crusted food residue. The Dietary Director verified the above findings.</p> <p>3. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded.</p> <p>According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.</p> <p>a. On 8/27/24 at 0810 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Assistant Director, the following was observed:</p> <ul style="list-style-type: none"> - Four stainless spatulas with white, black, and brown handles were chipped, deformed with rough edges, and worn off. - One can opener with white handle was observed dirty and had yellowish discoloration (metal part) which resembled rust. - One black peeler was observed dirty and worn off. - One yellow lemon squeezer was observed dirty with brownish stain and chipped yellow coating. - One rolling pin used for pizza was observed heavily marred and had brownish stain. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER LA Palma Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 LA Palma Ave Anaheim, CA 92801	

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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>The Dietary Assistant Director verified the above findings and stated the spatulas, can opener, peeler, lemon squeezer and rolling pin should not be used to prevent food contamination.</p> <p>b. On 8/27/24 at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director, the following was observed:</p> <ul style="list-style-type: none"> - One stainless slotted scooper was observed with a partially melted black handle. - Two rubber spatulas were observed chipped and discolored with partially melted red handles. - One stainless strainer was observed dirty with brownish stain and deformed. <p>The Dietary Director verified the above findings and stated the scooper, spatulas, and strainer should have been replaced.</p> <p>4. Review of the facility's P&P titled Sanitation and Infection Control dated 2011 showed all equipment should be sanitized to prevent the spread of disease and infection. All kitchen ware equipment and surfaces which come in contact with food will be cleaned and sanitized after each use.</p> <p>According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.</p> <p>a. On 8/27/24 at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. Two silver tongs were observed with dry and crusted brownish residue. The Dietary Director verified the above findings and stated the tongs would be discarded.</p> <p>b. On 8/27/24 at 0830 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. One white basting brush was observed with a fringed, clamped, crusted and worn off bristle with partially melted handle. The Dietary Director verified the above findings.</p> <p>5. Review of the facility's P&P titled Sanitation and Infection Control dated 2011 showed blenders, food processors and mixers will be cleaned and sanitized after each use. Remove all parts, wash in hot, soapy water, rinse, sanitize and air dry.</p> <p>According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food.</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>According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying.</p> <p>a. On 8/27/24 at 0805 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Assistant Director. Two heavy-duty blenders were observed stored on the counter shelves still wet with visible water inside. The Dietary Assistant Director verified the above findings and stated it was supposed to be air dried to prevent food contamination.</p> <p>b. On 8/27/24 at 0817 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. Two square clear containers stacked on top of each other and one clear measuring container used for water and sauces were stored on the shelves wet with visible water. The Dietary Director verified the above findings and stated it was supposed to be air dried to avoid moisture bacteria growth.</p> <p>c. On 8/27/24 at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. A dozen pink plastic drinking cups were stacked on top of each other and stored wet with visible water. The Dietary Director verified the above findings and stated it was supposed to be air dried.</p> <p>6. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean.</p> <p>On 8/27/24 at 0830 hours, during the initial kitchen tour a concurrent observation and interview was conducted with the Dietary Director. A black, greasy residue was observed on the kitchen hood. The Dietary Director verified the above finding and stated the dietary staff deep cleaned the hood and an outside company performed service for the kitchen hood once a year and was due to be serviced.</p> <p>7. Review of the facility's P&P titled Sanitation and Infection Control dated 2011 showed all equipment should be sanitized to prevent the spread of disease and infection.</p> <p>According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.</p> <p>On 8/27/24 at 0800 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Assistant Director. The microwave at a countertop table was observed with dry, crusted, whitish food residue inside the microwave and on the microwave's door. The Dietary Assistant Director stated the microwave was used to reheat the residents' food and was cleaned by the dietary staff after each meal and deep cleaned twice a week. The Dietary Assistant Director acknowledged the findings and verbalized the microwave should have been cleaned to prevent food contamination.</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>8. Review of the facility's P&P titled Cleaning the Ice Machine revised 4/2022 showed the ice machine shall be cleaned for maintenance of sanitary conditions in order to prevent food contamination and the growth of disease-producing organisms and toxins.</p> <p>Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacturer's recommendations, and the date recorded when cleaned. The Maintenance Supervisor can keep this record or it can be posted on the ice machine.</p> <p>According to the USDA Food Code 2017, Section 4-601.11, the equipment food-contact surfaces and utensils shall be clean to sight and touch.</p> <p>On 8/29/24 at 0906 hours, an observation, interview, and concurrent facility document review was conducted with the Maintenance Supervisor. The ice bin was observed full of ice. The ice machine's interior top portion adjacent to the water curtain located directly above the ice bin, was observed with a light yellowish/pinkish stain. The Maintenance Supervisor acknowledged the finding and stated the facility had one ice machine for the residents used. The Maintenance Supervisor stated the ice in the ice bin would be discarded and should not be served to the residents to prevent cross contamination. The Maintenance Supervisor stated the ice machine was cleaned once a month by the maintenance department and serviced by an outside company every six months.</p> <p>On 8/29/24 at 0952 hours, an interview was conducted with the Dietary Director. The Dietary Director verified the above findings and stated the ice on the ice bin should have been discarded and would not be served to the residents to avoid cross contamination.</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to document the resident's name on a facility document for one of 16 final sampled residents (Resident 366). This failure posed the risk for Resident 366 to not receive accurate and necessary care.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Facility Assessment undated showed the evaluation approach ensures that resident care is personalized, meets regulatory standards, and enhances overall resident well-being. The P&P further showed resident population assessments evaluates the thoroughness and accuracy of resident assessments including diseases, conditions, physical and behavioral health needs, cognitive status, and acuity levels. resident's evaluation</p> <p>Medical record review for Resident 366 was initiated on 8/27/24. Resident 366 was admitted to the facility on [DATE].</p> <p>Review of Resident 366's H&P examination dated 8/12/24, showed Resident 366 had the capacity to understand and make decisions.</p> <p>Review of Resident 366's Order Summary Report dated August 2024 showed a physician's order dated 8/10/24, for the bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 366's Grab Bar Use and Entrapment Risk Evaluation dated 8/10/24, showed no documented evidence of the resident's name on the facility document.</p> <p>On 8/28/24 at 1033 hours, a facility document review and concurrent interview with LVN 4 was conducted. LVN 4 verified the Grab Bar Use and Entrapment Risk Evaluation document found in Resident 366's medical record was not accurately completed and did not include the resident's name. LVN 4 stated the facility should include the resident's name on the medical record to ensure the resident received the proper care and treatment.</p> <p>On 8/29/24 at 1340 hours, an interview was conducted with the DON. The DON stated the facility documentation for the residents should include the name of the resident and date the documentation was completed. The DON acknowledged the above findings.</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>50967</p> <p>Based on interview, facility document review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of infections were implemented as evidenced by:</p> <ul style="list-style-type: none"> * The facility failed to ensure the water management program was implemented to include an assessment of the facility water systems to identify where Legionella (a bacterium commonly found in natural and man-made aquatic environments, warm stagnant water) and other opportunistic pathogens can grow and spread. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room. <p>These failures posed the risk for transmission of communicable diseases to other residents in the facility.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Legionnaire's Disease revised dated 6/2017 showed the facility to have a plan for the prevention of Legionnaire's disease, recognize the signs and systems of the disease, test as appropriate with a physician's order and report confirmed cases to the local and state health department. The facility will complete a Legionella Risk Assessment to determine their risk for Legionella outbreaks. This assessment will be completed annually. The facility will determine risk areas by completing the Building Water System Process Flowchart and implement controls and indicate where these controls are located by completing the Control Area Monitoring Flowchart.</p> <p>Review of the facility's water management program showed the Legionella Risk Assessment was last completed on 4/19/23. In addition, the water management program failed to show documentation for the flow diagram of the building, on how the water would flow through the building, and any areas in the building where the water may stagnate.</p> <p>On 8/29/24 at 1354 hours, an interview and concurrent facility document review was conducted with the Administrator. When the Administrator was asked about the facility's Legionella Risk Assessment for the current year, the Administrator stated it was not completed. In addition, the Administrator verified the facility did not have a water flow chart.</p> <p>2. Review of the facility's P&P titled Infection Control Policy-Laundry Services dated 5/2018 showed the facility to assure a clean supply of linens and to protect employees who handle and process the laundry. Personnel must handle, store, process, and transport linens to prevent the spread of infection.</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 8/29/24 at 1341 hours, an inspection of the laundry area and concurrent interview with the Maintenance Supervisor was conducted. The clean linen folding table was observed with two tiers. The water bottle, opened soda can, and radio were observed on top of clean linen folding table's top tier. Two purses, a container of cookies and white Styrofoam container in a clear plastic bag were observed on the clean linen folding table's bottom tier. The Maintenance Supervisor verified all the items on the clean linen folding table belong to the laundry staff. The Maintenance Supervisor stated the laundry folding table was a clean area and should not have the staff's personal items on the table.</p> <p>On 8/29/24 at 1441 hours, an interview was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and acknowledged the above findings.</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>39453</p> <p>Based on observation, interview, and facility document review, the facility failed to ensure the essential equipment was maintained in safe operating condition.</p> <p>* The facility failed to ensure the staff performed calibration before using a new glucometer (a device which measures the amount of sugar in the blood). This failure had the potential for residents requiring glucose checks to have inaccurate readings.</p> <p>* The facility failed to ensure the freezer compartment inside the refrigerator used for medications in Medication Room A was free of ice buildup. This failure had the potential to affect the refrigerator's functionality and the potential to affect the potency of the medications stored inside the refrigerator.</p> <p>Findings:</p> <p>1. Review of the Assure Platinum Blood Glucose Monitoring System Quality Assurance/ Quality Control Reference Manual, revised 8/2023, under Performing a Control Solution Test section, showed the following:</p> <ul style="list-style-type: none"> - Check the meter and test strips using Assure dose control solutions to confirm the meter and test strips are working properly; - Before using a new meter or a new bottle of test strips, conduct a control solution test following the procedure with the two different levels of control solution; and - Use control solution before testing with the meter for the first time. <p>On 8/28/24 at 1411 hours, an inspection of the glucometer in Medication Cart A and concurrent interview was conducted with LVN 3. An Assure Platinum glucometer with serial number 1040-4324393 was found inside Medication Cart A.</p> <p>Review of the Assure Pro Blood Glucose Monitoring System: Daily Quality Control Record for August 2024 failed to show documented evidence a daily quality control check was performed for the glucometer with serial number 1040-4324393.</p> <p>LVN 3 verified the above findings. LVN 3 stated the quality control checks for the glucometer were done nightly by the night shift nurse. LVN 3 stated the glucometer with serial number 1040-4324393 was brand new. LVN 3 could not provide documentation a calibration or quality control check was performed for the glucometer. LVN 3 stated she used the glucometer to perform the residents' blood glucose monitoring without performing a calibration or quality control check.</p> <p>2. On 8/28/24 at 0816 hours, an inspection of the refrigerator used for medications inside Medication Room A was conducted with RN 1. The freezer compartment inside the refrigerator used for medications was observed with a build-up of ice. RN 1 verified the above findings.</p> <p>(continued on next page)</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>On 8/28/24 at 1612 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete for 13 of 16 final sampled residents (Residents 15, 17, 20, 32, 33, 34, 35, 40, 44, 45, 48, 59, and 366) reviewed for grab bar use. This failure had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death.</p> <p>Findings:</p> <p>According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are:</p> <ul style="list-style-type: none"> - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. <p>Review of the facility's P&P titled Proper Use of Bed Rails dated on 8/2018 showed the facility to assess a resident's risk for entrapment prior to the installation of siderails or bedrails to ensure that the bed's dimensions are appropriate for the resident's size and weight. The facility will assess the resident's risk for entrapment for the use of a grab bar using the facility's grab bar assessment. This policy to reduce entrapment with the use of siderails has been developed utilizing the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment.</p> <p>Review of the facility's Siderail or Bedrail Assessment Guidance to Reduce Entrapment dated 8/26/24, showed check marks for Zone 1 next to the room numbers and N/A (Not Applicable) for Zones 5 and 6. However, Zones 2, 3, 4, and 7 were left blank. In addition, the assessment failed to show resident identifiers to indicate which room number was associated with their entrapment assessment.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. On 8/28/24 at 0900 hours, an observation for Resident 32 and concurrent interview with CNA 3 was conducted. Resident 32 was observed lying in bed with bilateral grab bars elevated. Resident 32 was awake alert and verbally responsive. CNA 3 verified Resident 32's bilateral grab bars were elevated. CNA 3 stated Resident 32 used the grab bars when getting up from the bed and to assist with turning during care.</p> <p>Medical record review for Resident 32 was initiated on 8/29/24. Resident 32 was admitted to the facility on [DATE].</p> <p>Review of Resident 32's H&P examination dated 8/2/24, showed Resident 32 had the capacity to understand and make decisions.</p> <p>Review of Resident 32's Informed Consent for a Grab Bar as an Enabler/Assistive Device dated 8/1/24, showed Resident 32's representative gave consent to the use of the grab bars.</p> <p>Review of Resident 32's Order Summary Report showed a physician's order dated 8/1/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 32's Grab Bar Use and Entrapment Risk Evaluation dated 8/2/24, showed the bed dimensions had been checked and were appropriate for the resident's size and weight for Zones 1 through 3; Zone 4 was no; and Zones 5 through 7 were not indicated on the Grab Bar Use and Entrapment Risk Evaluation.</p> <p>2. On 8/29/24 at 1040 hours, an observation for Resident 35 and concurrent interview with LVN 3 was conducted. Resident 35's bilateral grab bars were observed elevated. LVN 3 verified Resident 35's bilateral grab bars were elevated. LVN 3 stated Resident 35 used the grab bars to assist with turning during care. LVN 3 was observed attempting to move the grab bars down, however, they were locked in place and kept elevated.</p> <p>Medical record review for Resident 35 was initiated on 8/29/24. Resident 35 was admitted to the facility on [DATE].</p> <p>Review of Resident 35's H&P examination dated 8/26/24, showed Resident 35 had the capacity to understand and make decisions.</p> <p>Review of Resident 35's Informed Consent for a Grab Bar as an Enabler/Assistive Device dated 8/9/23, showed Resident 35 gave consent to the use of the grab bars.</p> <p>Review of Resident 35's Order Summary Report showed a physician's order dated 8/9/23, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 35's Grab Bar Use and Entrapment Risk Evaluation dated 8/9/23, showed the bed dimensions had been checked and were appropriate for the resident's size and weight for Zones 1 through 3; Zone 4 was no; and Zones 5 through 7 were not indicated on the Grab Bar Use and Entrapment Risk Evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 8/28/24 at 0905 hours, an observation for Resident 40 and concurrent interview with CNA 3 was conducted. Resident 40 was observed lying in bed with bilateral grab bars elevated. CNA 3 verified Resident 40's bilateral grab bars were elevated. CNA 3 stated Resident 40 used the grab bars to assist with turning during care.</p> <p>Medical record review for Resident 40 was initiated on 8/28/24. Resident 40 was admitted to the facility on [DATE].</p> <p>Review of Resident 40's H&P examination dated 2/24/24, showed Resident 40 did not have the capacity to understand and make decisions.</p> <p>Review of Resident 40's Informed Consent for a Grab Bar as an Enabler/Assistive Device dated 2/23/24, showed Resident 40's representative gave consent to the use of the grab bars.</p> <p>Review of Resident 40's Order Summary Report showed a physician's order dated 3/8/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 40's Grab Bar Use and Entrapment Risk Evaluation dated 2/23/24, showed the bed dimensions had been checked and were appropriate for the resident's size and weight for Zones 1 through 3; Zone 4 was no; and Zones 5 through 7 were not indicated on the Grab Bar Use and Entrapment Risk Evaluation.</p> <p>4. On 8/29/24 at 1037 hours, an observation for Resident 45 and concurrent interview with RNA 1 was conducted. Resident 45 was observed lying in bed asleep with bilateral grab bars elevated. RNA 1 verified Resident 45's bilateral grab bars were elevated. RNA 1 stated Resident 45 used the grab bars when to assist with turning during care and during transfer from bed to wheelchair.</p> <p>Medical record review for Resident 45 was initiated on 8/29/24. Resident 45 was admitted to the facility on [DATE].</p> <p>Review of Resident 45's H&P examination dated 8/2/24, showed Resident 45 had the capacity to understand and make decisions.</p> <p>Review of Resident 45's Informed Consent for a Grab Bar as an Enabler/Assistive Device dated 7/8/24, showed Resident 45's representative gave consent to the use of the grab bars.</p> <p>Review of Resident 45's Order Summary Report showed a physician's order dated 7/8/24, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 45's Grab Bar Use and Entrapment Risk Evaluation dated 8/2/24, showed the bed dimensions had been checked and were appropriate for the resident's size and weight for Zones 1 through 3; Zone 4 was no; and Zones 5 through 7 were not indicated on the Grab Bar Use and Entrapment Risk Evaluation.</p> <p>(continued on next page)</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/29/24 at 0919 hours, an interview and concurrent facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified he did not document on the Grab Bar Use and Entrapment Risk Evaluation and the licensed nurses were the ones completing the form. When asked if he informed the licensed nurses about the results of the grab bar entrapment measurements, the Maintenance Supervisor stated, No. The Maintenance Supervisor verified the Siderail or Bedrail Assessment Guidance to Reduce Entrapment dated 8/26/24, was inaccurate and incomplete. The Maintenance Supervisor stated he just started completing the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form on 8/26/24, and only completed the grab bar entrapment measurement for Zone 1. When the Maintenance Supervisor was asked to identify which residents were associated to the room numbers on the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form, the Maintenance Supervisor stated he did not have resident identifiers to show which resident beds were measured. In addition, the Maintenance Supervisor stated he was supposed to measure and document for Zones 1, 2, 3, and 7 for all the residents with grab bars ordered.</p> <p>On 8/29/24 at 1045 hours, an interview and concurrent facility document review was conducted with the DON. When asked about the entrapment assessment, the DON stated the admission nurses completed the Grab Bar Use and Entrapment Risk Evaluation form upon the resident's admission to the facility. The DON stated the beds automatically come with grab bars installed before the resident arrived to the facility and the grab bars were removed when it was not needed by the resident. The DON stated the admission nurses did not measure the grab bar entrapment zones indicated on the Grab Bar Use and Entrapment Risk Evaluation form, and the Maintenance Supervisor was responsible for measuring the entrapment zones. Furthermore, the DON stated the Maintenance Supervisor should document and provide the entrapment zone measurements to the admission nurses prior to the admission nurses completing the entrapment assessment.</p> <p>On 8/29/24 at 1441 hours, an interview was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and acknowledged the above findings.</p> <p>47474</p> <p>5. Medical record review for Resident 20 was initiated on 8/27/24. Resident 20 was admitted to the facility on [DATE].</p> <p>Review of Resident 20's H&P examination dated 6/6/24, showed Resident 20 had no capacity to understand and make decisions.</p> <p>Review of Resident 20's Order Summary Report dated August 2024 showed a physician's order dated 6/4/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 20's Grab Bar Use and Entrapment Risk Evaluation dated 6/4/24, showed the resident had right and left grab bars used to promote resident independence and as an enabler. The assessment showed Zones 1 to 4 were assessed; however, further review of the assessment showed no documented evidence Zones 5 to 7 were assessed.</p> <p>On 8/29/24 at 1328 hours, an interview with CNA 6 was conducted in Resident 20's room. CNA 6 verified Resident 20 used the bilateral grab bars during changes and repositioning.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Medical record review for Resident 366 was initiated on 8/27/24. Resident 366 was admitted to the facility on [DATE].</p> <p>Review of Resident 366's H&P examination dated 8/12/24, showed Resident 366 had the capacity to understand and make decisions.</p> <p>Review of Resident 366's Order Summary Report dated August 2024 showed a physician's order dated 8/10/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 366's Grab Bar Use and Entrapment Risk Evaluation dated 8/10/24, showed the resident had the right and left grab bars. The assessment showed Zones 1 to 4 were assessed; however, further review of the assessment showed no documented evidence Zones 5 to 7 were assessed.</p> <p>On 8/29/24 at 0850 hours, an interview with Resident 366 was conducted in her room. Resident 366 stated she used the bilateral grab bars when turning and repositioning.</p> <p>On 8/29/24 at 1316 hours, a facility document review and concurrent interview with RN 1 was conducted. RN 1 verified Residents 20 and 366's Grab Bar Use and Entrapment Risk Evaluations did not assess for Zones 5 to 7. RN 1 stated she completed the entrapment assessment and only reviews Zones 1 to 4.</p> <p>On 8/29/24 at 1340 hours, an interview was conducted with the DON. The DON acknowledged the above findings for Residents 20 and 366.</p> <p>48882</p> <p>7. On 8/28/24 at 0827 hours and on 8/29/24 at 0738 hours, Resident 44 was observed in bed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 44 was initiated on 8/27/24. Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>Review of Resident 44's H&P examination dated 3/21/24, showed Resident 44 had the capacity to understand and make decisions.</p> <p>Review of Resident 44's Order Summary Report dated 8/28/24, showed a physician's order dated 2/28/23, to apply bilateral grab bars as enablers to assist with bed mobility, turning, repositioning, and transfers.</p> <p>Review of Resident 44's Grab Bar Use and Entrapment Risk Evaluation dated 2/28/23, showed the bed dimensions have been checked and appropriate for the resident's size and weight for Zones 1 to 3. Zone 4 was marked no and Zones 5 to 7 were not indicated on the Grab Bar Use and Entrapment Risk Evaluation.</p> <p>Review of Resident 44's Grab Bar Use and Entrapment Risk Evaluation dated 7/25/24, showed Zones 1 to 4 were not marked as checked and appropriate for the Resident 44's size and weight, and failed to show the indications for the grab bars.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 33's MDS dated [DATE], showed Resident 33 required moderate assistance of one staff for bed mobility and transfer.</p> <p>Review of Resident 33's Order Summary Report dated 8/28/24, showed a physician's order dated 7/13/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfer.</p> <p>Review of Resident 33's Grab Bar Use and Entrapment Risk Evaluation dated 7/13/24, showed under summary of the findings, the bed dimensions had been checked and were appropriate for the resident. However, the entrapment zones for the bed measurement were incomplete. There were no measurement of all the entrapment zones appropriate for the resident using the grab bars in bed.</p> <p>10. On 8/27/24 at 1005 hours and 8/28/24 at 0929 hours, Resident 34 was observed in bed with both upper grab bars were elevated.</p> <p>Medical record review for Resident 34 was initiated on 8/27/24. Resident 34 was admitted to the facility on [DATE].</p> <p>Review of Resident 34's Order Summary Report dated 8/28/24, showed a physician's order dated 4/29/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 34's Grab Bar Use and Entrapment Risk Evaluation dated 4/29/24, showed under summary of findings, the bed dimensions had been checked and were appropriate for the resident. However, the entrapment zones for the bed measurement were incomplete. There were no measurement of all the entrapment zones appropriate for the resident using the grab bars in bed.</p> <p>On 8/29/24 at 1004 hours, an interview and concurrent facility document review for Residents 33 and 34 was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he was responsible for measuring the entrapment zones and assessment of the residents who had a grab bar in bed. When asked if he informed anyone in the facility about the results of the bed measurements and assessment of the grab bars in bed of the residents, he stated no. When asked if there were any documentation of the measurements of the grab bars in bed entrapment zones and assessments, the Maintenance Director verified there were no documentation and added he just started documenting on 8/26/24.</p> <p>On 8/29/24 at 1453 hours, an interview and concurrent facility document review for Residents 33 and 34 was conducted with the Administrator and MDS Coordinator. The Administrator and MDS Coordinator were informed and verified the above findings.</p> <p>49644</p> <p>11. On 8/27/24 at 0850 hours, during the initial tour of the facility, Resident 48 was observed lying in bed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 48 was initiated on 8/27/24. Resident 48 was admitted to the facility on [DATE].</p> <p>Review of Resident 48's MDS dated [DATE], showed Resident 48's cognition was intact.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 48's Order Summary Report showed a physician's order dated 7/5/24, may have bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfers.</p> <p>Review of Resident 48's Grab Bar Use and Entrapment Risk Evaluation dated 7/5/24, showed the bilateral grab bars was considered to promote resident independence and used as an enabler. The form also showed the bed dimensions for Zones 1, 2, and 3 had been checked and were appropriate for the resident's size and weight.</p> <p>Further review of Resident 48's medical record failed to show an entrapment assessment for Zone 7 was done.</p> <p>On 8/28/24 at 1208 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 48 had bilateral grab bars. LVN 5 stated Resident 48 was able to use the grab bar for turning and during physical therapy.</p> <p>On 8/29/24 at 0844 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 48's bed dimensions for Zones 1, 2, and 3 had been checked and were appropriate for the resident's size and weight. RN 1 verified questions for Zones 1 to 4 were completed and the other zones were not included in the form. RN 1 stated she was not sure why the other zones were not included in the form. RN 1 stated the licensed nurse completed the form and the Maintenance Supervisor checked the beds.</p> <p>On 8/29/24 at 0950 hours, an interview and concurrent record review for Resident 48 was conducted with the Maintenance Supervisor. The Maintenance Supervisor started documenting Zone 1 measurement on the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form on 8/26/24, and had no prior documentation. The Maintenance Supervisor had no documentation of the measurements for Zones 2, 3, and 7. The Maintenance Supervisor further stated he was supposed to check Zones 1, 2, 3, and 7. The Maintenance Supervisor verified the above findings and stated he was not able to provide the documentation for the measurement for Zones 2, 3, and 7 for Resident 48.</p> <p>On 8/29/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>50787</p> <p>12. On 08/27/24 at 0847 hours, an observation for Resident 17 was conducted. Resident 17 was observed lying in bed with bilateral grab bars elevated.</p> <p>On 8/29/24 at 0914 hours, an observation and concurrent interview with the DSD was conducted. When Resident 17 was asked if she used the grab bars, Resident 17 nodded her head, indicating yes. The DSD verified Resident 17 had bilateral grab bars elevated.</p> <p>Medical record review for Resident 17 was initiated on 8/29/24. Resident 17 was admitted to the facility on [DATE].</p> <p>Review of Resident 17's quarterly MDS dated [DATE], showed Resident 17 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 17's Informed Consent for a Grab Bar (s) As an Enabler/ Assistive Device dated 2/6/19, showed Resident 17 consented on the use of grab bars.</p> <p>Review of Resident 17's Order Summary Report dated 8/28/24, showed a physician's order dated 2/3/19, for bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, transfer.</p> <p>Review of Resident 17's Grab Bar Use and Entrapment Risk Evaluation dated 7/8/24, showed the bed dimensions had been checked and were appropriate for the resident's size and weight for Zones 1 to 3; Zone 4 was unmarked; and Zones 5 to 7 were not indicated on the Grab Bar Use and Entrapment Risk Evaluation. In addition, the Grab Bar Use and Entrapment Risk Evaluation form did not show the Maintenance Supervisor's signature on the signature portion of the form.</p> <p>50953</p> <p>13. Medical Record Review for Resident 15 was initiated on 8/28/2024. Resident 15 was admitted to the facility on [DATE].</p> <p>Review of Resident 15's Order Summary Report showed a physician's order dated 5/20/24, for bilateral grab bars as enabler to assist with bed mobility, turning, repositioning and transfer.</p> <p>On 8/27/24 at 0850 hours, an observation and concurrent interview was conducted with Resident 15. Resident 15 was observed lying in bed with bilateral grab bars elevated. Resident 15 stated she use grab bars to assist with turning in bed.</p> <p>On 8/28/24 at 0802 hours, an observation and concurrent interview was conducted with CNA 1. Resident 15 was observed lying in bed with bilateral grab bars elevated. CNA 1 verified Resident 15 had bilateral grab bar elevated and stated Resident 15 used the grab bars to help with turning and repositioning.</p> <p>Record review of Resident 15's Grab Bar Use and Entrapment Risk Evaluation dated 8/21/24, failed to show if the bed dimensions were checked and appropriate for the resident's size and weight for Zones 1 to 4.</p> <p>On 8/29/24 at 0937 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings.</p> <p>Cross references to F656 and F700.</p>		