STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain safe water temperature levels in 5 of 5 rooms tested for the water temperature. * The water temperatures were measured to read between 130.5 to 134 degrees Fahrenheit, when the normal temperature ranges were 105-120 degrees Fahrenheit. * The facility failed to provide education to the direct care staff regarding safe water temperature. These failures had the potential to cause severe burn injury to the residents and staff of the facility not to be aware of the safe water temperature.Findings: Review of the facility's P&P titled Water Temperatures, Safety of Residents dated 5/15/25, showed tap water in the facility shall be kept with in a temperature range to prevent scalding of residents. Under the section policy interpretation and implementation showed following:- Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperature of no more than 120 degrees Fahrenheit, or the maximum allowable temperature per state regulation;- Maintenance staff is responsible for checking thermostat and temperature control in the facility and recording these checks in a maintenance log;- Maintenance staff shall conduct periodic tap water temperature checks and record the water temperature in a safety log;- If at any time temperature water temperature feels excessive to touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor;- Direct Care staff shall be informed of risk factors for scalding/burns that are more common in the elderly, such as:o Decrease skin thickness;o Decreased skin sensitivityo Peripheral neuropathy;o Reduced reaction time;o Decreased cognition;o Decreased mobility;o Decreased communication Further review of the P&P showed the length of exposure to warm or hot water, the amount of skin exposed, and the resident's current condition affects weather or not exposure to certain temperature will cause scalding or burns. Nursing staff will be educated about the signs and symptoms of burns (first, second, and third degree) so that such injuries can be recognized and treated appropriately. On 9/10/25 at 1410 hours, an observation and concurrent interview was conducted with Maintenance Supervisor 1. Maintenance Supervisor 1 stated all the residents' rooms and the shower rooms in the facility had the same hot water supply. Maintenance Supervisor 1 further stated the closest room from the water heater was Room D, and the farthest room from the water heater was Room F. Maintenance Supervisor 1 tested the water temperature in residents rooms including the furthest and closest to the facility's water heater. The results showed the following:- Room B, temperature of 130 degrees Fahrenheit;- Room C, temperature of 134 degrees Fahrenheit;- Room D, temperature of 131 degrees Fahrenheit (closest from the water heater);- Room E, temperature of 133 degrees Fahrenheit; and,- Room F, temperature of 130.5 degrees Fahrenheit (farthest from the water heater). Maintenance Supervisor 1 verified the above readings and stated the temperature of the above residents' rooms were high and could cause scalding to the residents. Maintenance Supervisor 1 stated he would lower the water heater temperature immediately. Review of the facility's document titled Water Temperature Log from August to September 2025 showed the clinical and dietary water temperature to be is at 105 - 120 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maxi degrees Fahrenheit maximum. Further review of the water temperature showed the following:- dated 8/1/25 to 8/31/25, showed the water temperature of all the residents' rooms, shower rooms, kitchen, and laundry were tested daily. Further review of the water temperature for the residents' rooms and shower rooms showed the temperature ranged between 121- 146 degrees Fahrenheit with an average of approximately 133 degrees Fahrenheit.- dated 9/1/25 to 9/10/25, showed the water temperature of all the residents' rooms, shower rooms, kitchen and laundry were tested daily. Further review of the water temperature for residents rooms and shower rooms showed the temperature ranged between 116 to 141 degrees Fahrenheit with an average of approximately 130 degrees Fahrenheit. On 9/10/ 25 at 1503 hours, an interview and concurrent facility document review was conducted with Maintenance Supervisor 1 in the presence of the Administrator and DON . Maintenance Supervisor 1 stated Maintenance Assistants 1 and 2, and himself check the water temperature of the residents' rooms, and residents' shower rooms daily. Maintenance Supervisor 1 stated he was aware of the safe range for water temperature was at 105- 120 degrees Fahrenheit of the resident care areas including resident rooms and shower rooms. Maintenance Supervisor 1 stated he was aware about the risk of burns to the residents when the water temperature was above 120 degrees Fahrenheit. Maintenance Supervisor 1 verified the above water temperature log for August 2025 and September 2025 were above 120 degrees Fahrenheit up to 146 degrees Fahrenheit. Maintenance Supervisor 1 could not answer what to do when the water temperature was not within the range. Maintenance Supervisor 1 acknowledged he did not follow up. On 9/10/25 at 1503 hours, an interview was conducted with the Administrator. The Administrator acknowledged the above findings and stated she was not aware of the concern regarding the temperature of the residents' care areas being out of range. The Administrator stated she would work with the Maintenance Consultant and will maintain the water temperature within a safe range immediately. On 9/10/25 at 1525 hours, an interview was conducted with Maintenance Assistant 1. Maintenance Assistant 1 stated he measured the temperature of the residents' rooms and showers. Maintenance Assistant 1 stated he was aware a safe water temperature was less than 120 degrees Fahrenheit. Maintenance Assistant 1 verified the temperature log for August and September 2025 were above 120 degrees Fahrenheit up to 146 degrees Fahrenheit. Maintenance Assistant 1 was asked what he did when the water temperature of the residents' care areas was more than 120 degrees Fahrenheit. Maintenance Assistant 1 stated he reported it to the Maintenance Supervisor 1; however, Maintenance Assistant 1 stated he did not document when he notified Maintenance Supervisor 1. Maintenance Assistant 1 was asked what he did when the residents' care area water temperatures were out of range and Maintenance Supervisor 1 did not address the concern. Maintenance Assistant 1 stated he should have reported it to someone else and acknowledged he did not follow up. On 9/10/25 at 1529 hours, a follow-up water temperature check in resident room was conducted with the following result:- Room B, temperature of 115 degrees Fahrenheit;- Room C, temperature of 112 degrees Fahrenheit;- Room D, temperature of 115 degrees Fahrenheit; and,- Room F, temperature of 112 degrees Fahrenheit. On 9/10/25 at 1532 hours, an interview was conducted with the DON. The DON stated the facility had no incident of burn injury to the residents in the facility caused by water in the resident care areas. On 9/11/25 at 0829 hours, an interview was conducted with the Resident 47. Resident 47 stated he was able to go to the bathroom without staff assistance. Resident 47 stated he used the bathroom sink to wash his hands and always mixed hot and cold water to wash his hands. Resident 47 stated he never had any burn injury caused by facility water in the bathroom and shower. Medical record review for Resident 47 was initiated on 9/9/25. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's MDS assessment dated [DATE], showed Resident 47 was cognitively intact. On 9/11/25 at 0835 hours, an interview was conducted with Resident 5 and translated by CNA 1. Resident 5 stated he was able to go to the bathroom without staff assistance. Resident 5 stated he required the staff assistance for shower. Resident 5 stated he did not have any concern with the water being too hot in the facility and had no incident of burn injury caused by water in the bathroom (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and shower room. Medical record review for Resident 5 was initiated on 9/9/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. On 9/11/25 at 0814 hours, an interview was conducted with CNA 2. CNA 2 stated she provided showers to the residents. CNA 2 stated she never realized the water was hot. CNA 2 stated she used hot and cold water and made sure water was at safe temperature by touching before providing shower to the residents. CNA 2 stated she was not aware of any burn incidents caused by water temperature in the facility. 2. On 9/15/25 at 1020 hours, an interview was conducted with LVN 1. LVN 1 stated he mixed the hot and cold water while providing care to the residents and washing his hands. LVN 1 stated at some point, he felt the water temperature was too hot to touch. LVN 1 was asked what he did when he felt the water temperature being too hot to touch. LVN 1 stated he should have reported it to the RN supervisor and verified he did not. When asked if he received training on safe water temperature before 9/10/25, LVN 1 stated he did not receive any training on safe water temperature in the facility before 9/10/25. On 9/15/25 at 1035 hours, an interview was conducted with LVN 7. LVN 7 stated she never felt the water was too hot to touch and did not know if any burn incident happened to the residents. LVN 7 was asked if she received training on the safe water temperature before 9/10/25, she stated she did not remember. On 9/15/ 25 at 1042 hours, an interview and facility document review was conducted with the DSD. The DSD verified the in-service regarding safe water temperature was not provided to the staff before 9/10/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the residents were not allowed to have and self-administer the medication(s) found at the bedside for two nonsampled residents (Residents 35 and 78) who were not able to safely administer their own medications based on their self-administration assessment. * Resident 35 was assessed and determined not safe to self-administer her medications. However, Resident 35 had a bottle of Advil (NSAID, nonsteroidal anti-inflammatory drug) medications at the bedside and was self-administering the medication. Additionally, there was no physician's order and care plan problem addressing the resident's self-administration of the medication. * Resident 78 was assessed and determined not safe to self-administer his medications. However, Resident 78 had a box of Lidocaine patch (a topical medication used to relieve localized pain) and a bottle of Refresh eyedrops (artificial tears) medications at bedside and was self-administering the medications. Additionally, there was no physician's order and care plan problem addressing the resident's self-administration of his medication. These failures had the potential for Residents 35 and 78 to administer the medications inaccurately and could affect their well-being.Findings: Review of the facility's P&P titled medication - Self-Administration dated 1/2017 showed the following:- it is the responsibility of the IDT to determine if it is safe for the resident to self-administer drugs before the resident may exercise that right; and- the IDT must determine whether the resident or the nursing staff will be responsible for storage and documentation of the administration of the medications as well as the location where the medications will be administered. These determinations should appear on the resident's comprehensive plan of care. 1. On 9/9/25 at 0842 hours, during the initial tour of the facility, Resident 78 was observed lying in bed, with a bottle of Refresh eyedrops on his overbed table and a box of Lidocaine patch on his nightstand. Resident 78 stated he had been administering three drops of the artificial tears on his eyes two times a day, and he put the Lidocaine patch on his back when he feels like it. On 9/9/25 at 0906 and 0914 hours, Resident 78 was observed lying in bed with a bottle of Refresh eyedrops on his overbed table, and a box of Lidocaine patch on his nightstand. On 9/9/25 at 0917 hours, an observation for Resident 78 and concurrent interview was conducted with RN 1. RN 1 verified a bottle of Refresh eyedrops was observed on Resident 78's overbed table, and a box of Lidocaine patch was observed on the resident's nightstand. RN 1 stated the resident cannot keep medications at bedside, because he cannot administer the medications himself, and only the nurses could administer medications. Medical record review for Resident 78 was initiated on 9/9/25. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's Self-Administration of Medication assessment dated [DATE], showed Resident 78 did not want to self-administer medications, not physically able to administer medications, and preferred the licensed nurse to administer his medication. The assessment also showed the IDT determined it was not safe for Resident 78 to self-administer medications due to periods of confusion and generalized weakness. Review of Resident 78's plan of care failed to show a care plan problem was developed to address Resident 78's self-administration of the Lidocaine and eyedrops medication. Review of Resident 78's medical record failed to show a physician's order for the administration of the Lidocaine and eyedrops medications. 2. On 9/9/25 at 0900 and 0913 hours, during the initial tour of the facility, Resident 35 was observed lying in bed with a bottle of Advil on his nightstand. On 9/9/25 at 0915 hours, an observation for Resident 35 and a concurrent interview with RN 1 was conducted. RN 1 verified a bottle of Advil was observed on the resident's nightstand. Medical record review for Resident 35 was initiated on 9/9/25. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's Self-Administration of Medication assessment dated [DATE], showed Resident 35 did not want to self-administer medications, not physically able to administer medications, and preferred the licensed nurse to administer his medication. The assessment also showed the IDT determined it was not safe (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 35 to self-administer medications due to the resident being forgetful. Review of Resident 35's plan of care failed to show a care plan problem was developed to address Resident 35's self-administration of the Lidocaine and eyedrops medication. Review of Resident 35's medical record failed to show a physician's order for the administration of Advil medication. On 9/10/25 at 0907 hours, an interview was conducted with Resident 35. Resident 35 stated she brought the bottle of Advil to the facility, and she took the Advil medication when she had pain or when she had flu-like symptoms such as a cold or a runny nose. Resident 35 stated she took the medications given by the nurses and the Advil too. On 9/11/25 at 1129, an interview and concurrent medical record review for Residents 35 and 78 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified Residents 35 and 78 did not have a physician's order to administer the medications nor for the residents to self-administer the medications. On 9/15/25 at 0815 hours, an interview and concurrent medical record review for Residents 35 and 78 was conducted with the DON. The DON verified the above findings. The DON verified Residents 35 and 78 were not safe to self-administer their own medications per the IDT assessment. The DON further verified there were no physician's order to self-administer the medications, and no care plan to address the residents' self-administration of medications. The DON stated if a resident was assessed to be able to self-administer his/her own medication, there should be a physician's order for the resident's self-administration of medication, and this should be addressed in the resident's care plan. The DON stated the facility staff were supposed to check the resident's room and any facility staff who would see any medications at the bedside should report it to the licensed nurses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of five sampled residents (Residents 9, 11, and 34) reviewed for unnecessary medications were free from unnecessary medications. * The facility failed to ensure Resident 9 was monitored for adverse events such as orthostatic hypotension related to the use of psychotropic medications. Resident 9 had a physician's order for sertraline (medication used to help improve mood) and Depakote (anticonvulsant). * The facility failed to ensure Resident 11's documentation of meal intake was accurate to identify when the resident had a meal intake of less than 50% and failed to complete the monthly behavior summary related to the use of mirtazapine (antidepressant). * The facility failed to ensure Resident 34's order for Depakote medication showed the specific behavior targeted by the medication. These failures had the potential for the residents to experience adverse effects from the psychotropic medications, inaccuracy of monitoring and assessing, and unnecessary use of the psychotropic medications.Findings: 1. According to the National Library of Medicine's DailyMed, one of the adverse reactions of sertraline and Depakote medications may include cardiovascular reactions including postural hypotension (orthostatic hypotension). Review of the facility's P&P titled IIIB2: Antipsychotic Medication Use effective date 10/2017 showed the facility assured the residents were being adequately monitored for adverse consequences such as orthostatic hypotension. When the antipsychotics medications were used without monitoring, they may be considered unnecessary medications because of inadequate monitoring. Medical record review for Resident 9 was initiated on 9/10/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 8/4/25, showed Resident 9 had no capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 8/1/25, to administer sertraline 50 mg by mouth one tablet at bedtime for depression as manifested by verbalization of feeling depressed; - dated 8/5/25, to administer Depakote 125 mg by mouth one tablet two times a day for mood disorder as manifested by poor impulse control; and - dated 8/1/25, to monitor the resident's blood pressure lying and sitting for orthostatic hypotension every week on Sunday at 0700-1500 hours shift. Notify the physician if the difference of systolic blood pressure is 20 mmHg or greater or if diastolic blood pressure is 10 mmHg or greater. Review of Resident 9's MAR for August and September 2025 showed Resident 9 received the following medications on the following dates and times: - sertraline medication from 8/2 to 8/31/25 at 0900 at 1700 hours, and from 9/1 to 9/9/25 at 2100 hours; and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Depakote medication from 8/6 to 8/15/25 at 0900 hours and at 1700 hours, on 8/16/25 at 1700 hours, and from 8/17 to 8/31/25 at 0900 hours and at 1700 hours; and from 9/1 to 9/4/25 at 0900 hours and at 1700 hours, on 9/5/25 at 1700 hours, from 9/6 to 9/7/25 at 0900 hours and at 1700 hours, on 9/8/25 at 2100 hours, on 9/9/25 at 0900 hours and at 1700 hours, and on 9/10/25 at 0900 hours. Further review of Resident 9's medical record did not show documented evidence Resident 9 was monitored for orthostatic hypotension related to the use of sertraline and Depakote medications. On 9/10/25 at 1608 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 2. LVN 2 stated the residents taking the psychotropic medications needed to be monitored for orthostatic hypotension. LVN 2 verified there was no documentation of the order and the monitoring for orthostatic hypotension every Sunday per physician's order. LVN 2 stated the order to check Resident 9 for orthostatic hypotension did not show in the MAR because the order was not carried over for September 2025. LVN 2 verified there was no physician's order to discontinue the monitoring for the monitoring of the orthostatic hypotension related to the use of the sertraline and Depakote medications for Resident 9. On 9/10/25 at 1710 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 9. Cross reference to F656, example #2. 2. Medical record review for Resident 34 was initiated on 9/9/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's Order Summary Report showed a physician's order dated 3/7/25, for Depakote Delayed Release 125 mg tablet to be administered by mouth at bedtime for mood disorder manifested by poor impulse control leading to a fall from bed. On 9/11/25 at 1624 hours, an interview and concurrent medical record review was conducted with LVN 4 and the DON. When asked what behaviors LVN 4 monitor for Resident 34's poor impulse control leading to falling from bed, LVN 4 stated she monitored the resident for trying to get out of bed. When asked about specific behaviors, LVN 4 verified there were none. The DON verified Resident 34's behaviors targeted by the Depakote medication should have been more specific. On 9/12/25 at 1040 hours, an interview was conducted with LVN 5. When asked what behaviors LVN 5 would monitor for the resident's poor impulse control, LVN 5 stated behaviors such as hitting, grabbing at stuff, and verbal aggression. LVN 5 stated she would monitor the resident's behaviors based on the physician's order. LVN 5 reviewed Resident 34's physician's orders and verified there were no specific behaviors to monitor for the resident's poor impulse control. 3. Medical record review for Resident 11 was initiated on 9/9/25. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 8/28/25, showed Resident 11 had no capacity to understand and make decisions. Review of Resident 11's Order Summary Report showed the following physician's orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/7/25, to administer mirtazapine 7.5 mg one tablet by mouth at bedtime for depression manifested by poor oral intake; and - dated 8/27/25, to monitor poor oral intake less than 50% with meals. Review of Resident 11's MAR for August and September 2025 showed the following: - Resident 11 was administered the mirtazapine medication on 8/1, 8/2, 8/6 to 8/14, 8/16 to 8/20, 8/27 to 9/10/25 at 2100 hours; and - Resident 11's episodes of poor oral intake of less than 50% were documented in the MAR on 8/11, 8/15, and 9/1 to 9/10/25. Review of Resident 11's Task Documentation, under Nutrition - Amount section from 8/14 to 9/12/25, showed the following: - Resident 11 consumed 26 to 50% on 8/15/25 at 0913 and 2232 hours, 8/17/25 at 1841 hours, 8/19/25 at 1700 hours, 8/26/25 at 2212 hours, 8/27/25 at 1252 hours, 8/28/25 at 1256 hours, and 8/29/25 at 1313 and1738 hours; and - Resident 11 consumed 0-25% of his meal on 8/21/25 at 1337 hours. Further review of Resident 11's medical record did not show a monthly behavior summary was completed for August 2025 related to the use of the mirtazapine medication. On 9/12/25 at 1104 hours, an interview and concurrent medical record review for Resident 11 was conducted with the DON. When asked what the licensed nurses considered as poor intake, the DON stated the poor intake was when a resident consumed less than 50% of the meal tray. The DON further stated the licensed nurses would refer to the meal intake documentation of the CNAs. The DON verified the meal intake documentation showed Resident 11 consumed 26-50% on several occasions. When asked how they identify when Resident 11 consumed less than 50%, the DON stated they could not really identify because the electronic medical record did not give the CNAs a choice to document the actual percentage, but only ranges from 0 to 25%, 26 to 50%, 51 to 75%, and 76 to 100%. When asked what the facility should do when Resident 11 consumed less than 50% of his meal tray, the DON stated the licensed nurses or the CNAs would offer a supplement or alternative meal. When asked about the monthly behavior summary, the DON verified the monthly behavior summary was not completed. The DON stated Resident 11 was transferred to the acute care hospital from 8/22 to 8/26/25, and came back on 8/27/25, so they would start to complete the monthly behavior summary related to the mirtazapine medication use on 10/1/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure an injury of unknown origin was thoroughly investigated for one final sampled resident (Resident 34) investigated for injury of unknown origin. * There was no investigation conducted for Resident 34's skin discolorations on the left mid breast and upper backside. This failure resulted in a delay of identifying and investigating the cause for injury, with the potential to expose the resident to further injury or abuse.Findings: Review of the facility's Abuse Reporting and Prevention P&P revised April 2024, showed all injuries of unknown sources will be reported immediately to the Administrator, and will be investigated thoroughly. Medical record review for Resident 34 was initiated on 9/9/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 34's SBAR Communication Form dated 5/19/25, showed the resident had discoloration on her left mid breast and left upper backside. On 9/11/25 at 1508 hours, a telephone interview was conducted with LVN 7. LVN 7 stated when they noticed Resident 34's discolorations, the discolorations were purplish with a yellow border. LVN 7 stated she notified the RN. LVN 7 stated while assessing the resident, the resident denied being hit or having an injury. On 9/11/25 at 1618 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the SBAR Communication Form dated 5/19/25, was initiated due to skin discoloration. The DON stated the facility investigated change of conditions for skin discoloration from an unknown source. On 9/11/25 at 1649 hours, a follow-up interview was conducted with the DON. The DON stated she did not receive an incident report notifying the facility management of Resident 34's injuries of unknown origin, and therefore did not investigate the source of the resident's discolorations. The DON could not recall if she was notified by the nurses of the resident's discolorations. On 9/12/25 at 1428 hours, an interview was conducted with the Administrator. The Administrator stated the injuries of unknown origin were to be reported to the DON or Administrator immediately, and the facility will investigate the injury to determine its source.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide services to attain or maintain the highest practicable well-being for one of 17 final sampled residents (Resident 5). * The facility failed to clearly identify the current code status for Resident 5. This failure posed the risk of confusion, delay in the provision of care in accordance with the resident's treatment wishes.Findings: Review of the facility's P&P titled POLST - Physician Order for Life Sustaining Treatment dated 1/2017 showed the following: - The resident's wishes will be reviewed at the resident's quarterly care plan meeting or following a change of condition, or when the resident/healthcare surrogate requests a review. If the resident/healthcare surrogate expresses that he/she wants to change his/her wishes as indicated in his/her current POLST, the primary care physician or medical director is notified as soon as possible to discuss the potential changes with the resident/healthcare surrogate and document this discussion in the resident's clinical record. The primary care physician will then complete a new POLST form with the resident/healthcare surrogate; and - If the POLST conflicts with the resident's previously expressed healthcare instructions or advance directive, then to the extent of the conflict, the most recent expression of the resident's wishes are to be honored. Medical record review for Resident 5 was initiated on [DATE]. Resident 5 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's POLST dated [DATE], showed Resident 5's code status was DNR (Do Not Resuscitate) and selected comfort-focused treatment as medical interventions. The POLST was signed by the resident on [DATE]. Review of Resident 5's Order Summary Report showed the following physician's order dated [DATE]: - Do not resuscitate/DNR; and - Comfort-focused treatment. Review of Resident 5's baseline care plan for code status dated [DATE], showed Resident 5's code status of DNR and comfort-focused medical interventions with no artificial means. Further review of Resident 5's physician's order dated [DATE], showed the Do not resuscitate/DNR order was created on [DATE]. Review of Resident 5's POLST dated [DATE], showed Resident 5 selected attempt resuscitation/CPR (or a full code), and full treatment as medical interventions. The POLST was signed by the resident on [DATE]. Review of Resident 5's H&P Examination dated [DATE], showed Resident 5 had the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 5's IDT/Care Plan Conference Summary dated [DATE], showed Resident 5's code status was DNR, with comfort-focused medical interventions with hospital transfer. On [DATE] at 1432 hours, an interview and medical record review for Resident 5 was conducted with LVN 4. When asked what Resident 5's code status in the event the resident was found unresponsive, LVN 4 stated He is DNR. When asked how she would verify Resident 5's code status, LVN 4 answered I just know my patients. When asked if she would check Resident 5's medical record first to verify, LVN 4 answered no, because I know my patients. LVN 4 was asked to check Resident 5's medical record. LVN 4 was observed checking Resident 5's paper medical record, LVN 4 verified Resident 5 had two POLST forms in the chart. LVN 4 also checked Resident 5's electronic health record and LVN 4 verified Resident 5's care profile and physician's orders showed Resident 5 was DNR. LVN 4 stated I thought he was DNR. LVN 4 stated she would follow the POLST dated [DATE], which showed Resident 5 had a full code status. On [DATE] at 1435 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 5. When asked what Resident 5's code status in the event the resident was found unresponsive, LVN 5 was observed checking Resident 5's physical chart, and stated I would do a CPR. LVN 5 also checked Resident 5's electronic medical record, and verified Resident 5 had a physician's order for DNR code status. LVN 5 stated I am really confused. When asked who should be checking to ensure the POLST and the physician's orders matched, LVN 5 stated the social services department or the medical records department. On [DATE] at 1448 hours, an interview was conducted with the SSD. The SSD stated Resident 5's code status was initially DNR, but it was changed to a full code. The SSD stated Resident 5's code status was discussed during the care plan conference last [DATE], and there was no changes in code status, which meant Resident 5 was full code based on the POLST dated [DATE]. When asked if she also checked Resident 5's physician's orders to make sure Resident 5's code status was correct per the recent POLST, the SSD answered no, and stated she only looked at the POLST but not the physician's orders. The SSD stated the nurses should have placed a physician's order in the resident's electronic health record to reflect Resident 5's full code status per the POLST dated [DATE]. On [DATE] at 1452 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 verified Resident 5's code status in the POLST form dated [DATE], did not match the physician's order dated [DATE], showing Resident 5's DNR code status. RN 1 stated the facility staff would follow the POLST form dated [DATE], which meant Resident 5 was a full code, because it was the updated one, and it was signed by the resident and the doctor. On [DATE] at 1036 hours, an interview and concurrent medical record review for Resident 5 was conducted with the DON. When asked what Resident 5's code status in the event the resident was found unresponsive, the DON stated they should check Resident 5's electronic health record first, then refer to the paper chart to see the latest code status. The DON verified Resident 5's code status in his electronic health record was DNR, while the paper chart showed two POLST forms, showing Resident 5 was a DNR and a full code. Upon further medical record review, the physician's order for the DNR was ordered [DATE], but it was created on [DATE]. The DON stated maybe the LVN clarified the physician's order on [DATE]. On [DATE] at 1044 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 6, and the DON. LVN 6 verified she entered the physician's order for Resident 5's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DNR code status on [DATE], because that was when the facility started using and transitioning to electronic health record. LVN 6 stated she looked at Resident 5's physical chart and saw the POLST form dated [DATE], showing Resident 5's code status was DNR. LVN 6 stated the POLST form dated [DATE], showing Resident 5's code status was a full code, and was not on Resident 5's physical chart at that time. When asked when they should review Resident 5's code status, LVN 6 stated the IDT also reviewed Resident 5's code status during the care conference. The DON and LVN 6 verified the IDT/Care Conference Summary dated [DATE], showed Resident 5's code status was DNR. The DON stated they would follow the POLST form dated [DATE], which meant Resident 5 was a full code.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of 17 final sampled residents (Resident 3) who required hearing aids received the proper treatment and assistive device to maintain her hearing abilities. * The facility failed to ensure Resident 3's right and left hearing aids were applied as ordered by the physician. In addition, the facility failed to ensure the necessary actions were taken when Resident 3's left hearing aid was missing since February 2025 per the resident's responsible party. This failure had the potential for the resident to not clearly hear, understand, and make appropriate responses to the conversations. Findings: a. On 9/9/25 at 0940 hours, during the initial tour of the facility, Resident 3 was observed awake and lying in bed. When asked how she was doing, Resident 3 was pointing to her left ear and moving her head sideways. The surveyor wrote in a piece of paper and showed Resident 3. Resident 3 responded in a slurred speech she was doing ok and kept apologizing because she could not hear what the surveyor was saying. Resident 3 requested for the surveyor to talk louder. Medical record review for Resident 3 was initiated on 9/9/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 5/18/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had a minimal difficulty with her ability to hear (with hearing aid or hearing appliances if normally used). Review of Resident 3's Order Summary Report showed a physician's order dated 8/29/24, to apply the left and right hearing aids at 0900 hours and taken off at 2100 hours. The hearing aids to be kept in the medication cart one time a day and removed per schedule. Review of Resident 3's plan of care showed a care plan problem revised on 7/9/25, addressing Resident 3's impaired communication related to highly hearing impairment or absence of useful hearing and the use of right and left hearing aids. Review of Resident 3's MAR for July, August, and September 2025 showed the following:a. the left and right hearing aids were applied on the following dates and times:- 7/2 to 7/7/25 at 0900 hours, on 7/9 to 7/13/25 at 0900 hours, on 7/15 to 7/25/25 at 0900 hours, and on 7/27 to 7/31/25 at 0900 hours;- 8/1 to 8/11/25 at 0900 hours, 8/13 to 8/15/25 at 0900 hours, 8/17/25 at 0900 hours, and 8/19 to 8/31/25 at 0900 hours; and- 9/1 to 9/4/25 at 0900 hours, 9/6 to 9/7/25 at 0900 hours, and 9/9 to 9/11/25 at 0900 hours.b. the left and right hearing aids were removed on the following dates and times:- 7/1 to 7/31/25 at 2100 hours;- 8/1 to 8/31/25 at 2100 hours; and- 9/1 to 9/10/25 at 2100 hours. Further review of Resident 3's MAR for July, August, and September 2025 showed the application of the left and right hearing aids on 7/8, 7/26, 8/12, 8/16, 8/18, 9/5, and 9/8/25 at 0900 hours were left blank. On 9/9/25 at 1247 hours, 9/10/25 at 1230 and 1520 hours, and 9/11/25 at 0945 hours a follow up observation for Resident 3 was conducted. Resident 3 was observed without the left and right hearing aids on. b. Review of the facility's P&P titled Theft and Loss Program revised 1/2017 showed the following:- Upon admission, an inventory will be made of all the resident's property brought into the facility. The property will be listed on a two-part form, Resident's Clothing and Possessions form SNF-1062;- After completing the admission section of this form, the resident/family representative and facility representative will sign the form. The yellow copy will be given to the resident/family representative and the white copy will become a part of the resident's clinical record;- Whenever a loss occurs an immediate investigation should be completed by Social Services. A Theft and Loss Report, form JW A-112 should be utilized to document all losses and all relative findings should be documented. This form allows all investigation procedures to be described in detail;- The Theft and Loss Log will be used by Social Services to document all occurrences of theft and loss in the facility. A basic prerequisite for the programs' success is the early discovery of a loss, thorough investigation, obtaining accurate and factual information and timely handling of all investigations; and- The information to be recorded on the Theft and Loss log should include: (a) Shift when the loss occurred; (b) Time of day or night when the loss (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred; (c) The nurse assigned to the resident; (d) The time of loss may be indicative of visiting hours, shift change, decreased nursing staff on the floor, less supervision, lunch breaks, volunteers visiting, etc. Review of Resident 3's Resident's Clothing and Possessions dated 1/31/23, showed under the Description section - hearing aids was not checked. Review of Resident 3's Resident's Clothing and Possessions dated 5/11/25, showed under the Description section - hearing aids was not checked. On 9/11/25 at 1438 hours, an observation and concurrent interview for Resident 3 was conducted with CNA 3. When asked how she would communicate with the resident who had impaired communication skills, CNA 3 stated Resident 3 was able to demonstrate in action or point at what she needed. CNA 3 stated she had to speak to Resident 3 a little louder because the resident was hard of hearing. CNA 3 stated Resident 3 as far as she could remember, every time she took care of the resident, the resident had no hearing aids on. CNA 3 further stated she would see the hearing aids if Resident 3 had it on because she would clean or gave the resident a sponge bath and she would be checking the hearing aids all throughout her shift to make sure it would not be missing. CNA 3 stated she had to complete the inventory list for the resident's belongings upon admission and when the family member brought new items, she would add it to the form they were using when asked how she checked the resident's belongings. CNA 3 stated for hearing aids which were not being used or refused by the residents, the nurse usually kept it in their medication cart because those were very expensive. CNA 3 stated if there were missing belongings, she would report it to the nurses, start searching the room, and the nurse would continue with what needed to be done if the belongings were not found when asked regarding missing resident's belongings. On 9/11/25 at 1520 hours, an interview was conducted with LVN 2. LVN 2 stated she applied Resident 3's bilateral hearing aids yesterday and today she took it out in the morning because the resident kept on removing it. LVN 2 stated she had to keep it in the medication cart because the hearing aids were expensive. LVN 2 stated Resident 3 would refuse the hearing aids at times. When asked to see the hearing aids, LVN 2 checked the Medication Cart A for and took out a green container with Resident 3's name written on it. There was only the right hearing aid found in the green container. When asked again about the hearing aids, LVN 2 stated she applied the left and right hearing aids to Resident 3. On 9/11/25 at 1552 hours, an interview and medical record review was conducted with RN 2. RN 2 verified the nurses had been documenting the application of the bilateral hearing aids to the resident at 0900 hours. RN 2 stated if the resident refused the hearing aids, the nurse should use the code 2 for the refusal and should not be checking off the MAR or leave it blank. RN 2 was observed checking the Medication Cart A and found only the right hearing aid of Resident 3. RN 2 was also observed checking Resident 3's room. RN 2 verified she could not find the left hearing aid. RN 2 verified the bilateral hearing aids were not documented in the Resident's Clothing and Possessions list. RN 2 stated if the resident's belongings were missing, the staff would start searching for the lost items and contact the family as well. RN 2 stated if the missing belongings were not found, they had to report it to the Social Services department. RN 2 called Resident 3's RP 1. RN 2 stated the RP 1 told her the left hearing aid had been missing for a while. RN 2 stated she would inform the Social Worker regarding the missing left hearing aid of Resident 3. On 9/11/25 at 1737 hours, a telephone interview was conducted with Resident 3's responsible party. Responsible Party (RP) 1 stated the last time she saw the left hearing aid was on February 2025 and she informed one of the staff in the PM shift. Responsible Party 1 stated she had never seen the left hearing aid since then and she knew Resident 3 had only been using the right hearing aid. Responsible Party 1 stated Resident 3 had the habit of removing the hearing aids because it was hurting her ears. Responsible Party 1 stated she did not know her rights or what she could do, but she was told by one of the staff they would have the hearing aids fixed. Responsible Party 1 stated she had to yell when she talks to Resident 3 because the resident was hard of hearing. On 9/12/25 at 0820 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified she signed off Resident 3's MAR on 9/9/25 at 0900 hours for the left and right hearing aids. LVN 3 stated she thought the order was only to check (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if the hearing aids were in the medication cart. LVN 3 stated she found the green container of the hearing aids with Resident 3's name written on it. LVN 3 stated she did not really open the container to check how many hearing aids were in the container. On 9/12/25 at 0900 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated the last time she put on the right hearing aid to Resident 3 was probably last July 2025. LVN 2 stated she was unable to recall when was the last time she saw the left and right hearing aid of Resident 3. LVN 2 further stated she could not recall the date and who did she spoke with, but during the shift change hand-off report, she asked why there was only one hearing aid. LVN 2 stated she was told by the nurse it was already reported to the Social Worker. LVN 2 verified there was no documentation showing the left hearing aid was reported missing or the physician was informed about it. On 9/12/25 at 1538 hours, an interview and concurrent facility document review was conducted with the SSD. The SSD stated when there was missing resident's belongings, the nurse would initially search the room and if not found, the nurse would fill up the Theft/Loss form and notify the social services department. The SSD stated she would go to each department to search for the missing item and investigate. The SSD stated if the item was not found she would inform the resident's responsible party and the facility would cover the cost of the lost item. The SSD verified there was no report made by the nursing department Resident 3's left hearing aid was missing for the months of February to September 10, 2025. On 9/15/25 at 0841 hours, an interview and medical record review was conducted with the DON. The DON stated if the nurse checked off and initialed the treatment or medication in the MAR, it meant it was provided. The DON further stated the MAR should not be left blank because it would show we did not know what happened. The DON was informed and acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary GT care and services for one nonsampled resident (Resident 16). * The facility failed to ensure Resident 16's head of the bed was elevated to at least 30 degrees while the GT feeding was infusing. This failure posed the risk for Resident 16 developing complications related to Resident 16's GT such as aspiration which can lead to aspiration pneumonia and respiratory compromise.Findings: According to Taylor's Fundamentals of Nursing seventh edition under Nursing Considerations with Tube Feeding, make sure the resident is as upright as possible during feeding. If the resident is in bed during feedings, elevate the head of the bed at least 30 degrees during feeding and for one hour afterward to prevent reflux and aspiration. Medical record review for Resident 16 was initiated on 9/9/25. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 16's Order Summary Report showed the following physician's orders:- dated 7/2/25, to administer water flush via GT at 60 ml per hour for 20 hours;- dated 9/3/25, to administer Nutren 0.2 formula (calorically dense complete nutrition tube feeding formula for those with elevated caloric requirements and/or a fluid restriction that provides 2.0 kcal/ml of calories) to provide 860 ml (1720 kcal) via GT; and- dated 9/3/25, to administer the enteral feed via enteral pump and infuse at 43 ml per hour for 20 hours or until the volume is completed. Review of Resident 16's Resident Care Plan showed a care plan problem dated 6/8/25, to address Resident 16 required the GT feeding. The Approach Plan included to elevate the the head of the bed more than 30 degrees during feeding and one hour after feeding. On 9/11/25 at 0826 hours, Resident 16 was observed in bed, and the head of the bed was observed just slightly elevated at 20 degrees. Resident 16's Nutren 2.0 GT feeding formula was observed infusing via an enteral feeding pump at 43 ml per hour. Resident 16 was observed coughing. On 9/11/25 at 0830 hours, Resident 16 was observed in bed, and the head of bed was observed just slightly elevated at 20 degrees. Resident 16's Nutren 2.0 GT feeding formula was observed infusing via an enteral feeding pump at 43 ml per hour. A facility staff member was observed standing in front of the room and talking to Resident 16's roommate. The staff did not check Resident 16 nor adjusted the head of the bed. On 9/11/25 at 0832 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 16's head of the bed was elevated at 21 degrees while the GT feeding was infusing. When asked about the appropriate elevation of the head of the bed required during the GT feeding infusion, RN 1 answered 15 degrees. RN 1 was asked if it was appropriate to have Resident 16's head of bed elevated at 21 degrees while the GT feeding was infusing, RN 1 answered no, and further stated it should have been at 45 degrees to prevent aspiration. When asked if Resident 16 was able to use his bed remote control to place the head of the bed down, RN 1 answered no, and verified the bed control was not placed within Resident 16's reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure three of six final sampled residents (Residents 2, 3, and 5) remained free from accident hazards due to the use of the side rails. * The facility failed to ensure the less restrictive interventions were completed prior to the use of the right grab bar for Resident 2. * The facility failed to ensure the less restrictive interventions were completed prior to the use of the bilateral grab bars for Resident 3. * The facility failed to ensure less restrictive measures were provided prior to the use of the right grab bar for Resident 5. These failures had the potential for the residents to receive the unnecessary grab bars and could put the residents at risk for entrapment and serious injuries.Findings: Review of facility's P&P titled Siderails or Bedrails dated 8/2018 showed the following: - It is the policy of the facility that siderails or bed rails will only be used after other alternatives have been tried unsuccessfully and only with informed consent from the resident, physician and/or representative; - The facility will attempt to use appropriate alternatives prior to installing a side or bed rail; - The resident will be assessed for least restrictive measures such as the use of transfer poles or trapeze bars prior to the use of siderails or bed rails; and - Interventions that might be incorporated in care planning include (a) Providing a device such as a trapeze to increase a resident's mobility, (b) Providing frequent monitoring by staff with periodic assisted toileting for residents who attempt to arise to use the bathroom, and (c) Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information and are able to use the call bell device. 1. On 9/9/25 at 0812 hours, during the initial tour of the facility, Resident 2 was observed sleeping in bed with the right grab bar elevated. Medical record review for Resident 2 was initiated on 9/9/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed a physician's order dated 4/16/25, for the right grab bar as an enabler to assist with the bed mobility, turning, repositioning and transfers. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 had severe cognitive impairment and required partial/moderate assistance with mobility. Review of Resident 2's plan of care showed a care plan problem revised on 7/10/25, to address the use of the right grab bar. The approach plan did not include any less restrictive alternatives prior to the use of the right grab bar. Review of Resident 2's Bedrail/Grab Bar Use and Entrapment Risk Evaluation dated 7/10/25, showed the right grab bar was used as enabler for bed mobility and transfer. The evaluation did not show if (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any less restrictive measures were attempted prior to the use of the right grab bar. Review of Resident 2's H&P examination dated 7/16/25, showed Resident 2 was confused and with medical diagnosis of dementia. On 9/11/25 at 1214 hours, an observation and concurrent interview for Resident 2 was conducted with CNA 2. Resident 2 was observed awake, lying in bed with the right grab bar elevated. CNA 2 stated Resident 2 could help with the turning and the resident used the right grab bar during repositioning. 2. On 9/9/25 at 0940 hours, during the initial tour of the facility, Resident 3 was observed awake and lying in bed with the bilateral grab bars elevated. Medical record review for Resident 3 was initiated on 9/9/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed a physician's order dated 1/31/23, for the bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning, and transfers. Review of Resident 3's H&P examination dated 5/18/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's plan of care showed a care plan problem revised on 6/5/25, to address the use of the bilateral grab bars. The approach plan did not include any less restrictive alternatives prior to the use of the right grab bar. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had severe cognitive impairment and dependent with mobility. Review of Resident 3's Bedrail/ Grab Bar Use and Entrapment Risk Evaluation dated 7/10/25, showed the bilateral grab bar were used as an enabler for bed mobility and transfer. The evaluation did not show if any less restrictive measures were attempted prior to the use of the bilateral grab bar. On 9/11/25 at 1438 hours, an observation and concurrent interview for Resident 3 was conducted with CNA 3. Resident 3 was observed sleeping in bed with the bilateral grab bars elevated. CNA 3 stated Resident 3 was dependent from staff assistance with turning but during repositioning the resident could hold the grab bar with the left hand which was still strong. CNA 3 verified Resident 3's right hand was contracted. On 9/11/25 at 1552 hours, an interview and concurrent medical record review for Residents 2 and 3 was conducted with RN 2. RN 2 stated the nurses and physical therapists would assess the residents if they needed the grab bars. RN 2 stated the IDT team did the reevaluation for the use of the grab bars by the residents. RN 2 verified there were no less restrictive measures attempted prior to Residents 2 and 3's use of the grab bars. On 9/15/25 at 0841 hours, an interview and concurrent medical record review for Residents 2 and 3 was conducted with the DON. The DON verified there were no less restrictive measures attempted prior to Residents 2 and 3's use of the grab bars. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 9/9/25 at 0910 hours, during the initial tour of the facility, Resident 5 was observed in bed with the right grab bar elevated. Resident 5 stated he used the grab bar to get out of bed. Medical record review was initiated on 9/9/25. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed a physician's order dated 9/16/24, for the right grab bar as an enabler to assist with the bed mobility, turning, and repositioning. Review of Resident 5's Bedrail/ Grab Bar Use and Entrapment Risk Evaluation dated 6/11/25, showed the right grab bar was considered to promote resident independence, and used as an enabler. The evaluation did not show if any less restrictive measures were attempted prior to the use of side rails. Review of Resident 5's plan of care showed a care plan problem revised dated 7/21/25, to address the use of right grab bar. The approach plan did not include any less restrictive alternatives prior to the use of the right grab bar. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 was cognitively intact, and required supervision or touching assistance for chair/bed-to-chair assistance, sit to stand, sit to lying and lying to sitting on the side of the bed. Further review Resident 5's medical record failed to show documented evidence any less restrictive alternative was attempted prior to the use of the right grab bar. On 9/10/25 at 0912 hours, an interview for Resident 5 was conducted with CNA 6. CNA 6 stated Resident 5 used the right grab bar in repositioning. On 9/10/25 at 1432 hours, an interview for Resident 5 was conducted with LVN 4. LVN 4 stated she had seen Resident 5 use the right grab bar when standing up from the bed. On 9/11/25 at 1452 hours, an interview and concurrent medical record review was conducted with RN 1. When asked about the grab bars, RN 1 stated the nurse would assess the residents to see if they needed the grab bar. When asked about the less restrictive alternatives, RN 1 verified there were no less restrictive measures attempted prior to Resident 5's use of the grab bars. On 9/15/25 at 0825, an interview and concurrent medical record review was conducted with the DON. When asked about the less restrictive alternatives, the DON verified there were no less restrictive measures attempted prior to Resident 5's use of the grab bars. Cross reference to F909, examples #1, #2, and #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services for one of 17 final sampled residents (Resident 47), one nonsampled resident (Resident 13), one of five residents (Resident 34) reviewed for the unnecessary medications, and in one medication room (Medication room [ROOM NUMBER]). * The facility failed to clarify the order with the physician for the administration of the rapid acting insulin to Resident 34. * The facility failed to ensure Resident 47's tramadol (a controlled medication for pain) was accurately and appropriately unaccounted for. * The facility failed to ensure the multiple hydrocodone/ acetaminophen 5-325 mg (a controlled medication for pain) tablets removed from the supply were administered and documented in Resident 13's MAR. * The facility failed to ensure the controlled drug ABHR cream (a cream containing ativan, benadryl, haldol and reglan medications used to treat agitation, nausea, anxiety and vomiting particularly in terminally ill patients) was properly discarded in Medication room [ROOM NUMBER]. These failures had the potential for the residents to not receive the appropriate and/or necessary medications that could affect the residents' well-being and potential for the controlled medications diversion.Findings: 1. Medical record review for Resident 34 was initiated on 9/9/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's Order Summary Report showed the following physician's order: - dated 3/6/25, for Novolin 70/30 FlexPen (a mixture of intermediate acting and short-acting insulin) inject 10 units subcutaneously twice a day, and to administer the rapid acting insulin (Humalog, Novolog, Apidra) no more than 15 minutes before meals or give at the beginning of the meal (up to 15 minutes after the start of the meal, and hold the dose if a meal is skipped); and - dated 7/6/25, for Novolin R insulin (a short acting insulin), to be injected subcutaneously per the sliding scale based the resident's blood sugar level. On 9/12/25 at 1122 hours, a telephone interview was conducted with the Pharmacist Consultant. The Pharmacist Consultant stated Resident 34 was not currently receiving any rapid acting insulin, and the order should have been clarified with the physician. 2. Review of the facility's P&P titled IIA5: Controlled Medications effective August 2014 showed when a controlled medication is administered, the nurse enters the date and time, amount and signature on the accountability record, and then will initial the MAR after the medication is administered. Medical record review for Resident 47 was initiated on 9/9/25. Resident 47 was readmitted to the facility on [DATE]. Review of Resident 47's Antibiotic or Controlled Drug Record for tramadol hcl 50 mg tablets showed 52 tablets were supplied. The documentation space for the date and time the tablet was removed from the supply for tablet #31 was left blank and had an illegible, potentially scratched out signature. Review of Resident 47's MAR for August 2025 failed to show the missing dose was administered to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/25 at 1440 hours, an interview and concurrent record review was conducted with the DON. The DON reviewed Resident 47's Antibiotic or Controlled Drug Record for tramadol hcl 50 mg tablets and verified tablet #31 was not signed out from the supply appropriately. In addition, the DON verified the resident's MAR failed to show the missing tablet was administered to the resident. 3. Review of the facility's P&P titled IIA5: Controlled Medications effective August 2014 showed when a controlled medication is administered, the nurse enters the date and time, amount and signature on the accountability record, and then will initial the MAR after the medication is administered. Review of Resident 13's Antibiotic or Controlled Drug Record for hydrocodone/acetaminophen 5-325 mg tablets showed the tablets were removed from the supply on the following dates and times: - 7/24/25 at 1115 hours, - 7/26/25 at 1115 hours, -7/31/25 at 1010 hours, - 8/1/25 at 1145 hours, - 8/13/25 at 1440 hours, - 8/22/25 at 1340 hours, - 8/24/25 at 1040 hours, and - 8/27/25 at 1040 hours. Review of Resident 13's MAR for July and August 2025 failed to show the above hydrocodone/acetaminophen 5-325 mg tablets were administered to Resident 13. On 9/11/25 at 1440 hours, an interview and concurrent record review was conducted with the DON. The DON reviewed Resident 13's Antibiotic or Controlled Drug Record and MAR and verified the above tablets removed from the controlled medication supply were not documented in Resident 13's MAR and should have been. 4. Review of the facility's P&P titled IIA5: Controlled Medications effective August 2014 showed the Director of Nursing and the consultant pharmacist maintain the facility's compliance with the federal and state laws and regulations in the handling of controlled medications. On 9/10/25 at 1400 hours, during the inspection of Medication room [ROOM NUMBER] with LVN 6, an ABHR cream was observed outside the incineration container inside the locked cabinet where the container was kept. The ABHR cream container was observed to contain an amount of cream. LVN 6 verified the ABHR cream was considered a controlled medication and should not be kept in the medication room and rather should be in the DON's office. On 9/15/25 at 0841 hours, an interview was conducted with the DON. The DON stated all the controlled medications which need to be discarded should be given to her and placed in the incineration container which was inside the double locked cabinet in her office. The DON further stated the controlled medications would be destroyed by her together with the pharmacist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to ensure one of five final sampled residents (Resident 34) reviewed for unnecessary medications received appropriate pharmacological recommendations. * The facility's Pharmacist Consultant failed to make recommendations based on Resident 34's elevated hemoglobin A1c (a blood test that measures the average blood sugar (glucose) level over the past 2-3 months) results and insulin use for diabetic management. This failure had the potential for the resident's diabetic regimen not being promptly re-evaluated by the physician. Findings: Medical record review for Resident 34 was initiated on 9/9/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's admission MD/NP/PA Progress Note dated 3/7/25, showed the resident had Type 2 diabetes (a chronic condition characterized by high blood sugar levels due to the body's inability to use insulin effectively or produce enough insulin.). Review of Resident 34's Order Summary Report showed the following orders: - dated 7/6/25, for Novolin R insulin (a short acting insulin), to be injected subcutaneously per a sliding scale based the resident's blood sugar level. - dated 3/6/25, for Novolin 70/30 FlexPen (a mixture of intermediate acting and short-acting insulin) inject 10 units subcutaneously twice a day. Review of Resident 34's hemoglobin A1c laboratory results showed the following: - dated 4/11/25, results were elevated at 8.2% (normal result is usually 5.7%) - dated 8/7/25, results were more elevated at 8.8%, showing an increase in the residents blood sugar levels not controlled by diet and insulin. Review of the facility's monthly Drug Regimen Reviews dated 7/8, 8/7, and 9/8/25, showed the Pharmacist Consultant reviewed Resident 34's medical records. The Pharmacist Consultant failed to make recommendations based on Resident 34's elevated hemoglobin A1c results and further failed to follow-up with the physician. On 9/12/25 at 1122 hours, a telephone interview was conducted with the Pharmacist Consultant. The Pharmacist Consultant verified recommendations should have been made because the resident's hemoglobin A1c results had increased and he should have followed up with the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure two of five final sampled residents (Residents 3 and 34) reviewed for unnecessary medications were free from the unnecessary medications. * The facility failed to ensure Resident 3 was monitored for signs and symptoms of bleeding for the use of clopidogrel bisulfate (medication used to prevent dangerous blood clots). * The facility failed to ensure Resident 34 was monitored for bleeding related to clopidogrel bisulfate medication use. These failures had the potential for the residents to receive unnecessary medications and develop significant adverse effects.Findings: According to the FDA the approved Highlights of Prescribing Information for clopidogrel bisulfate revised 3/2021 showed the most common adverse reaction in adult patients are related to bleeding including life-threatening and fatal bleeding. 1. Medical record review for Resident 3 was initiated on 9/9/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed a physician's order dated 6/22/23, to administer clopidogrel bisulfate 75 mg one tablet by mouth one time a day for CVA prophylaxis. Review of Resident 3's H&P examination dated 5/18/25, showed Resident 3 had no capacity to understand and make decisions. Further review of Resident 3's medical record did not show documented evidence Resident 3 was observed or monitored for the signs and symptoms of bleeding related to the use of the clopidogrel bisulfate medication. On 9/11/25 at 1552 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 2. RN 2 stated Resident 3 was high risk for bleeding related to the use of the clopidogrel. RN 2 stated the signs and symptoms of bleeding could be blood in stool or urine, nosebleed, gum bleed, or bruising. RN 2 stated the resident should be monitored for signs and symptoms of bleeding. RN 2 verified there was no documented evidence Resident 3 was being monitored for signs and symptoms of bleeding. RN 2 further stated they would only record the signs and symptoms of bleeding as it occurred. On 9/15/25 at 0841 hours, an interview was conducted with the DON. The DON stated the clopidogrel medication could cause an adverse reaction of bleeding, so it was important to monitor the resident for early detection of signs and symptoms of bleeding and the physician would be notified right away. The DON was informed and acknowledged the findings for Resident 3. Cross reference to F656, example #1. 2. Medical record review for Resident 34 was initiated on 9/9/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's Order Summary Report showed a physician's order dated 3/7/25, for clopidogrel bisulfate an anticoagulant) 75 mg tablet by mouth daily for CVA prophylaxis. The report failed to show a physician's order to monitor the resident for signs or symptoms of bleeding due to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clopidogrel bisulfate use. On 9/11/25 at 1524 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated when a resident was on anticoagulants, they should be monitored for bleeding and bruising, and should check the resident's gums, stool and urine for bleeding and check their skin for bruising or bleeding. RN 1 stated Resident 34 should have had a physician's order to monitor for bleeding and the nurses should document the monitoring each shift on the MAR. Cross reference to F656, example #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 39.29%. Two of two licensed nurses (LVNs 2 and 3) were found to have made errors during the medication administration. * Resident 10 had a physician's order for metoprolol (antihypertensive medication) with parameter to hold if HR (heart rate) is less than 60 beats per minute (bpm). LVN 3 failed to check the resident's HR prior to administering the medication. In addition, Resident 10 did not receive the full dose of vitamin D3 (supplement) and Rena Vite (supplement) medications when there was residual left in the medicine cups after LVN 3 administered the medications via GT. * LVN 2 failed to ensure seven medications were not left in pill pouches used for crushing Resident 62's medications. * LVN 2 failed to administer Resident 63's calcium (supplement) 500 mg tablet. These failures resulted in the residents not receiving the medications as ordered by the physician and had the potential to compromise the health and safety of the residents.Findings: Review of the facility's P&P titled Medication Administration revised 4/2025 showed it was the policy of the facility the medications for the residents would be administered in a safe and timely manner, and as prescribed. The medications must be administered in accordance with the physician's orders, including any required time frame. 1. Medical record review for Resident 10 was initiated on 9/11/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 5/1/25, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's Order Summary Report showed the following physician's orders: - dated 4/19/21, to administer metoprolol tartrate 50 mg one tablet via GT every 12 hours for hypertension. Hold if SBP < 100 or HR < 60. Check BP (blood pressure) and HR prior to giving the medication; - dated 6/26/23, to administer vitamin D3 25 mcg one tablet via GT two times a day for supplement; and - dated 6/6/25, to administer Rena Vite one tablet via GT one time a day for supplement. a. On 9/11/25 at 0803 hours, a medication administration observation and concurrent interview for Resident 10 was conducted with LVN 3. LVN 3 prepared the medications to be administered to Resident 10. LVN 3 checked Resident 10's BP and stated she would be give the resident the metoprolol medication. LVN 3 stated the BP was 130/70 mmHg after checking Resident 10's blood pressure and proceeded with administering the medications to the resident via GT. LVN 3 was stopped when she was about to give the metoprolol medication to Resident 10. LVN 3 stated she forgot to check Resident 10's HR when asked if she needed to check the resident's HR prior to administering the medications. LVN 3 then proceeded to check Resident 10's HR. b. On 9/11/25 at 0910 hours, during the medication administration observation conducted with LVN 3, residues of vitamin D3 and Rena Vite mixed with water were observed in the medicine cups for each (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication after LVN 3 administered all of Resident 10's medications via GT. LVN 3 verified she finished administering Resident 10's medications and was about to throw all the medicine cups. LVN 3 stated she had to make sure all the medications for the resident were fully given otherwise the resident would not get the full dose of the medications. LVN 3 verified there were residues of vitamin D3 and Rena Vite left in the medicine cups. On 9/15/25 at 0841 hours, an interview was conducted with the DON. The DON stated for any medications with parameter ordered by the physician, the nurse had to follow it for the resident's safety because if it was not followed, it would cause more abnormality. The DON further stated if any abnormality was assessed prior to administering the medication, the nurse would notify the physician, and the medication use would be reevaluated. The DON stated all the medications, even crushed form, should be given fully. The DON stated for the medications given via GT, the medications should be crushed well and mixed with water as ordered. The DON further stated no sediments/residue should be left in the medicine cup for the resident to really get the full benefit of the medication. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 62 was initiated on 9/9/25. Resident 62 was admitted to the facility on [DATE]. On 9/10/25 at 0822 hours, a medication administration observation was conducted with LVN 2 for Resident 62. LVN 2 crushed the following ten medications in separate pill pouches:- vitamin C (supplement) 500 mg- carvedilol (a blood pressure medication) 25 mg- vitamin D 2000 units by mouth- clonidine hcl (a blood pressure medication) 0.3 mg- docusate sodium (a stool softener) 250 mg- hydrochlorothiazide (a diuretic) 25 mg - lisinopril (a blood pressure medication) 40 mg - multi-vitamin with minerals one tablet - amlodipine besylate (a blood pressure medication) 10 mg - Calcium with vitamin D 500 mg/200 units LVN 2 then poured the crushed medications in separate medication cups mixed with applesauce and administered them by mouth to the resident. The pill pouches were discarded into the trash bin attached to the medication cart. After the medication administration, seven of the 10 pill pouches had residual medications remaining. LVN 2 verified seven pill pouches had loose medication remnants and therefore failed to administer the full dose of the medications to the resident. 3. Medical record review for Resident 63 was initiated on 9/9/5. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report showed a physician's order dated 3/21/25, for calcium 500 mg tablet to be administered twice a day. The scheduled administration time was at 0900 hours. On 9/10/25 at 0755 hours, a medication administration observation was conducted with LVN 2 for Resident 63's 0900 medications. During the medication administration, LVN 2 administered six scheduled medications, however the calcium 500 mg tablet was not removed from the medication cart and administered to the resident. After the medication administration, LVN 2 signed off the medications as administered, disinfected the medication tray, stethoscope, and blood pressure cuff and stated she was done with her medication administration. LVN 2 was asked about the resident's calcium medication tablet scheduled, and verified she missed it because she did not scroll the eMAR page and didn't see the calcium tablet was scheduled to be administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure two plastic containers with clean scoops were free from dust and dry food crumbs. * The facility failed to ensure safe storage of food items. * The facility to ensure complete hair restraint was done by the dietary staff inside the kitchen. * The facility failed to ensure Resident 47 did not store food from the kitchen at the bedside. These failures had the potential to cause foodborne illness for residents who consumed food prepared in the kitchen.Findings: Review of the facility's document titled Diet Type Report dated 9/10/25, showed 56 of 64 residents were receiving food from the kitchen. 1. According to FDA Food Code 2022, 4-601.11, Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, 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. On 9/9/25 at 0805 hours, an observation and concurrent interview was conducted with [NAME] 1. Two plastic trays with scoops were observed with dust and dry food crumbs. [NAME] 1 verified the observation and stated the plastic trays with the scoops needed to be cleaned. 2. Review of the facility P&P titled Dietary - Labeling and Dating Foods revised 9/2016 showed it is the policy of the facility to label and date foods. Further review of the P&P showed frozen foods will be covered, clearly labeled and dated. a. On 9/9/25 at 0805 hours, an observation and concurrent interview was conducted with [NAME] 1. There were two big packages of meat covered with clear plastic. One was dated 8/26/25, and another was dated 9/4/25. The two packages of chicken did not show use by date, or when the meat would last. [NAME] 1 verified the observation and stated the two big packages of meat were chicken and the date on the meat was delivery date. [NAME] 1 was unable to answer how he ensured the quality of the food. b. On 9/9/25 at 0835 hours, an observation and concurrent interview was conducted with the Dietary Director. During observation of facility freezer, the following was identified:- French toast in a plastic bag with date of 9/5/25, and- multiple packages of ice cream in a clear plastic bag with the date of 9/8/25. The Dietary Director verified the observation and stated the date on the above items were delivery date from the vendor. The Dietary Director stated he was not required to label the food items in the freezer with a use by or expiration date. The Dietary Director was unable to answer when asked how he ensured the quality of food when it was delivered to the facility. 3. According to the USDA Food Code 2022, Section 2-402.11 (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils. On 9/10/25 at 1019 hours, during an observation, Dietary Aid 1 was in the kitchen with a hair restraint covering only half of the scalp. On 9/10/25 at 1154 hours, during an observation, Dietary Aid 1 and [NAME] 2 were in the kitchen with a hair restraint covering half of their scalps. The Dietary Director verified the observation and stated staff should completely restrain their hair. 4. On/9/9/25 at 0948 hours, an observation and concurrent interview was conducted with Resident 47. Resident 47 was sitting on the side of his bed. There was unlabeled bread covered in clear plastic, and a paper container with a reddish food item on the nightstand at the right side of his bed. Resident 47 stated the bread in a clear plastic was peanut butter and jelly sandwich which he received a couple hours ago from the facility's kitchen. Resident 47 further stated the paper container with reddish food item was kimchi (a traditional Korean staple dish of fermented vegetables, most commonly napa cabbage or Korean radish, seasoned with chili powder, garlic, and ginger) from the facility's kitchen 2 days ago. Resident 47 was asked if the facility staff were aware about the food items he had on the bedside. Resident 47 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated facility came to his room multiple times and the staff were aware about the food items he had in the bedside. On 9/9/25 at 0951 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified the above observation and stated Resident 47 was not allowed to store the food from the kitchen at the bedside. CNA 1 took the above food items away from Resident 47's room. Medical record review for Resident 47 was initiated on 9/9/25. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's MDS assessment dated [DATE], showed Resident 47 was cognitively intact. On 9/12/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. On 9/15/25 at 0838 hours, an interview was conducted with the Dietary Director. The Dietary Director was informed and acknowledged the above findings. The Dietary Director stated perishable food from the kitchen could not be stored at the bedside, it should be eaten immediately or discarded. The Dietary Director stated the kimchi and the peanut butter and jelly sandwich were perishable foods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the P&P was followed regarding outside food brought into the facility for one nonsampled resident (Resident 76). * There were unlabeled food items observed at Resident 76's bedside. * The facility failed to ensure the staff, residents, and/or their responsible party were educated on safe food handling guidelines. These failures had the potential to expose the residents who received food brought from the outside to food borne illnesses. Findings: Review of the facility's P&P titled Food from Outside Sources dated 4/2017 showed food brought in by the visitors for the residents is discouraged due to problems of infection control and conflicts between diets and consistency. Food brought in for residents should not be served by the dietary department, food brought into the facility by family members or visitors should be checked to confirm that the food is not in conflict with the residents prescribed diet. The P&P further showed visitors are discouraged from bringing in potentially hazardous foods, i.e., meat, fish, eggs, custards, milk products, etc. If such foods are brought into the resident, this should be consumed immediately but not stored in the facility and not shared with other residents within the facility. Further review of the P&P showed should the resident request that he/she be allowed to eat foods that are not in the prescribed diet plan, the dietary manager, dietitian or nurse should counsel the resident/responsible party on the risks and benefits of eating the food item and charted appropriately. On 9/9/2025 at 0901 hours, during an observation, Resident 76 was asleep in bed. There was an unlabeled container of food and two undated bags with sandwiches observed at the bedside. On 9/10/25 at 0844 hours, an interview was conducted with RN 1. RN 1 stated the facility had no refrigerator to store the food for the residents. In addition, RN 1 stated facility had no microwave to heat up the food brought in by the family. RN 1 stated visitors were allowed to bring food for the residents; however, it must be consumed immediately or to be discarded. When asked if RN 1 received the in-service on how to handle the food brought in from outside sources, RN 1 stated she did not remember receiving any training on how to handle the food brought in from outside sources. On 9/10/25 at 0850 hours, an interview was conducted with CNA 5. CNA 5 stated facility had no refrigerator to store the food brought in from outside for the residents. CNA 5 was asked if she received the in-service on how to handle the food brought in from outside, she stated she did not receive any training on how to handle the food brought in from outside sources. On 9/10/25 at 1015 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD verified she did not provide in-service to the staff of the facility regarding how to handle food brought in from outside sources. On 9/11/25 at 0821 hours, during an observation, Resident 76 was lying in bed. The following was observed stored at the bedside:- an unlabeled plastic container of pieces of apple, and blueberry; and,- an unlabeled bag of chips inside a plastic bag. On 9/11/25 at 0904 hours, an observation and concurrent interview was conducted with CNA 5. CNA 5 verified the above observation and stated Resident 76's family brought the food for the resident. CNA 5 further stated the facility did not store the food for the residents. CNA 5 stated some of the resident's family members asked her if the facility could store the food for the resident; however, she stated she was not allowed to store the food for the resident. On 9/12/25 at 1115 hours, an interview was conducted with Resident 76 with the Activity Assistant translating. Resident 76 stated her daughter brings food from home for her to eat. When asked if the facility provided education to her regarding how to handle the food from the outside sources, Resident 76 stated she did not remember. On 9/12/25 at 1159 hours, an interview and concurrent medical record review for Resident 76 was conducted with LVN 6. LVN 6 verified there was no documented evidence Resident 76 and/or their representative were educated on how to handle food brought in from outside sources. On 9/12/25 at 1204 hours, an interview was conducted with Responsible Party 2. Responsible Party 2 stated she occasionally brought food prepared at home for Resident 76. When asked if the facility provided education on how to hand the outside food, Responsible Party 2 stated she did not remember. On (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/12/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for August 2025 when the IP classified the infections as CAIs, HAIs, and those who did not meet the McGeer Criteria. In addition, the facility failed to ensure the monthly infection surveillance mapping included all infections in the facility. * The facility failed to ensure the residents' blankets, wedge pillows, and splints in the laundry area were stored in a clean and sanitary manner. * CNA 7 failed to wear a gown when providing care and changing the linens for Resident 16 who was on EBP precaution. * The facility failed to ensure the blood sugar machine was properly cleaned after LVN 2 used the machine to check Resident 22's blood sugar. In addition, LVN 2 failed to perform hand hygiene and changed gloves before checking Resident 22's blood sugar. * LVN 3 and the Care Plan Coordinator failed to wear a gown when providing care and/or medications to Resident 10 who had a GT and on EBP precaution. In addition, LVN 3 failed to handle the GT supplies in a sanitary manner for Resident 10 and perform hand hygiene every glove changes. * CNA 4 failed to wear a gown when providing care to Resident 54 who was on EBP precaution. * The facility failed to ensure Resident 70's door stay closed while on isolation precautions for COVID-19. These failures posed the risk of incomplete infection control data which could lead to missed infection trends and delayed outbreak detection, and the potential for cross-contamination and spread of infectious organisms in the facility.Findings: 1. Review of the facility's P&P titled Infection Control Program dated 7/2022 showed one of the objectives of the Infection Control Plan is to maintain records of nosocomial infection, infection control measures and surveillance. On 9/11/25 at 0927 hours, a concurrent interview, medical record review, and facility document review was conducted with the IP. The IP was asked to show the facility's infection control surveillance program for August 2025. Review of the facility's Infection Control Summary for August 2025 showed the following: - there were seven residents who had HAIs/nosocomial infections; - there were three residents who had CAIs; and - under the Antibiotic Review section, showed there were 15 residents who were treated with antibiotic, and the number of the residents treated with antibiotics but did not meet the minimum criteria showed acute 2, and facility 2. Review of the facility's surveillance log for August 2025 showed the columns for CAI, HAI, and infections that did not meet McGeer criteria and residents with signs or symptoms of infection who were not treated with antibiotics. The log further showed the following: - there were 13 residents on antibiotic medications, and one resident on antiviral medication; - there were nine residents on HAIs, six residents on CAIs, and four residents with infections that did not meet McGeer criteria; and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- there were 10 residents marked as surveillance only, Covid-19 positive. Review of the facility's monthly infection surveillance mapping for August 2025 showed the infections marked as CAI and HAI per the surveillance log; however, it did not include those residents who did not meet the McGeer criteria, and the Covid-19 infections. When asked about the Infection Control Summary report, the IP stated she used the Infection Control Summary report to present the infection control during the infection control meeting. The IP verified the number of CAIs and HAIs in the Infection Control Summary report did not match the number of CAIs and HAIs marked in the surveillance log. The IP stated the Infection Control Summary report and the log did not match because she only counted the new infections in the Infection Control Summary report, while the log showed the residents who was treated with antibiotics and those who also had a change in antibiotic treatments. The IP further verified the number of residents on antibiotic medications in the Infection Control Summary did not match the number of residents on antibiotic medications in the surveillance log. When asked how the surveillance log was completed, the IP stated she would check the surveillance form then see if the resident met the McGeer criteria or not. The IP stated she would categorized the infections as CAI, HAI, those who did not meet the McGeer criteria, and those residents for surveillance purposes only. The IP stated she excluded the infections from the HAI or CAI classification if they did not meet the McGeer criteria. When asked about the monthly infection surveillance mapping, the IP stated she used the map to know where the infections were, and from the maps she would where or what to focus on. The IP stated she only included the new infections classified as CAIs and HAIs, and did not include those who did not meet the McGeer criteria, and the Covid-19 infections. The IP verified the facility mapping of the infections did not reflect the actual resident's infections in the facility. 2. Review of the facility's P&P titled Infection Control Policy – Laundry Services dated 7/2019 showed it is the facility's responsibility to ensure that all laundry is handled, stored, processed and transported in a safe and sanitary manner. On 9/10/25 at 0759 hours, an inspection of the laundry room and concurrent interview was conducted with Maintenance Supervisor 1. The following was observed in the clean area of the laundry room: - resident's blankets were observed stored in a linen rack, adjacent to another rack containing very dusty wedge pillows and splints; and - both linen racks were positioned against the wall with chipped paint. Maintenance Supervisor 1 verified the above findings. 3. Review of the CMS QSO-24-08-NH dated 3/20/24, for Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs, showed MDRO transmission is common in long-term care facilities such as nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. The EBP refer to an infection control intervention designed to reduce transmission of MDROs that employ targeted gown and glove use during high-contact resident care activities. The EBP are used in conjunction with standard precautions and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Review of the facility's P&P titled Enhanced Standard Precautions dated 5/2024 showed the following: - EBP is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus and MDROs; - Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of HCP hands, clothes, and the environment such as morning and evening care, device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter, any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care, changing bed linens, and any care activity involving contact with environmental surfaces likely contaminated by the resident, including cleaning and disinfection performed by environmental services personnel. On 9/12/25 at 0849 hours, an EBP sign was observed posted outside Resident 16's room to alert anyone to perform hand hygiene before entering and when leaving the room. The sign also alerted the providers and staff to wear gloves and a gown for high-contact resident care activities. A cart containing gowns was observed inside the room. CNA 7 was observed inside the room assisting Resident 16, then observed placing the soiled linen inside a bag, while also holding another bag containing soiled incontinence brief. CNA 7 was wearing a mask and gloves but was not observed wearing a gown. On 9/12/25 at 0850 hours, an observation for Resident 16 and a concurrent interview was conducted with CNA 7. CNA 7 verified there was an EBP sign placed outside Resident 16's room. CNA 7 verified she changed Resident 16's incontinence brief and his bed linen. CNA 7 acknowledged she was only wearing a mask and gloves and did not wear a gown while providing high-contact activities for Resident 16. CNA 7 stated she did not wear a gown because she was in a hurry. Medical record review for Resident 16 was initiated on 9/9/25. Resident 16 was readmitted to the facility 6/13/25. Review of Resident 16's Order Summary Report showed a physician's order dated 12/27/24, for EBP for an indwelling medical device. On 9/15/25 at 0809 hours, an interview and concurrent medical record review for Resident 16 was conducted with the DON. The DON stated when a resident was on EBP, the staff who would provide a high-contact care activities should wear gloves and gown, in addition to hand hygiene. 4. Review of the facility's P&P titled Infection Control - DME revised 10/2011 showed it is the policy of the facility to properly and routinely sanitize the durable medical equipment (DME). When available, the manufacturer's instructions will be followed for cleaning non-critical care items. In the absence of manufacturer's cleaning instructions, the following will be used to clean and disinfect these items between resident use: bleach wipes or germicidal wipes will be used for DME after each use. It is the responsibility of the nursing personnel to properly and routinely sanitize DME after each use. Review of the facility's P&P titled Hand Hygiene revised 7/2019 showed it is the policy of the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of infection. The Procedure section showed the following: - Hand hygiene will be performed by staff as follows: before performing invasive procedures; before touching a resident; if gloves will be worn, before gloving; before touching a resident's belongings; after touching a resident; after touching a resident's belongings; before taking care of susceptible residents such as those who are severely immunosuppressed; before and after touching any kinds of wounds; after contact with mucous membranes, blood and body fluids, secretions and/or excretions; after touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important micro-organisms such as urine collecting devices, bedpans; during care when moving from a contaminated activity to a clean activity (for example after assisting a resident with toileting, before assisting with clean clothing); immediately after glove removal; after taking care of an infected resident or one who is likely to be colonized with micro-organisms of special clinical or epidemiologic significance; and before and after giving personal care to residents and/or self; and - If gloves are worn for a procedure, hand hygiene is to be performed before putting gloves on and after removal and disposal of gloves. On 9/10/25 at 1137 hours, a medication administration observation and concurrent interview for Resident 22 was conducted with LVN 2. LVN 2 was observed cleaning the blood sugar machine with alcohol wipes wearing gloves. LVN 2 then was observed checking the blood sugar of Resident 22 without changing the gloves and performing hand hygiene. LVN 2 was observed cleaning the blood sugar machine with alcohol wipes and placed it inside Medication Cart A. LVN 2 stated after checking the blood sugar of the residents, she would wipe the blood sugar machine with alcohol wipes and at the end of the shift, she would clean it with bleach. LVN 2 acknowledged she did not change her gloves and perform hand hygiene after she cleaned the blood sugar machine and before checking Resident 22's blood sugar. On 9/10/25 at 1210 hours, an interview was conducted with the IP. The IP stated the facility's protocol was to clean the blood sugar machine with bleach wipes after each resident used or after completing the task. The IP stated if the staff cleaned any DME like the blood sugar machine with gloves on, the expectation was for the staff to change the gloves and perform hand hygiene before proceeding to any procedure to be done to the resident. The IP further stated by doing so, it was preventing the transmission of bacteria to the resident. The IP was informed and acknowledged the above findings. 5. On 9/11/25 at 0803 hours, a medication administration observation and concurrent interview for Resident 10 was conducted with LVN 3. LVN 3 verified Resident 10's medications were being administered via GT and was on EBP precaution. The following were observed: - LVN 3 touched the tube feeding machine to stop it with gloves on, then started diluting/mixing the crushed medications in each cup with water without donning new gloves and performing hand hygiene. LVN 3 then proceeded to administer the medications to Resident 10 via GT without changing gloves and performing hand hygiene; - LVN 3 removed her gloves and started milking the GT catheter when it was clogged. LVN 3 wore new gloves without performing hand hygiene, then continued giving the medications via GT; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LVN 3 disconnected the 60-cc syringe being used for the medication administration from the GT when the GT became clogged again. LVN 3 placed the 60-cc syringe on the medicine tray without covering the tip of the syringe and reused the same syringe when she had to resumed the medication administration; - LVN 3 did not wear a gown all throughout the process of the medication administration. In addition, the Care Plan Coordinator also did not wear a gown when she came to assist LVN 3 to unclog Resident 10's GT. LVN 3 verified she and the Care Plan Coordinator did not wear the gown when they were doing high contact care activities to Resident 10 on the EBP precaution. LVN 3 verified she did not change gloves and performed hand hygiene during the above observations. LVN 3 stated she should have done proper hand hygiene in between gloves changes and wore the gown for infection control measures. LVN 3 stated she should have used a new 60-cc syringe when she continued with the medication administration after the GT started functioning . LVN 3 acknowledged she placed the syringe in the tray without covering the tip and the syringe got contaminated. On 9/11/25 at 1139 hours, an interview was conducted with the IP. The IP stated for the residents with GT, indwelling urinary catheter, dialysis access, central and peripheral IV lines and draining wounds, the EBP precaution should be observed. The IP stated the staff should be wearing the gowns and gloves when performing high contact resident care activities. The IP stated providing care to the GT and administering the medications via GT were considered high contact resident care activities. The IP stated the residents with an open access should be provided with extra infection control precautions to avoid causing or transmitting any bacteria that could lead to infection. The IP was informed and acknowledged the above findings. 6. Medical record review for Resident 54 was initiated on 9/9/25. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's Order Summary Report showed a physician's order dated 10/22/24, for EBP for an indwelling device, a GT. On 9/9/25 at 0853 hours, observation and interview was conducted with CNA 4. There was an EBP signage posted on the wall next to Resident 54's doorway showed staff must wear gloves and a gown for care activities including changing incontinent briefs, providing hygiene, and transferring. CNA 4 was observed standing at Resident 54's bedside, with the resident sitting at the edge of the bed, with a wheelchair next the bed. CNA 4 was observed wearing a procedure mask and gloves; however, CNA 4 was not wearing a gown. CNA 4 then proceeded to transfer Resident 54 to his wheelchair. CNA 4 stated she had changed the resident and then transferred him to his wheelchair. CNA 4 verified Resident 54 had a GT and acknowledged she should have worn an isolation gown while performing resident care and transfers. 7. Review of the CDC's Infection Control Guidance: SARS-CoV-2 (COVID-19) dated 6/24/24, showed resident's with suspected or confirmed COVID-19 should be placed in a room with the door closed. Medical record review for Resident 70 was initiated on 9/9/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70's Order Summary Report showed a physician's order dated 9/4/25, for Droplet (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Precautions for COVID -19. Review of Resident 70's care plan showed a care plan problem initiated on 9/4/25, for the resident being COVID-19 positive. The approaches included to keep the resident's door closed at all times. On 9/9/25 at 0841 hours, Resident 70's doorway was observed open. A Droplet Isolation signage was posted next to the resident's door. LVN 1 was observed pushing a medication cart past the resident's room while the door was open. On 9/9/25 at 0843 hours, an observation and interview was conducted with the DON. The DON stated the doors of the COVID-19 positive resident rooms should be closed at all times. The DON saw Resident 70's doorway was open. The DON stated it should have been closed, then the DON closed the door. On 9/10/25 at 0931 hours, an interview was conducted with the IP. The IP stated Resident 70 was confused and had behaviors of opening her door. The IP stated to prevent the COVID-19 from spreading, all the staff had been trained to ensure doors were closed for the residents with COVID-19. The IP stated the staff should have closed Resident 70's door when they observed it was open.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the regular inspection for all the facility beds was conducted as part of the regular maintenance program. * The facility failed to conduct a regular inspection of Residents 2, 3, and 5's beds, bed frames, and mattresses, as part of the regular maintenance program. These failures had the potential to compromise residents' safety, health, and well-being.Findings: Review of the facility's P&P titled Bed Safety revised 7/2018 showed the following: - The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment; - To try to prevent death/injury from the beds and related equipment (including the frame, mattress, side rails, grab bar, headboard, footboard, and bed accessories), the facility shall promote the following approaches, including inspection by maintenance staff of all beds and related equipment as part of the facility's regular bed safety program to identify any risks or problems including potential entrapment risks; and - The maintenance department shall provide a copy of inspections to the Administrator and report results to the QAPI Committee for appropriate action. Copies of the inspection results and QAPI Committee recommendations shall be maintained by the Administrator and/or Safety Committee. Review of the facility's Census dated 9/9/25, showed the facility had a 72-bed capacity and currently had 64 residents in the facility. Further review of the residents' medical records and facility documents showed there was no documented evidence the maintenance department conducted a routine inspection of all the beds and related equipment as part of the facility's regular bed safety program. For example: 1. Medical record review for Resident 2 was initiated on 9/9/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed a physician's order dated 4/16/25, for the right grab bar as an enabler to assist with the bed mobility, turning, repositioning and transfers. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 had severe cognitive impairment and required partial/moderate assistance with mobility. Review of Resident 2's H&P examination dated 7/16/25, showed Resident 2 was confused with medical diagnosis of dementia. Further review Resident 2's medical record failed to show documented evidence that a routine bed inspection was conducted. 2. Medical record review for Resident 3 was initiated on 9/9/25. Resident 3 was admitted to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE]. Review of Resident 3's Order Summary Report showed a physician's order dated 1/31/23, for the bilateral grab bars as an enabler to assist with bed mobility, turning, repositioning and transfers. Review of Resident 3's H&P examination dated 5/18/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had severe cognitive impairment and dependent with mobility. Further review of Resident 3's medical record failed to show documented evidence that a routine bed inspection was conducted. On 9/12/25 at 1157 hours, an interview and facility document review was conducted with the Maintenance Consultant and Maintenance Supervisor 2. The Maintenance Consultant stated the maintenance department was responsible for conducting the monthly bed inspections which include inspecting the grab bars, brakes, mattress, bed frame, headboard and footboard, and making sure the bed controls were operational. When asked to provide documentation of the recent bed inspection, the Maintenance Consultant and Maintenance Supervisor 2 showed the maintenance binder showing the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form. However, the maintenance binder did not show documented evidence a routine bed inspection, including inspecting the brakes, bed frame, mattress, headboard and footboard were conducted for the resident beds in the facility. The Maintenance Consultant and Maintenance Supervisor 2 verified the above findings. On 9/15/25 at 0841 hours, an interview was conducted with the DON. The DON stated the bed inspection of all the residents' beds should be part of the maintenance routine inspection to make sure all the beds were functioning properly for safety. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 5 was initiated on 9/9/25. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed a physician's order dated 9/16/24, for the right grab bar as an enabler to assist with bed mobility, turning, and repositioning. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 was cognitively intact, and required supervision or touching assistance for char/bed-to-chair assistance, sit to stand, sit to lying and lying to sitting on the side of the bed. Further review Resident 5's medical record failed to show documented evidence that a routine bed inspection was conducted. On 9/12/25 at 1157 hours, an interview was conducted with the Maintenance Consultant and Maintenance Supervisor 2. When asked about the bed inspection, the Maintenance Consultant stated the maintenance department was responsible for conducting the monthly bed inspections which include inspecting the grab bars, brakes, mattress, bed frame, headboard and footboard, and making sure the bed controls were operational. When the Maintenance Consultant and Maintenance Supervisor 2 were asked to provide documentation of the recent bed inspection, the Maintenance (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consultant and Maintenance Supervisor 2 showed the maintenance binder with the Siderail or Bedrail Assessment Guidance to Reduce Entrapment form. Review of the facility's document titled Siderail or Bedrail Assessment Guidance to Reduce Entrapment form dated 9/12/25, showed several room numbers with checkmarks to show the resident beds had a left or a right grab bars. The form also showed the measurements conducted on the different zones of entrapment as applicable. Further review of the form and the maintenance binder did not show documented evidence a routine bed inspection, including inspecting the brakes, bed frame, mattress, headboard and footboard, was conducted. The Maintenance Consultant and Maintenance Supervisor 2 verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility's P&P review, the facility failed to obtain and maintain a copy of the advance directives (a legal document stating a person's wishes about receiving medical care if the person is no longer able to make medical decisions) for two of four final sampled residents (Residents 8 and 33) reviewed for the advance directives. * The facility failed to inquire about the existence of an advanced directive for Resident 8. * The facility failed to maintain a copy of Resident 33's advanced directive in the resident's medical record. In addition, the facility failed to ensure Resident 33's POLST (Physician Orders for Life-Sustaining Treatment (a medical order that allows seriously ill or frail residents to specify their treatment wishes for the end of life, which is completed by a resident and their physician, nurse practitioner, or physician assistant, the bright pink POLST form details preferences for treatments like CPR, ventilators, and feeding tubes, traveling with the patient through different care settings) was complete. These failures had the potential for the residents' decisions regarding their health care and treatment options not to be honored.Findings: Review of the facility's P&P titled Advance Directives dated 4/2017 showed it was the policy of the facility that a resident may develop an advance directive relative to his/her refusal of medical or surgical treatment, which will be followed in accordance with this policy and procedure and current state law. Further review of the P&P 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. 1. Medical Record review for Resident 8 was initiated on [DATE]. Resident 8 was admitted to the facility on [DATE]. Review of the H&P examination dated [DATE]/25, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's POLST dated [DATE], under the Section D showed Resident 8 had a legally recognized decision maker and no advance directive. Further review of the POLST failed to show if the facility followed up with the resident or their representative regarding the existence of Resident 8' s advance directive. Review of Resident 8's Advance Health Care Directive Acknowledgement failed to show the signature of Resident 8 or their representative. Further review of the document failed to show if Resident 8 or their representative followed up with the resident or their representative regarding the existence of Resident 8's advance directive. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8 was cognitively intact. Further review of Resident 8's medical record failed to show if Resident 8 or their representative were asked if Resident 8 had completed an advanced directive. 2. Medical record review for Resident 33 was initiated on [DATE]. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's POLST dated [DATE], showed Section D was incomplete. Further review of the POLST failed to show if Resident 33 had an advance directive. Further review of Resident 33's medical record failed to show if the facility followed up with the resident or their representative regarding the existence of Resident 33's advance directive. Review of Resident 33's MDS assessment dated [DATE]/25, showed Resident 33 had severe cognitive impairment. On [DATE] at 1106 hours, an interview and concurrent medical record review for Residents 8 and 33 was conducted with the SSD. The SSD stated when the residents got admitted to the facility, the facility inquired about the existence of the residents' advance directive and documented to follow up in the resident's medical record. The SSD added if the resident had the capacity to make medical decisions, then the facility would provide the information regarding how to formulate an advance directive. The SSD verified Resident 8's medical record did not have documented evidence to show if the facility followed up with the resident or their representative regarding the existence of Resident 8's advance directive. The SSD stated Resident 33 had an advance directive; however, the SSD verified the copy of the advance directive was not available in the resident's medical record and readily retrievable by the facility staff. The SSD stated the copy of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	the resident's advance directive should have been maintained in Resident 33's medical record and should be readily retrievable by the facility staff. In addition, the SSD verified Resident 33's POLST Section D was incomplete and did not show if Resident 33 had an advanced directive. The SSD verified Resident 33's POLST was incomplete. On [DATE] at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary transfer/discharge services for one of two final sampled residents (Resident 51) reviewed for acute care hospitalization. * The facility failed to notify Resident 51 and/or their representative in writing regarding the transfer and reasons for the transfer, and the facility's bed hold policy when Resident 51 was transferred to the acute care hospital. This failure had the potential for the resident and/or their representative to be unaware about the transfer and reason(s) of transfer, and their rights to request a bed hold and return to the first available bed should the resident's acute care hospital stay exceed the seven-day bed-hold period.Findings: Review of the facility's P&P titled Discharge Process dated 10/2017 showed before the facility transfers or discharge a resident, the facility will notify the resident and the resident's representatives of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. Further review of the P&P showed before the facility transfers a resident to an acute care hospital or the resident goes on a therapeutic leave, the facility will provide written information to the resident and the representative that specifies the duration of the state bed hold policy during which the resident is permitted to return and resume residence and the information in the notice described above. A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period, may return to the facility to their previous room if it is available or immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. Medical record review for Resident 51 was initiated on 9/9/25. Resident 51 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 51's H&P examination dated 6/30/25, showed Resident 51 was able to make simple decision. Review of Resident 51's MDS assessment dated [DATE], showed Resident 51 was cognitively intact. Review of Resident 51's Physician Order Summary showed a physician's order dated 8/27/25, to transfer Resident 51 to the acute care hospital for further evaluation of low oxygen saturation and heart rate, and to provide the bed hold for seven days if admitted . Review of Resident 51's SBAR Communication Form dated 8/27/25, showed at 0543 hours, Resident 51 was transferred to the acute care hospital. Review of Resident 51's Notice of Transfer/discharge date d 8/27/25, showed the transfer location as the acute care hospital and the reason for the transfer was for Resident 51's welfare and the resident's needs could not be met in the facility. The section for the resident or resident representative signature did not show any entry. Further review of Resident 51's medical record failed to show if Resident 51 or their representative were provided with the written notice of transfer when Resident 51 was transferred to the acute care hospital on 8/27/25. Review of Resident 51's Bed Hold Informed Consent showed Resident 51 was transferred to the acute care hospital on 8/27/25, for low oxygen saturation. The consent showed, you have the option of requesting a seven (7) day bed hold to keep a bed vacant and available for return to this facility. Non-Medi-Cal beneficiaries are responsible for the reasonable cost not to exceed the beneficiaries daily room rate. Insurance may or may not cover such charges. Medical will cover the cost of the bed if the residence here of cost has been satisfied for the month, unless we receive the return notice from the attending physician that they stay in the hospital is expected to exceed seven days. If you desire this option, the facility must be notified within 24 hours of transfer. However, the consent did not show the signature of Resident 51 or their representative. Further review of Resident 51's medical record for Resident 51 did not show if Resident 51 or their representative was notified in writing of the facility's bed hold policy when Resident 51 was transferred to the acute care hospital on 8/27/25. On 9/11/25 at 1039 hours, an interview and concurrent medical record review for Resident 51 was conducted with RN 1. RN 1 verified Resident 51 was transferred to the acute care hospital on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	8/27/25. RN 1 stated Resident 51's representative was informed regarding the bed hold and notice of transfer; however, she was not able to find the documentation if the facility's bed hold policy and notice of transfer was provided to Resident 51 or their representative in writing. RN 1 stated she was not sure how the facility provided the transfer/discharge notices, and bed hold policies in writing, when the resident was not able to sign the document and the resident representative was not available at the time of the transfer. On 9/11/25 at 1106 hours, an interview was conducted with the SSD. The SSD stated she faxed the transfer discharge notice to the ombudsman for the facility; however, she did not mail or email the transfer/discharge notices, and bed hold policies to the resident or their representative. On 9/12/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the MDS assessment for significant change was completed timely for one of three residents (Resident 4) reviewed for closed records. * The facility failed to ensure the MDS assessment was completed in a timely manner when Resident 4 was admitted to the hospice services. This failure had the potential for the resident to not receive the necessary care and services based on the resident's assessment and needs.Findings: Review of CMS's Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19, showed a Significant Change in Status MDS is required to be performed when a resident enrolls in a hospice program. The RAI also showed a Significant Change in Status MDS assessment should be completed by the 14th calendar day after the determination that significant change in the resident's status occurred. Closed medical record review for Resident 4 was initiated on 9/9/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report dated 8/27/25, showed on 6/19/25, Resident 4 was admitted to hospice services. Review of Resident 4's MDS assessment showed an assessment for Significant Change dated 7/1/25. Further review of the MDS assessment showed a completion date of 7/9/25, 20 calendar days after Resident 4 was admitted to hospice services. On 9/11/25 at 1621 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 4's physician order for hospice services dated 6/19/25, triggered the MDS for Significant Change in Status dated 7/1/25. On 9/11/25 at 1634 hours, a telephone interview with the MDS Consultant was conducted with the MDS Coordinator present. The MDS Consultant stated a Significant Change in Status MDS must be completed by the 14th calendar day from a resident's order for hospice services. The MDS Coordinator then stated Resident 4's MDS should have been completed by 7/3/25. The MDS Coordinator acknowledged the MDS assessment was not completed timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the PASRR (Preadmission Screening and Resident Review) screening for one of five final sampled residents (Resident 9) reviewed for the unnecessary medications was accurately completed as per the facility's P&P. * The facility failed to complete a PASRR when the initial screening had inaccurate information indicating Resident 9 had no serious mental illness diagnosis. In addition, the facility failed to timely resubmit the required new Resident Review. This failure had the potential for the resident not to be screened accurately/timely and receive the necessary additional services if needed.Findings: Review of the facility's P&P titled PASRR (Preadmission Screening and Resident Review) revised 3/2019 showed the facility had to screen each resident, regardless of payment source, when applying for admission to, or residing in the facility, which is a Medicaid-certified facility, for mental illness and intellectual disability. The Procedure section showed all admissions to the facility will receive a Preadmission Screening prior to the admission of the resident. If the resident has already been admitted to the facility and the PASRR is being updated because the resident has exceeded the 30-day exempted hospital discharge or there is a significant change according to the MDS, this is considered a resident review status change. Medical record review for Resident 9 was initiated on 9/10/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's admission Diagnosis/Status from the acute hospital dated 8/1/25, showed Resident 9 had a diagnosis of anxiety disorder, major depressive disorder, and schizophrenia (a severe brain disorder in which people interpret reality abnormally). Review of Resident 9's DHCS letter regarding Notice of Exempted Hospital discharge date d 8/1/25, showed the negative Level 1 screening indicated a Level II mental health evaluation was not required. However, the form further showed if the individual remained in the nursing facility for longer than 30 days, the facility must resubmit a new Level 1 Screening as a Resident Review on the 31st day. Review of Resident 9's PASRR Level 1 Screening done by the acute hospital dated 8/1/25, showed the resident was not diagnosed with serious mental illness or had a suspected mental illness. However, the form showed the resident was receiving Risperdal (anti-psychotic medication) 0.25mg twice a day, Zoloft (anti-depressive medication) 50 mg daily, and Ativan (anti-anxiety medication) 0.5 mg every four hours. Review of Resident 9's H&P examination dated 8/4/25, showed Resident 9 had no capacity to understand and make decisions due to dementia. On 9/10/25 at 1201 hours, an interview and concurrent medical record review for Resident 9 was conducted with the MDS Coordinator. The MDS Coordinator stated she did not know in full details but she knew something got triggered at the acute hospital that would require the facility to resubmit a new Level 1 screening. The MDS Coordinator stated she would only review the resident's PASRR if it was positive or not. When asked if she reviewed the PASRR when the resident was admitted to the facility, the MDS Coordinator stated she did not review the information on the PASRR for accuracy. The MDS Coordinator verified the information in Resident 9's PASRR dated 8/1/25, was not accurate when the form indicated Resident 9 was not diagnosed with serious mental illness and the resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	was on psychotropic medications. The MDS Coordinator stated she should have initiated another PASRR. The MDS Coordinator also verified Resident 9 needed a new Level 1 Screening as a Resident Review on the 31st day of resident stay at the facility. The MDS Coordinator provided a document showing the screening was completed, however, the screening was done 9/2/25, past the 31st day requirement. On 9/10/25 at 1710 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop and implement a comprehensive person-centered care plan for three of 17 final sampled residents (Residents 3, 9, and 34). * The facility failed to ensure the care plan showed specific monitoring for signs and symptoms of bleeding related to the use of clopidogrel bisulfate (medication used to prevent dangerous blood clots) for Resident 3. * The facility failed to ensure the care plan included the monitoring of orthostatic hypotension related to the use of the psychotropic medications for Resident 9. * The facility failed to ensure a care plan was developed for anticoagulant monitoring for Resident 34. These failures had the potential to cause inconsistent, inappropriate, and inadequate plans of care for the residents in a vulnerable population.Findings: Review of facility's P&P titled Comprehensive Care Planning revised 3/2019 showed the care plan must include services that are to be provided to attain or maintain the resident's highest level of well-being and any services that have been recommended but has been refused due to the resident's right to refuse treatment. 1. Medical record review for Resident 3 was initiated on 9/9/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 5/18/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed a physician's order dated 6/22/23, to administer clopidogrel bisulfate 75 mg one tablet by mouth one time a day for CVA prophylaxis. Review of Resident 3's care plan for monitoring the cardiovascular system related to the use of CVA prophylaxis dated 7/9/25, failed to show the approach plan had specific monitoring for signs and symptoms of bleeding related to the use of the clopidogrel bisulfate medication. On 9/11/25 at 1552 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 2. RN 2 stated Resident 3 was high risk for bleeding related to the use of the clopidogrel medication. RN 2 stated the signs and symptoms of bleeding could be blood in stool or urine, nosebleed, gum bleed, or bruising. RN 2 verified Resident 3's care plan failed to address the need to monitor the resident for the signs and symptoms of bleeding related to the use of the clopidogrel bisulfate medication. On 9/15/25 at 0841 hours, an interview was conducted with the DON. The DON stated clopidogrel or Plavix medication could cause an adverse reaction of the bleeding, so it was important to monitor the resident for early detection of signs and symptoms bleeding and the physician would be notified right away. The DON further stated this should be reflected in the resident's plan of care. The DON was informed and acknowledged the findings for Resident 3. Cross reference to F757, example #1. 2. Medical record review for Resident 9 was initiated on 9/10/25. Resident 9 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 9's H&P examination dated 8/4/25, showed Resident 9 had no capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 8/1/25, to monitor the resident's blood pressure lying and sitting for orthostatic hypotension every week on Sunday at 0700 to 1500 hours shift. Notify the physician if the difference of systolic blood pressure is 20 mmHg or greater or if diastolic blood pressure is 10 mmHg or greater. - dated 8/1/25, to administer sertraline (medication used to help improve mood) 50 mg by mouth one tablet at bedtime for depression as manifested by verbalization of feeling depressed; - dated 8/5/25, to administer Depakote (anticonvulsant) 125 mg by mouth one tablet two times a day for mood disorder as manifested by poor impulse control; and Review of Resident 9's care plan for risk for drug related side effects due to use of the psychoactive medications dated 8/4/25, failed to include for the monitoring of the blood pressure for orthostatic hypotension every week. On 9/10/25 at 1608 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 2. LVN 2 stated the orthostatic hypotension needed to be monitored when the resident was taking the psychotropic medications. LVN 2 verified the care plan for Resident 9 failed to address the need to monitor the resident for the orthostatic hypotension related to the use of the psychotropic medications. On 9/10/25 at 1710 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings for Resident 9. Cross reference to F605, example #1. 3. According to the FDA the approved Highlights of Prescribing Information for clopidogrel bisulfate revised 3/2021 showed the most common adverse reaction in adult patients are related to bleeding including life-threatening and fatal bleeding. Medical record review for Resident 34 was initiated on 9/9/25. Resident 34 was readmitted to the facility on [DATE]. Review of Resident 34's Order Summary Report showed a physician's order dated 3/7/25, for clopidogrel bisulfate an anticoagulant) 75 mg tablet by mouth daily for CVA prophylaxis. Review of Resident 34's care plan for risk for skin tear/discoloration related to the antiplatelet and anticoagulant medications use initiated on 3/7/25 and revised on 6/10/25, showed interventions included to monitor the resident's skin daily for changes color and/or turgor. The care plan failed to show staff would monitor for bleeding related to anticoagulant use. On 9/11/25 at 1524 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated when a resident was on anticoagulants, they should be monitored for bleeding and bruising, and should check the resident's gums, stool and urine for bleeding and check their skin for bruising or bleeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	On 9/12/25 at 1024 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 34's care plan and verified the resident's care plan only showed to monitor the resident for skin tear/bruising for the anticoagulant medication use. The DON stated the care plan should also include observing the resident for bleeding from the stool, urine, and mouth related to anticoagulant therapy. Cross reference to F757, example #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to revise the resident centered care plan for one of six final sampled residents (Resident 54) reviewed for accidents. * The facility failed to revise Resident 54's care plan when Resident 54 had a fall and the facility added new interventions for safety. This failure had the potential for the resident's to not receive the necessary care and services.Findings: Review of the facility's P&P titled Fall Risk & Prevention of Injury to Include Pathological Fractures revised March 2019 showed after a resident's fall, the facility will investigate the resident's fall, and the IDT will make recommendations for additional approaches to help prevent further falls. Any additional approaches will be included in the residents plan of care. Medical record review for Resident 54 was initiated on 9/9/25. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's SBAR Communication Form dated 8/22/25, showed the resident had a seizure which resulted in a fall. Review of Resident 54's Status Post Fall Assessment - Rehab Department dated 8/22/25, showed the resident was sitting in his wheelchair when the fall occurred. The section for Recommendations showed don't leave resident unattended. On 9/9/25 at 0853 and 1155 hours, and 9/10/25 at 1135 hours, Resident 54 was observed with a caregiver. Review of Resident 54's care plan failed to show the resident had a caregiver for safety. On 9/12/25 at 0827 hours, an interview was conducted with Resident 54's Caregiver. The Caregiver stated they watch the resident for safety. On 9/12/25 at 0944 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated after a resident fall, the IDT will meet and make recommendations and the interventions will be added in the care plan. The DON reviewed Resident 54's Status Post Fall assessment dated [DATE], with recommendations to not leave the resident unattended. The DON clarified it was for when the resident was up in his wheelchair. The DON stated Resident 54 had caregivers provided by the resident's family that were usually with the resident from around 0800 to 0900 hours up to the evening around 2000 hours. The caregivers helped monitor the resident while up in his wheelchair for safety. The DON stated the resident was only up in his wheelchair when one of the caregivers was available to monitor him at all times. The DON verified Resident 54's care plan showed to provide close monitoring but was not revised to show the resident had caregivers and for the resident to be up in his wheelchair when the caregivers were available to provide the continuous monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0690 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the appropriate care and services for one of two final sampled residents (Resident 11) with an indwelling urinary catheter. * The facility failed to consistently monitor the amount of Resident 11's urinary output related to catheter use as per the physician's order. In addition, the facility failed to monitor the 24-hour total, and weekly evaluation of Resident 11's average intake and output. These failures posed the risk for the resident to have fluid imbalances resulting in kidney damage or heart failure, inadequate hydration leading to infection, and delayed detection of CAUTIs or catheter obstruction which could lead to sepsis and death.Findings: Review of the facility's P&P titled Intake and Output Measurement dated 10/2015 showed the following:- The following residents require measurement and documentation of intake and output every eight hours for SNF residents, including 24-hour totals and weekly evaluation for 30 days: residents with indwelling catheters, and resident with specific physician's orders for measurement of intake and output;- The intake and output are to be evaluated weekly to determine adequacy. If the amount is not adequate or if it is excessive for the physical condition of the resident, the physician is to be notified, and corrective action should be taken;- The licensed nurse is responsible for the weekly evaluation of the resident's intake and output; and- The documentation included date, amount of intake every eight hours for SNF residents, and amount of output every eight hours for SNF residents, 24-hour total of intake and output, and a weekly evaluation will be conducted of the resident's average 24-hours intake and output. On 9/9/25 at 0828 hours, 9/10/25 at 0849 hours, 9/11/25 at 0844 hours, and 9/12/25 at 0858 hours, Resident 11 was observed in bed and had an indwelling urinary catheter with the drainage bag observed hanging on the side of the bed. Medical record review for Resident 11 was initiated on 9/9/25. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Order Summary Report showed the following physician's orders:- dated 8/27/25, to monitor the intake and output for urinary retention every shift for 30 days; and- dated 9/2/25, for Foley catheter size French #16 with five to ten ml, for urinary retention. Review of Resident 11's Task Documentation, under the section for Monitor - Output dated 8/27 to 9/12/25, did not consistently show the actual amount of the urine output. Resident 11's urine output was documented as not applicable on the following dates and times:- 8/27/25 at 0027 hours;- 8/29/25 at 1025 hours;- 8/30/25 at 1108 hours- 9/1/25 at 1002 and 2009 hours;- 9/2/25 at 0122, 1106, and 2052 hours;- 9/4/25 at 1027 hours;- 9/5/25 at 1053 hours;- 9/6/25 at 0929 hours;- 9/7/25 at 1037 hours;- 9/10/25 at 1045 hours; and- 9/11/25 at 1128 hours. Review of Resident 11's COC (Change of Condition) monitoring showed the following handwritten notes:- dated 9/1/25 at 2200 hours, showed Resident 11 had a Foley catheter removal, one episode of urination noted;- dated 9/2/25 at 0500 hours, showed Resident 11 had a Foley catheter removal, and voiding freely;- dated 9/2/25 at 1443 hours, showed Resident 11 voided at 0700 to 1500 hour shift, in brief; and- dated 9/3/25 at 1451 hours, showed Resident 11 had no itching or rash around the insertion area, with no urine leakage, and noted with 1000 ml output. Further review of Resident 11's medical record failed to show documented evidence of the 24-hour total of the resident's intake and output, and weekly evaluation of the resident's average intake and output. On 9/12/25 at 1104 hours, an interview and medical record review for Resident 11 was conducted with the DON. The DON verified Resident 11 had an indwelling urinary catheter. The DON stated Resident 11 was readmitted on [DATE], with an indwelling urinary catheter and was removed for a bladder training on 9/2/25, but the indwelling urinary catheter was reinserted on 9/3/25. The DON stated the licensed nurses documented the resident's intake and output in the electronic health record. The DON verified the amount of Resident 11's urine output was not consistently documented per shift. The DON also verified the licensed nurses did not document a 24-hour total of Resident 11's intake and output and did not do a weekly evaluation of Resident 11's average intake and output.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage of medications. * The facility failed to ensure two opened and used vaginal creams labelled with an open date of 8/19 and 8/28/24, were properly stored. The medications were kept in the medication room together with floor stock medications. This failure had the potential for infection to the residents and potentially result in inappropriate administration of prescription medication.Findings: Review of the facility's P&P titled ID1: Storage of Medications effective date 4/2008 showed the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. On 9/10/25 at 1400 hours, an inspection of Medication room [ROOM NUMBER] was conducted with LVN 6. LVN 6 verified there were two opened and used vaginal cream labelled with an open date of 8/19/24 and 8/28/24 kept together in a cabinet with the floor stock medications. On 9/15/25 at 0841 hours, an interview was conducted with the DON. The DON stated once the medicated creams for the residents were opened and used, it should be kept in the medication cart and not in the medication room to prevent contamination with the other new and unopened medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure the garbage and refuse were properly stored in three of four garbage dumpsters. * The lids of the facility's garbage dumpsters were partially (approximately one and half inch or two inch) open. This failure had the potential to harbor pests or rodents which carry diseases.Findings: According to the USDA Food Code 2022, 5-501.113, Covering Receptacles, the receptacles and waste handling units for refuse shall be kept covered (B) with tight-fitting lids. Review of the facility P&P titled Sanitation and Infection Control - Waste Control and Disposal dated 5/2016 showed to keep lids of outside trash dumpsters closed. On 9/10/25 at 0831 hours, an observation of the dumpster area and concurrent interview was conducted with the Dietary Director. Three of four dumpsters were observed with garbage inside. The dumpster lids were partially open on both sides of the dumpsters (approximately around one and half inches or two inches). The Dietary Director verified the observation. The Dietary Director stated he did not follow up to have tight fitting lids for the dumpsters for the facility. The Dietary Director acknowledged disease carrying pets like flies and rodents could easily get in and out form the partially open sides of the dumpster. On 9/10/25 at 1220 hours, a small flying insect was observed in the Nursing Station A. On 9/10/25 at 0822 hours, a small flying insect was observed in the doorway of resident's Room A. On 9/12/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical records review, and facility P&P review, the facility failed to ensure the medical records were complete and accurate for two of four residents (nonsampled Residents 62 and 63) observed for medication administration, one of one final sampled residents (Resident 23) reviewed for the hospice, and one of one final sampled residents (Resident 51) reviewed for acute care hospitalization. * The facility failed to document the medication administration and monitoring in Resident 62's MAR on 9/5 and 9/8/25. * The facility failed to document the medication administration in Resident 63's MAR on 9/5 and 9/8/25. * The facility failed to ensure an updated POLST was available in the medical record when Resident 23 formulated an advance directive. * The facility failed to document the interventions provided when Resident 51 had a low oxygen saturation. These failures had the potential to negatively affect the residents' care and well-being as their medical records were incomplete/inaccurate.Findings: Review of the facility's P&P titled Medication Administration revised April 2025 showed the nurse must electronically sign the MAR for each appropriate medication after the administration. 1. Medical record review for Resident 62 was initiated on 9/9/25. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's MAR for September 2025 showed no documentation of the medication administration or monitoring for the following: - vitamin D (a supplement) 2000 units by mouth, on 9/5 and 9/8/25 at 0900 hours; - docusate sodium (a stool softener) 250 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - hydrochlorothiazide (a diuretic) 25 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - lisinopril (a blood pressure medication) 40 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - multi-vitamin with minerals (a supplement) one tablet by mouth, on 9/5 and 9/8/25 at 0900 hours; - amlodipine besylate (a blood pressure medication) one tablet by mouth, on 9/5 and 9/8/25 at 0900 hours; - calcium with vitamin D (a supplement) 500mg/200 units by mouth, on 9/5 and 9/8/25 at 0900 hours; - vitamin C (a supplement) 500 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - carvedilol (a blood pressure medication) 25 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - clonidine hcl (a blood pressure medication) 0.3 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - ferrous sulfate (an iron supplement) 325 mg by mouth, on 9/5 and 9/8/25 at 0730 hours; - metformin hcl (a diabetic medication) 1000 mg by mouth, on 9/5 and 9/8/25 at 0730 hours; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- potassium chloride ER (a potassium supplement) 60 mEq by mouth, on 9/5 and 9/8/25 at 0900 hours - Humulin R (a medication to lower blood sugar) 4 units subcutaneously, on 9/5 and 9/8/25 at 1130 hours - blood sugar checks to be done two hours after meals, on 9/5 and 9/8/25 at 0930 at 1430 hours; and - monitor the BP every eight hours for prn hydralazine use (a blood pressure medication), on 9/5 and 9/8/25 at 1400 hours. On 9/11/25 at 1456 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated all the medications and monitoring scheduled in the MAR must be documented to show if they were or not administered/completed. The DON stated there should be no documentation gaps in the MARs. The DON reviewed Resident 62's MAR for September 2025 and verified the above missing documentation. 2. Medical record review for Resident 63 was initiated on 9/9/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's MAR for September 2025 showed no documentation of the administration for the following medications: - chewable aspirin (an antiplatelet medication) 81mg by mouth, on 9/5/25 at 0900 hours; - Lantus 22 units subcutaneously, on 9/5/25 at 0900 hours; - losartan potassium (a blood pressure medication) 25 mg by mouth, on 9/5 and 9/8/25 at 0900 hours; - potassium chloride ER 20 mEq by mouth, on 9/5 and 9/8/25 at 0730 hours; - cholecalciferol (a supplement) 10,000 units by mouth, on 9/5 and 9/8/25 at 0900 hours; - calcium (a supplement) 500 mg by mouth, on 9/5 and 9/8/25 at 0900 hours - Vascepa (anti-lipidemia) 2 grams by mouth, on 9/5 and 9/8/25 at 0900 hours; and - Xarelto (a blood thinner) 2.5 mg by mouth, on 9/5 and 9/8/25 at 0900 hours. On 9/11/25 at 1456 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated all the medications and monitoring scheduled in the MAR must be documented to show if they were or not administered/completed. The DON stated there should be no documentation blanks in the MARs. The DON reviewed Resident 63's MAR for September 2025 and verified the above missing documentation. 3. Medical record review for Resident 23 was initiated on 9/9/25. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's POLST dated 2/3/19, showed the resident had no Advance Directive. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of resident 23's Advance Health Care Directive dated 10/28/20, showed the resident formulated an Advance Directive with the Ombudsman while resident was at the facility. Further review of Resident 23's medical record failed to show an updated POLST in the resident's medical records when she had formulated an Advance Directive on 10/28/20. On 9/12/25 at 1433 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 reviewed Resident 23's POLST and Advanced Directive. LVN 6 verified the POLST was completed prior to the resident formulating an Advance Directive, and a new POLST should have been completed to show the resident formulated an Advance Directive. 4. Review of the facility's P&P titled Emergency Care dated 1/2017 showed the facility will provide an emergency care to a resident in need of urgent services.If resident's condition has changed, the attending physician should be called and the changes that have been observed are to be reported. Emergency care is to be provided as necessary.Document details and the exact time the change of condition was noted, as well as initiation of emergency procedure and the resident's response to emergency care. Medical record review for Resident 51 was initiated on 9/9/25. Resident 51 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 51's Physician Order Summary showed a physician's order dated 8/27/25, to transfer Resident 51 to the acute care hospital for low oxygen saturation and heart rate for further evaluation and to provide the bed hold for seven days if admitted . Review of Resident 51's SBAR Communication Form dated 8/27/25, showed Resident 51 had a change in condition, the observed signs and symptoms were low oxygen saturation level of 64-70% (normal range between 95% and 100%) on continuous oxygen at a rate of 5 liters per minute and low heart rate of 42 beats per minute (a normal resting heart rate ranges from 60 to 100 beats per minute). Under the section for Nursing Notes showed the following: - at 0520 hours, showed Resident 51 was noted with low oxygen saturation, initially recorded at 64% while receiving continuous oxygen via nasal cannula at 5 liters per minute. Resident 51 was repositioned and placed into high Fowler's position and an oral and nasal care were provided. The oxygen saturation improved to 70% on oxygen at 5 liters per minute. An order was obtained to transfer Resident 51 to the emergency department, and - at 0543 hours, the emergency medical services arrived and transported Resident 51 to the emergency department of an acute care hospital. Further review of Resident 51's medical records failed to show documented evidence if the staff had increased the oxygen supplementation by more than 5 liters per minute to stabilize Resident 51 oxygen saturation level until Resident 51 was taken to the acute care hospital by the emergency medical services. On 9/11/25 at 0939 hours, an interview and medical record review for Resident 51 was conducted with RN 1. RN 1 stated the professional standard of practice when the residents have low oxygen saturation level in addition to physician notification and calling the paramedics was to increase the oxygen supplementation until the resident's oxygen level reaches more than 90%. RN 1 stated the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555329	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Palma Nursing Center	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)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	staff could have titrated the oxygen up to the rate of 10 liters per minute using a non-rebreather mask to stabilize resident oxygen saturation. RN 1 verified on 8/27/25, Resident 51's had a low oxygen saturation initially at 64% and improved to 70% on oxygen at a rate of 5 liters per minute. RN 1 stated a low oxygen saturation was an emergency situation for Resident 51 and the staff should have provided an emergency care including increasing the oxygen supplementation to Resident 51 and document in the medical records. RN 1 verified there was no documented evidence if the staff provided an additional oxygen supplementation when Resident 51 had an oxygen saturation of 70%, until Resident 51 was taken to the acute care hospital. On 9/11/25 at 1132 hours, a telephone interview was conducted with LVN 8. LVN 8 stated Resident 51 was on continuous oxygen inhalation at the time of assessment. Upon checking, the resident oxygen saturation was 64% the resident was placed in a high fowler's position, an oral and nasal care provided. Following this intervention, oxygen saturation increased to 70%. LVN 8 stated then he titrated oxygen up to 10 liters per minute using non- rebreather mask and oxygen saturation was then subsequently improved to 90%, then paramedics transferred the resident to the emergency department of an acute care hospital. LVN 8 stated he missed to document when he titrated oxygen up to 10 liters per minute and oxygen saturation for Resident 51 improved to 90%. LVN 8 stated he should have documented the emergency care provided to Resident 51. On 9/12/25 at 1430 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.