STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555651	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanley Healthcare Center	14102 Springdale Street Westminster, CA 92683

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** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the care plan for one of three sampled residents (Resident 1) was revised after Resident 1 had reported an abuse allegation against CNA 1. This failure put Resident 1 at risk of not receiving resident-centered care. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 12/2016 showed the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The P&P showed the comprehensive, person-centered care plan will include the following: a. measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; g. incorporates identified problem areas; h. incorporates risk factors associated with identified problems; k. reflects treatment goals, timetables and objectives in measurable outcomes; Medical record review for Resident 1 was initiated on 4/19/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Five-Day MDS dated [DATE], showed Resident 1 with a BIMS score of 9 (according to the MDS RAI Manual, a score of 8-12 indicates the resident's cognition is moderately impaired). Further review of the medical record showed Resident 1 had an allegation of CNA 1 pushing her off the shower chair and putting the hand around her throat. However, review of Resident 1's care plan showed no documented evidence of the revised care plan related to Resident 1's reported abuse allegation. (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
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(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	On 4/19/24 at 1416 hours, a concurrent interview and medical record review with LVN 1 was conducted. LVN 1 confirmed Resident 1 did not have a new or revised care plan to address the alleged abuse incident by CNA 1. LVN 1 stated the care plans were an important part of the resident's care and there should be a care plan for the abuse allegation. On 4/19/24 at 1456 hours, a concurrent interview and medical record review with the DON and DSD was conducted. The DON and DSD verified no care plan was created or updated for the abuse allegation incident between Resident 1 and CNA 1 on the day of the incident. The DON further stated the resident's care plans provided interventions on how the facility staff could care for the residents. The DON further stated the care plans were a guide for the resident's care. On 4/23/24 at 1240 hours, an interview with the Administrator and DON was conducted. The Administrator and DON acknowledged the above findings.