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	05/16/2025

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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview and closed medical record review, the facility failed to ensure the annual and discharge return- anticipated MDS assessments were completed within 14 calendar days after the ARD for the annual and discharge return anticipated assessments for one of two sampled residents (Resident 1). This failure had the potential of not identifying each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessments when the health problems had been identified. Findings: Closed medical record review for Resident 1 was initiated on 5/16/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Annual MDS assessment showed had an ARD of 4/25/25. The Annual MDS showed the status of the assessment was in progress and to be completed by 5/9/25 (seven days overdue), 21 days after the ARD of 4/25/25. Review of Resident 1's Discharge Return-Anticipated MDS had an ARD of 4/29/25. The Discharge Return-Anticipated MDS showed the status of the assessment was in progress and to be completed by 5/13/25 (three days overdue), 17 days after the ARD of 4/29/25. Review of Resident 1's progress note dated 4/29/25 at 1629 hours, showed Resident 1 was transferred to the acute care hospital. On 5/16/25 at 0952 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON stated Resident 1 was a long-term resident and was transferred to the acute care hospital on 4/29/25, with the anticipation of returning to the facility. The DON verified the above findings and stated the above MDS assessments for the annual and discharge return anticipated should have been completed within 14 calendar days of the ARD.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 39683 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 2) had the physician's orders for the indwelling urinary catheter use, care, and maintenance. This failure had the potential for the resident to develop indwelling urinary catheter related infection and/or complications. Findings: Medical record review for Resident 2 was initiated on 5/15/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's physician orders failed to show any orders for the indwelling urinary catheter use, care, and maintenance. On 5/15/25 at 1510 hours, Resident 2 was observed lying in bed, with a urinary drainage bag hanging on the left side of the resident's bed. On 5/15/25 at 1511 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 2 had an indwelling urinary catheter, and catheter care should be done every shift and documented in the TAR. LVN 1 reviewed Resident 1's medical record and verified there were no physician's orders for use of an indwelling urinary catheter, the catheter care and management. LVN 1 stated the resident should have the physician's orders for the indwelling urinary catheter use, catheter care, and management. On 5/16/25 at 0936 hours, an interview was conducted with the DON. The DON stated Resident 2 was admitted with an indwelling urinary catheter. The DON was informed and acknowledged the above findings.

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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 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** 39683 Based on interview, and medical record review, the facility failed to ensure the medical record was complete and accurately maintained for one of two sampled residents (Resident 2). * Resident 2's physician's order for wound care did not include the location of the wound. This failure had the potential for not providing necessary care and services due to incomplete medical records. Findings: Medical record review for Resident 2 was initiated on 5/15/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Skin and Wound Evaluation V7.0 dated 5/15/25, showed the resident had a Stage 3 pressure ulcer to the medial sacrum (bone at the base of the spine). Review of Resident 2's Order Summary Report showed a physician's order dated 5/15/25, to cleanse the Stage 3 pressure ulcer and surrounding DTI with normal saline, apply Betadine (an antiseptic solution) to the surrounding DTI tissue, and MediHoney (a wound care paste) to the Stage 3 wound, and cover with dry dressing daily and as needed. The order failed to show the location of the wound. On 5/16/25 at 0936 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 2's physician's orders and verified the resident's wound care order did not show the wound location but should have.

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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 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of the diseases and infections for one of two sampled residents (Resident 2). * The facility staff failed to ensure the EBP was maintained for Resident 2 with an indwelling urinary catheter during incontinence care. This failure had the potential to spread infectious organisms to the other residents in the facility. Findings: Review of the facility P&P titled Enhanced Barrier Precautions dated August 2022 showed EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms to residents. Gloves and gowns are to be used while performing high contact resident care activities, including when performing resident hygiene and changing briefs. Medical record review for Resident 2 was initiated on 5/15/25. Resident 2 was admitted to the facility on [DATE]. On 5/15/25 at 1408 hours, an observation and concurrent interview was conducted with the DSD/IP in Resident 2's room. An EBP signage was posted outside the resident's doorway and showed everyone must wear a gown and gloves for high-contact resident cares including when providing hygiene and changing briefs. The DSD/IP stated the EBP was for Resident 2 since she had an indwelling urinary catheter. Upon entering Resident 2's room, CNA 1 and RNA 1 were observed changing Resident 2's incontinent briefs wearing only gloves. The DSD/IP verified the above findings and stated the CNA and RNA should be wearing isolation gowns when providing incontinent care for Resident 2.