

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Stanley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.</p> <p>Based on interview, and facility document review, the facility failed to ensure an employee working as a CNA (a healthcare professional who provides basic resident care and support) at the facility held a valid and up-to-date license and met competency evaluation requirements for training. This failure had the potential to result in an unlicensed CNA providing direct care to the residents without proper the certification and training, and placing the residents' safety at risk. Findings: On 1/28/26, CDPH, L&C Program was forwarded a complaint from the CNA Misconduct, which showed CNA 1 picked up an afternoon shift on 1/26/26, at the facility. However, the person who showed up and claimed to be CNA 1 was male. The complainant alleged CNA 1 stole a TV out of the utility closet and left the scheduled shift. Upon further investigation by the facility, showed CNA 1 was a female individual and the male individual who showed up for the afternoon shift was unlicensed and working under CNA 1's license. On 2/4/26 at 1021 hours, an interview and facility document was conducted with the DON. Reviewed the facility's CDPH 530 (Nursing Staffing Assignment and Sign-in Sheet) form dated 1/26/26 with the DON, which showed CNA 1's time in and time out on 1/26/26. On 2/4/26 at 1456 hours, an interview was conducted with the DSD/IP. The DSD/IP stated her responsibilities included the verifying the employees' identity and license, conducting background check, providing orientations to the new facility staff, completing the schedule, conducting CNA audits, in-services, and administering vaccines. The DSD/IP stated on 1/26/26, CNA 1 from Registry Company 1 was scheduled to work for the evening shift (1500-2300 hours). When the evening shift started, the DSD/IP met the male individual, who presented to be CNA 1 and signed the assignment sheet. The DSD/IP stated she provided the facility orientation to CNA 1. The DSD/IP stated CNA 2 then provided a brief orientation to CNA 1 regarding the residents' care. The DSD/IP stated she did not check and/or verify CNA 1's identity using a government issued identification and their CNA license prior to or upon the start of the shift. In addition, the DSD/IP stated on 1/26/26 around 2200 hours, she received a message from LVN 1 informing her about CNA 1 leaving the facility with a television from the utility room and without a notice. Furthermore, the DSD/IP stated she was responsible for checking and verifying the identity and license of the unidentified male individual from Registry Company 1. The DSD/IP stated the negative outcome for failing to check and verify the facility staff or the registry staffs' identity and license was the potential to compromise the residents' safety. The DSD/IP stated she informed the Administrator and investigated the allegations and on 1/27/26, she found out CNA 1 was a female individual after she checked CNA 1's profile and identification on Registry Company 1. The DSD/IP stated she called CNA 1's phone number and CNA 1 verified with the DSD/IP that she did not accept the registry shift and did not come in to work at the facility on 1/26/26. The DSD/IP stated she did not know if the unidentified male individual, who presented to be CNA 1 from Registry Company 1 had a valid and current CNA license, and competency evaluation. On 2/5/26 at 1208 hours, an interview was conducted with the Administrator. The Administrator stated the DSD/IP and himself had access to</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555651
		If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Stanley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0729</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Registry Company 1, however, the DSD/IP was mainly responsible for requesting the registry staff as needed. The Administrator stated prior to the incident on 1/26/26 with CNA 1, the facility did not require to check and verify the registry staffs' identity using a government ID and their license since Registry Company 1 was supposed to check the registry staffs' identity and license. In addition, the Administrator stated the facility used only Registry Company 1 to request registry staff. On 2/5/26 at 1446 hours, an interview was conducted with the DON and DSD/IP. The DSD/IP stated she did not make an employee personnel file for any of the registry staff. The DSD/IP stated the employee personnel file of CNA 1 was obtained after the incident on 1/26/26. In addition, the DSD/IP stated she did not check and/or verify the identity, license, certification, and competency evaluations of all the registry staff from Registry Company 1 prior to 1/27/26. The DSD/IP stated she would not know if the registry staff who accepted the shift posted on Registry Company 1 was the same individual who showed up to facility to provide care for the residents and had an active license, since the facility did not check and/or verify their identity, license and their competency evaluation. On 2/5/26 at 1540 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.</p>		