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	03/06/2025

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 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** 32179 Based on the interview, medical record review, and facility P&P review, the facility failed to ensure the POLST was updated and the copy of advance directive form was obtained for one of 12 final sampled residents (Resident 1). This failure had the potential for the resident's decisions regarding their healthcare and treatment not being honored. Findings: Medical record review for Resident 1 was initiated on 3/3/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's POLST dated 8/2/24, showed the resident had no advance directive. Review of Resident 1's Advance Directive Acknowledgement form dated 8/5/24, showed the resident's family had executed an advance directive. However, review of Resident 1's medical record failed to show the copy of the resident's advance directive. On 3/4/24 at 1000 hours, an interview and concurrent medical record review was conducted with LVN 1 and the Social Services/Activities Director. When asked if Resident 1's family would like to execute an advance directive, both LVN 1 and the Social Services/Activities Director stated the resident's family member had executed an advance directive. When asked why the resident's POLST did not reflect the advance directive, the Social Services/Activities Director stated the POLST should have been updated because the resident's family member had executed an advanced directive. The Social Services/Activities Director further stated the facility did not follow up with Resident 1's family member to obtain a copy of the resident's advance directive. The Social Services/Activities Director stated she would contact the resident's family member to obtain a copy of Resident 1's advanced directive. The Social Services/Activities Director verified the above findings.

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: 555651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025

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F 0623

Level of Harm - Potential for minimal harm

Residents Affected - Some

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 52251

Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to notify the resident and/or their representative of the transfer and reason for the transfer in writing and send a copy of the Notice of Transfer/Discharge to the LTC Ombudsman for two of three closed record sampled residents (Residents 21 and 26). These failures posed the risk for the resident and/or their representative of not knowing about the appeal process and posed the risk of the LTC Ombudsman not being aware of the circumstances of the residents' transfer/discharge should an appeal be filed or requested by the resident or their representatives regarding the transfer.

Findings:

Review of the facility's P&P titled Transfer and Discharge revised 12/2016 showed the facility will provide written notices for emergency transfers to the resident or resident's representative and the Ombudsman. These may be sent when practicable but need to be sent before transfer or discharge.

Medical record review for Resident 21 was initiated on 3/6/25. Resident 21 was admitted to the facility on [DATE], and transferred to the acute care hospital on 2/17/25.

Review of Resident 21's Transfer/discharge date d 2/17/25, showed the reason for the transfer was due to possible G-tube infection or dislodgement.

However, further review of Resident 21's medical record failed to show documented evidience the resident and/or their representative was provided a written notification of the transfer and reason for the transfer. In addition, there was no documented evidence to show a copy of the notice of transfer was sent to the LTC Ombudsman.

On 3/6/25 at 1055 hours, an interview and concurrent medical record review was conducted with the Office Manager. The Office Manager verified the above findings and stated the facility did not send the written notices for the acute care hospital transfers. The Office Manager was unable to provide documentation to show the written notice of transfser was provided to the resident, resident's representative, and LTC Ombudsman.

On 3/6/25 at 1056 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 acknowledged the above findings and stated the facility did not send the written notices for the acute care hospital transfers. LVN 1 was unable to show any documentation of the written notice of transfer to either the resident, his representative or the LTC Ombudsman.

32179

2. Medical record review for Resident 26 was initiated on 3/3/25. Resident 26 was admitted to the facility on [DATE].

Review of Resident 26's Notice of Transfer/discharge date d 1/5/25, showed under the section for sending a copy to the LTC Ombudsman office was left blank.

(continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 26's progress notes dated 1/5/25, showed Resident 26 was discharged to home. On 3/5/25 at 1120 hours, an interview and concurrent medical record review was conducted with the Social Services/Activities Director. When asked if the facility had sent a copy of the Notice of Transfer/Discharge to the LTC Ombudsman for the resident's discharge, the Social Services/Activities Director verified the facility had not sent the notice. The Social Services/Activities Director was unable to provide documentation to show the LTC Ombudsman was notified about the resident's discharge. The Social Services/Activities Director verified the findings.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on interview and medical record review, the facility failed to ensure the MDS for discharge was completed and transmitted for one of 12 sampled residents (Resident 12). This failure had the potential for not having current information in the resident's medical record. Findings: Medical record review for Resident 12 was initiated on 3/5/25. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's progress note dated 10/15/24, showed Resident 12 was transferred and admitted to the acute care hospital. Review of Resident 12's Admission Record dated 2/9/24, showed Resident 12's most recent acute care hospital stay was between 10/14 to 10/18/24. Review of Resident 12's list of transmitted MDS assessment failed to show the MDS was completed to reflect Resident 12's October 2024 discharge from the facility. On 3/4/25 at 1359 hours, an interview was conducted with the Administrator. The Administrator was informed and verified 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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview and medical record review, the facility failed to accurately code the MDS related to RNA services for one of 12 final sampled residents (Resident 10). This failure posed a risk of the resident not receiving an individualized care plan tailored to their specific needs. Findings: Medical record review for Resident 10 was initiated on 3/3/24. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's MDS quarterly assessment dated [DATE] and 2/5/25, showed Section O for Restorative Nursing Program (range of motion - passive and active) was left blank. Review of Resident 10's Order Summary Report dated 3/4/25, showed the following physician's orders dated 9/4/24, for RNA: - The resident may wear a left knee orthosis and bilateral PRAFO for up to six hours, five times per week, for 90 days, as tolerated. Re-evaluation was scheduled for 11/21/24. - The resident may wear bilateral PRAFO on both ankles daily, five times per week, for up to six hours, as tolerated, for 90 days. Re-evaluation was also scheduled for 11/21/24. - Active assist and passive range of motion (AA/PROM) exercises were to be provided to all extremities daily, five times per week, for 90 days. Re-evaluation was scheduled for 11/21/24. On 3/6/25 at 0945 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. When asked about Resident 10's MDS assessment, Section O for the Restorative Nursing Program, the MDS Coordinator stated she could not locate the RNA program on the EHR for Resident 10. The MDS Coordinator further stated she did not have a computer access to view the RNA program in the EHR for Resident 10, which was the reason why the RNA was not coded in the resident's MDS for 11/5/24 and 2/5/25. On 3/6/25 at 1400 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP stated Resident 10 had been receiving RNA services, including active assist and passive range of motion exercises since September 2024. The DSD/IP acknowledged and verified Resident 10's MDS was inaccurate.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 52238 Based on observation, interview, and facility P&P review, the facility failed to ensure the services provided met the professional standards of care when LVN 2 failed to properly obtain the blood pressure for one of three residents (final sampled resident, Resident 3) observed for medication administration. This failure had the potential for the residents requiring blood pressure checks to have inaccurate readings. Findings: Review of the facility's P&P titled Blood Pressure, Measuring revised 2010 showed the steps in the Procedure section as follows: - To expose the resident's arm by rolling the sleeve up about five inches above the elbow. - To wrap the blood pressure cuff evenly around the upper arm, approximately one inch from the elbow. - When you locate the pulsation, place the diaphragm of the stethoscope firmly against the skin. Hold diaphragm in place with your hand. - With your free hand, pump air into the cuff by squeezing the bulb until you can no longer hear the pulsation. (Note: You must be watching the mercury level on the manometer while you are pumping the air in the cuff.) - When you hear the last pulsation sound, loosen the thumbscrew slowly to let the air out. Watch the mercury reading on the manometer. Listen for the first sound, note the number. This will be the top (systolic) reading. - To continue to listen for the pulsation sound and watch the mercury reading on the manometer. When you hear the last sound, note the number. This will be the lower (diastolic) reading. On 3/4/25 at 0919 hours, a medication administration observation was conducted with LVN 2 for Resident 3. LVN 2 was observed placing the blood pressure cuff and diaphragm of the stethoscope over Resident 3's upper arm and over his black long sleeve shirt to obtain the resident's blood pressure reading. Resident 3's blood pressure was 152/90 mm/Hg. On 3/4/25 at 1435 hours, an interview was conducted with LVN 2. LVN 2 verified she placed the blood pressure cuff and diaphragm of the stethoscope over Resident 3's black long sleeve shirt. LVN 2 verified the facility's process when obtaining the blood pressure was to place the blood pressure cuff and diaphragm of the stethoscope directly against the skin. LVN 2 stated placing the blood pressure cuff and diaphragm of the stethoscope over clothing could cause an inaccurate blood pressure reading and be difficult to hear. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 1444 hours, an interview was conducted with the DSD/IP. The DSD/IP stated the licensed nurses were trained regarding the process of correctly obtaining the blood pressure manually during their orientation skills training. The DSD/IP verified the correct process to obtain the blood pressure was the blood pressure cuff and diaphragm of the stethoscope was placed on the upper arm, directly on the skin. The DSD/IP also stated putting the diaphragm of stethoscope over clothing could give an inaccurate reading, if the licensed nurse was unable to hear the pulsation sound. On 3/5/25 at 0815 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52238 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 12 final sampled residents (Resident 8) who had limited mobility and ROM functions received the appropriate treatment and services to maintain or improve their ROM functions and prevent further decline in their ROM functions. This failure had the potential for Resident 8 to experience a decline in her physical abilities. Findings: Review of the facility's P&P titled Resident Mobility and Range of Motion revised July 2017 showed the residents will not experience an avoidable reduction in ROM. Residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. In addition, resident with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. On 3/3/25 at 0856 hours, an observation and concurrent interview was conducted with Resident 8. When asked about her experience at the facility, Resident 8 stated she had not received physical therapy since her admission to the facility. Resident 8 stated she requested for therapy to regain her ability to walk. Resident 8 further stated the DON had stopped by her room and stated she would speak to the PT. Medical record review for Resident 8 was initiated on 3/6/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 4/27/24, showed the resident could make her needs know but could not make medical decisions. Review of Resident 8's plan of care showed a care plan problem dated 2/10/25, addressing the resident's arthritis (joint inflammation) to the bilateral knees, hands and fingers with a goal for the resident to be free of complications related to arthritis (contractures, joint stiffness, swelling or decline in mobility). The interventions included to provide daily range of motion exercises both active and passive as tolerated. Review of Resident 8's Documentation Survey Report (intervention/tasks assigned to the CNAs) for March 2025 did not show documented evidence the ROM exercises were provided to Resident 8. Further review of Resident 8's medical record did not show the physician's orders for physical therapy or RNA services. In addition, there was no documented evidence the ROM exercises were provided to Resident 8. On 3/6/25 at 1027 hours, an interview was conducted with RNA 1. RNA 1 stated the PT wrote the order for the RNA services. RNA 1 also stated long-term residents were provided RNA services after being evaluated by the PT. RNA 1 verified Resident 8 did not receive RNA services. Additionally, RNA 1 stated Resident 8 was a long-term resident and had not been seen by the PT. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1052 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 8 was not fully independent and needed assistance from the staff with transfers. CNA 2 stated the CNAs did not provide ROM exercises to Resident 8 and only the RNA provided the ROM exercises with the residents. CNA 2 stated the residents who did not qualify for PT to help maintain their ROM, the CNAs helped with maintaining the residents' ROM. CNA 2 verified there were specific ADL tasks assigned to the CNAs and these tasks were documented in the resident's EHR. However, CNA 2 was unable to provide documentation to show the ROM exercises for Resident 8 were done. On 3/6/25 at 1115 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 8 had limited movement to her lower extremities. LVN 1 verified the facility did not provide the ROM exercises to Resident 8. LVN 1 verified Resident 8's care plan and intervention showed to provide daily ROM exercises both active and passive as tolerated. LVN 1 stated Resident 8 did not have PT or RNA services ordered by the physician. LVN 1 verified there was no documentation to show the daily exercises, both active and passive, were provided to the resident by the CNAs or licensed nurses. On 3/6/25 at 1115 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 8 had limited ROM to the lower extremities. The DON acknowledged Resident 8 should be receiving daily exercises for the ROM. The DON verified there was no documentation from the RNA to show the daily exercises for active and passive ROM exercises were provided to Resident 8. The DON also verified there was no documentation from the CNAs showing Resident 8 had been receiving daily ROM exercises.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 52251 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 3) reviewed for smoking remained free from accident hazards. * The facility failed to ensure Resident 3' smoking assessment was completed upon admission to the facility to determine if the resident was safe to smoke. This failure had the potential for the resident to sustain accidents and/or injuries. Findings: Review of the facility's P&P titled Smoking Policy revised July 2017 showed the residents who smoke must be assessed upon admission with a safe smoking assessment tool. On 3/3/25 at 1201 hours, an interview with was conducted with Resident 3 about his smoking privileges in the facility and how the facility staff had accommodated him. Resident 3 stated, they (the facility staff) take me out to the smoking area and wait with me while I smoke, there's an ashtray and they put the cover over me to keep me clean. On 3/3/25 at 1215 hours, an observation was conducted of the Smoking Patio. A fire extinguisher was observed inside the facility, close to the entrance of the Smoking Patio. A metal covered ashtray was also observed in the Smoking Patio. Medical record review for Resident 3 was initiated on 3/3/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 5/8/24, showed the resident had capacity to understand and make decisions. Further review of Resident 3's medical record failed to show the safe smoking assessment was completed for the resident. On 3/4/25 at 0958 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated the safe smoking assessment for the residents who smoked would be done upon admission to the facility. When LVN 2 was asked to show the documented safe smoking assessment for Resident 3, LVN 2 was unable to show the safe smoking assessment in Resident 3's medical record. LVN 2 further stated the facility just migrated to a different EHR application less than six months ago. On 3/4/25 at 1047 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged and verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for two of two final sampled residents (Residents 13 and 17) reviewed for oxygen therapy. * The facility failed to follow the physician's order for Residents 13 and 17's oxygen therapy. This failure had the potential for the residents to not receive the appropriate care and may negatively impact the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed to verify there is a physician's order for this procedure, review the physician's orders or facility protocol for oxygen administration. On 3/3/25 at 0907 hours, during the initial tour of the facility, Resident 13 was observed lying in bed and receiving oxygen at 5 liters per minute via nasal cannula which was attached to the oxygen machine concentrator . Medical record review for Resident 13 was initiated on 3/3/25. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's H&P examination dated 2/20/25, showed Resident 13 had the capacity to understand and make decisions. Review of Resident 13's Order Summary Report for March 2025 showed a physician's order dated 2/18/25, to administer oxygen at 4 liters per minute via nasal cannula as needed to keep the oxygen saturation levels above 90%. On 3/4/25 at 0842 hours, an observation, interview, and concurrent medical record review was conducted with the DSD/IP. The DSD/IP verified Resident 13's oxygen machine concentrator was set at 5 liters per minute and the physician's order for the oxygen was to be administered at 4 liters per minute as needed for Resident 13. The DSD/IP acknowledged the findings and stated the facility staff should follow the physician's order for the oxygen administration for Resident 13. 52238 2. On 3/3/25 at 0950 hours, during the initial tour of the facility, the nasal cannula for Resident 17 was observed on the resident's bed and Resident 17 was not observed in the room. On 3/4/25 at 1009 hours, an observation was conducted in Resident 17's room. Resident 17 was not observed in the room and the resident's nasal cannula was on the resident's bed. On 3/5/25 at 1316 hours, Resident 17 was observed sitting on her dual mobility walker and chair at the entrance of her room without oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 1327 hours, an observation and concurrent interview was conducted with Resident 17. Resident 17 verified she was to receive the oxygen continuously. Resident 17 stated she did not feel she needed to have the nasal cannula on when she was sitting down. Medical record for Resident 17 was initiated on 3/3/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed a physician's order dated 8/29/24, to administer the oxygen at 2 liters per minute via nasal cannula continuously for dyspnea. Review of Resident 17's H&P examination dated 2/17/25, showed the resident could make her needs known but could not make medical decisions. On 3/5/25 at 1327 hours, an observation and concurrent interview were conducted with CNA 1. CNA 1 verified the above findings. CNA 1 stated Resident 17 was supposed to receive continuous oxygen at 2 liters per minute. CNA 1 stated the resident removed the nasal cannula because the resident did not like wearing it. CNA 1 further stated the CNAs did not document Resident 17's refusal to wear the cannula but would notify the licensed nurses. On 3/5/25 at 1335 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 was observed checking Resident 17's oxygen saturation level which was 82% on room air. On 3/5/25 at 1502 hours, a follow-up observation was conducted with LVN 2 for Resident 17. LVN 2 was observed rechecking Resident 17's oxygen saturation level which was 100% with oxygen at 2 liters per minute.

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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** 43119 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure four of 12 final sampled residents reviewed for the side rail use (Residents 1, 12, 13, and 20) remained free from the accident hazards due to the use of side rails. * The facility failed to ensure the Facility Verification of Informed Consent for Resident 13 was accurately completed. The consent form had no physician's signature and date. Furthermore, the facility failed to ensure the physician's order was obtained for the use of the bilateral half side rails for Resident 13. * The facility failed to ensure a care plan was initiated for the use of the bilateral half side rails for Resident 20. * The facility failed to provide the manufacturer's manual for Resident 12's bed to show compatibility for the bed's side rails. In addition, Resident 12's assessment for the use of the side rails was not completed. * Resident 1's assessment for the side rails to attempt the least restrictive measures and the risk of entrapment were not completed. These failures had the potential risk for injuries to the residents. Findings: Review of the facility's P&P titled Proper Use of Side Rails revised date 12/2016 showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. The use of the side rails as an assistive device will be addressed in the resident care plan. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. Review of the facility's P&P titled Informed Consent revised date 8/8/11, showed before initiating the administration of the psychotherapeutic drugs, physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, the facility staff shall verify the resident's health record contains documentation that the resident was given informed consent for the proposed treatment or procedure. All of the informed consent verifications must be in writing prior to initiation of the treatment or procedure. Acceptable form is the Facility Verification of Informed Consent Form completed and signed by the prescribing physician. 1. Medical record review for Resident 13 was initiated on 3/3/25. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 13's Facility Verification of Informed Consent dated 11/13/24, showed the consent had missing physician's signature and date. Review of Resident 13's plan of care showed a care plan intervention dated 12/16/24, to use the bilateral half side rails to maximize independence with turning and repositioning in bed. Review of Resident 13's H&P examination dated 2/20/25, showed Resident 13 had a diagnosis of Alzheimer's disease and the capacity to understand and make decisions. Review of Resident 13's Order Summary Report dated 3/4/25, failed to show a physician's order for the use of the bilateral half side rails. On 3/3/25 at 0907 hours, during the initial tour of the facility, Resident 13 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 3/4/25 at 0836 hours, Resident 13 was observed lying in bed with the bilateral half side rails elevated. On 3/4/25 at 1110 hours, an observation and concurrent interview was conducted with the DSD/IP. The DSD/IP verified Resident 13 had the bilateral half side rails in place and stated there should be a physician's order and the informed consent should have been completed accurately and signed by the physician. Cross reference to F909, example #1. 2. On 3/3/25 at 0934 hours and 3/4/25 at 0851 hours, Resident 20 was observed lying in bed with the bilateral half side rails elevated at the head of the bed. Medical record review for Resident 20 was initiated on 3/3/25. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 20's Order Summary Report for March 2025 showed a physician's order dated 8/21/24, to apply the bilateral upper side rails while in bed for increased bed mobility and repositioning. Review of Resident 20's H&P examination dated 8/22/24, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's plan of care failed to show a care plan problem addressing Resident 20's bilateral half side rails use. On 3/6/25 at 1013 hours, an observation and concurrent interview was conducted with the DSD/IP. The DSD/IP verified the above findings and stated there should be a care plan to address the resident's use of the side rails for the facility staff to be aware of how to care for the resident. Cross reference to F909, example #2. 35346 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 3/4/25 at 0945 hours and 1212 hours, Resident 12 was observed in bed with the bilateral one-half upper side rails raised. Medical record review for Resident 12 was initiated on 3/4/25. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 10/20/24, showed Resident 12's diagnoses included advanced dementia and Parkinson's-type tremors. The H&P examination also showed Resident 12 had no capacity to make decisions. Further review of Resident 12's medical record failed to show a side rail assessment was completed for Resident 12. On 3/6/25 at 1035 hours, an interview and concurrent medical record review for Resident 12 was conducted with the DSD/IP. The DSD/IP verified Resident 12's side rail assessment was not completed. On 3/6/25 at 1042 hours, an interview and concurrent facility document review was conducted with the Maintenance Supervisor. When asked about the manufacturer's manual used to check the compatibility between Resident 12's bed and the installed side rails, the Maintenance Supervisor verbalized the facility did not have a manufacture's manual. Cross reference to F909, example #3. 32179 4. Medical review for Resident 1 was initiated on 3/3/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Safety Assessment for Siderail Usage dated 8/1/24, showed, No was documented for the alternative, least restrictive measures tried or considered and risk for entrapment. Review of Resident 1's plan of care showed a care plan problem dated 3/1/25, addressing the resident's moderate risk for falls due to confusion, incontinence, psychoactive drug use, lack of safety awareness, and a diagnosis of dementia. The interventions included to use the side rails as ordered. Review of Resident 1's Order Summary Report dated 3/4/25, showed a physician's order dated 8/28/24, for bilateral upper side rails up while in bed for mobility and repositioning. On 3/3/25 at 0800 and 1100 hours, Resident 1 was observed resting in bed with the bilateral side rails up (from head to waist). On 3/4/25 at 1230 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP was asked about the alternative, least restrictive measures tried or considered prior to the installation of Resident 1's side rails. The DSD/IP stated no alternatives or least restrictive measures were tried and verified there were no care plan developed and risk for entrapment assessment completed to address the resident's use of side rails. Cross reference to F909, example #4.

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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** 52251 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of medications for one of three residents (final sampled resident, Resident 8) observed for medication administration when: * LVN 1 failed to assess Resident 8's bowel status prior to administering a laxative (promotes bowel movements) medication as per the physician's order. This failure had the potential to negatively affect the resident's health conditions that could posed the risk for possible complications. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the medications are administered in accordance with the prescriber orders. On 3/4/25 at 0816 hours, a medication administration observation for Resident 8 was conducted with LVN 1. LVN 1 prepared and administered Resident 8's medications which included polyethylene glycol (laxative) powder 17 gm and Senna (laxative) 8.6 mg. LVN 1 administered the polyethylene glycol and Senna medications without assessing the resident's bowel status or checking the resident's medical record for her bowel elimination. Medical record review for Resident 8 was initiated on 3/4/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 4/27/24, showed the resident could make her needs known but could not make medical decisions. Review of Resident 8's Order Summary Report showed the following physician's orders: - dated 10/17/24, to administer polyethylene glycol 3350 oral powder 17 gm/scoop by mouth one time a day for bowel management; and to hold for loose stool. - dated 5/8/24, to administer Senna 8.6 mg one tablet by mouth two times a day for bowel management; and to hold for loose stool. On 3/4/25 at 0852 hours, an interview and concurrent medical record review was conducted with LVN 1 for Resident 8. When asked if LVN 1 had assessed the resident's bowel status prior to administering the laxative medications, LVN 1 verified she did not assess Resident 8's bowel status or check the resident's medical record for the resident's bowel elimination prior to administering the laxative medications. LVN 1 stated Resident 8 always wanted her laxatives and stool softeners. On 3/5/25 at 0824 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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** 52238 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the Pharmacy Consultant's identified drug recommendations were addressed for two of 12 final sampled residents (Residents 1 and 17). This failure posed the risk for the residents to have adverse consequences related to their medications. Findings: Review of the facility's P&P titled Medication Regimen Review revised 5/19 showed: - The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. - The attending physician documents in the medical record that the irregularity has ben reviewed and what (if any) action was taken to address it. 1. Medical record review for Resident 17 was initiated on 3/5/25. Resident 17 was admitted to the facility on [DATE]. a. Review of Resident 17's Order Summary Report showed a physician's order dated 9/6/24, to administer Preparation H (temporarily relieve swelling, burning, pain, and itching caused by hemorrhoids) 0.25 mg per rectal every six hours for hemorrhoids. Review of Resident 17's Consultant Pharmacist's Medication Regimen Review dated 12/9/24, showed if clinically feasible, please provide a duration of therapy for the Preparation H rectal ointment. b. Review of Resident 17's Order Summary Report showed a physician's order dated 12/12/24, to administer Benadryl (antihistamine) 25 mg one tablet by mouth at bedtime for allergy/itching. Review Resident 17's Consultant Pharmacist's Medication Regimen Review dated 1/16/25, showed the resident currently had an order for Benadryl 25 mg at bedtime for allergy/itching. The MRR further showed first generation antihistamines, such as Benadryl, possessed more anticholinergic and sedative effects than the new agents. Consult with the physician if a change to a less sedating agent, such as Zyrtec (antihistamine), Allegra (antihistamine), or Claritin (antihistamine) would be feasible for Resident 17. Further review of Resident 17's medical record failed to show the facility had addressed the Pharmacy Consultant's recommendations for the Preparation H and Benadryl medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 1013 hours, an interview was conducted with the DON. When asked about the facility's process for reviewing and addressing the Pharmacy Consultant's MRR recommendations, the DON stated she handed the MRR binder directly to the licensed nurse who then followed through and notified the physician with the specific recommendation. The licensed nurse would then write done next to the recommendation once the recommendation was addressed. The DON verified when the recommendation was addressed with the physician, whether the physician approved the recommendations or not, the licensed should document in the resident's progress notes. On 3/6/25 at 0900 hours, a follow-up interview was conducted with the DON. The DON provided her progress note documentation dated 3/6/25 at 0827 hours, which showed the LVN called Resident 17's hospice regarding the Consultant's Pharmacist's recommendation for the Preparation H medication for December 2024. On 3/6/25 at 0925 hours, a follow-up interview was conducted with the DON. The DON provided LVN 2's progress note dated 3/5/25 at 1903 hours, which showed the hospice company providing services to Resdient 17 acknowledging the pharmacy recommendation for the Benadryl medication for January 2025. The DON verified the pharmacy recommendations were followed up after she was informed by the surveyor for the pharmacy recommendations for December 2024 and January 2025 were not done for Resident 17. 32179 2. Medical record review for Resident 1 was initiated on 3/3/25. Resident 1 was admitted to the facility on [DATE]. Review of the Note to Attending Physician/Prescribers dated 2/8/25, showed the CMS guidelines released on 11/2017 indicated PRN psychotropic medications were now limited to 14 days. If the PRN psychotropic order needed to be extended beyond 14 days, it must be justified by the physician. Please evaluate the following order for a stop date: lorazepam (antianxiety medication) 2 mg/ml, administer 0.5 ml every four hours as needed for anxiety. Further review of Resident 1's medical record failed to show documented evidence the facility had addressed the pharmacy recommendations for the resident's lorazepam medication. On 3/5/25 at 1210 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP stated the facility had followed up with the physician regarding the pharmacist's drug regimen review recommendation for Resident 1's lorazepam medication. However, the DSD/IP acknowledged there was no documented evidence the pharmacy recommendation was followed up but assured the licensed nurses would contact the physician. The DSD/IP verified the above findings. On 3/5/25 at 1430 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 was asked if Resident 1 had experienced shortness of breath or episodes of anxiety. LVN 2 stated in the last two months, she had not observed the resident experiencing anxiety and had not administered the lorazepam during the day shift.

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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. 52251 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 11.11%. Two of two licensed nurses (LVNs 1 and 2) observed during the medication administration were found to have made an errors. * LVN 1 failed to reconstitute the polyethylene glycol medication as per the physician's order for Resident 8. LVN 1 reconstituted the polyethylene glycol medication with five oz of water instead of eight oz of water per the physician's order. * LVN 2 failed to reconstitute the polyethylene glycol medication as per the physician's order for Resident 3. LVN 2 reconstituted the polyethylene glycol medication with five oz of water instead of eight oz of water per the physician's order. In addition, LVN 2 failed to administer Resident 3's vitamin B12 (supplement) medication as ordered. These failures had the potential to negatively affect the residents' health conditions and posed the risk for possible complications or delay in interventions. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the medications are administered in accordance with prescriber orders, including any required time frames. 1. On 3/4/25 at 0816 hours, a medication administration observation for Resident 8 was conducted with LVN 1. LVN 1 prepared and administered Resident 8's medications, which included the polyethylene glycol powder 17 gm. LVN 1 was observed reconstituting the polyethylene glycol powder medication with five oz of water and administered it to the resident. LVN 1 verified she mixed the polyethylene glycol powder medication in a plastic cup with five oz of water. The plastic cup showed five oz on the bottom of the cup. Review of Resident 8's Order Summary Report showed a physician's order dated 10/17/24, to administer polyethylene glycol 3350 powder 17 gm/scoop by mouth one time a day for bowel management, to mix with eight oz of water. On 3/4/25 at 0852 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated she reconstituted the polyethylene glycol medication in five oz of water because that was the size of the plastic cup. LVN 1 verified Resident 8's physician's order for the polyethylene glycol medication showed to mix the medication with eight oz of water. 2. On 3/4/25 at 0919 hours, a medication administration observation for Resident 3 was conducted with LVN 2. LVN 2 prepared and administered Resident 3's medications, which included the polyethylene glycol powder 17 gm. LVN 2 was observed reconstituting the polyethylene glycol powder medication in five oz of water and administered it to the resident. LVN 2 verified she mixed the polyethylene glycol medication in a plastic cup with five oz of water. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 6/30/24, to administer polyethylene glycol 3350 powder 17 gm/scoop by mouth one time a day for bowel management, to mix with eight oz of water. - dated 9/11/24, to administer vitamin B12 100 mcg one tablet by mouth one time a day for supplement. Review of Resident 3's MAR for March 2025 showed the vitamin B12 medication was administered on 3/4/24 at 0900 hours, along with the other medications. However, during the medication administration observation with LVN 2, LVN 2 was not observed preparing and administering the vitamin B12 to Resident 3. On 3/4/25 at 1015 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified she did not administer the vitamin B12 medication to Resident 3 during the medication administration observation. LVN 2 verified she signed Resident 3's MAR for the vitamin B12 as administered on 3/4/25, along with the medications she administered during the medication administration observation. LVN 2 stated the medication was not availiable in the medication cart. In addition, LVN 2 verified Resident 3's physician's order for the polyethylene glycol medication showed to mix the medication in eight oz of water. On 3/5/25 at 0815 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the microwave utilized to warm up the food was maintained in sanitary condition and free of food residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the cutting board was kept in a sanitary condition and with cleanable surface. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 3/3/25, showed 23 of 23 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. According to the USDA Food Code 2022 Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 3/3/25 at 0757 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The kitchen microwave on a countertop shelf was observed to be dirty with white crumbs on the glass plate inside the microwave. The [NAME] verified the findings. 2. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed the hoods must be cleaned every two weeks and must be free of dust and grease. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 3/3/25 at 0757 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The kitchen hood over the stove had black, dirt residue. The [NAME] acknowledged the findings and stated the dietary staff cleaned the hood once a week on Wednesdays and the hood was also cleaned by an outside company. The sticker on the hood showed it was last serviced on 10/2024. 3. Review of the facility's P&P titled Sanitation dated 2023 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Plastic ware, china, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 3/3/25 at 0757 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The following was observed and verified by the Cook: - Two slotted scoops with black handles partially melted. - Two scoops with black handles partially melted. - One rubber spatula with red handle had chipped and cracked edges. - Two stainless steel spatulas with discolored and partially melted handles. - One stainless steel slotted spoon discolored with fuzzy film. - One stainless steel tong with black rubber handle partially melted and worn out. - One basting brush for butter had frayed bristles and worn out. - One white plastic cheese grater worn out with cracked, chipped, and broken edges. - Four stainless steel whisk with chipped and cracked rubber handles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The [NAME] acknowledged the above findings and stated the above items should have been replaced for infection control purposes. 4. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 3/3/25 at 0757 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The following was observed and verified by the Cook: - Two scoops with black handles had dry water spots. - One scoop with cream handle had fuzzy film and dry white crusted residue. - Two scoops with blue handles had dry crusted residue. - One scoop with white handle use for food portioning had fuzzy film. - One scoop with green handle use for food portioning had dry crusted residue and fuzzy film. - One scoop with blue handle use for food portioning had dry crusted residue and fuzzy film. - One mesh strainer had dry crusted residue. The [NAME] verified the above findings and stated all the dirty utensils should have been washed to prevent cross contamination. 5. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 3/3/25 at 0757 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The light brown, green, red, and yellow cutting boards were observed fuzzy, heavily marred and had deep groves. The [NAME] verified the findings and stated the cutting boards should have been changed and the facility had new ones to replace them. On 3/5/25 at 1614 hours, an interview was conducted with the Dietary Supervisor. The Dietary Supervisor acknowledged all the above findings and stated the following: - All the dirty utensils should have been sanitized to prevent the growth of bacteria and for infection control purposes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The microwave should have been cleaned for infection control purposes. - The chipped spatula should not be used because particles could fall and mixed in to the food. - The basting brush should have been replaced to prevent the bristles from getting mixed with the food. - The cutting boards were changed every three months and should have been replaced to prevent bacteria growth when not properly washed. - The mesh strainer should have been washed properly for infection control purposes. - The cheese grater should have been discarded and not used. - The whisk should have been replaced. - The hood over the stove was cleaned every six months and it was important to keep it clean to prevent dirt and grease from getting mixed with the food.

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F 0849

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32179

Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure two of three final sampled residents (Residents 1 and 13) reviewed for hospice services received the necessary care and services.

* The facility failed to ensure the hospice visit calendar was available in Resident 1's medical record and provide accurate documentation of the hospice staff visits for Resident 1. The facility also failed to ensure the care plan were updated and available in the resident's medical record.

* The facility failed to ensure the hospice visit calendar was available in Resident 13's medical record. Additionally, the facility failed to ensure a care plan was initiated for the hospice services provided for Resident 13.

These failures posed a risk of delayed communication and the provision of hospice care between the hospice provider and the facility.

Findings:

Review of the facility's P&P titled Hospice Program dated 7/2017 showed the facility has designated the DON to coordinate care provided to the resident by our facility staff and the hospice staff. She is responsible for the following:

- Obtaining the following information from the hospice: the most recent hospice plan of care specific to each resident, hospice election form, physician certification and recertification of the terminal illness specific to each resident.

- Ensuring that the facility staff provided orientation on the policies and procedures of the facility including the resident rights, appropriate form and record keeping requirements, to hospice staff furnishing care to the residents.

The P&P also showed the coordinated care plans for the residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being.

1. Medical record review for Resident 1 was initiated on 3/3/25. Resident 1 was admitted to the facility on [DATE].

Review of Resident 1's Order Summary Report dated 3/4/25, showed a physician's order dated 8/28/24, to admit Resident 1 to the facility under Hospice Provider A.

a. Review of Resident 1's hospice binder did not show a calendar to indicate when the hospice staff would visit the resident for January, February, and March 2025.

(continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 0930 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 was asked about the licensed nurse, social worker, and HA visits for January, February, and March 2025. LVN 1 was unsure and verified the hospice visit calendar was not in Resident 1's medical record. On 3/5/25 at 1430 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 was also unsure about Resident 1's hospice visit frequencies for January, February, and March 2025. LVN 2 verified the above findings. b. Review of Resident 1's Order Summary Report dated 3/4/25, showed a physician's order dated 8/28/24, to have the skilled nursing visits twice per week and three PRN visits for symptom management or condition changes. The HA visits were ordered twice per week for personal hygiene, ADL care, and ROM exercises. Review of the facility document titled CHHA Communication Sheet for January and February 2025 did not show the documented HA visit entries as ordered twice a week. Further review of the communication sheet showed documented entries on 1/30, 2/4, 2/26, and 2/28/25. On 3/5/25 at 1400 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DSD/IP. The DSD/IP was asked about the CHHA Communication Sheet for January, February, and March 2025. The DSD/IP was unable to provide the documentation to show the HA documented visits. The DSD/IP stated the HA should have documented their visits twice per week. The DSD/IP verified the above findings and stated Hospice Provider A's plan of care was followed. c. Review of Resident 1's hospice binder showed a physician's certification for hospice benefits covering the period from 10/1 to 11/29/24. The most recent plan of care for hospice was dated October 2024. On 3/5/25 at 1400 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DSD/IP. The DSD/IP was asked to show the latest physician certification and plan of care for hospice for Resident 1. The DSD/IP stated the last physician certification for hospice was on 11/29/24, and the plan of care from Hospice Provider A dated October 2024 was available in the resident's medical record. However, review of Resident 1's medical record and hospice binder did not show for an updated physician certification for December 2024 to March 2025 and there was no current hospice care plan. The DSD/IP stated the facility's care plan should have been updated to include the hospice visits from the skilled nursing hospice staff, social worker, HA, and other hospice staff. The DSD/IP verified the above findings. 43119 2. Medical record review for Resident 13 was initiated on 3/3/25. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's H&P examination dated 2/20/25, showed Resident 13 had a diagnosis of Alzheimer's disease and had the capacity to understand and make decisions. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 13's Order Summary Report for March 2025 showed a physician's order dated 2/20/25, to admit the resident to Hospice Provider A on routine level of care with a primary diagnosis of Alzheimer's disease. Review of the Resident 13's hospice binder did not show a calendar for January February, and March 2025 to show the schedule when the hospice staff were visiting Resident 13. Review of Resident 13's plan of care failed to show a care plan problem addressing Resident 13's hospice care services (focuses on improving the quality of life for individuals with terminal illnesses and their families by providing comfort, pain management, and emotional and spiritual support, rather than focusing on curing the disease). On 3/6/25 at 1117 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP was informed and acknowledged the above findings. The DSD/IP stated there should be a care plan to ensure the facility staff were aware of Resident 13's plan of care while receiving hospice care services. On 3/6/25 at 1529 hours, a follow-up interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP stated there should be a calendar in placed to ensure the facility staff were aware when the hospice staff were scheduled to visit the resident and to provide the hospice staff an update of Resident 13's condition.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32179 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the QAPI committee developed and implemented action plans to include monitoring the effectiveness of those plans in achieving and sustaining the improvement for a repeated deficient practice cited at F756. This was not in accordance with the facility's POC from the last recertification survey completed on 3/14/24. This failure had the potential to affect the quality of care for all the residents in the facility. Findings: Review of the facility's P&P titled Quality Assurance and Performance Review dated 2/2020 showed the QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: - Tracking and measuring performance; - Establishing goals and thresholds for performance measurement; - Identifying and prioritizing quality deficiencies; - Systematically analyzing underlying causes of systemic quality deficiencies; - Developing and implementing corrective action or performance improvement activities; and - Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. Review of the POC submitted by the facility to the CDPH, L&C Program for F756 cited from the last recertification survey completed on 3/14/24, showed the DON and/or a designee would be responsible and accountable to perform routine weekly audits of the pharmacy consultant recommendations to ensure the recommendations are completed on a monthly basis. On 7/16/18 at 1130 hours, an interview was conducted with the Administrator and DON. The DON was asked about the improvement action for the DRR cited in the previous recertification survey. The DON stated she should have assigned the charge nurse to review and address the DRR but forgot to do so. The DON stated she placed the DRR in the binder but should have assigned and given the DRR to the licensed nurse to ensure the DRR was followed up and communicated to the physician. The DON verified the above findings. Cross reference to F756.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were followed and implemented as evidenced by: * Residents 2, 6, 9, 18, and 22's physicians were not notified when the residents' infections did not meet the McGeer's criteria. * The facility failed to ensure Resident 627 had contact isolation precautions in place due to the clostridium difficile infection. * The Infection & Control Surveillance Log of Infections for February 2025 was inaccurate. Resident 627's CAI infection was not included in the log. * The blood pressure wrist machine used for the residents did not have a cleanable surface (Velcro with cloth material). * The facility failed to ensure the hospice licensed staff practiced EBP when providing wound care treatment for Resident 20 who was on the EBP. * CNA 3 did not wear gown when provided dressing and hygiene to Resident 7 who was on the EBP. These failures posed the risk of transmitting infections and not accurately tracking the infections and appropriate antibiotic use. Findings: 1. On 3/5/25 at 0923 hours, an interview, medical record review, and concurrent facility document review of the facility's Infection Control Program was conducted with the DSD/IP. a. Review of the facility's Infection Surveillance Monthly Report for January 2025 was conducted with the DSD/IP. The DSD/IP stated the report was used to track and report about the infections for January 2025. The DSD/IP verified the report failed to show how many residents did not meet the McGeer's criteria. Further review of the Infection Surveillance Monthly Report for January 2025 with the DSD/IP showed Residents 9, 18, and 22's physicians were not notified the residents' infections did not meet the McGeer's criteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43119 3. According to the CDC, enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for the residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition. Review of the facility's signage for Enhanced Barrier Precautions showed everyone must clean their hands, including before entering and when leaving the room. It also showed the providers and facility staff must wear gloves and gown for the following high-contact resident care activities: dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. Review of the facility's P&P titled Enhanced Barrier Precautions dated 8/2022 showed Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of MDROs to the residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/ or indwelling medical devices regardless of MDRO colonization. Medical record review for Resident 20 was initiated on 3/3/25. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 20's H&P examination dated 8/22/24, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's plan of care showed a care plan problem addressing Resident 20's enhanced barrier precautions due to bilateral lower extremity open wound. An intervention dated 2/20/25, included to utilize PPE (gown, gloves, face shield as indicated) during high contact resident care activities. On 3/3/25 at 1209 hours, Resident 20's room was observed with an enhanced barrier precaution signage posted by the door. The Hospice LVN was observed standing by the foot of the bed of Resident 20 and rendering wound care treatment. The Hospice LVN was observed wearing gloves but not wearing a gown. On 3/3/25 at 1211 hours, an interview was conducted with the Hospice LVN. The Hospice LVN verified the above findings. The Hospice LVN verified there was a signage by Resident 20's door showing Resident 20 was on the EBP. The Hospice LVN stated she missed the sign and should have worn a gown to prevent cross contamination. On 3/3/25 at 1220 hours, LVN 1 was informed of the above findings and stated the EBP signage was used to identify any open wound and the hospice staff should have worn the proper PPE for infection control purposes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 1013 hours, an interview was conducted with the DSD/IP. The DSD/IP acknowledged the above findings and stated the EBP included donning of gown, gloves, and mask for high contact activities such as wound care treatment to protect the resident from any MDRO and other infections. 32179 4. Medical record review of Resident 7 was initiated on 3/3/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's Order Summary Report dated 3/1/25, showed a physician's order dated 2/18/25, to place the resident on the EBP due to an indwelling urinary catheter. On 3/3/25 at 0830 hours, CNA 3 was observed assisting Resident 7 and handing a wet towel to the resident to wipe the resident's forehead and face. CNA 3 was observed not wearing a gown. In front of the resident's room door, a signage was observed indicating EBP and for the facility staff to wear a gown and gloves when providing direct care to the resident. On 3/4/25 at 0805 hours, CNA 3 was observed touching and repositioning Resident 7, and picking up Resident 7's urinary catheter bag, without wearing a gown. On 3/4/25 at 0830 hours, an interview was conducted with CNA 3. CNA 3 was informed of the above observations when she was providing care to Resident 7 without wearing a gown. CNA 3 stated she knew she needed to wear a gown but forgot to because she was rushing to assist the resident. CNA 3 verified the findings. On 3/4/25 at 0900 hours, an interview was conducted with LVN 1. LVN 1 was informed of the above findings and stated CNA 3 should have worn a gown and gloves in accordance with the EBP. LVN 1 verified Resident 7 had the EBP due to the presence of indwelling urinary catheter.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 52238 Based on observation, interview, and facility document review, the facility failed to ensure the essential equipment was maintained in safe operating condition. * The facility failed to ensure the quality control record for February and March 2025 reflected on the glucometer with the serial number 1040-4333929. This failure had the potential for the residents requiring glucose checks to have inaccurate readings. Findings: On 3/4/25 at 1339 hours, a concurrent review of the Assure Platinum Blood Glucose Monitoring System: Quality Control Record for February and March 2025 and inspection of the glucometer with the serial number 1040-4333929 was conducted with LVN 1. The log showed the glucometer quality control was completed for February and March 2025. However, when the glucose quality control results documented on the log were compared to the glucometer device's saved results (memory), it showed the glucose quality control results documented for 2/1 through 2/4, 2/6, 2/8 through 2/13, 2/16 through 2/20, 2/23 through 2/27, and 3/3/25, were not observed on the glucometer device. For example, the documented normal control result of 96 mg/dl and the high control result of 256 mg/dl documented on the log on 2/1/25, were not observed on the glucometer device. LVN 1 verified the above findings. On 3/5/25 at 0815 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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** 43119 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurately completed for four of 12 final sampled residents (Residents 1, 12, 13, and 20). This failure had the potential to negatively impact the residents, resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Side Rails revised date 12/2016 showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: - Bed mobility; - Ability to change positions, transfer to and from bed or chair, and to stand and toilet; - Risk of entrapment from the use of side rails; and - That the bed's dimensions are appropriate for the resident's size and weight. (continued on next page)

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 03/06/2025
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)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Bed Inspection Measurements dated 1/6/25, showed the bed numbers 13, 18, 19, and 26 were measured; however, the measurements for the bedframe lengths, mattress lengths, mattress heights, and zones pass or fail assessments were inaccurate. 1. On 3/3/25 at 0907 hours, during the initial tour of the facility, Resident 13 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 3/4/25 at 0836 hours, Resident 13 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 13 was initiated on 3/3/25. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's plan of care showed a care plan intervention dated 12/16/24, to use the bilateral half side rails to maximize independence with turning and repositioning in bed. Review of Resident 13's H&P examination dated 2/20/25, showed Resident 13 had a diagnosis of Alzheimer's disease and had the capacity to understand and make decisions. Cross reference to F700, example #1. 2. On 3/3/25 at 0934 hours and 3/4/25 at 0851 hours, Resident 20 was observed lying in bed with the bilateral half side rails elevated at the head of the bed. Medical record review for Resident 20 was initiated on 3/3/25. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 20's Order Summary Report for March 2025 showed a physician's order dated 8/21/24, to apply the bilateral upper side rails while in bed for increased bed mobility and repositioning. Review of Resident 20's H&P examination dated 8/22/24, showed Resident 20 had the capacity to understand and make decisions. On 3/6/25 at 1402 hours, an observation, interview, and concurrent facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified there were discrepancies between the actual bed measurements, assessments of the zones, and bed inspection measurements. On 3/6/25 at 1448 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator acknowledged the discrepancies between the actual bed measurements, assessment of the zones and the bed inspection measurements and stated the resident beds should have been measured accurately for safety reasons and to prevent the potential for entrapment. Cross reference to F700, example #2. 35346 (continued on next page)

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 03/06/2025

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

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 3/4/25 at 0945 and 1212 hours, Resident 12 was observed in bed with the bilateral one-half upper side rails raised. Review of the facility's bed measurement list showed Resident 12's bed was measured; however, the height of the mattress was inaccurately measured. Cross reference to F700, example #3. 32179 4. Medical record review for Resident 1 was initiated on 3/3/25. Resident 1 was admitted to the facility on [DATE]. Review of the facility's bed measurement list showed Resident 1's bed was measured; however, the height measurement of the mattress was inaccurate. On 3/6/25 at 1402 hours, an observation, interview, and concurrent facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified there was a discrepancy between the actual measurements and bed inspection measurements. Cross reference to F700, example #4.