STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555651	A. Building B. Wing	04/09/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility P&P review, facility document review, and the California Code of Regulations review, the facility failed to ensure a staff member was onsite during the evening and night shift, who could provide the respiratory services to the residents, in accordance with the residents' plan of care. * For the past year, on the evening and night shift, the facility failed to ensure a staff member was on site at the facility, who could provide respiratory services to the residents with oxygen titration orders. These failures had the potential to result in negative health outcomes for the residents. Findings: Review of the California Code of Regulations, Title 16, Section 1399.365, showed the respiratory care services the LVNs may perform in the long-term care setting. The respiratory services LVNs may not perform included the initial setup, change out, or replacement of a breathing circuit or adjustment of the oxygen liter flow or oxygen concentration. Review of the 2026 Facility Assessment revised 3/19/26, showed the purpose of the Facility Assessment is to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. Utilization of the Facility Assessment is to make decisions about our direct care staff needs, as well as our capabilities to provide services to the residents in our facility. This is a competency-based approach and focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. Residents will be admitted to the facility as long as their nursing and medical needs can be met by the facility. When a resident has been admitted to the facility and whose care needs cannot be met, the resident's physician will be immediately notified in effort to receive and order for the resident to be transferred to a facility that can meet the needs, care, and services required. Review of the Facility Assessment resident profile showed the following resident respiratory system conditions/diseases which the facility can provide care for: COPD, pneumonia, asthma, chronic lung disease, and respiratory failure. The average number of the residents receiving oxygen therapy at the facility was six. The Facility Assessment included the facility's staffing plan. The staffing plan showed the facility maintains adequate staffing on each shift to ensure that the residents' needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. The facility staffing plan showed the number of RNs who are assigned to each shift. Day shift 1 (one) RN, evening shift 0 (zero) RNs, and night shift 0 (zero) RNs. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation includes verification there is a physician's order for the procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Assemble oxygen equipment and supplies as needed. Oxygen therapy is administered by an oxygen mask, nasal cannula, and/or nasal catheter. A list of residents with active orders for the oxygen therapy was requested from the facility. Review of the Order Listing Report dated 4/6/26, showed 13 of 27 residents who resided at the facility had active orders for supplemental oxygen continuously and/or as needed. Residents 5 and 27 were included on (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the list and had orders for supplemental oxygen. 1. Medical record review for Resident 27 was initiated on 4/6/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 1/21/26, showed Resident 27 had a diagnosis of COPD and CHF. Resident 27's H&P showed he had the capacity to understand and make decisions. Review of Resident 27's active orders showed a physician's order dated 2/26/26, to monitor his oxygen saturation every shift and notify the physician if Resident 27's oxygen saturation was less than 92 percent. Resident 27 also had an order dated 2/26/26, for oxygen to be administered continuously at rate of two LPM (Fi02 28 percent) via nasal cannula for COPD. Additionally, Resident 27 had a physician's order dated 7/29/25, for BiPAP (FiO2 30 percent) at bedtime (at 2100 hours) which was to be removed in the morning (at 0600 hours). Review of Resident 27's Care Plan Report showed a care plan focus titled Ineffective Breathing Pattern related to acute and chronic respiratory failure, COPD, and dyspnea, initiated 7/6/25. The care plan interventions included monitoring Resident 27's oxygen saturation every shift, administering oxygen via nasal cannula at a rate of two LPM (Fi02 28 percent) as needed for shortness of breath and/or COPD exacerbation, and to apply BiPAP (Fi02 30 percent) at bedtime (at 2100 hours) for obstructive apnea. On 4/6/26 at 0820 hours, an observation and concurrent interview was conducted with Resident 27. Resident 27 was observed lying in his bed. Resident 27 was observed receiving continuous oxygen from an oxygen concentrator, at a rate of 2 LPM via nasal cannula. Resident 27 stated he received continuous oxygen for difficulty when breathing. A BiPAP machine was observed on top of Resident 27's bedside table. Resident 27 stated the nurse applied his BiPAP mask (with supplemental oxygen) every night at approximately 2100 hours and removed the BiPAP mask every morning at approximately 0600 hours. Resident 27 stated after the nurse removed his BiPAP mask in the morning, the nurse would then set up his oxygen concentrator to administer continuous oxygen at a rate of 2 LPM via nasal cannula. On 4/7/26 at 1512 hours, an interview, Facility Assessment review, and concurrent medical record review for Resident 27 was conducted with the DON. The DON verified the 2026 Facility Assessment showed the facility could provide respiratory services to the residents, in accordance with the physician's orders and the residents' plan of care. The DON verified the 2026 Facility Assessment was accurate specific to the RN staffing on the evening and night shift. The DON stated for the last year the facility did not have a RN assigned to work the evening or night shift at the facility. The DON stated LVNs were assigned to work the evening and night shift. The DON was asked what respiratory services LVNs could provide to the residents on the evening and night shift. The DON stated the LVNs could provide basic respiratory tasks and services and administer oxygen in emergent situations. The DON stated LVN basic respiratory tasks and services did not include the adjustment or titration of oxygen liter flow or oxygen concentration, in non-emergent situations. The DON verified on the evening and night shift, the facility did not have a nurse on site who could provide the respiratory services to the residents with oxygen titration orders. The DON then reviewed Resident 27's medical record. The DON verified Resident 27 had an active order for oxygen to be administered continuously by oxygen concentrator at rate of two LPM (Fi02 28 percent) via nasal cannula, for COPD. The DON stated the LVN assigned to the evening shift would remove Resident 27's continuous oxygen (administered by oxygen concentrator via nasal cannula) every evening at approximately 2100 hours, and then apply Resident 27's ordered BiPAP (FiO2 30 percent). The DON stated in the morning at approximately 0600 hours, the LVN would remove Resident 27's BiPAP and set up Resident 27's oxygen concentrator to administer continuous oxygen at a rate of 2 LPM via nasal cannula. The DON verified LVN basic respiratory tasks and services did not include the adjustment or titration of Resident 27's oxygen liter flow or oxygen concentration by the LVNs; however, the facility did not have an RN on site for the evening or night shift. 2. Medical record review for Resident 5 was initiated on 4/6/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 1/16/26, showed Resident 5 had a diagnosis of CHF. Review of Resident 5's active orders showed a physician's order dated 2/20/26, to monitor her oxygen saturation every shift for CHF. Additionally, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 5 had a physician's order dated 2/21/26, for oxygen to be administered continuously at rate of two LPM via nasal cannula, for CHF. Review of Resident 5's Care Plan Report showed a care plan focus titled Non-Compliant with Oxygen use, initiated 3/16/26. The care plan goals included Resident 5 will maintain an oxygen saturation greater than 90 percent. Care plan interventions included to monitor Resident 5's oxygen saturation level every shift and as needed. Review of Resident 5's Oxygen Saturation Summary showed the LVNs intermittently administered supplemental oxygen therapy to Resident 5. Examples included on 3/29/26 at 1524 hours, Resident 5's oxygen saturation was measured at 98 percent on room air. Then on 3/29/26 at 1758 hours, Resident 5 received oxygen via nasal cannula at a rate of 2 LPM and her oxygen saturation was measured at 98 percent. On 3/30/26 at 1420 hours, Resident 5's oxygen saturation was measured at 97 percent on room air. Then on 3/30/26 at 1854 hours, Resident 5 received oxygen via nasal cannula at a rate of 2 LPM and her oxygen saturation was measured at 97 percent. On 4/4/26 at 1406 hours, Resident 5's oxygen saturation was measured at 97 percent on room air. Then on 4/4/26 at 1922 hours, Resident 5 received oxygen via nasal cannula at a rate of 2 LPM and her oxygen saturation was measured at 97 percent. On 4/6/26 at 1335 hours, Resident 5's oxygen saturation was measured at 98 percent on room air. Then on 4/6/26 at 2336 hours, Resident 5 received oxygen via nasal cannula at a rate of 2 LPM and her oxygen saturation was measured at 96 percent. On 4/7/26 at 1520 hours, an interview and concurrent medical record review for Resident 5 was conducted with the DON. The DON verified Resident 5 had an active physician's order to monitor her oxygen saturation every shift and to administer oxygen continuously at rate of two LPM via nasal cannula, for CHF. The DON verified Resident 5's Oxygen Saturation Summary showed Resident 5 intermittently received supplemental oxygen therapy on the evening and night shift, throughout the months of March and April 2026. The DON stated Resident 5 would fluctuate between compliance and noncompliance with her continuous oxygen order. The DON verified the LVN basic respiratory tasks and services did not include the adjustment or titration of Resident 5's oxygen liter flow or oxygen concentration by LVNs; however, the facility did not have an RN on site for the evening or night shift.

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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 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. 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 for 27 of 27 residents who consumed food prepared in the kitchen. * 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 boards were kept in a sanitary condition and with cleanable surface. * Unlabeled and undated white powder was observed stored inside a plastic measuring cup on the countertop shelf. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 4/7/26, showed 27 of 27 residents consumed the food prepared in the kitchen. 1. 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. 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 4/6/26 at 0806 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with [NAME] 1. The kitchen hood over the stove had black, dirt residue. [NAME] 1 acknowledged the findings and stated the evening [NAME] 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 10/27/25. 2. 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 4/6/26 at 0806 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with [NAME] 1. The following was observed and verified by [NAME] 1:- One stainless steel scoop with a blue handle had an uneven edge.- One stainless steel scoop with a black handle partially melted.- Two stainless steel slotted scoops with gray handles partially melted.- One stainless steel scoop with a dark gray handle partially cracked.- One stainless steel whisk with deformed shape.- One rubber spatula with a red handle had chipped, cracked edges, and discolored.- One stainless steel dough cutter deformed and bent at the edges.- One dark brown cutting board had sticky, white residue. 3. 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 (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	necessary to preclude accumulation of soil residues. On 4/6/26 at 0806 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with [NAME] 1. The following was observed and verified by [NAME] 1:- One stainless steel scoop with a blue handle had fuzzy films.- Two stainless steel scoops with black handles had fuzzy films.- One stainless steel scoop with a green handle had water marks and fuzzy films. - Four stainless steel scoops with dark gray handles had dry water marks and fuzzy films.- One stainless steel scoop with light gray handle had fuzzy films.- Two stainless steel spoons had fuzzy films.- One stainless steel slotted spoon had dry water marks.- One stainless steel spatula had dry water marks.- Two measuring cups had dry, crusted residue. 4. Review of the facility's P&P titled Sanitation dated 2023 showed separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. 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 4/6/26 at 0806 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with [NAME] 1. The yellow and blue cutting boards were observed fuzzy, heavily marred, and had deep grooves. [NAME] 1 verified the findings. 5. According to the USDA Food Code 2017, Section 3-302.12, certain foods may be difficult to identify after they are removed from their original packaging. Consumers may be allergic to certain foods or ingredients. The mistaken use of an ingredient, when the consumer has specifically requested that it not be used, may result in severe medical consequences. The mistaken use of food from unlabeled containers could result in chemical poisoning. For example, foodborne illness and death have resulted from the use of unlabeled salt, instead of sugar, in infant formula and special dietary foods. Liquid foods, such as oils, and granular foods that may resemble cleaning compounds are also of particular concern. On 4/6/26 at 0806 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with [NAME] 1. An unlabeled and undated white powder was observed stored inside a plastic measuring cup on the countertop shelf. [NAME] 1 verified the findings and stated it was a food thickener, and it should have been labeled and dated. On 4/6/26 at 1529 hours, an interview was conducted with the DSS. The DSS acknowledged all the above findings and stated the following:- The hood over the stove was cleaned every six months by an outside company and the [NAME] cleans it every Wednesday. It should be kept clean and sanitary for infection control purposes and fire hazard.- All deformed and worn-out utensils should have been discarded and replaced for sanitation and infection control purposes.- The chipped spatula should not be used because particles could fall and mix in to the food.- All the dirty with dry crusted residue utensils should have been rewashed and sanitized for infection control purposes. - The cutting boards should have been replaced to prevent bacteria growth when not properly washed.-The food thickener should have been labeled and dated.

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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 - 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 Based on observation, interview, facility document review, and facility P&P review, the facility failed to implement their infection control program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program for the months of May 2025 through February 2026. The facility conducted surveillance of the resident's infections only when the residents were prescribed antimicrobial medications and/or if the residents were diagnosed with an infection. The facility failed to determine whether the residents who exhibited the signs and symptoms of infection and were not prescribed antimicrobial medications met the facility's criteria for infection (utilizing McGeer's Criteria). The facility failed to include these residents in the facility's infection control surveillance program. * The facility failed to ensure the clean laundry sorting table remained free from the staff's personal items. The laundry staff's purse and jacket were observed lying on the clean laundry sorting table. * The facility failed to ensure Resident 24's urinal was not stored on top of his overbed table adjacent to his water pitcher. These failures posed the risk for not preventing and identifying the residents infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings:

1. Review of the facility's P&P titled Surveillance for Infections revised 9/2017 showed the Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and prevent future infections. The criteria for such infections are based on the current standard definitions of infections. The Nursing Staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. Using the current suggested criteria for HAIs, determine if the resident has a HAI. For targeted surveillance collect information monthly from individual resident infection reports and enter line listing of infections by resident for the entire month. Summarize monthly data for each nursing unit by site and by pathogens.

On 4/9/26 at 0842 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's infection surveillance program specific to the residents. The IP stated when a resident exhibited signs and/or symptoms of infection and was prescribed an antimicrobial medication, or was diagnosed with an infection, she would then determine if the resident met the McGeer's Criteria. The IP stated the McGeer's Criteria was utilized to determine if a resident had a true infection.

Review of the facility's Infection Surveillance Monthly Reports from May 2025 through February 2026 showed the following infection surveillance data for HAIs, CAIs, and residents who did not meet the McGeer's Criteria (DNMC):

-5/2025: HAI - 7, CAI – 2, and DNMC - 0

-6/2025: HAI - 1, CAI – 0, and DNMC - 0

-7/2025: HAI – 4, CAI – 5, and DNMC - 0
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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-8/2025: HAI - 4, CAI – 1, and DNMC - 0

-9/2025: HAI - 0, CAI – 2, and DNMC - 0

-10/2025: HAI - 3, CAI – 7, and DNMC - 0

-11/2025: HAI -3, CAI –1, and DNMC –0

-12/2025: HAI - 5, CAI – 1, and DNMC - 0

-1/2026: HAI - 4, CAI –4, and DNMC - 0

-2/2026: HAI - 7, CAI – 0, and DNMC – 0

Further review of the facility's Infection Surveillance Monthly Reports from May 2025 through February 2026 showed documentation that all the residents included in the facility's infection surveillance program were determined to have either a HAI or CAI (with prescribed antimicrobial medications or having been diagnosed with an infection). The Infection Prevention and Control Surveillance logs failed to show any residents who did not meet the McGeer's criteria.

The IP verified between the months of May 2025 through February 2026 no resident in the facility was classified as having not met the McGeer's Criteria. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications (or was not diagnosed with an infection) if the facility initiated the McGeer's criteria form and included these residents in the facility's infection surveillance program. The IP stated the facility did not initiate the McGeer's criteria form for residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications (or were not diagnosed with an infection).

The IP was asked how many residents had met McGeer's criteria and were not prescribed antimicrobial medications, from May 2025 through February 2026 (excluding residents who were diagnosed with an infection). The IP stated she was uncertain, as the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications (or had not been diagnosed with an infection).

2. Review of the facility's P&P titled Laundry and Linen revised 2014 showed to separate soiled and clean linen at all times. Keep soiled and clean linen separate at all times.

On 4/8/26 at 1503 hours, an observation and concurrent interview was conducted with Housekeeper 1. An observation of the facility's laundry room was conducted with Housekeeper 1. The counter designated for clean laundry sorting was observed with Housekeeper 1's purse and jacket lying on the countertop, adjacent to clean linens. Housekeeper 1 verified the findings and stated the staff personal items should not be stored on the clean laundry sorting counter adjacent to clean linens, for infection control.

3. Medical record review for Resident 24 was initiated on 4/6/26. Resident 24 was admitted to the facility on [DATE].

Review of Resident 24's H&P examination dated 2/18/26, showed the resident had the capacity to understand and make decisions.
(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/6/26 at 0832 hours, during the initial tour of the facility, Resident 24 was observed awake, lying in the bed. The overbed table was observed with urinals with urine and adjacent to Resident 24 water pitcher. Resident 24 stated that he was waiting for the CNA to empty the urinals. On 4/6/26 at 0842 hours, an observation and concurrent interview for Resident 24 was conducted with CNA 1. CNA 1 stated the urinals should not be on the overbed table where the clean water pitcher was, to prevent infection. On 4/9/26 at 0957 hours, an interview was conducted with the DON. The DON was asked about the process where the urinals should be placed. The DON stated it was not supposed to be on top of the overbed table, and needed to be placed at the side of the overbed table to prevent infection and for sanitary purposes. The DON verified the above findings. On 4/9/26 at 1039 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the informed consent was obtained for the use of the bilateral side rails and psychotropic medications for one of five final sampled residents (Residents 6) reviewed for unnecessary medications. * The facility failed to obtain an informed consent for Resident 6's use of the lorazepam (medication to treat anxiety), buspirone (medication to treat anxiety), and bilateral side rail use. In addition, the facility failed to update the informed consent for citalopram (medication to treat depression) when the medication was increased for Resident 6. These failures had the potential for Resident 6 to be unaware of the risks associated with the use of psychotropic medications and bilateral side rails which could negatively affect the resident's well-being.Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 7/2023 showed anytime new orders are received that results in a material change in circumstances or risk, a new informed consent is required. All informed consent verifications must be in writing prior to initiation of the treatment or procedure. Acceptable forms are:a. The facility Verification of Informed Consent Form completed and sign by the prescribing physician.b. A written, signed statement from the ordering healthcare practitioner stating that informed consent was obtained and who it was obtained from.The signed Informed consent must be placed in the resident's chart. Review of the facility's P&P titled Proper Use of Side Rails revised 12/2016 showed the purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptom. Consent for side rails use will be obtained from the resident or legal representative after presenting potential benefits and risks. Medical record review for Resident 6 was initiated on 4/6/26. Resident 6 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 6's H&P examination dated 10/26/25, showed the resident had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report dated 4/9/26, showed the following physician's orders:- dated 10/31/25, to administer lorazepam 0.5 mg to give one tablet every Tuesday and Friday for anxiety manifested by aggression on shower days;- dated 2/2/26, to administer citalopram 10 mg to give one tablet every morning and at bedtime for depression manifested by crying and sad facial features;- dated 2/27/26, to administer buspirone 15 mg to give one tablet two times a day for anxiety manifested by persistent screaming; and- dated 4/6/26, for may have bilateral one half siderails up while in bed for mobility and repositioning. a. Review of Resident 6's medical record failed to show informed consents for buspirone and lorazepam medications, and bilateral one-half siderails were obtained. b. Further review of Resident 6's medical record failed to show an informed consent was obtained when the citalopram medication was increased from citalopram 10 mg one time a daily to citalopram 10 mg every morning and at bedtime. On 4/6/26 at 0930 hours, during the initial tour of the facility. Resident 6 was observed lying in bed with the bilateral one- half siderails elevated. On 4/8/26 at 1106 hours, an interview and concurrent interview for Resident 6 was conducted with CNA 1. CNA 1 stated Resident 6 used the side rails to hold during diaper changes. On 4/8/26 at 1349 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified the informed consents for the lorazepam buspirone medications and bilateral one-half side rails were not obtained. The DON stated the informed consent should have being obtained to inform the risk of the use of the psychotropic medications and bilateral one-half rails. The DON verified all the above findings. On 4/9/26 at 1430 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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NAME OF PROVIDER OR SUPPLIER Stanley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Residents 3) reviewed for unnecessary psychotropic medications was free from unnecessary psychotropic drugs. * The facility failed to monitor Resident 3's orthostatic (a sudden drop in blood pressure upon standing, defined as a reduction of greater than or equal to 20 mmHg systolic or 10 mmHg diastolic within three minutes of standing which may cause dizziness, lightheadedness, and fainting) blood pressure related to the use of the quetiapine (antipsychotic medication). In addition, the facility failed to document what nonpharmacological interventions were attempted when Resident 3 had episodes of bizarre delusions related to the use of the quetiapine medication. This failure had the potential for Resident 3 to have adverse complications from the medication and to not provide accurate data to the prescriber in determining the dose adjustments of the psychotropic medications for the resident. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 7/2022 showed the residents will not receive medications that are not clinically indicated to treat a specific condition. Nonpharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medication when possible. Residents receiving psychotropic medications are monitored for adverse consequences, including; cardiovascular effect - irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, and orthostatic hypotension. 1. Medical record review for Resident 3 was initiated on 4/6/26. Resident 3 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 3's care plan problem for the use of the psychotropic medications quetiapine related to schizoaffective disorder dated 2/4/25, showed interventions included to monitor for orthostatic hypotension - monitor blood pressure while lying and sitting. Notify MD if there's a drop of 20 mmHg or more in the SBP; 10 mmHg on DBP every Monday day shift. Review of Resident 3's Order Summary Report showed the following physician's orders:- dated 10/31/25, to monitor nonpharmacological interventions for anti-psychotic medication: 1) Offer to talk with the resident and redirect the resident with a calm and reassuring conversation.2) Assist the resident to identify triggers/measures that relieve fear and to set goals. every shift - dated 2/18/26, to administer quetiapine 100 mg medication by mouth, in the morning for schizoaffective disorder as manifested by bizarre delusions.- dated 2/18/26, to administer quetiapine 200 mg medication by mouth, in the evening for schizoaffective disorder as manifested by bizarre delusions. Review of Resident 3's MDS quarterly assessment 1/10/26, showed Resident 3 with a BIMS score of 14, which meant cognitively intact. Review of Resident 3's MARs for March and April 2026 failed to show Resident 3's orthostatic blood pressure in the lying and sitting position were monitored. Further review of Resident 3's medical record failed to show what nonpharmacological interventions were attempted when Resident 3 had episodes of bizarre delusions on the following dates and times:-dated 4/2/26, day shift - two episodes; -dated 4/3/26, day shift - two episodes;-dated 4/4/26, day shift - two episodes;-dated 4/4/26, evening shift - one episode;-dated 4/5/26, evening shift - one episode;-dated 4/6/26, evening shift - one episode; and-dated 4/7/26, day shift - two episodes On 4/7/26 at 1355 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated the reading for orthostatic hypotension should have systolic and diastolic blood pressure reading for the lying and sitting position to monitor the side effects of the medication, where the drop in the resident's blood pressure may cause dizziness, fainting and potential fall. The DON verified the above findings and further stated the licensed nurse should have documented what nonpharmacological interventions were used to be effective. On 4/9/26 at 1039 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASRR Level 1 Screening (identifies if a resident has a suspected mental illness or intellectual/developmental disability or related condition) contained accurate information specific to mental illness, for one of two residents (Resident 4) reviewed for PASRR. *Resident 4 had a diagnosis of bipolar disorder; however, the PASRR Level 1 Screening showed Resident 4 had no diagnosed mental illness. This failure had the potential for Resident 4 not to receive a PASRR Level II Mental Health Evaluation (determines if the resident can benefit from specialized mental health services), which posed the risk for Resident 4 not obtaining recommendations for specialized services to address the resident's mental health needs.Findings: Medical record review for Resident 4 was initiated on 4/6/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's PASRR Level 1 Screening results dated 1/13/25, showed Resident 4 had no diagnosed serious mental illness. Review of Resident 4's Neuropsychiatric assessment dated [DATE], showed Resident 4 had a diagnosis of bipolar disorder and PTSD. On 4/7/26 at 1013 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON reviewed Resident 4's medical record and verified Resident 4's PASRR Level I Screening dated 1/13/25, showed Resident 4 had no diagnosed serious mental illness. The DON verified this information was incorrect as Resident 4 had a diagnosis of bipolar disorder and PTSD. The DON stated the PASRR Level 1 Screening needed to contain accurate information, to ensure a Level II mental health evaluation was conducted if needed, which was performed to determine if a resident would benefit from specialized mental health services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to ensure one of 13 final sampled residents (Resident 8) attained and maintained their highest practicable physical well-being. * The facility failed to apply the foot cradle for Resident 8 in accordance with the physician's order. This failure had the potential for delays in providing the necessary care and services for Resident 8.Findings: 1. Medical record review for Resident 8 was initiated on 4/6/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed a physician's order dated 7/13/24, for may have foot cradle in bed to prevent skin breakdown. Review of Resident 8's H&P examination dated 6/15/25, showed the resident had the capacity to understand and make decisions. On 4/6/26 at 0838 hours, during the initial tour of the facility, Resident 8 was observed awake, lying in the bed. Further observation of Resident 8's room failed to show a foot cradle in bed. On 4/9/26 at 0858 hours, an observation and concurrent interview for Resident 8 was conducted with CNA 2. CNA 2 verified there was no foot cradle attached to the bed for Resident 8. On 4/9/26 at 0859 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified the above findings. The DON stated the foot cradle was used to prevent skin breakdown for Resident 8. On 4/9/26 at 1039 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the appropriate dialysis (a life-sustaining treatment for kidney failure that filters waste and excess fluids from the blood) care was provided for one of 13 final sampled residents (Residents 8) who was receiving dialysis services. * The facility failed to ensure a dialysis emergency kit was available at the bedside for Resident 8. This failure had the potential for the resident to experience medical complications.Findings: 1. Medical record review for Resident 8 was initiated on 4/6/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed a physician's order dated 7/13/24, to check the dialysis site for bleeding and signs or symptoms of infection every shift. Review of Resident 8's Order Summary Report showed a physician's order dated 7/13/24, for left arm AV shunt (a direct connection between an artery and a vein, often surgically created in the arm for hemodialysis) dialysis site. Review of Resident 8's H&P examination dated 6/15/25, showed Resident 8 had the capacity to understand and make decisions. On 4/6/26 at 0838 hours, during the initial tour of the facility, Resident 8 was observed awake, lying in the bed with left arm AV shunt. Resident 8 stated he went to the dialysis every Tuesday and Saturday. Further observation of Resident 8's room failed to show a dialysis emergency kit was available at the resident's bedside. On 4/6/25 at 1001 hours, an interview was conducted with LVN 1. LVN 1 verified the above findings and stated the dialysis emergency kit was needed to be available to use when there was bleeding at Resident 8's dialysis site. On 4/9/25 at 0957 hours, an interview was conducted with the DON. The DON stated the resident who had dialysis should always be checked for bleeding at the dialysis access site. The DON further stated the dialysis emergency kit was important to always be available and accessible in the resident's room for any complications observed in the dialysis access site. The DON was informed and acknowledged the above findings. On 4/9/26 at 1039 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of four final sampled residents (Residents 2 and 6) reviewed for the use of side rails remained free from the accident hazards associated with the use of the elevated side rails. * The facility failed to ensure the side rails assessment was accurate or completed, and/or the least restrictive measures were provided prior to the use of the side rails for Residents 2 and 6. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: Review of the facility's P&P titled Proper Use of Side Rails revised 12/2016 showed the purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptom. When side rails usage is appropriate, the facility will assess the space between the mattress and siderails to reduce the risks for entrapment (the amount of space may vary, depending on the type of bed and mattress being used. - Less restrictive intervention that will be incorporated in the care planning include:a. Providing restorative care to enhance abilities to stand safely and to walk;b. Providing trapeze to increase bed mobility;c. Placing the bed lower to the floor and surrounding the bed with a soft mat;d. Equipping the resident with a device that monitors attempts to arise;e. Providing staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/[NAME]. Furnishing visual and verbal reminders to use the call bell for residents who can comprehend this information.- Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of siderails. 1. Medical record review for Resident 2 was initiated on 4/6/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Bed Rail assessment dated [DATE], failed to show an assessment which showed the reason Resident 2 needed siderails, and least restrictive interventions were tried prior to the use of side rails. Review of Resident 2's MDS quarterly assessment dated [DATE], showed Resident 2 had a BIMS score of 15 (which meant cognitively intact). Review of Resident 2's Order Summary Report showed a physician's order dated 4/3/26, for may have bilateral one-half side rails up while in bed for mobility and repositioning. On 4/6/26 at 0921 hours, during the initial tour of the facility, Resident 2 was observed lying in bed. The bilateral one-half siderails in bed were not elevated. On 4/8/26 at 1542 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON verified the above findings and stated an assessment for least restrictive interventions should have been tried prior to the use of the side rails. 2. Medical record review for Resident 6 was initiated on 4/6/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's Bed Rail assessment dated [DATE], failed to show an assessment to show the reason Resident 6 needed siderails, and the least restrictive interventions were tried prior to the use of the side rails. Review of Resident 6's H&P examination dated 10/26/25, showed the resident had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report showed a physician's order dated 4/6/26, for may have bilateral one-half side rails up while in bed for mobility and repositioning. On 4/6/26 at 0911 hours, during the initial tour of the facility, Resident 6 was observed lying in bed with bilateral one-half side rails elevated. On 4/8/26 at 1349 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified the above findings and stated an assessment for the least restrictive interventions should have been tried prior to the use of the side rails. On 4/9/26 at 1430 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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the required physician visits were done timely for one of 13 final sampled residents (Resident 15). * The facility failed to ensure Resident 15 was visited by the physician every 60 days. This failure had the potential to result in an undetected decline in medical, health, or psychosocial condition and can lead to a delay in the necessary care, treatment, and services.Findings: 1. Review of the facility's P&P titled Physician Visits revised 4/2013 showed the attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. After the first ninety (90) days, if the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits maybe established, but not to exceed every sixty (60) days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation. Medical record review for Resident 15 was initiated on 4/6/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's MDS quarterly assessment dated [DATE], showed Resident 15 had a BIMS (Brief Interview for Mental Status) score of 3 (which meant severe cognitive impairment). Review of Resident 15's Physician Visit Notes failed to show documented evidence the required physician's visits were made between January to April 2026. On 4/9/26 at 0957 hours, an interview and concurrent medical record review for Resident 15 was conducted with the DON. The DON verified the last face to face documented physician visit for Resident 15 was on 12/30/25. The DON further stated that there should be a monthly visit from the physician. On 4/9/26 at 1039 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the availability of the prescribed medications for one of five sampled residents (Resident 5) reviewed for unnecessary medications. * Resident 5 had a physician's order for Cobenfy (psychotherapeutic medication). The licensed nurse was unable to administer the evening dose of Cobenfy on two consecutive days, due to the unavailability of the medication. This failure posed the risk for inhibiting the therapeutic effects of the medication.Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with the prescriber orders, including any required time frame. Medical record review for Resident 5 was initiated on 4/6/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed a physician's order dated 2/20/26, to administer Cobenfy 100-20 mg capsule orally two times a day (at 0900 and 1700 hours) for schizophrenia manifested by bizarre delusions. Review of Resident 5's MAR dated 3/2026 showed documentation that the licensed nurse failed to administer Resident 5's Cobenfy 100-20 mg capsule orally on 3/28 and 3/29/26, at 1700 hours. Review of Resident 5's Administration note dated 3/28/26 at 1827 hours, showed Resident 5's Cobenfy 100-20 mg capsule was not administered on 3/28/26 at 1700 hours, due to the unavailability of the medication. Resident 5's physician and the pharmacy were informed. Review of Resident 5's Administration note dated 3/29/26 at 1753 hours, showed Resident 5's Cobenfy 100-20 mg capsule was not administered on 3/29/26 at 1700 hours, due to the unavailability of the medication. Further review of the documentation showed as per the pharmacy, Resident 5's medication was on order. On 4/7/26 at 1408 hours, an interview and concurrent medical record review for Resident 5 was conducted with the DON. The DON verified Resident 5 did not receive her Cobenfy 100-20 mg oral capsule on 3/28 and 3/29/26 at 1700 hours, in accordance with the physician's order. The DON stated her expectation was the pharmacy should ensure Resident 5's Cobenfy was available to be administered, in accordance with the physician' s order. The DON stated administering the Cobenfy medication as ordered by the physician was important to ensure effective management of Resident 5's symptoms associated with schizophrenia.

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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** Based on interview, medical record review, and facility document review, the facility failed to follow up the MRR recommendation for one of five sampled residents (Resident 6) reviewed for unnecessary medications. * The facility failed to implement the pharmacy recommendations approved by physician to change the ibandronate (medication to prevent bone weakening) administration time for Resident 6. This failure placed Resident 6 at an increased risk for developing preventable adverse effects of the medication. Findings: Medical record review for Resident 6 was initiated on 4/6/26. Resident 6 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 10/26/25, showed the resident had no capacity to understand and make decisions. Review of Resident 6 's Order Summary Report showed the following physician order dated 10/26/25, may administer ibandronate 150 mg one tablet once a month on every 28th day of the month, give with eight ounces of water and have the resident remain in an upright position for at least one hour after administration. Review of Resident 6's MAR for March 2026 showed the ibandronate 150 mg medication was given on 3/28/26 at 0600 hours. Review of Resident 6's MRR for March 2026 showed a recommendation from the pharmacy consultant to change the ibandronate administration time at 0600 hours to 0500 hours. On 4/9/26 at 0913 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified the recommendation of the pharmacy consultant was not followed and stated she missed the recommendation. On 4/9/26 at 1430 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8%. One of three licensed nurses (LVN 2) was found to have made errors during the medication administration to one final sampled resident (Resident 4). * LVN 2 failed to administer the cholecalciferol (supplement) and fluticasone (medication to treat allergies) medications as ordered for Resident 4 due to the unavailability of the medications. These failures had the potential to negatively affect the residents' health conditions and posed the risk of possible complications or delays in interventions. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. 1. On 4/7/26 at 0834 hours, a medication administration observation for Resident 4 was conducted with LVN 2. LVN 2 prepared and administered the following medications to Resident 4:- one tablet of Abilify (antipsychotic medication) 20 mg- one tablet of docusate sodium (stool softener) 100 mg- one tablet of finasteride (medication to treat enlarged prostate gland causing difficulty urinating) 5 mg- one tablet of vitamin B-12 (supplement) 500 mcg- two tablet of Keppra (medication to treat seizures)1000mg (total 2000 mg)- one tablet of potassium chloride (supplement) 20 mEq- one tablet of lacosamide (medication to treat seizures)100 mg- clear lax (a stool softener to relieve occasional constipation) 17 grams with 6 oz. of water- Refresh liquigel (used to relieve dry eyes) Medical record review for Resident 4 was initiated on 4/6/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed the following physician's order:- dated 7/13/25, to administer cholecalciferol 125 mcg (5000 unit) one tablet by mouth one time a day for supplement - dated 7/13/25, to administer fluticasone nasal spray 50 mcg one spray in both nostrils twice a day for allergy On 4/7/26 at 0923 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 2. LVN 2 verified there were no available supplies of the cholecalciferol and fluticasone medications for Resident 4 to be given during the medication administration. On 4/9/26 at 0957 hours, an interview was conducted with the DON. The DON stated during the administration of medications, if the medication was not available in the medication cart, the licensed nurses were expected to follow up with the central supply/pharmacy to obtain the medication and administer the medication as soon as possible. The DON further stated if the medication was held, she expected the licensed nurse to inform the physician and document in the progress notes the reason the medication was held. On 4/9/26 at 1039 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555651	A. Building B. Wing	04/09/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility P&P, the facility failed to provide the necessary pharmacy services to ensure the proper storage of medications for one of three medication carts (Medication Cart 1) inspected. * The facility failed to ensure the treatment supplies were stored properly. This failure had the potential to alter the efficacy of the stored treatment supplies and pose the risk of infection to the residents.Findings: Review of the facility's P&P titled Storage of Medication Labeling and Storage revised 2/2023 showed the nursing staff is responsible for maintaining the storage and preparation areas in a clean, safe and sanitary manner. On 4/6/25 at 1046 hours, an observation of Medication Cart A and concurrent interview was conducted with the DON. The following was observed:- one individual pack of sterile gauze bandage roll open with package's description showed it contained sterile in unopened, undamaged package.- three individual pack open Medi strip reinforced wound closure, with package's description showed it was a single use only dressing. During the observation and concurrent interview with the DON, the DON was asked about the process of opening an individual pack supply. The DON stated the individual pack was a single use only and needed to discard all open and unused pouches to maintain the individual package was sterile. The DON verified the above findings. On 4/9/26 at 1039 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in one of one garbage dumpster. This failure had the potential to attract pests and rodents that carry diseases.Findings: Review of the facility's P&P titled Miscellaneous Areas, Garbage and Trash dated 2023 showed the garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. According to the 2022 FDA Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 4/6/26 at 0740 hours, an observation of the facility's one outside garbage dumpster was conducted. The garbage dumpster was observed with the lid partially propped open by the garbage bags, preventing the lid from fully closing. On 4/6/26 at 1529 hours, an interview was conducted with the DSS. The DSS was shown a photograph of the dumpster taken on 4/6/26 at 0740 hours. The DSS verified the above findings and stated the dumpster lid should be fully closed at all times, to prevent rodents from entering or exiting the trash and for infection control purposes.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were complete and accurately documented for four of 13 final sampled residents (Residents 2, 6, 8, and 11). * The facility failed to ensure the safety assessment for siderails usage for Residents 2, 6, and 11 were accurate in accordance with the physician's orders. * The facility failed to ensure Resident 6's informed consent for buspirone (medication to treat anxiety), and citalopram (medication to treat depression) were maintained in the residents' medical record. * The facility failed to ensure Resident 8's blood pressure access site was accurately documented in the medical record. * The facility failed to ensure Section D of Resident 11's POLST (Physician Orders for Life-Sustaining Treatment) was signed and dated by the physician. These failures have the potential for the residents care needs not being met as their medical information were inaccurate and incomplete.Findings: 1. Review of the facility's P&P titled Hemodialysis Access Care revised 9/2010 showed the hemodialysis devices may only be accessed by medical personnel who have received training and demonstrated clinical competency regarding the use of these devices. To prevent infection and/or clotting, do not use the access arm to take blood pressure. Medical record review for Resident 8 was initiated on 4/6/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed the following physician order dated 7/13/24, dialysis site left arm shunt. Review of Resident 8's care plan problem for hemodialysis related to renal failure dated 11/7/24, showed interventions including to not draw blood or take blood pressure on the left arm. Review of Resident 8's H&P examination dated 6/15/25, showed the resident had the capacity to understand and make decisions. Review of Resident 8's documentation of blood pressure for March and April 2026 showed the following:- on 3/8/26 at 1711 hours, a blood pressure reading of 128/64 mmHg on the left arm;- on 3/9/26 at 1722 hours, a blood pressure reading of 121/72 mmHg on the left arm;- on 3/11/26 at 1028 hours, a blood pressure reading of 120/70 mmHg on the left arm;- on 3/23/26 at 1906 hours, a blood pressure reading of 130/66 mmHg on the left arm;- on 3/27/26 at 1707 hours, a blood pressure reading of 132/71 mmHg on the left arm;- on 3/29/26 at 1115 hours, a blood pressure reading of 132/68 mmHg on the left arm; and- on 4/2/26 at 1700 hours, a blood pressure reading of 128/78 mmHg on the left arm. On 4/6/26 at 0838 hours, during the initial tour of the facility, Resident 8 was observed awake, lying in bed, with AV shunt noted on the left arm. Resident 8 stated he went to dialysis every Tuesday and Saturday. On 4/9/26 at 0848 hours, an interview was conducted with Resident 8. Resident 8 stated he never allowed the licensed nurses to take his BP on the left upper arm. On 4/9/26 at 0957 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified the BPs were not taken on Resident 8's left arm and the documentation for the BP readings for March and April 2026 were inaccurate. The DON further stated taking the BP on the access site will increase the resident's risk for infection and blood clot to the left AV shunt. On 4/9/26 at 1039 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Psychotropic Medication Use revised 7/2023 showed the signed informed consent must be placed in the resident's chart. Medical record review for Resident 6 was initiated on 4/6/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 10/26/25, showed the resident does not have the capacity to understand and make decisions. Review of Resident 6's Order Summary Report dated 4/9/26, showed the following physician's orders:- dated 2/2/26, to administer citalopram 10 mg to give one tablet every morning and at bedtime for depression manifested by crying and sad facial features; and- dated 2/27/26, to administer buspirone 15 mg to give one tablet two times a day for anxiety manifested by persistent screaming. Further review of Resident 6's medical (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record failed to show documented evidence a copy of the informed consent for the buspirone and citalopram medications were placed in the resident's chart. On 4/8/26 at 1349 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified the informed consents for the buspirone and citalopram medications were not accessible in Resident 6's medical record. (Cross reference F552) 3. Medical record review for Resident 11 was initiated on 4/6/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's POLST dated 8/7/25, showed under Section D-Information and Signatures, the signature of the physician and date were left blank. Review of Resident 11's H&P examination dated 4/2/26, showed Resident 11 had the capacity to understand and make decisions. On 4/9/26 at 1054 hours, an interview and concurrent medical record review for Resident 11 was conducted with DON. The DON verified the signature of the physician and date were blank on the POLST form. The DON further stated the physician should have signed and dated the POLST. 4. Review of the facility's P&P titled Proper Use of Side Rails revised 12/2016 showed the purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. a. Medical record review for Resident 2 was initiated on 4/6/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS quarterly assessment dated [DATE], showed Resident 2 had a BIMS score of 15 (which meant cognitively intact). Review of Resident 2's Safety Assessment for Side rail usage dated 4/1/26, showed an assessment for the one-fourth side rail. Review of Resident 2's Order Summary Report showed a physician's order dated 4/3/26, for may have bilateral one-half side rails up while in bed for mobility and repositioning. On 4/6/26 at 0911 hours, during the initial tour of the facility, Resident 2 was observed lying in bed. The bilateral one-half side rails in bed were not elevated. On 4/8/26 at 1542 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON verified the above findings. b. Medical record review for Resident 6 was initiated on 4/6/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 10/26/25, showed the resident had no capacity to understand and make decisions. Review of Resident 6's Safety Assessment for Side rail usage dated 4/1/26 showed an assessment for one-fourth side rail. Review of Resident 6's Order Summary Report showed a physician's order dated 4/6/26, for may have bilateral one-half side rails up while in bed for mobility and repositioning. On 4/6/26 at 0911 hours, during the initial tour of the facility, Resident 6 was observed lying in bed with bilateral one-half elevated. On 4/8/26 at 1349 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified the above findings. c. Medical record review for Resident 11 was initiated on 4/6/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 10/26/25, showed the resident had no capacity to understand and make decisions. Review of Resident 11's Safety Assessment for Side rail usage dated 4/1/26 showed an assessment for the one-fourth side rail. Review of Resident 11's Order Summary Report showed a physician's order dated 4/3/26, for may have bilateral one-half side rails up while in bed for mobility and repositioning. On 4/6/26 at 0923 hours, during the initial tour of the facility, Resident 11 was observed lying in bed with bilateral one-half elevated. On 4/9/26 at 1054 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified the above findings. On 4/9/26 at 1430 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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NAME OF PROVIDER OR SUPPLIER Stanley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and facility document review, the facility failed to ensure the daily nursing PPD was posted with an accurate information. * The facility failed to update the daily nursing PPD with the correct date, staffing data, and census. This failure had the potential for the residents and visitors to not be informed about the facility's staffing.Findings: On 4/7/26 at 0940 hours, an observation was conducted of the daily nursing PPD posting. Review of the facility's daily nursing PPD showed a date of 3/31/26. Review of the facility's daily nursing PPD posted on the wall near the business office, failed to show the correct date, census, and staffing data. On 4/7/26 at 1005 hours, an interview was conducted with the DSD. The DSD stated the NOC or morning shift charge nurses were the staff responsible for removing the old projection and replacing it with their new projection each day. The DSD stated the daily nursing PPD posting was important due to having admissions and discharges often, and to ensure they were not over or understaffed. The DSD acknowledged and verified the above findings.