STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555688	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Point Healthcare & Wellness Centre, LP	3415 W Ball Road Anaheim, CA 92804

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medial record review, and facility P&P review, the facility failed to conduct an inventory of a resident's personal property in accordance with the facility's P&P for one of five sampled residents (Resident 2). * The facility failed to conduct the inventory of Resident 2's personal property when he was admitted and discharged from the facility. This failure had the potential for the resident's property to get lost or stolen. Findings: Review of the facility's P&P titled Personal Property revised 7/14/17, showed the residents are encouraged to retain and use personal possessions, as space permits. During the admission process the admissions staff will inform the resident of the need to mark the resident's belongings with the resident's name and to notify nursing when additional items are brought to the facility, so they can be added to the resident's inventory list. Admissions staff will also inform the resident that items removed from the facility need to be removed from the inventory list. Upon admission the CNA/designee will conduct a personal property inventory of the resident's property and place in the medical record. Upon discharge home, the resident will review the resident inventory to ensure all personal items are taken. The resident will sign the inventory indicating that all personal property is released to them. If an item(s) is missing, the staff will initiate a search and notify social services/designee in accordance with the Theft and Loss policy for resolution. I f the resident is transferred to the acute hospital, and is expected to return to the facility, the resident's CNA will inventory the resident's property at the time of transfer. The facility may decide to keep the resident's personal property in the resident's room during the bed hold or may pack the items and place them in secured storage pending the resident's return. Medical record review for Resident 2 was initiated on 7/31/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Clinical Admission note dated 7/8/24 at 2130 hours, showed Resident 2 was alert and oriented, communicated verbally with clear speech, was able to understand, and be understood when speaking. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1507 hours, an interview was conducted with Resident 2. Resident 2 stated he was transferred to the acute care hospital on 7/21/24, and after he was discharged from the acute care hospital, he then returned to the facility to retrieve his personal property. Resident 2 stated when he returned to the facility to retrieve his belongings, the social worker assisted him with loading his vehicle. Resident 2 stated he was given three boxes which contained his personal belongings. Resident 2 stated at the time he loaded his vehicle, he realized several of his personal belongings were missing. Resident 2 stated the following items were missing: a coffee pot, a bathroom kit with medicated shampoo, artist pencils, two beach towels, six pairs of socks, six pairs of hospital socks, a white belt, a bluetooth speaker, and a nebulizer. Resident 2 stated he informed the social worker, and she informed him thatshe would follow up with Resident 2 regarding his alleged missing property; however, Resident 2 stated the social worker failed to follow up with him. On 8/5/24 at 1642 hours, an interview was conducted with Social Worker 2. Social Worker 2 stated Resident 2 returned to the facility to obtain his personal belongings. Social Worker 2 stated the CNAs had boxed up his personal property and then provided Resident 2 with his personal property. Social Worker 2 stated she assisted in carrying some of Resident 2's personal property to his vehicle. Social Worker 2 stated she provided Resident 2 with his amplifier, guitar holder, and clothing. Social Worker 2 was asked if Resident 2 claimed any of his personal property was missing. Social Worker 2 stated Resident 2 informed her that a couple t-shirts were missing, at which time Social Worker 2 retrieved Resident 2's t-shirts from the facility and gave the t-shirts to Resident 2. Social Worker 2 was asked if she documented the items released to Resident 2, to which Social Worker 2 replied, her duties did not consist of inventorying Resident 2's personal property. Social Worker 2 stated the CNAs would usually inventory the resident's property on admission and discharge from the facility. Review of Resident 2's Resident Inventory form dated 7/8/24, failed to show any documentation of Resident 2's personal property upon admission to the facility. Further review of the form failed to show documentation specific to any personal property provided to Resident 2 upon discharge. On 8/6/24 at 1130 hours, an interview and concurrent medical record review was conducted with the DON. The DON was asked to describe the facility's P&P specific to safeguarding resident personal property. The DON stated upon admission to the facility, a resident's personal property would be inventoried and documented on the Resident Inventory form. The resident's inventory form was updated with any additional property brought into the facility. The DON stated upon discharge from the facility, all personal property released to the resident would bedocumented on the Resident Inventory form. The DON stated both resident and staff were to sign the inventory form verifying the personal property the resident possessed upon admission, brought into the facility after admission, and the property released to the resident upon discharge from the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was asked if she was aware of any personal property Resident 2 claimed missing upon his discharge from the facility, to which she replied, she was not. The DON was asked to review Resident 2's medical record including Resident 2's Resident Inventory form dated 7/8/24, to locate documentation specific to what personal property Resident 2 possessed during his stay at the facility and the personal property provided to Resident 2 when he returned to the facility to retrieve his personal property. The DON reviewed Resident 2's medical record and stated Resident 2's medical record failed to show any documentation specific to Resident 2's personal property, therefore could not determine what personal property Resident 2 possessed during his stay at the facility, or what personal property was provided to Resident 2 when he was discharged from the facility. The DON stated the staff who admitted Resident 2 to the facility should have documented in Resident 2's Resident Inventory Form what personal property Resident 2 possessed at the time of his admission on 7/8/24. The DON stated the staff member and Resident 2 needed to sign the Resident Inventory Form, attesting to the property in Resident 2's possession. The DON stated the staff who released Resident 2's personal property upon his discharge from the facility should have documented the property released to Resident 2. The DON stated the facility staff and Resident 2 also should have signed the Resident Inventory form, attesting to the property released to Resident 2. The DON stated the facility was unable to determine what personal property was brought in upon admission and released to Resident 2 upon his discharge from the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility to implement their P&P related to abuse reporting for one of five sampled residents (Resident 1). * The Activities Assistant failed to report the abuse allegation to the Administrator when Resident 1 informed the Activities Assistant that a CNA was mad and threw towels on Resident 1's bed. This failure had the potential for the abuse allegation not investigated thoroughly and posed a risk of not providing appropriate actions to prevent further abuse. Findings: Review of the facility's P&P titled Abuse Reporting and Investigations revised 3/2018 showed the purpose of the facility's policy is to protect the health, safety, and welfare of facility residents, by ensuring that all reports of resident abuse are promptly reported and thoroughly investigated. Allegations of abuse are to be reported to the Administrator or designated representative immediately. When the Administrator or designated representative receives a report of an incident or suspected incident of resident abuse, the Administrator or designated representative, will initiate an investigation immediately. Medical record review for Resident 1 was initiated on 7/31/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 11/3/23, showed Resident 1 had the capacity to understand and make decisions. On 8/1/24 at 1155 hours, an interview was conducted with Resident 1. Resident 1 stated after taking a shower, CNA 4 threw towels at her. Resident 1 stated CNA 4 then told Resident 1 to dry herself. Resident 1 stated CNA 4 brought her out of the shower area while Resident 1 was still wet. Resident 1 stated she was unable to dry her back without assistance. Resident 1 stated she felt cold, and the incident made her feel humiliated. On 8/1/24 at 1318 hours, an interview was conducted with the Activities Assistant. The Activities Assistant stated she interviewed Resident 1 specific to an allegation made involving CNA 4. The Activities Assistant stated Resident 1 told her that CNA 4 would always yell at Resident 1. Resident 1 told the Activities Assistant that CNA 4 was always mad at Resident 1 for anything Resident 1 did. The Activities Assistant stated she documented Resident 1's allegation and reported the allegation to the Administrator who served as the facility's Abuse Coordinator. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activities Assistant was asked if Resident 1 conveyed additional concerns specific to CNA 4. The Activities Assistant stated Resident 1 told her that CNA 4 would get mad when Resident 1 asked CNA 4 for supplies. The Activities Assistant stated Resident 1 told her there was an incident in which CNA 4 got mad at Resident 1 and threw towels on Resident 1's bed. Resident 1 stated she was scared because CNA 4 was always mad, and Resident 1 did not know why. The Activities Assistant was asked if she informed the Administrator of Resident 1's allegation when CNA 4 was mad and threw towels on Resident 1's bed, to which the Activities Assistant stated she did not. The Activities Assistant was asked if she asked Resident 1 for details specific to this allegation, to which she replied, she did not. The Activities Assistant was asked if she asked Resident 1 how the alleged incident made Resident 1 feel, to which she replied, she did not. On 8/1/24 at 1443 hours, an interview was conducted with the Administrator. The Administrator was asked if he was aware of Resident 1's allegation when CNA 4 threw towels at Resident 1 while in the shower and if he was aware of Resident 1's allegation CNA 4 was mad and threw towels on Resident 1's bed. The Administrator stated he was unaware of the allegations. The Administrator acknowledged and further stated all allegation of abuse should be reported to him.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the information obtained from the physical assessment was documented in the resident's medical record for one of five sampled residents (Resident 2). This failure had the potential for not knowing the resident's health condition due to incomplete medical record. Findings: Review of the facility's P&P title Change of Condition Notification revised 4/1/15, showed the licensed nurse will assess the change of (resident) condition and determine what nursing interventions are appropriate. Before notifying the attending physician, the licensed nurse must observe and assess the overall condition utilizing a physical assessment and chart review. A licensed nurse will document the following: date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes. Medical record review for Resident 2 was initiated on 7/31/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's SBAR for Change In Condition dated 7/17/24 at 2030 hours, showed RN 3 documented Resident 2 claimed he slipped while he was taking a shower and hit his head on the floor. The documentation showed per Resident 2, he was able to get back up and did not call for help. The documentation further showed Resident 2 complained of pain on the left rib cage, had no head injury noted, vital signs were stable, and the physician was made aware and recommended for neuro checks for 72 hours. Further Review of Resident 2's SBAR dated 7/17/24, failed to show the documentation specific to Resident 2's left rib cage assessment afterResident 2 complained of pain on the left rib cage. On 8/5/24 at 1602 hours, an interview was conducted with RN 3. RN 3 verified she was informed Resident 2 allegedlyslipped while taking a shower on 7/17/24. RN 3 stated she conducted a physical assessment of Resident 2 status post his alleged fall. When asked if RN 3 assessed Resident 2's left rib cage, RN 3 stated Resident 2 would not allow her to complete an assessment of his left rib area. However, RN 3 acknowledged she observed Resident 2 had his shirt off and RN 3 could see Resident 2's left rib cage with one small red line without swelling. RN 3 verified she failed to document her observation of Resident 2's left rib cage with one small red line without swelling in Resident 2's medical record. RN 3 stated she should have documented this information in Resident 2's medical record to ensure an accurate medical record was maintained.