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	03/06/2025

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

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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 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** 49258 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the personal property of one nonsampled residents (Resident 100) was protected from loss or theft. * The facility failed to ensure Residents 100's personal items were labeled with the resident's name and included in the resident's inventory list. These failures 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 following: - The facility will make every effort to maintain the security of the resident's property while helping to create a home-like environment; - During the admission process, the Admissions staff will inform the resident/resident representative 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 that they can be added to the resident's inventory list; - A copy of the written inventory shall be provided to the resident or the person acting on he resident's behalf. Subsequent items brought into or removed from the facility shall be added to or deleted from the personal property inventory by the facility at the request of the resident, resident's family, or a person acting on behalf of a resident; and - The IDT will review the resident's inventory for accuracy during the resident's quarterly care plan conference. Any changes or additions to the inventory will be made at this time. (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 3/5/25 at 0932 hours, an observation and concurrent interview was conducted with Resident 100. Resident 100 was observed fixing her belongings in the room. Resident 100's bed area was observed with multiple belongings. Resident 100 stated it was like home for her. Resident 100 stated the most valuable items she had were the laptop which was brought by her family about two months after she was admitted to the facility, black bluetooth head phones, and lavender lap desk with mouse pad and phone holder which she had since last December 2024, and a music box with moving lights which her family just brought a month ago. The items were observed with no resident name label. When asked if the facility was aware of all the belongings she had in the room, Resident 100 stated she had informed the nurses, nursing assistants, or social workers whenever her family brought in new items for her because she was told everything should be recorded. Resident 100 stated she knew if the items were not in her inventory list, the facility would not be liable if she lost her items. Resident 100 further stated when she got the lap desk, bluetooth head phones, and music box, she handed the list to the social services department because the nursing told her to do so. Medical record review for Resident 100 was initiated on 3/5/25. Resident 100 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 100's Resident Inventory form dated 7/26/23, showed one pair of glasses, one cellphone with charger, one back brace, one hair brush, and one stuff animal. Further review of Resident 100's inventory list did not show any updated list of all the items the resident had in her room including the above valuable items she mentioned. Review of Resident 100's MDS dated [DATE], showed Resident 100 was cognitively intact. On 3/5/25 at 1151 hours, an interview and concurrent medical record review was conducted with CNA 7. CNA 7 stated the CNAs were primarily responsible in checking and documenting the resident's belongings on admission and discharge in the inventory form. CNA 7 stated they would have to update the inventory list if the resident had informed them of the new items brought in by the family. CNA 7 stated Resident 100 had so many belongings in the room. CNA 7 verified the inventory list form for Resident 100 did not show all the belongings that Resident 100 had. CNA 7 stated the inventory list form was not updated and verified Resident 100's personal items did not have the resident's name on it. On 3/6/25 at 0909 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 stated Resident 100 had been in the facility for a long time. LVN 8 stated when the resident was admitted , the charge nurse would give the inventory form to the CNA for the CNA to check the belongings. LVN 8 stated the residents were informed to notify the staff if they have new belongings especially the valuable items so the staff could update the inventory list. LVN 8 further stated the facility staff should update the inventory list if they saw the resident had so many belongings at the bedside. LVN 8 verified the inventory list for Resident 100 was not updated since 7/26/23. On 3/6/25 at 0924 hours, an interview was conducted with the SSD. The SSD stated if the resident or family member let the social services department know a new belonging was brought in the facility, the social services staff could update the resident's inventory list. The SSD stated she was aware Resident 100 had so many belongings in her room. The SSD stated she was not aware Resident 100 handed the social services department any list of the new belongings brought in by the resident's family member. The SSD stated the staff should update the inventory list if the resident had been staying in the facility for long term and if the resident had so many personal items in the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1458 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON stated the facility staff should update the resident's inventory list right away when the resident informed them of the new items brought in by the resident's family member. The ADON stated the facility staff should make every effort to update the inventory list especially for the long-term residents in the facility. The ADON further stated during the quarterly care plan meeting with the resident and family, the facility would remind the resident and resident's family member to update the inventory list. The ADON verified during the last care plan meeting for Resident 100 on 1/22/25, the documentation did not show the inventory list was discussed or updated. The ADON was notified and acknowledged the above findings for Resident 100.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51367 Based on interview, facility documents review, and facility P&P review, the facility failed to ensure the abuse P&P was implemented for one of five sampled residents (Resident 120) investigated for abuse. * The facility failed to ensure two alleged perpetrators (LVNs 2 and 7) were immediately suspended pending the outcome of the investigation for the abuse allegation for Resident 120. This failure had the potential for the resident to be vulnerable for further abuse, mistreatment, and injury. Findings: Review of the facility's P&P titled Abuse Prevention and Management revised 5/30/24, showed the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. Reports of resident abuse, mistreatment, neglect, exploitation, injuries of an unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated. If the suspected perpetrator is an employee, remove the employee immediately from the care of the resident(s) and immediately suspend the employee pending the outcome of the investigation in accordance with facility policies. Furthermore, employees of this facility who have been accused of resident abuse or a crime will be suspended from duty until the results of the investigation have been reviewed by the Administrator. Review of the facility's SOC 341 form(report of suspected dependent adult/elder abuse) dated 2/17/25, showed Resident 120 claimed two nurses were causing him emotional distress. On 2/18/25 at 1010 hours, the CDPH, L&C (California Department of Public Health, Licensing and Certification) program surveyor followed up with the facility to inquire about the alleged perpetrators for Resident 120's allegation of abuse. The DON identified the alleged perpetrators as LVNs 2 and 7. Review of the facility's conclusion report dated 2/20/25, showed two nurses had yelled at him and felt it caused him emotional distress. The facility was not able to substantiate Resident 120's claim regarding LVNs 2 and 7 yelled at the resident. Further review of the conclusion report failed to show LVNs 2 and 7 were suspended pending the outcome of other investigation. Medical record review for Resident 120 was initiated on 3/4/25. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's H&P examination dated 9/24/24, showed the resident could make needs known but could not make medical decisions. Review of Resident 120's SBAR Communication Form dated 2/24/25 at 1400 hours, showed the resident reported two facility nurses alleged caused him emotional distress. On 3/5/25 at 1609 hours, an interview was conducted with LVN 7. LVN 7 stated she was aware of the allegation of abuse Resident 120 claimed against her. LVN 7 verified she was not suspended from the facility pending investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 0804 hours, and interview was conducted with LVN 2. LVN 2 stated she was aware of the allegation of abuse Resident 120 claimed against her. LVN 2 verified she was not suspended from the facility pending the investigation. On 3/6/25 at 1038 hours, a concurrent interview and facility P&P review was conducted with the Administrator and DON. The DON stated the alleged perpetrators were identified by Resident 120. The Administrator stated the abuse investigation was initiated on 2/17/25, and the investigation was concluded on 2/20/25. The Administrator verified he did not suspend LVNs 2 and 7 because he was thinking of knowing what he knew from the information prior, which was Resident 120 was the one yelling at the nurses. The Administrator verified the P&P showed employees of the facility who had been accused of resident abuse or a crime would be suspended from duty until the results of the investigation had been reviewed by the Administrator.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 37726 Based on observation and interview, the facility failed to ensure the garbage was properly stored in two of six garbage dumpsters. This failure had the potential to attract pests/rodents that carried a disease. Findings: According to the 2022 FDA Food Code, 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 3/3/25 at 1132 hours, an observation of the facility's garbage dumpsters was conducted. Two of six dumpsters were observed with the lids open and garbage inside. The dumpsters were observed with the lids propped open by garbage, preventing the lids from fully closing. On 3/4/25 at 1601 hours, an interview was conducted with the Administrator. The Administrator verified the findings (via a photograph taken of the findings). The Administrator stated the garbage company was scheduled to pick up the garbage at the facility six times a week.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37726 Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases. * The facility failed to implement the testing, monitoring, and establishment of acceptable ranges of disinfectant chemicals levels throughout the facility's water supply in accordance with the facility's water management P&P for water management, and the facility's plan for Legionella control. * The laundry room and equipment were not maintained to ensure a clean area, and free from potential contamination. These failures had the potential for the spread of infection to the residents, staff and visitors in the facility. Findings: 1. According to the CMS QSO-17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to the policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. - Develops and implements a water management program that considers the ASHRAE (American Society of Heating Refrigerating and Air-Conditioning Engineers) industry standards and the CDC (Centers for Disease Control and Prevention) toolkit; and - Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's P&P titled Water Management revised 5/25/23, showed the facility will develop and utilize the water management strategies, using the core elements of a water management plan, to reduce the risk of growth and spread of Legionella and other opportunistic water-borne pathogens in facility water systems. Control measures and corrective actions include quarterly measurement of the water quality throughout the system to ensure changes that may lead to Legionella growth are not occurring. Quarterly maintenance and monitoring of the disinfectant and other chemicals levels in cooling towers and hot tubs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Water Management Committee Minutes dated 2/27/25, showed the water management testing includes testing of the PH levels, chlorine levels and chloramine levels. The facility will delegate to an outside company (Company 1) to check the levels monthly, starting in March of 2025. On 3/6/25 at 1535 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the facility had yet to implement the testing and monitoring of the disinfectant chemicals (chlorine and chloramine) levels throughout the facility water supply. The IP stated the implementation would begin this month (March 2025). Additionally, the IP stated the facility would establish an acceptable ranges for the disinfectant chemicals. 45064 2. Review of facility's P&P titled Laundry Services revised dated 1/1/12, showed a clean and safe environment is always maintained. On 3/6/25 at 1530 hours, a laundry room inspection was conducted with the Housekeeping Supervisor. The following was observed in the laundry room: - the outside of Washing Machine 1's door had large amounts of brown stains and white mineral-like residue; - the pipes on the back of Washing Machine 1 had brown stain and hard white substance, mineral-like residue; and - the wall next to Washing Machine 1 showed signs of damage with cracks and gap between the wall and baseboard. The Housekeeping Supervisor verified the above findings and stated she would try to scrape the yellow stains and white mineral-like residue. The Housekeeping Supervisor further stated she would let the maintenance know to repair the damaged wall.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51367 Based on interview, facility document review, and facility P&P (Policy and Procedure) review, the facility failed to implement the antibiotic stewardship program. * The facility failed to ensure the infection control data gathered in the surveillance log was accurately documented in the Infection Control Report for January 2025. * The facility failed to provide documentation of the McGeer's criteria used to determine if the residents met the criteria for true infection. * The facility failed to ensure Resident 54 was accurately assessed for true infection when an Ampicillin (antibiotic medication to treat infection) was prescribed. These failures had the potential for inappropriate use of antibiotics and increased risk of drug-resistant organisms. Findings: According to the CDC, the antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Core Elements of Antibiotic Stewardship for Nursing Homes | Antibiotic Prescribing and Use | CDC Review of the facility's P&P titled Antibiotic Stewardship revised 5/20/21, showed the purpose of the Antibiotic Stewardship is to optimize the use of antibiotics by improving prescribing practices and reduce inappropriate antibiotic use. - The facility will implement an Antibiotic Stewardship Program to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for residents. - The facility has chosen to use Revisited McGeer's Criteria (2012) for surveillance - The IP (Infection Preventionist/Infection prevention program coordinator) is responsible for tracing the following antibiotic stewardship processes: whether or not the resident's condition met McGeer's Criteria when the antibiotic was ordered - The IP will coordinate the collection and reporting of date for the Infection Control Committee meetings from all members of the team. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 3/6/25 at 1251 hours, an interview and concurrent infection control program review was conducted with the IP. Review of the facility's Infection Prevention and Control Surveillance Log for January 2025 showed 15 residents did not meet the McGeer's criteria for true infection. However, the review of the January 2025 Infection Control Report showed a total of 17 residents who did not meet the McGeer's criteria. The IP reviewed both reports and verified the information on the surveillance log did not match the information documented on the January 2025 Infection Control Report. The IP further stated inaccurate reports affected the infection control process and the teaching and in-services to the staff, and the discussion in the QAPI meeting and the action plans. In addition, the Monthly Infection Control Report showed the facility acquired six HAI: three residents with urine infection, two residents with skin/wound infection; and one resident with eye/ear infection. However, the review of the facility's mapping for HAI infection for January 2025 failed to show the resident with eye/ear infection included in the facility's mapping for infection. The IP acknowledged and verified the findings. 2. On 3/6/25 at 1251 hours, an interview and concurrent infection control program review was conducted with the IP. During the interview, the IP was asked for the facility's process regarding the resident's assessment to determine true infection. The IP stated the facility used the McGeer's criteria. When asked for the documentation of the McGeer's criteria, the IP was not able to provide one. The IP stated she just looked at the facility's infection control surveillance log and the signs and symptoms listed. The IP further stated she referenced the long version of the McGeer's form; however, no documentation was provided. Further review of the Infection Prevention and Control Surveillance Log showed on the bottom of the form, to utilize McGeer's Criteria to determine infections for Infection Control Surveillance Purposes. Review of the facility's Infection Screening Evaluation was provided by the IP. The screening form was being used when an antibiotic was initiated. The form was asking for symptoms and at the end of the evaluation, infection analysis was listed about Loeb's Criteria and McGeer's criteria. However, the assessment screening did not show how the system came up with meeting or not meeting the McGeer's criteria. For example, the facility provided a blank McGeer's screening for GI Tract Infections. The form showed the following: Both of the following criteria must be present: 1. One of the following GI sub-criteria: a) Diarrhea: three or more liquid or watery stools above what is normal for the resident within a 24-hour period b) Presence of toxic megacolon (abnormal dilation of the large bowel, documented radiologically) 2. One of the following diagnostic sub-criteria: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1445 hours, an interview and concurrent medical record review for Resident 54 was conducted with the DON. The DON acknowledged and verified the above findings.