

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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER West Anaheim Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 3033 W Orange Ave 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 - Potential for minimal harm Residents Affected - Some	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. 32179 Based on observation and interview, the facility failed to maintain a clean, safe, and homelike environment for four of 12 final sampled residents (Residents 4, 8, 9, and 19) and one nonsampled resident (Resident 13). * There was a brownish colored stain on Resident 19's wall. * There were brown and white stains on Residents 8 and 13's curtains. * There was a brown feeding formula, GT tube cap and multiple gauze pads on the floor between Residents 4 and 8's beds. * There were feeding stains on Resident 8's IV pump and two other feeding pumps. * There was brownish colored droplet stains on the wall behind Resident 9's head of bed. Additionally, there was dry and brown colored residue on Resident 9's enteral feeding pump device and vacuum regulator. These failures had the potential to negatively impact the residents' safety and quality of life. Findings: Review of the facility's P&P titled Safe and Homelike Environment dated 6/20/24, showed the housekeeping and maintenance services will maintain a good working, sanitary, orderly and comfortable environment. Each resident will be provided a safe, clean, comfortable and homelike environment, allowing resident to sue to bring momentos and personal belongings to the extent possible. 1. On 1/6/25 at 0830 and 1035 hours, Resident 19's wall was observed stained with a brownish color. On 1/6/25 at 0230 hours, an interview was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator acknowledged the staff should have cleaned the wall as soon as they saw there was splash from the enteral feeding. The DSD/ MDS verified the above findings. (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 - Potential for minimal harm Residents Affected - Some	2. On 1/6/25 at 0900 and 1100 hours, Resident 8's curtain was observed with brown and white stains. Additionally, there was a brown feeding formula, GT tube cap and multiple gauze pads on the floor between Residents 4 and 8's beds. There were feeding stains on Resident 8's IV pump and two other feeding pumps. On 1/6/25 at 0230 hours, an interview was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator acknowledged Resident 8's curtain should have been replaced and the floor should have been cleaned daily. The DSD/MDS Coordinator stated if the nurse spilled the enteral feeding, they should have cleaned it right away. The DSD/MDS Coordinator further stated the staff should have kept the room environment and medical equipment clean. The DSD/MDS Coordinator verified these findings. 3. On 1/6/25 at 0820 and 1040 hours, Resident 13's curtains were observed with brown and white stains. On 1/6/25 at 0230 hours, an interview was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator acknowledged Resident 13's curtain should have been replaced and kept clean. The DSD/MDS Coordinator verified the findings. 48882 4. On 1/8/25 at 0822 hours and 1/9/25 at 0818 hours, an observation was conducted in Resident 9's room. The wall behind Resident 9's bed and the vacuum regulator attached to the wall were observed with brownish colored droplet stains. Resident 9's enteral feeding pump device was also observed with dry light brownish colored residue. On 1/9/25 at 0900 hours, a concurrent observation and interview was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated the stain appeared to be from the enteral feeding formula. When asked who was responsible for the cleaning of the residents' walls and equipment, LVN 2 stated upon noticing the stains, the licensed nurses and/or therapists were responsible for informing the Environmental Services staff to clean. LVN 2 further stated the residents' walls and equipment should be kept clean to ensure a clean, homelike environment for the residents. On 1/9/25 at 0905 hours, an interview was conducted with the EVS Aide 1. EVS Aide 1 stated she was responsible for the cleaning of the resident rooms for the sub-acute unit at the facility. When asked how she was informed of the rooms that needed to be clean, EVS Aide 1 stated the staff would notify her of the rooms that needed to be cleaned. When asked if she had been informed the wall in Resident 9's room needed to be cleaned, EVS Aide 1 stated she was not aware. On 1/9/25 at 0937 hours, an interview was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator stated the EVS staff were responsible for the cleaning of walls and equipment in the residents' rooms. On 1/9/25 at 1213 hours, an interview was conducted with the DON. The DON stated the residents' rooms and equipment should be cleaned of stains and wiped down. The DON further stated, all stains should be reported by the staff member when first observed to ensure the stains were cleaned. On 1/9/24 at 1444 hours, the DON was informed and acknowledged the above findings.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services for the use of GT for one of 12 final sampled residents (Residents 12) and one nonsampled resident (Resident 13). * The facility failed to ensure Resident 12's enteral feeding formula was labeled with the time as per the facility's P&P. * The facility failed to ensure RN 2 checked for gastric residual prior to the administration of the GT medication for Resident 13, as per the facility P&P. These failures posed the risk for complications related to the use of the GT for Residents 12 and 13. Findings: Review of the facility's P&P titled Enteral Feeding, Administration revised 2/2023 showed the pump bags, syringe and tubing are to be changed every 24 hours and properly labeled with the date, time, and nurse's initials. Review of the facility's P&P titled Medication Administration Through a Feeding Tube revised 2/2023 showed medications will be administered via the feeding tube by an RN or LVN, per the physician's orders. The P&P further showed to place the continuous tube feeding on hold and check the residual and tube placement per procedure. 1. Medical record review for Resident 12 was initiated on 1/6/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 8/2/24, showed Resident 12 was GT dependent. Review of Resident 12's Active Order Sets: Dietary Orders dated 1/8/25, showed a physician's order dated 5/28/24, to administer Glucerna 1.5 (enteral feeding formula) at the rate of 50 ml/hr for 20 hours per day. On 1/6/25 at 0959 hours, Resident 12 was observed lying in bed and the GT enteral feeding was observed infusing Glucerna 1.5 at 50 ml/hr. The Glucerna 1.5 enteral feeding formula bottle was observed labeled with the date and rate, however the time was not documented on the enteral feeding bottle. On 1/9/25 at 0853 hours, Resident 12 was observed lying in bed. The GT formula feeding was observed off. The Glucerna 1.5 enteral feeding formula was observed hanging on the feeding pump pole with 850 ml of enteral feeding formula remaining in the bottle. The enteral feeding formula bottle was labeled with Resident 12's name, room, the date, and the rate, however, a time was not observed on the label. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 0955 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 stated when starting a new enteral feeding formula bottle, the enteral feeding formula should be labeled with the resident's name and room number, the date, the time the formula was started, and the infusion rate. LVN 3 further stated the enteral feeding formulas should be discarded after 24 hours. When asked when Resident 12's current enteral feeding formula was started, LVN 3 verified the above findings and stated she did not know when the enteral feeding formula was started. On 1/9/25 at 1213 hours, an interview was conducted with the DON. The DON stated when administering the enteral feeding formulas, the licensed nurses were expected to label the enteral feeding formula with the resident's name, the date and time the enteral feeding formula was started and the rate. When asked about the purpose of the labeling of the time on the enteral formula, the DON stated the enteral feeding formulas should be labeled with the time to ensure the infusion of the enteral feeding formula did not exceed 24 hours. On 1/9/24 at 1444 hours, the DON was informed and acknowledged the above findings. 2. Medical record review for Resident 13 was initiated on 1/8/25. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Active Order Sets dated 1/8/25, showed the following physician's orders: - dated 9/20/19, to monitor the GT residual before feeding and as needed. If residual was greater than 500 ml, to hold the feeding for one hour, then reassess. - dated 12/3/24, to administer Glucerna 1.5 at the rate of 55 ml/hr for 20 hours per day via the GT. On 1/8/25 at 0825 hours, a medication administration observation was conducted with RN 2. RN 2 was observed placing her stethoscope on Resident 13's stomach and used a syringe to check Resident 13's GT placement. RN 2 was not observed checking Resident 13's gastric residual volume prior to the administration of Resident 13's medications and water flushes via the GT. On 1/8/25 at 0847 hours, an interview was conducted with RN 2. RN 2 verified she did not check for gastric residual for Resident 13 prior to the administration of medications via the GT during the medication administration observation. On 1/9/25 at 1213 hours, an interview was conducted with the DON. The DON stated for the medication administrations through the GT, the licensed nurses were expected to check the placement of the GT via auscultation and check for the gastric residual prior to the administration of the medications. On 1/9/24 at 1444 hours, the DON was informed and acknowledged the above findings.		

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 32179 Based on observation and interview, the facility failed to ensure the medications were stored properly. * There were two ounces of Zinc Oxide paste (medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) at Resident 14's bedside table. This failure had the potential for visitors to have access to medications. Findings: Review of the facility's P&P titled Control: Procurement, storage, and security of medications dated 9/2024 showed all medications, needle and syringes are stored in a lockable areas and are accessible only to personnel duty authorized to dispense and/or administer medications. On 1/6/25 at 0830 and 1115 hours, Resident 14 was observed with two tubes of two ounces of Zinc Oxide paste at Resident 14's bedside table. On 1/6/25 at 1420 hours, a concurrent interview and medical record review was conducted with the DSD/MDS Coordinator. The DSD/ MDS Coordinator stated the Zinc Oxide paste should have been locked in the treatment cart. The The DSD/ MDS Coordinator verified these findings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the kitchen utensils were air dried prior to storage. * The facility failed to ensure the kitchen utensils were in good condition. * The facility failed to ensure the kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's untitled document dated 1/6/25, showed two of 22 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Food Preparation revised 1/2023 showed non-porous cutting boards in good condition are used and sanitized between uses. Color coded cutting boards for raw meat, poultry, fish, and prepared foods, fruits and vegetables and allergies are utilized to prevent cross contamination. 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. During the initial kitchen tour on 1/6/25 at 0824 hours, a concurrent observation and interview was conducted with the Dietary Director. Eight cutting boards (four white, one yellow, two red, and one purple) were observed heavily marred, discolored, and fuzzy with deep grooves. The Dietary Director acknowledged the findings and stated the cutting boards should have been tossed and replaced. 2. Review of the facility's P&P titled Dish and Ware Washing/ Care of Dishmachine revised 12/2022 showed towel drying dishes is not allowed. Air drying: as the racks of dishes come from the machine, they should be allowed to air dry. If the drying space is too small to allow dishes to air dry. Allow silver to air dry by letting it stand for a few minutes after washing. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 1/6/25 at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. The following items were wet with visible water, and stored inside the drawer for clean utensils: - Five slotted scoops with green handles - Three scoops with green handles - Three scoops with black handles - Three slotted scoops with black handles - One scoop with blue handle The Dietary Director acknowledged the above findings and stated all the scoops should have been air dried and not stored in the clean drawer wet. 3. Review of the facility's P&P titled Dish and Ware Washing/ Care of Dishmachine revised 12/2022 showed the sanitary dishes, cooking vessels and utensils are free from visible soil, stains, greasy film, cracks and chips, and bacteria. Review of the facility's P&P titled Food Preparation revised 1/2023 showed the cooking equipment is to be clean and in good working order. 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 1/6/25 at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. The following was observed: - Three small mesh strainers with wooden handles were deformed and discolored (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One large mesh strainer with a wooden handle was deformed and discolored - Two stainless steel potato mashers had an orange/brown discoloration - One stainless steel whisk with a cracked gray handle - One stainless steel whisk with a partially melted gray handle - Two green scoops used for food portioning were worn out with peeling handles - One cream scoop used for food portioning was worn out with a discolored and peeling handle - One red scoop used for food portioning was fuzzy with a discolored handle - One white basting brush was frayed, discolored, and worn out - Six rubber spatulas with red handles were cracked, chipped at the edges, and discolored - One stainless steel slotted spatula with a brown handle was deformed and bent at one of the edges - One stainless steel spatula with a brown handle was deformed, bent at the edges and had linear black discoloration which resembled a burn mark The Dietary Director acknowledged the above findings and stated all kitchenware should have been tossed and has not been used. 4. Review of the facility's P&P titled Dish and Ware Washing/ Care of Dishmachine revised 12/2022 showed the sanitary dishes, cooking vessels and utensils are free from visible soil, stains, greasy film, cracks and chips, and bacteria. Review of the facility's P&P titled Food Preparation revised 1/2023, showed cooking equipment is to be clean and in good working order. 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 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 1/6/25 at 0824 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Dietary Director. The following was identified: - One scoop with a blue handle, three scoops with yellow handles and one scoop with a gray handle used for food portioning were dirty, had water marks and were dry, crusted food residue (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One stainless steel blue spatula was fuzzy and dirty The Dietary Director acknowledged the above findings and stated all kitchenware should have been washed. 5. 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. During the initial kitchen tour on 1/6/25 at 0824 hours, a concurrent observation and interview was conducted with the Food Service Supervisor. Black dirt, grease residue was observed on the kitchen stove hood. The Food Service Supervisor verified the findings and stated the janitor was supposed to clean the stove hood every other day. The Food Service Supervisor stated it was important to clean the stove hood for air circulation to prevent smoke and grease build up.		

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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** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the medical records for two of 12 final sampled residents (Residents 12 and 19) were accurate. * The facility failed to ensure Resident 12's weekly wound assessment for 12/19/24 was recorded in the medical record. Additionally, the wound treatments administered to the resident did not match the Wound Consultant Physician's orders, and there was no documentation of the clarifications made on the physician's orders. * The facility failed to ensure Resident 19's skin assessment for measuring pressure sores and non-pressure sores was documented upon readmission and on a weekly basis. These failures had the potential for Residents 12 and 19's care needs not being met as their medical information was inaccurate. Findings: Review of the facility's P&P titled Charting Guidelines revised 3/2024 showed to document the normal findings as well as abnormal findings as this shows that the resident was being assessed. When physician intervention is required, document the time the physician was contacted and the time he responded. When new orders are implemented, the chart needs to reflect the resident notification and response to the intervention. Under the section Documentation Requirements showed special focus: weekly document requirements for the assessment of pressure sore progress/skin conditions. Review of the facility's P&P titled Skin Integrity revised 6/2024 showed the patient's skin integrity from head to toe will be assessed upon admission and on each shift. Detailed assessment should be completed: i. Within 24 hours of admission and then weekly thereafter; ii. With a change in condition; upon discovery of a new wound; iii. Within 24 hours post-debridement, if possible. Further review of the facility's P&P showed to document the description of each resident's wound (in centimeters) to include the following: location, length, width, depth, and all aspects of general wound care. 1a. Medical record review for Resident 12 was initiated on 1/6/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's MDS dated [DATE], showed Resident 12 had severely impaired cognitive skills, and one Stage 4 pressure injury present upon admission or reentry. (continued on next page)		

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 12's plan of care showed a care plan problem dated 11/1/24, addressing Resident 12's risk for skin breakdown and/or pressure ulcer. The interventions showed to administer treatment as ordered and monitor the response, and weekly documentation to include the measurement of each area of skin breakdown (width, length, and depth). Review of the facility's document titled Pressure Ulcer Log- Subacute Unit for December 2024 showed the weekly wound assessment for Resident 12's sacral pressure injury for the following dates: 12/5, 12/12, and 12/26/24. The assessments included the size, depth, stage, and color of Resident 12's sacral wound. However, there was no documentation in the log for the weekly wound assessment for 12/19/24. Review of Resident 12's medical record failed to show documentation of the weekly wound assessment, including the size, depth, stage, and description for Resident 12's sacral pressure injury for 12/19/24. On 1/8/25 at 1329 hours, a concurrent interview and medical record review for Resident 12 was conducted with the DON. The DON verified the above finding. The DON stated for the residents with wounds, the wounds were measured weekly and documented in the facility's pressure ulcer log. The DON stated on 12/19/24, the measurements for Resident 12's sacral pressure injury was obtained with the Wound Consultant and the measurements were discussed during the daily communication meeting. The DON stated the nurse should have documented Resident 12's weekly wound assessment on 12/19/24, in the Pressure Ulcer Log. b. Review of Resident 12's Wound Physician Consultation Notes dated 12/12 and 12/19/24, showed the following additional orders: - for the sacral region Stage 3 Pressure Injury, to cleanse the wound with wound cleanser, to apply collagen with silver (collagen dressing with antimicrobial), to cover with foam dressing, daily and as needed. Review of Resident 12's Treatment Record for December 2024 showed the following treatments: - dated 12/5/24, for the opened sacral Stage 3, to cleanse with normal saline, pat dry, apply medihoney (medical grade honey intended for wound care) with calcium alginate with silver (antimicrobial dressing) and cover with foam dressing every shift and as needed if peeled off/soiled for 14 days, to reevaluate on 12/19/24. The treatment record showed the above treatment was administered from 12/6/24 to 12/18/24, during the 0700 to 1900 hours and the 1900 to 0700 hours shifts. - dated 12/19/24, for the reopened sacral Stage 3, to cleanse with normal saline, pat dry, apply medihoney with calcium alginate with silver and cover with foam dressing every shift and as needed if peeled off/soilage for 14 days, to reevaluate on 1/3/25. The treatment record showed the above treatment was administered from 12/19/24 to 12/25/24, for the 0700 to 1900 hours and the 1900 to 0700 hours shifts, and on 12/26/24 during the 0700 to 1900 hours shift. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER West Anaheim Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 3033 W Orange Ave 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.			
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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 1/8/25 at 1103 hours, a concurrent interview and medical record review for Resident 12 was conducted with LVN 1. LVN 1 verified the above findings and stated the wound treatment administered did not match the Wound Consultant Physician's orders. LVN 1 stated she informed the physician that the facility needed to special order the collagen and the Wound Consultant had ordered to continue the previous treatment order until the collagen was available. When asked to show the documentation LVN 1 had clarified the order, LVN 1 stated she did not document in the resident's progress notes. When asked about the discrepancy in the wound cleansing agent and the frequency of the dressing changes, LVN 1 stated she had clarified the order with the physician. When asked to show the documentation she clarified the order, LVN 1 stated she did not document the order clarifications in Resident 12's medical record. On 1/9/25 at 1213 hours, a concurrent interview and medical record review for Resident 12 was conducted with the DON. The DON stated, if the nurse clarified a physician's order, the DON expected the nurse to document the order clarification in the resident's records. The DON verified the above findings and stated LVN 1 should have documented the order clarification to ensure the resident's medical record accurately reflected the care the resident was receiving. On 1/9/25 at 1444 hours, the DON was informed and acknowledge the above findings. 32179 2. Review of the facility's P&P titled Assessment Body dated 10/2023 showed the licensed nurse shall perform the weekly skin checks according to the weekly summary schedule. Body assessments will be completed upon admission of the resident by the licensed nurse. Observation will be documented. Medical record Review for Resident 19 was initiated on 1/6/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Skin Body Check Sheet dated 12/12/24, showed under the diagram section, superficial erythema on the right and left buttocks, and the mid spine was unable to be determined. There was no documentation of measurements of the erythema. On 1/8/25 at 1500 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 was asked about the readmission skin assessment for pressure sore measurements and description for 12/12 and 12/19/24. LVN 1 was unable to provide the documents for 12/12 and 12/19/24. LVN 1 stated she had been off for a week and was not aware if the assessments had been completed. LVN 1 stated the wound consultant made an assessment on 12/19/24, and verified it was not in the chart. LVN 1 stated the licensed nurses should have documented the weekly assessment and verified all of the above findings.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to prevent the development and transmission of diseases and infections. * RN 1 failed to disinfect the stethoscope after use on Resident 1 and prior to exiting the room. * RN 2 failed to disinfect the stethoscope after use on Resident 13 and prior to exiting the room. * CNA 1 failed to remove the gown and gloves and perform hand hygiene after touching Resident 1's surroundings and before touching Resident 10's environment. * Three linen cart covers were observed to be dirty, stained with black, white, and brown colors, and worn out. These failures had the potential to result in the transmission of infection to a vulnerable population of residents in the facility. Findings: Review of the facility's P&P titled Patient Equipment Use Maintenance and Cleaning dated 6/27/21, showed all reusable instruments and equipment will be thoroughly cleaned and decontaminated prior to use on a patient. 1a. On 1/7/25 at 0828 hours, during the medication administration observation for Resident 1, RN 1 was observed using a stethoscope and syringe to check for the GT placement. After completing Resident 1's medication administration, RN 1 removed the gloves and gown, washed his hands, and exited Resident 1's room. RN 1 did not disinfect the stethoscope prior to exiting Resident 1's room. On 1/7/25 at 0844 hours, an interview was conducted with RN 1. RN 1 stated the stethoscope should be disinfected after use on each resident and prior to exiting the resident's room. RN 1 verified he did not disinfect his stethoscope after using the stethoscope to check Resident 1's GT placement, and prior to exiting Resident 1's room. RN 1 stated he should have disinfected his stethoscope to prevent the transmission of organisms between residents. 1b. On 1/8/25 at 0831 hours, during the medication administration observation for Resident 13, RN 2 was observed using a stethoscope and irrigation syringe to check for the GT placement for Resident 13. After completing Resident 13's medication administration, RN 2 removed the gloves, placed the stethoscope on her workstation cart, and removed the gown. RN 2 performed hand hygiene and exited Resident 13's room. RN 2 did not disinfect the stethoscope prior to exiting Resident 13's room. RN 2 moved the stethoscope from the top of the cart to the bottom compartment of her workstation cart. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 0845 hours, an interview was conducted with RN 2. RN 2 was asked about the facility protocol for disinfection of multi- use equipment's like the stethoscope. RN 2 stated the stethoscope should be disinfected before and after use on a resident and before exiting the resident's room. RN 2 verified she did not disinfect the stethoscope after using on Resident 13, and prior to exiting Resident 13's room. On 1/8/25 at 1515 hours, an interview was conducted with the IP 1. IP 1 stated all the resident rooms, except for one room was on EBP. When asked about the facility protocol for the disinfection of the multi-use equipment on residents, IP 1 stated the staff are expected to disinfect the equipment after each use and prior to exiting the resident's room to prevent the transmission of organisms to other surfaces and residents. On 1/9/25 at 1444 hours, the DON was informed and acknowledge the above findings. 2. Review of the facility document titled Enhanced Barrier Precautions (undated), showed everyone must clean their hands, including before entering and when leaving the room. The sign showed do not wear the same gown and gloves for the care of more than one person. Medical record review for Resident 10 was initiated on 1/6/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Active Order Sets: Care Order/Instructions showed a physician's order dated 8/26/24, Resident 10 may have one to one feeding assistance three times per day for seven days a week with weighted spoon and grip cup during meals, per resident request. May self-feed as tolerated. On 1/6/25 at 1145 hours, a concurrent observation and interview was conducted with CNA 1 in Resident 10's room. There was an EBP sign posted outside of Resident 1 and 10's room. CNA 1 was observed wearing gloves and placed Resident 10's lunch tray on Resident 10's bedside table. CNA 1 then was observed donning a gown and with the same pair of gloves, walked by Resident 1's bed and tucked Resident 1's blanket under. CNA 1 then pulled the privacy curtain between Resident 1 and Resident 10 and was observed grabbing Resident 10's bedside table to move the table towards Resident 10. CNA did not remove his gown or gloves after contact with Resident 1's environment and before coming in contact with Resident 10's environment. CNA 1 stated he was preparing to assist Resident 10 with his lunch. CNA 1 verified he did not change his gloves and gown between touching each resident's environment. CNA 1 stated the gloves and gowns should be used for one resident and should not be used again for a different resident. CNA 1 further stated he should have removed the gloves and gown and donned a new pair of gloves before touching Resident 10's environment. On 1/8/25 at 1515 hours, an interview was conducted with IP 1. IP 1 stated all the resident rooms in the unit, except for one room was on EBP. IP 1 stated when moving from one resident to another resident in the same room, staff were expected to remove the gown and gloves, perform hand hygiene, and don a new gown and gloves. IP 1 further stated, the same gown or glove may not be worn between residents and should be removed prior to assisting the next resident. (continued on next page)		

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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 1213 hours, an interview was conducted with the DON. The DON stated when the staff members were in the residents' rooms providing care to a resident, the staff members were expected to doff their gown and gloves and perform hand hygiene before moving on to the next resident in the same room. The DON further stated the staff member should not wear the same gown and/or gloves for a different resident to prevent the transmission of organisms and infections to the other residents. On 1/9/25 at 1444 hours, the DON was informed and acknowledge the above findings. 32179 3. On 1/6/25 at 0805 and 1105 hours, three linen cart covers located in the hallway in front of Room A were observed dirty, worn out and stained with black, white, and brown colors. On 1/6/24 at 1420 hours, an interview was conducted with the DSD/MDS Coordinator. The DSD/MDS Coordinator stated the covers should be clean and verified the findings.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on interview, medical record review, and facility P&P review, the facility failed to administer the pneumococcal vaccines to two of five residents reviewed for vaccinations (final sampled residents, Residents 4 and 19). This failure had the potential to cause medical complications related to pneumococcal infections for the affected residents. Findings: Review of the facility's P&P titled Pneumococcal Vaccine, Administration and Guidelines dated 1/2024 showed under section procedure, all the patients will be assessed for prior vaccination history during admission, provide the resident or legal representative with the latest edition of the vaccine information statement developed by the CDC, administer the vaccine, and document in MAR. 1. Medical record review for Resident 4 was initiated on 1/6/25. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 4's Pneumococcal Vaccine dated 7/8/24, showed Resident 4's RP consented for the resident to receive the pneumococcal vaccine. However, there was no documented evidence the vaccine was administered to Resident 4. There was no documented evidence to explain why the pneumococcal vaccine was not administered to the resident after the consent was obtained on 7/8/24. 2. Medical record review for Resident 19 was initiated on 1/6/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Pneumococcal Vaccine dated 9/30/24, showed Resident 19's RP consented for the resident to receive the pneumococcal vaccine. However, there was no documented evidence the vaccine was administered to Resident 19. There was no documented evidence to explain why the pneumococcal vaccine was not administered to the resident after the consent was obtained on 9/30/24. On 1/8/25 at 1530 hours, a concurrent interview and medical record review was conducted with the IPs 1 and 2. IPs 1 and 2 were asked if Residents 4 and 19 were offered the pneumococcal vaccine. IPs 1 and 2 stated they had offered the vaccine and obtained consents but it was not administered to the residents. IPs 1 and 2 verified the findings.		