STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the regular posted menu reflected the residents' food preferences for one of 14 final sampled residents (Resident 2) and one nonsampled resident (Resident 32). * Resident 2 and 32's food preferences were not honored. In addition, there was no alternate menu and posted for the residents who preferred Hispanic food. These failures had the potential to result in decreased meal satisfaction, reduced meal intake, unintended weight loss, and a negative impact on residents' psychosocial wellˆbeing.Findings: Review of the facility's P&P titled Menus dated October 2017 showed menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). Menus for regular and therapeutic diets are written at least two weeks in advance and are dated and posted in the kitchen at least one week in advance. Menu items and available snack reflect the religious cultural and ethnic preference of residents whenever reasonable. The dictation reviews and approves all menus. Input from the resident is considered in menu planning. Copies of menus are posted in at least two resident areas, in positions and in print large enough for residents to read them. Review of the facility's document titled Mexican food Menu (Alternatives) dated 4/7/26, showed the following list of food items:-Tacos (frozen)-Burritos (frozen)-Quesadilla (Flour and Corn Tortillas)-Chile Relleno (frozen)-Chorizo (frozen)-Enchiladas (frozen) On 6/2/26 at 0841 hours, an interview was conducted with Resident 2. Resident 2 stated the food in the facility was not good and lacked taste. Resident 2 stated he felt the facility treated Hispanic residents differently from other residents. Resident 2 explained Hispanic residents received different food, while non-Hispanic residents were served the regular menu items. Resident 2 stated he preferred regular food, but the facility continued to give him Hispanic food, which he did not like. Resident 2 further stated all Hispanic residents were given Hispanic food. On 6/2/26 at 1221 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed receiving his meal in the dining room. Resident 2's meal tray contained Chile relleno, a small bowl of beans with broth, salad, and dessert. Resident 2 appeared upset when he received the tray and stated he had been served the same meal, Chile relleno, the previous day. On 6/2/26 at 1225 hours, Resident 32 was observed receiving his meal in the dining room. Resident 2's meal tray contained Chile relleno, a small bowl of beans with broth, salad, and dessert. Resident 32 was observed looking for staff to request other food item, he stated he needed tortilla to go with the beans that was served. Review of the facility's lunch menu for 6/2/26, showed the following items: herb and spice roast beef with gravy, mashed potatoes, spinach au gratin, Caesar salad, fruit mix, crumble cake. Further review of the menu did not show chili relleno, a small bowl of beans to be served. Review of facility's meal tickets (undated) showed eight out of 30 residents were listed as preferring Hispanic food. On 6/2/26 at 1242 hours, an interview and facility document review was conducted with the DSS. The DSS stated residents who preferred Hispanic food received Hispanic food from the alternate menu. The DSS verified the menu was not posted. On 6/2/26 at 1440 (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours, an interview was conducted with [NAME] 1. [NAME] 1 stated eight out of 35 residents preferred Hispanic food. [NAME] 1 stated the residents were served regular meals unless they specifically request Hispanic food [NAME] 1 stated facility did not have separate menu for the residents who requested Hispanic food. [NAME] 1 stated the facility prepared whatever was available to make Hispanic food such as quesadilla, and frozen items. [NAME] 1 stated all eight residents including Residents 2 and 32 who preferred Hispanic food received Chile relleno and beans with broth that day. On 6/4/26 at 1522 hours, a telephone interview was conducted with the RD. The RD stated the facility did not have sperate Hispanic menu for residents who preferred Hispanic food. The residents were being served food from regular menu unless they request Mexican food item form the alternate Hispanic food menu. The RD stated facility could not make separate menu for the resident who prefer Hispanic food because the facility did not have enough space, staff and it was not cost effective. The RD stated she was working with DSS to include Hispanic food item one or two times a week. On 6/4/26 at 1430 hours, an interview was conducted with the Administrator and RN 1. The Administrator and RN 1 were informed and acknowledged the above findings. Cross reference to F806

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the food preferences were honored for one of 14 final sampled residents (Resident 2) and three of seven nonsampled residents (Resident 29, 18, and 30). * The facility failed to ensure Resident 2's food preferences were honored when he stated he did not want to receive only Hispanic food; however, he continued to be served Hispanic food. * The facility failed to ensure food preferences for Residents 18, 29, and 30 were honored when they all preferred to have Mexican food. These failures had the potential for decreased meal intake, weight loss, and a negative impact on the residents' psychosocial wellbeing.Findings: 1. On 6/2/26 at 0841 hours, an interview was conducted with Resident 2. Resident 2 stated the food in the facility was not good and lacked taste. Resident 2 stated he felt the facility treated Hispanic residents differently from other residents. Resident 2 explained Hispanic residents received different food, while non-Hispanic residents were served the regular menu items. Resident 2 stated he preferred regular food, but the facility continued to give him Hispanic food, which he did not like. Resident 2 further stated all Hispanic residents were given Hispanic food. Medical record review for Resident 2 was initiated on 6/2/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 10/10/25, showed Resident 2 had the capacity to understand and make decisions. Review of the Resident Council Minutes dated 5/25/26, showed Resident 2 stated he would like to be served all types of food, not just Hispanic food. The minutes further showed under the Resident Council Departmental Response section, the dietary department documented Resident 2 requested a variety of food, not only Hispanic food. The response on the minutes showed the facility would provide the daily menu items, which had been previously offered; however, Resident 2 had refused them, which was why he was being served Hispanic alternatives. The facility stated they would revert to serving him the regular menu items, which included a variety of foods. Review of the facility's lunch menu for 6/2/26, showed the following items: herb and spice roast beef with gravy, mashed potatoes, spinach au gratin, Caesar salad, fruit mix, crumble cake. On 6/2/26 at 1238 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed receiving his meal in the dining room. Resident 2's meal tray contained chile relleno, a small bowl of beans with broth, salad, and dessert. Resident 2 appeared upset when he received the tray and stated he had been served the same meal, chile relleno, the previous day. Resident 2 stated the facility was serving him the same food again and he wanted to receive the regular menu items instead. The DSS entered the dining room and spoke with Resident 2. Resident 2 stated he wanted to receive the regular menu food and not just Hispanic food. The DSS brought him the regular menu meal. Resident 2 was subsequently observed eating the herb and spice roast beef with gravy, mashed potatoes, spinach au gratin, Caesar salad, fruit mix, and crumble cake. On 6/4/26 at 1448 hours, an interview and concurrent facility document review was conducted with the DSS. The DSS verified during the Resident Council meeting on 5/25/26, Resident 2 stated he (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wanted a variety of foods and not just Hispanic food. The DSS stated Resident 2 would keep changing his mind regarding food preferences; however, the DSS was unable to provide documentation showing Resident 2 requested Hispanic food at any time after 5/25/26. On 6/5/26 at 1214 hours, an interview was conducted with RN 1. RN 1 was informed and acknowledged the above findings. 2. On 6/3/26 at 1000 hours, the facility's menu was observed posted in the hallway outside the facility's dining room. Further review showed there was only one meal which included Mexican food items for Week 1. On 6/3/26 at 1059 hours, a resident council meeting was held with Spanish speaking residents. The residents were asked about their experiences with food served at the facility. Residents 29 and 30 reported the following during the meeting: - Resident 29 stated he liked Mexican food but rarely was served Mexican meals. Resident 29 stated he did not like meat and he did not understand why the staff repeatedly asked for his preferences but continued serving foods he did not want; and - Resident 30 stated he informed the staff he disliked pork and lasagna but continued to receive meals containing pork and lasagna. Resident 30 also stated he liked Mexican food. a. Medical record review for Resident 29 was initiated on 6/3/26. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's H&P examination dated 4/18/26, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's diet card (undated) showed Resident 29 liked Mexican food, and fish and chicken only. b. Medical record review for Resident 30 was initiated on 6/3/26. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 9/25/25, showed Resident 30 had the capacity to understand and make decisions. Review of Resident 30's diet card (undated) showed Resident 30 liked Mexican food and disliked pork. On 6/4/26 at 1429 hours, an observation was conducted of Resident 29 and [NAME] 2. Resident 29 was observed explaining he did not like American foods and liked Mexican food to [NAME] 2. Resident 29 further stated he did not like beef but was served beef. Resident 29 stated he was always served milk despite repeatedly informing staff milk caused him diarrhea. Resident 29 stated he discussed this request with nursing staff and used pictures to communicate his preferences. c. On 6/5/26 at 1408 hours, an interview was conducted with Resident 18. When asked about the food served, Resident 18 stated he liked Mexican food. When asked if he was served Mexican food at the facility, Resident 18 stated he would have to ask for Mexican food, but he never knew what he would be served. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 18 was initiated on 6/5/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's diet card (undated) showed Resident 18 liked Mexican food. On 6/3/26 at 1447 hours, an interview and concurrent facility document review was conducted with the CDM. The CDM reviewed the facility's list of frozen Mexican food items and stated the food items were served to residents who requested Mexican food. When asked where this list was posted, the CDM verified the list of frozen food items was not posted to inform residents about this list of food items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen (30 out of 35 residents were receiving food prepared in the kitchen). * The facility failed to ensure food preparation equipment was air dried. * The facility failed to ensure the safe storage of food items. * The facility failed to ensure kitchen equipment was maintained in a sanitary condition. * The facility failed to ensure appropriate beard restraint was worn by an outside vendor technician inside the kitchen. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of Diet Type Report dated 6/2/26, showed 30 out of 35 residents were receiving food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganisms can begin to grow. On 6/2/26 at 0751 hours, an observation and concurrent interview was conducted with [NAME] 1. A stainless-steel tray was observed stacked with other stainless-steel trays. The stainless-steel tray was observed to be stored wet. [NAME] 1 verified the observation and stated the kitchen staff should have air dried the stainless-steel tray before storing it. 2. Review of the facility's P&P titled Food Receiving and Storage (undated) showed food shall be received and stored in a manner that complies with safe food handling practices. All food stored in the refrigerator or freezer are covered, labeled and dated. All foods belongings to the residents are labeled with the resident's name, the item and the use by date. a. On 6/2/26 at 0751 hours, an observation and concurrent interview was conducted with [NAME] 1. An open bottle of teriyaki sauce was observed in the dry storage area. The instruction on the bottle showed to shake well before using and refrigerate after opening for best quality. [NAME] 1 verified the above observation and stated the teriyaki sauce should have been stored in the refrigerator. b. Review of the facility's P&P titled Foods Brought By Family/Visitors dated October 2017 showed Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). On 6/2/26 at 1556 hours, an observation and concurrent interview was conducted with RN 1. A refrigerator to store the resident's food brought in from outside was observed with the following:- A plastic container with pieces of watermelon dated 5/24/26.- A blue plastic cup with rice pudding that was not labeled with the date.RN 1 verified the findings and stated the watermelon should have been discarded and the rice pudding should have been labeled. RN 1 was observed removing both items and stated she would discard them. 3. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, 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. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils. Equipment food - contact surfaces and utensils shall be clean to sight and touch. On 6/2/26 at 0751 hours, an observation of the kitchen and concurrent interview was conducted with [NAME] 1. The following was observed:- A brown, white and green cutting board was observed heavily marred with whitish discoloration. [NAME] 1 verified the observation and stated the above cutting boards needed to be replaced. [NAME] 1 was then observed replacing the cutting boards with the new ones.- A (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plastic blender was observed with a hairline cracked and had whitish discoloration. [NAME] 1 verified the observation and stated the blender needed to be replaced. [NAME] 1 was then observed replacing blender with the new one.- A scoop in a plastic container with scoops was observed with dried food residue and water marks. [NAME] 1 verified the observation and stated the scoop needed to be cleaned again. 4. According to the USDA Food Code 2022, Section 2-402.11 (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils. On 6/3/26 at 0928 hours, an observation and interview was conducted with [NAME] 2. An outside vendor technician with full beard was observed inside the kitchen. The outside vendor technician was not observed to be wearing beard restraint. On 6/3/26 at 0930 hours, an interview was conducted with the outside vendor technician and [NAME] 2. The outside vendor technician stated he was not instructed to wear the beard restraint inside the kitchen. [NAME] 2 verified the observation and stated outside vendor technician should wear beard restraint. [NAME] 2 was then observed instructing the outside vendor technician to wear beard restraint. On 6/5/26 at 1214 hours, an interview was conducted with RN 1. RN 1 was 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
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and the facility P&P review, the facility failed to ensure two of two final sampled resident (Residents 4 and 28) reviewed for hospice services had received coordinated hospice services. * The facility failed to ensure Hospice A staff followed the established visit calendar. In addition, Hospice A skilled nursing visits progress notes were not available in Resident 4's medical record. * The facility failed to ensure Resident 4's hospice plan of care was incorporated into the facility's care plan. * The facility failed to ensure Hospice A was notified when morphine (narcotic pain medication) and oxygen orders were discontinued by the facility for Resident 4. In addition, the facility failed to ensure Hospice A medication list contained dosages of the medications for Resident 4. * The facility failed to ensure hospice services were not provided to Resident 28 after hospice had been discontinued by the physician. Resident 28 received a CHHA visit after the hospice discharge. These failures posed the risk of the delays in communication and in the provision of coordinated hospice care for the residents between the hospice provider and the facility. Findings: Review of the facility's P&P titled Hospice Program dated July 2017 showed the facility has designated the DON to coordinate care provided to the resident by the facility staff and the hospice staff. The DON was responsible for the following: - Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; - Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family; - Ensuring that the facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians. Further review of the P&P showed coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. 1. Medical record review for Resident 4 was initiated on 6/2/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 1/27/26, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's Order Summary Report showed a physician's order dated 2/1/26, to admit Resident 4 to Hospice A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of Resident 4's Hospice A calendar for May 2026 showed scheduled RN visits on 5/7, 5/11, 5/18, and 5/28/26. Review of Resident 4's Resident Hospice A flowsheet showed Resident 4 was visited by the RN on 5/9, 5/11, 5/18, and 5/29/26. On 6/4/26 at 0915 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 4 was on hospice services. When asked when the hospice staff visited the resident, LVN 2 stated she was unsure whether Hospice A's RN visited once week or twice a week. LVN 2 further stated she was unsure which specific dates the hospice RN staff came to visit and assessed the resident. b. Further review of Resident 4's medical record did not show progress notes from Hospice A's RN for the visits on 5/9, 5/11, 5/18, and 5/29/26. c. Review of Resident 4's plan of care failed to show the hospice plan of care was incorporated into the facility's care plan for the resident. d. Review of Resident 4' s Hospice A medication list showed the following: - dated 9/30/24, for acetaminophen (pain medication) to administer one suppository rectal every four hours as needed for fever/temp and mild to moderate pain. - dated 9/30/24, for Dulcolax (laxative) to administer one suppository rectally one time a day as needed for constipation. - dated 9/30/24, for ipratropium-albuterol (a prescription bronchodilator combination used to manage wheezing, shortness of breath, and airflow blockages) to administer one unit through respiratory (inhalation) every four hours as needed for cough and shortness of breath. - dated 9/30/24, for morphine sulphate 0.5 tablet to administer orally every two hours as needed for pain and shortness of breath. - dated 9/30/24, for senna-tabs (laxative) to administer one tablet orally one time a day as needed for constipation. - dated 9/30/24, for Zofran (medication to prevent and treat severe nausea and vomiting) to administer one tablet via sublingual (under the tongue) every six hours as needed for nausea and vomiting. - dated 1/28/25, for oxygen to give via nasal cannula 2-5 liters per minute continuously as needed for shortness of breath. - dated 1/27/26, for cholecalciferol (vitamin D3; supplement) to administer one tablet oral one time a day for supplement. - dated 4/20/26, for mirtazapine (antidepressant medication) to administer 0.5 tablet orally one time a day for appetite to give at bedtime. However, further review of the above medication list did not show the dosage of the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Review of Resident 4's Order Summary Report dated 6/4/26, did not show a physician's order for the morphine medication and oxygen. Review of Resident 4's Order Audit Report for discontinued medication showed the following orders: - Morphine sulphate medication order was discontinued by the facility's physician on 6/2/26, due to non- use. - Oxygen order was discontinued by the facility's physician on 10/7/25. Further review of Resident 4's medical record failed to show if Hospice A was notified or consulted before the discontinuation of the above medication and oxygen. On 6/4/26 at 0920 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. RN 1 verified Hospice A's RN did not follow the scheduled visit calendar and stated the Hospice A staff should have followed the established visit calendar to ensure coordinated hospice services for Resident 4. RN 1 further verified she was unable to locate the progress notes documenting Hospice A's RN visits for the above dates and stated the hospice visit documentation should be made available as soon as possible following each visit. RN 1 verified Hospice A's plan of care had not been incorporated into the facility's plan of care and stated the incorporation of the hospice plan of care into the facility's plan of care was necessary to ensure all the staff were aware of and consistently implementing the resident's hospice interventions. RN 1 also verified the above hospice medication list did not include medication dosages and the facility had discontinued the resident's orders for the morphine medication and oxygen; however, Hospice A's medication list continued to show the morphine medication and oxygen orders were to be administered as needed. RN 1 stated she was unable to find documented evidence to show Hospice A had been notified of the discontinuation of the morphine medication and oxygen orders by the facility. 2. Medical record review for Resident 28 was initiated on 6/2/26. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's physician's order dated 8/25/25, showed to discharge the resident from hospice services on 8/30/25. Review of Resident 28's hospice Discharge summary dated [DATE], showed the resident was discharged from hospice services due to hospice care no longer being appropriate. Review of Resident 28's hospice Flow Sheet initiated 7/7/25, showed the resident received a hospice CHHA visit on 9/2/25, after the hospice services had ended. On 6/3/26 at 0814 hours, an interview and concurrent medical record review was conducted with the IP/DSD. The IP/DSD stated Resident 28 had received hospice services and verified hospice services were discontinued on 8/30/25. The IP/DSD verified the hospice Flow Sheet showed a CHHA visit was conducted by hospice staff on 9/2/25. The IP/DSD stated there should not be any hospice staff visits after hospice services were discontinued 8/30/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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 interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain infection control practices to help prevent the development and transmission of diseases and infection. * The facility failed to follow infection control practices to properly disinfect the facility and residents' soiled laundry. * The facility failed to ensure the decorative fountain was monitored and maintained to minimize the growth and spread of waterborne pathogens and other contaminants. * The facility failed to maintain an accurate infection control surveillance for Resident 11. * The facility failed to ensure the staff offered hand hygiene to the residents prior to meal service. These failures resulted in a lack of timely and adequate identification of resident's infections and potential for an increased risk for the transmission of microorganisms to other residents Findings: 1. Review of the facility's P&P titled Departmental (Environmental Services) – Laundry and Linen, revised January 2014 showed laundry may be processed in the following temperature cycles: - High-temperature processing, by washing linen in water that is at least 160 degrees F, for a minimum of 25 minutes. - Low-temperature processing, by washing linen in water that is at least 71-77 degrees F and use a 125-part-per-million (ppm) chlorine bleach rinse. On 6/4/26 at 0920 hours, a laundry area inspection was conducted with the Maintenance Supervisor and Housekeeping/Laundry Staff 1. One industrial washer and dryer were observed in the laundry area, four buckets of laundry solutions were next to the washer with a hose coming from the lids, supplying laundry solutions to the washer. The buckets were labeled as follows: - Bucket 1, Laundry P.H. Builder. - Bucket 2, Bold Blue Laundry Detergent - Bucket 3, Soft N Sour Alkalinity Neutralizer and Fabric Softener - Bucket 4, Bleach Laundry Brightener The Maintenance Supervisor stated the machine automatically pulled the solutions depending on the wash setting selected. Housekeeping/Laundry Staff 1 stated washer setting seven was the only setting that used bleach and was for heavily soiled laundry and items with infectious waste like C. difficile. The Maintenance Supervisor stated the washing machine used both high-temperature and low-temperature with chemicals to disinfect soiled laundry. a. The temperature gauge located on the plumbing pipe behind the washer was observed not functional, the Maintenance Supervisor stated it had been broken for a few months. A water-heater was observed in the laundry area; however, it was unplugged and not being used. Inspection of the water-heater located in a closet outside of the laundry room, had a digital display which showed the temperature was set to 150 degrees F. The temperature gauge located on the pipe by the wall behind the water heater showed a temperature of 145 degrees F, which was verified by the Maintenance (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Supervisor. The Maintenance Supervisor stated the water-heater and hot water pipe supplied hot water to the washer. When asked how the facility ensured soiled laundry was disinfected, the Maintenance Supervisor stated per the laundry supply vendor, the lower temperature was fine because the laundry products had disinfectants. The Maintenance Supervisor observed the laundry solutions in the buckets feeding to the washing machine and verified they were a pH booster, fabric softener, detergent, and bleach. When asked what of the other three products had disinfectants, since the bleach was only used for heavily soiled items or laundry contaminated with infectious waste like C. difficile, the Maintenance Supervisor stated he would have to check. On 6/4/26 at 1323 hours, an interview was conducted with the Administrator. The Administrator stated he researched the laundry products and was unable to find any of the products being used, other than the bleach, were disinfectants. 2. Review of the facility's P&P for Legionella Bacteria dated 4/9/26, showed Legionnaires disease is a potentially fatal or permanently debilitating form of pneumonia which can affect anyone, but which principally affects those who are susceptible because of age, illness and/or immunosuppressant. It is caused by the bacterium Legionella pneumophila and related bacteria. Legionella bacteria can be found naturally in environmental water sources and may also be found in cooling tower systems, hot and cold-water systems, and other areas where water is stored. The P&P also showed: - The decorative fountain was an area where possible legionella (and other opportunistic waterborne pathogens) could grow and spread in the facility water system. - The Maintenance Supervisor will place one Trichloro-s- triazinetrione (a highly concentrated, dry chlorine compound used primarily as a disinfectant) tablet in all standing water sources that could be a risk for legionella bacteria, and identified the decorative fountain as an area of possible legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. Review of the facility's water management binder showed a Weekly Water Treatments to Water Fountain to Prevent Legionella Bacteria Growth log. The log showed the Maintenance Supervisor added Trichloro-s-triazinetrione tablet to the fountain weekly and showed when the fountain was emptied and if the fountain was free of debris and bacterial growth. The log failed to show if the fountain water was tested to ensure appropriate chemical levels were reached. On 6/3/26 at 1001 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator stated the Maintenance Supervisor tested the decorative fountain weekly, but does not document it on the log. On 6/4/26 at 0933 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor by the decorative fountain, located in the patio area against the outside wall of the employee break room. The Maintenance Supervisor brought a container of Trichloro-s-triazinetrione tablets, and stated since the tablets were larger, he puts half a tablet in every week and will also add 1/4 of a tablet a few times a week. The Maintenance Supervisor stated he put in half a tablet over the weekend, and a partially dissolved tablet was observed in the fountain. The Trichloro-s-triazinetrione tablets container's label showed to add two eight-ounce tablets per 10, 000 gallons of pool water every week, and ensure a free available chlorine level of 1 - 4 ppm. The Maintenance Supervisor retrieved a bottle of test strips and stated those were the test strips he used. The bottle was labeled QAC (Quaternary Ammonium Compound - a chemical used to kill bacteria, viruses, and mold on hard, non-porous surfaces). The Maintenance Supervisor verified the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	test strips were labeled for QAC, and he was informed QAC was not a chlorine-based disinfectant. The Maintenance Supervisor tested the fountain water with the same test strips, which showed a light-yellow color which indicated zero ppm of QAC. 3. Review of the facility's Monthly Antibiotic Log for February 2026 showed Resident 11 received gentamicin drops and Levaquin (both antibiotics) for HAI. Medical record review for Resident 11 was initiated on 6/2/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Infection Surveillance Data Collection Form dated 2/11/26, showed the resident was started on gentamycin sulfate ophthalmic solution 0.3% drops for a right ear infection. The form originally listed the antibiotic as a prophylaxis for an ear infection; however, prophylaxis was crossed out and to treatment. Review of Resident 11's Infection Surveillance Data Collection Form dated 2/11/26, showed the resident was started on Levaquin 500 mg by mouth daily for seven days, for a right ear infection. The form showed the resident's symptoms met three of four required criteria and therefore, did not meet the criteria for an infection. The form showed the resident was currently on gentamycin drops to his right ear and the physician also ordered the Levaquin antibiotic. However, review of Resident 11's medical record failed to show additional symptoms to determine if a true infection criteria was met. On 6/4/26 at 1324 hours, an interview and concurrent records review was conducted with the IP/DSD. The IP/DSD stated the Resident received antibiotics in February 2026, for a right ear infection which met criteria. The IP/DSD then reviewed the Surveillance Data Collection Form criteria and Resident 11's medical record and verified the resident's symptoms did not meet criteria for a true infection and was recorded incorrectly on the Monthly Antibiotic Log for February 2026. The IP/DSD verified the incorrect data was reported to the QA committee. 4. Review of the facility's P&P titled Handwashing/Hand Hygiene revised August 2019 showed the facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after eating or handling food. On 6/2/26 at 1150 hours, a dining observation was conducted in the dining room. The CNAs were observed wheeling the residents to the dining room, in preparation for lunch. Residents 2 and 32 were observed waiting for the lunch to be served. On 6/2/26 at 1213 hours, CNAs 1, 3, and 4 were observed passing the meal trays to the residents in the dining room. CNAs 1, 3, and 4 were not observed offering Residents 2 and 32 and six other residents hand hygiene prior to receiving meal trays. On 6/2/26 at 1228 hours, an interview was conducted with Resident 2. Resident 2 stated he washed his hand long before he came into the dining room for lunch; however, the staff did not offer him to perform hand hygiene right before his lunch. On 6/2/26 at 1234 hours, an interview was conducted with CNA 1. CNA 1 stated he was there to pass (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the meal trays to the residents and did not offer the hand hygiene. CNA 1 stated he was unsure if hand hygiene was offered to the residents before he passed the meal trays to the residents. On 6/2/26 at 1252 hours, an interview was conducted with CNAs 3 and 4. CNA 3 stated he did not offer hand hygiene before he passed the meal trays to the residents and did not see any other staff offering hand hygiene to the residents before meal was served. CNA 4 stated she did not offer hand hygiene before she passed the meal trays to the residents in the dining room and before she fed the residents in the dining room. On 6/2/26 at 1522 hours, an interview was conducted with the IP/DSD. The IP/DSD was asked if staff should offer hand hygiene to the residents right before serving meals in the dining room, the IP/DSD stated staff should offer hand hygiene to the residents before serving meals to the residents. The IP/DSD was informed of the above findings and acknowledged the above findings. The IP/DSD stated the staff should have offered hand hygiene to the residents in the dining room right before the meal was served. On 6/5/26 at 1214 hours, an interview was conducted with RN 1. RN 1 was 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
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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. Based on observation and interview, the facility failed to maintain a clean and functional environment in one of 17 rooms (Room A) observed. * The facility failed to ensure Room A's ceiling vents were free of black, two resident-use cabinets had intact knobs and the shared restroom had no lifted floor tile. This failure posed a risk to the residents' ability to reside in a clean, safe, and homelike environment. Findings: On 6/3/26 at 0850 hours, during a medication administration observation inside Room A, the following was observed:- three ceiling air vents with black substances surrounding the vent surfaces;- a lifted tile inside the shared restroom for Room A ; and- two cabinets used for the residents' clothing with missing knobs. On 6/3/26, at 0900 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the above findings. When asked to provide documentation of when the ceiling vents in Room A were last cleaned, the Maintenance Supervisor stated a log was not kept to document the vent cleaning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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 two of five final sampled residents (Residents 24 and 35) reviewed for unnecessary medications were monitored appropriately for the use of the psychotropic medications. * Resident 24's orthostatic hypotension was not completed as ordered in both lying down and seated positions. In addition, the resident's medical record failed to show documentation of the resident's refusal of the orthostatic hypotension monitoring and if the physician was notified of the resident's refusal. * The facility failed to ensure the manifestation being monitored for Resident 35 matched with the behaviorˆmonitoring documentation supporting the use of the resident's psychotropic medications. These failures had the potential to negatively impact the residents' health outcomes and well-being. Findings: 1. Review of the facility's P&P titled Blood Pressure, Measuring revised September 2010 showed orthostatic hypotension is defined as a 20 mm/Hg (or greater) decline in systolic blood pressure or a 10 mm/Hg (or greater) decline in diastolic blood pressure upon standing (or sitting). The policy showed to measure orthostatic blood pressure, obtain the resident's blood pressure while lying and again after helping the resident to a standing (or sitting) position. Note the changes in both the systolic and diastolic measurements. Document if the resident refused the treatment, the reason(s) why and the intervention taken, and notify the supervisor if the resident refuses the treatment. Review of the facility's P&P titled Psychotropic Medication Use revised February 2025 showed the residents will be monitored for adverse consequences including cardiovascular effects, which included orthostatic hypotension. Medical record review for Resident 24 was initiated on 6/2/26. Resident 24 was readmitted to the facility on [DATE]. Review of Resident 24's Order Summary Report showed the following physician's orders: - dated 4/11/26, for risperidone (antipsychotic medication) 0.5 mg by mouth at bedtime for schizoaffective disorder. - dated 5/14/26, to monitor BP while lying down for orthostatic hypotension every week. Notify the physician for a difference in SBP of 20 mmHg or greater, or if DBP was 10 mmHg or greater. - dated 5/14/26, to monitor BP while sitting for orthostatic hypotension every week. Notify the physician for a difference in SBP of 20 mmHg or greater, or if DBP was 10 mmHg or greater. Further review of the resident's Order Summary Report did not show the resident had any physician's orders for BP medications. Review of Resident 24's Care Plan showed a care plan focus dated 4/11/26, addressing the resident's risk for adverse effects due to antipsychotic medication use. The interventions included monitoring the resident's BP every Sunday while lying and sitting for orthostatic hypotension. Notify the physician for a difference in SBP of 20 mmHg or greater, or if DBP was 10 mmHg or greater. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 24's MAR for May 2025 showed the following: - On 5/17/26 at 0900 hours, the resident's BP was 125/72 mmHg for both lying and seated positions. - On 5/24/26 at 0900 hours, the resident's BP was 126/67 mmHg for both lying and seated positions. - On 5/31/26 at 0900 hours, the resident's BP was 118/80 mmHg for both lying and seated positions. On 6/3/26 at 1533 hours, an interview and concurrent medical record review was conducted with LVN 1 for Resident 24. LVN 1 stated the BP was checked in different positions to check for a drop in the BP measurements. When asked why the BP measurements were identical for both positions for the dates and times above, LVN 1 stated the resident refused and he didn't want to leave it blank in the MAR. LVN 1 verified the resident's medical record did not show the resident's refusal. LVN 1 stated the purpose for checking the resident for orthostatic hypotension was because the resident was taking blood pressure; however, Resident 24 had no physician's orders for BP medication. On 6/3/26 at 1544 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 24's orthostatic hypotension blood pressure monitoring was to check for adverse reactions from the antipsychotic medication. RN 1 stated BPs should change at least slightly from lying to sitting. RN 1 stated if a resident refused BP orthostatic hypotension monitoring, the licensed nurse should explain the purpose, attempt again later and notify the physician if refusal continues. On 6/3/26 at 1609 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated he did not notify Resident 24's physician of her refusal for orthostatic hypotension monitoring. 2. Medical record review for Resident 35 was initiated on 6/2/26. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 3/12/26, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's MAR for June 2026 showed Resident 35 was administered sertraline (antidepressant) 200 mg daily for major depressive disorder manifested by episodes of negative view of himself, with a start date of 3/11/26. Further review the MAR showed Resident 35 was administered divalproex (mood stabilizer) ER 250 mg four tablets at bedtime for major depressive disorder manifested by overly concerned with health, with a start date of 4/16/26. On 6/2/26 at 1000 hours, Resident 35 was observed talking to himself. During an interview with Resident 35, Resident 35 verbalized concerns with pain related to his arthritis. On 6/2/2026 at 1447 hours, Resident 35 was observed sleeping in bed. 0n 6/4/2026 at 0825 hours, Resident 35 was observed sitting in bed eating breakfast. On 6/4/2026 at 1100 hours, an interview was conducted with CNA 2. When asked about Resident 35, CNA 2 stated Resident 35 spent most of his time in his room. On 6/5/26 at 0924 hours, an interview and concurrent medical record review was conducted with LVN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. When asked about manifestations monitored and the indications for use of Resident 35's divalproex medication, including what overly concerned with health meant, LVN 3 stated the behaviors monitored for the divalproex medication included episodes where Resident 35 stated that nobody helped him with his pain management. LVN 3 stated Resident 35 had a pain management specialist and was administered pain medication for his pain. When asked about Resident 35's sertraline manifestations negative view of himself and what this meant, LVN 3 stated Resident 35 was monitored for episodes in which he verbalized feeling his life was stuck. LVN 3 verified both manifestations being monitoring for Resident 35's divalproex and sertraline medications were not consistent with manifestation documented in Resident 35's medical record (overly concerned with health and negative view of himself).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to provide written notification to the resident and/or the resident's representative of the transfer, reason for the transfer, and facility's bed hold policy when the resident was transferred to the acute care hospital for one of two residents (Resident 38) reviewed for discharge. * The facility failed to provide written notification to Resident 38 and/or the resident's representative of the transfer, reason for the transfer, and the facility's bed hold policy when the resident was transferred to the acute care hospital on 5/13/26. This failure had the potential for the resident and/or the resident's representative not being informed of the appeal process and the circumstances of the transfer/discharge should the resident and/or the resident's representative believe the transfer or discharge was inappropriate or involuntary, and to be unaware of their rights to request a bed hold and return to the first available bed should the resident's acute care hospital stay exceed the seven-day bed-hold period. Findings: a. Review of the facility's P&P titled Transfer or Discharge Notice dated March 2025 showed the resident or resident representative are notified of impending transfer or discharge and the reason for move in writing and in a language and manner they understand. A copy of notice is sent to the office of the State Long Term Care Ombudsman. Closed medical record review for Resident 38 was initiated on 6/4/26. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's H&P examination dated 4/18/26, showed Resident 38 had no capacity to understand and make decisions. Review of Resident 38's Order Summary Report dated 5/13/26, showed to send Resident 38 to the acute care hospital for the GT replacement. Review of Resident 38's Progress Note dated 5/13/26 at 0830 hours, showed Resident 38 was sent to the acute care hospital. Review of Resident 38's Notice of Transfer/discharge date d 5/13/26, showed the transfer location for the acute care hospital and the reason for the transfer was for Resident 38's welfare and Resident 38's needs could not be met in the facility. Under the section for the resident or resident's representative signature was blank. Further review of Resident 38's medical record failed to show if Resident 38 or the resident's representative as provided with the written Notice of Transfer/Discharge when Resident 38 was transferred to the acute care hospital on 5/1326. b. Review of the facility's P&P titled Bed Holds and Returns dated October 2022 showed the residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided with written notice about these policies at least twice:- Notice 1: well in advance of the transfer (e.g. in the admission packet); and- Notice 2: at the time of transfer (or, if the transfer was emergency within 24 hours).Further review of the P&P showed multiple attempts to provide the resident's representative with Notice 2 should be documented in cases where the staff were unable to reach and notify the representative timely. Review of Resident 38's Bed Hold Informed Consent showed Resident 38 was transferred to the acute care hospital on 4/10/25, and the resident's representative for Resident 37 was notified; however, the informed consent did not show if Resident 38 or the resident's representative were notified regarding the facility's bed hold policy when Resident 38 was transferred to the acute care hospital on 5/13/26. Further review of the Bed Hold Informed Consent showed, you will have the absence of requesting a seven (7) day bed hold to keep a bed vacant and available for return to this facility. Non-Medi-Cal beneficiaries are responsible for reasonable cost not to exceed the beneficiaries daily room rate. Insurance may or may not cover such charges. Medical will cover the cost of the bed if the residence here of cost has been satisfied for the month, unless we receive return notice from the attending physician that they stay in the hospital is expected to exceed seven days. If you desire this option, the facility must be notified within 24 hours of transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 38's medical record did not show if Resident 38 or the resident's representative was notified in writing of the facility's bed hold policy when Resident 38 was transferred to the acute care hospital on 5/13/26. On 6/4/26 at 1114 hours, an interview and concurrent medical record review for Resident 38 was conducted with the IP/DSD. The IP/DSD verified Resident 38 was transferred to the acute care hospital on 5/13/26, and stated she was unable to locate documentation to show the facility's bed-hold policy was provided in writing to Resident 38 or the resident's representative at the time of the transfer on 5/13/26. The IP/DSD also verified the Notice of Transfer/Discharge did not contain the resident's or the residents' representative's signature. The IP/DSD stated she was unable to find documented evidence that a written Notice of Transfer/Discharge was provided to Resident 38 or the resident's representative when the resident was transferred to the acute care hospital on 5/13/26. The IP/DSD stated the Social Services department was responsible for mailing the written Notice of Transfer/Discharge and the facility's bed-hold policy to the resident or the resident's representative whenever a resident was transferred to the acute care hospital. On 6/4/26 at 1138 hours, an interview and concurrent medical record review for Resident 38 was conducted with the Social Services/Activity Director. The Social Services/Activity Director verified she did not mail or send the written Notice of Transfer/Discharge or the facility's bed-hold policy to the resident or the resident's representative when Resident 38 was transferred to the acute care hospital on 5/13/26. On 6/5/26 at 1214 hours, an interview was conducted with RN 1. RN 1 was 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
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 revise the comprehensive plan of care to reflect the resident's current care needs and appropriate interventions for one of 14 final sampled residents (Resident 20). * The facility failed to ensure the care plan for Resident 20's basal cell cancer (type of skin cancer) lesion (damaged tissue) on left side of her nose was revised to include the regular trimming of the fingernails, despite the resident's known episodes of picking at the wound and the resident being observed with long, pointy fingernails. This failure posed the risk of not providing Resident 20 with individualized and person-centered care. Findings: Review of facility's P&P titled Care Plans, Comprehensive Person-Centered revised December 2016 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Further review of the P&P showed assessments of residents are ongoing and care plans are revised as information about the resident and the residents, and the residents' conditions change. On 6/2/26 at 0918 hours, an observation and concurrent interview was conducted with CNA 1. Resident 20 was observed lying on a stretcher in her room, with CNA 1 at her side. A dark red wound was observed on the bridge of Resident 20's nose. CNA 1 stated Resident 20 had a history of skin cancer and frequently picked at the wound, which tended to bleed. Resident 20 was also observed to have long fingernails on both hands. Medical record review for Resident 20 was initiated on 6/2/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's admission Records dated 6/4/26, showed diagnoses including basal cell carcinoma (type of cancer) of skin of the nose. Review of Resident 20's Care Plan revised 7/11/25, showed a care plan problem addressing the basal cell cancer lesion on the left side of nose and documented episodes of the resident picking at her nose. The interventions included educating resident not to pick or scratch her nose and explaining risk benefits. Further review of the care plan did not include an intervention trimming residents' fingernails. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had memory problems and moderately impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 20 was dependent on the staff for activities of daily living. Review of Resident 20's H&P examination dated 10/25/26, showed Resident 20 had no capacity to understand and make decisions. On 6/3/26 at 1522 hours, an observation and concurrent interview was conducted with LVN 2. Resident 20 was observed with a dark red wound on the bridge of her nose and with long fingernails on both hands. The fingernails on the right hand were observed to be pointy and had brownˆcolored residue. LVN 2 stated Resident 20 had a habit of picking at the wound on her nose. LVN 2 was asked to measure the resident's fingernails and was observed performing the assessment. The fingernails on the left hand measured approximately 0.2-0.3 cm in length, while the fingernails on the right hand measured approximately 0.4 cm and were pointy. LVN 2 verified the observations and stated that, given the resident's habit of picking at her nasal wound, her fingernails should have been trimmed regularly. LVN 2 further stated that nail trimming should have been included as an intervention in the care plan addressing the basal cell cancer lesion and the resident's picking behavior. LVN 2 reviewed the resident's care plan and verified the care plan problem addressing the basal cell cancer lesion on the left side of the resident's nose and episodes of picking at the area, did not include an intervention for regular nail trimming. On 6/5/26 at 1214 hours, an interview was conducted with RN 1. RN 1 was 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
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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 interview, medical record review, and facility P&P review, the facility failed to provide treatment and care in accordance with the professional standards of practice for two of 14 final sampled residents (Residents 7 and 20). * The facility failed to ensure Resident 20's nails were trimmed regularly to prevent her from picking or scratching the wound on the bridge of her nose. This failure had the potential to contribute to continued trauma to the wound site, delayed healing, increased risk of infection, and further deterioration of the resident's skin integrity. * The facility failed to ensure Resident 7 had a physician's order and care plan for the application of bilateral heel protectors (a quilted bootˆlike device secured with hookˆandˆloop tape to prevent heel breakdown) or bilateral hand rolls (a soft padded device placed in the palm to prevent hand contracture). This failure had the potential to result in the use of unassessed and unapproved interventions, inadequate monitoring of the resident's skin and safety needs, and increased risk for injury or skin breakdown. Findings: 1. Review of the facility's P&P titled Activities of Daily Living (ADLs), Supporting dated 3/2018 showed the residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. On 6/2/26 at 0918 hours, an observation and concurrent interview was conducted with CNA 1. Resident 20 was observed lying on a stretcher in her room, with CNA 1 at her side. A dark red wound was observed on the bridge of Resident 20's nose. CNA 1 stated Resident 20 had a history of skin cancer and frequently picked at the wound, which tended to bleed. Resident 20 was also observed to have long fingernails on both hands. Medical record review for Resident 20 was initiated on 6/2/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's admission Records dated 6/4/26, showed diagnoses including basal cell carcinoma (type of cancer) of skin of the nose. Review of Resident 20's Care Plan revised 7/11/25, showed a care plan problem addressing the basal cell cancer lesion on the left side of nose and documented episodes of the resident picking at her nose. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had memory problems and moderately impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 20 was dependent on the staff for activities of daily living. On 6/3/26 at 1522 hours, an observation and concurrent interview was conducted with LVN 2. Resident 20 was observed with a dark red wound on the bridge of her nose and with long fingernails on both hands. The fingernails on the right hand were observed to be pointy and had brownˆcolored residue. LVN 2 stated Resident 20 had a habit of picking at the wound on her nose causing it to bleed. LVN 2 was asked to measure the resident's fingernails and was observed performing the assessment. The fingernails on the left hand measured approximately 0.2–0.3 cm in length, while the fingernails on the right hand measured approximately 0.4 cm and were pointy. LVN 2 verified the observations and stated that, given the resident's habit of picking at her nasal wound, her fingernails (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been trimmed regularly. LVN 2 stated Resident 20's pointy fingernails on the right hand could cause continued trauma to the wound site, delayed healing, increased risk of infection. On 6/5/26 at 1214 hours, an interview was conducted with RN 1. RN 1 was informed and acknowledged the above findings. Cross reference to F657. 2. Medical record review for Resident 7 was initiated on 6/2/26. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's Orders Summary dated 6/3/26, failed to show the physician's orders for bilateral heel protectors or bilateral hand rolls. Review of Resident 7's plan of care failed to show a care plan problem addressing the use of bilateral heel protectors and bilateral hand rolls. On 6/2/26 at 0855 hours, Resident 7 was observed in bed with bilateral hand rolls applied. The resident's feet were not visible due to bedding. On 6/3/26 at 1016 hours, an interview and concurrent observation was conducted with CNA 5 for Resident 7. Resident 7 was observed lying in bed, with a bed sheet over the resident. CNA 5 pulled back the bedding and Resident 7 was observed wearing bilateral heel protectors and bilateral hand rolls. On 6/3/26 at 1517 hours, an interview and concurrent observation was conducted with the RNA for Resident 7. Resident 7 was observed lying in bed with bilateral heel protectors on; the hand rolls were observed on the resident's bedside table. The RNA verified the resident was wearing bilateral heel protectors and stated she had not seen the hand rolls before and suggested they may have been brought in by the family. On 6/3/26 at 1549 hours, an observation, interview and concurrent medical record review was conducted with RN 1 for Resident 7. RN 1 stated any device applied to a resident should have a physician's order and be included in the care plan. RN 1 stated she was unaware the heel protectors and hand rolls were being applied to the resident. RN 1 verified the heel protectors and hand rolls should have physician's orders for the application as well as being included in the care plan. RN 1 verified the resident's medical record contained no physician's orders for the heel protectors and hand rolls, and no care plan to address their use and monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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** Based on observation, interview, and medical record review, the facility failed to ensure the appropriate care and services for the use of the GT for one of four sampled residents (Resident 27) reviewed for GT use. * The facility failed to ensure Resident 27's GT tubing was not touching the floor. In addition, the facility failed to clean the syringe used to flush and administer medications via GT after use. These failures posed the risk of complications related to Resident 27's GT. Findings: Medical record review for Resident 27 was initiated on 6/2/26. Resident 27 was readmitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 4/18/26, showed Resident 27 had no capacity to understand and make decisions. Further review of the H&P showed diagnoses including status post GT placement. On 6/2/26 at 1615 hours, a medication administration observation was conducted with LVN 1. LVN 1 was observed administering medications to Resident 27 via GT. During the medication administration, Resident 27's GT tubing was observed falling to the floor. LVN 1 then picked the tubing up from the floor and placed it onto Resident 27's GT pole. Following medication administration, LVN 1 placed the syringe used to administer medications into a plastic bag without cleaning it and exited the resident's room. When asked about Resident 27's GT tubing falling to the floor, LVN 1 stated he would change the cap of the tubing. 6/5/26 at 1233 hours, a telephone interview was conducted with LVN 1. LVN 1 verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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 observation, interview, and medical record review, the facility failed to provide the necessary pharmaceutical services to ensure accurate administration of the medications: * The facility failed to ensure three unknown pills were properly wasted. This failure posed the risk of medication diversion. * The Administrator, who was not a licensed nurse, had a key to the narcotic destruction storage cabinet. This failure resulted in unauthorized access to controlled substances. * The storage closet used to store enteral feedings did not have a thermometer or temperature log. This failure posed a risk of the enteral products not to be maintained at appropriate room temperature. * Resident 27's stool softener (docusate sulfate) was not held, when Resident 27 had episodes of loose bowel movements. This failure posed the risk of Resident 27 suffering from further loose bowel movements and dehydration.Findings: a. On 6/4/26 at 0932 hours, an inspection of the facility's medication storage room and concurrent interview was conducted with RN 1. Three unknown pills were observed sitting on the edge of the medication disposal container. RN 1 verified the findings and acknowledged the pills were not disposed of properly. RN 1 stated the pills should have been placed directly into the disposable container with the lid closed. b. On 6/4/26 at 0932 hours, an inspection of the facility's narcotic destruction storage area and concurrent interview was conducted with the IP/DSD and RN 1. During the inspection, the IP was observed retrieving a key to the narcotic destruction storage cabinet from the IP's personal purse located inside an open office containing a photocopier. The IP verified the key was easily accessible. When asked who had access (keys) to the narcotic destruction cabinet, RN 1 stated she, the IP, and Administrator each had a key that opened the cabinet where the narcotics to be destroyed were stored. When RN 1 opened the cabinet, bubble packs of medication including Keflex (antimicrobial), hydrocodone-acetaminophen (narcotic pain medication), clonazepam (antianxiety), and morphine (narcotic pain medication) were observed inside the cabinet. When asked why the Administrator, who was not licensed, had a key, RN 1 stated it was in case the cabinet needed to be opened and she or the IP were not in the facility. c. According to [NAME] Nutrition, Jevity (type of enteral feeding) was to be stored at room temperature. On 6/4/26, at 1000 hours, an inspection of the enteral feeding storage closet and concurrent interview was conducted with the IP. The closet contained bottles of Jevity (enteral feeding formula) and boxes of the nutritional supplements labeled for storage in a cool, dry place and to avoid excessive heat. The closet did not contain a thermometer nor was there a temperature log. The IP verified the closet did not contain a thermometer or a temperature log to ensure the enteral feedings were stored at room temperature. d. Medical record review for Resident 27 was initiated on 6/3/26. Resident 27 was readmitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 4/18/26, showed Resident 27 had no capacity to understand or make decisions. Review of Resident 27's MAR for April and May 2026 showed Resident 27 was administered docusate sodium 100 mg, two tablets twice daily, with instructions to hold the medication when Resident 27 had loose stools. Review of Resident 27's CNA ADLs for bowel movements showed a total of 19 loose bowel movements were documented for Resident 27 in April 2026. However, further review of Resident 27's MAR April 2026 showed Resident 27's docusate sodium was not held when the resident had loose stools. Review of Resident 27's CNA ADLs for bowel movements showed a total of 17 loose bowel movements were documented for Resident 27 in May 2026. Further review of Resident 27's MAR May 2026 showed Resident 27's docusate sodium was not held when the resident had loose stools. On 6/5/26 at 1233 hours, a telephone interview was conducted with LVN 1. LVN 1 was informed review of Resident 27's CNA ADLs for bowel movements showed Resident 27 had episodes of loose stools in April and May 2026 but was administered docusate sodium. When asked about administering the docusate sodium medication when Resident 27 had loose stools, LVN 1 stated the CNAs were not reporting when the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had loose stools and stated it was the CNAs responsibility to notify nursing staff. On 6/5/26 at 1500 hours, an interview was conducted with RN 1. RN 1 was 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
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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 interview, medical record review, and facility P&P review, the facility failed to ensure the resident's medical record was accurate for one of 14 final sampled residents (Resident 28). * Resident 28's POLST was inaccurate when it showed the resident's DPOA had designated Family Member 1 as the Health Care Agent. * The facility failed to complete a Significant Change MDS when Resident 28's hospice services were discontinued. * Resident 28's MDS assessment was incorrectly coded to show the resident received hospice services when services had already been discontinued. These failures resulted in incomplete and inaccurate medical records, which have the potential to negatively impact continuity of care and clinical decisionˆmaking.Findings: Medical record review for Resident 28 was initiated on 6/2/26. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 2/26/26, showed the resident had no mental capacity to understand and make decisions. a. Review of Resident 28's POLST dated 9/4/25, showed the resident's Advance Directive dated 11/13/20, showed Family Member 1 as the Health Care Agent. Review of Resident 28's medical record failed to include an Advance Directive. However, a Durable Power of Attorney for Financial Management dated 11/13/20, was filed directly behind the resident's POLST. Review of Resident 28's Durable Power of Attorney for Financial Management dated 11/13/20, did not show a designated Health Care Agent. A section titled Nomination of Guardian or Conservator, showed in the event the court decided it was necessary to appoint a guardian or conservator for the resident, the resident nominated Family Member 1 to be considered by the court to serve as the resident's guardian or conservator. However, the resident's medical record failed to contain any court documents to show the court appointed a conservator or guardian. On 6/3/26 at 0814 hours, an interview and concurrent medical record review was conducted with the SS/AD. The SS/AD reviewed Resident 28's POLST and DPOA. The SS/AD stated she realized the resident's DPOA was for financial matters only but had listed it on the POLST regardless. The SS/AD stated Family Member 1 was unable to provide an Advance Directive or any other documents to establish the resident's Health Care Agent, and the resident had no mental capacity to formulate an Advance Directive for a Health Care Agent. The SS/AD verified the POLST was incorrect. b. Review of Resident 28's physician's orders showed an order dated 8/25/25, to discharge the resident from hospice services on 8/30/25. Review of Resident 28's MDS assessments showed a quarterly MDS assessment was completed on 6/25/25, and an Annual MDS assessment completed on 9/23/25. Review of Resident 28's medical record failed to show a comprehensive Significant Change MDS (or a comprehensive Annual MDS) was completed within 14 days after the resident's hospice services were discontinued on 8/30/25 (due to be completed by 9/14/26). c. Review of Resident 28's MDS assessment dated [DATE], incorrectly showed the resident received hospice care within the past 14 days (from 2/24/26 through 3/9/26). On 6/3/26 at 0814 hours, an interview and concurrent medical record review was conducted with the IP/DSD. The IP/DSD reviewed Resident 28's physician's orders and verified the resident's hospice services were discontinued on 8/30/25. On 6/3/26 at 0844 hours, an interview and concurrent medical record review was conducted with the QA Nurse. The QA Nurse stated a comprehensive MDS assessment should be completed within 14 days after hospice services are discontinued. The QA Nurse reviewed Resident 28's MDS assessments and verified a comprehensive Significant Change or Annual MDS assessment was not completed within 14 days. The QA Nurse also reviewed Resident 28's quarterly MDS assessment dated [DATE], and verified the assessment incorrectly showed the resident received hospice care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 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** Based on interview, medical record review, and facility document review, the facility failed to implement the facility's antibiotic stewardship program to ensure timely physician notification for one nonsampled resident (Residents 11) who received antibiotics for infections that did not meet McGeer's criteria. * The facility failed to ensure Resident 11's symptoms met the criteria for cellulitis/soft tissue/wound infection. In addition, the facility failed to notify the physician the resident's symptoms did not meet the criteria, and to reassess the need for continued antibiotic therapy. These failures had the potential to result in unnecessary antibiotic use and contribute to the development of multidrugˆresistant organisms (MDROs).Findings: Review of the facility's Monthly Antibiotic Log for February 2026 showed Resident 11 received gentamicin drops and Levaquin (antibiotics) for a HAI. Medical record review for Resident 11 was initiated on 6/2/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Infection Surveillance Data Collection Form dated 2/11/26, showed the resident was started on gentamycin sulfate ophthalmic solution 0.3% drops for a right ear infection. The form originally listed the antibiotic as a prophylaxis for an ear infection; however, prophylaxis was crossed out and to treatment. Review of Resident 11's Infection Surveillance Data Collection Form dated 2/11/26, showed the resident was started on Levaquin 500 mg by mouth daily for seven days, for a right ear infection. The form showed the resident's symptoms met three of four required criteria and therefore, did not meet the criteria for an infection. The form showed the resident was currently on gentamycin drops to his right ear and the physician also ordered Levaquin. However, review of Resident 11's medical record failed to show additional symptoms to determine if a true infection criteria was met. On 6/4/26 at 1324 hours, an interview and concurrent medical record and facility document review was conducted with the IP/DSD. The IP/DSD stated Resident 11 received antibiotics in February 2026, for a right ear infection, which met criteria. The IP/DSD then reviewed the Surveillance Data Collection Form criteria and Resident 11's medical record and verified the resident's symptoms did not meet criteria, and the physician was not notified to reassess the need for continued antibiotic therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure the residents' care equipment was maintained in a safe operating condition. * LVN 3 was observed using a Velcro wrist blood pressure (BP) cuff machine during a medication administration observation. The BP (blood pressure) machine was used on multiple residents, was not serviced or maintained as per the manufacturer's manual and was not properly cleaned according to the manual's instruction. This failure posed the risk of crossˆcontamination and inaccurate blood pressure readings for the residents.Findings: Review of the manufacturer's instruction for the Velcro wrist BP machine showed the machine was to be cleaned with a soft dry cloth and the device was to be serviced by the manufacturer. On 6/3/26 at 0925 hours, a medication administration observation and concurrent interview was conducted with LVN 3. LVN 3 was observed using a Velcro wrist BP machine to obtain Resident 22's BP and heart rate. LVN 3 verified the Velcro BP machine was used on multiple residents. When asked for the device manual, LVN 3 stated it was not kept in the medication cart. When asked how the machine was cleaned, LVN 3 showed a container of Clorox wipes and stated the wipes used to clean the wrist BP cuff machine. On 6/3/26 at 0951 hours, an interview was conducted with RN 1. When asked when the wrist BP cuff was last calibrated or serviced, RN 1 stated if the machine malfunctioned, a new machine would be purchased. When asked which machine was used to train and in-service staff, RN 1 stated the staff were trained using a BP tower. RN 1 verified there was no documented evidence to show the staff were trained on the proper use, cleaning or maintenance of the wrist Velcro blood pressure machine used on multiple residents.