STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055689	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 develop the comprehensive care plan to reflect the individual care needs for one of three sampled residents (Resident 1). * The facility failed to develop a care plan to address Resident 1's alleged abuse incident on 1/9/26. This failure had the potential risk of not providing the appropriate, consistent, and individualized care to Resident 1.Findings: Review of the facility's P&P titled Care Planning revised 2/2021 showed it is the policy of this facility that the IDT shall develop a comprehensive care plan for each resident. Medical record review for Resident 1 was initiated on 1/22/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10/17/25, showed the resident did not have the capacity to understand and make decisions. Review of Resident 1's Progress Note dated 1/9/26, showed at around noon, the police came in stating the resident's wife called them and claimed Resident 1 was abused, bruised and burned. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 1/9/26, showed the resident had right hand discoloration. Review of Resident 1's Progress Notes dated 1/9, 1/13-1/15/26, showed Social Services provided psychosocial support to the resident. Further review of the notes failed to show psychosocial support was provided from 1/10 - 1/12/26, after the incident occurred on 1/9/26. Review of Resident 1's medical record failed to show a care plan was developed to address the resident's alleged abuse on 1/9/26. On 2/3/26 at 1053 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no care plan to address Resident 1's alleged abuse on 1/9/26. RN 1 stated the licensed nurse should have done a care plan for the alleged abuse so the staff could monitor Resident 1 and have goals and interventions in place. On 2/3/26 at 1607 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no care plan to address the resident's alleged abuse on 1/9/26. The DON stated the staff did not do the alleged abuse care plan because it was unsubstantiated, no harm was done, and there was no change in condition. The DON further stated the social worker provided psychosocial support and visits daily. The DON stated the licensed nurse did a care plan for the resident's hand discoloration.

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