STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056145	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Grove Post Acute	12882 Shackelford Lane Garden Grove, CA 92841

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **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 provide the reasonable accommodations to meet the needs for one of seven sampled residents (Resident 4). * The facility failed to ensure Resident 4's call light was within the resident's reach. This failure had the potential to negatively impact the residents' physical and psychosocial well-being or result in a delay to receive care. Findings: Review of the facility's P&P titled Call Lights revised on January 2017 showed it is the policy of the facility to respond to the resident's request and needs. When the resident is in bed or in the wheelchair or chair in the room, staff should make sure the call light was within easy reach of the resident. Medical record review for Resident 4 was initiated on 8/26/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS Quarterly assessment dated [DATE], showed the resident had clear speech. Resident 4 could sometimes make themselves understood and sometimes was able to understand others. Resident 4 had a limitation in the range of motion to both upper extremities. Review of Resident 4's H&P examination dated 6/8/25, showed the resident could make their needs known but could not make medical decisions. Review of Resident 4's care plan dated 6/27/25, showed the resident had an actual fall with approaches/ intervention to place call light within reach. On 8/26/25 at 1400 hours, during an observation, Resident 4 was lying in bed. The call light was clipped at the right corner of the mattress by the head of the bed, and the call light cord was dangling off the resident's bed. The resident's call light was not within reach. On 8/26/25 at 1550 hours, during an observation, Resident 4 was lying in bed. The call light was still clipped at the right corner of the mattress by the head of the bed, and was not within the resident's reach. On 8/26/25 at 1554 hours, an observation of Resident 4 and concurrent interview was conducted with CNA 6. CNA 6 verified the resident's call light was not within reach for the resident to use and was clipped by Resident 4's right corner of the mattress by the head of the bed. CNA 6 stated Resident 4 had the ability to use call light when needing assistance. CNA 6 repositioned the call light within Resident 4's reach. On 8/26/25 at 1645 hours, an interview was conducted with the DON. The DON stated she expected the staff to make sure the resident's call lights were always within the resident's reach at all times. Cross reference F689.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 provide the necessary care and services to ensure two of seven sampled residents (Residents 4 and 7) attained and maintained the highest practicable physical well-being. * The facility failed to ensure Resident 4's sling was positioned properly to the resident's left arm as ordered by the physician. Additionally, the facility failed to provide toileting schedule as ordered by the physician for Resident 4. * The facility failed to ensure Resident 7's left thumb had a splint as ordered by the physician. These failures had the potential to negatively impact Residents 4 and 7 physical well-being.Findings: 1. Medical record review for Resident 4 was initiated on 8/26/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS Quarterly assessment dated [DATE], showed the resident had clear speech. Resident 4 could sometimes make themselves understood and sometimes was able to understand others. Resident 4 had a limitation in range of motion to both upper extremities. Review of Resident 4's H&P examination dated 6/8/25, showed the resident could make needs known but could not make medical decisions. a. Review of Resident 4's Radiology Interpretation dated 7/2/25, showed the resident had a mildly displaced fracture across the neck of the left humerus with lying soft tissue swelling along the deltoid. Review of Resident 4's care plan for the fracture at the neck of the let humerus mildly displaced dated on 7/2/25, showed interventions including applying the sling to the left shoulder at all times. Review of Resident 4's Order Summary Report showed the following physician orders: - dated 7/2/25, may place sling on the left shoulder at all times every shift. - dated 7/15/25, to apply sling to left upper arm at all times and monitor for skin integrity every shift. On 8/26/25 at 1550 hours, during an observation, Resident 4 was awake and lying on bed. Resident was wearing a sling, however, it was not supporting the resident' left arm. On 8/26/25 at 1600 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 checked Resident 4's sling and verified it was not supporting the left arm. LVN 2 stated he would ask someone to help him fix the sling. On 8/26/25 at 1655 hours, during an observation, Resident 4 was sleeping in bed. Resident 4 was observed wearing the sling. However, the sling was still not supporting the left arm. On 8/26/25 at 1657 hours, an interview was conducted with LVN 2. LVN 2 stated he could not place the sling on properly to Resident 4 because CNA 6 was changing the resident's undergarment. LVN 2 stated he will fix it later. LVN 2 further stated the resident had an order to apply the sling to left arm at all times for treatment of the fractured arm. b. Review of facility's P&P titled Continence/ Incontinence of Bladder Management revised October 2017 showed the programs that require staff involvement and assistance include prompted voiding, which is appropriate for use with dependent or more cognitively impaired residents. This involves regular monitoring with encouragement to report continence status; prompting on a scheduled basis; and praise and positive feedback when the resident is continent and attempts to toilet. Another program that requires staff involvement and assistance is habit training/scheduled voiding, which calls for scheduled use of the bathroom at regular intervals on a planned basis. Review of Resident 4's care plans showed the following: - dated 6/27/25, showed the resident had an actual fall with approach/ intervention to assist to bathroom as needed every two hours and as needed and to place call light within reach. - dated 7/2/25, showed the resident had a witnessed fall seen to independently walk to the restroom without calling for help or assistance with approach/ intervention listed to place on bladder training program. Review of Resident 4's Order Summary Report showed a physician's order dated 7/9/25, toileting program for 90 days. Review of Resident 4's medical record failed to show documented evidence a toileting program schedule was implemented for the resident according to physician's order and resident's plan of care. On 8/26/25 at 1554 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 4 was not being taken to the restroom. CNA 4 further stated resident was being cleaned and changed when soiled. CNA stated resident had the ability to inform staff when need to urinate. CNA 4 stated she was not aware Resident 4 was on toileting schedule program. On 8/26/25 at 1600 hours, an interview was conducted LVN 2. LVN 2 stated he did not know Resident 4 was on toileting schedule. LVN 2 further stated he will ask the RN about toileting schedule policy. On 8/26/25 at 1610 hours, a medical records review was conducted with LVN 4. LVN verified Resident 4's medical records failed to show a toileting program schedule was initiated for the resident. On 8/26/25 at 1615 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 4 should have been taken to the restroom upon awakening, before and after meals and at bedtime. LVN 2 further stated the CNA should have documented in the

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 the necessary care and services to prevent a fall incident for one of seven sampled residents (Resident 4). * The facility failed to assess and notify the resident's physician and family member when Resident 4 was found on the floor mattress. These failures had the potential to negatively impact the resident's well-being.Findings: Review of facility's P&P titled Fall Risk/ Prevention revised July 2018 showed if a resident sustains a fall, the licensed nurse is to be notified immediately prior to moving the resident. The licensed nurse will assess the resident immediately and an incident report will be completed with an investigation. Special emphasis should be placed on events leading up to the fall, the condition of the resident at the time of the fall and the environment where the resident fell. The incident report and the investigation will be reviewed by the Interdisciplinary Team with recommendations for additional approaches in an attempt to prevent further falls. Review of facility's P&P titled Post Fall Policy revised [DATE], showed Following a resident's fall, the licensed nurse will assess the resident and fill out an incident report with the investigation. Emphasis should be placed on the events leading up to the fall, the condition of the resident following the fall and the environment where the resident was found. The incident report is to be given to the Director of Nurses for review and any necessary follow up. Each time a resident sustains a fall, the Fall Risk Assessment needs to be updated. The Fall Risk Meeting Assessment form shall be completed within 72 hours and placed in the clinical record under Assessments. Rehab. Therapy is responsible for completing a Post Fall Assessment with any recommendations to prevent repeated falls. These forms will be reviewed by the Interdisciplinary Team/Committee but are to be filled out by the designated person in the facility. Falls will be logged. The Committee Chairperson will present the Quality Assurance Committee Report on falls to the QAPI Committee quarterly. The resident's plan of care should be updated following a fall. Medical record review for Resident 4 was initiated on 8/26/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS Quarterly assessment dated [DATE], showed the resident had clear speech. Resident 4 could sometimes make themselves understood and sometimes was able to understand others. Resident 4 had a limitation in range of motion to both upper extremities. Resident 4 required substantial/ maximal assistance in toileting and mobility. Resident 4 was frequently incontinent of urine function and was continent of bowel function. Review of Resident 4's H&P examination dated 6/8/25, showed the resident could make needs known but could not make medical decisions. Review of Resident 4's care plans showed the following: - dated 6/27/25, showed the resident had an actual fall with approach/ intervention to assist to bathroom as needed every two hours and as needed and to place call light within reach. - dated 7/2/25, showed the resident had a witnessed fall seen to independently walk to the restroom without calling for help or assistance with approach/ intervention listed to place on bladder training program. Review of Resident 4's Order Summary Report showed the following physician orders:- dated 7/9/25, toileting program for 90 days. - dated 7/9/25, bed mattress on the floor on the right side and floor mat on the left side of the bed to prevent to minimize injury from falling. Review of Resident 4's Social Work Progress Note dated 8/6/25, showed Resident 4 was found lying down on the mattress on the floor. Further review of Resident 4's medical record failed to show Resident 4 was assessed, the physician and family member were notified and follow-up care and monitoring were provided for the resident. On 8/27/25 at 1133 hours, an interview and a concurrent record review was conducted with the SSD. The SSD verified Resident 4 was found lying on the floor mattress on 8/6/25, however she does not remember the time. The SSD stated she informed LVN 3 of the incident. On 8/27/25 at 1140 hours, an interview and a concurrent medical record review was conducted with the DON. The DON stated the floor mattress sed to prevent injury. The DON further stated a resident who was found on the floor mattress is considered a fall incident and the Fall policy should be followed. The DON stated she did not know Resident 4 was found on the floor mattress by the SSD on 8/6/25. The DON verified Resident 4's medical record failed to show an assessment of the resident was conducted, and the physician and the family member were notified of the resident's fall on 8/6/25. On 8/27/25 at 1516 hours, an interview was conducted with LVN 3. LVN 3 verified the SSD informed him of Resident 4 was found on the floor mattress on 8/6/25. LVN 3 stated he did not thought of it as a fall because resident was found on the floor mattress. LVN 3 stated he did not initiate to call the physician and the resident's family member. On 8/28/25 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate care and services related to GT were provided for two of seven sampled residents (Residents 2 and 3). * Resident 2 was provided with Glucerna (enteral feeding formula) 1.2 at 65 cc/hour via GT, when the physician's order specified it to be 50 cc/hour. * Resident 3 was provided with water flush at 30 cc/hour via GT, when the physician's order specified it to be 35 c/hour. These failures posed the risk for complications related to the use of GT for Residents 2 and 3.Findings: Review of the facility's P&P titled Gastrostomy Tube Feeding via Continuous Pump revised January 2017 showed it is the policy of the facility to provide nourishment via continuous pump to the residents who are unable to obtain adequate nourishment orally, as ordered by the resident's attending physician. 1. Medical record review for Resident 2 was initiated on 8/26/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Nutritional Assessment Progress Note dated 8/14/25, showed the resident had a trend in weight gain. The RD planned to decrease the GT feeding rate of the Glucerna 1.2 at 50 ml/hour to provide 1000 ml/1200 kcal per day secondary to trend weight gain. Review of Resident 2's Order Summary Report showed an order dated 8/15/25, to administer enteral feeding of Glucerna 1.2 at 50 ml/hour for 20 hours via an enteral pump to provide with 1000/1200 kcal per day or until volume limit is consumed or completed. Review of Resident 2's care plan for trending weight gain dated 8/15/25, showed interventions included to provide Glucerna 1.2 at 50 ml/hour to provide 1000 ml/ 1200 kcal per day. Review of Resident 2's H&P examination dated 8/21/24, showed the resident had no capacity to understand and make medical decisions. On 8/26/25 at 1150 hours, during an observation, Resident 2 was in bed with the GT feeding container. The feeding container had Glucerna 1.2 labeled 65 cc/hour dated 8/26/25 at 1200 hours. The GT feeding Glucerna 1.2 was infusing at 65 cc/hour and water flush at 40 cc/hour via continuous pump. On 8/26/25 at 1153 hours, an interview was conducted with LVN 4. LVN 4 stated she just started the enteral feeding via GT to Resident 2. On 8/26/25 at 1446 hours, an observation of Resident 2's GT feeding was conducted with LVN 4. LVN 4 verified Glucerna 1.2 was infusing at 65 cc/hour via continuous pump. On 8/26/25 at 1450 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 2's Order Summary Report showed an order dated 8/15/25 to administer enteral feeding of Glucerna 1.2 at 50 ml/hour for 20 hours via an enteral pump to provide with 1000/1200 kcal per day or until volume limit was consumed or completed. LVN 2 verified Resident 2's GT feeding was set at 65 cc/ hour and verified Resident 2 received 15 ml/hour higher than the physician's prescribed enteral feeding. 2. Medical record review for Resident 3 was initiated on 8/26/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 10/5/24 showed the resident had no capacity to understand and make medical decisions. Review of Resident 3's Order Summary Report showed an order dated 8/18/25, to flush the GT with minimum of 35 cc of water every hour for 20 hours to provide 700 ml/day. On 8/26/25 at 1412 hours, during an observation, Resident 3 was in bed with GT water flush bag labeled with date 8/26/25, and the time hung at 2400 hours. The GT pump was infusing at 30 cc/hour via continuous pump. On 8/26/25 at 1426 hours, an observation of Resident 3's GT water flushing and concurrent interview was conducted with LVN 6. LVN 6 verified Resident 3's GT water flush infusing at 30 cc/hour via continuous pump. On 8/26/25 at 1430 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified Resident 3's order to flush GT with minimum of 35 cc of water every hour for 20 hours to provide 700 ml/day. LVN 6 verified resident received 5 ml/ hour lower than the physician's prescribed enteral water flush. On 8/28/25 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings.