STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
French Park Care Center	600 E Washington Avenue Santa Ana, CA 92701

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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

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

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F 0607 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 ensure the identification, reporting, and investigation was completed when one of three sampled residents (Resident 1) reviewed for abuse, reported two abuse allegations against another resident. * On 11/16/25, Resident 1 alleged Resident 2 was going to hit her, resulting in Resident 1 feeling threatened, scared, and unsafe. Resident 1 reported the alleged incident to facility staff. * On 11/26/25, Resident 1 alleged Resident 2 threatened to cut her into pieces, resulting in Resident 1 feeling threatened and unsafe. Resident 1 reported the alleged incident to facility staff. These failures of the facility to identify, report, and investigate Resident 1's allegations of abuse posed the risk for resident-to-resident abuse to occur in a highly vulnerable population.Findings: Review of the facility's P&P titled Abuse, Neglect, and Exploitation revised 12/19/22, showed it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written P&P's that prohibit and prevent abuse. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. An alleged violation is a situation or occurrence that is observed or reported by staff or residents but has not yet been investigated. An immediate investigation is warranted when suspicion of abuse or reports of abuse occur. Written procedures for investigation include providing complete and thorough documentation of the investigation and reporting all alleged violations to the Administrator and state agency. The Administrator will follow up with government agencies to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Medical record review for Residents 1 was initiated on 12/1/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of Resident 1's H&P examination dated 10/1/25, showed Resident 1 had the capacity to understand and make decisions. a. On 12/1/25 at 1230 hours, an interview was conducted with Resident 1. Resident 1 stated Resident 2 had threatened her on two separate occasions and the facility failed to address her concerns. Resident 1 stated she then contacted the state agency to report the incidents. Resident 1 stated the first incident occurred on the morning of 11/16/25. Resident 1 stated she was sitting in her wheelchair inside of her room. Resident 1 stated she observed Resident 2 sitting in her wheelchair, in the hallway at the entrance to Resident 1's room. Resident 1 stated Resident 2 began to yell and curse at Resident 1. Resident 1 stated Resident 2 had raised her arm and clenched her fist. Resident 1 stated Resident 2 was yelling that Resident 1's wheelchair belonged to Resident 2. Resident 1 stated she then self-propelled her wheelchair out of her room and into the hallway. Resident 1 stated as she passed Resident 2, Resident 2 still had her arm raised with a clenched fist, and Resident 2 was yelling you have my wheelchair; I will kill you. Resident 1 stated she believed Resident 2 was going to hit her. Resident 1 stated she felt threatened, scared, and unsafe. Resident 1 stated she then reported the incident to LVN 1. On 12/1/25 at 1313 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 1 informed her of an alleged incident involving Resident 2 allegedly occurring on 11/16/25. LVN 1 further stated Resident 1 said Resident 2 blocked the entrance to Resident 1's room and began to scream and yell at Resident 1. At some point, Resident 2 lifted her arm and made a fist. Resident 1 reported having felt uncomfortable and threatened as she believed Resident 2 was going to hit her. LVN 1 stated she reported the alleged incident to the Administrator (facility's Abuse Coordinator). Medical record review for Resident 2 was initiated on 12/1/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 9/8/25, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's Care Plan Report revised 9/24/25, showed Resident 2 had a diagnosis of schizophrenia. The care plan showed Resident 2 had the potential to be verbally aggressive related to psychosis manifested by verbal aggression towards others. On 12/1/25 at 1445 hours, an interview was conducted with the Administrator. The Administrator verified he was the facility's Abuse Coordinator. The Administrator stated he was unaware of the abuse allegation made by Resident 1 against Resident 2 for the incident on 11/16/25. The Administrator further stated he was unaware Resident 1 reported feeling uncomfortable and threatened as she believed Resident 2 was going to hit her. The Administrator stated if he was aware, he would have reported the alleged incident to the state agency and conducted an investigation