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	02/12/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 a baseline care plan was developed and implemented within 48 hours of admission for one of three sampled residents (Resident 1). * The facility failed to develop and implement a baseline care plan that addressed pressure injuries and wounds for Resident 1, who was admitted with pressure ulcers and other wounds. * The facility incorrectly created a baseline nutritional care plan that included interventions to feed Resident 1 who was not able to take in nutrition or liquids by mouth and was dependent on enteral tube feedings for his nutritional and hydration needs. These failures posed the risk for Resident 1 not to receive the necessary treatment and services to meet Resident 1's individualized care needs and for Resident 1 to potentially suffer harm due to incorrectly rendered care.Findings: Review of the facility's P&P titled Baseline Care Plan revised 12/29/22, showed the facility will develop and implement a baseline care plan within 48 hours of a resident's admission and will include the minimum health care information necessary to properly care for a resident and meets professional standards of practice. The P&P also showed interventions shall be initiated to address the resident's special needs such as wound care and dietary orders. Closed medical record review for Resident 1 was initiated on 2/12/26. Resident 1 was admitted to the facility on [DATE] and discharged from the facility on 2/2/26. Review of Resident 1's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. a. Review of Resident 1's initial skin assessment dated [DATE], showed Resident 1 had the following 10 pressure injuries and wounds present upon admission: - pressure injury to the sacrococcygeal area;- unstageable pressure injury to the Right hip;- unstageable pressure injury to the Left hip;- pressure injury to the left gluteal fold;- pressure injury to the left heel;- unstageable pressure injury to the side of the right foot;- surgical incision on the right upper with separated wound edges;- skin tear on the antecubital space of the right arm;- open wound on the front of the right knee; and- open wound on the front of the left ear. Review of Resident 1's baseline care plan initiated on 1/29/26, did not show a care plan regarding pressure injuries or wounds was developed or initiated. On 2/12/26 at 1330 hours, an interview and concurrent medical record review for Resident 1 was conducted with the IP. The IP stated the purpose of a care plan was for communication. The IP stated the purpose of a baseline care plan was to catch every wound. The IP stated if the care plan was missing for a wound, the wound could get overlooked. The IP stated each specific wound should have its own care plan with the specific interventions being provided. On 2/12/26 at 1400 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 2. LVN 2 confirmed there was no care plan regarding wounds for Resident 1. LVN 2 stated Resident 1 should have had a wound care plan. LVN 2 stated the purpose of the wound care plan was to assess how the wound was progressing and to change the intervention if the treatment was not working. LVN 2 stated the purpose of the care plan was also to make goals. LVN 2 stated a care plan was a form of (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
	555103	A. Building B. Wing	02/12/2026

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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication. On 2/12/26 at 1430 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON reviewed each of the wounds listed on the skin assessment. The DON stated it is the expectation that each wound has a specific care plan. The DON stated the treatment nurses usually create the wound care plan because they conduct the assessment and implement the treatment orders. The DON stated the purpose of the care plan was to communicate to the staff what interventions are being done for a resident. The DON confirmed there was no care plan for any of the wounds. The DON stated the plan of care for a resident could be compromised or jeopardized if a plan wasn't done. The DON stated for example a treatment modality could have been missed such as the resident needing a low air loss mattress. b. Review of Resident 1's Order Summary Report showed the following physician's orders: - dated 1/29/26, NPO diet; and - dated 1/29/26, enteral feed order. Review of Resident 1's swallowing evaluation dated 1/30/26, showed loss of liquids/solids from the mouth when eating or drinking, residual food left in his mouth after meals, and coughing or choking during meals or when swallowing medications. Review of Resident 1's Physician Progress Note dated 1/31/26, showed the resident was nonverbal, NPO, and fed via GT. Review of Resident 1's nutritional care plan dated 2/2/26, showed the following interventions: - honor the resident's food preferences and offer a substitute if the resident ate less than 50% of the meal; and- allow the resident ample time to eat and drink. On 2/12/26 at 1430 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated Resident 1 was NPO and on an enteral feeding. The DON stated she expected the nutritional care plan to address Resident 1's NPO status and enteral feeding. The DON stated the current nutritional care plan did not reflect the physician orders. The DON stated the nutritional care plan was incorrect and could have caused staff to think Resident 1was able to take in food or water by mouth. The DON stated if Resident 1 had been given food or water by mouth he could have aspirated it into is lungs accidentally.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure documentation for one of three sampled residents (Resident 1) was accurate and maintained within accepted professional standards and practices. * Multiple entries in Resident 1's nursing progress notes incorrectly indicated he was able to verbalize, communicate his needs, and was oriented, despite Resident 1 being nonverbal and having severe cognitive impairment. * Nursing care was documented as being provided to Resident 1 after he had been discharged from the facility. This failure posed the risk for changes in Resident 1's condition to be missed, miscommunication between care providers, and for Resident 1 to receive incorrect treatment.Findings: Review of the facility's P&P titled Documentation in Medical Record revised 12/19/22, showed documentation should be factual, accurate, and reflect objective information based on first-hand knowledge of the assessment. Closed medical record review for Resident 1 was initiated on 2/12/26. Resident 1 was admitted to the facility on [DATE] and discharged from the facility on 2/2/26. Review of Resident 1's Physician Progress Note dated 1/31/26, showed the resident was nonverbal. Review of Resident 1's Nursing Progress Note dated 1/31/26, showed the resident denied pain or discomfort at that time. Review of Resident 1's Skilled Nursing Evaluations dated 1/31 to 2/2/26, showed the following documentation: - under the neurological assessment section, the resident followed commands and denied weakness, tremors, numbness, or tingling; - under the mental status assessment section, the resident was alert and oriented x 3, communicated verbally, speech was clear, and was able to understand and be understood when speaking; and- under the mental status assessment section, Resident 1 had mild cognitive impairment with some confusion. Review of Resident 1's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 1's Nursing Progress Note dated 2/2/26, showed the resident denied pain or discomfort at that time. b. Review of Resident 1's Nursing Progress Note dated 2/2/26, showed Resident 1 was transferred to the hospital for a low hemoglobin level. Review of Resident 1's Nursing Progress Note dated 2/4/26, showed the resident was on a GT feeding, a wound vac was in place and functioning as ordered, IV antibiotics were continued, and no signs of active infection noted. On 2/12/26 at 1430 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated there was a lot of confusion and inaccuracies in the nursing record. The DON stated the documentation made it appear Resident 1 was nonverbal one shift, and then the next shift was alert and talking. The DON stated the documentation made it unclear whether the resident improved or declined in function. The DON stated it was a serious concern because the delivery of care and the care plan were jeopardized. The DON stated if a family member called, it could have caused panic to the family member. The DON stated the resident left on 2/2/26, the nurse could not have assessed the resident on 2/4/26. The DON stated it was unclear if the nurses were really doing their assessments as required or just copying and pasting documentation. The DON stated she expected the documentation to be accurate.