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	04/23/2026

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 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. Based on observation, interview, medical record review, and facility document review, the facility failed to provide the necessary pharmaceutical services to ensure for an accurate reconciliation of the controlled medications in one of two medication carts reviewed for controlled medication reconciliation. * The facility failed to ensure the controlled medication count during the change of shift was completed and the Controlled Drugs - Count Record was signed by two licensed nurses. These failures had the potential for inaccurate reconciliation, and drug diversion of the controlled medications.Findings: On 4/20/26 at 0625 hours, an interview and concurrent facility record review was conducted with RN 5. Review of Controlled Drugs - Count Record for April 2026 of Station C, Cart D showed the Nurse On 3-11 shift (PM shift) and Nurse Off 3-11 shift was not signed on 4/19/26. RN 5 verified the Review of Controlled Drugs - Count Record for April 2026 had missing entry and stated there should be a two license nurses signature during the change of shift to indicate the controlled drug count was completed at the end of the shift. On 4/23/26 at 1412 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to do narcotic drug count during change of shift and were expected to sign the Controlled Drugs - Count Record. On 4/23/26 at 1416 hours, an interview was conducted with the DON and the Administrator. The DON and the Administrator was informed and acknowledged the above findings.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **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 pharmacy services to ensure the proper storage, labeling, and disposal of medications for four of five medication carts and two of two medication rooms inspected, and two of 35 final sampled residents (Residents 12 and 16) who had medications at bedside. * The facility failed to ensure the residents' medications had appropriate pharmacy labels in accordance with regulations and the facility's policy and procedure. * The facility failed to ensure the expired medications were not mixed with active medications and were properly separated for proper disposal. * The facility failed to ensure the multi-use, multi-dose injectable medication vials and insulin pens were properly labeled with the open dates immediately after being removed from the medication refrigerator. * The facility failed to ensure the oral medication was stored properly for Resident 12 when a container of antacid (over the counter medications used to quickly relive heartburn, acid indigestion and sour stomach by neutralizing stomach acid) was observed on top of Resident 12's overbed table. * The facility failed to ensure a topical antiseptic was stored properly for Resident 16 when a bottle of povidone -iodine (a solution which prevents infection, often used to clean and disinfect the skin after an injury or before a procedure) was observed on top of Resident 16's overbed table. These failures had the potential to negatively impact the residents' health outcomes.Findings: 1. Review of the facility's P&P titled Medication Labels dated 4/2014 showed medications are labeled in accordance with facility requirements and state and federal laws .If a label does not fit directly onto the product .the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container .Each prescription medication label includes .Resident's name .direction for use .date dispensed .quantity of medication .Name, address, and telephone number of dispensing pharmacy, Prescription number .Nonprescription medications not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name . On 4/21/26 at 1530 hours, an inspection of Medication Cart 3 located at Nursing Station 3 and concurrent interview was conducted with LVN 15. Medication Cart 3 drawer was observed with 22 packets of lidocaine (local numbing medication for pain management) 5% patch, rubber banded together, with no pharmacy label. LVN 15 stated there were two residents who had orders for the lidocaine patch. LVN 15 stated someone must have taken them out of the manufacturer box. LVN 15 verified there was no pharmacy label to indicate which resident(s) the lidocaine packets belonged to. On 4/23/26 at 0940 hours, an interview was conducted with the DON. The DON stated if it was not an over-the-counter medication, there should be a resident label on the medication. On 4/23/26 at 1020 hours, an interview with the Consultant Pharmacist was conducted. The Consultant Pharmacist stated there should have been a box with the pharmacy label. The Consultant Pharmacist stated the labeled box and the lidocaine packets should not have been separated and the lidocaine packets should have been left in the medication cart with the box. 2. Review of the facility's P&P titled Discontinued Medications revised on 1/2025 showed when the medications are expired, discontinued .the medications are marked as discontinued or stored in a separate location and later destroyed .the discontinued drug container shall be marked or otherwise (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified and shall be stored in a separate location designated solely for this purpose . a. On 4/21/26, at 1315 hours, an inspection of the Nursing Station 2 Medication Room and concurrent interview was conducted with RN 3. The medication room shelf was observed with one manufacturer box containing 100 unit-dosed tablets of ferrous gluconate (iron supplement) 325 mg which had the manufacturer expiration date of 3/2026. RN 3 verified the ferrous gluconate tablets were expired and should not have been left on the medication shelf. b. On 4/21/26 at 1530 hours, an inspection of Medication Cart 3 located at Nursing Station 3 and concurrent interview was conducted with LVN 15. Medication Cart 3 was observed with one blister pack containing cyclobenzaprine (a muscle relaxant) 5 mg with the expiration date of 2/22/26. LVN 15 confirmed the medication was expired and stated it should have been removed and placed in the medication room for destruction. c. On 4/21/2026 at 1605 hours, an inspection of Medication Cart 1 located at Nursing Station 2 and concurrent interview was conducted with LVN 16. Medication Cart 1 was observed with three blister cards each containing clonidine (medication for high blood pressure) 0.5 mg with expiration dates of 9/6/25, and 4/15 and 1/15/26. LVN 16 verified all the three blister packs were expired and needed to be placed with the other expired medications in the medication room for disposal. d. On 4/23/2026, at 1110, an inspection of Medication Cart 3 located at Nursing Station 1 and concurrent interview was conducted with LVN 17. The medication cart was observed with the following medications that were past the beyond use date after it was opened: - one Lantus Solostar (synthetic insulin to regulate blood sugar) 100 units per ml insulin pen with the open date of 3/22/26; and - one Lantus Solostar 100 units per ml insulin pen with the open date of 3/25/26. Review of the pharmacy label on both insulin pens showed to discard unused portion after 28 days. LVN 17 confirmed both pens had been opened and used beyond 28 days and were expired. Review of the manufacturer's prescribing information for Lantus Solostar Insulin pen showed .not in-use (unopened) .room temperature .28 days .In-use (opened) .28 days .room temperature . 3. Review of the facility's P&P titled Vials and Ampules of Injectable Medications dated 4/2008 showed the vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal .The date opened and the initials of the first person to use the vial are recorded on multi-dose vials (on the vial label or an accessory label affixed for that purpose) . a. On 4/21/26, at 1228, an inspection of Nursing Station 3 Medication Room and concurrent interview was conducted with RN 3. The medication room refrigerator was observed with one injectable multi-dose vial of cyanocobalamin (medication to treat vitamin B12 deficiency and anemia) 1 mg/ml visibly low in volume with the plastic protective cap removed. The vial was observed to not have an open date on the vial. RN 2 verified and stated there should be an open date on the vial when the vial was used. b. On 4/21/26, at 1530, an inspection of Medication Cart 3 located at Nursing Station 3 and concurrent (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview was conducted with LVN 15. Medication Cart 3 was observed with 3 ml Novolog (synthetic insulin to regulate blood sugar) KwikPen insulin pen with no open date in the cart drawer stored at room temperature. LVN 15 verified there was no open date on the Novolog insulin pen. Review of the manufacturer's prescribing information for Novolog Insulin pen showed .not in-use (unopened) Room Temperature .28 days .In-use (opened) Room Temperature .28 days . c. On 4/23/2026 at 1045 hours, an inspection of Medication Cart 1 located at Nursing Station 1 and concurrent interview was conducted with LVN 10. Medication Cart 1 was observed with one 3ml Lantus Solostar insulin pen and one 3ml Humalog (synthetic insulin to regulate blood sugar) insulin pen with no open date written on the pen. The insulin pens were stored at room temperature in the medication cart drawer. LVN 10 verified and stated the staff needed to enter the open date on both the insulin pens and the pharmacy label. On 4/23/26 at 1020 hours, an interview was conducted with the Consultant Pharmacist. The Consultant Pharmacist stated the clock starts when the insulin pens come out of the medication refrigerator. Review of the manufacturer's prescribing information for Humalog KwikPen Insulin pen showed .not in-use (unopened) Room Temperature .28 days .In-use (opened) .28 days .room temperature . 4. On 4/20/26 at 715 hours, during the initial tour of the facility, a container of Antacid tablets with approximately one third of tablets left in the container was observed on top of Resident 12's overbed table in front of Resident 12. Resident 12 was asked if she was taking them, Resident 12 responded Yes, I don't want to bother them and will take it when I need to. Resident 12 further stated she got the antacid medication from home. Review of Resident 12's medical record was initiated on 4/20/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 5/8/25, the neurological examination, showed Resident 12 followed commands and answers appropriately. Review of Resident 12's MAR April 2026 showed a physician's order for calcium carbonate (antacids) tablet 500 mg chewable tablet as needed and simethicone(medication to relieve painful symptoms of excess gas, such as bloating, pressure, and flatulence) tablet 80 mg oral tablet as needed were administered. However, further review of the MAR showed these medications were not administered to Resident 12. On 4/20/26 at 913 hours, an interview was conducted with LVN 4. LVN 4 verified Resident 12's antacid medication on top of the overbed table. LVN 4 stated this should not be there and asked Resident 12 if she could remove the antacid medication. Resident 12 got upset and threw the antacid container at the foot part of the bed. On 4/21/26 at 0815 hours, an interview was conducted with RN 4. RN 4 acknowledged the antacid medication on top of Resident 12's overbed table, the resident should not have it. 5. On 4/20/25 at 905 hours, during initial tour of the facility, Resident 16 was in bed being shaved by a family member. A plastic bottle of povidone -iodine (topical antiseptic used to prevent infections in (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minor cuts, scrapes, and burns by killing bacteria, fungi, and viruses) three quarters full on top of Resident 16's overbed table positioned against the wall across Resident 16's bed. Resident 16's family member was asked if anyone needed the povidone- iodine bottle, Resident 16's family member stated, I don't know. Medical record re4view for Resident 16 was initiated on 4/20/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 2/24/26, showed Resident 16 was unable to make decisions. Review of Resident 16's Order Summary Report dated 4/20/26 showed the following physician's orders: - dated 4/17/26, to cleanse left lateral heel DTI (deep tissue injury) with normal saline pat dry, apply povidone iodine and LOA (leave open to air) every day shift for 21 days and to cleanse right medial heel DTI with normal saline, apply povidone- iodine and LOA every day shift for 21 days. On 4/20/26 at 922 hours, an interview was conducted with RN 6. RN 6 verified the povidone iodine on top of Resident 16's overbed table positioned against the wall across Resident 16's bed. RN 6 stated I did my rounds this morning, this was not there, the family sometimes put it there. RN 6 was asked where the family member would get the povidone iodine from, RN 6 did not respond to the question instead RN 6 stated no medications should be at bedside. On 4/20/26 at 1138 hours, an interview was conducted with LVN 5. LVN 5 acknowledged the povidone iodine observed on Resident 16's overbed table and stated, it is not supposed to be there, we did rounds. On 4/23/26 at 1600 hours an interview was conducted with the Administrator and the DON. The Administrator and DON were informed and acknowledged the above findings.