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	07/23/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and manufacturer document review, the facility failed to maintain the essential equipment in the safe operating conditions when:* The facility failed to maintain three of three ice machines in sanitary working condition.* The facility failed to ensure the manufacture specifications were followed for one of three ice machines. These failures had the potential to cause contamination of ice in a highly vulnerable population of 145 residents who received ice from the ice machines.Findings: Review of the Diet Count by Diet report completed by the facility on 7/15/25, showed 145 residents in the facility received an oral diet. Review of the USDA Food Code 2022, Section 4-501.11, Good Repair and Proper Adjustment showed equipment shall be maintained in a state of good repair and sanitary working condition. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A. Equipment, food contact surfaces and utensils shall be clean to sight and touch. 1.a. On 7/15/25 at 1033 hours, an observation of Ice Machine 1 and concurrent interview was conducted with the Maintenance Director. Upon inspection of the internal components of the ice machine, a brown residue was found on the ice machine evaporator (the part of the ice machine where ice was made), a yellow residue was found on the water curtain (a panel that directs the ice from the evaporator to the ice storage bin), a gray residue was found in the ice chute, (the part of the ice machine that directs ice from the harvester to the ice storage bin), and a yellow residue was found on the ice storage bin deflector (a device that directs the ice into the bin). The Maintenance Director verified the findings. b. On 7/15/25 at 1033 hours, an observation of Ice Machine 2 and concurrent interview was conducted with the Maintenance Director. Observed were two metal screws located in the ice storage bin held the ice bin deflector in place. Red and brown stains were noted on the metal screws and the sides of the ice storage bin. The Maintenance Director verified the findings. c. On 7/15/25 at 1120 hours, an observation of Ice Machine 3 and concurrent interview was conducted with the Maintenance Director. Upon inspection of the internal ice machine components, brown and black residues were noted on the evaporator, and black and gray residues were noted on the water curtain of the evaporator. The Maintenance Director verified the findings. 2. Review of the manufacturer guidelines found on the inside panel of Ice Machine 1 showed: Scale Removal and Sanitizing Instructions: 6. Pour eight ounces of Scotsman Clear 1 ice machine scale remover into the reservoir. On 7/16/25 at 0916 hours, an observation of Ice Machine 1 and concurrent interview was conducted with Vendor 1. Vendor 1 stated he used Nucalgon nickel safe ice machine cleaner to clean the internal components of the ice machines. Vendor 1 stated the Nucalgon nickel safe ice machine cleaner was equivalent to Scotsman Clear 1. Vendor 1 further stated the ice machine company raised the prices of the cleaners so the company he worked for used a generic cleaner. Vendor 1 stated he cleaned many different brands of ice machines and it was not possible to use the appropriate cleaner for each brand of ice machine.

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	07/23/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate, complete, and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of bed side rails for seven of 10 final sampled residents (Residents 35, 36, 49, 51, 85, 122, and 153) and one nonsampled resident (Resident 146) reviewed for siderails. * The facility failed to ensure the residents' entrapment assessments were accurately completed for Residents 35, 36, 49, 51, 122, and 153. * The facility failed to ensure Residents 85 and 146 's bilateral grab bars bed entrapment assessment was accurate and completed. These failures had the potential to negatively impact the residents, resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Side Rails revised date 12/19/22, showed entrapment was an event in which a resident is caught, trapped, or entangles in the space in or about the bed rail. The resident assessment should assess the resident’s risk of entrapment between the mattress and bed rail or in bed rail itself. The Maintenance Director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. Further review of the P&P showed as part of the resident’s comprehensive assessment, the following components will be considered when determining the resident’s needs, and whether or not the use of bed rails meets those needs: a. Medical diagnosis, conditions, symptoms, and/ or behavioral symptoms b. Size and weight (continued on next page)

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	07/23/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Sleep habits d. Medications e. Acute medical or surgical interventions f. Underlying medical conditions g. Existence of delirium h. Ability to toilet self safely i. Cognition j. Communication k. Mobility (in and out of bed) l. Risk of falling 1. On 7/15/25 at 1035 hours, during the initial tour of the facility, Resident 36 was observed asleep in the bed with the bilateral grab bars elevated at the head of the bed. Medical record review for Resident 36 was initiated on 7/15/25. Resident 36 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 36's H&P examination dated 9/3/24, showed Resident 36 had no capacity to understand and make decisions. Review of Resident 36's Order Summary Report for July 2025 showed a physician's order dated 3/17/25, for bilateral grab bar every shift for bed mobility and turning. Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 36 dated 3/18/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed. 2. On 7/22/25 at 1021 hours, during an observation with the Maintenance Director, Resident 49’s bed was observed with the bilateral grab bars elevated at the head of the bed. Medical record review for Resident 49 was initiated on 7/21/25. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 8/24/24, showed Resident 49 had the capacity to understand and make decisions. Review of Resident 49's Order Summary Report for July 2025 showed a physician's order dated 6/6/25, for bilateral grab bar every shift for enabler for bed mobility and transfers. Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 49 (continued on next page)

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	07/23/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 1/7/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed. 3. On 7/15/25 at 1106 hours, during the initial tour of the facility, Resident 51 was observed in bed with the bilateral grab bars elevated at the head of the bed. Medical record review for Resident 51 was initiated on 7/16/25. Resident 51 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 51's H&P examination dated 5/29/25, showed Resident 51 had the capacity to understand and make decisions. Review of Resident 51's admission MDS assessment dated [DATE], showed Resident 51 had a BIMS score of 14, indicating intact cognition. Review of Resident 51's Order Summary Report for July 2025 showed a physician's order dated 5/30/25, for bilateral grab bar every shift for bed mobility and transfers. Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 51 dated 6/12/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed. 4. On 7/15/25 at 1513 hours, during the initial tour of the facility, Resident 122 was observed in bed with the bilateral grabs bar elevated at the head of the bed. Medical record review for Resident 122 was initiated on 7/16/25. Resident 122 was admitted to the facility on [DATE]. Review of Resident 122's H&P examination dated 5/2/25, showed Resident 122 had the capacity to understand and make decisions. Review of Resident 122's admission MDS assessment dated [DATE], showed Resident 122 had a BIMS score of 14, indicating intact cognition. Review of Resident 122's Order Summary Report for July 2025 showed a physician's order dated 5/1/25, for bilateral grab bar every shift for bed mobility and transfers. Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 122 dated 5/30/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show Zone 7 was measured and if it passed or failed. 5. On 7/17/25 at 0857 hours, an observation and concurrent interview was conducted with Resident 153. Resident 153 was observed sitting up in a wheelchair and the resident's bed was observed with the bilateral grab bars elevated at the head of the bed. Medical record review for Resident 153 was initiated on 7/16/25. Resident 153 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 153's H&P examination dated 9/8/24, showed Resident 153 had the capacity to (continued on next page)

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	07/23/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand and make decisions. Review of Resident 153's Quarterly MDS assessment dated [DATE], showed Resident 153 had a BIMS score of 12, indicating moderately impaired cognition. Review of Resident 153's Order Summary Report for July 2025 showed a physician's order dated 3/18/25, for bilateral grab bar every shift for bed mobility and transfers. Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 153 dated 1/7/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed. On 7/22/25 at 1006 hours, an observation, interview, and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated the measurements of the bed, spaces in between the mattress, grab bars, and headboards were taken using a tape measure. The Maintenance Director verified there were discrepancies between the assessments of the Zones and Zone 7, which was not reflected in the Bed System Measurement Device Test Results Worksheets. In addition, the Maintenance Director stated the measurements were done to prevent entrapment and Zone 7 should have been reflected and added on the form. On 7/22/25 at 1548 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings. 6. On 7/15/25 at 1035 and 1625 hours, and on 7/16/25 at 1101 hours, Resident 35 was observed lying on his bed with the 1/2 (half) siderail elevated on the right side of the bed and the 3/4 siderail elevated on the left side of the bed. Medical record review for Resident 35 was initiated on 7/15/25. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 35’s Bed System Measurement Device Test Results Worksheet dated 4/29/25, did not show if Zone 7 was measured and if Resident 35’s side rail had passed the Zone 7 entrapment assessment for the use of the siderails. Review of the Resident 35’s Order Summary Report showed the following physician’s orders: - dated 7/16/25, for the 1/2 right bed rail when in bed for positioning and ease of mobility, secondary to generalized weakness. - dated 4/24/25, for the 3/4 left bed rail while in bed to self-assist with turning and repositioning due to left upper extremity paraparesis (partially unable to move) related to spinal cord injury and to promote sense of security. Review of Resident 35’s plan of care showed a care plan revised on 7/16/25, addressing the siderail management for the risk of entrapment and impairment in skin discoloration. The goal showed Resident 35 would be provided with the safe use of the side rails. The interventions included to check the siderails regularly to ensure they were securely attached and in good working condition. Further review of the P&P showed to visually check bed the mattress and rail for appropriateness of the (continued on next page)

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	07/23/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident’s dimensions. On 7/22/25 at 1006 hours, an observation, interview, and concurrent medical record review for Resident 35 was conducted with the Maintenance Director. Resident 35 was observed lying on his bed with the 1/2 siderail elevated on the right side of the bed and the 3/4 siderail elevated on the left side of the bed. The Maintenance Director verified the above observation and stated Resident 35 had the 1/2 siderail on the right side of the bed and the 3/4 siderail on the left side of the bed. The Maintenance Director reviewed the Bed System Measurement Device Test Results Worksheet dated 4/29/25, and verified the document did not show if Zone 7 was measured, and if Resident 35 passed the Zone 7 measurement for the use of the siderails. On 7/22/25 at 1503 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 7. On 7/15/25 at 1057 hours, an observation was conducted for Resident 85’s bed. Resident 85 was observed lying on the bed and watching TV with the bilateral grab bars elevated. Medical record review for Resident 85 was initiated on 7/15/25. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85’s Order Summary Report showed a physician’s order dated 5/14/25, for the bilateral grab bars for turning and repositioning. On 7/22/25 at 1043 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director was asked to show the documentation for Resident 85's bilateral grab bars bed entrapment assessment. The Maintenance Director showed the facility's document titled Bed System Measurement Device Test Results Worksheet dated 5/25/25, for Resident 35. The worksheet showed the following zones were assessed and measured: for Zone 1, passed, four inches for Zone 2, passed, two inches. for Zone 3, passed one and one eighth. for Zone 4, passed two inches. for Headboard Zone 6, passed, half. However, there was no documentation to show the assessment, measurement, and result (passed or failed) for Zone 7. In addition, there was no specified unit of measurement used for Zones 3 and 6. 8. On 7/15/25 at 1113 hours, during the initial tour of the facility, an observation was conducted for Resident 146’s bed. Resident 146 was not observed his room. However, Resident 146's bed was observed with the bilateral grab bars elevated. Medical record review for Resident 146 was initiated on 7/15/25. Resident 146 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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	07/23/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 146’s Order Summary Report showed a physician’s order dated 6/12/25, for the bilateral grab bars for bed mobility and repositioning. On 7/22/25 at 1041 hours, an interview and concurrent medical record review was conducted with the Maintenance Director. The Maintenance Director was asked to show the documentation for Resident 146's bilateral grab bars bed entrapment assessment. The Maintenance Director showed the facility's document titled Bed System Measurement Device Test Results Worksheet dated 3/18/25, for Resident 146. The worksheet showed the following zones were assessed and measured: for Zone 1, passed, four inches. for Zone 2, passed, one and 1/8. for Zone 3, passed, one and 1/8. for Zone 4, passed, one inch. for Headboard Zone 6, passed and 1/2. However, there was no documentation to show the assessment, measurement and result for Zone 7. In addition, there was no specified unit of measurement used for Zones 2, 3, 4, and 6. The Maintenance Director verified there was inaccuracy in completion of the entrapment assessments for Residents 85 and 146.

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	07/23/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 one of five final sampled residents (Resident 89) was free from the unnecessary psychotropic drugs (any drug that affects brain activity associated with mental processes and behavior).* The facility failed to ensure non-pharmacological interventions were implemented for the depression and behaviors exhibited by Resident 89. This failure had the potential to place the residents at risk of receiving unnecessary medications and an increased risk of serious medication adverse reactions. Findings: Review of the facility's P&P titled Use of Psychotropic Medication use revised 3/17/25, showed in part, a psychotropic drug is any drug that affects the brain activities associated with the mental processes and behavior, which includes the antipsychotics, anxiolytics, hypnotics, and antidepressants . non pharmacological interventions must be attempted unless contraindicated to minimize the need for psychotropic medication, use the lowest possible dose, or discontinue the medication.Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was admitted to the facility on [DATE], and readmitted on [DATE].Review of Resident 89's MDS dated [DATE], showed Resident 89 had a memory problem and severely impaired cognitive skills for daily decision making.Review of Resident 89's Order Summary Report showed a physician's order dated 3/19/25, for mirtazapine (antidepressant medication) 30 mg oral tablet one tablet by mouth at bed time for depression as manifested by crying.Review of Resident 89's Monitor Record for July 2025 showed from 7/1 to 7/22/25, Resident 89 had 56 episodes of depression as manifested by crying spells related to the use of mirtazapine.Review of Resident 89's medical record did not show the non-pharmacological interventions were identified or documented as an option to be implemented when Resident 89 had episodes of depression as manifested by crying spells related to the use of mirtazapine medication.On 7/22/25 at 1426 hours, an interview and concurrent medical record review for Resident 89 was conducted with LVN 2. LVN 2 verified Resident 89 was receiving the mirtazapine medication. LVN 2 also verified Resident 89 had 56 episodes of depression as manifested by crying spells. LVN 2 was not able to show the non-pharmacological interventions documentation when Resident 89 had episodes of depression as manifested by crying spells.On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings.

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	07/23/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to send a copy of the notice of discharge to the representative of the Office of the State Long Term Care Ombudsman for one of three sampled residents (Resident 194) reviewed for closed records. This failure posed the risk of the LTC (Long term Care) Ombudsman not being aware of the circumstances of the resident's transfer/discharge should the resident and their representative believe the transfer or discharge was inappropriate or involuntary. Findings: Review of the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, showed the facility will maintain evidence that the notice was sent to the Ombudsman. For Non-Emergency Transfers or Discharges - initiated by the facility, return not anticipated .(b.) Provide transfer/discharge notice to the resident/representative and Ombudsman as indicated. Closed medical record review for Resident 194 was initiated on 7/15/25. Resident 192 was admitted to the facility on [DATE], and discharged to home on 6/14/25. Review of Resident 194's Order Summary Report showed a physician's order dated 6/9/25, to discharge the resident to home with medications on 6/10/25. Review of Resident 194's Licensed Progress Notes dated 6/14/25, showed the discharge instructions were given to the resident's caregiver and the resident was discharged home. Further review of Resident 194's closed medical record did not show any documentation the State LTC Ombudsman was notified of the resident's discharge. On 7/21/25 at 1538 hours, an interview and concurrent closed medical record review was conducted with the Medical Records Director. The Medical Records Director was asked to show documentation of the Ombudsman notification regarding Resident 194's discharge. The Medical Records Director verified she could not find any documentation of the Ombudsman notification in the resident's medical record. However, the Medical Records Director stated she would follow-up with the SSD if their department have a separate log book for the Ombudsman notifications upon a resident's transfer or discharge. On 7/22/25 at 1310 hours, an interview and concurrent closed medical record was conducted with the SSD. The SSD was asked to show documentation of the Ombudsman notification regarding Resident 194's discharge to home. The SSD verified she could not provide a copy of the Ombudsman notification when Resident 194 was discharged home. On 7/23/25 at 1124 hours, the Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.

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	07/23/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and medical record review, the facility failed to ensure a comprehensive care plan was developed for one of 35 final sampled residents (Resident 86).* Resident 86's care plan specific to oxygen administration failed to include the oxygen administration parameters. The nursing staff failed to attempt to administer the lowest amount of oxygen required to maintain Resident 86's oxygen saturation level at 92 % or greater, in accordance with the physician's order. This failure placed the resident at risk for not being provided appropriate, consistent, and individualized care. Findings: Medical record review for Resident 86 was initiated on 7/15/25. Resident 86 was admitted to the facility on [DATE]. Review of Resident 86's physician's order dated 6/18/25, showed an order for oxygen to be administered at two liters per minute via nasal cannula, may titrate (oxygen rate) to maintain an oxygen saturation greater than or equal to 92%. On 7/15/25 at 1050 hours, an observation and concurrent interview was conducted with Resident 86. Resident 86 was observed lying in her bed and receiving continuous oxygen therapy via a nasal cannula, at a rate of six liters per minute. Resident 86 stated a past COVID-19 infection had caused damage to her lungs, having resulted in her need for oxygen therapy. Resident 86 stated she did not know the rate of oxygen she was receiving as the nursing staff had set the rate. On 7/15/25 at 1554 hours, an observation, interview, and concurrent medical record review, was conducted with LVN 12. Resident 86 was observed lying in her bed. Resident 86 was observed receiving continuous oxygen via a nasal cannula, at a rate of six liters per minute. LVN 12 was asked the maximum rate of oxygen she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation greater than or equal to 92%, in accordance with the physician's order. LVN 12 stated she was uncertain, as the order failed to specify a maximum rate of oxygen. LVN 12 then stated she would consult with Resident 86's RN (RN 5). On 7/15/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with RN 5. RN 5 verified Resident 86's medical record failed to show documentation specific to the rate of oxygen Resident 86 was receiving. RN 5 was informed that Resident 86 had received continuous oxygen therapy via a nasal cannula, at a rate of six liters per minute, from 1050 hours to 1604 hours. RN 5 reviewed and verified Resident 86's medical record showed documentation Resident 86's oxygen saturation level was 98% (on 7/15/25 at 0908 hours) and 97% (on 7/15/25 at 1557 hours). RN 5 was asked the maximum rate of oxygen that she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation level greater than or equal to 92 percent, in accordance with the physician's order. RN 5 stated in accordance with the facility's P&P for oxygen administration, Resident 86 could receive oxygen at a maximum rate of five liters per minute via nasal cannula. RN 5 stated the oxygen administered at a rate greater than five liters per minute would be administered via an oxygen mask to ensure optimal oxygen absorption. RN 5 stated the nursing staff should have attempted to titrate Resident 86's oxygen to the lowest rate possible between 1050 and 1604 hours, while maintaining Residents 86's oxygen saturation level at 92% or greater. On 7/17/25 at 1016 hours, an interview and concurrent medical record review was conducted with the ADON. Review of Resident 86's care plan addressing oxygen therapy initiated 4/11/24, showed Resident 86 had impaired gas exchange. Resident 86's care plan failed to show information specific to the maximum rate in which nursing staff could titrate Resident 86's oxygen, via the nasal cannula. The ADON stated Resident 86's care plan should have included the oxygen administration parameters and the nursing staff should have attempted to administer the lowest amount of oxygen required to maintain Resident 86's oxygen saturation level at 92% or greater, in accordance with the physician's order.

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	07/23/2025

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 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. **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 necessary care and services were provided to two out of 35 final sampled residents (Residents 85 and 195). * The facility failed to ensure Resident 85's Infectious Disease Physician's recommendation dated 5/17/25, for an urgent MRI of the right hip was communicated to the ordering Physician and arranged in a timely manner. * The facility failed to ensure Resident 195's Intake and Output (I&O) were documented. These failures had the potential to affect Resident 85 and 195's well-being. Findings: 1. Review of the facility’s P&P titled Provision of Physician Ordered Services dated 5/15/23, showed for Diagnostic tests: a.) Facility will maintain a schedule of diagnostic tests in accordance with physician’s orders. b.) Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to appropriate entity. c.) Qualified nursing personnel will receive the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders. Ordering physician will be notified of results upon receipt if deemed “critical” and/or require immediate attention. d.) Documentation of consultations, diagnostic tests, the results and date/time of Physician notification will be maintained in the resident’s clinical record. e.) In instances where diagnostic testing or consultations are not available to be performed onsite or the physician has requested that the services be performed at an offsite facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments. For follow-up appointments: Facility staff will assist residents in scheduling and attending follow-up appointments as ordered by the physician, physician assistant, nurse practitioner, or clinical nurse specialist. Review of the facility’s P&P titled Physician Services dated 12/19/22, showed the resident’s attending physician participates in the resident’s assessment and care planning, monitoring changes in resident’s medical status, and providing consultation or treatment when called by the facility. Medical Record Review for Resident 85 was initiated on 7/15/25. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85’s MDS assessment dated [DATE], showed Resident 85 had a BIMS Score of 12, indicating moderate cognitive impairment. Review of Resident 85’s Order Summary Report showed the following physician’s orders: - dated 6/20/25, for MRI of the right hip with/without contrast. Needs to be scheduled. - dated 7/11/25, for MRI of the right hip without contrast, scheduled for 7/28/25 at 1335 hours. On 7/17/25 at 0943 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked to show documentation of Resident 85’s appointment with an outside physician for May 2025. RN 1 showed a faxed documentation dated 6/5/25, for Resident 85’s (continued on next page)

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	07/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	telemedicine appointment with the Infectious Disease physician with a date of service on 5/17/25. The faxed documentation showed Resident 85’s Infectious Disease physician’s recommended for urgent MRI of the right hip to assess the size of the abscess (pus collection). RN 1 was asked to show documentation from the licensed staff reviewed the Infectious Disease physician's telemedicine progress notes and notified Resident 85's ordering physician about the recommendation for the urgent MRI. RN1 verified there was no documentation in the resident's medical record from the licensed staff about the telemedicine appointment on 5/17/25, and if the Infectious Disease physician's progress notes and recommendations were reviewed and relayed to the resident's ordering physician. RN 1 was also asked about the facility's process when making arrangements for Resident 85's recommended urgent MRI of the right hip. RN 1 stated the facility had a calendar for communicating the residents’ needed appointments. However, RN 1 verified there was no documentation on the facility's calendar to show the request to make arrangements for Resident 85's urgent MRI of the right hip or if the MRI was scheduled. RN 1 verified Resident 85 had a physician's order dated 6/20/25, to schedule the MRI of the right hip with/without contrast and a physician's order dated 7/11/25, to show the MRI was scheduled for 7/28/25. When RN 1 was asked if the appointment for the urgent MRI should have been arranged sooner, since the Infectious Disease physician’s recommendation was dated 5/17/25, RN 1 acknowledged the urgent MRI should have been arranged sooner and communicated among the licensed staff. On 07/17/2025 at 1318 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD was asked if there was a communication relayed by the licensed staff for Resident 85’s Infectious Disease recommendation for the urgent MRI of the right hip from 5/17/25. The SSD verified she could not find any documentation to show the licensed staff communicated with the Social Services department about Resident 85’s need for the urgent MRI of the right hip. On 7/17/25 at 1335 hours, an interview and concurrent medical record review was conducted with the Case Manager. The Case Manager was asked about the facility's process when a resident needed an urgent MRI scheduled as recommended by a physician outside of the facility. The Case Manager stated the licensed staff would communicate to the Social Services department or to the facility's case managers once there was be a physician’s order. The Case Manager stated when a resident needed an urgent procedure, the facility could contact the resident's insurance company for immediate authorization and arrangement. When the Case Manager was asked to show documentation when she was notified Resident 85 needed an urgent MRI of the right hip recommended from the Infectious Disease physician’s on 5/17/25, the Case Manager acknowledged she was not able to find documentation of the communication regarding Resident 85’s need to arrange for an urgent MRI of the right hip. The Case Manager stated the request for the urgent MRI should have been communicated so the appointment could be arranged, however, it was not endorsed to her. On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings. 2. Closed medical record review for Resident 195 was initiated on 7/15/25. Resident 195 was admitted to the facility on [DATE], and discharged to acute care hospital on 1/22/23. Review of Resident 195's H&P examination dated 12/28/22, showed Resident 195 had capacity to understand and make decisions. Review of Resident 195’s Order Summary Report dated 12/16/22, showed a physician’s (continued on next page)

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	07/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order to record the intake and output (I&O) every shift for 30 days. Reassess continuation of the intake and output after 30 days. Further review of Resident 195's medical record failed to show documented evidence Resident 195’s I&O values were documented as ordered. On 7/18/25 at 1017 hours, an interview and concurrent closed medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 verified there was no documented evidence Resident 195's I&O values were documented. On 7/21/25 at 1409 hours, an interview and concurrent closed medical record review for Resident 195 was conducted with RN 3. RN 3 verified Resident 195 had a physician’s order to monitor the I&O for 30 days, however, RN 3 verified there was no documentation of the resident's I&O values. On 7/22/25 at 0900 hours, an interview was conducted with the Medical Records Director. The Medical Records Director verified Resident 195 had a physician’s order to monitor the resident’s I&O for 30 days, however, the Medical Records Director verified there was no documented evidence Resident 195’s I&O were documented. On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated if there was a physician’s order to monitor the I&O, the nursing staff should have documented the resident's I&O. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.

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	07/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 necessary care and services were provided to prevent the development and worsening of pressure injuries and promote the healing of existing pressure injuries four of five final sampled residents (Residents 28, 98, 122, and 131) reviewed for pressure injuries. * The facility failed to ensure the low air loss (LAL) mattress setting was consistent with the residents' weight. This had the potential for the residents to not receive the appropriate care and services to promote healing or prevent the development and worsening of pressure injuries. Findings: 1. Review of the facility P&P titled Use of Support Surfaces revised date 9/12/23, showed support surfaces will be chosen by matching the potential therapeutic benefit with the resident’s specific situation. Further review of the P&P showed support surfaces will be utilized in accordance with manufacturer recommendations. Considerations for utilizing specialized support surfaces: a. Medical condition. b. Size and weight. c. Mobility and activity levels. d. Need for microclimate control or shear reduction. e. Presence of pressure injuries, including severity and location. f. Risk for developing a pressure injury or at high risk for additional pressure injuries. g. Pain or discomfort. h. Bottoms out on the current surface. On 7/15/25 at 1056 hours, during the initial tour of the facility, Resident 98 was observed positioned on her back and lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at four. Review of the LAL mattress device showed level four setting was for a weight of 175 pounds. Medical record review for Resident 98 was initiated on 7/15/25. Resident 98 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 98's H&P examination dated 8/20/24, showed Resident 98 had the capacity to understand and make decisions. Review of Resident 98's Quarterly MDS assessment dated [DATE], showed Resident 98 had a BIMS score of 15, indicating intact cognition. Review of Resident 98's Order Summary Report for July 2025 showed a physician's order dated 8/16/24, for the LAL mattress: check device function and pressure setting set per the resident’s weight every shift. (continued on next page)

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	07/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/25 at 1351 hours, an observation and concurrent interview was conducted with Resident 98 inside the resident’s room. Resident 98 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at three. Review of the LAL mattress device showed level three setting was for a weight of 140 pounds. When Resident 98 was asked if the LAL mattress she was lying on was comfortable, the resident stated she was more comfortable, and the LAL mattress was better after it the pressure level was adjusted. In addition, the resident stated the past few days her back hurt when the pressure level was set at four. On 7/17/25 at 1530 hours, an interview was conducted with LVN 3. LVN 3 was informed of the above findings and stated the LAL mattress was monitored by the Treatment nurse, but she also conducted a quick visual check by looking at the numbered pressure setting based on the resident’s weight to provide comfort. On 7/22/25 at 1502 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed and acknowledged the above findings. The ADON stated the LAL mattress setting was based on the resident's weight and it was important to have the correct setting to achieve the therapeutic level and comfort for the residents. 2. On 7/15/25 at 1513 hours, during the initial tour of the facility, Resident 122 was observed positioned on her back and lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at five. Review of the LAL mattress device showed level five setting was for a weight of 210 pounds. Medical record review for Resident 122 was initiated on 7/16/25. Resident 122 was admitted to the facility on [DATE]. Review of Resident 122's H&P examination dated 5/2/25, showed Resident 122 had the capacity to understand and make decisions. Review of Resident 122's admission MDS assessment dated [DATE], showed Resident 122 had a BIMS score of 14, indicating intact cognition. Review of Resident 122’s Care Plan dated 5/15/25, showed an intervention for the LAL mattress for comfort, with the setting to be per resident comfort level or weight every shift for skin maintenance. Review of Resident 122's Order Summary Report for July 2025 failed to show a physician's order for the use of the LAL mattress. On 7/16/25 at 1652 hours, an interview was conducted with LVN 15. LVN 15 was informed of the above findings. LVN 15 stated the LAL mattress was monitored by the Treatment nurse and the pressure setting should be reevaluated due to the weight setting discrepancy. On 7/22/25 at 1526 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed of the above findings and acknowledged there was no physician's order for the LAL mattress prior to the resident's use. Furthermore, the ADON stated the LAL mattress setting was based on the resident's weight and it was important to have the correct setting to achieve the therapeutic level and comfort for the residents. (continued on next page)

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	07/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the Owner’s Operator and Maintenance Manual for MicroAir MA60 Alternating Pressure System and MA65 Alternating Pressure On-Demand Low Air Loss System revised 2/2008 showed the resident comfort pressure ranges from Soft (level zero) to Firm (level nine). The Comfort Control LED (light-emitting diode) displays the resident comfort pressure levels from zero to nine and provides a guide to the caregiver to set approximate comfort pressure level depending on the resident weight. Medical record review for Resident 28 was initiated on 7/15/25. Resident 28 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 28's Quarterly MDS assessment dated [DATE], showed Resident 28 had a BIMS score of 7, indicating severe cognitive impairment. Review of Resident 28’s Order Summary Report for July 2025 showed a physician’s order dated 7/15/25, for LAL mattress: Check for device function and for the pressure setting set per the resident's comfort every shift for skin maintenance. On 7/15/25 at 1042 hours, an observation and concurrent interview was conducted with Resident 28 inside the resident’s room. Resident 28 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at six. Review of the LAL mattress device showed level six setting was for a weight of 245 pounds. When Resident 28 was asked if the LAL mattress she was lying on was comfortable, the resident stated she was not comfortable and replied, “the mattress is too hard.” On 7/15/25 at 1050 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2 inside Resident 28’s room. LVN 2 verified the above findings. When LVN 2 asked Resident 28 if she wanted the LAL mattress at a softer or firmer level, Resident 28 replied she wanted the LAL mattress to be “softer.” LVN 2 verified Resident 28 weight was 134 pounds on 7/3/25, and the mattress setting should have been set at a comfort pressure level of three, which was the setting was for a weight of 140 pounds. On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated the LAL mattress should be set according to the resident’s weight and then with the resident's comfort. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings. 4. On 7/15/25 at 1222 and 1627 hours, and 7/16/25 at 0835 and 1134 hours, Resident 131 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at eight. Review of the LAL mattress device showed comfort pressure level eight corresponded to the weight of 315 pounds. On 7/17/25 at 1351 hours, Resident 131 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at four. Review of the LAL mattress device showed comfort pressure level four corresponded to the weight of 210 pounds. Medical record review for Resident 131 was initiated on 7/15/25. Resident 131 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 131’s MDS assessment dated [DATE], showed Resident 131 had memory (continued on next page)

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	07/23/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problem and severely impaired cognitive skills for daily decision making. Further review of the MDS assessment showed Resident 131 was dependent on the facility staff for his activities of daily living. Review of Resident 131's Order Summary Report showed a physician's order dated 6/6/25, for LAL mattress for wound healing and comfort. Review of Resident 131’s Braden Scale for Predicting Pressure Ulcer Risk dated 6/19/24, showed Resident 131 was at a very high risk for pressure ulcer. Review of Resident 131’s Weights and Vitals Summary showed on 7/3/25, Resident 131 had the weight of 103 pounds. On 7/16/25 at 1143 hours, an observation, interview, and concurrent medical record review for Resident 131 was conducted with LVN 13. LVN 13 stated Resident 131 was nonverbal and unable to express his comfort level or show facial features of discomfort. LVN 13 verified the observation of Resident 131's LAL mattress set at a comfort level of eight, which corresponded to the weight of 315 pounds. LVN 13 verified Resident 131's most recent weight of 103 pounds. On 7/17/25 at 1353 hours, an observation, interview and concurrent medical record review for Resident 131 was conducted with LVN 14. LVN 14 stated Resident 131 was at a very high risk for developing pressure ulcers and the LAL mattress was provided to Resident 131 to prevent development of the pressure ulcer. LVN 14 stated Resident 131 was nonverbal and unable to express his comfort level or show facial features of discomfort, so the LAL mattress should be set as per Resident 131’s weight. LVN 14 verified the observation of Resident 131’s LAL mattress set at a comfort level of four, which corresponded to the weight of 210 pounds. LVN 14 stated Resident 131’s LAL mattress should have been set as per the resident’s weight, which was103 pounds and the comfort level for Resident 131 should have been set to two and not four or eight. On 7/22/25 at 1503 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	07/23/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 treatment was provided to prevent the decline in the ROM functions for one of six final sampled residents (Resident 5) reviewed for ROM functions.* The facility failed to ensure the physician's orders to apply the left AFO and bilateral elbow splints to Resident 5's extremities were followed. In addition, Resident 5's skin was not assessed when the left AFO and bilateral elbow splints were applied. This failure had the potential for Resident 5 to sustain a decline in ROM functions, leading to muscle atrophy (loss of muscle mass and strength) and decrease in functioning.Findings: Review of the facility's P&P titled Restorative Nursing Programs dated 12/19/22, showed the restorative care will be provided to help promote optimal safety and independence. The RNA was performed daily to the residents by maintaining a good body alignment and proper positioning. Residents identified during comprehensive assessment process will receive the RNA services including the application of splint or brace assistance. On 7/15/25 at 1007 hours, during the initial tour of the facility, Resident 5 was observed awake in the activity room and had contractures (shortening and hardening of muscles, tendons or other tissues, leading to a deformity) on both the upper and lower extremities. A splint device was applied on both arms. Medical record review for Resident 5 was initiated on 7/16/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's plan of care showed a care plan problem dated 5/29/25, addressing the Restorative Nursing Program for the application of the splint/brace. The interventions included the application of the bilateral elbow splints for two to four hours or as needed and the application of the left AFO. The interventions also included the assessment of the skin before applying and removing the splints. However, there were no interventions included in the care plan to perform Resident 5's skin assessment when the bilateral elbow splints and left AFO were applied to the resident. Review of Resident 5's Documentation Survey Report for June 2025 showed two entries/ times where the RNA documented the application and removal of the left AFO and bilateral elbow splints during the 7 AM-3 PM shift. However, the report only showed one time/ entry was documented for either the application or removal of the left AFO on the following dates: 6/2, 6/16, 6/17, 6/20, 6/21, 6/24, 6/25, 6/26, 6/27, 6/29, and 6/30/25, and for the bilateral splints on the following dates: 6/2, 6/3, 6/16, 6/17, 6/20, and 6/24/25. It was unclear whether the entries on the listed dates were documented for the application or removal of the left AFO and bilateral elbow splints, since the report did not specify. Further review of the report failed to show documented evidence the skin assessment was completed when the left AFO and bilateral elbow splints were applied to Resident 5. Review of Resident 5's Documentation Survey Report for July 2025 showed two entries/ times where the RNA documented the application and removal of the left AFO and bilateral elbow splints during the 7 AM-3 PM shift. However, the report only showed one time/ entry was documented for either the application or removal of the left AFO on the following dates: 7/2-7/4, 7/6-7/9, and 7/11-7/20/25, and for the bilateral splints on the following dates: 7/6, and 7/15-7/20/25. It was unclear whether the entries on the listed dates were documented for the application or removal of the left AFO and bilateral elbow splints, since the report did not specify. Further review of the report failed to show documented evidence the skin assessment was completed when the left AFO and bilateral elbow splints were applied to Resident 5. On 7/21/25 at 1047 hours, an interview and concurrent medical record review for Resident 5 was conducted with RNA 1. RNA 1 verified Resident 5 had RNA services ordered for the application of the left AFO and bilateral elbow splints. RNA 1 was asked what time the left AFO and bilateral elbow splints were applied to Resident 5. RNA 1 reviewed the medical record and verified there was documentation of the time when the left AFO and bilateral elbow splints were applied and removed from Resident 5. However, the record was inaccurate and missing entries. RNA 1 was asked about Resident 5's skin (continued on next page)

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	07/23/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when the left AFO and bilateral elbows were applied. RNA 1 stated the RNAs checked the resident's skin before the application and after the removal from Resident 5. RNA 1 verified and acknowledged there was no documentation about the skin assessment of Resident 5 when the left AFO and bilateral elbow splints were applied. On 7/21/25 at 1503 hours, an interview and concurrent medical record review for Resident 5 was conducted with the RN 2. RN 2 stated the licensed nurses were responsible for the supervision of the RNA during the application of the splints and devices to the residents. RN 2 verified Resident 5's physician's order for the RNA application of the left AFO and bilateral elbow splints. RN 2 verified and acknowledged the missing documentation of the times when the left AFO and bilateral elbow splints were applied and removed from Resident 5 on the above listed dates. In addition, RN 2 verified and acknowledged there was no documentation about the skin assessment of Resident 5 when the left AFO and bilateral elbow splints were applied. On 7/23/25 at 1528 hours, an interview for Resident 5 was conducted with the DON. The DON was informed and verified the above findings.

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	07/23/2025

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 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. **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 prevent an accidents for one of four final sampled residents (Resident 4) reviewed for prevention of accident hazards. The facility failed to implement the floor mats on both sides of Resident 4's bed for safety, in accordance with the physician's order. This failure put the resident at high risk of serious injuries from a fall.Findings: Review of the facility's P&P titled Falls Prevention Program dated 12/19/22, showed the facility's fall prevention on all residents should be assessed for fall risk and receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The fall interventions included to provide additional interventions as directed by the resident's assessment including assistive devices. During the initial tour of the facility on 7/15/25 at 0816 hours, Resident 4 was observed in bed with the bed in lowest position. However, there was no floor mat observed on the side of the resident's bed. Medical record review for Resident 4 was initiated on 7/16/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 2/4/25, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's Fall Risk Evaluation dated 2/17/25, showed Resident 4 was considered to be at risk for falls. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 had moderate cognitive impairment. Review of Resident 4's plan of care showed a care plan problem revised 7/18/25, addressing Resident 4's risk of fall or injury. The interventions included to place bilateral floor mats for safety precaution. Review of Resident 4's Order Summary Report dated 7/23/25, showed a physician's order dated 2/1/24, to place bilateral floor mats for safety precaution every shift. On 7/21/25 at 0935 hours, an observation and concurrent interview for Resident 4 was conducted with CNA 2. CNA 2 stated Resident 4 had weakness on the left side of his body and needed total assist on all ADL care. CNA 2 stated the resident was unable to turn and reposition himself in bed. However, CNA 2 stated the resident was able to grab the side rail when turned to his right side and unable to grab the bar when turning to his left side. When CNA 2 was asked if there were floor mats on both sides of the bed while inside Resident 4's room, CNA 2 verified and acknowledged there were no floor mats at the sides of the bed. On 7/21/25 at 1407 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 was asked about Resident 4's floor mats. RN 2 stated she was made aware by the facility staff about the resident's floor mats and stated the physician should have been made aware to discontinue the order for the floor mats, since the resident was not able to move independently in the bed. RN 2 stated she notified the resident's physician. On 7/23/25 at 1528 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	07/23/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 appropriate care and services to prevent UTIs for three of three final sampled residents (Residents 12, 63, and 89) reviewed for the use of indwelling urinary catheter (thin, flexible tube inserted into the bladder through the urethra to drain urine). * The facility failed to ensure the urinary catheter tubing was not touching the floor for Residents 12 and 63. * The facility failed to ensure indwelling urinary catheter care was provided as per the care plan to Resident 89. These failures had the potential for the residents to develop UTIs.Findings: 1. Review of the Centers for Disease Control and Prevention's article (undated) titled Catheter-Associated Urinary Tract Infection (CAUTI) showed a UTI is an infection in the urinary tract system (including the bladder and the kidneys). Germs can travel along the catheter, and if they enter the urinary tract, may cause an infection in the bladder or kidneys. Prevention of the CAUTIs include proper catheter insertion techniques, regular monitoring, and prompt removal of the catheter when no longer needed. Review of the facility’s P&P titled Catheter Care dated 12/19/22, showed it was the policy of the facility to ensure that the residents with indwelling catheter receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Further review of the P&P showed catheter care will be performed every shift and as needed by nursing personnel. On 7/15/25 at 1436 hours, Resident 89 was observed lying on her bed, and the indwelling urinary catheter was observed hanging on the right lower side of her bed. Review of Resident 89’s plan of care dated 3/4/25, showed a care plan problem addressing the resident's use of an indwelling urinary catheter. The goal showed the resident would not show signs and symptoms of urinary tract infection, and the interventions included to provide a Foley catheter (a type of an indwelling catheter) care as ordered. Review of Resident 89’s Order Summary Report showed a physician's order dated 3/19/25, for indwelling urinary catheter sized FR 16, balloon sized 10 cc, as needed for neurogenic bladder (medical condition where nerve damage affects the bladder's ability to store and release urine), change for blockage, leaking, pulled out, excessive sedimentation, and change the urinary catheter drainage bag as needed and with every change of the indwelling urinary catheter. Further review of the physician's orders did not show the order for urinary catheter care. Review of Resident 89's MDS assessment dated [DATE], showed Resident 89 had a memory problem and severely impaired cognitive skills for daily decision making. Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was admitted to the facility on [DATE], and readmitted on [DATE], with an indwelling urinary catheter. Review of Resident 89’s admission Record dated 7/16/25, showed Resident 89 had a history of UTI. (continued on next page)

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	07/23/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/25 at 1435 hours, an observation, interview, and concurrent medical record review for Resident 89 was conducted with RN 1. RN 1 stated the facility provided urinary catheter care to the residents who had indwelling urinary catheter to prevent UTI. RN 1 stated the indwelling urinary catheter care required a physician's order, and the licensed nurses provided the urinary catheter care to the residents. RN 1 verified Resident 89 had the indwelling urinary catheter. RN 1 verified the resident's plan of care showed to provide indwelling urinary catheter care as ordered. However, Resident 89 had no physician's order for the catheter care. RN 1 further stated she was not able to find the documentation to show if the indwelling urinary catheter care was provided to Resident 89. RN 1 stated the physician’s order should have been obtained and the indwelling urinary catheter care should have been provided to Resident 89 as per the care plan. On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings. 2. On 7/15/25 at 1455 hours, during the initial tour of the facility, an observation was conducted for Resident 12. Resident 12 was observed laying on the bed. Resident 12's indwelling urinary catheter drainage bag was observed without sediments. However, Resident 12’s indwelling urinary catheter drainage bag was observed touching the floor. Medical record review for Resident 12 was initiated on 7/15/25. Resident 12 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 12’s MDS assessment dated [DATE], showed the resident had a BIMS score of 7, which indicated severe cognitive impairment. Record Review of Resident 12’s Order Summary Report dated 7/21/25, showed a physician’s order dated 3/3/25, for an indwelling urinary catheter to change for blockage, leaking, pulling out, excessive sedimentation, and to change catheter drainage bag as needed and with every change of indwelling urinary catheter. On 7/15/25 at 1508 hours, an observation of Resident 12’s indwelling urinary catheter drainage bag and concurrent interview was conducted with LVN 9. LVN 9 verified the resident's indwelling urinary catheter drainage bag was touching the floor. LVN 9 stated when Resident 12’s bed was placed in low position, the indwelling urinary catheter drainage bag should be placed inside a basin, to prevent the drainage bag from touching the floor. LVN 9 was observed getting a basin for the indwelling urinary catheter drainage bag. On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings. 3. On 7/15/25 at 1123 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 63. Resident 63 was observed awake in bed. Resident 63's indwelling urinary catheter drainage bag was observed placed on the side of the bed and touching the floor. Medical record review for Resident 63 was initiated on 7/16/25. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report dated 7/17/25, showed a physician's order dated (continued on next page)

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	07/23/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/8/25, for an indwelling urinary catheter to change the catheter drainage bag as needed and with every change of indwelling urinary catheter. On 7/17/2025 at 1048 hours, an observation and concurrent interview for Resident 63 was conducted with LVN 3. LVN 3 was asked about Resident 63's catheter drainage bag and LVN 3 verified Resident 63 had a catheter. LVN 3 was informed about the observation of the resident's indwelling urinary catheter drainage bag touching the floor. LVN 3 verified and acknowledged the resident's indwelling urinary catheter drainage bag was placed at the side of the bed and touching the floor. LVN 3 stated she instructed her CNA to place the indwelling urinary catheter drainage bag in a basin in order for the drainage bag to not directly touch the floor. On 7/17/2025 at 1126 hours, an interview for Resident 63 was conducted with the DON. The DON was informed and verified the above findings.

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility's P&P review, the facility failed to ensure the respiratory care and services were provided for six of nine final sampled residents (Residents 36, 54, 86, 89, 104, and 122) and two nonsampled residents (Residents 69 and 80).* The facility failed to ensure the oxygen was administered as per the physician's order for Resident 89. In addition, there was no documentation for the PRN administration of the oxygen and the reason why the oxygen was administered to Resident 89.* Resident 86 had a physician's order to administer continuous oxygen via a nasal cannula and to titrate the oxygen rate to maintain an oxygen saturation level of 92% or greater. Resident 86 received continuous oxygen therapy at a rate of six liters per minute via nasal cannula for approximately five hours. The facility failed to attempt to titrate the oxygen to a lower rate to maintain Resident 86's oxygen saturation level at 92% or greater. Additionally, the facility had exceeded the maximum rate of oxygen (five liters per minute) allowed to be administered to Resident 86 via nasal cannula, in accordance with the facility's P&P. * The facility failed to ensure Resident 69's oxygen tubing was not touching the floor.* The facility failed to ensure Resident 80's oxygen tubing was dated and labeled.* The facility failed to ensure Resident 104's physician's order for nebulizer breathing treatment was carried out. The breathing treatment was discontinued; however, the nebulizer machine, mask, and tubing were observed at the bedside undated and not placed inside a clear plastic bag when not in use.* The facility failed to ensure Resident 54's BiPAP (Bilevel Positive Airway Pressure, a non-invasive ventilation device that helps individuals with breathing difficulties by delivering pressurized air through a mask or nasal plugs, used to treat sleeping disorder and other respiratory issues where breathing assistance is needed) tubing assembly, water tub and mask were regularly cleaned to prevent the growth of germs as indicated on Resident 54's BiPAP user guide. * The facility failed to follow the physician's order for Residents 36 and 122's oxygen therapy. These failures had the potential for the residents to not receive the appropriate respiratory care and increase risks of the infection.Findings: 1. Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident’s goals and preferences. Oxygen is administered under orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. Further Review of the P&P showed the staff shall notify the physician of any changes in resident condition, including changes in vital signs, oxygen concentration, or evidence of complications associated with the use of oxygen. Types of oxygen delivery systems include nasal cannulas (where oxygen is administered through plastic cannulas in the nostrils). Effective for low oxygen concentrations, less than 40 percent (equivalent to a rate of five liters per minute). On 7/15/25 at 1048 hours, Resident 89 was observed lying in her bed. Resident 89 was observed receiving oxygen via nasal cannula at five liters per minute. On 7/15/25 at 1627 hours, Resident 89 was observed lying in her bed. Resident 89 was observed receiving oxygen via nasal cannula at four liters per minute. On 7/16/25 at 1053 hours, Resident 89 was observed lying in her bed. Resident 89 was observed receiving oxygen at 3.5 liters per minute. Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was admitted to the (continued on next page)

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE], and readmitted on [DATE]. Review of Resident 89’s MDS assessment dated [DATE], showed Resident 89 had a memory problem and severely impaired cognitive skills for daily decision making. Review of Resident 89’s Order Summary Report showed the physician’s order dated 7/16/25, to administer PRN oxygen via nasal cannula at 2-4 liters per minute. May titrate oxygen up to 5 liters per minute to maintain oxygen saturation level greater or equal to 92 % at maximum titration, as needed. Further review of Resident 89's medical record did not show the documented reason why the oxygen was being administered to Resident 89. In addition, Resident 89's medical record did not show the documentation of the oxygen administration. On 7/16/25 at 1104 hours, an observation and concurrent medical record review for Resident 89 was conducted with LVN 2. LVN 2 stated if the resident required the PRN administration of the oxygen, then the reason for PRN administration of the oxygen should be documented; and if the resident's condition required continuous administration of the oxygen, then the physician should be notified and the order for continuous oxygen administration should be obtained. In addition, the PRN administration of the oxygen should be documented and indicate the amount of oxygen being delivered to the resident. LVN 2 verified the above observation and stated Resident 89 had been receiving continuous oxygen administration since she started working at the facility for the last two months. LVN 2 reviewed Resident 89's medical record and stated she was not able to find a documented reason why the oxygen was being administered to Resident 89. LVN 2 reviewed the oxygen saturation levels of Resident 89 for July 2025 and verified there was no documentation of the oxygen saturation levels below 92 %. In addition, LVN 2 verified there was no documentation of the amount of oxygen being administered to Resident 89. On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings. 2. Medical record review for Resident 86 was initiated on 7/15/25. Resident 86 was admitted to the facility on [DATE]. Review of Resident 86’s physician’s order dated 6/18/25, showed an order for the oxygen to be administered at two liters per minute via nasal cannula, may titrate (oxygen rate) to maintain an oxygen saturation greater than or equal to 92 %. Review of Resident 86’s plan of care showed a care plan problem initiated 4/11/24, addressing the resident's oxygen therapy. The care plan showed Resident 86 had impaired gas exchange. On 7/15/25 at 1050 hours, an observation and concurrent interview was conducted with Resident 86. Resident 86 was observed lying in her bed. Resident 86 was observed receiving continuous oxygen therapy via a nasal cannula at a rate of six liters per minute. Resident 86 stated a past COVID-19 infection had caused damage to her lungs, having resulted in her need for oxygen therapy. Resident 86 stated she did not know the rate of the oxygen she was receiving as nursing staff had set the rate. On 7/15/25 at 1554 hours, an observation, interview, and concurrent medical record review was conducted with LVN 12. Resident 86 was observed lying in her bed. Resident 86 was observed receiving continuous oxygen via a nasal cannula at a rate of six liters per minute. LVN 12 was asked (continued on next page)

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the maximum rate of oxygen that she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation level greater than or equal to 92 %, in accordance with the physician’s order. LVN 12 stated she was uncertain, as the order failed to specify a maximum rate of oxygen. LVN 12 obtained Resident 86’s oxygen saturation level (while receiving six liters of oxygen) which yielded a result of 97 %. LVN 12 then stated she would consult with Resident 86’s RN (RN 5). On 7/15/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with RN 5. RN 5 verified Resident 86’s medical record failed to show documentation specific to the rate of oxygen Resident 86 was receiving. RN 5 was informed Resident 86 had received continuous oxygen therapy via a nasal cannula at a rate of six liters per minute, from 1050 hours to 1604 hours. RN 5 reviewed and verified Resident 86’s medical record showed documentation that Resident 86’s oxygen saturation level was 98 % (on 7/15/25 at 0908 hours) and 97 % (on 7/15/25 at 1557 hours). RN 5 was asked the maximum rate of oxygen she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation level greater than or equal to 92 %, in accordance with the physician’s order. RN 5 stated in accordance with facility’s P&P for oxygen administration, Resident 86 could receive oxygen a maximum rate of five liters per minute via nasal cannula. RN 5 stated the oxygen administered at a rate greater than five liters per minute would be administered via an oxygen mask, to ensure optimal oxygen absorption. RN 5 stated the nursing staff should have attempted to titrate Resident 86’s oxygen to the lowest rate possible between 1050 and 1604 hours, while maintaining Residents 86’s oxygen saturation level at 92 % or greater. RN 5 stated Resident 86’s physician should have been informed if Resident 86 required continuous oxygen at a rate of six liters per minute via nasal cannula, to maintain an oxygen saturation level of 92 % or greater. RN 5 stated she would inform Resident 86’s physician and seek clarification specific to Resident 86’s oxygen therapy order. Cross reference to F656. 3. On 7/15/25 at 0804 hours and 7/17/25 at 1031 hours, Resident 69 was observed in bed with the oxygen at two liters per minute via nasal cannula. Resident 69's oxygen tubing was observed touching the floor. Medical record review for Resident 69 was initiated on 7/16/25. Resident 69 was admitted to the facility on [DATE]. Reviewed of Resident 69's Order Summary Report dated 7/17/25, showed a physician's order dated 7/16/25, to administer oxygen via nasal cannula at 2 to 4 liters per minute. On 7/17/25 at 1031 hours, an observation and concurrent interview for Resident 69 was conducted with LVN 4. LVN 4 verified Resident 69's oxygen tubing was touching the floor. LVN 4 stated the oxygen tubing should not be touching the floor. On 7/17/25 at 1101 hours, an interview for Resident 69 was conducted with the DON. The DON was informed and verified the findings. 4. On 7/15/25 at 0911 hours, during the initial tour of the facility, Resident 80 was observed in bed awake. Resident 80 was observed with oxygen at three liters per minute via nasal cannula and the oxygen tubing was unlabeled and undated. Medical record review for Resident 80 was initiated on 7/16/25. Resident 80 was admitted to the (continued on next page)

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE]. Review of Resident 80's Order Summary Report dated 7/17/25, showed a physician's order dated 7/16/25, to administer oxygen via nasal cannula at 2 to 5 liters per minute. ON 7/17/25 at 1045 hours, an observation and concurrent interview for Resident 80 was conducted with LVN 3. LVN 3 was asked about Resident 80's use of the oxygen via nasal cannula. LVN 3 verified and acknowledged the oxygen tubing was unlabeled and undated. LVN 3 stated the night shift nurse changed the oxygen tubing once a week every Sunday and usually labeled and dated the oxygen tubing. On 7/17/25 at 1112 hours, an interview for Resident 80 was conducted with the DON. The DON was informed and verified the findings. 5. On 7/15/25 at 1006 hours, during the initial tour of the facility, Resident 104 stated she was using the nebulizer machine at beside when she needed it due to her breathing problem. Resident 104's nebulizer mask was observed on top of the nebulizer machine undated. Medical record review for Resident 104 was initiated on 7/17/25. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's physician's order dated 3/24/24, to administer ipratropium-albuterol solution (inhaler medication) 0.5 to 2.5 mg/3 ml via inhalation orally every six hours for shortness of breath for 14 days. However, the physician's order for breathing treatment was discontinued 4/1/25. On 7/21/25 at 1330 hours, an interview and concurrent medical record review for Resident 104 was conducted with LVN 5. When LVN 5 was asked about Resident 104's breathing treatment, LVN 5 verified Resident 104 was receiving a breathing treatment. LVN 5 then accessed the resident's electronic medical record when LVN 5 was asked about the medication for the breathing treatment. LVN 5 verified and acknowledged the breathing treatment via nebulizer was discontinued on 4/1/25. LVN 5 verified the nebulizer machine was at the bedside and the nebulizer tubing was placed on top of the nebulizer machine. LVN 5 stated the nebulizer machine should have been removed and cleaned when the physician's order for breathing treatment was discontinued. LVN 5 stated the nebulizer tubing and mask should have been placed on the clear plastic bag when not in use. On 7/23/25 at 1528 hours, an interview for Resident 104 was conducted with the DON. The DON was informed and verified the findings. Cross reference to F657. 6. Review of the BiPAP AirCurve 10 VAUTO S ST user guide manual showed the ResMed AirCurve 10 VAUTO, AirCurve 10 S and AirCurve 10 ST are bilevel positive airway pressure devices. Under the About your device section showed: 1. Air outlet 2. Air filter cover 3. Power inlet 4. Serial number and device number 5. Water tub 6. Screen 7. Adapter cover 8. SD card cover. Setup. Caution. Do not overfill the water tub as water may enter the device and air tubing. 1. Place the device on a stable level surface. 2. Plug the power connector into the rear of the device. Connect one end of the power cord into the power supply unit and the other end into the power outlet. 3. Connect the air tubing firmly to the air outlet located on the rear of the device. 4. Open the water tub and fill it with distilled water up to the maximum water level mark. Do not fill the water tub with hot water. 5. Close the (continued on next page)

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water tub and insert it into the side of the device. 6. Connect the free end of the air tubing firmly onto the assembled mask. Caring for your device. It is important that you regularly clean your AirCurve 10 device to make sure you receive optimal therapy . Regularly clean your tubing assembly, water tub and mask to receive optimal therapy and to prevent growth of germs that can adversely affect your health. The website of ResMed AirCurve 10 VAUTO S ST, www.resmed.com, showed it is generally recommended to clean the BiPAP mask daily to maintain its quality and prevent the growth of germs that could adversely affect your health. Disassemble the mask components and clean them gently with warm water and mild soap each day. Regularly cleaning is vital to ensure effective therapy and comfort during use. On 7/15/25 at 1143 hours, during the initial tour of the facility, Resident 54 was observed with a BiPAP machine, tubing and mask by his bedside table. Resident 54's BiPAP tubing and mask were observed in a clear bag labeled with Resident 53's name and dated with 6/29/25. Medical record review was for Resident 54 was initiated on 7/15/25. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review Resident 54’s Order Summary Report showed a physician’s order dated 5/25/25, for the BiPAP use every evening and night shift monitoring of mask placement. Review of Resident 54's MAR for June 2025 showed the BiPAP was administered from June 1 through June 30 2025. However, there was no specific documentation to show Resident 54's BiPAP machine, tubing, and mask were cleaned. Review of Resident 54's TAR and Respiratory Administration Record (RESP) did not show specific documentation when Resident 54's BiPAP machine, tubing, and mask were cleaned. Review of Resident 54's Respiratory Therapist record log on the SNF BiPAP monthly changes (changes are to be done as needed when soiled or malfunctioning) showed the following: - Circuit (First Monday) showed the dates for 5/29, 6/2, N/A, 7/1/25 and N/A; - Mask (First Monday) showed the dates for 5/29, 6/2, N/A, 7/1/25 and N/A; - Bacterial Filter (First and Third Monday) showed the dates for 5/29, 6/2, 6/16, 7/1, and 7/15/25; and - Air Filter (Six Months) showed the dates for 5/29/25, N/A, N/A, N/A, and N/A. On 7/15/25 at 0922 hours, an observation, interview, and concurrent medical record review on Resident 54 was conducted with LVN 2. LVN 2 was asked who was responsible for checking and cleaning Resident 54's BiPAP machine, tubing, and mask. LVN 2 stated for Resident 54, the Respiratory Therapists were responsible for cleaning and checking Resident 54's BiPAP machine, tubing, and mask. LVN 2 was informed Resident 54's BiPAP tubing and mask were placed in a clear bag dated 6/29/25. LVN 2 checked and verified the BiPAP tubing and mask were stored in a clear bag dated 6/29/25. LVN 2 was also asked if she could show any documentation on the resident's electronic medical record when Resident 54's BiPAP machine, tubing assembly and mask were last cleaned. LVN 2 verified she was not able to find documentation on the resident's electronic medical record, however would reach out to Resident 54's RT if there was a separate record log for the (continued on next page)

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaning. On 7/15/25 at 1202 hours, an observation and a concurrent interview was conducted with RT 1. RT 1 verified Resident 54's BiPAP tubing and mask were stored in a clear bag dated 6/29/25. When RT 1 was asked if he was assigned to Resident 54 and the process on cleaning Resident 54's BiPAP machine, tubing, and mask, RT 1 stated he was assigned to Resident 54 and Resident 54's BiPAP machine, tubing, and mask were cleaned monthly. RT 1 was also asked to provide a copy of Resident 54's ResMED AirCurve 10 VAUTO S ST user guide manual and to show documentation in the resident's electronic medical record when Resident 54's BiPAP machine, tubing, and mask were cleaned. RT 1 stated he would provide a copy of Resident 54's BiPAP user guide manual and show the documentation when Resident 54's BiPAP machine, tubing, and mask were last cleaned. On 7/18/25 at 0912 hours, an interview and a concurrent medical record review was conducted with the RT 1. RT 1 verified Resident 54's MAR for June 2025 showed Resident 54 was administered breathing/ventilation treatment using Resident 54's BiPAP machine, tubing, and mask from June 1 through June 30, for the evening and night shift. RT 1 was asked to show specific documentation showing Resident 54's BiPAP tubing assembly, water tub, and mask were cleaned regularly to receive optimal therapy and prevent the growth of germs as instructed by Resident 54's BiPAP user guide manual. RT 1 showed the SNF BiPAP monthly changes record log; however, there was no specification on when Resident 54's BiPAP tubing assembly, water tub, and mask were cleaned. RT 1 further verified the BiPAP equipment cleaning should have been documented. On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings. 7. On 7/15/25 at 1035 hours, during the initial tour of the facility, Resident 36 was observed lying in bed and receiving oxygen at 3.5 liters per minute via nasal cannula, which was attached to the oxygen machine concentrator. Medical record review for Resident 36 was initiated on 7/15/25. Resident 36 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 36's H&P examination dated 9/3/24, showed Resident 36 had no capacity to understand and make decisions. Review of Resident 36's Order Summary Report for July 2025 showed a physician's order dated 5/30/25, to administer oxygen at two liters per minute via nasal cannula every shift for low oxygen saturation levels. On 7/16/25 at 1614 hours, an observation, interview, and concurrent medical record review was conducted with LVN 7. LVN 7 verified Resident 36's oxygen machine concentrator was set at 3.5 liters per minute and the physician's order for the resident's oxygen was to be administered at two liters per minute every shift. LVN 7 acknowledged the findings and stated the facility staff should follow the physician's order for the oxygen administration for Resident 36. On 7/21/25 at 1554 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed of the above findings and stated the physician’s order for oxygen administration should have been followed. (continued on next page)

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	07/23/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. On 7/15/25 at 1513 hours, during the initial tour of the facility, Resident 122 was observed lying in bed and asleep with eyes closed. There was no oxygen signage nor oxygen concentrator in the resident's room. Medical record review for Resident 122 was initiated on 7/16/25. Resident 122 was admitted to the facility on [DATE]. Review of Resident 122's H&P examination dated 5/2/25, showed Resident 122 had the capacity to understand and make decisions. Review of Resident 122's Order Summary Report for July 2025 showed a physician's order dated 4/30/25, to administer oxygen at 2-3 liters per minute via nasal cannula, may titrate oxygen to maintain oxygen saturation levels greater than or equal to 91% every shift. On 7/16/25 at 1600 hours, an observation and concurrent interview was conducted with Resident 122. Resident 122 stated she had not used oxygen for awhile in the past two to three months. On 7/16/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with LVN 15. LVN 15 verified Resident 122 had a physician's order for oxygen to be administered at 2-3 liters per minute every shift and was discontinued on 7/16/25 at 1124 hours. On 7/22/25 at 1526 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed of the above findings and acknowledged the physician's order for oxygen was to administered 2-3 liters per minute every shift for Resident 122. The ADON stated the physician’s order for continuous oxygen administration should have been followed or discontinued when oxygen was not used.

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	07/23/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 dialysis care was provided for one of 35 final sampled residents (Resident 9).* The facility failed to assess Resident 9's dialysis access site (AV shunt) for a bruit and thrill every shift in accordance with the facility's P&P. This failure had the potential for the facility staff failing to identify impaired functionality of Resident 9's AV shunt, and posed the risk for negative health outcomes in the event Resident 9's dialysis access site was to become inoperable. Findings: Review of the facility's P&P titled hemodialysis revised 6/5/23, showed the nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist. Medical record review for Resident 9 was initiated on 7/15/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's physician's order dated 12/23/24, showed an order for hemodialysis on Tuesday, Thursday, and Saturday. Further review of Resident 9's medical record failed to show documentation Resident 9's dialysis access site was assessed every shift during the month of June 2025 and from 7/1 through 7/17/25. On 7/23/25 at 1024 hours, an interview was conducted with LVN 8. LVN 8 stated Resident 9 had hemodialysis on Tuesday, Thursday, and Saturdays. LVN 8 stated Resident 9's dialysis access site consisted of a left upper arm AV shunt. LVN 8 was asked about the facility's process for assessing Resident 9's dialysis access site. LVN 8 stated on Resident 9's dialysis days, the facility nursing staff would assess Resident 9's dialysis site for a bruit and thrill and document the assessment on the facility's Dialysis Communication Form. On 7/23/25 at 1106 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated in accordance with the facility's P&P, Resident 9's dialysis access site should have been assessed for the bruit and thrill every shift to ensure functionality, rather than only being assessed on dialysis days. The DON verified Resident 9's medical record failed to show documentation Resident 9's dialysis access site was assessed every shift during the month of June 2025 and from 7/1 through 7/17/25.

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	07/23/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmacy services in accordance with the physician's orders and the facility's P&P for one of six residents (Resident 9) reviewed for unnecessary medications and three of four medication carts observed.* The facility failed to ensure Resident 9's scheduled morning medications were administered after Resident 9 had returned to the facility from his dialysis appointment.* The facility failed to ensure the narcotic log sheets were signed by the licensed nurses during the controlled medication reconciliation for Medication Carts A, B, and C.These failures had the potential for negative health outcomes and posed the risk for diversion of controlled medications.Findings: Review of the facility’s P&P titled Medication Administration revised 12/19/22, showed the medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as order by the physician and in accordance with professional standards of practice. Administer medications within 60 minutes prior or after scheduled time unless otherwise ordered by the physician. 1. Medical record review for Resident 9 was initiated on 7/15/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9’s physician’s order dated 12/23/24, showed an order for hemodialysis on Tuesday, Thursday, and Saturday. Review of Resident 9’s Order Summary Report dated 7/23/25, showed the following medications were ordered to be administered on 7/8/25 at 0900 hours: - calcium acetate (phosphate binder medication) 667 mg orally for end stage renal disease; - docusate sodium (stool softener) 100 mg orally for bowel management; - Eliquis (anticoagulant medication) 2.5 mg orally for DVT prophylaxis; - escitalopram oxalate (antidepressant medication) 20 mg orally for depression; - gabapentin (neuropathic pain medication) 300 mg orally for neuropathy; - glipizide (diabetes medication) 5 mg orally for diabetes mellitus; - [NAME]-Vite (B-complex vitamin & folic acid) one tablet orally for supplement; and - sevelamer (phosphate binder medication) 800 mg orally for hyperphosphatemia. Review of Resident 9’s MAR dated July 2025 showed documentation the above listed medications were not administered on 7/8/25 at 0900 hours, in accordance with the physician’s order and the facility’s P&P. (continued on next page)

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	07/23/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9’s Dialysis Communication Form dated 7/8/25, showed Resident 9 had returned to the facility from his dialysis appointment on 7/8/25 at 0940 hours. On 7/23/25 at 1024 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 reviewed Resident 9’s Dialysis Communication Form dated 7/8/25, and verified Resident 9 returned to the facility from his dialysis appointment on 7/8/25 at 0940 hours. LVN 8 then reviewed Resident 9’s MAR dated 7/8/25, and verified the documentation which showed the above listed medications were not administered on 7/8/25 at 0900 hours, as ordered by Resident 9’s physician. LVN 8 stated in accordance with the facility’s P&P for medication administration, when Resident 9 returned to the facility from his dialysis appointment on 7/8/25 at 0940 hours, Resident 9’s scheduled 0900 hours medications should have been administered as ordered by the physician. 2.a. Review of the facility’s P&P titled Controlled Substance Administration & Accountability revised 6/5/23, showed it is the policy of this facility to promote safe, high-quality care, compliant with state and federal regulations regarding monitoring the use of controlled substance. This facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Under Policy Explanation and Compliance Guidelines, for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. Review of Medication Cart C’s Narcotic Logbook showed multiple missing licensed nurses’ signatures on the following days and shifts: - for the outgoing licensed nurse on 6/12/25, for the 7 am - 7 pm shift; - for the outgoing licensed nurse on 6/17/25, for the 7 am - 7 pm shift; and - for the outgoing and incoming licensed nurses on 7/11/25, for the 7 am - 7 pm shift. On 7/17/25 at 0915 hours, an interview and concurrent facility document review was conducted with RN 4. RN 4 verified multiple licensed nurses’ signatures were missing in the Narcotic Logbook. RN 4 stated the licensed nurses must make sure the logbooks were signed by two licensed nurses during the outgoing and incoming shifts, to ensure the narcotic medications were accounted for the day. b. Review of Medication Cart A’s Narcotic Logbook showed multiple missing licensed nurses’ signatures on the following days and shifts: - for the incoming licensed nurse on 6/15/25, for the 11-7 shift; - for the incoming licensed nurse on 6/27/25, for the 3-11 shift; - for the outgoing licensed nurse on 6/27/25, for the 11-7 shift; and - for the outgoing licensed nurse on 6/30/25, for the 7-3 shift. On 7/17/25 at 1025 hours, an interview and concurrent facility document review was conducted with LVN 10. LVN 10 verified the missing licensed nurses’ signatures on the above dates and shifts on the Narcotic Logbook. (continued on next page)

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	07/23/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of Medication Cart B’s Narcotic Logbook showed multiple missing licensed nurses’ signatures on the following days and shifts: - for the incoming licensed nurse on 4/29/25, for the 7-3 shift; and - for the outgoing licensed nurse on 4/29/25, for the 3-11 shift. On 7/17/25 at 1042 hours, an interview and concurrent facility document review was conducted with LVN 8. LVN 8 verified the missing licensed nurses’ signatures on the Narcotic Logbook. On 7/23/25 at 1125 hours, an interview and concurrent facility document review was conducted with DON. The DON verified the above findings. The DON stated the licensed nurses should have signed the Narcotic Logbook to ensure the controlled medications were accounted for when they came and/or left work.

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	07/23/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and labeling of the residents' medications, for one of four medication rooms, two of eight medication carts, and one of 35 final sampled residents (Resident 1) and one nonsampled resident (Resident 171).* Resident 171's olanzapine (antipsychotic medication) medication bottle was labeled with the incorrect administration time. * The physician's order for ferrous sulfate liquid and the ferrous sulfate liquid supplement medication bottle label failed to show the prescribed dose to be administered to Resident 171.* The facility failed to ensure the orally administered medications were kept separate from externally used medications, e.g., eye drops and suppositories (medication given, inserted rectally or vaginally). * The facility failed to ensure the opened insulin (medication to lower down blood sugar level) pen or vial labeled with an open date more than 28 days was immediately removed from the medication cart. * One opened bottle of Remedy Anti-fungal Powder (used to treat common fungal infections) was observed on Resident 1's bedside table. However, Resident 1 did not have a physician's order for the Remedy Anti-fungal Powder. These failures had the potential to result in medication administration errors, potential for medication to lose stability and effectiveness, and had the potential to negatively impact the residents' well-being. Findings: Review of the facility’s P&P titled Labeling of Medications and Biologicals revised 12/19/22, showed all the medications used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. 1. Medical record review for Resident 171 was initiated on 7/15/25. Resident 171 was admitted to the facility on [DATE]. Review of Resident 171’s physician’s order dated 7/10/25, showed to administer olanzapine zydis 5 mg orally at noon for psychosis manifested by auditory hallucinations, aggressive behavior, and pulling on the GT. On 7/21/25 at 1030 hours, an inspection of Medication Cart D was conducted with LVN 8. Medication Cart D contained Resident 171’s olanzapine medication. The label affixed to Resident 171’s medication bottle, which contained Resident 171’s olanzapine zydis 5 mg tablets, showed to give one tablet by mouth in the morning (however, the physician’s order showed to administer at noon) for psychosis manifested by auditory hallucinations, aggressive behavior, and pulling on the GT. LVN 8 verified the label was inaccurate as Resident 171’s physician ordered the olanzapine zydis 5 mg tablet to be administered at noon. 2. Review of Resident 171’s physician’s order dated 4/3/25, showed to administer ferrous sulfate liquid solution 220 mg/5 ml, give 7.5 ml via GT one time a day for supplement. On 7/21/25 at 0839 hours, a medication administration observation, interview, and concurrent medical record review was conducted with LVN 8. LVN 8 was observed preparing and administering Resident 171’s prescribed morning medications. LVN 8 prepared and administered Resident 171’s ferrous sulfate liquid solution. LVN 8 was asked the dose of the ferrous sulfate liquid solution she administered to Resident 171. LVN 8 stated she administered 7.5 ml. However, LVN 8 was unable to (continued on next page)

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	07/23/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	state the total dose (in mg) she administered to Resident 171. LVN 8 then verified Resident 171’s physician’s order for ferrous sulfate liquid solution and the ferrous sulfate supplement bottle label failed to show the prescribed total dose to be administered to Resident 171. 3. Review of the facility’s P&P titled Medication Storage, revised date 12/19/22, showed in part, it is the policy of this facility to ensure all the medications housed in our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer’s recommendations and sufficient to ensure proper sanitation, temperature, light ventilation, moisture control, segregation, and security. Under Policy Explanation and Compliance Guidelines, Internal products: Medications to be administered by mouth are stored separately from other formulations (i.e., eye drops, ear drops injectables). External Products: disinfectants and drugs for external use are stored separately from internal and injectable medications. On 7/16/25 at 1520 hours, an inspection of Medication Room A and concurrent interview was conducted with LVN 7. The following was observed stored together on the upper shelf attached to the wall: - four boxes of Pure Gentle Enema Saline Laxative; - two boxes of hemorrhoidal suppositories; - one box of Stye sterile lubricant eye ointment; and - multiple bottles of oral/ tablet medications. LVN 7 verified the above findings. On 7/16/24 at 1555 hours, an observation and concurrent interview was conducted with DON. The DON verified the three different routes of medications were stored together in one shelf. The DON stated the medications should be separated by compartments. 4. Review of the facility’s P&P titled Labeling of Medications and Biologicals revised 12/19/22, showed in part, all the medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Biologicals are made from a variety of natural sources and are used to treat, prevent, and diagnose diseases and medical conditions. They may include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues and recombinant therapeutic proteins. Labels for multi-use vials must include all opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. On 7/17/25 at 0915 hours, an inspection of Medication Cart C and concurrent interview was conducted with RN 4. The following was observed: - one opened vial of lispro Insulin 100 u/ml (type of insulin injected to lower the blood sugar level) labeled with an opened date of 6/18/25, which is more than 28 days, per facility's P&P. RN 4 verified the finding and stated the insulin should have been discarded on 7/16/25, and a new vial should have been ordered. (continued on next page)

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	07/23/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the facility’s P&P titled Medication Storage, revised 12/19/22, showed all drugs and biologicals will be stored in locked compartments (such as medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Medical record review for Resident 1 was initiated on 7/15/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 6/30/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1’s Order Summary Report on 7/15/25, showed no documented evidence the resident had a physician's order for the Remedy Anti-fungal Powder medication. On 7/15/25 at 1147 hours, an observation and concurrent interview was conducted with Resident 1 inside the resident’s room. One opened bottle of Remedy Anti-fungal Powder was observed on Resident 1’s bedside table. When Resident 1 was asked if the nursing staff applied the powder on her, Resident 1 verified the nursing staff had applied the antifungal powder before. Resident 1 stated the antifungal powder was applied on her under breasts and abdomen. On 7/15/25 at 1201 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1 inside Resident 1’s room. LVN 1 verified the above findings. LVN 1 verified the bottle of Remedy Anti-fungal Powder was opened. LVN 1 also verified there was no physician's order for the antifungal powder. LVN 1 stated the medications needed a physician’s order prior to administering the medication and the nursing staff would contact the physician for an order. On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated the antifungal powder was considered a medication and should have a physician’s order. The DON stated the nursing staff obtained a physician’s order and the resident now had orders for the antifungal powder. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.

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	07/23/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one sampled resident (Resident 93) received the appropriate consistent carbohydrate diet as ordered by the physician. This failure had the potential to cause elevation of the resident's blood sugar. Findings:On 7/15/25 at 1201 hours, Resident 93 was observed eating lunch in the first floor dining room. Review of Resident 93's meal ticket (used to identify the resident's diet and food preferences for meal service) showed Resident 93 required a consistent carbohydrate diet with no added salt (a diet intended to reduce blood sugar variations). Resident 93 had a blueberry streusel dessert on her meal tray.Review of the facility menu spreadsheet dated 7/15/25, showed the desert for the consistent carbohydrate diet for lunch was two pear halves, not blueberry streusel dessert.On 7/15/25 at 1201 hours, a concurrent interview and observation was conducted with LVN 6 who was in the dining room. LVN 6 verified Resident 93 was supposed to receive a consistent carbohydrate diet from her meal ticket. LVN 6 verified the dessert served to Resident 93 was the blueberry streusel. LVN 6 stated he was only comparing the meal tray ticket to the diet list and did not have the menu spreadsheet to determine if the food items served were the correct ones.Medical record review for Resident 93 was initiated on 7/15/25. Resident 93 was admitted to the facility on [DATE]. Review of the Physician Order Report showed a physician's order dated 5/13/25, to provide Resident 93 with a consistent carbohydrate diet with no added salt.On 7/15/25 at 1430 hours, an interview and concurrent medical record review was conducted with the DSS. The DSS verified the above findings and stated Resident 93 required a consistent carbohydrate diet and should have received two pear halves for dessert.

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	07/23/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure sanitary requirements were met in the kitchen as evidenced by: 1. Two of three ice scoop holders were not clean and one of three ice scoop holders contained standing water. 2. The plate cover rack was not clean. 3. More than ten plate covers did not have a smooth and cleanable surface. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population of 145 who consumed food prepared in the kitchen and ice from the ice machines. Findings:Review of the facility document titled Diet Count by Diet report dated 7/15/25 showed, 145 of 180 residents in the facility received food prepared in the kitchen. 1. Review of the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. On 7/15/25 at 1056 hours, a concurrent interview and observation of the ice machine scoop holders located in the first floor ice machine room was conducted with the Maintenance Director. Three ice scoop holders were observed to be visibly soiled, and the standing water was observed inside one of the scoop holders. The Maintenance Director verified the findings and stated the housekeeping staff was responsible to clean the ice scoop holders. On 7/15/25 at 1120 hours, a concurrent interview and observation of the ice machine scoop holders located in the second floor ice machine room was conducted with the Maintenance Director. The inside of ice scoop holders were visibly soiled and had a pink residue. The Maintenance Director verified the ice scoop holders were not clean. On 7/17/25 at 0928 hours, a concurrent interview and review of the ice scoop holder photographs was conducted with the Housekeeping Director. The Housekeeping Director stated the ice scoop holders were cleaned daily with soap and water. When shown photographs of the visibly soiled ice scoop holders with standing water, the Housekeeping Director verified the ice scoop holders were not clean and they must be free of standing water. 2. According to the USDA Food Code 2022 Section 4-101.19 Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling or that require frequent cleaning shall be constructed of a corrosion-resistant, nonabsorbent, smooth material. On 7/15/25 at 0845 hours, a concurrent interview and kitchen observation was conducted with the Assistant DSS. More than 20 plate covers were observed to be visibly worn and frayed. The Assistant DSS verified the meal tray covers were visibly worn and frayed. 3. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. On 7/15/25 at 0845 hours, a concurrent interview and kitchen observation was conducted with the assistant DSS. The plate cover rack was observed to be visibly soiled with a sticky residue. The Assistant DSS verified the visibly soiled, sticky residue on the plate cover rack. The Assistant DSS stated the plate cover racks must be cleaned and sanitized and further verified that the meal tray covers must have a smooth, cleanable surface.

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	07/23/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to implement a safe food handling policy to ensure outside foods brought into the facility for residents by visitors were properly prepared and stored for safe consumption. * The facility failed to ensure the residents' foods inside Refrigerator A were labeled with the residents' names. * The facility failed to provide specific documentation on Resident 49's care plan addressing the problem of risk on storage of food in Resident 49's restroom bathtub. * The facility failed to ensure the facility's P&P for the use and storage of foods brought in by the family or visitors included any food safety related concerns such as time and temperature control and safe food handling and preparation. These failures had the potential to result in foodborne illnesses in a highly susceptible resident population.Findings: 1. On 7/15/25 at 1021 hours, an observation and concurrent interview was conducted with the IP. An observation was conducted of the residents’ refrigerator (Refrigerator A). Four Tai [NAME] shrimp fried rice packages were observed inside of Refrigerator A. The shrimp fried rice packages were labeled with a room number; however, the packages were not labeled with the resident's name. Additionally, a four-ounce container of chocolate chip ice cream was observed inside of a plastic bag inside of Refrigerator A. The ice cream container was labeled with a room number; however, the container was not labeled with the resident's name. The ice cream was leaking from the top of the container and into the plastic bag. The IP verified the above findings and stated the resident food items needed to be labeled with the residents’ name, to identify whom the items belonged to. The IP stated labeling food items with only a room number was insufficient, as residents may change rooms within the facility. The IP stated the ice cream needed to be discarded as it was leaking and touching the inside of the plastic bag in which it was stored. The IP stated the ice cream should not be served to the residents for infection control. 2. Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 8/5/24, showed it is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. All food items brought in that are manufactured and does not require refrigeration, may be kept in the resident room inside a lock tight container that is provided by the resident. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative. If any part of this policy is not followed, the facility reserves the right to protect others by not allowing food items to be brought into the facility for a resident. The facility staff will assist the residents in accessing and consuming food that is brought in by resident and family or visitors if the resident is not able to do so on their own. On 7/15/25 at 1055 hours, during the initial tour of the facility, an observation was conducted inside Residents 49 and 146's shared restroom. The bathtub inside Residents 49 and 146's restroom was observed with seven boxes of [NAME] Berry Farm raspberry and strawberry cookies. Medical record review for Resident 49 was initiated on 7/15/25. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Record Review of Resident 49's MDS assessment dated [DATE], showed Resident 49 had a BIMS score of 13, indicating intact cognition. (continued on next page)

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	07/23/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 49's progress notes and plan of care did not show specific documentation that education was provided to Resident 49 regarding the risk of storing food items in a shared restroom’s bathtub. Medical record review for Resident 146 was initiated on 7/15/25. Resident 146 was admitted on [DATE] Review of Resident's 146's MDS assessment dated [DATE], showed Resident 146 had a BIMS score of 13, indicating intact cognition. On 7/21/25 at 0941 hours, a follow up observation of Residents 49 and 146's shared restroom and concurrent interview was conducted with Residents 49 and 146. Seven boxes of [NAME] Berry Farm raspberry and strawberry cookies and boxes of chicken noodles were observed in the shared restroom's bathtub. Resident 49 was asked if all the food items in the bathtub belonged to him. Resident 49 stated he stored all his food items in the bathtub. When Resident 49 was asked if the facility staff provided him education regarding safe food handling and storage, Resident 49 refused to answer. On 7/21/25 at 1332 hours, an observation, interview and concurrent medical record review was conducted with the RN 2. RN 2 was informed of the observation regarding Resident 49's food items stored in the shared resident restroom's bathtub. RN 2 was asked if Resident 146 was using the restroom. RN 2 stated Resident 146 was not using the restroom, however, the shared restroom was also used for washing the washcloths used for Resident 146's personal hygiene. RN 2 was observed checking Residents 49 and 146's shared restroom and verified Resident 49's food items in the bathtub. RN 2 verified there was no documentation to show Resident 49 was provided education regarding safe food handling and storage of food items, and the risk when storing food items in the restroom. On 7/21/25 at 1341 hours, an interview and concurrent medical record review was conducted with Social Services Assistant 2. Social Services Assistant 2 was informed of the above findings. Social Services Assistant 2 stated Resident 49 had hoarding tendencies and noticed the resident's food items in the resident's room and in the shower. Social Services Assistant 2 stated she spoke with Resident 49 on 7/17/25, to clean all the food excess but Resident 49 declined. When Social Services Assistant 2 was asked to show documentation Resident 49 was provided with education about the risk of storing food in the restroom's bath tub, Social Services Assistant 2 verified there was no documentation. On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the findings. 3. Review of the facility's P&P titled Use and Storage of Food Brought In By Family and Visitors revised 8/5/24, showed all the food brought in by visitors should be checked by nursing to ensure compatibility with the resident’s diet. However, there P&P did not address any food safety related concerns such as time and temperature control and safe food handling and preparation. On 7/17/25 at 0959 hours, an interview and concurrent facility's document review was conducted with the IP. The IP verified the facility's outside food policy did not address for safe food handling, preparation, and time and temperature controls. (continued on next page)

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	07/23/2025

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/25 at 1113 hours, an interview and concurrent facility's document review was conducted with the admission Director. When the admission Director was asked to review the facility's outside food policy, the admission Director verified there was no mention in the facility’s outside food policy of safe food handling, preparation, storage, and appropriate time and temperature controls.

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	07/23/2025

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment;2. A plan to maximize recruitment and retention of direct care staff; and3. A contingency plan for staffing needs.This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings:According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan.Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 7/23/25 at 1443 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment was dated 5/14/25, and verified there were no direct care staff, direct care representatives, residents, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were plan to maximize recruitment and retention of the direct care staff or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.

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	07/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections.* The facility failed to ensure the soiled laundry was not stored in the clean laundry area.* The facility failed to ensure the facility staff performed hand hygiene before and after wearing gloves during the wound treatment observation for one nonsampled resident (Resident 120).* The facility failed to ensure the appropriate transmission-based precaution door signage was placed for one final sampled resident (Resident 162).These failures had the potential for cross-contamination and spread of infectious organisms in the facility. Findings:1. Review of the facility’s P&P titled Handling Soiled Linen dated 12/19/22, showed it is the policy of the facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Further review of the P&P showed used or soiled linen shall be collected at the bedside (or point of use such as dining room) and placed in a linen bag or designated linen receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Further review of the P&P showed soiled linen shall be kept separate from the clean linen. On 7/18/25 at 1029 hours, an observation of the laundry area and concurrent interview was conducted with the House Keeping Supervisor and DSD Assistant. Two soiled laundry bin, one with soiled mops and the other one with soiled towels were observed uncovered in the clean laundry area. The House Keeping Supervisor verified the observation and stated the two soiled laundry bin should not have been stored in the clean laundry area. The House Keeping Supervisor was observed taking soiled laundry bin out of the clean linen area. 2. Review of the facility’s P&P titled Hand Hygiene revised 12/19/22, showed all the staff will perform proper hand hygiene procedures to prevent the spread of the infection to other personnel, residents and visitors. Further review of the P&P showed the use of the gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Under the section Hand Hygiene Table showed to perform hand hygiene with either soap and water or alcohol-based hand rub, before applying and after removing personal protective equipment (PPE), including gloves. Medical record review for Resident 120 was initiated on 7/18/25. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120’s Order summary Report showed a physician’s order dated 7/8/25, to cleanse the coccyx (tailbone) pressure injury with normal saline, pat dry, apply xeroform (non adhering dressing), apply zinc (used to treat or prevent skin irritation like cuts, burns or diaper rash), and cover with a silicone dressing daily and as needed for soilage every day shift for wound management. On 7/18/25 at 0918 hours, a wound care observation for Resident 120 was conducted with LVN 11. Resident 120 was observed being awake in bed. LVN 11 was observed performing hand hygiene and wearing a gown and a clean pair of gloves. LVN 11 began by cleaning Resident 120’s wound on the coccyx area with normal saline. LVN 11 then changed to a clean pair of gloves without performing hand hygiene and proceeded to pat the wound dry. Subsequently, LVN 11 changed to a second clean pair of gloves, again without performing hand hygiene, and applied the xeroform to the wound. LVN 11 (continued on next page)

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	07/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then donned a third clean pair of gloves, still without performing hand hygiene, and applied the zinc ointment to the wound. Lastly, LVN 11 changed into a fourth pair of gloves, once more without performing hand hygiene, and applied the silicone dressing. On 7/18/25 at 0935 hours, an interview was conducted with LVN 11. LVN 11 was informed and verified of the above observation. LVN 11 stated she should have performed hand hygiene before donning each pair of clean gloves. On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings. 3. Review of the facility’s P&P titled Infection Prevention and Control Program revised 12/19/22, showed in part, this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Residents, family members , and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. Isolation signs are used to alert staff, family members, and visitors of transmission-based precautions. Medical record review for Resident 162 was initiated on 7/15/25. Resident 162 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 162's physician's orders showed the following orders: - dated 6/26/25, for ID consult (Infectious Disease doctor) due to Multidrug Resistant Infection; and - dated 7/14/25, to administer Zyvox (antibiotic) 800 mg on tablet by mouth two times a day for UTI for seven days, and Bactrim DS (antibiotic) 800-160 mg one tablet by mouth two times a day for seven days for infection. On 7/15/25 at 1515 hours, an observation, interview, and concurrent medical record review was conducted with LVN 9 for Resident 162. Resident 162's room door was closed. There was an EBP signage posted on the entrance door. Review of Resident 162’s physician's order dated 7/11/25, showed an order for contact isolation: MDRO urine. LVN 9 verified the resident had an order for contact isolation and should have a contact isolation signage on the door instead of the EBP signage. LVN 9 was observed changing the door signage to a contact isolation and removed the EBP signage. On 7/15/25 at 1555 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	07/23/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and facility P&P review, the facility failed to accurately monitor and address the use of the antibiotics when the resident's condition did not meet the McGeer's criteria (a set of criteria used in long term care facilities to identify if residents' symptoms meet the criteria of a true infection) or Loeb minimum criteria (a set of minimum clinical criteria used to guide the initiation of antibiotic therapy for suspected infections in residents of long term care facilities) for one of five final sampled residents (Resident 89) reviewed for antibiotic stewardship. This failure had the potential risk for continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics and the development of antibiotic resistant bacteria. Findings: Review of the facility's P&P titled Antibiotic Stewardship Program revised 12/19/22, showed it is the policy of the facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The program included antibiotic use protocols as a system to monitor antibiotic use.the facility uses the (CDC's NHSN Surveillance Definition, updated Mcgeer's criteria, or other surveillance tool) to define infection. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. Review of the facility's document titled Infection Surveillance Monthly Report for June 2025 showed Resident 89 was admitted to the facility on [DATE]. Resident 89 had a productive cough with purulent sputum, and fever on 6/28/25. Resident 89 was prescribed Zithromax (antibiotic) 250 mg oral tablet. Further review of the Infection Surveillance Monthly Report did not show if the above symptoms met the McGeer's criteria for true infection or Loeb's minimum criteria to treat the infection with antibiotics. Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was readmitted to the facility on [DATE]. Review of Resident 89's Infection Screening Evaluation dated 6/28/25, showed Resident 89 was afebrile (no fever), had unproductive new or increased cough, and had recent chest x-ray showing new infiltrates consistent with pneumonia. Further review of the Infection Screening Evaluation failed to show if the symptoms experienced by Resident 89 met the McGeer's criteria for true infection or Loeb's minimum criteria to treat the infection with antibiotics. However, review of Resident 89's Antibiotic Time Out dated 7/1/25, showed Zithromax oral tablet 250 mg two tablets via GT one time only for presenting clinical symptoms of fever, and increased sputum. Under the section narrative notes, showed physician was notified Resident 89 was afebrile and had mild secretion, antibiotic time out was suggested, and Resident 89's infection met the McGeer's criteria. Further review of the Resident 89's medical record failed to show if Resident 89 had a fever or increased sputum or productive cough. On 7/18/25 at 1417 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked about the facility's antibiotic stewardship program. The IP stated the facility used the McGeer's criteria. The IP stated if a resident did not meet the criteria for a true infection using the McGeer's criteria, the physician would be notified. The IP verified the above findings and stated Resident 89 did not have a fever and purulent sputum. The IP verified the symptoms Resident 89 experienced on 6/28/25 did not meet the McGeer's criteria for true infection. The IP stated she should have accurately notified the physician regarding Resident 89's symptoms that did not meet the McGeer's Criteria for a true infection when the antibiotic was ordered. On 7/22/25 at 1503 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	07/23/2025

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 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 35 final sampled residents (Resident 63). The facility failed to ensure the call light for Resident 63 was within the residents' reach. This failure had the potential to negatively impact the resident's physical and psychosocial well-being or would result in delayed provision of care.Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely Response dated 12/19/22, showed the facility was adequately equipped with a call light. The facility staff will ensure the call light is within reach of resident and secured as needed. On 7/15/25 at 1016 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 63. Resident 63 was observed in bed, awake, and stated he needed assistance. When asked how he could call for the facility staff's assistance, Resident 63 stated he pressed the red button but he was unable to find it. Resident 63 added he just yelled and called the licensed nurse. Resident 63's call light button was observed on the floor. On 7/15/25 at 1016 hours, summoned RNA 1 to Resident 63's room and informed RNA 1 that Resident 63 needed an assistance. RNA 1 checked the resident and the resident made RNA 1 known that he needed assistance. RNA 1 was asked where the call light button was for the resident. RNA 1 verified the call light button was on the floor. RNA 1 stated the call light button should have been with the resident while in bed. Medical record review for Resident 63 was initiated on 7/16/25. Resident 63 was admitted to the facility on [DATE]. On 7/21/25 at 0923 hours, an observation and concurrent interview with Resident 63 was conducted. Resident 63 was in bed awake and stated he needed his nurse because he was in pain. When Resident 63 was asked where his call light button was, Resident 63 was unable to find the call light button. The call light button was observed on the floor, not within the reach of the resident. Summoned CNA 1 to the resident's room, who was assigned to Resident 63 and informed CNA 1 Resident 63 needed assistance. CNA 1 was observed asking the resident what he needed and the resident informed CNA 1 he needed pain medication for his leg pain. CNA 1 was asked how Resident 63 called for the licensed nurse, CNA 1 stated Resident 63 was able to use the call light button and sometimes he called out the name of his licensed nurse. When CNA 1 was asked where the call light button of Resident 63 was, CNA 1 verified and acknowledged Resident 63's call light button was on the floor. CNA 1 stated Resident 63 kept moving in the bed and sometimes the call light button fell from the bed. CNA 1 stated the call light button usually had a clip to hold onto the bed sheet, to prevent the call light from being misplaced. CNA 1 was observed placing the call light button near the resident and attached the clip on the resident's bedsheet. On 7/22/2025 at 1453 hours, an interview for Resident 63 was conducted with RN 2. RN 2 was asked about the call light button of the residents. RN 2 stated the call light buttons should always be within the reach of the resident for them to call the facility staff when they needed an assistance. RN 2 was informed of the observation of Resident 63's call button found in the floor. RN 2 verified and acknowledged the above findings.

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	07/23/2025

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 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 copy of the advance directive was maintained in the resident's medical record for one of 35 final sampled residents (Resident 51). This had the potential for the facility to provide treatment and services against the resident's wishes.Findings: Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives revised date 12/19/22, showed on admission the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. In the event the resident is unable to formulate an advance directive due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Review of Resident 51's medical record was initiated on 7/16/25. Resident 51 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 51's H&P examination dated 5/29/25, showed Resident 51 had the capacity to understand and make decisions. Review of Resident 51's admission MDS assessment dated [DATE], showed Resident 51 had a BIMS score of 14, indicating intact cognition. Review of Resident 51's Physician Orders for Life Sustaining Treatment (POLST) dated 5/27/25, showed under Section D for Information and Signatures, Resident 51 had an advance directive. Review of Resident 51's Advance Directive Acknowledgment form dated 5/27/25, showed Resident 51 had executed an advance directive however, there was no copy of the advance directive in Resident 51's medical records. On 7/23/25 at 1249 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the findings and stated a copy of the resident's advance directive should be in the resident's chart to confirm the resident's wishes.

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	07/23/2025

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 comprehensive plan of care for one of 35 final sampled residents (Resident 104) was revised to reflect the resident's current care needs and interventions. The facility failed to ensure Resident 104's plan of care was revised to address Resident 104's breathing treatment. This posed the risk of not providing Resident 104 with individualized and person-centered care. Findings:Findings: Review of the facility's P&P titled Comprehensive Care Plans dated 12/19/22, showed the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment. On 7/15/25 at1006 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 104. Resident 104 stated she used the nebulizer machine (medical device used to treat respiratory conditions) at bedside when she needed it due to her breathing problem. Resident 104's nebulizer mask was observed on top of the nebulizer machine undated. Medical record review for Resident 104 was initiated on 7/17/25. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's physician's order dated 3/24/24, with the discontinued date of 4/1/25, showed to administer ipratropium-Albuterol solution (inhaler medication) 0.5 to 2.5 mg/3 ml via inhalation orally every six hours for shortness of breath for 14 days. Review of Resident 104's plan of care showed a care plan problem dated 9/24/24, addressing Resident 104's breathing treatment use for shortness of breath. However, the plan of care was not revised to reflect the discontinued physician's order for the breathing treatment. On 7/23/25 at 1528 hours, an interview was conducted with the DON for Resident 104. The DON was informed and verified the above findings. Cross reference F695, example #7.

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	07/23/2025

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 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observation and interview, the facility failed to comply with CA State law SB 1383 dated 1/1/22, which mandated the facilities to separate the organic waste from their waste stream. This failure had the potential to increase the environmental impact of the facility thus adversely impacting the residents' health and well-being. Findings: On 7/16/25 at 0906 hours, an observation and concurrent interview was conducted with the DSS and Maintenance Director for the facility's trash area. The facility did not have separate bins for separating the organic waste from the facility's waste stream per the CA SB 1383. The DSS and Maintenance Director both verified the facility did not separate the organic waste from the facility's waste stream. The DSS and Maintenance Director further verified the facility did not have the required organic waste bins.

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	07/23/2025

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 0842 Level of Harm - Potential for minimal 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, facility document review, and facility P&P review, the facility failed to ensure complete and accurate resident medical records and facility records were maintained for one of three sampled residents reviewed for closed records (Resident 195), one nonsampled resident (Resident 171), and the Resident Council record. * Resident 171's scheduling details for the administration of olanzapine zydis (antipsychotic medication) showed conflicting information specific to the medication administration time. * The facility failed to ensure complete and accurate documentation on the Resident Council Agenda/ Minutes record for the months of March, April, May, and June 2025. * The facility failed to ensure the Notice Proposed Transfer/Discharge form was accurately completed and signed for Resident 195. These failures had the potential for the residents' care needs not being met as the facility records and resident medical records were inaccurate. Findings: 1. Medical record review for Resident 171 was initiated on 7/15/25. Resident 171 was admitted to the facility on [DATE]. Review of Resident 171’s physician’s order dated 7/10/25, showed to administer olanzapine zydis 5 mg orally at noon for psychosis manifested by auditory hallucinations, aggressive behavior, and pulling the GT. Review of Resident 171’s Scheduling Details dated 7/14/25, showed the olanzapine zydis 5 mg was to be administered orally in the morning at 0900 hours. However, further review of Resident 171’s Scheduling Details dated 7/14/25, showed a conflicting administration time (of 1200 hours) for the olanzapine zydis 5 mg to be administered to Resident 171. On 7/21/25 at 0839 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 171’s Scheduling Details dated 7/14/25, showed to administer the olanzapine zydis 5 mg both in the morning at 0900 and at 1200 hours. LVN 8 stated the time of 0900 hours was inaccurate, as Resident 171’s physician ordered the medication to be administered at 1200 hours. Cross reference F761 example #1. 2. On 7/16/25 at 0834 hours, an interview was conducted with the Activities Director. The Activities Director was asked how many times the residents met for the Resident Council and to show the Resident Council Minutes from March – July 2025. The Activities Director stated the Resident Council committee usually meet once a month, every last Wednesday of the month or when the residents agreed to reschedule the meeting. The Activities Director provided the facility’s Resident Council Agenda/Minutes from March through July 2025. Review of the facility’s document titled Resident Council Agenda/ Minutes for March through June 2025 showed the issues identified by the Resident Council. The response from the department to those issues was also documented, however, the sections to show if the issues had been resolved to the residents’/family’s reasonable satisfaction were left unchecked (yes or no) on 3/26, 4/30, 5/12, and 6/9/25. (continued on next page)

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	07/23/2025

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 7/16/25 at 1032 hours, an interview was conducted during the Resident Council meeting with Residents 18, 125, 130, 141, 144, and 152. Residents 18, 125, 130, 141, 144 and 152 were asked if their concerns/issues were followed up or resolved by the facility. All the residents stated their previous concerns/issues had been resolved. On 7/18/25 at 0820 hours, an interview and concurrent facility document review was conducted with the Activities Director. The Activities Director was informed of the incomplete documentation on the Resident Council Agenda/ Minutes for March through June 2025 as mentioned above. The Activities Director verified she was responsible for following up and ensuring the issues were resolved and document on the Resident Council Agenda/ Minutes. The Activities Director verified the above findings. On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings. 3. Closed medical record review for Resident 195 was initiated on 7/15/25. Resident 195 was admitted to the facility on [DATE], and discharged to the acute care hospital on 1/22/23. Review of Resident 195's H&P examination dated 12/28/22, showed Resident 195 had no capacity to understand and make decisions. Review of Resident 195’s Notice Proposed Transfer/Discharge form dated 1/22/23, failed to show documented evidence of a Resident and/or Representative’s Signature. Further review showed Resident 195 was transferred and/or discharged to Hospital A. Review of Resident 195’s physician’s order dated 1/22/23, showed a physician’s order to transfer the resident to Hospital B's ER via 911 ambulance for further evaluation d/t (due to) low oxygen saturation. On 7/18/25 at 1017 hours, an interview and concurrent closed medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated the information on the Notice Proposed Transfer/Discharge form should accurately match with the physician’s transfer orders. LVN 6 also stated the form should be completed. LVN 6 verified there was no signature of the resident or resident's representative on the form. On 7/21/25 at 1409 hours, an interview and concurrent closed medical record review was conducted with RN 3. RN 3 verified the above findings. RN 3 stated Resident 195’s Notice Proposed Transfer/Discharge form showed the resident was transferred or discharged to Hospital A. However, RN 3 verified the physician’s order showed the resident was to transfer to Hospital B. RN 3 stated the Notice Proposed Transfer/Discharge form should have been updated to accurately reflect the physician’s transfer order to document where the resident was transferred or discharged to from the facility. On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated she expected the licensed nurses to accurately complete the Notice Proposed Transfer/Discharge form, to include the correct location of the transfer or discharge and signature of the resident or resident's representative. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.