STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. Building B. Wing	04/23/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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, facility document review, and facility P&P (Policy and Procedure) review, the facility failed to ensure two of five residents (Residents 74 and 179) reviewed for accidents remained free from accident hazards. * The facility failed to ensure Resident 179 was safely transferred from her bed to her wheelchair. This failure resulted in Resident 179 hitting her leg on a wheelchair and sustained a 10-cm (centimeters) abrasion and large hematoma (a collection of clotted blood outside blood vessels, caused by trauma or injury, leading to swelling, pain, and skin discoloration) on her right anterior (situated at or toward the front of the body) shin. * The facility failed to ensure Resident 74's cigarettes and cigarette lighters were stored safely in accordance with the facility's Resident Smoking P&P. This failure had the potential for the residents who were not safe to independently possess a lighter to injure themselves or cause a fire.Findings: 1. Review of the facility's P&P titled Safe Resident Handling/Transfers dated 12/19/22, showed it is the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. All residents require safe handling when transferred to prevent or minimize the risk for injury. Medical record review for Resident 179 was initiated on 4/20/26. Review of Resident 179 Facesheet (quick access to essential patient information, including demographics, insurance, allergies, current medications, and key medical history) dated 4/22/26, Resident 179 was admitted to the facility on [DATE]. Review of Resident 179's MDS (Minimum Data Set - a standardized assessment tool) dated 1/30/26, showed Resident 179's had a BIMS (Brief Interview of Mental Status - a tool used to assess the resident cognitive (the mental processes involved in gaining knowledge, understanding, and comprehension, including thinking, memory, reasoning, and learning) status) score of 14 (cognitively intact). Review of Resident 179's Care Plan Report showed the care plan focus problem to address the following: - ADL (Activities of Daily Living - basic skills necessary for individuals to independently care for themselves, such as eating, bathing and mobility) self-care performance deficit related to impaired function and mobility, due to spinal stenosis (narrowing of the spinal canal, which compresses the spinal cord and nerves, usually caused by age-related wear and tear), scoliosis (abnormal, sideways curvature of the spine), and osteoporosis (a disease that weakens bones, making them fragile and (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	prone to fractures) initiated on 2/10/26; - at risk for falls related to impaired function and mobility initiated on 1/26/26. The care plan goal was for Resident 179 not to sustain serious injury. The care plan interventions included Resident 179 needed to be supplied with appropriate adaptive equipment (devices designed to enhance independence, functionality, and participation for individuals with physical, cognitive, or sensory disabilities) or devices as needed, revised on 2/10/26; and - potential for skin tear of bilateral upper and lower extremities initiated on 1/26/26. The care plan interventions included use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Review of Resident 179's Nurses Progress Note dated 4/1/26 at 0812 hours, showed Resident 179 sustained a skin tear to her right shin during transfer to her wheelchair. Review of Resident 179's Skin Check note dated 4/1/26 at 0959 hours, showed Resident 179 sustained a skin tear to her right leg with moderate bleeding and a hematoma noted. A skin flap was placed back and Steri-Strips (sterile, breathable, adhesive skin closures) were applied. Review of Resident 179's Daily Skilled Services note dated 4/1/26 1550 hours, showed earlier in the day Resident 179 reported an injury to her right lower extremity. Nursing was aware and recommended to avoid out of bed activities and to keep right lower extremity elevated to reduce inflammation. Strengthening of the left lower extremity in supine position (lying flat on the back) in all possible ranges of motion, avoiding right lower extremity. Review of Resident 179's Physician Progress Note dated 4/1/26 at 2121 hours, showed while transferring Resident 179 into her wheelchair this morning, Resident 179's leg got stuck/caught in the wheelchair, causing a large 10-cm abrasion and large hematoma on her right anterior shin. Review of Resident 179's Nurses Progress Note dated 4/1/26 at 2141 hours, showed Resident 179 was on monitoring for a skin tear on the front of her right lower leg and Resident 179 complained of pain level of six out of 10 (in a pain scale of 0-10, 0 = no pain and 10 = severe pain) to her lower right leg. Review of Resident 179's Skin Check dated 4/17/26 at 1036 hours, showed a physician examined Resident 179 who ordered to wrap Resident 179's right lower leg with an ace bandage (a stretchable wrap used to provide compression) for one week, with a follow up scheduled for next week for possible incision (to cut into with a sharp instrument) and drainage. On 4/20/26 at 1249 hours, an observation and concurrent interview was conducted with Resident 179. Resident 179 was observed lying in her bed with a bandage wrapped around her right lower leg. Resident 179 was asked if she had sustained an injury to her right leg. Resident 179 stated approximately three weeks ago, she sustained an injury while RNA (Restorative Nursing Assistant) 1 was transferring her from her bed to her wheelchair. Resident 179 stated RNA 1 failed to utilize the gait belt (a durable belt worn around a resident's waist to provide caregivers a secure, safe, and comfortable grip for assisting with walking, standing, or transferring) while transferring her and her leg got caught on a piece of metal on the front side of her wheelchair where the footrest would be attached, as a result her right lower leg was injured. Resident 179 stated after her leg hit the wheelchair she yelled for RNA 1 to stop; however, RNA 1 could not control her momentum, which (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	caused the skin to tear off the front of her leg. Resident 179 stated the trauma from her leg hitting the wheelchair caused her leg to bleed and at the time of the injury she suffered a lot of pain. Resident 179 stated she was upset when the staff failed to transfer her properly and she was injured as a result. Resident 179 stated she had weakness in her lower extremities due to injuries to her back and staff would need to use the gait belt when transferring her from her bed to her wheelchair. Resident 179 stated the use of the gait belt offered her more stability and made her feel safe. Resident 179 stated the facility's rehabilitation staff would always utilize the gait belt when transferring her from her bed to the wheelchair; however, the CNAs (Certified Nursing Assistant) and RNAs assigned to the floor did not always utilize the gait belt when transferring her from her bed to her wheelchair. Resident 179 stated after she sustained the injury the facility staff took a photograph of her injury and reported the incident to her family. Resident 179 stated her leg had yet to heal completely and remained swollen. Resident 179 stated the treatment nurse informed her the physician may incise and drain the swollen area to promote healing. Resident 179 stated her goal was to be discharged home with her family and hopefully her leg would heal soon. On 4/22/26 at 1002 hours, a telephone interview was conducted with RNA 1. RNA 1 stated on 4/1/26, during the morning shift, she was assigned to provide care for Resident 179. RNA 1 stated she had cared for Resident 179 once before on 3/31/26. RNA 1 was asked to describe how Resident 179 sustained the injury to her right lower leg during the transfer from her bed to her wheelchair on 4/1/26. RNA 1 stated Resident 179 had an appointment on the morning of 4/1/26. RNA 1 stated she needed to transfer Resident 179 from her bed to the wheelchair. RNA 1 stated she independently transferred Resident 179 from her bed to her wheelchair. RNA 1 stated while she was transferring Resident 179 from her bed to the wheelchair, Resident 179 had difficulty bending her knees, which made it difficult for her to transfer Resident 179 to her wheelchair. RNA 1 further stated the previous morning Resident 179 was able to bend her knees. RNA 1 stated she believed Resident 179 sustained the injury to her right lower leg when Resident 179's right leg hit the metal on the front of the wheelchair where the footrest would be attached. RNA 1 was asked if she utilized a gait belt during the transfer, to which RNA 1 replied, she had not. RNA 1 stated she was not informed Resident 179 needed a gait belt during transfers from her bed to the wheelchair. RNA 1 further stated she was not familiar with Resident 179, having been assigned to care for Resident 179 only on two occasions. On 4/22/26 at 1420 hours, an interview and concurrent medical record review for Resident 179 was conducted with the Director of Rehabilitation. Review of Resident 179's Physical Therapy Treatment Encounter notes dated 3/23/26, showed for transfers (sit to stand), Resident 179 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). The Director of Rehabilitation stated substantial/maximal assistance meant the staff would provide 75 to 80 percent assistance during the sit-to-stand transfers for Resident 179. The Director of Rehabilitation stated the facility protocol was for the staff to always utilize a gait belt when independently transferring the residents from their beds to their wheelchairs. The Director of Rehabilitation stated the facility RNAs and CNAs (Certified Nursing Assistant) were trained to utilize the gait belts when independently transferring the residents from their beds to their wheelchairs, regardless of the level of assistance the residents would require. On 4/23/26 at 1101 hours, an interview and concurrent facility document review for Resident 179 was conducted with the DON (Director of Nursing). The DON stated the facility conducted a risk management investigation specific to Resident 179's injury sustained on 4/1/26, during the transfer from her bed to her wheelchair. The DON stated interviews with Resident 179 and the facility staff were conducted. The DON stated according to Resident 179, on the morning of 4/1/26, while being transferred from her bed to her wheelchair, she scraped her leg against her wheelchair. The DON (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated the facility also interviewed RNA 1 who performed the transfer of Resident 179 from her bed to her wheelchair. The DON stated according to RNA 1, during the transfer, Resident 179 was seated at the edge of the bed and Resident 179 was unable to stand up completely. RNA 1 stated she could not place Resident 179 back into bed due to Resident 179's low air loss mattress (a specialized medical support surface designed to prevent and treat pressure injuries by providing, through a blower, constant airflow to manage moisture and heat). RNA 1 then proceeded to transfer Resident 179 to the wheelchair at which time she sustained an injury to her right lower leg. The DON was asked to describe the facility's investigative conclusion. The DON stated RNA 1 failed to secure Resident 179 during the transfer and RNA 1 should have utilized a gait belt to help stabilize Resident 179 during the transfer. The DON stated the facility practice was to utilize the gait belts when the staff independently transfer the residents from their beds to their wheelchairs, regardless of the level of assistance the residents would require. The DON stated the staff would receive this training upon hire and annually. Cross reference to F684, example #1. 2. Review of the facility's P&P titled Resident Smoking dated 4/20/26, showed it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. Smoking materials will be stored appropriately. On 4/20/26 at 0750 hours, during the initial tour of the facility, an observation and concurrent interview was conducted at Resident 74's bedside. Resident 74 was observed sitting on bed in fowler's position (a standard patient positioning technique where the head of the bed is elevated). An open package of cigarettes, orange-colored cigarette lighter and black-colored cigarette lighter in a plastic cup were observed on top of the overbed table at Resident 74's bedside. The open package of cigarettes, orange and black-colored cigarette lighters were within Resident 74's reach. On 4/20/26 at 0751 hours, an interview was conducted with CNA 6. CNA 6 was asked if the residents could keep their cigarettes and cigarette lighters at bedside, CNA 6 answered, yes, but they smoke downstairs. Medical record review for Resident 74 was initiated on 4/20/26. Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's H&P (History and Physical) examination dated 1/8/25, showed Resident 74 had the capacity to make decisions. Review of Resident 74's Progress Notes dated 4/17/26, an initial note on smoking showed Resident 74 may smoke with supervision. Review of Resident 74's Smoking assessment dated [DATE], showed a goal for Resident 74 to adhere to the tobacco/smoking policies of the facility, initiated on 4/17/26; however, the assessment did not show the safe and appropriate storage of smoking materials. On 4/20/26 at 1433 hours, a follow-up observation was conducted in Resident 74's room. A black -colored lighter previously observed was still in a plastic cup on top of Resident 74's overbed table. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LVN (Licensed Vocational Nurse) 2 was immediately called to the room and verified the presence of the black lighter in a cup on top of Resident 74's overbed table. LVN 2 was observed removing the lighter from Resident 74's overbed table and stated, he is not supposed to keep this. On 4/21/26 at 0811 hours, another follow up observation was conducted in Resident 74's room. An orange-colored cigarette lighter was observed at the end of Resident 74's overbed table on the left side of the bed. On 4/21/26 at 0813 hours, an interview was conducted with CNA 7. CNA 7 observed and verified the orange-colored cigarette lighter on top of the overbed table at Resident 74's bedside. CNA 7 was asked should the cigarette lighter be kept by Resident 74, CNA 7 responded, I have to find out, I don't know. CNA 7 was observed removing the cigarette lighter from Resident 74's overbed table. On 4/21/26 at 0815 hours, an interview was conducted with RN 4. RN 4 was made aware of the observations conducted at Resident 74 bedside on 4/20/26 at 0750 and 1433 hours and 4/21/26 at 0811 hours, where there were open package of cigarette and cigarette lighters at Resident 74's bedside table. RN 4 stated Resident 74 should not have cigarettes and cigarette lighters at bedside. On 4/23/26 at 1600 hours an interview was conducted with the Administrator and the DON. The Administrator and DON were informed of Resident 74 having cigarettes and cigarette lighters at bedside and acknowledged the findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and facility P&P review, the facility failed to ensure the appropriate respiratory care was provided for five of eight final sampled residents (Residents 2,11, 14, 20, and 72) and one nonsampled resident (Resident 31) reviewed for respiratory care. * The facility failed to ensure Residents 2 and 11's oxygen concentrator filter was free of thick, dust like particles. * The facility failed to ensure Resident 14's nebulizer administration set-up was changed every seven days according to the facility's P&P. * The facility failed to ensure Resident 20 was provided with oxygen as ordered. Additionally, the facility failed to ensure the CPAP tubing and headgear was changed weekly as ordered by the physician and as per the facility policy. * The facility failed to ensure Resident 31's nebulizer breathing mask was changed weekly. * The facility failed to ensure a physician's order was obtained for the administration of continuous oxygen therapy via the nasal canula for Resident 72. In addition, the facility failed to ensure a care plan problem was developed for Resident 72's use of the oxygen via the nasal canula. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: 1. Review of the facility's P&P titled Cleaning and Disinfection of Resident Care Equipment dated 12/19/22, showed resident care equipment can be a source of indirect transmission of pathogens. Direct care staff can clean single resident equipment when visibly soiled and according to routine schedule (where applicable). a. On 4/20/26 at 0855 hours, during the initial tour of the facility, Resident 2 was observed lying in bed, on ventilator administered via tracheostomy in progress. The oxygen concentrator filter at the side of the concentrator unit near the foot part of the bed was observed to be covered with dust like particles. Medical record review for Resident 2 was initiated on 4/20/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 2/10/26, showed Resident 2 had no capacity to make medical decisions. Review of Resident 2's Order Summary Report dated 4/23/26, showed the physician's orders dated 4/15/26, for tracheostomy tube Shiley flex cuff size 7.5 inner cannula to change every day shift for prevention of tissue granulation and infection, and ventilator settings: pressure control mode: AC set RR: 10 set Pressure: 25 cm H20 Set PEEP: 5 cm H2O, Set PS: O cmH2O at: 3L/min, may titrate oxygen L/min to maintain oxygen saturation at greater or equal to 92%, humidication: HME apply ventilator continuous as needed for ventilator settings check. b. On 4/20/26 at 1129 hours, during the initial tour of the facility, Resident 2 was observed lying in bed, with oxygen in progress administered via tracheostomy. The oxygen concentrator at bedside at the right side near the foot of the bed was observed to have a filter covered with dust like particles. Medical record review for Resident 11 was initiated on 4/23/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 4/14/26, showed Resident 11 had findings of neurologic impairment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 11's Order Summary Report dated 4/23/26, showed the physician's orders dated 1/20/26, for tracheostomy tube: Portex uncuffed size 6 change inner cannula every night shift, and oxygen via T-bar at five liters per minute, may titrate oxygen to maintain oxygen saturation greater or equal to 92% every shift. On 41/20/26 at 1131 hours, an interview was conducted with LVN 5. LVN 5 verified the oxygen concentrator filters of Resident 2 and 11 were covered with dust like particles. LVN 5 stated the RT's change it, the filters are supposed to be clean, that's dirty. On 4/20/26 at 1136 hours, an interview was conducted with RT 1. RT 1 verified the dirty oxygen concentrator filters of Resident 2 and 11. RT 1 stated we have a third-party company who would come and clean these concentrators and changes the filters. When asked about the schedule, RT 1 stated I will find out but I could change these filters now, I just need to get a new one. On 4/23/26 at 1600 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 4/20/26 at 0736 hours, an observation was conducted at Resident 31's bedside. Resident 31's nebulizer was observed inside a clear storage bag and the nebulizer mask was labeled with date of 2/16. Medical record review for Resident 31 was initiated on 4/20/26. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 31's Order Summary Report dated 4/22/26, showed a physician's order dated 4/7/26, to administer ipratropium- albuterol inhalation solution (breathing treatment medication) 0.5-2.5 mg/3 ml, inhale orally every six hours as needed for shortness of breath or wheezing. On 4/20/26 at 0738 hours, an interview and concurrent observation of Resident 31 was conducted with LVN 10. LVN 10 stated the nebulizer masks should be changed weekly, every Sundays. LVN 10 verified the above findings and was observed discarding the nebulizer mask and tubing in the trash can. 3. Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen was administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident goals and preferences. Oxygen was administered under orders of a physician, except in the case of an emergency. Oxygen warning signs must be placed on the door of the resident room where oxygen is in use. On 4/20/26 at 0728 and 1149 hours, Resident 72 was observed receiving continuous oxygen at a rate of 4 liters per minute via nasal canula. An oxygen warning sign was not observed posted on the door of Resident 72's room. Medical record review for Resident 72 was initiated on 4/20/26. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Order Summary Report failed to show a physician's order for the use of continuous oxygen therapy via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 72's Care Plan Report failed to show a care plan problem was developed to address Resident 72's use of continuous oxygen therapy via nasal canula. On 4/20/26 at 1153 hours, an observation, interview and concurrent medical record review for Resident 72 was conducted with LVN 10. LVN 10 verified Resident 72 was currently receiving continuous oxygen at a rate of 4 liters per minute via nasal canula. LVN 10 also verified an oxygen warning sign was not posted on the door of Resident 72's room. LVN 10 reviewed Resident 72's medical record and verified there was no physician's order for Resident 72's use of the continuous oxygen therapy via nasal canula. On 4/22/26 at 1105 hours, a follow-up interview and concurrent medical record review for Resident 72 was conducted with LVN 10. LVN 10 verified a care plan problem was not developed for Resident 72's use of continuous oxygen therapy via nasal canula. On 4/23/26 at 1552 hours, an interview was conducted with the DON. The DON stated for the administration of continuous oxygen therapy, there should be physician's order and a care plan initiated/developed to address the use of continuous oxygen therapy. The DON further stated the oxygen tubing, including the nasal canula and nebulizer mask, should be changed weekly. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Medical record review for Resident 20 was initiated on 4/20/26. Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had a BIMS score of 15, indicating resident had intact cognitive capacity. a. Review of Resident 24's Order Summary Report showed the following physician's orders: - dated 10/27/25, to administer oxygen via nasal cannula at 2 liters per minute every shift; and - dated 12/1/25, the RN to titrate the oxygen to five liters per minute to maintain an oxygen saturation greater or equal to 92% and call MD if oxygen saturation is less than 92% at a maximum titration as needed. On 4/20/26 at 0749 hours, during the initial tour of the facility, Resident 20 was observed with oxygen at a rate of 4 liters per minute via nasal cannula. On 4/21/26 at 1059 hours, a follow-up observation of Resident 20 in the room and concurrent interview and record review was conducted with LVN 19. LVN 19 verified Resident 20 had oxygen at a rate of 4 liters per minute via nasal cannula. LVN 19 verified Resident 19 had a physician's order for oxygen via nasal cannula only at a rate of 2 liters per minute every shift. On 4/21/26 at 1104 hours, an observation of Resident 20 in the room and a concurrent interview and record review was conducted with RN 3. RN 3 verified Resident 20's oxygen rate was at 4 liters per minute via nasal cannula. RN 3 verified Resident 20's physician order dated 12/1/25, showed RN to titrate oxygen to five liters per minute to maintain oxygen saturation greater or equal to 92%. RN 3 stated he did not titrate the resident's oxygen rate this morning. RN 3 verified Residents 20's MAR for (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	April 2026 failed to show a documentation the oxygen was titrated as needed. RN 3 verified residents oxygen saturation level at 0910 hours was at 95%. RN 3 stated resident's oxygen rate should have been at 2 liters per minute only since Resident 20's oxygen saturation was greater than 92%. On 4/23/26 at 1442 hours, an interview was conducted with the DON and Administrator. The DON and the Administrator were informed and acknowledged the findings as above. b. Review of the facility's P&P titled CPAP/BiPAP Cleaning revised on 12/19/22, showed weekly cleaning activities to a. wash headgear/straps in warm, soapy water and air dry; and b. Wash tubing with warm, soapy water and air dry. Review of Resident 20's Order Summary Report showed a physician's order dated 12/1/25; to clean CPAP tubing and headgear, submerge and let soak in warm water and soap, rinse thoroughly and let air dry every Monday. On 4/21/26 at 1104 hours, an observation and concurrent interview was conducted with Resident 20. Resident 20 was observed with CPAP machine at bedside. The CPAP tubing and headgear was observed in a plastic bag dated 4/13/26. Resident 20 stated she uses he CPAP machine at night. Resident 20 further stated she did not see a nurse cleaned her CPAP tubing and headgear yesterday. On 4/21/26 at 1116 hours, an observation for Resident 20 and concurrent interview was conducted with RN 3. RN 3 verified Resident' 20s CPAP tubing and headgear was observed in a plastic bag dated 4/13/26. RN 3 stated the tubing and headgear should have been cleaned yesterday and labeled the bag with the date the CPAP tubing and headgear was cleaned. On 4/23/26 at 1442 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the findings as above. 5. Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed to change the nebulizer tubing and delivery devices weekly and as needed, per manufacturers recommendation or per facility policy and if they become soiled or contaminated. Medical record review for Resident 14 was initiated on 4/20/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's MDS admission assessment dated [DATE], showed Resident 14's cognitive skills for daily decision making was severely impaired. Review of Resident 14's Order Summary Report showed the following physician's order: - dated 3/24/26, to administer albuterol (a bronchodilator medication used to relax the muscles around the airways in the lungs, making it easier to breathe) inhalation solution 0.5-2.5 mg/ml 1 vial four times a day for shortness of breath or wheezing; and - dated 3/26/26, to administer acetylcysteine (medication to treat thick mucus in respiratory conditions) 10% inhalation solution, to give 10 ml four times a day for mucous secretion. On 4/20/26 at 0800 hours, during the initial tour of the facility, Resident 14's nebulizer tubing was (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed on the resident's nightstand in a plastic bag without a name and date. On 4/20/26 at 0806 hours, a follow-up observation for Resident 14 and concurrent interview was conducted with the IP. The IP verified Resident 14's nebulizer tubing was in the plastic bag with no name and date. The IP stated the night shift licensed nurses were to change the nebulizer tubing every week and would need to label the plastic bag with the resident's name and date when it was changed. On 4/23/26 at 1341 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to change the nebulizer tubing every Sunday and to label the plastic bag with the resident's name and date. On 4/23/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management 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 provide the appropriate pain management for two of three final sampled residents (Residents 17 and 20) reviewed for pain management. * The facility failed to accurately document the pain level and administer the oxycodone (narcotic pain medication) according to the physician's orders for Resident 17. * The facility failed to administer the hydrocodone-acetaminophen (narcotic pain medication) according to the physician's orders for Resident 20. These failures had the potential to put Residents 17 and 20 at risk for ineffective pain management and/or adverse effects related to the use of unnecessary pain medications.Findings: Review of the facility's P&P titled Pain Management revised 3/17/25, showed based upon the pain evaluation, the facility in collaboration with the attending physician/prescriber, other health care professional and the resident and/or the resident's representatives will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain. Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. 1. On 4/20/26 at 0700 hours, an interview was conducted with Resident 17. Resident 17 stated she had generalized body pain and pain on her back that was usually a 10 out of 10 pain (a pain level from 4 to 10, using a pain scale of 0 to 10 with 0= no pain and 10= worst pain). Medical record review for Resident 17 was initiated on 4/20/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 2/22/26, showed Resident 17 was able to understand and make treatment decisions. Review of Resident 17's Order Summary Report dated 4/22/26, showed the following physician's orders: - dated 4/1/26, to administer oxycodone 5 mg give 0.5 (half) tablet by mouth every four hours as needed for moderate to severe pain (a pain level from 4 to 10), to try the nonpharmacological interventions before providing the medication and to document the following: 1. Repositioning, 2. Dim light/quiet room, 3. Relaxation, 4. Distraction, 5. TV (television)/Music, 6. Other- to indicate in the progress notes and to indicate if the non-pharmacological interventions was ineffective or effective; and - dated 4/13/26, to administer oxycodone 5 mg give one tablet by mouth every four hours as needed for moderate to severe pain, to try the nonpharmacological interventions before providing the medication and to document the following: 1. Repositioning, 2. Dim light/quiet room, 3. Relaxation, 4. Distraction, 5. TV/Music, 6. Other- to indicate in the progress notes and to indicate if the nonpharmacological interventions was ineffective or effective. Review of Resident 17's MAR for April 2026 showed Resident 17 was administered the oxycodone 5 mg medication for on the following dates, times and pain levels: - dated 4/2/26 at 2025 hours, for a pain level of 0; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 4/3/26 at 1842 hours, for a pain level of 0; - dated 4/5/26 1430 hours, for a pain level of 3; - dated 4/8/26 1345 hours, for a pain level of 3; - dated 4/8/26 2207 hours, for a pain level of 0; - dated 4/13/26 1238 hours, for a pain level of 0; - dated 4/20/26 1230 hours, for a pain level of 3; and - dated 4/21/26 1302 hours, for a pain level of 3. On 4/22/26 at 1027 hours, an interview and concurrent medical record review for Resident 17 was conducted with LVN 10. LVN 10 stated Resident 17 usually complained of lower back pain and was administered with the oxycodone pain medication as needed for moderate to severe pain. LVN 10 stated when Resident 17 complained of pain, the pain level was assessed, and the nonpharmacological interventions implemented first. LVN 10 stated if the nonpharmacological interventions were ineffective, then the licensed nurse would administer the PRN pain medication as per the physician's orders and within the ordered parameters. LVN 10 reviewed Resident 17's medical record and verified the oxycodone medications were not administered to Resident 17 as ordered by the physician. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 20 was initiated on 4/20/26. Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had a BIMS score of 15, indicating the resident had intact cognitive capacity. Review of Resident 20's Order Summary Report dated 4/22/26, showed a physician's order dated 6/10/25 to administer hydrocodone-acetaminophen 5-325 mg tablet by mouth every four hours as needed for moderate (4-7 scale) to severe pain (8-10 scale), to try the nonpharmacological interventions before providing the medication and to document the following: 1. Repositioning, 2. Dim light/quiet room, 3. Relaxation, 4. Distraction, 5. TV/Music, 6. Other- to indicate in the progress notes and io indicate if the nonpharmacological interventions was ineffective or effective. Review of Resident 17's MAR for April 2026 showed Resident 20 was administered the hydrocodone-acetaminophen 5-325 mg on 4/6/26 at 1655 hours, when Resident 17's pain level was 3 and was not within the pain parameter of 4 to 10 as ordered by the physician. On 4/21/26 at 1252 hours, an interview and concurrent medical record review for Resident 20 was conducted with LVN 19. LVN 19 stated Resident 20 should not have received the hydrocodone-acetaminophen 5-325 mg for complain of pain level of 3. On 4/23/26 at 1442 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate hemodialysis care was provided for four of 35 final sampled residents (Residents 14, 26, 49, and 72) and three nonsampled resident (Residents 39, 41, and 97) who were receiving dialysis services. * The facility failed to ensure a hemodialysis emergency kit was available at the bedside for Residents 14, 26, 39, and 97. * The facility failed to ensure Resident 41's dialysis communication record was complete and the hemodialysis center's recommendation to hold Resident 41's metoprolol (blood pressure medication) on dialysis days was followed and communicated to the physician. In addition, the facility failed to ensure Resident 41's hemodialysis access was monitored as per the care plan. * The facility failed to ensure Resident 49's hemodialysis communication were complete and accurate. In addition, the facility failed to ensure Resident 49's fluid restriction, fluid intake and output related to hemodialysis were consistently followed and monitored. * The facility failed to ensure Resident 72's hemodialysis communication record was complete and accurate. These failures had the potential for the residents to not receive appropriate hemodialysis care and treatment and could negatively affect the residents' well-being. Findings: Review of the facility's P&P titled Hemodialysis revised on 6/5/23, showed the facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices. The compliance section showed in part the nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. 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. 1. Review of the facility's P&P titled Hemodialysis revised on 6/5/23, showed this facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. a. On 4/20/26 at 0622 hours, during the initial tour of the facility, Resident 39 was observed awake, lying in the bed with a right upper chest perma-catheter. Resident 39 stated he would go to to the hemodialysis treatment every Tuesdays, Thursdays, and Saturdays. Further observation of Resident 39's room failed to show a hemodialysis emergency kit was available at Resident 39's bedside. Medical record review for Resident 39 was initiated on 4/20/26. Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's Order Summary Report showed a physician's order dated 3/6/26, to monitor the dialysis site on the right upper chest perma-catheter every shift for sign and symptom of infection. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 4/20/26 at 0715 hours, during the initial tour of the facility, Resident 97 was observed awake, lying in bed, with AV shunt noted on Resident 97's left arm. Resident 97 stated he would go to hemodialysis treatment every Tuesdays, Thursdays and Saturdays. Further observation of Resident 97's room failed to show a dialysis emergency kit was available at Resident 97's bedside. Medical record review for Resident 97 was initiated on 4/20/26. Resident 97 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 97's H&P examination dated 4/4/26, showed Resident 97 had the capacity to understand and make decisions. Review of Resident 97's Order Summary Report showed a physician order dated 3/31/26, to monitor dialysis site on the left upper arm AV shunt for redness, swelling, bleeding, and pain every shift. On 4/20/26 at 1157 hours, an observation and concurrent interview for Residents 39 and 97 was conducted with RN 3. RN 3 verified Residents 39 and 97 did not have a hemodialysis emergency kit at bedside. RN 3 stated the dialysis emergency kit was needed at Residents 39 and 97 bedside and should be available to use when there was bleeding at Resident 39 and 97's dialysis access site. c. On 4/20/26 at 0800 hours, during the initial tour of the facility, Resident 14 was observed awake, lying in the bed. Resident 14 was observed to have a right thigh perma-catheter. Further observation of Resident 14's room failed to show a hemodialysis emergency kit was available at Resident 14's bedside. Medical record review for Resident 14 was initiated on 4/20/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's MDS admission assessment dated [DATE], showed Resident 14's cognitive skills for daily decision making was severely impaired. Review of Resident 14's Order Summary Report showed a physician's order dated 4/19/26, to monitor the hemodialysis access site at the right thigh perma-catheter for sign and symptom of infection every shift. d. On 4/20/26 at 0812 hours, during the initial tour of the facility, Resident 26 was observed awake, lying in bed, and eating breakfast. Resident 26 stated he would go to the hemodialysis treatment every Tuesdays, Thursdays, and Saturdays. Further observation of Resident 26's room failed to show a hemodialysis emergency kit was available at Resident 26's bedside. Medical record review for Resident 26 was initiated on 4/20/26. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 26's Order Summary Report showed a physician's order dated 9/30/25, to monitor the hemodialysis site on the right upper chest perma-catheter every shift for sign and symptom of infection. Review of Resident 26's H&P examination dated 10/1/25, showed Resident 26 had no capacity to make decisions. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26 Care Plan Report dated 10/17/25, showed a with focus care plan for hemodialysis related to end stage renal disease and the interventions included to monitor, document and report as needed for signs of the following bleeding, hemorrhage bacteremia, septic shock and report to MD if indicated. On 4/20/26 at 1150 hours, an observation and concurrent interview for Resident 14 and 26 was conducted with LVN 2. LVN 2 verified the above findings and stated the hemodialysis emergency kit was needed at Resident 14 and 26's bedside and should be available to use when there was bleeding at Resident 14 and 26 's hemodialysis access site. On 4/23/25 at 1341 hours, an interview was conducted with the DON. The DON stated the residents who had hemodialysis treatment should always be checked for bleeding at the hemodialysis access site. The DON further stated the hemodialysis emergency kit was important to always be available and accessible in the residents' room for any complications observed in the hemodialysis access site. The DON was informed and acknowledged the above findings. On 4/23/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Closed medical record review for Resident 41 was initiated on 4/21/26. Resident 41 was admitted to the facility on [DATE], and transferred to Hospital 2 on 4/16/26. Review of Resident 41's MDS assessment dated [DATE], showed Resident 41 had moderately impaired cognition and was coded for receiving hemodialysis treatments. Review of Resident 41's Order Summary Report dated 4/23/26, showed the following physician's orders: - dated 4/7/26, to hold metoprolol (blood pressure medication) 25 mg and iron (supplement) on hemodialysis days; and - dated 4/9/26, for Resident 41's hemodialysis treatments every Tuesday, Thursday, and Saturdays with Dialysis Center B. The pick-up time was 1230 hours and the chair time was at 1330 hours. a. Review of Resident 41's Dialysis Communication Forms showed the following missing and inaccurate documentation: - dated 3/31/26 , the post-hemodialysis section including the assessment for Resident 41's hemodialysis access location/status, catheter dressing, presences of bleeding, and post-dialysis treatment vital signs (BP (blood pressure), pulse, respirations, temperature, and pain) was blank. - dated 4/2/26, the pre-hemodialysis section failed to show the documentation of Resident 41's hemodialysis access location and status; and the dialysis center section failed to show Resident 41's post- hemodialysis weight; - dated 4/7/26, the dialysis center section failed to show the documentation of Resident 41's hemodialysis access location and status; and - dated 4/11/26, the dialysis center section failed to show Resident 41's post- hemodialysis weight. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Further review of Resident 41's Dialysis Communication Forms showed the following documentation: - dated 4/2/26, for the dialysis center section, under additional information showed a documentation by the hemodialysis nurse: please do not give any blood pressure medications on the day of the hemodialysis to prevent hypotension (low blood pressure) during treatment; and - dated 4/4/26, Resident 41 received hemodialysis treatment. Under the hemodialysis center section, the documentation showed to hold metoprolol, iron, and ESA (erythropoiesis-stimulating agents, used to treat anemia). Review of Resident 41's MAR for April 2026 showed the documentation on 4/4/26 at 0900 hours, Resident 41 was administered the metoprolol 25 mg medication. Further review of Resident 41's medical records failed to show the documentation if the recommendations from the hemodialysis center on 4/2 and 4/4/26 was communicated to the physician on those days. Review of Resident 41's Progress Notes dated 4/7/26 (three days later) at 1124 hours, showed the licensed nurse documented she called the hemodialysis center to clarify the orders from 4/4/26, and sending the order back for clarification. c. Review of Resident 41's Care Plan Report showed a care plan problem dated 4/8/26, addressing Resident 41's need for hemodialysis treatments related to end stage renal disease. The interventions included to monitor the hemodialysis access site in the right subclavian vein for R= redness, S=swelling, B=bleeding, P=pain; and to monitor the access site for bruit and thrill and notify the physician if bruit and thrill were absent. Further review of the Resident 41's Order Summary Report failed to show a physician's order for the monitoring of Resident 41's hemodialysis catheter. Review of Resident 41's medical record failed to show the licensed nurses documentation for the monitoring of Resident 41's hemodialysis access site. On 4/23/26 at 1101 hours, an interview and concurrent medical record review for Resident 41 was conducted with RN 3. RN 3 stated the hemodialysis communication forms were used as a form of communication between the facility and the hemodialysis center. RN 3 stated all sections of the dialysis communication form should be completed. RN 3 further stated when the resident returned to the facility after the hemodialysis treatment, the licensed nurse was responsible for assessing the residents and checking to ensure the hemodialysis center section was complete and any recommendations were communicated to the physician and documented in the progress notes. RN 3 reviewed Resident 41's medical records and verified there was no documentation of the monitoring of Resident 41's hemodialysis access site and there was no documentation to show the physician was informed on 4/2 and 4/4/26 of the recommendations by the hemodialysis center. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 72 was initiated on 4/20/26. Resident 72 was admitted to the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 had moderately impaired cognition. Review of Resident 72's Order Summary Report dated 4/21/26, showed the following physician's orders: - dated 4/1/26 , to check Resident 72's left chest perma-catheter every shift for signs and symptoms of complications or adverse reactions.; and - dated 4/6/26, for Resident 72's hemodialysis treatments every Tuesday and Saturdays with Dialysis Center A and the pick-up time was at 1000 hours and the chair time was at 1045 hours. Review of Resident 72's Dialysis Communication Forms showed the following missing and/or inaccurate documentation: - dated 4/7/26 , the post-hemodialysis section showed the licensed nurse documented Resident 72's catheter location was in the left upper chest and the Yes was selected for the presence of bruit and thrill; - dated 4/11/26, the hemodialysis center section failed to show the documentation of the dialysis end time; and the post-hemodialysis section showed the licensed nurse documented Resident 72's catheter location was in the left upper chest and the Yes was selected for the presence of bruit and thrill; - dated 4/14/26, the hemodialysis center section failed to show the documentation of the dialysis end time ; and the post-hemodialysis section showed the licensed nurse documented Resident 72's catheter location was in the left upper chest and the Yes was selected for the presence of thrill; - dated 4/18/26, the hemodialysis center section failed to show the documentation of the hemodialysis end time and the hemodialysis catheter location/status; and - dated 4/21/26, the hemodialysis center section failed to show the documentation of the hemodialysis catheter location/status; and the post-hemodialysis section failed to show the documentation of Resident 72's dialysis catheter location/status. A Yes was marked for the assessment of thrill. On 4/22/26 at 1120 hours, an interview and concurrent medical record review for Resident 72 was conducted with LVN 10. LVN 10 stated Resident 10 had a perma- catheter in the left chest. LVN 10 reviewed Resident 10's hemodialysis communication forms and verified the above findings. LVN 10 stated the dialysis communication forms were inaccurate and should be completed accurately. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Medical record review for Resident 49 was initiated on 4/20/26. Resident 49 was admitted to the facility on [DATE]. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 49's H&P examination note dated 8/6/25, showed Resident 49 had the capacity to understand and make decision. Resident 49 had ESRD and on hemodialysis. a. Review of Resident 49's Order Summary Report dated 4/22/26, showed a physician's order dated 10/14/25, for hemodialysis treatment every Mondays, Wednesdays and Fridays and the pick-up time was at 0830 hours, and the chair time was at 0930 hours. Review of Resident 49's Care Plan Report showed a care plan problem revised on 1/28/25, addressing Resident 49's need for hemodialysis treatments related to end stage renal disease. The interventions included to monitor vital signs pre-hemodialysis and after hemodialysis and to notify physician of significant abnormalities including signs and symptoms of hypotension. Review of Resident 49's Dialysis Communication Forms showed the following missing and/or inaccurate documentation: - dated 3/20/26, the Pre-Dialysis Information, shunt/ catheter location was marked 0 Zero The Post-Dialysis Information section including the assessment for Resident 41's hemodialysis access location/status, catheter dressing, assessment of bruit and thrill, presence of bleeding, general condition of the resident, vital signs (BP, pulse, respirations, temperature, and pain) and the nurse signature were blank - dated 4/16/26, an inaccurate date supposedly 4/15/26, showed the Post-Dialysis Information section including the assessment for Resident 41's hemodialysis access location/status, catheter dressing, assessment of bruit and thrill, presence of bleeding, general condition of the resident, vital signs (BP, pulse, respirations, temperature, and pain) and the nurse signature were blank - dated 4/17/26, showed the Post-Dialysis Information section including the assessment for Resident 41's hemodialysis access location/status, catheter dressing, assessment of bruit and thrill, presence of bleeding, general condition of the resident, vital signs (BP, pulse, respirations, temperature, and pain) and the nurse signature were blank - dated 4/20/26, the Pre-Dialysis Information, showed medications administered prior to dialysis, meal/ snack sent, additional information and the nurse signature were blank'. The Post-Dialysis Information section including the assessment for Resident 41's hemodialysis access location/status, assessment of bruit and thrill, general condition of the resident, vital signs (BP, pulse, respirations, temperature, and pain) and the nurse signature were blank - dated 4/22/26, showed the Post-Dialysis Information section including the assessment for Resident 41's hemodialysis access location/status, catheter dressing, assessment of bruit and thrill, presences of bleeding, general condition of the resident, vital signs (BP, pulse, respirations, temperature, and pain) and the nurse signature were blank On 4/22/26 at 1330 hours, an observation and a concurrent interview of Resident 49 was conducted in the resident's room. Resident 49 was observed sitting in a wheelchair. Resident 49 stated she had returned from hemodialysis treatment few minutes ago. On 4/22/26 at 1403 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 3. RN 3 stated Resident 49 had just returned from hemodialysis treatment. RN 3 (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verified the Dialysis Communication Form had missing documentation for the hemodialysis access location/status, catheter dressing, assessment of bruit and thrill, presences of bleeding, general condition of the resident, vital signs and the nurse signature. RN 3 stated the Resident 49 should have been assessed upon arrival from hemodialysis and the Dialysis Communication Form should have been completed to document resident's condition. On 4/23/26 1450 hours, an interview was conducted with the DON and Administrator. The DON and the Administrator was informed and acknowledged the above findings. b. Review of the facility's P&P titled Fluid Restriction revised 12/19/22, showed the fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. Water will not be provided at the bedside unless calculated into the daily total fluid restriction. On 4/20/26 at 0747 hours, during the initial tour of the facility the Resident 49 was observed sitting in her wheelchair. A water pitcher with a straw was observed on the resident's bedside table. The pitcher at Resident 49's beside table had no graduated measurement. On 4/20/26 at 0747 hours, an observation of Resident 49 in the room and concurrent interview was conducted with LVN 18. LVN 18 verified Resident 49 had a water pitcher on the bedside table. LVN 18 stated if the resident was on fluid restriction there should be no water pitcher at the resident's bedside. Review of Resident 49's Order Summary Report dated 4/22/26, showed a physician's order dated 6/5/25 for the following: - fluid restriction of 1500 ml/day: nursing for total of 780 ml (0700 hours to 1500 hours shift = 300 ml, 1500 hours to 2300 hours shift = 300 ml, and 2300 shift to 0700 hours shift = 180 ml) dietary for total of 720 ml (breakfast = 240 ml, lunch = 240 ml, and dinner = 240 ml); and - to record intake &output. Intake to be recorded in ml. Output to be recorded by number of times the resident voided. Review of Resident 49's Documentation Survey Report v2 for April 2026 failed to show the intake and output monitoring by the CNAs. On 4/20/26 at 1137 hours, an interview was conducted with Resident 49. Resident 49 stated she drank the water from the pitcher. Resident 49 further stated she was not able to tell the staff whenever she drinks from her water pitcher. On 4/20/26 at 1030 hours, an observation and concurrent interview was conducted with CNA 15. CNA 15 verified Resident 49 had a non-graduated measuring pitcher at the bedside table. CNA 15 stated she would not know how much fluid Resident 49 would consume from the pitcher. CNA 15 further stated Resident 49 would also drink fluids from the meal tray. CNA 15 stated Resident 49's fluid intake and output was not being measured. On 4/22/26 at 1120 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 3. Review of Resident 49's Monitor Record for April 2026 showed the resident's intake and output was not recorded on 4/12, 4/16, and 4/17/26. RN 3 stated the intake and output (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented by the licensed nurses in the Monitor Record should include the fluids consumed by the resident from the meal tray. On 4/23/26 at 1105 hours, an interview was conducted with the DSD. The DSD stated Resident 49 was on fluid restriction and should not have any water pitcher at bedside. The DSD stated the CNAs did not record the intake and output; however, the CNAs should report to the charge nurse verbally the resident's intake and output for the shift. On 4/23/26 1450 hours, an interview was conducted with the DON and Administrator. The DON and the Administrator was informed and acknowledged the findings as above. Cross reference to F842, item #2.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **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 medication therapy/management for three of four residents (Residents 31, 129, and 187) observed for the medication administration which resulted to a medication error rate of 12.5%. * The facility failed to ensure the medications were administered as ordered by the physician for Residents 31 and 129. * The facility failed to ensure the medications via GT were administered as per the facility's P&P and accepted standards of practice for Resident 187. These failures had the potential for the residents to experience GT complications and ineffective medication therapy management by not receiving medications timely.Findings: 1. Review of the facility's P&P titled Ordering and Receiving Medications from the Dispensing Pharmacy dated 1/2022 showed Medications .are received from the dispensing pharmacy on a timely basis .If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form/ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy .Reorder medication five days in advance of need to assure an adequate supply is on hand .The refill order is called in, faxed, or otherwise transmitted to the pharmacy . a. On 4/20/26 at 0900 hours, a medication administration observation for Resident 129 and concurrent interview was conducted with LVN 13. LVN 13 prepared five oral medications for Resident 129. LVN 13 stated Resident 129's morning dose of amlodipine (medication for high blood pressure) 7.5 mg was not available and LVN 13 would have to check if the pharmacy had delivered it. LVN 13 was observed to not administer Resident 129's morning dose of amlodipine 7.5 mg. Medical record review for Resident 129 was initiated on 4/20/26. Resident 129 was admitted to the facility on [DATE]. Review of Resident 129's Order Details showed a physician's order dated 4/20/26, to administer amlodipine 7.5 mg by mouth one time a day for high blood pressure. Review of Resident 129's MAR for April 2026 showed Resident 129's amlodipine 7/5 mg medication was scheduled to be administered at 0900 hours. The MAR showed on 4/20/26, the amlodipine medication was documented as not given and had the code 2 (See Progress Notes). The MAR for April 2026 further showed the amlodipine 7.5 mg dose was given to Resident 129 on 4/20/26 at 1846 hours. b. On 4/20/26, at 1020, a medication administration observation for Resident 31 Administrator concurrent interview was conducted with LVN 10. LVN 10 prepared 12 oral medications for Resident 31. LVN 10 stated Resident 31's morning dose of apixaban (a blood thinner to prevent blood clot) 2.5 mg and metoprolol (medication for high blood pressure) 25 mg were not available. LVN 10 was observed to not administer Resident 31's morning doses of apixaban 2.5 mg and metoprolol 25 mg medications. Medical record review for Resident 31 was initiated on 4/20/26. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 31's Order Details showed a physician's order dated 4/7/26, for the following medications:- apixaban 2.5 mg by mouth two times a day for DVT prophylaxis; and- metoprolol 25 mg one-half tablet by mouth every 12 hours for high blood pressure. Review of Resident 31's MAR for April 2026 showed two doses of apixaban 2.5 mg and one morning dose of metoprolol 25 mg were documented as not given with the code 6 (See Progress Notes). Review of Resident 31's Progress Notes dated 4/20/26 at 1446 hours, showed the pharmacy was called and the staff inquired regarding the status of the metoprolol 25 mg and apixaban 2.5 mg medications. The notes showed the pharmacy stated they were already working on the apixaban order and reordered the metoprolol 25 mg due to an error from the last reorder of not going through. On 04/20/26 at 1412 hours, an interview was conducted with LVN 10. When asked about Resident 31's apixaban and metoprolol medications, LVN 10 had not contacted the pharmacy yet regarding the two medications that were not available for Resident 31 and would contact the pharmacy when the mid-day medication administration for the residents were completed. LVN 10 stated Resident 31's apixaban 2.5 mg medication was reordered on 4/19/26, and there was no record of the reordering of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's metoprolol 25 mg medication. LVN 10 verified Resident 31's apixaban and metoprolol medications were not available. On 4/23/26 at 0940 hours, an interview was conducted with the DON. The DON was made aware of Resident 31 and 129's missing medications during the medication administration and acknowledged the reordering of the residents' medications was not done timely. The DON stated the nurses needed to order the medications timely and would need to communicate with other staff. The DON also stated the nurses needed to notify the MD if the resident missed any dose of the medications. On 4/23/26 at 1020 hours, an interview was conducted with the Consultant Pharmacist. The Consultant Pharmacist stated there should not be any reason to be out of the medications which could be set for autofill by the dispensing pharmacy. 2. Review of Center for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) letter 13-02-NH titled Nursing Homes - Clarification of Guidance related to Medication Errors and Pharmacy Services posting date 11/2/12, showed for administering medications via tube feeding, the standard of practice is to administer each medication separately and flush the tubing between each medication. An exception would be if there is a physician's order that specifies a different flush schedule for an individual resident, for example because of a fluid restriction. Failure to flush before and in between each medication administration is considered a single medication error and would be included in the calculation for medication errors exceeding 5 percent . American Society for Parenteral and Enteral Nutrition (ASPEN) publication dated 11/4/16, in Journal of Parenteral and Enteral Nutrition, Volume 41, Issue 1, pages 15-103, titled ASPEN Safe Practices for Enteral Nutrition Therapy showed Medication Delivery via Enteral Access Devices .Provide appropriate tube irrigation around the timing of drug administration .Prior to administering medication, stop the feeding and flush the tube with at least 15 mL water .Administer the medication using a clean enteral syringe .Flush the tube again with at least 15 mL water, taking into account the patient's volume status .Repeat with the next medication .Flush the tube one final time with at least 15 mL water . Review of the facility's P&P titled Enteral Tube Medication Administration dated 10/2017 showed to safely and accurately administer oral medications through an enteral tube .Administer medication .Administer each medication separately and flush with at least 15 ml of water or other appropriate liquid between each medication . On 4/20/26 at 1020, a medication administration observation was conducted for Resident 187 with LVN 14. LVN 14 prepared the following medications for Resident 187: - one tablet of finasteride (medication to treat enlarged prostate which aids in fertility) 5 mg and 500 mg of calcium carbonate (supplement) both crushed into powder; - 10 ml of docusate (stool softener) 50 mg per 5 ml oral solution; and - 17 grams of polyethylene glycol 3350 (medication for constipation) powder. LVN 14 was observed adding all four medications in a plastic cup containing approximately four ounces of water and mixed them before administering the medication together into Resident 31's GT. On 4/20/26 at 1425 hours, an interview was conducted with LVN 14. When asked about Resident 187's administered medications via GT, LVN 10 was not aware each medication should be administered via GT one medication at a time and stated Resident 187 preferred taking the medications with as minimal water as possible. LVN 10 stated would look in the resident's medical record to see if there was any documentation in the resident's care plan about giving the medications via GT all together. On 4/20/26 at 1445 hours, an interview was conducted with the DON. The DON acknowledged the medication via GT needed to be administered one medication at a time. On 4/23/26 at 0940 hours, a follow-up interview was conducted with the DON. The DON verified there was no documentation of Resident 187's preference or for all the medications to be administered at the same time with minimal water during medication administration via GT. On 4/23/2 at 1020 hours, an interview was conducted with the Consultant Pharmacist. The Consultant Pharmacist stated the current standards would not support mixing and giving all medications at the same time via GT.

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

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

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

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **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 ensure the menu was followed. * The facility failed to ensure the residents were served the sour cream sauce with the pork cutlet (as per the menu), instead of the sweet glaze sauce. The food substitution was not communicated in advance to the residents. * Resident 54 was not offered the alternative menu when he refused to eat his breakfast and lunch. These failures had the potential to not meet the residents' nutritional needs and negatively impact the residents' nutritional health.Findings: Review of the facility's document titled Diet Type Report dated 4/20/26, showed 155 of 191 residents in the facility received food prepared in the kitchen. 1. Review of the facility's document titled Diet Spreadsheet (undated) for Tuesday, Week 1, showed the residents on regular diet, regular- easy to chew diet, soft and bite-sized diet, minced and moist diet, pureed diet, CCHO diet, and renal diet were to be served the pork cutlet with sour cream sauce. On 4/21/26 at 1139 hours, during the lunch trayline observation, the [NAME] was observed to have served the pork cutlet with an orange-colored glaze, instead of the sour cream sauce. On 4/21/26 at 1332 hours, an interview was conducted with the Cook. The [NAME] was made aware about the observation of the pork cutlet with an orange-colored glaze during tray line. The [NAME] stated the orange-colored sauce was a sweet glaze. The [NAME] verified the menu showed to serve the pork cutlet with sour cream sauce for the lunch meal. The [NAME] stated he could not find the sour cream when he was preparing the sauce for the pork cutlet so he made the sweet glaze instead. The [NAME] stated he did not inform the DSS. On 4/21/26 at 1510 hours, an interview was conducted with DSS 2. DSS 2 stated the menu should be followed and the residents should be served the items on the menu. DSS 2 stated if the items on the menu were not available, the cook should inform the DSS, who would update the menu and inform the residents of the change. DSS 2 stated she was not informed by the [NAME] that the facility was out of sour cream. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Standardized Menus revised on 12/19/22, showed Alternative menus will be available if the primary menu or immediate selections for particular meal are not to resident's liking. The policy further showed if during meal observations, a resident's dietary intake appears inadequate, the facility will make reasonable efforts to review and/or adjust the menu and/or the individual resident's food plan to meet the nutritional, religious, cultural, and ethnic needs, and preferences of the resident. Medical record review for Resident 54 was initiated on 4/20/26. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 54's H&P examination dated 12/7/25, showed Resident 54 had the capacity to understand and make decisions. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 54's Nutrition amount eaten on 4/21/26, showed Resident 54 refused meals for breakfast and lunch. On 4/21/26 at 1238 hours, an observation and concurrent interview was conducted with Resident 54. Resident 54 was observed without a lunch meal and stated he returned the tray because he did not like potatoes and beans. Resident 54 further stated he was not offered an alternative menu. On 4/22/26 at 0818 hours, an interview and concurrent medical record review for Resident 54 was conducted with RN 2. RN 2 stated Resident 54 had refused his breakfast and lunch on 4/21/26. When asked about the facility's process when the residents refuse meals, RN 2 explained a substitution order form should be filled in and provided to the kitchen. When asked to provide documentation of alternative menu for Resident 54, RN 2 stated the substitution order form cannot be found and there was no documentation in Resident 54's medical record. On 4/23/26 at 1029 hours, an interview was conducted with CNA 1. CNA 1 stated she does not remember offering an alternative menu to Resident 54 and does not recall completing the substitution form. On 4/23/26 at 1509 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the dietary texture guidelines were followed as per the facility's P&P for 22 residents who were on the pureed texture diet. * The pureed pork cutlet, pureed green beans, pureed bread, and pureed orzo rice (rice-shaped pasta) were observed to be runny and failed to hold their shape. This failure posed a risk to cause residents' choking or aspiration (a condition in which food, liquids, saliva, or vomit is breathed into the airway) episodes.Findings: Review of the facility's document titled Diet Type Report dated 4/20/26, showed 22 of 155 residents in the facility who received food prepared in the kitchen received a pureed texture diet. Review of the facility's P&P titled Puree Food Preparation on 12/19/22, showed it is the policy of the facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance. Puree foods shall be prepared in such a manner to prevent lumps or chunks. The goal is a smooth, soft, homogenous consistency similar to mashed potatoes. On 4/21/26 at 1150 hours, during the lunch meal tray line, an observation of Resident 140's lunch tray line was conducted with the RD. Review of Resident 140's lunch meal ticket showed Resident 140 was on a pureed thin liquid diet. An inspection of Resident 140's lunch tray showed a scoop of pureed pork with an orange sauce on top, a scoop of pureed bread, pureed green beans, and pureed orzo rice. The pureed pork, beans, rice, and bread were observed not holding its shaped, runny and touching the surrounding entrees. The RD verified the above findings and stated the pureed entrees should hold their shape and if prepared too watery, it may lead to aspiration. The RD was observed stopping the tray line and asking the cook to make the puree items thicker. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen. * The facility failed to ensure the proper labeling of food in the kitchen. * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the kitchen utensils were in good condition. * The facility failed to ensure the items in the kitchen was discarded after the use-by date. These failures had the potential for exposure to food-borne illnesses for a medical vulnerable population of 155 residents who received food prepared in the kitchen.Findings: Review of the facility's document titled Diet Type Report dated 4/20/26, showed 155 of 191 residents in the facility received food prepared in the kitchen. 1. According to USDA Food Code 2022, Section 3-501.17, Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking (undated), showed date marking requirements apply to containers of processed food that have been opened and to food prepared, if held for more than 24 hours, shall be clearly marked to indicate the date or day by which the food shall be consumed on the premise, sold, or discarded. Review of the facility's P&P titled Food Safety and Food Storage revised on 11/4/24, showed practices to maintain safe refrigerated storage include: iv. labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it us used by its use-by-date, or frozen (where applicable)/discarded. On 4/20/26 at 0615 hours, an initial tour of the kitchen was conducted with DSS 1 and the following were observed:- two ham sandwiches stored inside Refrigerator A were not labeled with the preparation or the use-by date;- two boxes of mighty shakes (nutritional shakes) stored inside Refrigerator B were not labeled with the date the shakes were placed the refrigerator. The label on the shake cartons showed to store frozen, thaw at or below 40 degrees F and to use the thawed product within 14 days; and- an orange juice box connected to the juice dispenser. The juice box was labeled with the received date of 4/14/26, and the best by date of 10/14/26. However, the juice box was not observed with the opened date. DSS 1 verified the above findings and stated the food items should be labeled with the use-by date when placed inside the refrigerator. DSS 1 stated the mighty shakes once placed in the refrigerator should be discarded after 14 days. When asked, DSS 1 stated she did not know when the orange juice was opened. DSS 1 further stated when the juice boxes were first opened and connected to the juice dispenser, the boxes should be labeled with the opened, and use-by dates. 2. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C), nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. According to USDA Food Code 2022, 4-602.13, Non-Food Contact Surfaces (undated) showed the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. Review of the facility's P&P titled Food Safety and Food Storage revised on 11/4/24, showed all equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. On 4/20/26 at 0615 hours, an initial tour of the kitchen was conducted with DSS 1 and the following were observed:- the metal racks holding the plastic trays inside Refrigerator A had dry yellow residue and multiple dry white particles;- the black blender lid was had dry food particles;- the detachable blender blade had tan colored residue;- the gray blender had dry yellow and brown-colored food residue;- a white brush was wet and had orange-colored residue;- a black plastic serving spoon had white-colored residue;- a slotted portion server had yellow residue on the handle;- a yellow handle scooper was wet and had yellow-colored residue;- the stationary can opener had brownish fuzzy substance; and- two sheet pans had brownish-black colored stains. DSS 1 verified the above findings and stated the food preparation equipment should be clean. 3. According to the USDA Food Code 2022, Section 4-101.11, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Multiuse, Characteristics (undated) showed for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/20/26 at 0615 hours, an initial tour of the kitchen was conducted with DSS 1 and the following were observed:- two chipped spatulas;- one white spatula was stained with brownish discoloration; and- one metal spatula with white handle was observed with melted handle. DSS 1 verified the above findings. 4. On 4/20/26 at 0615 hours, an initial tour of the kitchen was conducted with DSS 1 and the following were observed:- nine 16-oz bags of Splenda (a sweetener) had a use-by date of 10/25/25;- six cans of vanilla pudding (in the emergency food supply) was labeled with the best-by date of 11/10/25; and- one box of iced tea, connected to the juice dispenser was labeled with the best-by date of 2/20/26. DSS 1 verified the above findings. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, medical record review, facility document review, and facility P&P review, the facility failed to establish and maintain the infection control program and practices designed to help prevent the development and transmission of diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for January through April 2026. The facility conducted surveillance only on the residents who exhibited signs and symptoms of infection and were prescribed antimicrobial medications. The facility failed to ensure the residents exhibited signs and symptoms of an infection, met the facility's criteria of a true infection (Mc Geer's Criteria) but were not prescribed antimicrobial medications. * The facility failed to ensure Residents 2, 8, 44 and 93's tube feeding pump were clean and free from dusts and dried up formula. * The facility failed to ensure infection control practices were maintained when Resident 19's respiratory suction machine was observed placed directly on the floor. * The facility failed to ensure Resident 24 was provided with a clean blanket and not the blanket obtained which was lying on top of the soiled linen cart. * The facility failed to ensure Resident 77's syringe used to administer medications via GT was changed daily. * The facility failed to ensure Resident 157 who had a GT had an order for EBP. * The facility failed to ensure CNA 5 wore the appropriate PPE when providing care to Resident 200 who was on EBP. * The facility failed to ensure pneumonia cases were screened for possible Legionnaire's disease. These failures posed the risk of not identifying the residents' risk of infections and thereby preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility.Findings: Review of the facility's P&P titled Infection Surveillance dated 12/19/22, showed the following: - a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections, - the facility will collect data to properly identify possible communicable diseases or infections before they spread. - all resident infections will be tracked. Separate site- specific measures may be tracked as prioritized from the infection control risk assessment. 1.a. Review of the facility's Infection Surveillance Reports for February through April 2026 showed the infection control surveillance was only conducted for the residents who were prescribed with antibiotics. There was no documented evidence of residents who exhibited signs and symptoms of infection who met the facility's criteria for a true infection (Mc Geer's Criteria) but were not prescribed antimicrobial medications, such as the residents diagnosed with Candida Auris infection were included in the surveillance reports. On 4/22/26 at 1016 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked the process of how the Infection Surveillance was done, the IP stated the residents with had signs and symptoms of infection and had an order for antibiotics were on the list. The IP further stated the residents with signs and symptoms of infection and were not prescribed with antibiotics, were not included in the Infection Surveillance list. The IP was asked if the CAI percentage included the residents with Candida Auris, the IP responded all the residents with Candida (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Auris were colonized and were not on the Infection Surveillance list. The IP was asked how many residents with Candida Auris the facility have currently, the IP stated 30 residents in the subacute unit with Candida Auris. Review of the Monthly Infection Surveillance Reports for January through April 2026 showed the following: - January 2026, total of 42 cases, 13 CAIs and 29 HAIs; - February 2026, total of 33 cases, 8 CAIs and 25 HAIs; - March 2026, total of 39 cases, 5 CAIs and 31 HAIs; and - April 2026 (4/1 - 4/22/26), total of 4 CAIs and 17 HAIs. Reviewed the facility's monthly Infection Surveillance Report from January 2026 through April 2026 showed documentation of the residents having HAI or CAI and were prescribed with antimicrobial medications. The IP verified the residents listed all had antimicrobial orders. Further review of the facility's Infection Surveillance Report from January through April 2026 showed the facility failed to conduct surveillance for all the resident infections, specifically to the residents who had signs and symptoms of infection and were not included in Infection Surveillance Report. When asked how the residents with symptoms of infection and not on antimicrobials were monitored, the IP stated she would check the progress notes on how they were. The IP was further asked, if these residents' infection symptoms recur after two weeks, if she would remember these residents had prior infection symptoms when their names were not on the Infection Surveillance Report, the IP did not respond. b. Review of the facility's monthly Infection Surveillance Report for January 2026 showed the following onsets: - dated 1/16/26, for Resident 40's Vancocin (medication to treat infection) 125 mg oral capsule; - dated 1/16/26, for Resident 95's Bleph-10 Ophthalmic solution 10% (eyedrops to treat infection); - dated1/20/26, for Resident 129's Amoxicillin potassium Clavulanate (medication to treat infection) 875-125 mg , and - dated 1/25/26, for Resident 142's Piperacillin Sodium – Tazobactam Solution 3-0, 375 mg (medication to treat infection). However, further review of the report did not show the type of infection Residents 40, 95, 129, and 142 had and whether the respective infections met McGeer's criteria. Further review of Infection Surveillance Report showed the following: - for January 2026, with 42 residents with infections, seven residents were documented as met the Mc Geer's Criteria; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- for February 2026, 33 residents with infections, three residents were documented as did not meet the Mc Geer's criteria; - for March 2026, 39 residents with infections, 13 were documented as met the criteria and one resident was documented as did not meet the Mc Geer's criteria; and - for April 2026, 21 residents with infections had no documentation if they met the McGeer's criteria of a true infection or not. The IP stated she did not complete the McGeer's and Loeb's form anymore, she has her own checklist and did her documentation on the respective residents Infection Assessments. The IP was requested to show her checklist, and no checklist was shown. Medical record review for Resident 76 was conducted on 4/22/26. Resident 76 was admitted to the facility on [DATE]. Resident 76 was identified to have chest congestion, cough, difficulty of breathing/ shortness of breath and fever on 2/18/26 with infection category as unknown. Review of Resident 76's Infection Screening Evaluation dated 2/18/26, did not show the Infection Analysis Data was checked off if Loeb's or McGeer's Criteria was met with the respiratory symptoms identified. The IP stated it was missed. 2. Review of the facility's P&P titled Medication Administration dated 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 ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. On 4/20/26 at 0807 hours, an initial tour to the facility was conducted. Resident 77's GT feeding pump was observed. Resident 77's GT feeding had completed. A GT syringe inside a bag was labeled with Resident 77's name, room number and was dated 4/18/26, and hanging on the GT pole on Resident 77's right side of the bed. The GT syringe was observed to have whitish remnants at the tip and some brownish to blackish fluid at the bottom of the plastic bag which contained the syringe. Review of Resident 77's medical record was initiated on 4/20/26. Resident 77 was admitted to the facility on [DATE]. Review of Resident 77's Order Summary Report dated 4/23/26, showed the physician's order dated 3/7/26, for NPO diet and enteral feed orders. On 4/20/26 at 0826 hours, an interview was conducted with LVN 2. LVN 2 verified Resident 77's GT syringe hanging on the GT pole at the right side of Resident 77's bed was labeled with Resident 77's name and was dated 4/18/26, with whitish remnants at the tip of the syringe and some brownish to blackish fluid at the bottom of the plastic bag enclosing the syringe. LVN 2 stated we have to change the GT syringes daily. On 4/20/26 at 0832 hours, an interview was conducted with RN 4. RN 4 acknowledged Resident 77's GT syringe was dated 4/18/26 with whitish remnants at the tip of the GT syringe and some brownish to blackish fluid at the bottom of the plastic bag enclosing the syringe. RN 4 stated, it needed to be changed daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility's P&P titled Routine Cleaning and Disinfection dated 12/19/22, showed it is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infection to the extent possible. a. On 4/20/26 at 634 hours, during an initial tour to the facility, Resident 93 had GT feeding was observed in progress. The top handle of the GT feeding pump down to the display screen was observed to have dust-like particles and stains of dried-up formula. Medical record review for Resident 93 was initiated on 4/23/26. Resident 93 was admitted to the facility on [DATE]. Review of Resident 93's H&P examination dated 4/21/25, showed Resident 93 had no capacity to understand and make decisions. Review of Resident 93's Order Summary Report dated 4/23/26, showed a physician's order dated 9/11/25, to administer continuous enteral feeding: Fibersource HN (enteral feeding formula) at 75 ml/hours for 20 hours, to start at 1200 hours until 1500 ml/ 1800 kcal. b. On 4/20/26 at 745 hours, during an initial tour to the facility, Resident 44's GT feeding pump display screen, up to the handle, extending to the back and to the right side of the GT feeding pump where the GT tubing connector cap was placed had stains of dried-up feeding formula and dust-like particles. On 4/20/26 at 0830 hours, an interview was conducted with CNA 6. CNAs 6 verified Resident 44's the tube feeding pump was dirty and stated, the nurses do that. Review of Resident 44's medical records was initiated on 4/20/26. Resident was admitted to the facility on [DATE]. Review of Resident 44's H&P examination dated 1/22/26, showed Resident 44 was unable to make decisions. Review of Resident 44's Order Summary Report dated 4/23/26, showed a physician's order dated 4/16/26, to administer continuous enteral feeding of Nutren 2.0 (enteral feeding formula) at 70 ml/hour for 12 hours, start at 1800 hours, off at 0600 hours or until 840 ml has been infused. On 4/20/26 at 0832 hours, an observation for Residents 44 and 93 and concurrent interview was conducted with RN 4. RN 4 acknowledged Resident 44's GT feeding pump display screen, up to the handle, extending to the back and to the right side of the tube feeding pump where the GT tubing connector cap was placed had stains of dried-up feeding formula and dust-like particles; and Resident 93's GT feeding pump top handle down to the display screen have dust-like particles and stains of dried-up formula. RN 4 stated Oh my, it should be clean, I will take care of it. c. On 4/20/26 at 855 hours, during an initial tour to the facility, Resident 2 was observed lying in bed with the GT feeding in progress. The top portion of the GT feeding pump, above the display screen had dust like particles and to the right side of the tube feeding pump where a GT tubing connector cap was placed had stains of dried-up formula. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 2 was initiated on 4/20/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 2/10/26, showed Resident 2 had no capacity to make medical decisions. Review of Resident 2's Order Summary Report dated 4/23/26, showed a physician's order dated 4/15/26, to administer continuous enteral feeding of Peptamen 1.5 (enteral feeding formula) at 50 ml/hour for 20 hours to start at 1200 hours until 1000 ml has infused. On 4/20/26 at 1138 hours, an observation and concurrent interview was conducted with LVN 5, LVN 5 verified the presence of dust like particles on the top portion of the Resident 2's tube feeding pump above the display screen and stains of dried-up formula where the GT connector cap was placed. LVN 5 stated when there was a crevice (a narrow gap), it would need a little steamer. d. On 4/20/26 at 854 hours, during the initial tour of the facility, Resident 8's front part of the GT feeding pump was observed to have dust like particles and a brownish residue inside the GT tubing connector cap. On 4/20/26 at 1140 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 8's GT feeding pump had dust like particles and a brownish reside inside the GT tubing connector cap. LVN 5 stated was dirty. Medical record for Resident 8 was initiated on 4/21/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 1/7/26, showed Resident 8's mental status was chronically impaired with severe global deficits, largely nonverbal and rarely able to express or comprehend communication. Review of Resident 8's Order Summary Report dated 4/23/26, showed a physician's order dated 2/7/26, to administer continuous enteral feeding Diabetisource AC (enteral feeding formula) at 60 ml/hour, to start at noontime until 1080 ml has infused. On 4/21/26 at 1001 hours, an interview was conducted with the IP. The IP was made aware and acknowledged Resident 2, 8, 44, and 93's GT feeding pumps were not clean. The IP stated the GT feeding pumps were cleaned as needed by the nurses and CNAs and the deep cleaning of the GT pumps were done by the housekeeping staff. The IP further stated GT feeding pumps should have been cleaned. 4. Review of the facility's P&P titled Water Management Program dated 12/19/22, showed the following: - it is the policy of the facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens in the facility's water systems are based on nationally accepted standards. - all cases of health care associated legionellosis or other opportunistic waterborne pathogens shall be reported to the local state health officials, followed by an investigation which included: the IP will (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigate all cases of definite health care associated legionnaire's disease for the source of legionella, the IP will also investigate for the source of legionella when two or more health care associated legionnaire's disease is identified; elements of an investigation may include reviewing medical and microbiology records, actively identifying all new and recent residents with health care associated pneumonia and testing them for legionella using both culture of lower respiratory secretions and the legionella urinary antigen test, developing a line list of cases, evaluating potential environmental exposures, performing an environment assessment, performing environmental sampling as indicated by environmental assessment, sub typing and comparing clinical and environmental isolates, decontaminating environmental resources, working with local ad/or state health department staff and reviewing and possibly revising the water management program with input from local and/or state health department staff. Review of the facility's Infection Surveillance Reports from January to March 2026 showed documentation of the residents having HAI for pneumonia as follows: - January 2026 showed six cases; - February 2026 showed two cases; and - March 2026 showed one case. Review of the facility's Infection Control Surveillance Reports from January to March 2026 showed documentation of the residents having HAI – pneumonia were prescribed with antimicrobials medications. On 4/22/26 at 1104 hours, an interview and concurrent record review was conducted with the IP and Maintenance Director. The IP stated the facility would review the policy on water management, and an investigation was only done if the facility have a positive in-house legionnaire's case, then we will follow the investigative steps. The IP and Maintenance Director were asked how the facility could be definitively classifying the resident as positive or negative for legionella or only suspected based on symptoms and clinical findings, the IP stated true, we will discuss with our Safety Meeting next week. On 4/23/26 at 1216 hours, an interview and concurrent facility document and facility P&P review was conducted with the DON. The DON stated legionella testing was done if there was a case of legionnaires. However, when the DON was asked how the facility would know if a resident was legionella positive, if the resident was not tested in the facility, the DON stated then we have to test in house. On 4/23/26 at 1600 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 5. Medical record review for Resident 19 was initiated on 4/20/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19 had a BIMS score of 15, meaning cognitively intact. Review of Resident 19's Order Summary Report showed a physician order dated 3/15/26, to suction (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	secretion PRN for increase secretion. On 4/20/26 at 0644 hours, during the facility initial tour, Resident 19's respiratory suction machine was observed on Resident 19's left side of the bed, directly placed on the floor. On 4/20/26 at 0724 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 verified Resident 19's respiratory suction machine was placed directly on the floor. LVN 6 stated Resident 19 had a room change last week and the respiratory suction machine should have been placed on a table to prevent infection. On 4/23/26 at 1509 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. 6. Medical record review for Resident 24 was initiated on 4/20/26. Resident 24 was admitted to the facility on [DATE]. On 4/21/26 at 0849 hours, an observation and concurrent interview was conducted with CNA 14. CNA 14 was observed assisting Resident 24 with a shower in the resident's shower room. Resident 24 was observed sitting in a shower chair. Resident 24's gown and blanket were observed lying on top of a lined cart labeled soiled linen. At the conclusion of Resident 24's shower, CNA 14 was observed removing Resident 24's blanket from the top of the soiled linen cart and then covered Resident 24 with the blanket. CNA 14 verified the findings and stated for infection control, she should not have used the blanket she obtained from the top of the soiled linen cart to cover Resident 24. 7. Review of the facility's P&P titled Enhanced Barrier Precaution revised 6/17/24, showed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier precautions/Enhanced Standard precaution should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with the residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Medical record review for Resident 200 was initiated on 4/20/26. Resident 200 was admitted to the facility on [DATE]. Review of Resident 200's Order Summary Report showed a physician's order dated 9/2/25, for Enhanced Barrier Precaution related to the use of GT every shift. On 4/20/26 at 0735 hours, an observation for Resident 200 was conducted with CNA 5. CNA 5 was observed providing care to Resident 200 without a gown. Resident 200 was observed to be on EBP isolation with visible posting and presence of PPE cart outside the room. On 4/20/26 at 0742 hours, an interview was conducted with CNA 5. CNA 5 verified she did not use a gown when providing care to Resident 200. CNA 5 stated Resident 200 was on EBP precaution for her GT, and she should wear a gown when providing care to the residents on EBP. On 4/23/26 at 1341 hours, an interview was conducted with the DON. The DON was asked about the residents who were on enhanced barrier precautions. The DON stated she expected all the facility staff should be aware and knowledgeable about the residents who were placed on the enhanced barrier precaution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings 8. Review of Facility's P&P for titled Enhanced Barrier Precautions revised on 3/10/25, showed Enhanced Based Precautions are indicated for residents with any of the following: i. Wounds (examples: chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (examples: central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO and ii. Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions do not apply. On 4/20/26 at 0648 hours, during the initial tour of the facility, Resident 157 was observed with a GT. Resident 157's name by the door had no identification if the resident was on enhanced based precaution. Medical record review for Resident 157 was initiated on 4/20/26. Resident 157 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 157's H&P examination dated 8/13/25, showed Resident 157 had no capacity to understand and make decisions. Review of Resident 157's Plan of Care showed a care plan problem dated 8/13/25, addressing resident on enhanced barrier precaution related to GT use. On 4/20/26 at 1500 hours, an interview and concurrent record review for Resident 157 was conducted with LVN 4. LVN 4 verified Resident had GT. LVN 4 verified resident's physician order failed to show an order for Enhanced Barrier Precaution. On 4/23/26 at 1453 hours, an interview was conducted with the DON. The DON stated Resident 157 should have an order for Enhanced Barrier Precaution related to the GT. The DON was informed and acknowledged the findings as above.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical records review, facility document and facility P&P review, the facility failed to implement their antibiotic stewardship program when the facility failed to conduct an assessment for the McGeer's criteria to determine the true infection for two of two residents (Residents 10 and 11) who were located at the SNF and sub acute unit. * The facility failed to ensure the infection treated for Residents 10 and 11 reviewed was classified as CAI, HAI, if met or did not meet the Mc Geer's criteria. This failure had the potential for inaccurately identification of true infections and potentially inhibited the residents' physicians from discontinuing unnecessary antimicrobials.Findings: Review of the facility's P&P titled Antibiotic Stewardship Program dated 12/19/22, showed it is the policy of this 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 Infection Preventionist, with oversight from the Director of Nursing, serve as the leader of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility. Review of the facility's Infection Control binder showed the monthly Infection Surveillance Reports for January through April 2026. The surveillance reports did not completely indicate if the residents' infection meets or does not meet the Mc Geer's Criteria. Furthermore, the Infection Screening Evaluation on the residents' medical record did not show all the criteria used to assess for Mc Geer's criteria to determine the true infection. a. Medical record review for Review of Resident 10 was initiated on 4/23/26. Resident 10 was admitted to the facility on [DATE]. Reviewed Resident 10's H&P examination dated 3/10/26, showed Resident 10 had the capacity to understand and make decisions. Review of the facility's monthly Infection Surveillance Report for March 2026 showed Resident 10 was prescribed with Vancomycin HCL (antibiotics) IV solution; however, the report did not show if the infection treated was CAI, HAI, if met or did not meet the Mc Geer's criteria. Review of Resident 10's Infection Screening Evaluation dated 3/9/26, showed Resident 10 had an active diagnosis of infection. The infection analysis did not indicate if Resident 10 met or did not meet Loeb's or Mc Geer's criteria. b. Medical record for Resident 11 was initiated on 4/23/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 4/14/26, showed the findings of neurologic impairment. Review of Resident 11's Order Summary Report dated showed a physician's order dated 4/22/26, to give Vancomycin HCl Oral Suspension 50 mg via GT every six hours for c-difficile bacteria for 10 days. Review of the facility's monthly Infection Surveillance Report for April 2026 showed Resident 11 was prescribed with Vancomycin HCL oral suspension 50 mg/ml; however, the report did not show if the infection treated was CAI, HAI, if met or did not meet Mc Geer's criteria. On 4/23/26 at 1058 hours, an interview and concurrent medical record review was conducted with the IP. The IP was asked if Resident 11's infection for the April 2026 was CAI or HAI, the IP stated, diarrhea developed here. When pointed out there was no indication on the Infection Surveillance Report for April 2026 if Resident 11's infection was a CAI or HAI, the IP stated I don't know where my CAI is, it's not like highlighted like that On 4/23/26 at 1600 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide dignity and respect for one of one final sampled resident (Resident 203) and one nonsampled resident (Resident 123) reviewed for dignity. * CNA 7 was observed standing over Resident 123 while assisting the resident with her meal. * The facility failed to provide a privacy bag to cover Resident 203's indwelling urinary catheter drainage bag. These failures posed a risk for the residents to not be treated with dignity and respect.Findings: 1. Medical record review for Resident 123 was initiated on 4/20/26. Resident 123 was admitted to the facility on [DATE]. On 4/20/26 at 0830 hours, an observation for Resident 123 and concurrent interview was conducted with CNA 7. CNA 7 was observed standing over Resident 123 while feeding Resident 123 who was sitting in a reclining chair. CNA 7 verified he was standing over Resident 123 while feeding the resident who was sitting in the reclining chair. CNA 7 stated he was standing because there was no chair and there was no space beside the resident. CNA 7 stated he should be sitting in a chair when feeding Resident 123. On 4/23/26 at 1435 hours, an interview was conducted with the DON. The DON stated the CNAs were expected to sit when feeding the residents. The DON was informed and acknowledged the finding as above. 2. Medical record review for Resident 203 was initiated on 4/20/26. Resident 203 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 203's H&P examination dated 3/3/26, showed Resident 203 had the capacity to understand and make decision. Review of Resident 203's MDS assessment dated [DATE], showed Resident 203 had obstructive uropathy and an indwelling urinary catheter. On 4/20/26 at 0750 hours, an observation was conducted of Resident 203. Resident 203 was observed in bed while CNA 13 was assisting Resident 203 with his breakfast. Resident 203's indwelling urinary catheter drainage bag was observed with yellow urine and hanging on the left side of Resident 203's bed. However, the urinary drainage bag was not observed inside a privacy bag and the drainage bag could be seen from the doorway of Resident 203's room. On 4/20/26 at 0807 hours, an interview and concurrent observation was conducted with CNA 13. CNA 3 stated Resident 203 was incontinent of bowel and had a urinary catheter. CNA 13 verified Resident 203's urinary drainage bag did not have a privacy cover. CNA 13 verified the urinary drainage bag with the urinary contents in the bag could be seen from the doorway of Resident 203's room. On 4/23/26 at 1124 hours, an interview was conducted with RN 3. RN 3 stated all the residents with the indwelling urinary catheter attached to a urinary drainage bag should be provided with the drainage privacy bag to provide the residents with dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 resident or responsible party was fully informed and an informed consent was obtained prior to the use of the psychotropic medications for one of one final sampled resident (Resident 159) reviewed for the psychotropic medication. * The facility failed to ensure Resident 159's informed consent forms were completed prior to Resident 159's use of olanzapine (antipsychotic medication), escitalopram oxalate (Lexapro, antidepressant), and Depakote (medication used to treat epilepsy, bipolar mania, and prevent migraines) medications. These failures had the potential for the resident and the responsible party to be unaware of the risks associated with the psychotropic medications and the potential side effects.Findings: Review of the facility's P&P titled Use of Psychotropic Medication(s) revised on 3/17/25, showed a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. The indications for initiating, maintaining, or discontinuing medication(s), as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. Nonpharmacological interventions must be attempted unless clinically contraindicated to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medication, an advance of such initiation or increase. The indications for the use of any psychotropic drug will be documented in the medical record. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options, and the preferred option to accept or decline in a formal the facility deems to use (e.g. written consent form, narrative note, etc.) Medical record review for Resident 159 was initiated on 4/20/26. Resident 159 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 159's H&P examination dated 8/20/25, showed Resident 159 had no capacity to understand and make decisions. Review of Resident 159's Order Summary Report dated 4/23/26, showed the following physician's orders:- dated 4/17/26, to administer Depakote delayed release 125 mg tablet via GT two times a day for mood stabilizer as manifested by mood swings;- dated 4/17/26, to administer escitalopram oxalate (Lexapro) 10 mg tablet via GT at bedtime for depression as manifested by expression of depression and nodding. To try nonpharmacologic interventions before providing the medication and document: 1. Repositioning 2. Dim light/quiet room [ROOM NUMBER]. Relaxation Tech 4. Distraction 5. TV/Music 6. Other (indicate in progress notes). Indicate if non pharmacologic interventions is ineffective or effective; and- dated 4/15/26, to administer olanzapine 2.5 mg one tablet via GT one time a day for psychosis as manifested by anger outburst. To try non pharmacologic interventions before providing medication and document: 1. Repositioning 2. Dim light/quiet room [ROOM NUMBER]. Relaxation technique 4. Distraction 5. TV/Music 6. Other (indicate in progress notes). Indicate if non pharmacologic interventions is ineffective/effective. Review of Resident 159's Psychotherapeutic Drug Informed Consent Form for Lexapro 10 mg medication at bedtime (undated) showed missing information for following sections:- Psychotherapeutic Drug Information for Caution and Warning Summary;- Prescriber Signature date; - Resident/Resident's Representative Signature; and - Licensed Nurse Signature (if applicable). Review of Resident 159's Psychotherapeutic Drug Informed Consent Form for olanzapine 2.5 mg one time a day dated 1/26/26, showed missing (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information for the following sections:- Psychotherapeutic Drug Information for Probable Side Effects and Significant Risks Associated with Use of Psychotherapeutic Drug and Reasonable Alternative Mode(s) of Treatment or Possible Nonpharmacologic Approaches that could Address resident's Needs;- Prescriber Signature's name and date; and- Resident/Resident's Representative Signature. Review of Resident 159's Psychotherapeutic Drug Informed Consent Form for Depakote 125 mg two times a day dated 1/26/26, showed missing information for the following sections:- Psychotherapeutic Drug Information for Probable Side Effects and Significant Risks Associated with Use of Psychotherapeutic Drug and Reasonable Alternative Mode(s) of Treatment or Possible Nonpharmacologic Approaches that could address the resident's needs; - Prescriber Signature's name and date; and - Resident/Resident's Representative Signature. Review of Resident 159's MAR for April 2026 showed Resident 159 was administered with the following medications:- escitalopram oxalate 10 mg at bedtime which started on 4/18/26; - Depakote delayed release 125 mg tablet via GT two times a day which started on 4/18/26; and - olanzapine 2.5 mg one tablet via GT one time a day which started on 4/16/26. On 4/23/26 at 1049 hours, an interview and concurrent record review for Resident 159 was conducted with RN 3. RN 3 verified Resident 159 was administered with the psychotherapeutic medications. RN 3 verified the Psychotherapeutic Drug Informed Consent Forms were incomplete as above. RN 3 stated the informed consent should contain the complete information to educate the resident or responsible party of the treatment for their rights to be informed. On 4/23/26 at 1447 hours, an interview was conducted with the DON. The DON stated the informed consents should be complete and accurate. The DON was informed and acknowledged of the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 medications were safely administered to two of 35 final sampled residents (Residents 20 and 54). * Resident 54 had the Albuterol HFA inhaler (a breathing treatment) at the bedside. Resident 54 did not have a physician's order to keep this medication at bedside. * Resident 20 had Blink geltears (treats moderate to severe dry eye) eye drops, GeriCare artificial tears (lubricating eye drops formula provides extended comfort and hydration for dry, irritated eyes) eye drops, and Comfort Ear natural moisturizer (soothes and comforts dry irritated ears) ear drops on top of the bedside table. These failures had the potential for the residents to administer the medications inaccurately, develop adverse reactions from the medications, and negatively affect the resident's well-being.Findings: Review of the facility's P&P titled Resident Self-Administration of Medications revised 12/19/22, showed a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The policy further showed the following conditions are met for bedside storage to occur; (a) the manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective, and (b) the medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. 1. On 4/20/26 at 0920 hours, an observation and concurrent interview was conducted with Resident 54. Resident 54 was observed with Albuterol HFA inhaler at bedside. Resident 54 stated he would use the inhaler for his allergy and the last time he used the medication was last night. Resident 54 further stated the facility would provide him the inhaler when it runs out. On 4/20/26 at 0923 hours, an observation and concurrent interview and record review for Resident 54 was conducted with RN 1. RN 1 verified Resident 54 had the Albuterol HFA inhaler at the bedside. RN 1 verified Resident 54 had no physician's order to administer the Albuterol HFA inhaler medication by himself. Medical record review for Resident 54 was initiated on 4/20/26. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 54's H&P examination dated 12/7/25, showed Resident 54 had the capacity to understand and make decisions. Review of Resident 54's Order Summary Report failed to show a physician's order for Resident 54 to self-administer the Albuterol HFA inhaler medication. Review of Resident 54's Self-Administration of Medications assessment dated [DATE], showed Resident 54 needed assistance on administering the medication by various routes. Additionally, the assessment further showed Resident 54 preferred for the license nurse to provide all the medication administrations. However, the Albuterol HFA inhaler was left at Resident 54's bedside for the resident to administer the medication. On 4/22/26 at 0926 hours, an interview and concurrent interview and medical record review was conducted with RN 2. RN 2 verified Resident 54 did not have a physician's orders to self-administer the Albuterol HFA inhaler medication. RN 2 verified Resident 54's Self-Administration of Medications (continued on next page)

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	555103	A. Building B. Wing	04/23/2026

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment showed Resident 54 needed assistance on administering the medication by various routes and preferred for the license nurse to provide all medication administration. On 4/23/26 at 1509 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. 2. Medical record review for Resident 20 was initiated on 4/20/26. Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had a BIMS score of 15 indicating resident had intact cognitive capacity. On 4/21/26 at 1044 hours, an observation and concurrent interview was conducted with Resident 20. Resident 20 was observed with Blink geltears eye drops, GeriCare artificial tears eye drops, and Comfort Ear natural moisturizer ear drops on top of the bedside table. Resident 20 stated the nurse left the eye and ear drops for her to administer by herself. Resident 20 further stated she forgot to give it back to the nurse this morning. On 4/21/26 at 1046 hours, a follow-up observation and concurrent interview and record review for Resident 20 was conducted with LVN 19. LVN 19 verified Resident 20 had the Blink geltears eye drops, GeriCare artificial tears eye drops, and Comfort Ear natural moisturizer ear drops on top of the bedside table. LVN 19 verified Resident 20 had no physician's order for the Blink geltears eye drops, GeriCare artificial tears eye drops and Comfort Ear natural moisturizer ear drops, and for Resident 20 to administer the medications by herself. On 4/23/26 at 1442 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 obtain a copy of an advance directive for one of four final sampled residents (Resident 203) reviewed for the advanced directive. * The facility failed to obtain and maintain a copy of Residents 203's advance directive in the medical record. This failure had the potential for Resident 203's wishes not followed related to the provision of medical treatment and services.Findings: Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives revised 12/19/22, showed 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. Medical record review for Resident 203 was initiated on 4/20/26. Resident 203 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 203's MDS assessment dated [DATE], showed Resident 203 had a BIMS score of 3 (severe cognitive impairment). Review of Resident 203's Advance Directive Acknowledgement form dated 12/15/25, showed Resident 203 had executed an advance directive. However, further review of Resident 203's medical record failed to show a copy of the advance directive. On 4/23/26 at 0910 hours, an interview and concurrent medical record review for Resident 203 was conducted with the SSD. The SSD stated if the resident or responsible party acknowledged they had an advance directive, a copy should be kept in the medical record. The SSD verified a copy of Resident 203's advance directive was not maintained in Resident 203's medical record. On 4/23/26 at 1509 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **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 physician was notified timely for one of three residents (Resident 41) reviewed for acute care hospitalizations. * The facility failed to notify the physician timely to obtain orders for Resident 41's critically low hemoglobin levels of 6.6 g/dL. When Resident 41's physician was notified, an order to transfer Resident 41 to an acute care hospital for further evaluation and treatment was documented (over nine hours after the licensed nurse reviewed the laboratory results). This failure had the potential to delay the medical interventions for Resident 41. Findings: Review of the facility's P&P titled Notification of Changes reviewed 12/19/22, showed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications. Review of the facility's P&P titled Laboratory Services and Reporting revised 12/19/22, showed the facility promptly notified the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range. Closed medical record review for Resident 41 was initiated on 4/21/26. Resident 41 was admitted to the facility on [DATE] and transferred to Hospital 2 on 4/16/26. Review of Resident 41's Laboratory Report dated 4/15/26, showed the following laboratory results:- glucose: 49 mg/dL (critically low, reference range from 70 to 110 mg/dL), and- hemoglobin: 6.6 g/dL (critically low, reference range 12.0 to 18.0 g/dL). Further review of the laboratory report showed the above laboratory results were reviewed by LVN 8 on 4/15/26 at 1612 hours. Review of Resident 41's eINTERACT Change in Condition Evaluation dated 4/16/26, showed the licensed nurse documented Resident 41 had critically low hemoglobin levels of 6.6 g/dL and hematocrit 21.8 %. The physician was notified of the change of condition and gave the order to transfer Resident 41 to an acute care hospital for further evaluation and treatment. The eINTERACT Change in Condition Evaluation form further showed the physician was notified on 4/16/26 at 0200 hours (over nine hours after the licensed nurse reviewed the laboratory results). Further review of Resident 41's Progress Notes failed to show the documentation the physician was informed of Resident 41's critically low hemoglobin between 4/15/26 at 1612 hours when LVN 8 reviewed the laboratory report to 4/16/26 at 0200 hours. On 4/23/26 at 1128 hours, a telephone interview was conducted with LVN 8. LVN 8 stated towards the end of her shift on 4/15/26, she was informed by RN 3 of Resident 41's critically low glucose level. LVN 8 stated she was handed the laboratory report for Resident 41's low glucose level by RN 3. LVN 8 stated before the end of her shift, she addressed Resident 41's glucose result and had contacted the physician regarding Resident 41's low glucose level. On 4/23/26 at 1143 hours, a telephone interview was conducted with the Laboratory Manager from Laboratory A. The Laboratory Manager reviewed Resident 41's laboratory records and stated on 4/15/26 at 1542 hours, the laboratory had informed the facility of Resident 41's hemoglobin level of 6.6 g/dL and glucose level of 49 mg/dL. On 4/23/26 at 1403 hours, a follow-up telephone interview was conducted with LVN 8. LVN 8 stated RN 3 had informed her of Resident 41's low glucose only and she had addressed the change in condition. LVN 8 stated at the end of her shift, she saw the laboratory reports for Resident 41 to be reviewed in the computer; therefore, she clicked reviewed on Resident 41's laboratory results. When asked if LVN 8 reviewed the results in the laboratory report, which included the hemoglobin level for Resident 41, LVN 8 stated she did not. LVN 8 further stated she thought the laboratory report was already reviewed by the RN Supervisor, so she selected reviewed. On 4/23/26 at 1420 hours, a telephone interview was conducted with RN 5. RN 5 stated during her shift on 4/16/26, she reviewed Resident 41's laboratory reports and noted the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	critically low hemoglobin level. RN 5 stated she reviewed Resident 41's medical records and noted the critically low hemoglobin was not addressed to the physician so she notified the physician and received the order to transfer Resident 41 to an acute care hospital for further evaluation and treatment. On 4/23/26 at 1530 hours, an interview and concurrent medical record review for Resident 41 was conducted with the Nurse Consultant and the Director of Clinical Informatics and Applications. The Director of Clinical Informatics and Applications stated when the licensed nurse selected reviewed on the specific laboratory report, it meant all the laboratory results available in the report were reviewed by the licensed nurse. On 4/23/26 at 1552 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to review all the laboratory results included in the laboratory report and when the licensed nurse selected reviewed that meant the report was reviewed by the licensed nurse. The DON stated upon review of the laboratory report, any critical laboratory values should be reported to the physician timely. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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 six residents (Resident 17) reviewed for unnecessary medications was free from unnecessary psychotropic medications. * The facility failed to ensure Resident 17 was monitored for the specific behavior of restlessness and inability to relax related to the use of the lorazepam (antianxiety medication). This failure had the potential for the resident to receive unnecessary medication and experience the adverse effects from the psychotropic medications. In addition, it has potential for not providing the correct data to the prescriber necessary to adjust the dosage of the psychotropic medication.Findings: Review of the facility's P&P titled Use of Psychotropic Medications reviewed 3/17/25, showed the psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Medical record review for Resident 17 was initiated on 4/20/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 2/22/26, showed Resident 17 was able to understand and make treatment decisions. Review of Resident 17's Order Summary Report dated 4/22/26, showed a physician's order dated 4/7/26, to administer lorazepam 0.5 mg, give one tablet by mouth at bedtime for anxiety as manifested by restlessness and inability to relax. Further review of Resident 17's Order Summary Report failed to show a physician's order for the monitoring of Resident 17's behavior of restlessness and inability to relax related to the use of the lorazepam medication. On 4/22/26 at 1027 hours, an interview and concurrent medical record review for Resident 17 was conducted with LVN 10. LVN 10 stated for the use of the psychotropic medications, the residents were monitored for the specific behaviors related to the use of the psychotropic medication every shift. When asked for the monitoring documentation of the specific behaviors related to Resident 17's use of the lorazepam medication, LVN 10 reviewed Resident 17's medical records and stated she was unable to find the documentation if Resident 17 was monitored for the specific behaviors of restlessness and inability to relax. On 4/23/26 at 1552 hours, an interview was conducted with the DON. The DON stated the residents who were administered the psychotropic medication should be monitored for the specific behaviors related to the use of the psychotropic medication to determine if the medication was effective. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 timely report an abuse allegation for one of four final sampled residents (Resident 12) investigated for abuse. * The facility failed to report Resident 12's allegation of abuse, when the Ombudsman and Family Member 1 (Resident 12's family member) reported Resident 12 stated she felt a sensation of a wooden stick/spoon penetrate her body by a CNA. This failure placed the resident at risk for potential ongoing abuse, lack of protection from potential abuse, and resulted in a delay for CDPH and local law enforcement intervention. Findings: Review of the facility's P&P titled Abuse, Neglect, and Exploitation revised 12/19/22, showed the facility will report all abuse allegations no later than 24 hours. According to the WIC S 15630 effective 1/1/24, showed the facility will report all abuse allegations to CDPH, local law enforcement, and the long-term care ombudsman no later than 24 hours. Review of the facility's SOC 341 dated 4/22/26, showed during a care conference with the Ombudsman and facility staff on 4/22/26, the Ombudsman and Family Member 1 reported Resident 12 stated she felt a sensation of a wooden stick/spoon penetrate her body by a CNA. The form showed the alleged incident occurred on 8/17/25. Medical record review for Resident 12 was initiated on 4/20/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's eInteract SBAR Summary to Providers dated 8/25/25, showed at 1543 hours, the resident reported staff using a wooden object and inserting it into her anal and vaginal area. Review of Resident 12's medical record failed to show the abuse allegations were reported to CDPH, local law enforcement, and the long-term care Ombudsman. On 4/23/26 at 0850 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated prior Resident 12's care conference, the resident and Family Member 1 reported a CNA with an unknown last name took Resident 12 to a dark room with two other people, forced Resident 12 onto a table on all fours (on her hands and knees) and put a wooden spoon in her posterior and churned it around while the resident screamed and fought back. The Ombudsman stated Family Member 1 reported this allegation back in August 2025. Resident 12 and Family Member 1 informed the Ombudsman they previously reported the abuse allegation to the previous Administrator. Resident 12 informed the Ombudsman the facility never followed up with her about the abuse back in August 2025 and the CNA has continued to work with her, and every time she saw the CNA, it was like a slap in the face. On 4/23/26 at 0952 hours, an interview was conducted with the Administrator. The Administrator stated the facility determined the CNA listed in the SOC 341 was CNA 2. The Administrator also stated he was unable to find records to show the facility reported Resident 12's abuse allegation when facility staff was aware of the allegation. On 4/23/26 at 1026 hours, a follow-up telephone interview was conducted with the Ombudsman. The Ombudsman stated the facility did not report an abuse allegation for Resident 12 to their office prior to 4/22/26. Cross reference F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 timely investigate an abuse allegation for one of four final sampled residents (Resident 12) investigated for abuse. * The facility failed to investigate Resident 12's allegation of abuse, when the Ombudsman and Family Member 1 (Resident 12's family member) reported Resident 12 stated she felt a sensation of a wooden stick/spoon penetrate her body by a CNA. This failure placed the resident at risk for potential ongoing abuse and lack of protection from potential abuse. Findings: Review of the facility's P&P titled Abuse, Neglect, and Exploitation revised 12/19/22, showed the facility will immediately investigate all reports of abuse to determine if abuse or mistreatment occurred, as well as the extent. The Administrator will report the facility's investigation results within five working days of the incident. Review of the facility's SOC 341 dated 4/22/26, showed during a care conference with the Ombudsman and facility staff on 4/22/26, the Ombudsman and Family Member 1 reported Resident 12 stated she felt a sensation of a wooden stick/spoon penetrate her body by a CNA. The form showed the alleged incident occurred on 8/17/25. Medical record review for Resident 12 was initiated on 4/20/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's eInteract SBAR Summary to Providers dated 8/25/25, showed at 1543 hours, the resident reported staff using a wooden object and inserting it into her anal and vaginal area. Review of Resident 12's care plan for behavioral problem related to bipolar disorder dated 9/2/25, showed the resident was noted making statements indicative of delusional thinking and unfounded accusations. On 4/23/26 at 0850 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated prior Resident 12's care conference, the resident and Family Member 1 reported a CNA with an unknown last name took Resident 12 to a dark room with two other people, forced Resident 12 onto a table on all fours (on her hands and knees) and put a wooden spoon in her posterior and churned it around while the resident screamed and fought back. The Ombudsman stated Family Member 1 reported this allegation back in August 2025. Resident 12 and Family Member 1 informed the Ombudsman they previously reported the abuse allegation to the previous Administrator. Resident 12 informed the Ombudsman the facility never followed up with her about the abuse back in August 2025 and the CNA has continued to work with her, and every time she saw the CNA, it was like a slap in the face. On 4/23/26 at 1006 hours, an interview was conducted with Resident 12. Resident 12 stated she reported the abuse to the facility when it happened back in August 2025, but no one had ever gotten back to her about it. The resident stated the CNA had cared for her since, most recently on Monday night, and it was like a slap in the face every time she saw the CNA. On 4/23/26 at 1551 hours, an interview was conducted with the Administrator. The Administrator stated he was unable to find records to show Resident 12's initial abuse allegation was investigated in August 2025 by the prior Administrator. Cross reference F609.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASRR Level 1 screening was performed prior to the resident's admission to the facility for one of two residents (Resident 10) reviewed for PASRR. * The facility failed to ensure the PASRR Level 1 screening was performed prior to Resident 10's admission to the facility. This failure posed the risk for inappropriate placement in a long-term care nursing home and if a PASRR Level II Mental Health Evaluation was required, the facility subsequently could not provide the resident with the necessary recommended specialized mental health service.Findings: Medical record review for Resident 10 was initiated on 4/20/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination from Hospital 1 dated 2/27/26, showed Resident 10 had a past medical history of depression and psychoactive substance abuse. Review of Resident 10's medical record showed Resident 10 was admitted to the facility from Hospital 1 on 3/9/26. Further review of Resident 10's medical record failed to show documentation if the PASRR level 1 screening was performed prior to Resident 10's admission to the facility. On 4/21/26 at 1143 hours, an interview and concurrent medical record review for Resident 10 was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 10 was admitted to the facility from Hospital 1 on 3/9/26, and the PASRR Level 1 screening was not performed prior to Resident 10's admission to the facility. The MDS Coordinator stated the facility would conduct a PASRR Level 1 screening for Resident 10 to ensure Resident 10 was screened for serious mental illness, intellectual disability, developmental disability or related conditions and if necessary, would receive a Level II Mental Health Evaluation.

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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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to meet the resident care needs for five of 35 final sampled residents (Residents 19, 49, 87, 129 and 179). * The facility failed to conduct quarterly care conference meetings and obtained the hospice plan of care for Resident 19. * The facility failed to ensure the insulin injection sites were rotated for Residents 49 and 129. * The facility failed to ensure Resident 87's neurological assessment was complete after Resident 87 had an unwitnessed fall on 4/7/26. * The facility failed to obtain and document the measurements of Resident 179's wound on the initial assessment when Resident 179 sustained an abrasion and large hematoma on her right anterior shin during a staff assisted transfer from her bed to her wheelchair. In addition, the facility failed to obtain and document the measurements of Resident 179's wound on the weekly wound assessments. These failures had the potential for the residents to not receive the necessary care and services and negatively affect the residents well-being. Findings: 1. Review of the facility's P&P titled Skin assessment dated [DATE], showed a skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter. The assessment may also be performed after a change in condition. Guidelines showed to consider the general status of the resident's skin: color, temperature, moisture status, sensory perception, skin texture, skin turgor, and perfusion. Documentation of the skin assessment includes observation, type of wound, description of wound (measurements, color, type of tissue in wound bed, drainage, odor, and pain). Medical record review for Resident 179 was initiated on 4/20/26. Resident 179 was admitted to the facility on [DATE]. Review of Resident 179's Care Plan Report initiated on 1/26/26, showed a care plan focus titled Potential for Skin Tear of bilateral upper and lower extremities. The care plan interventions included use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of Resident 179's Nurses Progress Note dated 4/1/26 at 0812 hours, showed Resident 179 sustained a skin tear to her right shin during transfer to her wheelchair. Review of Resident 179's Skin Check note dated 4/1/26 at 0959 hours, showed Resident 179 sustained a skin tear to her right leg with moderate bleeding and a hematoma noted. A skin flap was placed back and Steri-Strips (sterile, breathable, adhesive skin closures) were applied. Review of Resident 179's Physician Progress Note dated 4/1/26 at 2121 hours, showed while transferring Resident 179 into her wheelchair this morning, Resident 179's leg got stuck/caught in the wheelchair causing a large 10 cm abrasion and large hematoma on her right anterior shin. Review of Resident 179's MDS assessment dated [DATE], showed Resident 179 had a BIMS score of 14 (cognitively intact). On 4/20/26 at 1249 hours, an observation and concurrent interview was conducted with Resident 179. Resident 179 was observed lying in her bed with a bandage wrapped around her right lower leg. Resident 179 was asked if she had sustained an injury to her right leg. Resident 179 stated (continued on next page)

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French Park Care Center	600 E Washington Avenue Santa Ana, CA 92701

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately three weeks ago, she sustained an injury while RNA (Restorative Nursing Assistant) 1 was transferring her from her bed to her wheelchair. Resident 179 stated RNA 1 failed to utilize the gait belt (a durable belt worn around a resident's waist to provide caregivers a secure, safe, and comfortable grip for assisting with walking, standing, or transferring) while transferring her and her leg got caught on a piece of metal on the front side of her wheelchair where the footrest would be attached, as a result her right lower leg was injured. Resident 179 stated after her leg hit the wheelchair she yelled for RNA 1 to stop; however, RNA 1 could not control her momentum, which caused the skin to tear off the front of her leg. Resident 179 stated the trauma from her leg hitting the wheelchair caused her leg to bleed and at the time of the injury she suffered a lot of pain. Resident 179 stated she was upset when the staff failed to transfer her properly and she was injured as a result. Resident 179 stated she had weakness in her lower extremities due to injuries to her back and staff would need to use the gait belt when transferring her from her bed to her wheelchair. Resident 179 stated the use of the gait belt offered her more stability and made her feel safe. Resident 179 stated the facility's rehabilitation staff would always utilize the gait belt when transferring her from her bed to the wheelchair; however, the CNAs and RNAs assigned to the floor did not always utilize the gait belt when transferring her from her bed to her wheelchair. Resident 179 stated after she sustained the injury the facility staff took a photograph of her injury and reported the incident to her family. Resident 179 stated her leg had yet to heal completely and remained swollen. Resident 179 stated the treatment nurse informed her the physician may incise and drain the swollen area to promote healing. Resident 179 stated her goal was to be discharged home with her family and hopefully her leg would heal soon. On 4/22/26 at 0849 hours, an interview and concurrent medical record review was conducted with the facility's treatment nurse LVN 20. LVN 20 was asked to describe his process for assessing and documenting the resident injuries and/or wounds. LVN 20 stated when a resident sustained an injury or developed a wound, a licensed nurse would conduct an initial assessment and weekly assessments thereafter. LVN 20 stated the licensed nurse would document the initial assessment and weekly assessment on the facility's Skin Check form. LVN 20 stated the wound assessment would include the type of wound, description of the wound including the location, measurements, color, drainage, odor, and presence of pain. LVN 20 stated the purpose of assessing and documenting the initial and weekly wound assessments was to determine whether the resident's wound had improved or worsened, and to notify the physician of a worsening condition to obtain necessary treatment orders. LVN 20 reviewed Resident 179's medical record and verified he conducted and documented his initial assessment of Resident 179's wound when Resident 179 sustained the wound on 4/1/26, and the weekly assessment thereafter on 4/9 and 4/17/26. LVN 20 stated he documented his assessments on Resident 179's Skin Check form. Resident 179's Skin Check forms dated 4/1, 4/9, and 4/17/26 were reviewed with LVN 20. LVN 20 verified and stated he did not measure Resident 179's wound on 4/1, 4/9 and 4/17/26. On 4/23/26 at 1101 hours, an interview and concurrent medical record review for Resident 179 was conducted with the DON. The DON was asked to describe the facility's P&P for assessing and documenting resident injuries and/or wounds. The DON stated in accordance with the facility's Skin Assessment P&P, the initial and weekly wound assessments should include documentation specific to the type of wound, description of the wound (location, measurements, color, drainage, odor, presence of pain). The DON stated the purpose of assessing and documenting wound measurements was to help determine whether the resident's wound improved or worsened. The DON stated if a resident's wound worsened the physician would then be notified and any new treatment orders would be implemented. The DON reviewed Resident 179's medical record and verified Resident 179's Skin Check forms dated 4/1, 4/9, and 4/17/26, failed to show if the measurements were obtained of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 179's wound. Further review of Resident 179's medical record showed on 4/1/26 at 0752 hours a change of condition assessment was conducted by a licensed nurse; however, the COC assessment also failed to show if the measurements were obtained of the wound Resident 179 sustained during the transfer from her bed to her wheelchair. The DON verified and acknowledged the findings. Cross reference to F689, example #1. 2. Review of the facility's P&P titled Hospice Services Facility Agreement revised on 12/19/22, showed the designated member of the facility working with hospice representative is responsible for: a. Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services; and b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. The policy further showed obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each resident. Medical record review for Resident 19 was initiated on 4/20/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's MDS assessment dated [DATE], showed Resident 19 had a BIMS score of 15 (cognition was intact). On 4/22/26 at 1408 hours, an interview and concurrent medical record review for Resident 19 was conducted with the SSD. The SSD verified Resident 19 was admitted to hospice services on 11/14/25. The SSD stated the facility's IDT would meet with the hospice representative quarterly. The SSD further stated the most recent IDT meeting was on 4/8/26; however, review of Resident 19's Interdisciplinary Care Conference assessment showed the form was blank. On 4/22/26 at 1424 hours, an interview and concurrent medical record review for Resident 19 was conducted with the DON. The DON stated she was the hospice coordinator of the facility. The DON further stated she had not attended the hospice IDT meeting for Resident 19. When asked when the quarterly meeting after Resident 19's hospice admission was, the DON stated in February 2026. The DON verified Resident 19's Interdisciplinary Care Conference assessment dated [DATE] at 1529 hours, had no discussion about the hospice services for Resident 19 and there was no hospice representative involved in the meeting. The DON stated there was an IDT meeting dated 4/8/26, and verified Interdisciplinary Care Conference dated 4/8/26, was also incomplete. When asked to show copies of hospice plan of care, the DON verified it was not available on Resident 19 hospice binder and Resident 19 medical records. 3. Review of the facility's P&P titled Fall Prevention Program revised on 12/28/23, showed monitor for changes in resident's cognition, gait, ability to rise/sit, balance. The policy further showed monitor the vital signs in accordance with facility policy. Medical record review for Resident 87 was initiated on 4/20/26. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's MDS assessment dated [DATE], showed Resident 87 had a BIMS score of 13 (cognition was intact). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 87's Progress Notes dated 4/7/26 at 1900 hours, showed Resident 87 was found lying on the floor in a supine position next to the bed. The progress notes further showed the primary care provider feedback was for neurological check for 72 hours. Review of Resident 87's Neurological Flowsheet initiated on 4/7/26 at 1900 hours, showed the neurological assessments should be completed every 15 minutes x 4 (times four), then every 30 minutes x 2 (times two), then every hour x 2, then every two hours x 2, then every four hours x 4, and then every eight hours x 3 (times three). Further review of Resident 87's Neurological Flowsheet showed neurological assessment was not completed for 4/9/26 at 0200 hours, 4/9/26 at 1000 hours, and 4/9/26 at 1800 hours. On 4/22/26 at 1343 hours, an interview and concurrent medical record review for Resident 87 was conducted with LVN 3. LVN 3 verified Resident 87 had an unwitnessed fall on 4/7/26 at 1900 hours, and the primary care provider feedback was for neurological assessment for 72 hours. LVN 3 further verified the neurological assessment was missing for 4/9/26 at 0200 hours, 4/9/26 at 1000 hours, and 4/9/26 at 1800 hours. On 4/23/26 at 1509 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 4. Medical record review for Resident 49 was initiated on 4/20/26. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 8/6/25, showed resident had the capacity to understand and make decision. Review of Resident 49's Order Summary Report dated 4/22/26, showed the following physician's orders: - dated 6/26/25, to administer insulin Regular Human (medication to lower blood sugar levels) injection solution, to inject as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime; and - dated 10/26/25, to administer Lantus SoloStar (a long-acting insulin used once daily used to treat diabetes by controlling blood sugar for 24 hours) subcutaneous solution, to inject 22 units subcutaneously two times a day. Review of Resident 49's Location of Administration Report for April 2026 showed the glargine insulin and the regular human insulin were administered consecutively on the same injection sites on the following dates and times: - dated 4/1/26 at 0810 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/1/26 at 1753 hours, Lantus SoloStar was administered to the LLQ of the abdomen; - dated 4/2/26 at 1700 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/2/26 at 1703 hours, regular insulin was administered to the LLQ of the abdomen; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/3/26 at 1643 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/3/26 at 1635 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/4/26 at 1651 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/4/26 at 1655 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/8/26 at 1646 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/8/26 at 1647 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/9/26 at 0543 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/9/26 at 1659 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/9/26 at 1702 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/9/26 at 0536 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/10/26 at 1801 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/11/26 at 0937 hours, Lantus SoloStar insulin was administered to the LUQ of the abdomen; - dated 4/11/26 at 1057 hours, regular insulin was administered to the LUQ of the abdomen; - dated 4/15/26 at 0909 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/15/26 at 1656 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/19/26 at 0854 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen; - dated 4/19/26 at 1247 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/19/26 at 1836 hours, regular insulin was administered to the LLQ of the abdomen; - dated 04/20/26 at 1643 hours, regular insulin was administered to the LLQ of the abdomen; - dated 4/21/26 at 1648 hours, regular insulin was administered to the LLQ of the abdomen; abd - dated 4/21/26 at 1649 hours, Lantus SoloStar insulin was administered to the LLQ of the abdomen. On 4/22/26 at 1120 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 3. RN 3 verified the above findings and stated the insulin injection site should be rotated with each insulin administration. On 4/23/26 at 1423 hours, an interview was conducted with the DON and Administrator. The DON stated the expectation from the licensed nurses was to rotate the injection site with administration of each insulin. The DON and Administrator was informed and acknowledged the above findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Medical record review for Resident 138 was initiated on 4/20/26. Resident 138 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 138's MDS assessment dated [DATE], showed Resident 138 had a BIMS score of 14 (cognition was intact). Review of Resident 138's Order Summary Report dated 4/23/26, showed a physician's order dated 1/26/26, to administer insulin lispro (a rapid-acting insulin to lower blood sugar levels) injection solution, to inject as per sliding scale subcutaneously before meals and at bedtime. Review of Resident 138's's Location of Administration Report for April 2026 showed the insulin lispro was administered consecutively on the same injection sites on the following dates and times: - dated 4/5/26 at 1157 hours, insulin lispro was administered to the LLQ of the abdomen; - dated 4/6/26 at 1058 hours, insulin lispro was administered to the LLQ of the abdomen; - dated 4/18/26 at 1746 hours, insulin lispro was administered to the LLQ of the abdomen; - dated4/18/26 at 2115 hours, insulin lispro was administered to the LLQ of the abdomen; - dated 4/20/26 at 1644 hours, insulin lispro was administered to the LLQ of the abdomen; and - dated 4/21/26 at 1654 hours, insulin lispro was administered to the LLQ of the abdomen. On 4/22/26 at 1038 hours, an interview and concurrent medical record review for Resident 138 was conducted with RN 3. RN 3 verified the above findings and stated the insulin injection site should be rotated with each insulin administration. On 4/23/26 at 1425 hours, an interview was conducted with the DON and Administrator. The DON stated the expectation from the licensed nurses was to rotate the injection site with administration of each insulin. The DON and Administrator was informed and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility P&P review, the facility failed to ensure the necessary care and services were provided for two of eight final sampled residents (Residents 20 and 28) reviewed for weight loss. * The facility failed to ensure the physician was informed of Resident 20's weight loss of 5.19 % in one month. * The facility failed to ensure the RD recommendation for weekly weight for four weeks was followed when Resident 28 had a significant weight loss of 11.8% in six months. These failures had the potential for Residents 20 and 28 to not receive the necessary intervention to prevent further weight loss.Findings: Review of the facility's P&P titled Weight Management Policy revised on 11/1/24, showed the interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. 1. Medical record review for Resident 28 was initiated on 4/21/26. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's MDS assessment dated [DATE], showed Resident 28 had a BIMS score of 12 (cognition was intact). Review of Resident 28's SBAR Communication Form dated 2/11/26, showed Resident 28 had a 11.8% weight loss in six months and the RD recommended weighing Resident 28 every week for four weeks. Review of Resident 28's Weights and Vitals Summary showed a recorded weight on 2/3/26 at 1656 hours, 3/4/26 at 1206 hours, and 4/5/26 at 1209 hours. Further review of Resident 28's Weights and Vitals Summary did not show a recorded weekly weight for four weeks after Resident 20 had an 11.8% weight loss in six months on 2/11/26. On 4/22/26 at 0836 hours, an interview and concurrent facility record review was conducted with CNA 4. CNA 4 stated when the residents were on weekly weight monitoring, the residents' names were written on the Weight Binder folder. CNA 4 verified Resident 28 was not on the list for February 2026 weekly weight monitoring. On 4/22/26 at 1013 hours, an interview and concurrent record review for Resident 28 was conducted with RN 2. RN 2 verified Resident 28 had an 11.8% weight loss on 2/11/26, and RD recommendation for weekly weight for four weeks. RN 2 also verified Resident 28's had no recorded weekly weight for four weeks on the Weights and Vitals Summary. On 4/23/26 at 1509 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. 2. Review of the facility's P&P titled Weight Management Policy revised on 11/1/24, showed the facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors; b. Evaluating/analyzing the assessment information; and c. Developing and consistently implementing pertinent approaches; and d. Monitoring the effectiveness of interventions and revising them as necessary. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 20 was initiated on 4/20/26. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 had a BIMS score of 15 indicating resident had intact cognition. Review of Resident 20's Weight Report on 3/4/26, showed Resident 20 weighed 270 pounds and on 4/5/26, Resident 20 weighed 256 pounds. Review of Resident 20's Care Plan Report showed a care plan problem revised on 4/8/26, addressing Resident 20 had nutritional problem or risk for altered intake. The interventions included to monitor, record and report to the physician as needed. Review of Resident 20's SBAR Communication Form dated 4/8/26 at 2116 hours, showed Resident 20 had lost 5% of weight within the past month, the provider and notification and feedback showed pending. Further review of Resident 20's Nurses Progress Notes failed to show a follow up call was made to inform the physician of Resident 20's weight loss. On 4/22/26 at 1034 hours, an interview and concurrent record review for Resident 20 was conducted with RN 3. RN 3 verified Resident 20's weight loss of 5.19%. RN 3 verified the physician was not notified of the resident's weight loss. RN 3 stated a follow up call should have been made to notify physician of Resident 20's weight loss for any laboratory orders needed. On 4/23/26 at 1450 hours, an interview was conducted with the DON and Administrator. The DON and Administrator was informed and acknowledged the findings as above.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the appropriate care and services for the use of GT for one of two final sampled residents (Resident 5) reviewed for GT care. * The facility failed to ensure Resident 5's enteral feeding formula bottle was labeled with the start time. This failure had the potential for Resident 5 to receive outdated GT feeding formula and posed a risk for complications related to use of the GT.Findings: Medical record review for Resident 5 was initiated on 4/20/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Order Summary Report dated 4/23/26, showed a physician's order dated 9/12/25, to administer the enteral feeding of Peptamen 1.5 (a type of enteral feeding formula) at the rate of 50 ml per hour; to start the feeding at 1200 hours until 1000 ml have infused. On 4/20/26 at 0827 hours, Resident 5 was observed lying in bed and the GT feeding was observed infusing Peptamen 1.5 at 50 ml/hr. The Peptamen 1.5 enteral feeding formula bag was observed labeled with the date of 4/19/26. and rate; however, the start time was not documented on the enteral feeding bag. On 4/20/26 at 0900 hours, a concurrent interview and observation was conducted with LVN 9. LVN 9 stated when hanging a new enteral feeding bag, the enteral feeding formula bag should be labeled with the resident's name, the date and time the enteral feeding formula was started and infusion rate. LVN 9 further stated the enteral feeding formulas should be discarded after 24 hours. When asked when Resident 5's current enteral feeding formula was started LVN 9 verified the GT bag label and stated she did not when the enteral feeding formula was started. On 4/23/26 at 1552 hours, an interview was conducted with the DON. The DON stated the enteral feeding formulas were good for 24 hours and should be discarded after 24 hours. The DON further stated the licensed nurses were expected to label the enteral feeding formulas with the resident's name, the ordered rate, and start date and time of the feeding formula. The DON stated the starting date and time should be labeled to determine when the feeding formula should be discarded. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **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 maintain the IV accesses for one final sampled resident (Resident 159) and one nonsampled resident (Resident 37) who had peripheral IV access. * The facility failed to ensure Resident 37's peripheral IV access was labeled with the date, time, and licensed nurse's initials when it was inserted and discontinue when not in used. *The facility failed to ensure Resident's 159's peripheral IV access was assessed after the completion of intravenous therapy and discontinued when not in use. These failures posed the risk of the residents developing complications related to the use of the peripheral IV catheter.Findings: Review of facility's P&P titled Intravenous Therapy revised 12/19/22, showed the facility will adhere to accepted standards of practice regarding infusion practices. IV sites are changed every seventy-two (72) hours unless otherwise ordered by the physician, if the site becomes infiltrated, or if the resident exhibits signs and symptoms of phlebitis. In the event an IV is left in place longer than seventy-two (72) hours, IV site care will be done every twenty-four (24) hours. IV sites are checked every four (4) hours or as per facility protocol and PRN for signs and symptoms of infection or inflammation. Factors that may affect frequency of assessment include a. Ability of resident to report symptoms of pain, redness, etc.; b. Type of infusion - is it an irritant or vesicant; c. Location of IV catheter - is it inserted in an area of flexion; and d. Facility policy based on long-term care IV policies and procedures. IV documentation is recorded in the nurses' notes and/or Medication Administration Record. The nurse will notify the practitioner to assess the need for continuation of the catheter if not being used for IV fluids or medications and will discontinue as per the practitioner's order. 1. Medical record review for Resident 37 was initiated on 4/20/26. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/20/26 at 0855 hours, during the initial tour of the facility, Resident 37 was observed in her bed. Resident 37 was able to show a peripheral IV access on her right hand. The peripheral IV access was observed with a transparent dressing; however, the dressing was not labeled with the date, time, and licensed nurse's initials. Review of Resident 37's H&P examination dated 1/26/26, showed Resident 37 had the capacity to understand and make decisions. Review of Resident 37's Order Summary Report dated 4/22/26, failed to show Resident 37 had an active physician's orders for an IV medication or IV maintenance. On 4/20/26 at 0905 hours, an observation, interview, and concurrent medical record review for Residents 37 was conducted with RN 3. RN 3 verified Resident 37's peripheral IV access was not labeled with the date, time, and licensed nurse's initials. RN 3 stated the last time Resident 37's peripheral IV access was used was last week. On 4/23/26 at 1341 hours, an interview was conducted with the DON. The DON stated the peripheral IV access should be labeled with the date of the insertion and initials of the staff that started the peripheral IV access. The DON stated the peripheral IV access should be discontinued within 24 hours when not in use to prevent infection at the site. (continued on next page)

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	555103	A. Building B. Wing	04/23/2026

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 4/20/26 at 0735 hours, during the initial tour of the facility, an observation of Resident 159 was conducted in the resident's room. Resident 159 was observed lying in bed with peripheral IV access on the Resident 159's left foot. Medical record review for Resident 159 was initiated on 4/20/26. Resident 159 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 159's H&P examination dated 8/20/25, showed Resident 159 had no capacity to understand and make decisions. Review of Resident 159's Order Summary Report dated 4/23/26, failed to show Resident 159 had an active physician's orders for an IV medication or therapy. Review of Resident 159's IV Administration Report for April 2026 showed Resident 159 was administered with piperacillin sodium-tazobactam sodium (broad-spectrum intravenous antibiotic used to treat serious bacterial infections) intravenous solution 3.375 gram intravenously every eight hours which started on 4/10/26 at 2200 hours, and the last dose was administered on 4/14/26 at 2200 hours. Further review of Resident 159's IV Administration Report April 2026 showed the IV site was checked for signs and symptoms of complications or adverse reactions from intravenous therapy every shift started which on 4/7/26 at 0700 – 1500 hours shift, and the last peripheral IV access check was documented on 4/15/26 at 2300 – 0700 hours shift. Further review or Resident 159's medical record failed to show if the physician was notified for the continuation of Resident 159's peripheral IV access if not being used for IV fluids or medications per facility policy. On 4/21/26 at 1010 hours, an observation, interview, and concurrent medical record review for Residents 159 was conducted with RN 3. RN 3 verified Resident 159 had a peripheral IV access on the resident's left foot. RN 3 verified resident's piperacillin sodium-tazobactam sodium intravenous solution was completed on 4/14/26 at 2200 hours and the peripheral IV access was last checked six days ago on 4/15/26 at 2300 – 0700 hours shift. RN 3 verified resident's medical records failed to show if the physician was notified for the continuation of Resident 159's peripheral IV access when not in used. On 4/23/26 at 1421 hours, an interview was conducted with the DON. The DON stated the peripheral IV access should be discontinued within 24 hours when not in use to prevent possible complications of the intravenous therapy. On 4/23/26 at 1425 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, medical record review, and facility document review, the facility failed to provide the necessary pharmaceutical services to ensure for an accurate reconciliation of the controlled medications in one of two medication carts reviewed for controlled medication reconciliation. * The facility failed to ensure the controlled medication count during the change of shift was completed and the Controlled Drugs - Count Record was signed by two licensed nurses. These failures had the potential for inaccurate reconciliation, and drug diversion of the controlled medications.Findings: On 4/20/26 at 0625 hours, an interview and concurrent facility record review was conducted with RN 5. Review of Controlled Drugs - Count Record for April 2026 of Station C, Cart D showed the Nurse On 3-11 shift (PM shift) and Nurse Off 3-11 shift was not signed on 4/19/26. RN 5 verified the Review of Controlled Drugs - Count Record for April 2026 had missing entry and stated there should be a two license nurses signature during the change of shift to indicate the controlled drug count was completed at the end of the shift. On 4/23/26 at 1412 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to do narcotic drug count during change of shift and were expected to sign the Controlled Drugs - Count Record. On 4/23/26 at 1416 hours, an interview was conducted with the DON and the Administrator. The DON and the Administrator was informed and acknowledged the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and facility P&P review, the facility failed to ensure the facility food was appetizing and palatable for two of 155 residents (Residents 138 and 139) who received food prepared in the facility kitchen. * The facility failed to ensure Residents 138 and 139 received food that was appetizing and palatable. This deficient practice had the potential to impact the residents' nutritional status, and not meet the residents' desires to be served food they felt was palatable and attractive.Findings: Review of the facility's P&P titled Standardized Menus revised on 12/19/22, showed the facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances of the Food and Nutrition Board of the National Research Council. On 4/20/26 at 0635 hours, during the initial tour of the facility, an interview was conducted with Resident 139. Resident 139 stated the food was terrible. On 4/20/26 at 0830 hours, during the initial tour of the facility, an interview was conducted with Resident 138. Resident 138 stated the food was not good. On 4/21/26 at 1332 hours, a regular meal test tray observation and concurrent interview was conducted with the covering the RD and MDS Coordinator. The RD and MDS Coordinator tasted the following entrees: the pork cutlet with an orange glaze, whole green beans, orzo rice, and blueberry crumble dessert bar. The RD agreed the orzo rice lacked flavor and the texture was mushy and too soft, and green beans were too soft. The MDS Coordinator stated the green beans were too soft and orzo rice had no flavor and the texture was soft, almost like puree. On 4/23/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **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 accommodate the drink preferences for one of one resident (Resident 49) reviewed for hydration. * The facility failed to ensure Resident 49 was provided with 120 ml of cranberry juice as listed in Resident 49's meal ticket. This failure had the potential to affect Resident 49's overall meal intake and hydration status.Findings: Review of the facility's P&P titled Fluid Restriction revised 12/19/22, showed the fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. Medical record review for Resident 49 was initiated on 4/20/26. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 8/6/25, showed Resident 49 had the capacity to understand and make decision and the diagnoses included ESRD and on hemodialysis. Review of Resident 49's Order Summary Report dated 4/22/26, showed a physician's order dated 6/5/25, for fluid restriction of 1500 ml/day: - nursing for a total of 780 ml (0700 hours to 1500 hours shift = 300 ml, 1500 hours to 2300 hours shift = 300 ml, and 2300 shift to 0700 hours shift = 180 ml); and- dietary for a total of 720 ml (breakfast = 240 ml, lunch = 240 ml, and dinner = 240 ml) On 4/21/26 at 1307 hours, an observation and concurrent interview was conducted with Resident 49 in her room. Resident 49 was observed in her wheelchair eating lunch. Resident 49's meal tray was observed with no beverage. Resident stated she would like to have her juice. Review of Resident 49's meal ticket for lunch dated 4/21/26, showed 120 ml of cranberry juice in the beverage section. On 4/21/26 at 1310 hours, an observation of Resident 49's meal tray in her room and concurrent interview was conducted with CNA 11. CNA 11 verified Resident 49 was not served with 120 ml of cranberry juice. CNA 11 verified Resident 49's lunch meal ticket dated 4/21/26, showed 120 ml of cranberry juice for Resident 49's beverage. On 4/23/26 at 1423 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the findings as above.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of 35 final sampled residents (Resident 49) and one nonsampled resident (Resident 97) were complete and accurately documented. * The facility failed to ensure Resident 49's blood pressure access site was accurately documented in the resident's medical record. * The facility failed to ensure Resident 97 's blood pressure access site was accurately documented in the medical record. These failures have the potential for the residents' care needs not being met as their medical information was inaccurate and incomplete.Findings: 1. Review of the facility's P&P titled Hemodialysis revised 6/5/23, showed this facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The resident will not receive blood pressures or laboratory sticks on the arm where the dialysis access device is located. Medical record review for Resident 97 was initiated on 4/20/26. Resident 97 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 97's care plan problem for hemodialysis related to End Stage Renal Disease dated 1/21/26, showed interventions included to not draw blood or take blood pressure on the left arm, hemodialysis access site left upper arm AV shunt. Review of Resident 97's Order Summary Report showed a physician's order dated 3/31/26, for no blood pressure and no blood draw in left arm. Review of Resident 97's H&P examination dated 4/4/26, showed Resident 97 had the capacity to understand and make decisions. Review of Resident 97's documentation of blood pressure for April 2026 showed the following: - on 4/10/26 at 1024 hours, a blood pressure reading of 122/55 mmHg on the left arm; - on 4/10/26 at 1305 hours, a blood pressure reading of 112/68 mmHg on the left arm; - on 4/10/26 at 1451 hours, a blood pressure reading of 124/76 mmHg on the left arm; - on 4/11/26 at 1101 hours, a blood pressure reading of 134/76 mmHg on the left arm; - on 4/12/26 at 1326 hours, a blood pressure reading of 111/61 mmHg on the left arm; - on 4/15/26 at 1123 hours, a blood pressure reading of 124/76 mmHg on the left arm; - on 4/15/26 at 1411 hours, a blood pressure reading of 118/76 mmHg on the left arm. - on 4/16/26 at 1057 hours, a blood pressure reading of 119/74 mmHg on the left arm; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/17/26 at 0503 hours, a blood pressure reading of 138/64 mmHg on the left arm; - on 4/17/26 at 1324 hours, a blood pressure reading of 118/76 mmHg on the left arm; - on 4/18/26 at 1034 hours, a blood pressure reading of 117/76 mmHg on the left arm; - on 4/19/26 at 1035 hours, a blood pressure reading of 120/64 mmHg on the left arm; - on 4/19/26 at 1339 hours, a blood pressure reading of 122/68 mmHg on the left arm; - on 4/20/26 at 1433 hours, a blood pressure reading of 138/68 mmHg on the left arm; and - on 4/21/26 at 0007 hours, a blood pressure reading of 130/68 mmHg on the left arm On 4/20/26 at 0715 hours, during the initial tour of the facility, Resident 97 was observed awake, lying in bed with AV shunt noted on the left arm. Resident 97 stated he went to dialysis every Tuesdays, Thursdays, and Saturdays. On 4/21/26 at 1550 hours, an interview and concurrent medical record review for Resident 97 was conducted with LVN 1. LVN 1 verified the BPs were not taken on Resident 97's left arm and the documentation for the BP readings for April 2026 were inaccurate. LVN 1 stated taking the BP on the access site will increase the resident's risk for infection and blood clot to Resident 97's left AV shunt. On 4/22/26 at 1549 hours, an interview was conducted with Resident 97. Resident 97 stated he never allowed the licensed nurses to take his BP on the left upper arm. On 4/23/26 at 1341 hours, an interview and concurrent medical record review for Resident 97 was conducted with the DON. The DON verified the findings and stated taking the BP on the access site will increase the risk for obstruction on Resident 97 dialysis site. On 4/23/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 49 was initiated on 4/20/26. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's plan of care showed a care plan problem revised on 1/28/25, addressing Resident 49's need for hemodialysis treatments related to End Stage Renal Disease (final stage of chronic kidney disease). The interventions included to monitor the vital signs pre-dialysis and after dialysis and to notify physician of significant abnormalities including signs and symptoms of hypotension and take blood pressure and not to draw blood on the left arm. Review of Resident 49's H&P examination note dated 8/6/25, showed the resident had ESRD and on dialysis. Resident had the capacity to understand and make decision. Review of Resident 49's Order Summary Report dated 4/22/26, showed a physician's order dated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/5/25, for no blood pressure and no blood draw in the left arm. Review of Resident 49's documentation of blood pressure for April 2026 showed the following: - on 4/2/26 at 1248 hours, 121/75 mmHg (Sitting left arm); - on 4/4/26 at 1651 hours, 148/72 mmHg (Lying left arm); - on 4/5/26 at 1818 hours, 140/70 mmHg (Lying left arm); - on 4/6/26 at 1827 hours, 141/82 mmHg (Sitting left arm); - on 4/6/26 at 0047 hours, 134/72 mmHg (Lying left arm); - on 4/7/26 at 1411 hours, 147/78 mmHg (Sitting left arm); - on 4/7/26 at 0627 hours, 142/77 mmHg (Lying left arm); - on 4/7/26 at 0111 hours, 136/71 mmHg (Lying left arm); - on 4/8/26 at 0646 hours, 127/69 mmHg (Lying left arm); - on 4/8/26 at 0031 hours, 132/75 mmHg (Lying left arm); - on 4/9/26 at 0509 hours, 133/84 mmHg (Lying left arm); - on 4/9/26 at 0006 hours, 130/79 mmHg (Lying left arm); - on 4/10/26 at 0016 hours, 133/75 mmHg (Lying left arm); - on 4/10/26 at 07:13 hours, 137/75 mmHg (Lying left arm); - on 4/13/26 at 0250 hours, 142/77 mmHg (Lying left arm); - on 4/14/26 at 1222 hours, 141/78 mmHg (Sitting left arm); - on 4/14/26 at 0413 hours, 130/70 mmHg (Lying left arm); - on 4/14/26 at 0121 hours, 124/78 mmHg (Lying left arm); - on 4/15/26 at 1657 hours, 156/72 mmHg (Lying left arm); - on 4/15/26 at 0702 hours, 131/65 mmHg (Lying left arm); - on 4/15/26 at 0206 hours, 122/63 mmHg (Lying left arm); - on 4/15/26 at 0205 hours, 131/75 mmHg (Lying left arm); (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/20/26 at 1354 hours, 136/71 mmHg (Sitting left arm); - on 4/20/26 at 0654 hours, 129/75 mmHg (Lying left arm); and - on 4/20/26 at 0134 hours, 136/61 mmHg (Lying left arm) On 4/20/26 at 0740 hours, during the initial tour of the facility, Resident 49 was observed awake, sitting in her wheelchair. Resident 49 stated she went to dialysis on Mondays, Wednesdays, and Fridays. Resident 49 was observed with AV shunt on the left arm. On 4/22/26 at 1330 hours, an interview was conducted with Resident 49. Resident 49 stated the nurses took her blood pressure readings from the right arm because she had AV shunt on her left arm. On 4/22/26 at 1405 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 3. RN 3 verified the resident's blood pressure should not be taken from the resident's left arm because the resident had AV shunt and as ordered by the physician not to take the blood pressure readings on the left arm. RN 3 verified the blood pressure were documented as taken on Resident 49's left arm as above. RN 3 verified the blood pressure readings were inaccurate. RN 3 stated the nurses should document in the medical records accurately. On 4/23/26 at 1434 hours, an interview was conducted with the DON and the Administrator. The DON and the Administrator were informed and acknowledged the above findings. Cross reference F698

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure two of two posted daily nursing Direct Care Service Hours Per Patient Day reviewed had accurate information. * The facility failed the posted daily nursing PPD had the current date and PPD information. This failure had the potential for the residents and visitors to not be informed about the facility's staffing.Findings: Review of the facility's P&P titled Nursing Staffing Posting information revised 3/10/25, showed it is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information:a. Facility name.b. The current date.c. Facility's current resident census.d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurse/Licensed Vocational Nurses iii. Certified Nurse AidesThe facility will post the Nursing Staffing Sheet at the beginning of each shift. On 4/20/26 at 1320 hours, an observation, facility document review, and concurrent interview was conducted with RN 3. The Census and Direct Care Service Hours Per Patient Day (DHPPD) form dated 4/16/26, was observed posted on the wall near the 2nd floor elevator entrance. In addition, a posted facility form which contained the projected and actual NHPPD was dated 4/17/26. RN 3 verified the posted daily nursing PPD failed to show the current PPD information. On 4/20/26 at 1345 hours, an observation, facility document review and concurrent interview was conducted in the front lobby with the DON. The Census and Direct Care Service Hours Per Patient Day (DHPPD) form dated 4/16/26, was observed posted on the wall. In addition, a posted facility form which contained the projected and actual NHPPD was dated 4/17/26. The DON verified the posted daily nursing PPD failed to show the current PPD information. On 4/23/26 at 1341 hours, an interview was conducted with the DON. The DON stated the DSD was responsible for removing the old projection and replacing it with the new projection each day. The DON stated the daily nursing PPD posting was important due to having admissions and discharges often, and to ensure they were not over or understaffed. The DON acknowledged and verified the above findings. On 4/23/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.