

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Alta Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13075 Blackbird Street Garden Grove, CA 92843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the discharge and transfer process was thoroughly completed for one of eight sampled residents (Resident 6). * The facility failed to ensure Resident 6 was provided with the Notice of Proposed Discharge/Transfer form in a language and manner the resident understood. * The facility failed to show the documentation of the actual date, time, mode of transportation, and notification to the resident's representative when Resident 6 was transferred out to another SNF facility. In addition, the facility failed to ensure a report was provided the receiving SNF facility. * The facility failed to ensure the Long-Term Care Ombudsman was notified of Resident 6's transfer to another facility until after the resident was transferred. These failures had the potential for the resident's representative to be unaware of the resident's discharge and the resident to have an inappropriate discharge. Findings: Review of the facility's P&P titled Transfer or discharge date d 2001 showed the following: 1. A Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. 2. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: a. The basis for the transfer or discharge; b. That an appropriate notice was provided to the resident and/or legal representative; c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition; g. Disposition of personal effects; h. Disposition of medications; i. Others as appropriate or as necessary; and j. The signature of the person recording the data in the medical record. Review of the facility P&P titled, Discharge Summary and Plan (undated) showed every resident has an individualized discharge plan, which begins at admission and is part of the comprehensive care plan. The purpose of the discharge plan is to ensure a safe transition from the facility to the post-discharge setting. The discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and the representative to develop interventions to meet the resident's discharge goals and needs that must be addressed before the resident can be safely discharged (e.g., caregiver support and education, rehabilitation, etc.). The final discharge plan of care shows what arrangements have been made for the resident regarding: a. where the resident will live after leaving the facility; b. follow-up care the resident will receive from other providers, and that provider's contact information; c. needed medical and non-medical services (including medical equipment); d. community care and support services, if needed; and e. when and how (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to contact the continuing care provider. Review of the facility's P&P titled Charting and Documentation (undated) showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 6 was initiated on 7/29/26. Resident 6 was admitted to the facility on [DATE]. Resident 6 was transferred to another SNF on 7/10/26. Review of Resident 6's H&P examination dated 6/13/26, showed Resident 6 had the capacity to understand and make decisions. Review of Resident 6's Social Services Assessment and Documentation showed the following:- dated 10/1/24, showed Resident 6 was Vietnamese speaking only, but can make all his needs known; and- dated 5/19/26, showed Resident 6 was able to make most needs known in Vietnamese and some English. Review of Resident 6's Physician Progress Note dated 7/2/26, showed the resident is of Vietnamese descent; language barriers and cultural adjustment to custodial care are considered. a. Review of Resident 6's Notice of Proposed Transfer and Discharge form dated 7/10/26, showed Resident 6's name, relationship self, and Resident 6's signature. Further review of the document showed the notice was written in English language. Review of Resident 6's medical record dated 7/10/26, failed to show any documentation of who provided Resident 6 with the Notice of Proposed Transfer and Discharge, whether Resident 6 was explained what the form was, what language the explanation was provided in, and if Resident 6 understood what he was signing. On 7/29/26 at 1457 hours, an interview was conducted with RT 1. When asked what language he spoke to Resident 6, RT 1 stated he would speak to Resident 6 in Vietnamese. On 7/29/26 at 1520 hours, an interview and concurrent medical record review for Resident 6 was conducted with the SSD. When asked how the SSD communicated with Resident 6, the SSD stated her SSA speaks Vietnamese. When asked if the resident or family addressed concerns with the staff speaking the same language, the SSD stated she received a message from Family Member 2 regarding issues of the new facility staff not speaking Vietnamese. On 7/30/26 at 1415 hours, an interview was conducted with the Administrator. The Administrator stated the Notice of Proposed Transfer and Discharge notice the facility had was in English, but a translator can be utilized. On 7/30/26 at 1500 hours, an interview and concurrent medical record review was conducted with the DON. When asked if she can verify if Resident 6 understood the signed Notice of Proposed Transfer and Discharge notice, the DON stated no. When asked what language the Notice of Proposed Transfer and Discharge was given to Resident 6, the DON verified the document provided to the resident was in English. b. Review of Resident 6's Advance Health Care Directive dated 5/3/23, showed the Power of Attorney for healthcare designated was Family Member 1. Review of Resident 6's Progress Note dated 7/10/26, failed to show any documentation if the resident representative was notified, the date, time, and mode of transportation on the day Resident 6 was transferred to another SNF facility. In addition, the facility failed to show the receiving SNF facility received a report regarding Resident 6 prior to the transfer. On 7/30/26 at 1046 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. When asked what the process for transfer would include, the DON stated to document when the resident left the facility, accompanied by who, providing report to the receiving facility, and the resident's status. The DON verified there were no documentation on the day when Resident 6 was transferred out of the facility, and there was no documented evidence showing the report was given to the receiving SNF facility. c. Review of Resident 6's Progress Note dated 7/1/26, showed a late entry documentation by the SSD. The notes showed the SSD discussed the discharge planning with (continued on next page)		

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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 interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of eight sampled residents (Resident 1). * The facility failed to follow the physician's order to administer Resident 1's TPN continuously as ordered by the physician. This failure had the potential for Resident 1 to develop adverse effects due to interruption of treatment, including unstable metabolic activity, and nutritional deficits. * The facility failed to monitor Resident 1's blood glucose level every six hours as ordered by the physician while receiving TPN. This failure had the potential for Resident 1's to develop adverse effects from unrecognized hyperglycemia or hypoglycemia and delayed medical intervention. * The facility failed to monitor Resident 1's intake and output consistently and accurately per physician's order and according to the facility's P&P while resident was receiving TPN. This failure had the potential for Resident 1 to develop adverse effects from undetected fluid imbalance and complications related to TPN therapy. Findings: Review of the facility's P&P titled TPN/ PPN Administration dated March 2023 showed the facility must ensure that all nurses responsible for the care and management of residents receiving TPN/ PPN are knowledgeable and competent in the administration procedures and potential complications associated with this therapy. A physician's order is required and must include, but is not limited to: TPN/PPN solution, additives, volume and rate, continuous or cyclical infusion (if cyclical, specific tapering schedule must be ordered), flush protocol, daily or weekly weights, intake and output, blood glucose monitoring, laboratory monitoring, and dextrose for infusion in the event of unplanned interruption of the TPN/PPN solution. Ongoing clinical monitoring must include, but is not limited to: vital signs, daily or weekly weights per physician order, intake and output, blood glucose monitoring, urinalysis as indicated, electrolytes as ordered, CBC (complete blood count, a blood test to determine health status, including anemia and infection), and other pertinent laboratory studies as warranted by the resident's condition. The nurse must monitor for signs and symptoms of the following complications such as hypoglycemia, hyperglycemia, fluid imbalance, electrolyte imbalance, site assessment, systemic infection, malnourishment, and catheter complications. Medical record review for Resident 1 was initiated on 7/29/26. Resident 1 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 7/7/26, showed Resident 1 had capacity to understand and make decisions. Review of Resident 1's MDS 5-day PPS (Prospective Payment System) assessment dated [DATE], showed Resident 1's BIMS score was 13, indicating intact cognition. a. Review of Resident 1's Order Summary Report showed the following physician's orders: - dated 7/21/26, to administer TPN daily at 2300 hours with non-protein - 530 kcal, total 24 hours protein - 47 Gm; dextrose final concentration -10%; amino acid final concentration - 3%; Sodium Chloride-80 mEq/day; potassium chloride 20 mEq/day; and calcium gluconate 4 mEq/day. Add multivitamin-12, 10 ml per bag to run 65 ml per hour to infuse total volume of 1560 ml in 24 hours. - dated 7/24/26, to administer TPN daily with non-protein - 530 kcal, total 24 hours protein - 47 Gm; dextrose final concentration -10%; amino acid final concentration - 3%; Sodium Chloride-80 mEq/day; potassium chloride 20 mEq/day; and calcium gluconate 4 mEq/day. Add multivitamin-12, 10 ml per bag to run 65 ml per hour to infuse total volume of 1560 ml in 24 hours. - dated 7/29/26, administer TPN daily with non-protein - 530 kcal, total 24 hours protein - 47 Gm; dextrose final concentration -10%; amino acid final concentration - 3%; Sodium Chloride-70 mEq/day; sodium acetate 10 mEq/day; potassium chloride 20 mEq/day; and calcium gluconate 4 mEq/day. Add multivitamin-12, 10 ml per bag to run 65 ml per hour to infuse total volume (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 1560 ml in 24 hours continuously. Review of Resident 1's TPN/ PPN Medication Record (undated) showed the TPN IV solution was hung on 7/28/26 at 1330 hours. On 7/29/26 at 0834 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was lying in her bed resting. The TPN bag labeled hung on 7/28/26 at 1330 hours, contained approximately 500 ml solution was observed attached to resident's left arm from the intravenous (IV) machine pump; however, the IV machine pump was turned off. Resident 1 stated she did not know why the IV pump was turned off but stated the machine should be on all the time. On 7/29/26 at 0853 hours, a follow up observation of Resident 1 and concurrent interview was conducted with LVN 1. LVN 1 verified the IV machine pump was off and stated RN 1 was responsible for the resident's TPN. LVN 1 stated she did not know why the IV pump was turned off. On 7/29/26 at 0900 hours, an interview was conducted with RN 1. RN 1 stated he did not know the IV machine pump was off and was assigned to pass medication today. RN 1 further stated he did not receive report regarding the TPN infusion for Resident 1 during shift handoff. On 7/29/26 at 0930 hours, an observation, interview, and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 verified Resident 1's TPN was ordered to infuse continuously at 65 ml per hour. RN 2 verified approximately 500 ml remained in the bag and stated the pump had been turned back on by RN 1. On 7/29/26 at 1003 hours, a follow up interview was conducted with RN 1. RN 1 stated he restarted the TPN after being informed by the surveyor. RN 1 verified the machine showed 966 ml infused. RN 1 stated he cleared the IV pump when he hung a new TPN bag yesterday at 1330 hours. RN 1 verified the resident received less TPN than ordered. RN 1 further stated the pump must have been off since 0430 hours this morning and the resident should have received 1300 ml by this time. RN 1 stated he did not know who turned off the IV pump. On 7/30/26 at 1430 hours, an interview was conducted with the DON. The DON stated the expectation was for the licensed nurses to ensure the TPN was infused continuously. The DON was informed and acknowledged the above findings. b. Review of the facility's P&P titled Continuous Glucose Monitoring (undated) showed for intermittent readings at designated (ordered) intervals: use a scan the sensor with the reader; record the time, date, and glucose reading in the medical record or flow chart; and notify the practitioner if the reading is within notification thresholds, or if the resident is experiencing symptoms of hyper or hypoglycemia. Review of Resident 1's Order Summary Report dated 7/29/26, showed a physician's order dated 7/22/26, to monitor blood sugar every six hours, if blood sugar was less than 70 mg/dL or greater than 250 mg/dL, notify the physician. Review of Resident 1's MAR for July 2026 showed a physician's order dated 7/22/26, to monitor blood sugar every six hours, if blood sugar was less than 70 mg/dL or greater than 250 mg/dL notify the physician was marked with check marks and initialed by the licensed nurses. Review of Resident 1's Weight and Vital Summary: Vital Blood Sugar dated 7/30/26, showed the following: - on 7/24/26 at 1845 hours, the resident's blood sugar level was 127 mg/dL; - on 7/24/26 at 0915 hours, the resident's blood sugar level was 118 mg/dL; and- on 7/29/26 at 2120 hours, the resident's blood sugar level was 147 mg/dL. Further review of Resident 1's medical record failed to show a documentation the resident's blood sugar level was monitored every six hours and/or if the physician was notified as required. On 7/30/26 at 1240 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 verified the physician's order for blood glucose monitoring and that the resident's blood glucose monitoring was not consistently done as ordered by the physician. RN 1 stated the resident's blood glucose should have been monitored every six hours and should have been documented in the MAR or in the blood glucose flow sheet. RN 1 verified the resident's medical record failed to show a documentation of the resident's blood glucose level was monitored consistently every six hours as ordered by the physician. On 7/30/26 at 1506 hours, an interview was conducted with the DON. The (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON was informed and acknowledged the above findings. c. Review of the facility's P&P titled Intake, Output Recording (undated) showed to verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy. Fluids taken intravenously are recorded by the licensed nurse. Record the fluid intake as soon as possible after the resident has consumed the fluids. At the end of your shift, total the amounts of all liquids the resident consumed. Review of Resident 1's Order Summary Report dated 7/29/26, showed the following physician's order: - dated 7/21/26, provide clear liquid diet, thin consistency. - dated 7/21/26, to administer TPN daily at 2300 hours with non-protein - 530 kcal, total 24 hours protein - 47 Gm; dextrose final concentration -10%; amino acid final concentration - 3%; Sodium Chloride-80 mEq/day; potassium chloride 20 mEq/day; and calcium gluconate 4 mEq/day;. Add multivitamin-12, 10 ml per bag to run 65 ml per hour to infuse total volume of 1560 ml in 24 hours. - dated 7/24/26, to administer TPN daily with non-protein - 530 kcal, total 24 hours protein - 47 Gm; dextrose final concentration -10%; amino acid final concentration - 3%; Sodium Chloride-80 mEq/day; potassium chloride 20 mEq/day; and calcium gluconate 4 mEq/day. Add multivitamin-12, 10 ml per bag to run 65 ml per hour to infuse total volume of 1560 ml in 24 hours. - dated 7/28/26, to document intake and output every shift, and total intake and output for 24 hours daily for TPN. - dated 7/29/26, to administer TPN daily with non-protein - 530 kcal, total 24 hours protein - 47 Gm; dextrose final concentration -10%; amino acid final concentration - 3%; Sodium Chloride-70 mEq/day; sodium acetate 10 mEq/day; potassium chloride 20 mEq/day; and calcium gluconate 4 mEq/day. Add multivitamin-12, 10 ml per bag to run 65 ml per hour to infuse total volume of 1560 ml in 24 hours continuously. Review of Resident 1's MAR for July 2026 showed intake and output every shift, and total intake and output for 24 hours daily for TPN documentation beginning 7/28/26: - on 7/28/26, 7-3 shift intake was 60 ml, output was 2; 3-11 shift intake was 520 ml, output was 2; and 11-7 shift intake was 30 ml, output was 2. The total intake in 24 hours showed 1560 ml, and output was 6; however, the shift intakes did not reconcile with expected TPN infusion.- on 7/29/26, 7-3 shift intake was 200 ml, output was 1; 3-11 shift intake was 300 ml, output was 2; and 11-7 intake was 30 ml, output was 1. Total intake in 24 hours was 1200 ml, and output was 6. However, further review of Resident 1's medical record failed to show the resident's intake and output was monitored since 7/21/26, when the resident was readmitted to the facility with an order for TPN. On 7/29/26 at 1447 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 1 was on liquid diet and requested for some water sometimes. CNA 2 further stated she was not sure if the resident was being monitored for intake and output. On 7/30/26 at 1245 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 verified the physician's order for intake and output monitoring as above. RN 2 verified the intake and output monitoring that was started on 7/28/26, was inaccurate. RN 2 also verified there was no documentation for the monitoring of the resident's intake and output since 7/21/26, when the resident was administered the TPN. On 7/30/26 at 1445 hours, an interview was conducted with the DON. The DON stated the intake and output monitoring should have been completed for Resident 1 to assess fluid balance. The DON was informed and acknowledged the above findings.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record, and facility P&P review, the facility failed to ensure appropriate respiratory care was provided for one of two sampled resident (Resident 1) reviewed for respiratory care. * The facility failed to ensure Resident 1 received oxygen as ordered. This failure had the potential to affect the resident's respiratory health and overall well-being. Findings: Review of the facility's P&P titled Oxygen Administration dated 1/31/23, showed to verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Medical record review for Resident 1 was initiated on 7/29/26. Resident 1 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 7/7/26, showed Resident 1 had capacity to understand and make decisions. Review of Resident 1's MDS 5-day PPS assessment dated [DATE], showed Resident 1's BIMS score was 13, indicating intact cognition. Review of Resident 1's Order Summary Report showed a physician's order dated 7/24/26, to administer oxygen at 2 liters per minute via nasal cannula as needed for oxygen saturation less than 92% as needed. On 7/29/26 at 0834 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed resting in bed with oxygen delivered via nasal cannula at 3 liters per minute. Resident 1 stated she needed oxygen for her breathing. On 7/29/26 at 0853 hours, a follow up observation, interview and concurrent interview for Resident 1 was conducted with LVN 1. LVN 1 verified the resident's oxygen concentrator was set at 3 liters per minute. LVN 1 verified the resident's physician's order for 2 liters per minute PRN. LVN 1 stated she did not know why the resident was receiving oxygen at 3 liters per minute. On 7/30/26 at 1523 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		