STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555515	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Vista at Morningside	2525 Brea Blvd. Fullerton, CA 92835

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the necessary wound care services to one of nine sampled residents (Resident 1). * The facility failed to provided Resident 1's wound treatment as per the physician's order. In addition, the facility failed to accurately monitor and document the wound care provided to Resident 1. This failure had the potential for the resident's wound to become worse and negatively affect the resident's well-being.Findings: Medical record review for Resident 1 was initiated on 8/27/25. Resident 1 was admitted to the facility on [DATE], and transferred to an acute care facility on 8/16/25. Review of Resident 1's SBAR Communication Form dated 7/31/25, showed Resident 1 had a skin tear to the right distal medial aspect of the right lower leg. Review of Resident 1`s Order Summary Report showed a physician's order dated 7/31/25, for full thickness skin tear to the right distal medial aspect of lower leg, to apply Steri-Strips (adhesive bandage strips used to close small wounds) x 1(one) every shift for 21 days; and to monitor for evidence of infection or drainage, if drainage noted, cover with foam dressing and if an infection is noted, to notify the physician. Review of Resident 1's Progress Note dated 7/31/25, showed Resident 1 presented with a full thickness skin tear to the right distal/medial aspect of lower leg, measured size of 6 cm (length) by 2.5 cm (width), able to visualize adipose tissue/muscle, large amounts of serosanguinous (drainage that consists of clear serum and blood), and bleeding stopped when pressure applied. The skin tear was approximated and Steri-Strips was applied. Review of Resident 1's Plan of Care dated 7/31/25, showed a care plan problem addressing Resident 1`s full thickness skin tear to the right distal medial aspect of lower leg. The interventions included to provide treatment as ordered. Review of Resident 1's Treatment Administration Record for August 2025 showed a check mark to indicate the task was completed on 8/1 to 8/15/25, for the full thickness skin tear to the right distal medial aspect of lower leg, to apply Steri-Strips x 1(one) every shift for 21 days; and to monitor for evidence of infection or drainage, if drainage noted, cover with foam dressing and if an infection is noted to notify the physician. Review of Resident 1's Progress Notes showed documentation for the following dates:- dated 8/1/25, the treatment given as ordered;- dated 8/2/25, the treatment given as ordered;- dated 8/3/25, Steri-Strips was intact;- dated 8/4/25, Steri-Strips was intact; and- dated 8/5/25, new orders per physician for cephalexin (antibiotic) three times a day for cellulitis. Review of Resident 1's SBAR Communication Form dated 8/5/25, showed Resident 1 developed cellulitis (bacterial infection of the skin and underlying tissues) on her right lower leg. On 9/2/25 at 1522 hours, a telephone interview was conducted with LVN 1. LVN 1 stated he was notified on 7/31/25, that Resident 1 had a skin tear on her right lower leg as a result of CNA 2 accidently opening the restroom door hitting Resident 1's leg and causing injury to her right lower leg. LVN 1 stated he instructed CNA 2 to apply pressure so he can notify the treatment nurse. When asked what the appearance of the wound was, LVN 1 stated it had a flap and was still bleeding, so it was covered with a foam dressing. On 9/4/25 at 1508 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 1's skin tear was being monitored. When asked how the wound was monitored, LVN 2 stated no complaints of pain and was observed for redness. When asked if the foam dressing was opened, LVN 2 stated no, we did not open it unless there was a lot of drainage. When asked how the wound was being monitored if the foam dressing was not removed, LVN 2 stated we monitor around the foam dressing, monitor for increased discharge, and monitor for pain. On 9/4/25 at 1556 hours, an interview and concurrent medical record review was conducted with Treatment Nurse 1. Treatment Nurse 1 stated Resident 1 was observed with a foam dressing on her right lower leg. When asked if a treatment was rendered, Treatment Nurse 1 stated when I saw it, it was covered with a foam dressing, I lifted it up, cleansed with normal saline, and covered it with a foam dressing. When asked what the physician's treatment order for Resident 1's wound, Treatment Nurse 1 stated she assumed the treatment included cleaning the wound because that was what the facility would normally do. Treatment Nurse 1 verified there were no cleansing orders, and stated Resident 1's wound orders were not complete and should have been clarified. On 9/16/25 at 1422 hours, the Administrator was made aware and acknowledged the above findings.

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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 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. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 4) reviewed for safety was free from accident/hazards. * The facility failed to ensure Residents 4 was evaluated to handle and consume hot beverages as per the facility's P&P. In addition, Residents 8 and 9 were also not evaluated to handle and consume hot beverages. * RNAs 1 and 2 failed to notify a licensed nurse immediately after Resident 4 spilled hot tea onto her lap. * The facility failed to ensure Resident 4 was provided the immediate and appropriate interventions when Resident 4 spilled hot tea to her left upper thigh. In addition, the facility failed to obtain a physician's order to properly treat a burn for Resident 4's left thigh. Theses failures resulted in Resident 4 sustaining a blisters to her left thigh and delay in the provision of the necessary and appropriate care/interventions which could potentially affect the resident's well-being.Findings: Review of the facility's P&P titled Accidents and Incidents Investigating and Reporting Procedure revised 2/2022 showed:1. Regardless of how minor an accident or incident may be, including injuries of unknown source, it must be reported to the department supervisor as soon as such accident/incident is discovered or when information of such accident/incident is learned, and2. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the residents attending physician or physician on call when there has been a(an) accident or incident involving the resident,2. The nurse will record in the resident's medical record information relative to the changes in the resident's medical/mental condition or status,3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant information for the provider, including (for example) information prompted by the Interact SBAR Communication Form, and4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. According to the United States Product Safety Commission, Avoiding Tap Water Scalds (undated), showed most adults will suffer a third-degree burns if exposed to 150 degree Fahrenheit water for two seconds. Burns will also occur with a six-second exposure to 140 degree Fahrenheit water or with a thirty second exposure to 130 degree Fahrenheit water. Even if the temperature is 120 degrees Fahrenheit, a five minute exposure could result in third-degree burns. According to the National Library of Medicine dated 8/2023 showed the older adults are particularly susceptible to burn injuries due to increasing dementing illness, sensory impairment, poor mobility, slow reaction times, and medication side effects. Review of the facility's letter to CDPH L&C Program dated 9/5/25, showed on 9/4/25, during routine care, CNA observed blisters to Resident 4's left upper thigh. The charge nurse and RN supervisor evaluated the resident and observed three blisters to the left upper thigh. Further investigation was conducted, and it was noted that on 9/3/24, during lunchtime in the main dining room, Resident 4 spilled warm tea on her lap. Medical record review for Resident 4 was initiated on 9/9/25. Resident 4 was admitted to the facility on [DATE]. Resident 4 has a diagnosis of hemiplegia (one side paralysis) and hemiparesis (one sided muscle weakness) affecting the right side, aphasia (impaired ability to understand or form speech) following a cerebral infarction (condition where blood flow to brain was interrupted, causing tissue damage), and generalized muscle weakness. Review of Resident 4's H&P examination dated 11/22/24, showed Resident 4 had no capacity to understand and make medical decisions. Review of Resident 4's Plan of Care initiated on 11/22/24, and revised on 1/24/25, for the OT care plan showed Resident 4 demonstrated a decreased in ADL care function due to deficits in strength aphasia, right sided weakness, deficits in gross motor, and fine motor coordination, aerobic capacity, and balance deficits status post cerebral vascular accident (stroke). Review of Resident 4's MDS assessment dated [DATE], under Section GG-Functional Abilities showed the following:- for Functional Limitation in Range of Motion, showed Resident 4 had impairments on one side for the upper extremities (shoulder, elbow, wrist and hands), and - for Self-Care - Eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food/or liquid once the meal is placed before the resident), showed Resident 4 required supervision or touching assistance (the helper provides verbal cues and /or touching/steadying and/or contact guard assistance as the resident complete the activity). On 9/10/25 at 1216 hours, an observation

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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 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 interview, medical record review, and facility P&P review, the facility failed to ensure the necessary respiratory care services were provided for one of nine sampled residents (Resident 2). * The facility failed to ensure Resident 2 was provided with the continuous oxygen via nasal cannula and Resident 2's oxygen saturation was maintained greater than 92% as ordered by the physician. These failures had the potential for the resident to not receive the necessary respiratory services and negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Physicians Orders and Telephone Orders dated 11/2017 showed the physicians orders shall be obtained prior to the administration of any medication or treatment from a personal lawfully authorized to prescribe for and treat human illness. All orders must be specific and complete and no standing orders shall be accepted. All orders shall be specific and complete with all the necessary details to carry out the prescribed order without any question. Medical record review for Resident 2 was initiated on 8/27/25. Resident 2 was admitted to the facility on [DATE], and transferred to an acute care facility on 8/27/25. Resident 2's diagnosis included lung cancer, acute and chronic respiratory failure with hypoxia (condition where there is an inadequate supply of oxygen to the body's tissues) and dependence on supplemental oxygen. Review of Resident 2's Order Summary Report showed a physician's order dated 8/25/25, to administer oxygen at two to five liters per minute via nasal canula to keep the oxygen saturation greater than 92% every shift. Review of Resident 2's Weights and Vitals Summary showed the oxygen saturation on the following dates and times:- dated 8/26/25 at 1006 hours, 92% on room air;- dated 8/26/25 at 1709 hours, 92% oxygen via nasal cannula; and- dated 8/27/25 at 0323 hours, 93% on room air. Review of Resident 2's Progress Note dated 8/27/25, showed Resident 2 was desaturating with an oxygen saturation of 93% at 0430 hours to 51% at 0520 hours. Resident 2 was sent to an acute care facility via paramedics. On 9/11/25 at 1248 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 2's order showed to keep Resident 2 on continuous oxygen, and the oxygen should remain on at all times. RN 1 verified the oxygen should have been titrated to maintain an oxygen saturation greater than 92% as per the physician's orders . On 9/16/25 at 1422, the Administrator was made aware and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	**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 medical information was complete and accurate for two of nine sampled residents (Residents 1 and 4). * The facility failed to ensure Resident 1's intake, output, and eating percentage documentation were complete and accurate. * The facility failed to document the incident when Resident 4 spilled hot tea on her left thigh on 9/3/24. These failures had the potential for the residents to receive inadequate care as their clinical information were incomplete and inaccurate.Findings: Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed all the services provided to the resident, progress towards the care plan goals, or any changes in the residents mental, physical, functional or psychosocial condition, shall be documented in the residents medical record. The medical record should facilitate communication between the interdisciplinary team regarding the residents condition and response to care. The following information is to be documented in the resident medical record: a. Objective observations;b. Medications administered;c. Treatments or services performed;d. Changes in the resident's condition;e. Events, incidents or accidents involving the resident; andf. Progress toward or changes in the care plan goals and objectives.Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Medical record review for Resident 1 was initiated on 8/27/25. Resident 1 was admitted to the facility on [DATE], and discharged to an acute care facility on 8/16/25. Review of Resident 1's Order Summary Report showed a physician's order dated 7/25/25, to monitor the intake and output every shift, document the intake and output in ml every shift. Review of Resident 1's Documentation Survey Report for August 2025 showed the documentation of the fluid intake and urine output on the following dates and times:- dated 8/1/25 at 2300-0700 hours, showed NA (not applicable);- dated 8/3/25 at 0700-1500 hours, had no entry;- dated 8/5/25 at 2300-0700 hours, showed NA - dated 8/6/25, 1500-2300 hours, had no entry;- dated 8/6/25 at 2300-0700 hours, showed NA- dated 8/8/25 at 2300-0700 hours, showed NA- dated 8/9/25 at 0700-1500 hours, had no entry;- dated 8/11/25 at 2300-0700 hours, showed NA- dated 8/12/25 at 2300-0700 hours, had no entry; and- dated 8/13/25 at 1500-2300 hours, had no entry. Review of Resident 1's Documentation Survey Report for August 2025 showed the documentation of the eating percentage on the following dates and times:- dated 8/5/25 at 0900 hours, showed 10 (not attempted due to environmental limitations (e.g., lack of equipment or weather constraints);- dated 8/6/25 at 0900 hours, showed 10- dated 8/6/25 at 1800 hours, had no entry;- dated 8/8/25 at 090 hours, showed 10- dated 8/9/25 at 0900 and 1300 hours, had no entry;- dated 8/12/25 at 1800 hours, showed 10 - dated 8/13/25 at 1800 hours, had no entry On 9/10/25 at 1550 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and stated the multiple blank entries in Resident 1's Documentation Survey Report were missed charting. The DON further stated documenting NA and 10 for the intake, output, and eating percentage would be an incorrect documentation. On 9/16/25 at 1422 hours, the Administrator was made aware and acknowledged the above findings. 2. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the residents attending physician or physician on call when there has been a(an) accident or incident involving the resident,2. The nurse will record in the resident's medical record information relative to the changes in the resident's medical/mental condition or status,3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant information for the provider, including (for example) information prompted by the Interact SBAR Communication Form, and4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Medical record review for Resident 4 was initiated on 9/9/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Progress Note dated 9/4/25, showed at approximately 1830 hours, CNA alerted the charge nurse and RN supervisor of the redness on Resident 4's left upper thigh while providing care to the resident. The note further showed Resident 4 had blisters on her left thigh. Review of Resident 4's Interdisciplinary Progress Note dated 9/5/25, showed during the routine care on 9/4/25, the assigned CNA observed blisters to Resident 4's left upper thigh. The charge nurse and RN supervisor evaluated the resident and observed three blisters to the resident's left upper thigh and the surrounding skin was intact. The note further showed on 9/3/25, during the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 maintain the infection control practices to help prevent the development and transmission of diseases and infections for three of nine sampled residents (Residents 4, 6, and 7). * Treatment Nurse 1 failed to perform hand hygiene and changed her gloves after removing the soiled wound dressing for Resident 4. In addition, Treatment Nurse 1 failed to dispose the unused gauze brought in resident's room and ensure the alcohol based sanitizer used was not expired. * CNA 4 failed to wear gloves and perform hand hygiene after touching contaminated items inside Resident 4's contact isolation room. In addition, CNA 4 then proceeded to deliver Resident 7's meal tray without performing hand hygiene. * CNA 4 failed to wear gloves and perform hand hygiene after touching contaminated items inside Resident 6's contact isolation room. In addition, CNA 4 then proceeded to feed Resident 6 without performing hand hygiene. These failures had the potential for the transmission of disease-causing pathogens and infections to the staff and residents.Findings: Review of the facility's P&P titled Wound Care revised 10/2010 showed;1. Verify there is a physician's order;2. Put on exam glove. Loosen tape and remove dressing;3. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly;4. Antiseptic (as ordered)5. Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart.6. The following information should be recorded in the resident's medical record. a. The type of wound care given;b. The date and time the wound care was given;c. All assessment data (i.e., wound bed color, size, drainage etc.) obtained when inspecting the wound;d. The signature and title of the person recording the data. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2019 showed all the personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Review of the facility's P&P titled Isolation-Categories of Transmission-Based Precautions revised 9/2022 showed under the section for Contact Isolation, the staff and visitors wear gloves (clean, non-sterile) when entering the room. While caring for a resident, the staff will change gloves after having contact with infective material (for example, fecal material, and wound drainage). Gloves are removed and hand hygiene performed before leaving the room. The staff to avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. 1. On [DATE] at 1332 hours, a wound care treatment observation to Resident 4 was conducted with Treatment Nurse 1. Treatment Nurse 1 was observed placing the supplies needed for wound treatment into a small basket, which included a half pack of disposable gauze. Treatment Nurse 1 proceeded to remove the old dressing on Resident 4's left upper thigh and with the same gloves, entered the restroom and grabbed a cup with soapy water. Treatment Nurse 1 proceeded to clean Resident 4's wounds without performing hand hygiene or glove change. Treatment Nurse 1 was then observed while cleaning Resident 4's wounds reached into the gauze package and touched the inside of the gauze package with her gloves. After Resident 4's wound treatment, Treatment Nurse 1 was observed sanitizing her hands with an expired alcohol-based sanitizer after cleaning her workstation. Treatment Nurse 1 also returned the unused package of gauze inside Treatment Cart 1. On [DATE] at 1410 hours, an interview was conducted with Treatment Nurse 1 after completing the wound care for Resident 4. When asked what the expiration date on the hand sanitizer, Treatment Nurse 1 verified it had expired on 5/2025. When asked what she did with the unused gauze, Treatment Nurse 1 stated once she removed one half of the pack, she would continue to use the leftover gauze for the remainder of her residents until the half pack of unused gauze was empty. Treatment Nurse 1 acknowledged hand hygiene practices should have been performed after removing the old dressing and to throw away the unused and contaminated gauze. On [DATE] at 1523 hours, an interview was conducted with the DON. The DON acknowledged the expired hand sanitizer should have been discarded. The DON stated the process for proper hand hygiene while providing wound care would be to perform hand hygiene after removing the soiled dressing. The DON stated any unused disposable supplies would be disposed of if they were brought into a resident's room. 2. On [DATE] at 1209 hours, an observation was conducted for CNA 4 delivering the lunch trays. a. CNA 4 was observed holding a lunch tray, placed the lunch tray on top of the contact isolation cart outside the room, and donned an isolation gown before entering Resident 4's room. CNA 4 placed the lunch tray on Resident 4's bedside table, with bare hands moved Resident 4's bedside table around to accommodate Resident 4's sitting position and then removed the lids