| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555520 | A. Building<br>B. Wing | 01/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Leisure Court Nursing Center | 1135 Leisure Court<br>Anaheim, CA 92801 |

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

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**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 protect the resident's right to be free from physical abuse by another resident. * Resident 2 pushed Resident 1, causing Resident 1 to fall on the floor. This failure resulted in Resident 1 sustaining a left lateral superior pubic ramus and left inferior pubic fractures and/or psychosocial harm to the resident.Findings: Review of the facility's P&P titled Abuse Reporting and Prevention revised 4/2024 showed to ensure resident rights are protected by providing a method of investigation and reporting of alleged violations involving mistreatment, neglect, abuse including injuries of unknown sources, unusual occurrences, unauthorized photographs, unauthorized video recordings, unauthorized postings on social media of nursing home residents and misappropriation of resident property. This also includes any physical or chemical restraint not required to treat a resident's symptoms. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish, or deprivation of an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Review of the facility's SOC 341 dated 1/8/26 at 1620 hours, showed Resident 1 tried to get into Resident 2's room. Resident 2 pushed Resident 1 on the chest, Resident 1 back off and got out of balance and fall. a. Review of Resident 2's medical record was initiated on 1/22/26. Resident 2 was admitted on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 2's SBAR Communication Form and Progress Notes dated 1/8/26, showed at 1700 hours, Resident 2 had an altercation with Resident 1. Resident 2 did not want Resident 1 to enter her room. Resident 2 stated she was trying to stop Resident 1 from entering her room, pushed her and Resident 1 lost her balance and fell. b. Review of Resident 1's medical record was initiated on 1/22/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 6/20/25, showed the resident did not have the capacity to understand and make decisions. Review of Resident 1's Physical Therapy Treatment Encounter Notes dated 1/8/26, showed the resident's functional status with bed mobility was set-up or clean-up assistance, transfers were set up or clean up assistance and walks 150 feet with supervision or touching assistance with no assistive device. Review of Resident 1's Physical Therapy Treatment Encounter Note dated 1/23/26, showed the resident's functional status with bed mobility was partial to moderate assistance, transfers were partial to moderate assistance, and walks 10 feet with substantial/ maximal assistance with use of two-wheeled walker Review of Resident 1's SBAR Communication Form and Progress Notes dated 1/8/26, showed Resident 1 had an unwitnessed fall. Resident 1 complained of pain to left hip at scale of five out of 10 (pain scale of 0-10, 0 = no pain to 10 = severe pain), was crying and pointing to the area. Review of Resident 1's Radiology Patient Report<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated 1/8/26, showed fracture of the left superior and inferior pubic rami. The age of the fracture was indeterminate. Review of Resident 1's Nurses Progress Notes dated 1/9/26 at 1005 hours, showed the resident was transferred to acute care hospital for further evaluation. Review of Resident 1's CT scan from the acute care facility dated 1/9/26, showed recent fractures involving left lateral superior pubic ramus and left inferior pubic ramus. Review of Resident 1's Order Summary Report showed the following physicians orders:- dated 6/19/25, to administer acetaminophen (pain reliever) 325 mg, give two tablets orally every six hours as needed for mild pain of one to three.- dated 1/8/26, to apply Lidoderm (pain reliever) patch 5% to left hip topically in the morning and off at night time for pain to left hip for seven days.- dated 1/16/26, to administer hydrocodone-acetaminophen (narcotic) 5-325 mg, give one tablet orally every six hours as needed for pain scale of six to 10. Review of Resident 1's MAR for January 2026 showed the following medications were administered on the following dates and times to address the resident's pain: * Acetaminophen 325 mg, give two tablets orally every six hours as needed for mild pain 1-3 was administered to the resident on the following dates and times:- dated 1/9/26, at 0800 hours for pain level of 8.- dated 1/10/26, at 0524 hours for pain level of 3, at 1130 hours for pain level of 6 and 2100 hours for pain level of 5.- dated 1/11/26, at 0202 hours for pain level of 3, and at 1000 hours for pain level of 3.- dated 1/12/26, at 0900 hours for pain level of 3, and at 1600 hours for pain level of 4.- dated 1/13/26, at 1602 hours for pain level of 4.- dated 1/15/26, at 0500 hours for pain level of 3, at 1003 hours for pain level of 3 and 2135 hours for pain level of 5.- dated 1/16/26, at 1025 hours for pain level of 3.- dated 1/17/26, at 0501 hours for pain level of 3.- dated 1/18/26, at 0900 hours for pain level of 3.- dated 1/19/26, at 0746 hours for pain level of 3.- dated 1/20/26, at 0753 hours for pain level of 3.- dated 1/21/26, at 0546 hours for pain level of 3, and at 1157 hours for pain level of 3. * Hydrocodone-acetaminophen 5-325 mg, give one tablet orally every six hours as needed for pain scale 6-10 was administered to the resident on 1/22/26 at 0501 hours for pain level of 7, and at 1240 hours for pain level 7. * Lidoderm (lidocaine) patch 5% to left hip topically in the morning and off at night time for pain to left hip for seven day, from 1/9/26 to 1/15/26. On 1/21/26 at 1345 hours, during an observation, Resident 1 was up in wheelchair with both legs elevated. Resident 1 appeared to be confused. On 1/21/26 at 1425 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 1 used to walk in the hallways and was able to complete activities of daily living with set up or assisted supervision. CNA 1 further stated the resident was currently totally dependent on staff after falling two weeks ago. CNA 1 stated the resident usually stayed in bed and complained of pain since returning from the hospital. On 1/22/26 at 0854 hours, a follow-up observation was conducted for Resident 1. Resident 1 was in bed sleeping. On 1/22/26 at 1126 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 1 used to walk in the hallway. LVN 2 further stated the resident stayed in bed and had episodes of screaming and yelling due to pain. LVN 2 stated resident required extensive assistance with the activities of daily living, and needed to be repositioned with two person assistance because of pain. On 1/22/26 at 1315 hours, a phone interview was conducted with LVN 1. LVN 1 stated Resident 2 admitted to pushing Resident 1 when Resident 1 was trying to get into her room on 1/8/26. On 1/22/26 at 1649 hours, an interview was conducted with LVN 3. LVN 3 stated on 1/8/26 approximately 1620 hours, Resident 1 was found on the floor by Room A. Resident 1 was crying and complaining of pain to the hip. LVN 3 further Resident 2 was standing by the door of Room A. LVN 2 stated Resident 2 stated she gave Resident 1 a little shove to stop her from going into her room. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**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 implement the P&P to ensure the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one of two sampled residents (Resident 1). * The facility failed to report an allegation of abuse in a timely manner when Resident 2 pushed Resident 1, causing Resident 1 to fall on the floor. This failure had the potential for abuse to go unreported and uninvestigated timely.Findings: Review of the facility's P&P titled Abuse Reporting and Prevention revised 4/2024 showed the administrator, or his/her designee, will report each alleged abuse to the Ombudsman's office and the Department of Public Health immediately or within 2 hours per Section 1418.91 of the Health and Safety Code. If the alleged violation does not involve abuse and does not result in serious bodily injury, the facility should report the violation within 24 hours. Serious Bodily Injury - 2-hour limit: If the events that caused the reasonable suspicion of abuse resulted in serious bodily injury to a resident, the covered individual shall report the suspicion of abuse immediately, but not later than 2 hours after forming the suspicion. Any allegation of physical abuse should be reported within two hours. A resident to resident altercation should be reviewed as a potential situation of abuse. When either or both residents have a cognitive impairment or mental disorder it does not automatically mean that an abuse did not occur. If, during the investigation, it is determined that the resident's actions were willful or deliberate then abuse has occurred. For incidents involving resident-to-resident abuse that did not result in bodily harm where the alleged abuser is a resident diagnosed with Dementia, facilities are required to notify the ombudsman and local law enforcement in writing within 24 hours. If the event caused actual harm, it still needs to be reported to the ombudsman and local law enforcement within two hours. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, or mental anguish, or deprivation of an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish. Review of the facility's SOC 341 - Report of Suspected Dependent/Elder Abuse dated 1/8/26, showed the facility reported an abuse allegation to the CDPH, L&C Program on 1/9/26 at 0906 hours. The SOC 341 showed Resident 1 was the alleged victim and Resident 2 was the alleged suspected abuser. The SOC 341 showed Resident 2 pushed Resident 1 and caused Resident 1 to fall and complain of pain. a. Review of Resident 2's medical record was initiated on 1/22/26. Resident 2 was admitted on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 2's SBAR Communication Form and Progress Notes dated 1/8/26, showed at 1700 hours, Resident 2 had an altercation with Resident 1. Resident 2 did not want Resident 1 to enter her room. Resident 2 stated she was trying to stop Resident 1 from entering her room, pushed her and Resident 1 lost her balance and fell. b. Review of Resident 1's medical record was initiated on 1/22/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 6/20/25, showed the resident did not have the capacity to understand and make decisions. Review of Resident 1's SBAR Communication Form and Progress Notes dated 1/8/26, showed Resident 1 had an unwitnessed fall. Resident 1 complained of pain to left hip at scale of five out of 10, was crying and pointing to the area. Review of Resident 1's Radiology Patient Report dated 1/8/26, showed fracture of the left superior and inferior pubic rami. The age of the fracture was indeterminate. On 1/22/26 at 1315 hours, a telephone interview was conducted with LVN 1. LVN 1 stated Resident 2 admitted to pushing<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 1 when Resident 1 was trying to get into her room on 1/8/26. On 1/22/26 at 1332 hours, a phone interview was conducted with RN 2. RN 2 verified the event between Resident 1 and 2 happened on 1/8/26 at 1620 hours. RN 2 further stated LVN 1 interviewed Resident 2, who stated she informed LVN 1 of the incident on 1/8/26. RN 2 stated he did not notify the CDPH, ombudsman and the local law enforcement within two hours of the incident. RN 2 further stated the SOC 341 was sent to CDPH, ombudsman and the local law enforcement on 1/9/26. On 1/22/26 at 1649 hours, an interview was conducted with LVN 3. LVN 3 stated on 1/8/26 approximately 1620 hours, Resident 1 was found on the floor by Room A. Resident 1 was crying and complaining of pain to the hip. LVN 3 further Resident 2 was standing by the door of Room A. LVN 2 stated Resident 2 stated she gave Resident 1 a little shove to stop her from going into her room. On 1/22/26 at 1434 hours, a telephone interview was conducted with the DON. The DON stated the RN initially reported to him, there was no injury to Resident 1 at the time. The DON further stated the RN relayed a wrong information to him. The DON stated the CDPH, ombudsman and the local law enforcement should have been notified within two hours of the incident. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**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 required skilled nursing services for one of four sampled resident (Resident 1). * The facility failed to timely notify the physician of Resident 1's abnormal radiology result. * The facility failed to manage Resident 1's pain after a fall. These failures had the potential to negatively impact the resident's well-being.Findings: Review of Resident 1's medical record was initiated on 1/22/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 6/20/25, showed the resident did not have the capacity to understand and make decisions. a. Review of the facility's P&P titled Laboratory and Radiology Documentation revised 8/2016 showed the radiology reports and the abnormal laboratory results are to be called to the physician promptly by the licensed nurse. Review of Resident 1's Order Summary Report showed a physician's order dated 1/8/26, for right and left hip with pelvis x-ray. Review of Resident 1's Radiology Patient Report dated 1/8/26, showed fracture of the left superior and inferior pubic rami. The age of the fracture was indeterminate. Review of Resident 1's Nurse Progress Notes dated 1/8/26, showed at 2103 hours, x-ray of bilateral hips no acute fracture to right hip, the left superior and inferior pubic rami the age is indeterminate, faxed to primary. On 1/22/26 at 1142 hours, an interview and a concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 verified Nurse Progress Notes dated 1/8/26 at 2103 hours showed x-ray result was faxed to the primary physician. RN 1 verified Resident 1's medical record failed to show the physician was called for the abnormal radiology report. RN 1 stated the results should have been called to the physician because the abnormal result requires immediate action. On 1/22/26 at 1332 hours, a telephone interview was conducted with RN 2. RN 2 verified he faxed the radiology report; however, failed to notify the primary physician of the abnormal radiology report because the results showed indeterminate age. On 1/22/26 at 1434 hours, a telephone interview was conducted with the DON. The DON stated the expectation of reporting of the abnormal radiology report was for the licensed nurses to immediately report to the physician to prevent delay in treatment. b. Review of facility's P&P titled Pain Management Protocol showed whenever the presence of pain was identified, the process of pain assessment and management will begin. At the identification of pain, the pain rating should always be included in documentation. Pain assessment process showed to complete the pain assessment form, and initiate assessment flow sheet. Documentation on the flow sheet should reflect every as needed medication administered, response to the medication and non-pharmacological intervention. Review of Resident 1's SBAR Communication Form and Progress Notes dated 1/8/26, showed Resident 1 had an unwitnessed fall. Resident 1 complained of pain to her left hip at scale of five out of 10 (pain scale of 0-10, 0 = no pain to 10 = severe pain), was crying and pointing to the area. Review of Resident 1's Radiology Patient Report dated 1/8/26, showed fracture of the left superior and inferior pubic rami. The age of the fracture was indeterminate. Review of Resident 1's Order Summary Report showed the following physicians orders:- dated 6/19/25, to administer acetaminophen (pain reliever) 325 mg, give two tablets orally every six hours as needed for mild pain of one to three; and- dated 1/8/26, to apply Lidoderm (pain reliever) patch 5% to left hip topically in the morning and off at night time for pain to left hip for seven days. Review of Resident 1's MAR for January 2026 showed the following medications were administered on the following dates and times to address the resident's pain: * Acetaminophen 325 mg, give two tablets orally every six hours as needed for mild pain scale of 1-3 was administered to the resident on the following dates and times:- dated 1/9/26, at 0800 hours for pain level of 8.- dated 1/10/26, at 0524 hours for pain level of 3, at 1130 hours for pain<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | level of 6 and 2100 hours for pain level of 5.- dated 1/11/26, at 0202 hours for pain level of 3, and at 1000 hours for pain level of 3.- dated 1/12/26, at 0900 hours for pain level of 3, and at 1600 hours for pain level of 4.- dated 1/13/26, at 1602 hours for pain level of 4.- dated 1/15/26, at 0500 hours for pain level of 3, at 1003 hours for pain level of 3 and 2135 hours for pain level of 5. * Lidoderm (lidocaine) patch 5% to left hip topically in the morning and off at night time for pain to left hip for seven day, from 1/9/26 to 1/15/26. Review of Resident 1's Nurses Progress Notes failed to show a physician was notified when Resident 1's reported pain levels was above the mild pain scale of 1-3 on the following dates and times:- dated 1/10/26 at 1130 hours for pain level of 6 and 2100 hours for pain level of 5;- dated 1/12/26 at 0900 hours for pain level of 3, and at 1600 hours for pain level of 4;- dated 1/13/26 at 1602 hours for pain level of 4; and- dated 1/15/26 at 2135 hours for pain level of 5. Review of Resident 1's medical record failed to show a pain documentation flow sheet to reflect every needed medication was administered, the response to the medication and non-pharmacological pain intervention per facility protocol. On 1/22/26 at 1332 hours, a telephone interview was conducted with RN 1. RN 1 stated he did not know if LVN 3 gave the acetaminophen medication to Resident 1 after the fall. On 1/22/26 at 1649 hours, an interview was conducted with LVN 3. LVN 3 stated on 1/8/26 at approximately 1620 hours, Resident 1 was found on the floor by Room A. Resident 1 was crying and complaining of pain to the hip. LVN 3 further stated she did not recall if she administered the acetaminophen medication to the resident after the resident was found on the floor on 1/8/26. On 1/22/26 at 1434 hours, a telephone interview was conducted with the DON. The DON stated his expectation of the licensed nurses was to administer the pain medication to Resident 1 when they complained of pain and crying. On 1/23/26 at 0910 hours, an interview and a concurrent record review was conducted with RN 1. RN 1 verified the above information regarding the order for the acetaminophen medication and the dates and times the medication was administered for pain levels of four and above. RN 1 verified Resident 1 was seen by the physician on 1/16/26 with a new order for hydrocodone-acetaminophen 5-325 mg to manage pain from six to 10. RN 1 verified the pain levels of four and above were not reported to the physician until 1/16/26. RN 1 further verified Resident 1's medical record failed to show a pain documentation flow sheet to reflect every needed medication was administered, response to the medication and any non-pharmacological pain interventions. RN 1 stated there should have been monitoring of the resident's pain, non-pharmacological pain interventions and adverse reaction in the resident's MAR. Cross reference to F600, Example A. |