

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: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the residents were free from unnecessary psychotropic drugs for four of five sampled residents (Residents 4, 7, 38, and 52) reviewed for unnecessary medication, two of 22 final sampled residents (Residents 9 and 10), and two nonsampled residents (Residents 80 and 83). * The facility failed to ensure Resident 38's orthostatic blood pressure was accurately monitored, as ordered by the physician, for the use of the quetiapine (antipsychotic) medication. In addition, the facility failed to ensure non-pharmacological interventions were implemented for the documented observed behaviors. * The facility failed to ensure Resident 52's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the quetiapine (antipsychotic) medication. * The facility failed to ensure the rationale was documented from the physician for increasing the dose of Remeron (antidepressant) medication was based on Resident 7's assessed condition. *The facility failed to ensure Resident 9's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the quetiapine (antipsychotic) medication. *The facility failed to ensure Resident 10's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the quetiapine (antipsychotic) medication. * The facility failed to ensure Resident 4's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the quetiapine (antipsychotic) and risperidone (antipsychotic) medications. In addition, the facility failed to ensure consistent documentation of the non-pharmacological interventions implemented for the documented observed targeted behaviors. *The facility failed to ensure Residents 80 and 83's medical record contained documentation to explain the prescribing practitioner's rationale for extending beyond 14 days the PRN orders for the psychotropic drug class of benzodiazepines. These failures had the potential for adverse effects from the psychotropic medications, not providing the correct data to the prescriber to adjust the dosage of the medications and to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed a psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics, and antidepressant. Psychotropic medication may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. 1. Medical record review for Resident 38 was initiated on 6/15/26. Resident 38 was admitted to the (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: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 38's H&P examination dated 6/12/25, showed Resident 38 can make needs known but cannot make medical decisions. Review of Resident 38's Order Summary Report showed the following physician's orders: - Dated 6/1/26, to administer quetiapine 25 mg by mouth two times a day. - Dated 6/10/25, to monitor Resident 38's for orthostatic hypotension; to monitor the blood pressure (BP) in the lying and sitting position, every Wednesday during the day shift; and to notify the physician of a difference of 20mmHg or greater for the systolic BP or 10 mmHg or greater for the diastolic BP; and - Dated 6/10/25, to monitor episodes of scratching self and record number of episodes every shift; Review of Resident 38's MAR for June 2026 showed the following documentation for the orthostatic BP readings: - On 6/3/26, the blood pressure readings were documented as 122/64 mmHg for the lying and sitting positions; and - On 6/17/26, the blood pressure readings were documented as 124/68 mmHg for the lying and sitting positions. Review of Resident 38's MAR for June 2026 showed the following documentation for the monitoring for episode of scratching self every shift: - On 6/1/26, three episodes during evening shift and one episode during the night shift; - On 6/2/26, one episode during the night shift; - On 6/3/26, three episodes during evening shift and one episode during the night shift; - On 6/5/26, one episode during the day shift; - On 6/7/26, one episode on day shift, three episodes during evening shift and one episode during the night shift; - On 6/9/26, one episode during the night shift; - On 6/10/26, three episodes during the evening shift; - On 6/11/26, one episode during the day shift; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 6/12/26, one episode during evening shift and one episode during the night shift; - On 6/13/26, one episode during the day shift; - On 6/14/26, one episode on day shift, three episodes during evening shift, and one episode during the night shift; - On 6/15/26, three episodes during evening shift and one episode during the night shift; and - On 6/16/26, one episode during the day shift; Further review of Resident 38's medical record failed to show documented evidence of the non-pharmacological interventions implemented for the documented targeted behaviors on the above dates and shifts. On 6/17/26 at 0851 hours, an interview and concurrent medical record review for Resident 38 was conducted with RN 1. RN 1 verified the blood pressures for the lying and sitting positions were the same as recorded on 6/3/26 and 6/17/26. RN 1 stated a change in resident movement would change the blood pressure from lying to sitting position. RN 1 further stated there were no documented evidence of the non-pharmacological interventions implemented when Resident 38 had episodes of scratching. 2. Medical record review for Resident 52 was initiated on 6/15/26. Resident 52 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 52's MDS quarterly assessment dated [DATE], showed Resident 52's Cognitive Skills for Daily Decision Making, moderately impaired. Review of Resident 52's Order Summary Report showed the following physician's orders: - Dated 3/2/26, to administer quetiapine 25 mg by mouth at bedtime. - Dated 3/2/26, to monitor for orthostatic hypotension; to monitor the blood pressure in the lying and sitting position, every Tuesday during the day shift; and to notify the physician of a difference of 20mmHg or greater for the systolic BP or 10 mmHg or greater for the diastolic BP. Review of Resident 52's MARS for April, May, and June 2026 showed the following documentation for the orthostatic BP readings: - On 4/7/26, the blood pressure readings were documented as 130/88 mmHg for the lying and sitting positions; - On 4/28/26, the blood pressure readings were documented as 124/71 mmHg for the lying and sitting positions; (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 5/5/26, the blood pressure readings were documented as 124/78 mmHg for the lying and sitting positions; and - On 6/9/26, the blood pressure readings were documented as 124/72 mmHg for the lying and sitting positions. On 6/17/26 at 1357 hours, an interview and concurrent medical record review for Resident 52 was conducted with RN 1. RN 1 verified the blood pressure readings for the lying and sitting position were the same as recorded on the above dates. RN 1 stated a change in resident movement would change the blood pressure from lying to sitting position. On 6/18/26 at 0844 hours, an interview was conducted with the DON. The DON verified the above findings. The DON stated the blood pressure readings were not accurate and stated the blood pressure readings for lying and sitting would have some differences in the blood pressure readings. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 7 was initiated on 6/15/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's MDS dated [DATE], showed Resident 7 had moderately impaired cognitive function. Review of Resident 7's Order Summary Report dated 6/17/26, showed the following physician's orders: - Dated 5/27/26, to administer Remeron 15 mg 1 tablet by mouth at bedtime for depression manifested by poor meal intake less than 50% every meal; and - Dated 3/14/26, to monitor meal percentage of less than 50% every meal. Review of Resident 7's Behavior & Psychotropic Summary for Remeron medication use showed for the months of April and May 2026, there were increased number of episodes of Resident 7 eating less than 50% of meals. On 5/27/26, the Remeron medication dose was increased from 7.5 mg to 15 mg by mouth at bedtime. Review of Resident 7's Physician Progress note dated 5/27/26, failed to show a rationale for the increase dose of the medication. There was no other progress note from the prescribing physician for the rationale of increase dose of the Remeron. On 6/17/26 at 1405 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 3. RN 3 verified Resident 7's use of Remeron medication for depression with manifestation behavior of poor appetite. RN 3 verified the increased number of episodes of poor appetite from the previous months based on the behavior monthly summary data. RN 3 verified the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	increased dose of Remeron medication from 7.5 mg to 15 mg. RN 3 stated the RD recommended the increased dose of the Remeron medication. However, RN 3 was asked if there was documentation from the RD for the recommendation of the increase dose of the medication. RN 3 verified there was no documentation in the medical record for the rationale of the dose increased of the Remeron. 4. Medical record review for Resident 9 was initiated on 6/15/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's MDS dated [DATE], showed Resident 9 had moderately impaired cognitive skills. Review of Resident 9's Order Summary Report dated 6/17/26, showed the following physician's orders: - Dated 5/12/26, to administer quetiapine 25 mg by mouth at bedtime for psychosis manifested by yelling/screaming without provocation.- Dated 6/12/25, to monitor for orthostatic hypotension ever week on Wednesday, for BP in lying position.- Dated 6/12/25, to monitor for orthostatic hypotension ever week on Wednesday, for BP in sitting position. Review of Resident 9's MARs for May and June 2026 showed the orthostatic blood pressures (sitting and lying) were scheduled to be monitored every Wednesday. However, the blood pressure readings for both positions (lying and sitting) were the same as follows:- On 5/13/26 , the blood pressure readings were 140/70 mmHg for sitting and lying positions.- On 5/27/26, the blood pressure readings were 136/58 mmHg for sitting and lying positions.- On 6/3/26, the blood pressure readings were 150/60 mmHg for sitting and lying positions. - On 6/10/26, the blood pressure readings were 140/70 mmHg for sitting position and lying positions. 5. Medical record review for Resident 10 was initiated on 6/15/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's MDS dated [DATE], showed Resident 10 had moderately impaired cognitive skills. Review of Resident 10's Order Summary Report dated 6/17/26, showed the following physician's orders: - Dated 6/4/26, to administer quetiapine 50 mg by mouth at bedtime for schizoaffective disorder.- Dated 6/24/25, to monitor for orthostatic hypotension every week on Saturday, with BP in lying position.- Dated 6/24/25, to monitor for orthostatic hypotension every week on Saturday, with BP in sitting position. Review of Resident 10's MARs for April and May 2026 showed the orthostatic blood pressures (sitting and lying) were scheduled to be monitored every Wednesday. However, the blood pressure readings for both positions (lying and sitting) were the same as follows:- On 4/4/26, the blood pressure (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readings were 126/82 mmHg for sitting and lying positions. - On 4/11/26, the blood pressure readings were 128/84 mmHg for sitting and lying positions. - On 4/18/2, the blood pressure readings were 128/76 mmHg for sitting and lying positions. - On 5/2/26, the blood pressure readings were 136/82 mmHg for sitting and lying positions. - On 5/16/26, the blood pressure readings were 122/72 mmHg for sitting and lying positions. - On 5/23/26, the blood pressure readings were 128/76 mmHg for sitting and lying positions. - On 5/30/26, the blood pressure readings were 128/72 mmHg for sitting and lying positions. On 6/17/26 at 1333 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 2. LVN 2 verified the physician's orders for psychotropic medication and the monitoring for orthostatic hypotension. LVN 2 was asked to review the orthostatic hypotension record for Resident 10. LVN 2 verified the result of the blood pressure monitoring had the same reading data recorded for lying and sitting positions. LVN 2 stated the monitoring was inaccurate. On 6/17/26 at 1346 hours, an interview and concurrent medical record review for Residents 9 and 10 was conducted with RN 3. RN 3 stated the monitoring of the orthostatic hypotension was for the psychotropic medication's side effects due to the medication had the effect on the position of the resident when lying and sitting. RN 3 stated she expected the monitoring of the blood pressure to be accurate for the residents benefit. RN 3 was asked to review Residents 9 and 10's previous monitoring of the orthostatic hypotension. RN 3 verified the blood pressure readings were inaccurate due to the same reading on both lying and sitting positions. RN 3 added the nurses should have monitored the blood pressure accurately. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Residents 7, 9, and 10 was conducted with the DON. The DON was informed and verified the above findings. 6. Medical record review for Resident 4 was initiated on 6/15/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 5/31/26, showed Resident 4 was unable to make independent medical decisions. a. Review of Resident 4's Order Summary Report dated 6/18/26, showed the following physician's orders: - Dated 4/14/26, to administer quetiapine 50 mg via GT at bedtime for psychosis with agitation manifested by striking out. - Dated 4/14/26, for the use of the quetiapine and risperidone (antipsychotic) medications, to monitor (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4's for orthostatic hypotension; to monitor the blood pressure (BP) in the lying and sitting position, every Wednesday during the 0700 to 1500 hours shift; and to notify the physician of a difference of 20mmHg or greater for the systolic BP or 10 mmHg or greater for the diastolic BP. - Dated 4/21/26, to administer risperidone 1 mg via GT at bedtime for psychosis manifested by angry outburst. Review of Resident 4's MARs for May and June 2026 showed the following documentation for the orthostatic BP readings: - On 5/6/26, the BP readings were documented as 118/69 mmHg for the lying and sitting positions. - On 6/3/26, the BP readings were documented as 123/71 mmHg for the lying and sitting positions. - On 6/17/26, the BP readings were documented as 118/64 mmHg for the lying and sitting positions. b. Review of Resident 4's Order Summary Report dated 6/18/26, showed the following physician's orders dated 4/14/26: - For the use of the escitalopram (antidepressant medication), to monitor Resident 4 and record the number of episodes of crying every shift. - For the use of the risperidone medication, to monitor Resident 4 and record the number of episodes of angry outbursts every shift. - For the use of the quetiapine medication, to monitor Resident 4 and record the number of episodes of striking out every shift. Review of Resident 4's MAR for May and June 2026 showed the following documentation for the monitoring of Resident 4's behaviors: * For the monitoring for episodes of crying out every shift, the licensed nurse documented two episodes during the evening shift (1500 to 2300 hours) on 5/9/26. * For the monitoring for episodes of angry outburst every shift, the licensed nurse documented the following: - On 5/9/26, two episodes during the evening shift and - On 5/31/26, one episode during the night shift (2300 to 0700 hours). * For the monitoring for episodes of striking out every shift, the licensed nurse documented one episode during the night shift on 6/1/26. Further review of Resident 4's medical record failed to show documented evidence the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-pharmacological interventions were implemented for the documented targeted behaviors on the above dates and shifts. On 6/17/26 at 1108 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 reviewed Resident 4's medical record and verified the above findings. On 6/18/26 at 1000 hours, an interview was conducted with the DON. The DON stated the residents administered with the psychotropic medications should be monitored for side effects and targeted behaviors every shift. The DON stated if the target behaviors were observed, the licensed nurse should attempt and document the non-pharmacological interventions implemented. The DON further stated if the non-pharmacological interventions were effective, it would potentially lead to less episodes of the behaviors and possibly GDR of the psychotropic medication. The DON stated the residents administered the antipsychotic medications were monitored for orthostatic hypotension weekly. The DON stated for the monitoring of orthostatic hypotension, the resident's BP readings were obtained in different positions and the BP readings compared. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 7. Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed the psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. Residents do not receive psychotropic drugs pursuant to a PRN order unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic drugs are limited to 14 days. For psychotropic PRN medications, excluding antipsychotics, if the attending physician or prescribing practitioner believes that is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Medical record review for Resident 80 was initiated on 6/16/26. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's Order Summary Report showed the following orders: - Dated 4/21/26, for Restoril (benzodiazepine medication) 15 mg oral capsule by mouth as needed for insomnia for 14 days. - Dated 6/5/26, for Restoril 15 mg oral capsule by mouth as needed for insomnia for 30 days. Review of Resident 80's MAR from 4/21/26 to 6/10/26, showed Resident 80 was administered Restoril three times in April 2026, 15 times in May 2026, and five times to date in June 2026. On 6/18/26 at 1109 hours, an observation was conducted on Resident 80 in Room A. Resident 80 was observed sleeping in the room. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Medical record review for Resident 83 was initiated on 6/16/26. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed the following physician's orders: - Dated 3/22/25, to administer Ativan (benzodiazepine medication) 1 mg by mouth every six hours PRN anxiety for 90 days; - Dated 8/4/25, to administer Ativan 1 mg by mouth every six hours PRN anxiety for 90 days; - Dated 10/22/25, to administer Ativan 1 mg by mouth every six hours PRN anxiety for 90 days; - Dated 3/22/26, to administer Ativan 1 mg by mouth every six hours PRN anxiety for 90 days; and - Dated 5/11/26, to administer Ativan 1 mg by mouth every six hours PRN anxiety for 30 days; On 6/18/26 at 1428 hours, an interview was conducted with the DON. The DON stated the facility did not have the documentation of the prescribing practitioner's rationale for the PRN psychotropic orders for Residents 80 and 83 to be extended beyond 14 days.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - 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 review, and facility P&P review, the facility failed to ensure one of 22 final sampled residents (Resident 67) and two nonsampled residents (Residents 41 and 109) reviewed for respiratory care were provided with the appropriate respiratory care and services. * The facility failed to ensure Resident 41's nasal cannula tubing and storage bag were changed every seven days. * The facility failed to ensure Resident 67 was administered with the oxygen therapy as ordered by the physician; and failed to ensure Resident 67's nasal cannula tubing was dated and labeled. In addition, the facility failed to ensure a sign to show oxygen in use was posted outside the resident's room. * The facility failed to ensure a physician's order was obtained for Resident 109's use of oxygen administration. In addition the facility failed to ensure the oxygen tubing was dated and labeled. These failures had the potential for the residents to not receive the appropriate respiratory care and services, and may negatively impact the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Oxygen Concentrator revised 6/2017 showed it is the policy of this facility to use disposable prefilled humidifier, tubing and cannulas, as applicable, for resident receiving oxygen. Cannulas should be replaced weekly. On 6/15/26 at 0844 hours, during the initial tour of the facility, an observation was conducted for Resident 41. Resident 41 was observed lying in bed and was receiving oxygen at 2 LPM via nasal cannula attached to the oxygen concentrator. Medical record review for Resident 41 was initiated on 6/15/26. Resident 41 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 3/28/26, showed Resident 41 had no capacity to make medical decisions. Review of Resident 41's Order Summary Report showed a physician's order dated 4/16/26, to replace nasal cannula every Sunday, every day shift. On 6/15/26 at 0857 hours, an observation, interview and concurrent medical record review for Resident 41 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the nasal cannula should have been changed every seven days, for infection control. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Oxygen Administration revised 3/2017 showed to verify there is a physician's order for the oxygen administration. The following equipment and supplies are necessary when performing this procedure: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	- portable oxygen cylinder or concentrator, - nasal cannula, oxygen mask or non-rebreather ask(as ordered), and - No Smoking/Oxygen in Use sign. Review of the facility's P&P titled Oxygen Concentrator revised 6/2017 showed it is the policy of this facility to use disposable prefilled humidifier, tubing and cannulas, as applicable, for resident receiving oxygen. Cannulas should be replaced weekly. On 6/15/26 at 0900 hours, during the initial tour of the facility, Resident 67 was observed receiving continuous oxygen therapy at 3.5 LPM via nasal canula. The nasal canula was connected to the oxygen concentrator and was observed unlabeled and undated. The oxygen in-use sign was not observed outside of the resident's room. Medial record review for Resident 67 was initiated on 6/15/26. Resident 67 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 67's H&P examination dated 1/22/26, showed Resident 67 had the capacity to understand and make decisions. Review of Resident 67's Order Summary Report for June 2026 showed the following physician's orders: - dated 1/14/26, to administer continuous oxygen at 2 LPM via nasal cannula, for acute respiratory failure. - dated 1/16/26, to replace the nasal cannula every Sunday (day shift) for oxygen therapy and maintenance. On 6/15/26 at 0921 hours, an interview and concurrent observation of Resident 67 was conducted with the DON. The DON stated for the residents administered with the oxygen therapy, there should be a signage outside of the resident's door to alert the individuals coming into room that there was oxygen in use. The DON stated the oxygen tubing should be labeled with the date and changed weekly. The DON verified the nasal cannula tubing was undated and Resident 67 was receiving 3.5 LPM of continuous oxygen. When asked how long the nasal cannula tubing had been in use, the DON stated he did not know. The DON also verified Resident 67 did not have an oxygen in use sign outside the room door. On 6/17/26 at 0830 hours, an interview and concurrent medical record review for Resident 67 was conducted with the DON. The DON verified Resident 67 had a physician's order to administer continuous oxygen at 2 LPM via nasal cannula. The DON stated the oxygen therapy should be administered as ordered by the physician. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	acknowledged the above findings. 3. On 5/15/26 at 0855 hours, during the initial tour of the facility, Resident 109 was observed in bed receiving oxygen therapy at 2 LPM via nasal cannula. The oxygen tubing was observed unlabeled and undated. On 6/15/26 at 0956 hours, an observation and concurrent interview was conducted with LVN 5 at Resident 109's bedside. LVN 5 was asked about the oxygen tubing of Resident 109. LVN 5 verified there was no label on the oxygen tubing and stated there should be a label with the date and the resident's name on the oxygen tubing. Medical record review for Resident 109 was initiated on 6/15/26. Resident 109 was admitted to the facility on [DATE]. Review of Resident 109's Order Summary Report failed to show documented evidence a physician's order was obtained for the administration of the oxygen therapy to Resident 109. On 6/18/26 at 1104 hours, an interview and concurrent medical record review for Resident 109 was conducted with RN 3. RN 3 stated the oxygen tubing was changed once a week, and labeled with date and name of the resident. RN 3 was informed of the findings for Resident 109's oxygen tubing that was unlabeled. RN 3 verified the findings. RN 3 was asked if there was a physician's order obtained for the use of oxygen therapy for Resident 109. RN 3 reviewed Resident 109's medical record and verified there was no physician's order for the use of oxygen therapy. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Resident 109 was conducted with the DON. The DON was informed and verified the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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, and facility document review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with a cleanable surface. * The facility failed to ensure the food in the walk-in refrigerator was thrown out after the use by date. These failures had the potential to cause foodborne illnesses for the 97 residents who consumed food prepared in the kitchen. Findings: Review of the facility's document titled Diet Texture dated 6/15/26, showed 97 of 105 residents were receiving food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. On 6/15/26 at 0746 hours, during the initial tour of the kitchen and concurrent observation and interview with the DSS, five cutting boards were observed with fuzzy and heavily marred grooves. The DSS verified the findings. 2. On 6/15/26 at 0746 hours, during the initial tour of the kitchen and concurrent observation and interview with the DSS, the walk-in refrigerator was observed with the following:- a plastic storage container of zucchini with the used by date of 6/12/26; and- a plastic storage container of butter/margarine with the used by date of 6/14/26. The DSS verified the above findings. On 6/18/26 at 1011 hours, an interview was conducted with the Assistant Administrator and DSS. The Assistant Administrator and DSS verified the above findings. The DSS stated the cutting boards should have been replaced. The DSS further stated the plastic storage containers of zucchini and the butter/margarine should have been discarded. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	Provide and implement an infection prevention and control program. **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 implement the facility's infection prevention and control program in accordance with the facility's P&P.* The facility failed to maintain an accurate infection control surveillance program for January 2026 through May 2026 and failed to ensure the Surveillance Data was accurate to determine whether the residents' infection met McGeer's (a standardized surveillance definitions used to detect infections in long-term care facilities, ensuring consistent reporting and monitoring) criteria for true infection for Residents 2, 21, 37, 52, 71, 93, and 112.* The facility failed to ensure the water management plan was available which addressed and identified where Legionella (a type of bacteria found in water that causes Legionnaires' disease, a severe form of pneumonia, when inhaled as tiny water droplets) and other opportunistic waterborne pathogens could grow and spread, control measures to prevent the growth of the pathogens, and how to monitor them. * The facility failed to ensure a treatment cart was kept in sanitary condition when multiple pieces of paperwork were stored inside one of two treatment carts (Treatment Cart 1). These failures posed the risk of not identifying the residents' infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility. Findings: Review of the facility's P&P titled Infection Control Program revised 7/2022, showed surveillance of residents and their family members will include maintenance of an infectious disease log by the facility's staff, monthly recording of incidents by infection sites, and auditing medical records of diagnostic tests, lab, and x-ray reports and screening exams. The objectives of the Infection Control Plan included maintaining accurate records of nosocomial infections, infection control measures, and surveillance. Review of the facility's P&P titled Infection Control Program System revised 1/2023, showed the facility had designated an infection control nurse as the Infection Preventionist (IP) to oversee the infection control program. The IP manages the monitoring and tracking of the clinical status of residents to detect and prevent the transmission of infection and disease. The IP collects data and analyzes the information, utilizing the facility's surveillance tools, to develop strategies to prevent further infection transmission. The IP utilizes the revised McGeer's Criteria for definitions of infection for Infection Control Surveillance purposes. 1. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2026 through May 2026 showed the following resident infection surveillance data for HAIs (Healthcare Acquired Infections), CAIs (Community Acquired Infections) and DNMC (Did Not Meet Criteria): - For January 2026: HAI - 11, CAI &ndash;0, and DNMC &ndash; 8; - For February 2026: HAI - 13, CAI &ndash;4, and DNMC &ndash; 7; - For March 2026: HAI - 11, CAI &ndash;4, and DNMC &ndash; 10; - For April 2026: HAI - 5, CAI &ndash;2, and DNMC &ndash; 5; and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	- For May 2026: HAI - 3, CAI & 1, and DNMC & 2; On 6/16/26 at 1047 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated he was responsible for conducting surveillance and tracking of infections in the facility. The IP stated for any residents with signs and/or symptoms of an infection, the licensed nurse was responsible for completing a change of condition evaluation, notifying the physician, and carrying out any orders for laboratory tests, cultures, or diagnostics tests. The IP stated the McGeer's criteria was utilized to determine if the infection was a true infection. The IP further stated he was responsible for completing or reviewing the McGeer's criteria Surveillance Tool (if initiated by the licensed nurses) and making the determination if the infection was an HAI, CAI, or DNMC. The IP stated the correct McGeer's criteria surveillance tool should be selected for the infection and the surveillance tool should be complete and accurate. The IP stated the tracking of infection type, presenting signs and/or symptoms, onset dates of symptoms, diagnostics tests, prescribed antimicrobial therapy, and determination of HAI, CAI, and DNMC were documented in the monthly surveillance log. Review of the Surveillance Data Collection Forms for Residents 2, 21, 37, 52, 71, 93, and 112 was conducted with the IP. The residents' Surveillance Data Collection Forms showed the following documentation: a. For Resident 93, the Surveillance Data Collection Form for respiratory tract infections & pneumonia/lower respiratory tract was used. The form (undated) showed the following: - the temperature, pulse, and respirations were blank - under the criteria for pneumonia showed all three criteria must be met; however, the form showed new or increased cough and sputum production were selected. Criteria 1: the interpretation of the chest radiograph demonstrating pneumonia or the presence of new infiltrate and criteria 3: at least one constitutional criterion were not selected. - the antibiotic treatment prescribed for Resident 93 was doxycycline (antimicrobial) 100 mg by mouth two times a day for five days. - further review of the form failed to show the selection of HAI, CAI, or the documentation of additional notes. - Review of the Infection Prevention and Control Surveillance Log for January 2026 showed Resident 93's infection was documented as HAI, common cold/pharyngitis. b. For Resident 2, the Surveillance Data Collection Form for respiratory tract infections & pneumonia/lower respiratory tract was used. The form (undated) showed the following: - the date of onset of symptoms, temperature, pulse, and respirations were blank, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	- under the criteria for pneumonia showed all three criteria must be present. For criteria 1- interpretation of chest radiograph as demonstrating pneumonia or the presence of new infiltrates. For criteria 2- at least one respiratory sub criteria: new/increased cough, sputum production oxygen saturation less than 94% on room air , new or changed lung examination abnormalities, respiratory rate of 25 breaths per minute or more. For criteria 3- at least one of the constitutional criteria: fever, leukocytosis, acute mental status change or acute functional decline. However, none of the criteria were selected. - the antibiotic treatment prescribed for Resident 2 was levofloxacin 250 mg by mouth every 48 hours for eight days. - further review of the form failed to show the selection of HAI, CAI, or documentation of additional notes. - Review of the Infection Prevention and Control Surveillance Log for February 2026 showed the type of infection for Resident 2 was not selected. Further review of the log showed pneumonia was documented under organism or culture, Resident 2 had no mental status change, and the resident had a positive x-ray on 2/9/26. However, the section for signs and symptoms was blank. The infection was documented as CAI. c. For Resident 71, the Surveillance Data Collection Form for other infections was used. The form (undated) showed the following: - the temperature and pulse were blank - the antibiotic prescribed for Resident 71 was cefepime (antimicrobial) 2 gm IV every 12 hours for 7 days, for the diagnosis of leukocytosis. - further review of the form failed to show the selection of HAI, CAI, or documentation of additional notes. - Review of the Infection Prevention and Control Surveillance Log for February 2026 showed Resident 71's infection was documented as a urinary tract infection and DNMC. However, a Surveillance Tool for urinary tract infections was not utilized for Resident 71's infection. d. For Resident 112, the Surveillance Data Collection Form for urinary tract infections without an indwelling catheter was used. The form (undated) showed the following: - the temperature, pulse, and respirations were blank - the form showed both criteria 1 and 2 must be selected. However, only criteria 2 was selected: at least 100, 000 cfu/mL of no more than two species of microorganisms in a voided urine sample. - the antibiotic prescribed for Resident 112 was meropenem (antimicrobial) 1 gm IV daily for two days. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	- further review of the form showed the selection of CAI. - Review of the Infection Prevention and Control Surveillance Log for March 2026 showed the documentation Resident 112 had agitation, hematuria, and no mental status change. Resident 112's infection was documented as CAI. e. For Resident 21, the Surveillance Data Collection Form for respiratory tract infections & pneumonia/lower respiratory tract was used. The form (undated) showed the following: - the temperature, pulse, and respirations were blank, - under the criteria for pneumonia showed all three criteria must be present. For criteria 1- interpretation of chest radiograph as demonstrating pneumonia or the presence of new infiltrates. For criteria 2- at least one respiratory sub criteria: new/increased cough, sputum production oxygen saturation less than 94% on room air , new or changed lung examination abnormalities, respiratory rate of 25 breaths per minute or more. For criteria 3- at least one of the constitutional criteria: fever, leukocytosis, acute mental status change or acute functional decline. However, only criteria 1 was selected. - the antibiotic treatment prescribed for Resident 21 was Zithromax (antimicrobial) 500 mg daily for two days. - further review of the form showed the selection CAI. - Review of the Infection Prevention and Control Surveillance Log for March 2026 showed the following documentation for Resident 21: pneumonia was documented under organism or culture, no mental status change, and the resident had a positive x-ray on 3/25/26. The infection was documented as CAI. f. For Resident 52, the Surveillance Data Collection Form for urinary tract infections without an indwelling catheter was used. The form (undated) showed the following: - the temperature, pulse, and respirations were blank - the form showed both criteria 1 and 2 must be selected; however, none of the criteria were selected. - the antibiotic prescribed for Resident 52 was ertapenem (antimicrobial) 1 gm for two days. - further review of the form showed the selection of CAI. - Review of the Infection Prevention and Control Surveillance Log for March 2026 showed the documentation Resident 52 had increased agitation, confusion, and anxiety and no mental status change. The section for organism or culture was blank. Resident 52's infection was documented as CAI. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	g. For Resident 37, the Surveillance Data Collection Form for respiratory tract infections & pneumonia/lower respiratory tract was used. The form (undated) showed the following: - the temperature, pulse, and respirations were blank, - under the criteria for lower respiratory tract showed all three criteria must be present. For criteria 1- chest radiograph not performed or negative for pneumonia or new infiltrates. For criteria 2- at least two respiratory sub criteria: new/increased cough, sputum production, oxygen saturation less than 94% on room air, new or changed lung examination abnormalities, pleuritic chest pain, or respiratory rate of more than or equal to 25 breaths per minute. For criteria 3- at least one of the constitutional criteria: fever, leukocytosis, acute mental status change or acute functional decline. However, for criteria 2, only one sub criteria: new or changed lung examination abnormalities was selected. - the antibiotic treatment prescribed for Resident 37 amoxicillin 875-125 mg three times a day for three days. - further review of the form showed the selection CAI. - Review of the Infection Prevention and Control Surveillance Log for April 2026 showed the infection was documented as CAI. On 6/16/26 at 1112 hours, an interview and concurrent facility document review was conducted with the IP. The IP reviewed the medical records for Residents 2, 21, 37, 52, 71, 93, and 112 and verified the classification of Residents 2, 21, 37, 52, and 112's infections as true infections were incorrect. The IP stated the determination of a true infection should be accurate to effectively conduct surveillance and track the prevalence of infections in the facility. The IP stated the Surveillance Tools used for Residents 71 and 93 were incorrect and the correct McGeer's Surveillance tool should be selected and completed to accurately determine if the criteria met for true infection. On 6/18/16 at 1000 hours, an interview was conducted with the DON. The DON stated the IP was responsible for the surveillance of infections in the facility. The DON stated the monthly surveillance report should be accurate and the determination of true infections and whether the infection was HAI, CAI, or DNMC should be accurate. 2. Review of the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease revised 7/2018, showed the facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	mycobacteria, and fungi) could grow and spread in the facility water system. - Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air-Conditioning Engineers) industry standard and the CDC toolkit. - Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. - Maintains compliance with other applicable federal, state, and local requirements. Review of the facility's P&P titled Policy for Legionnaire's Disease revised 6/2017, showed it is the policy of the facility to have a plan for the prevention of Legionnaire's disease. Under the section titled Process to Develop a Water Management Program showed the facility will develop a Water Management Program which will be reviewed annually. Review of the facility document titled Legionella Risk assessment dated [DATE], showed a form which was completed in order to determine if the facility needed a water management program to reduce the risk of Legionella growth and spread. The form showed the facility should have a water management program for the building's hot and cold-water distribution systems. Review of the facility's water management program binder failed to show documented evidence of the facility' Water Management Program which specified testing protocols, acceptable ranges for control measures, and corrective actions taken when control limits were not maintained. On 6/18/26 at 1000 hours, an interview and concurrent facility document review was conducted with the DON and IP. The DON and IP stated all documents related to the facility's water management and Legionella testing were kept in the water management binder. The DON and IP were asked to show the facility's Water Management Program in the binder. The DON and IP reviewed the binder and verified the facility's water management program was not in the water management binder. On 6/18/26 at 1035 hours, a follow- up interview and concurrent facility P&P review was conducted with the DON. The DON stated the facility did not develop a Water Management Program. The DON reviewed the facility's P&P titled Policy for Legionnaire's Disease and verified the P&P showed the facility would develop a Water Management Program and identify risk areas in which Legionella can grow. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Infection Control Program System dated 1/23, showed the facility has established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Some	Review of the facility's P&P titled Storage of Medications dated 1/25, showed medications storage areas are kept clean and free of clutter. On 6/15/26 at 1129 hours, an observation of Treatment Cart 1 and interview was conducted with LVN 3. LVN 3 stated they were the treatment nurse using Treatment Cart 1 for 6/15/26. When Treatment Cart 1 was inspected, multiple pieces of paperwork were stored inside Treatment Cart 1. LVN 3 stated the paperwork had been stored in Treatment Cart 1 since 6/12/26. On 6/16/26 at 1448 hours, an interview was conducted with LVN 4. LVN 4 stated they were the treatment nurse using Treatment Cart 2 on 6/16/26. LVN 4 stated they would not store treatment care paperwork in the treatment cart because the paperwork could get lost. LVN 4 stated it was not clean to store the paperwork in the treatment cart. On 6/17/26 at 0947 hours, an interview was conducted with the MRD. The MRD verified the facility records were not to be stored in the treatment cart. On 6/17/26 at 1410 hours, an interview was conducted with the IP. The IP stated only treatment items such as medications were to be stored in the treatment cart. The IP stated the treatment cart was supposed to be clean and the introduction of outside items would make the treatment cart dirty. On 6/18/26 at 0924 hours, an interview was conducted with the DON. The DON stated the paperwork should not have been stored in the treatment cart. The paperwork should have been placed in a binder or folder. The treatment cart should only store treatments.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to accurately monitor and address the use of the antibiotics for two final sampled resident (Residents 2 and 52) and three nonsampled residents (Residents 21, 37, and 112) reviewed for antibiotic stewardship. * Residents 2, 21, 37, 52, and 112 who did not meet the McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) were prescribed antimicrobial therapy. These failures resulted in continued use of unnecessary antibiotic therapy, increasing the risk of adverse drug reactions and the development of antibiotic-resistant organisms. According to the Centers for Disease Control and Prevention (CDC), antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile (a type of bacteria that can cause diarrhea and inflammation of the colon), increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Infection Control, Antimicrobial Stewardship revised 1/2017 showed the goal of the antimicrobial stewardship is to optimize clinical outcomes while minimizing, unintended consequence of antimicrobial use. Unintended consequences the facility is attempting to prevent include the following: Toxicity Many selections of pathogenic organisms such as clostridium difficile. The emergence of resistant pathogens and/or multi-drug resistant organisms. The facility (IP, DON, and/or pharmacy) will:- Report on the number of antibiotics prescribed and the number of residents treated each month.- Include a separate report for the number of residents on antibiotics that did not meet McGeer's criteria for active infection. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2026 through May 2026 showed the following resident infection surveillance data for HAIs (Healthcare Acquired Infections), CAIs (Community Acquired Infections) and DNMC (Did Not Meet Criteria):- For January 2026: HAI - 11, CAI -0, and DNMC - 8;- For February 2026: HAI - 13, CAI -4, and DNMC - 7;- For March 2026: HAI - 11, CAI -4, and DNMC - 10;- For April 2026: HAI - 5, CAI -2, and DNMC - 5; and- For May 2026: HAI - 3, CAI -1, and DNMC - 2; On 6/16/26 at 1047 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated he was responsible for conducting surveillance and tracking infections in the facility. The IP stated for any residents with signs and/or symptoms of an infection, the licensed nurse was responsible for completing a change of condition evaluation, notifying the physician, and carrying out any orders for laboratory tests, cultures, or diagnostics tests. The IP stated the McGeer's criteria was utilized to determine if the infection was a true infection. The IP further stated he was responsible for completing or reviewing the McGeer's criteria surveillance tool (if initiated by the licensed nurses) and making the determination if the infection was an HAI, CAI, or DNMC. The IP stated for the residents admitted to the facility on antimicrobial therapy, the McGeer's criteria surveillance tool was used to determine true infection. The IP stated if the infections did not meet the criteria for true infection, the physician would be notified and any orders to discontinue or continue the antimicrobial therapy would be documented. Review of the Surveillance Data Collection Forms for Residents 2, 21, 37, 52, and 112 was conducted with the IP. After reviewing Residents 2, 21, 37, 52, and 112's Surveillance Data Collection Forms and medical records, the IP verified the resident's infections did not meet the McGeer's criteria for true infection, the residents were prescribed and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed the antimicrobial therapy, and the forms did not indicate the infection DNMC. On 6/18/26 at 1000 hours, an interview was conducted with the DON. The DON stated the determination of true infection and the classification of HAI, CAI, and DNMC should be accurately determined and reported. The DON stated the purpose of the antibiotic stewardship program was to ensure the prescribed antimicrobial therapy was appropriate to prevent the unnecessary use and resistance to antibiotics. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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, facility document review, and facility P&P review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatment regarding the use of psychotropic medications for one of five sampled residents (Resident 38) and one nonsampled resident (Resident 80) reviewed for unnecessary medications. * The facility failed to ensure the informed consents for quetiapine (antipsychotic) and buspirone (anxiety) medications were renewed after six months for Resident 38. * The facility failed to ensure three of three informed consents for Resident 80's Restoril (hypnotic) medication were completed in a timely manner with the prescriber's signatures. These failures posed the risk for the residents and their responsible parties not understanding risks and benefits of the psychotropic medications and the potential side effects. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed a psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics, and antidepressants. Review of the facility's P&P titled Informed Consent dated 4/2024 showed there is a requirement for the facility to renew informed consent every six months. 1. Medical record review for Resident 38 was initiated on 6/15/26. Resident 38 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 38's H&P examination dated 6/12/25, showed Resident 38 can make needs known but cannot make medical decisions. Review of Resident 38's Order Summary Report showed the following physician's orders: - dated 6/10/25, to administer buspirone 5 mg by mouth two times a day; and - dated 6/1/26, to administer quetiapine 25 mg by mouth two times a day. Review of Resident 38's Verification of Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device for quetiapine medication showed the resident/responsible party was informed on 12/10/25, and the physician who obtained the informed consent signed the consent form on 11/30/25. Review of Resident 38's Verification of Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device for buspirone medication showed the resident/responsible party (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was informed on 12/10/25, and the physician who obtained the informed consent signed the consent form on 11/30/25. On 6/17/26 at 0851 hours, an interview and concurrent medical record review for Resident 38 was conducted with RN 1. RN 1 verified the informed consents for buspirone and quetiapine medications were not renewed after six months. RN 1 further stated the informed consents should be renewed every six months. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Informed Consent Policy dated 4/2024 showed the attending physician, PA, or NP must obtain the informed consent of the resident or their responsible party for purposes of prescribing, ordering, or increasing an order for a psychotherapeutic medication. Medical record review for Resident 80 was initiated on 6/16/26. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's Verification of Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device dated 4/21, 5/8, and 6/5/26, showed the prescriber signature's fields were blank. Review of Resident 80's Order Summary Report showed a physician's order dated 4/21/26, for Restoril 15 mg oral capsule by mouth as needed for insomnia for 14 days. Review of Resident 80's MAR from 4/21 to 6/10/26, showed Resident 80 was administered Restoril medication three times in April 2026, 15 times in May 2026, and five times to date in June 2026. Review of Resident 80's physician's orders showed a medication order dated 6/5/26, for Restoril 15 mg oral capsule by mouth as needed for insomnia for 30 days. On 6/18/26 at 1109 hours, an observation for Resident 80 was conducted in Room A. Resident 80 was observed sleeping. On 6/18/26 at 1428 hours, an interview and concurrent medical record review for Resident 80 was conducted with the DON. The DON verified Resident 80's Verification of Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device for the Restoril medication dated 4/21, 5/8, and 6/5/26, showed the prescriber signature fields were blank.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide a reasonable accommodation to meet the needs of one of 105 residents in the facility (Resident 111). * The facility failed to ensure Resident 111's call light was within the resident's reach. This failure had the potential to negatively impact the resident's psychosocial well-being and cause delays in receiving the needed care. Findings: Review of the facility's P&P titled Call Light revised 5/2017 showed it is the policy of the facility to respond to the resident's request and needs. When the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident. 1. Medical record review for Resident 111 was initiated on 6/15/26. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's H&P examination dated 6/10/26, showed Resident 111 had the capacity to understand and make decisions. On 6/15/26 at 0952 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 111. Resident 111's call light button was observed hanging on the left side of the headboard behind Resident 111. Resident 111 stated he could not locate his call light button. RN 2 was called to Resident 111's room and an observation and concurrent interview was conducted with RN 2. RN 2 stated Resident 111 would call for help by pressing his call light button. RN 2 verified the call light button was hanging on the left side of the headboard and Resident 111 could not reach the call light button. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0578 Level of Harm - 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 ensure the resident was assisted with the formulation of the advance directive (legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions) for one of 22 final sampled residents (Resident 68) reviewed for advance directives. * Resident 68 who wished to formulate an advance directive was not provided assistance by the facility. This failure had the potential for the resident's decisions regarding the healthcare and treatment options not being honored. Findings: Review of the facility's P&P titled Advance Directives revised 4/2017 showed prior to, or upon admission, the residents would be provided with written information concerning the resident's rights under State law to accept or refuse medical or surgical treatment and the resident's right to prepare an advance directive. If a resident requests assistance in developing an advance directive, their request should be referred to the social service staff. Social service staff will assist residents in completing an advance directive, durable Power of Attorney for Healthcare, if the resident wishes to execute one. [NAME] service staff will arrange for the Ombudsman to complete and witness the document. Medical record review for Resident 68 was initiated on 6/15/26. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's Advance Directive Acknowledgement form dated 5/18/26, showed Resident 68 selected the option he had not executed an advance directive and wished to execute an advance directive. However, review of Resident 68's medical records failed to show a copy of Resident 68's advance directive or the documentation Resident 68 was assisted to formulate the advance directive. Review of Resident 168's MDS assessment dated [DATE], showed Resident 68 was cognitively intact. On 6/16/26 at 1451 hours, an interview and concurrent medical record review for Resident 68 was conducted with the Social Services Assistant. The Social Services Assistant verified the above findings. The Social Services Assistant stated if the resident/Responsible Party would like to formulate the advance directive, the Social Service staff was responsible for calling the Ombudsman and coordination of the formulation of the resident's advance directive with the Ombudsman. The Social Service Assistant stated the resident should be assisted with the formulation of the advance directive as soon as possible and the assistance documented in the resident's medical record. On 6/18/26 at 1000 hours, an interview was conducted with the DON. The DON stated if the Resident had verbalized that he would like to formulate the advance directive, the facility should assist the resident in formulating the advance directive as soon as possible to ensure the resident's wishes were honored in the event they no longer had the capacity. The DON further stated the Social Services staff were responsible for assisting the resident to formulate the advance directive, and if the Social Services staff had attempted to assist the resident to formulate the advance directive, the Social Services staff should have documented in the resident's medical record. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **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 implement the restraint free periods for one of 22 final sampled residents (Resident 7) reviewed. * The facility failed to ensure Resident 2's use of pommel cushion in wheelchair had a physician's order and informed consent obtained; and a care plan developed prior to the application of the restraint to the resident. These failures posed the risk of compromising the resident's independence and psychosocial well-being. Findings: Review of the facility's P&P titled Physical Restraints dated 9/2017 showed restraints will only be used after other alternatives have been tried unsuccessfully and only after a thorough assessment, informed consent from the resident or their responsible party, a physician's order and a care plan to address the use of the restraint. Physical restraints include the use of such devices as arm restraints, hand mittens, roll belts, seat belts, Geri-chairs, lap cushions, and trays that the resident cannot remove, side rails or bed rails, bed alarms or wheelchair alarms. On 6/15/26 at 1320 hours, during the initial tour of the facility, Resident 7 was observed in the activity room, seated in her wheelchair with a pommel cushion on the seat. Medical record review for Resident 7 was initiated on 6/16/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 3/16/26, showed the resident had no capacity to understand and make decisions. Review of Resident 7's Order Summary Report for 6/2026 failed to show documented evidence a physician's order was obtained for the use of the pommel cushion in the wheelchair. In addition, the medical record failed to show an informed consent was obtained for the use of pommel cushion in the wheelchair prior to the application of the device. On 6/17/26 at 1323 hours, an interview for Resident 7 was conducted with CNA 1. CNA 1 verified Resident 7's use of the pommel cushion in the wheelchair and was totally dependent on staff on all ADL's. On 6/17/26 at 1405 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 3. RN 3 verified the findings and stated Resident 7's reason for the use of the pommel cushion in the wheelchair was to prevent the resident from sliding down from the wheelchair. RN 3 verified there was no physician's order, consent, and care plan for the use of the pommel cushion in the wheelchair. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F656.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as 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 recommendations from the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level II determination was incorporated into the resident care for two of four final sampled residents (Residents 19 and 67) reviewed for PASRR. * The facility failed to coordinate the Level II PASRR recommendation into the assessment and care planning for Resident 19. * Resident 67's Level II PASRR Mental Health Evaluation was conducted on 6/5/25, with recommended specialized services. Resident 67 was readmitted to the facility on [DATE]; however, the facility failed to incorporate the Level II PASRR recommendations into Resident 67's plan of care. These failures had the potential for Residents 19 and 67 of not receiving adequate care that was recommended by PASARR Level II determination and evaluation report assessed by an appropriate state-designated authority. Findings: Review of the facility's P&P titled PASRR (Preadmission Screening Resident Review) revised 3/2019 showed it is the policy of the facility to screen each resident, regardless of payment source, when applying for admission to, or residing in the facility, which is Medicaid-certify facility, for mental illness and intellectual disability. Review of the facility's P&P titled PASRR (Preadmission Screening Resident Review) revised 3/2019 showed all admissions to the facility will receive a Preadmission Screening (PAS) prior to admission of the resident. If the result of the Level I screening is positive due to a diagnosed or suspected mental illness identified, the Level I screening will automatically be sent to the DHCS Contractor for a Level II prescreening call. 1. Medical record review for Resident 19 was initiated on 6/15/26. Resident 19 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 19's Initial Preadmission screening (PAS) dated 5/26/26, showed Level 1 &ndash; Positive. The following were the recommended specialized add-on services: services and supports that supplement nursing facility care to address mental health needs. - Mental Health Rehabilitation Activities &ndash; These include therapeutic community, dance, music, art, exercise, leisure, recreation, orientation, education and/or skill building activities. - Activities of Daily Living (ADL) Training/Reinforcement &ndash; Skill training and support to improve day to day activities such as dressing, bathing, feeding, toileting and grooming. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Supportive services & interactions with facility staff that encourage problem solving, socialization, reality orientation or focus on your therapeutic goals. - Psychotherapy/Counseling & Individual and/or group and/or family treatment provided by a licensed mental health professional. Therapy may include a combination of strategies and techniques such as supportive, cognitive behavioral, psychodynamic, art/music, counseling, skills training, and existential therapies, among others. - Psychiatry Consultation and/or Follow up care & services to provide psychopharmacological intervention and monitoring of mental conditions. These providers will evaluate the efficacy and necessity of psychiatric medications, review lab profiles, make adjustments as needed, and address side effects. - Safety Monitors & safety monitors for risks of falls. - Pharmacy Consultation & services to review pharmacological issues such as drug interactions and black box warnings. - Pain Services Consultation & comprehensive assessment and treatment of pain issues. Pain treatment providers should consider substance use. If applicable, and potentially unreported pain due to communication difficulties. - Ophthalmology Consultation & services to assess and treat eye disorders. - Physical Therapy Consultation & services to enhance and restore functional ability and quality of life to those with physical impairments. - Occupational Therapy Consultation & services to improve independence in activities of daily living. - Speech Therapy Consultation - services to address impairment of speech, voice, language, communication and swallowing. - Dietary Consultation & services to manage weight and/or special nutritional needs. - Social Services Consultation & services to discuss goals and coordinate care. Social workers can also arrange safe and orderly transition to alternative levels of care when appropriate and facilitate communication with other caregivers. - Continence Evaluation & assessment and treatment of continence related issues. - Accessibility Accommodations & accessibility accommodations address physical, sight, hearing, and/or communication impairment and must be provided in any alternative placement. A facility should provide bedrails and shower bars. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 19's care plan dated 5/26/26, failed to show an individualized care plan for PASRR Level II recommendation. Review of Resident 19's H&P examination dated 5/28/26, showed the resident had a medical history of bipolar disorder (is a lifelong mental health condition characterized by extreme shifts in mood, energy and activity levels). Review of Resident 19's MDS 5 days PPS assessment dated [DATE], showed BIMS summary score 8 (meaning moderately impaired cognition). On 6/17/26 at 0841 hours, an interview and concurrent medical record review were conducted with the MDS Coordinator. The MDS Coordinator failed to show a personalized care plan for the PASRR Level II recommendation from the DHCS Psychologist. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings. 2. Review of Resident 19's PASRR letter dated 5/27/26, showed a Level 1- positive as conducted at the facility and followed by Level II PASRR evaluation on 5/27/26, by a psychologist from DHCS who had reviewed the findings of the evaluation and made a determination for the most suitable setting for resident care and any needs for specialized services. The Individualized Determination Report was based on a review of the resident's medical and social history which revealed a significant medical condition with mental stressors that require nursing care. Medical record review for Resident 67 was initiated on 6/15/26. Resident 67 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 67's Notice of PASRR Level I Screening Results dated 6/2/25, showed Resident 67's Level 1 screening was positive for serious mental illness and a Level II mental health evaluation referral was required. Review of the letter sent to Resident 67 by the Department of Health Care Services dated 6/5/25, showed the PASARR Level II Evaluation was conducted on 6/4/25. The letter showed as a result of Resident 67's Level II evaluation, the following specialized services were recommended for Resident 67: mental health rehabilitation activities, activities of daily living training/reinforcement, supportive services, psychotherapy, neuropsychology consultation, psychiatry consultation, safety monitors, pharmacy and pain services consultations. Review of the Resident 67's Notice of Attempted Evaluation dated 1/16/26, (from the acute care hospital), showed a SMI Level II mental health evaluation was not scheduled because the individual was discharged from the facility. Resident 67 was readmitted on [DATE], and review of Resident 67's Notice of PASRR Level I Screening Results dated 3/26/26, showed Resident 67's Level 1 screening was positive for serious mental illness and a Level II mental health evaluation referral was required. (continued on next page)		

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: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the letter sent to Resident 67 by the Department of Health Care Services dated 3/27/26, showed after reviewing the positive SMI Level I screening and speaking with facility staff, a SMI Level II mental health evaluation was not scheduled for the following reason: the individual currently has a duplicate PASRR on file. The case was not closed. Review of Resident 67's plan of care records failed to show a care plan problem addressing the recommendations from the PASARR Individualized Determination Report. On 6/17/26 at 0855 hours, an interview and concurrent medical record review for Resident 67 was conducted with RN 3. RN 3 verified the above findings. RN 3 stated there should have been a follow-up to address the duplicate PASRR mentioned in the letter. RN 3 reviewed Resident 67's medical record and verified a care plan was not developed to address the recommendations in Resident 67's PASRR determination report. On 6/18/26 at 1000 hours, an interview was conducted with the DON. The DON stated upon admission or readmission to the facility, the PASRR Level 1 should be completed and sent to the facility. The DON stated the PASRR should be reviewed for accuracy and if unable to complete, there should be a follow-up conducted. The DON was informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the resident centered comprehensive care plan was developed for one of 22 final sampled residents (Resident 7). *The facility failed to ensure Resident 7's care plan was created for the use of pommel cushion in wheelchair. This failure posed the risk to not provide Resident 7 with the appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Care Planning - Interdisciplinary Team dated 1/2017 showed the facility's Interdisciplinary Team is responsible for the development of an individualized resident centered comprehensive care plan for each resident. The care plan is based on the resident's needs and comprehensive assessment. During an observation of Resident 7 on 6/17/2026 at 1320 hours, Resident 7 up in the wheelchair in the Activity Room with a pommel cushion on the seat. Medical record review for Resident 7 was initiated on 6/16/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's History and Physical examination dated 3/16/26, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's plan of care records did not show the care plan problem was developed to address Resident 7's use of the pommel cushion in the wheelchair. There were no documented care interventions in place to address the use of the cushion. On 6/17/26 at 1323 hours, an interview was conducted for Resident 7 with CNA 1. CNA 1 verified Resident 7's use of the pommel cushion in wheelchair and totally dependent on staff on all ADL's. On 6/17/26 at 1405 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 3. RN 3 verified and stated Resident 7's use of the pommel cushion in wheelchair to prevent the resident from sliding down the wheelchair. RN 3 verified there was no physician's order, consent, and care plan for the use of pommel cushion in Resident 7's wheelchair. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F604.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 22 final sampled residents (Resident 2) was revised to reflect the resident's current care needs and interventions. * Resident 2's care plan for risk for renal failure was not revised to address the correct dialysis access site and the amount of fluid restriction as ordered by the physician. This failure posed the risk of not providing the resident with individualized and person-centered care. Findings: Review of the facility's P&P titled Care Planning - Interdisciplinary Team dated 1/2017 showed the resident, resident family and/or the resident's legal representative/guardian or surrogate to participate in the development and revisions to the residents centered care plan. Medical record review for Resident 2 was initiated on 6/15/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Plan of Care showed a care plan problem dated 4/22/26, addressing Resident 2's dialysis/renal failure problem. However, the care plan failed to show documented evidence for Resident 2's dialysis access site. In addition, the care plan interventions failed to include Resident 2's amount of fluid restriction per physician's order. Review of Resident 2's H&P Physician Progress Note dated 4/23/26, showed Resident 2 had a diagnosis of End Stage Renal Disease (ESRD) and on hemodialysis. Review of Resident 2's MAR for June 2026 showed the following physician's orders:- dated 4/20/26, to reapply pressure dressing to the right anterior chest tunnel dialysis catheter as needed if with bleeding;- dated 4/20/26, to provide fluid restriction of 1500 ml per day; and - dated 4/22/26, to remove Resident 2's right anterior chest tunnel dialysis catheter pressure dressing status post dialysis approximately four to six hours after dialysis every evening shift on Monday, Wednesday, and Friday. On 6/17/26 at 1354 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 2. LVN 2 verified Resident 2 was on hemodialysis every Monday, Wednesday, and Friday. LVN 2 verified the care plan for Resident 2 addressing the dialysis problem was not revised and did not include the dialysis access site and the specific amount of fluid restriction. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility record review, and facility P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for three of 22 final sampled residents (Residents 9, 10, and 19). * The facility failed to ensure the insulin (medication that regulates the amount of sugar level in the bloodstream) injection sites were rotated as ordered by the physician, for Residents 9 and 10. * The facility failed to ensure Resident 19's left forearm skin discoloration was monitored and care planned. These failures had the potential to result in ineffective treatment, worsening skin conditions, altered medication effectiveness, impaired insulin absorption, and tissue damage which could lead to negative resident outcomes. Findings: Review of the facility's P&P titled Insulin Administration dated 10/2013 showed the licensed nurse administer the insulin to residents in a safe manner. The nursing staff will follow the physician's order for the type of insulin, dosage, strength, and method of administration. The steps for the insulin injection included the selection of the injection sites and should be rotated preferably within the same general area such as the abdomen, thigh and upper arm. According to Taylor's Clinical Nursing Skills, seventh edition, the various sites used for subcutaneous injections are the outer aspect of the upper arm, the abdomen (from below the costal margin to the iliac crest), the anterior aspect of the thigh, the upper back, and the upper ventral (upper front) or dorsogluteal area (buttocks). It is necessary to rotate sites or areas for injections to prevent buildup of fibrous tissue and permit complete absorption of the medication. 1. Medical record review for Resident 9 was initiated on 6/16/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had moderately impaired cognitive skill. Review of Resident 9's Order Summary Report dated 6/17/26, showed the following physician's orders: - dated 3/1/26, to administer insulin glargine (a long-acting insulin designed to manage high blood sugar levels) 10 units subcutaneously in the morning and to rotate injection sites; and - dated 3/13/26, to administer Novolin R (a short-acting insulin designed to manage high blood sugar levels) as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime and to rotate injection sites. (continued on next page)		

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: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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	Review of Resident 9's Location of Administration Report for May 2026 showed the Novolin R insulin was administered consecutively on the same injection sites on the following dates and times: - on 5/2/26 at 0645 hours, Novolin R insulin was administered to the RLQ (right lower quadrant) of the abdomen; - on 5/2/26 at 1125 hours, Novolin R insulin was administered to the RLQ of the abdomen; - on 5/4/26 at 0618 hours, Novolin R insulin was administered to the LLQ (left lower quadrant) of the abdomen; - on 5/4/26 at 1130 hours, Novolin R insulin was administered to the LLQ of the abdomen; - on 5/4/26 at 1753 hours, Novolin R insulin was administered to the LLQ of the abdomen; - on 5/4/26 at 2009 hours, Novolin R insulin was administered to the LLQ of the abdomen; - on 5/13/26 at 1659 hours, Novolin R insulin was administered to the LLQ of the abdomen; and - on 5/13/26 at 2223 hours, Novolin R insulin was administered to the LLQ of the abdomen. On 6/17/26 at 1418 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 3. RN 3 verified the physician's orders for the insulin use with routine and sliding scale coverage. RN 3 was asked about the injection sites. RN 3 reviewed the MAR for the location of injection sites administration for Resident 9. RN 3 stated the injection sites should be rotated to prevent any side effects and skin problems. RN 3 verified and acknowledged there were times the injection sites were not rotated when the insulin injections were administered to Resident 9. 2. Medical record review for Resident 10 was initiated on 6/16/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's MDS assessment dated [DATE], showed Resident 10 had moderately impaired cognitive skill. Review of Resident 10's Order Summary Report dated 6/17/26, showed the following physician's orders: - dated 11/12/25, to administer insulin aspart (a short-acting insulin designed to manage high blood sugar levels) 6 units subcutaneously with meals; and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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	- dated 3/16/26, to administer insulin glargine (a long-acting insulin designed to manage blood sugar levels) 54 units subcutaneously in the morning and to rotate injection sites. Review of Resident 10's Location of Administration Report for June 2026 showed the insulin aspart was administered consecutively at the same injection sites on the following dates and times: - on 6/4/26 at 1515 hours and 6/5/26 at 0715 hours, insulin aspart was administered to the LLQ of the abdomen; - on 6/7/26 at 0732 and 1253 hours, insulin aspart was administered to the LLQ of the abdomen; and - on 6/15/26 at 0747 and 1231 hours, insulin aspart was administered to the left arm. On 6/17/26 at 1333 hours, an interview and concurrent medical record for Resident 10 was conducted with LVN 2. LVN 2 verified the physician's order for the insulin injection for routine and sliding scale coverage. LVN 2 stated they rotated the sites so that the area would not easily bruise, or not have injuries when administering insulin injections. LVN 2 was informed of the findings and verified the location of the administrations of the insulin were at the same area and not rotated. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Resident 10 was conducted with the DON. The DON was informed and verified the above findings. 3. On 6/15/26 at 0904 hours, an observation and concurrent interview was conducted with Resident 19. Resident 19 was observed lying in bed with purplish skin discoloration on the left forearm. When Resident 19 was asked what happened on the left arm skin discoloration, Resident 19 stated he did not know how it happened. Resident 19 further stated that no one hurt him. Medical record review for Resident 19 was initiated on 6/15/26. Resident 19 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 19's MDS 5 days PPS assessment dated [DATE], showed a BIMS summary score of 8 (meaning moderately impaired cognition). Review of Resident 19's Shower/Body Check Sheet dated 6/13 and 6/16/26, failed to show documentation of the skin discoloration on the left forearm. Review of Resident 19's Order Summary Report dated 6/17/26, failed to show a physician's order to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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	monitor the skin discoloration on the left forearm. Review of Resident 19's Plan of Care dated 5/26/26, failed to show a care plan to address the skin discoloration on the left arm. On 6/17/26 at 0758 hours, an interview and concurrent medical record review for Resident 19 was conducted with RN 1. RN 1 verified the above findings. When RN 1 was asked about the process when a skin discoloration was found on a resident, RN 1 stated if the origin of the skin discoloration was unknown, the facility would start a change of condition and investigate what happened and why there was a skin discoloration. RN 1 further stated there was no physician's order to monitor Resident 19's skin discoloration and no care plan was developed to address the skin discoloration. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of a new pressure ulcer (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) for one of two final sampled residents (Resident 24) reviewed for pressure ulcers. * The facility failed to ensure Resident 24's alternating pressure pad (APP) mattress was connected to the device unit and properly working. This failure placed Resident 24 at risk of not benefiting from the therapy provided by the APP mattress and be at high risk of developing new pressure ulcers. Findings: Review of the facility's P&P titled Alternating Pressure Pad (undated) showed an alternating pressure pad (APP) is an overlay or mattress system designed to prevent and treat pressure injuries (bed sores). It works by cyclically inflating and deflating air cells to continuously shift pressure points and promote blood circulation. Further review of the P&P showed for the tubing connection: to connect the air hoses from the pad to the pump nozzles and to ensure the hoses are free of twists, kinks, or pinching between the bed frames. Review of the facility's P&P titled Pressure Ulcer/Injury Management revised 7/2019 showed a plan of care will be initiated upon admission and or upon identification of residents at high risk for the development of pressure ulcers/injuries. A plan of care will be developed for the prevention and/or treatment of identified pressure ulcer/injuries. Pressure reducing mattresses will be provided for the residents if necessary. On 6/15/26 at 0832 hours, during the initial tour of the facility, Resident 24 was observed lying in bed. The alternating pressure pad (APP) device was observed turned on and hanging on the headboard of Resident 24's bed. The tubing extending from the APP device was observed lying on the ground and not connected to the mattress pad under Resident 24. Medical record review for Resident 24 was initiated on 6/15/26. Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 24's H&P examination dated 3/18/26, showed Resident 24 had no capacity to understand and make decisions. Review of Resident 24's plan of care for skin breaks/pressure ulcer, showed a care plan problem dated 3/16/26, addressing Resident 24's risk for the development of skin breaks and pressure ulcer. The interventions include providing a therapeutic mattress, repositioning as often as needed, and the use of the APP mattress. Review of Resident 24's MDS assessment dated [DATE], showed Resident 24 was totally dependent, where the helper does all the effort, for the following mobility activities: roll left and right, sit to lying, lying to sitting on the side of the bed, and chair/bed to chair transfers. Further review of the MDS assessment showed Resident 24 was at risk of developing pressure ulcers/injuries. Review of Resident 24's Order Summary Report for June 2026 showed a physician's order dated 4/10/26, to provide Resident 24 with the APP mattress for skin prevention and management. To check for the proper setting and function every shift and monitor every day. On 6/15/26 at 1015 hours, Resident 124 was observed dressed, and lying on her back. The GT feeding was observed infusing with a left and right arm splint were observed in place. The tubing connected from the APP mattress device was observed lying on the ground and not connected to the APP mattress. On 6/15/26 at 1225 hours, Resident 24 was observed lying in bed on her right side. The GT feeding was observed turned off. The APP mattress device was observed turned on; however, the tubing was observed on the ground, not connected to the APP mattress. The APP mattress under Resident 24 was not observed to be inflated. On 6/15/26 at 1240 hours, an interview and concurrent observation for Resident 24 was conducted with RN 4. RN 4 stated the APP mattress was used for prevention of the development of (continued on next page)		

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: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injuries in the resident. RN 4 stated the staff entering the resident's room should check to ensure the APP mattress was working properly by checking that the APP mattress device was turned on and the mattress was inflated. RN 4 was asked to check Resident 24's APP mattress and RN 4 verified the above findings. On 6/17/26 at 1045 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 2. RN 2 stated Resident 24 was totally dependent on the staff assistance for care and was at risk for developing pressure injuries. RN 2 reviewed Resident 24's medical record and verified the physician's order and care plan interventions for the APP mattress. On 6/18/26 at 1000 hours, an interview was conducted with the DON. The DON stated the purpose of the APP mattress was to provide the residents comfort and to prevent the development of pressure injuries for the residents who were at risk. The DON stated all staff entering the room should be checking to see if the APP mattress device and the APP mattress were working properly. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate treatment and services were provided to one of two final sampled residents (Resident 11) reviewed for positioning/mobility. * The facility failed to assess and check the skin of Resident 11 when the splint device was applied. In addition, the plan of care to address Resident 11's joint mobility failed to include the interventions for skin assessments when the splint device was applied to Resident 11's left hand. These failures had the potential to affect the resident's well-being while wearing the splint device. Findings: Review of the facility's P&P titled Splint Application revised 5/2017 showed it is the policy of the facility that the splint be applied correctly to maintain the resident's range of motion and prevent contractures and further loss of range of motion. The restorative nursing assistant is responsive for the application and removal of the splint. The splint is usually left in place for six days a week for a period of two hours per day, or as tolerated. Medical record review for Resident 11 was initiated on 6/15/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's H&P examination dated 5/31/26, showed Resident 11 was unable to make independent medical decisions. Review of Resident 11's Order Summary Report showed the following physician's orders dated 7/22/25:- RNA to apply the hand splint to the left hand five times a week or as tolerated every Monday, Tuesday, Thursday, Friday, and Saturday. Review of Resident 11's Plan of Care for Joint Mobility, revised 4/12/26, showed a care plan problem for risk of further joint contracture. The interventions included the RNA programs for the application of the left hand splint for four hours, five days a week, or as tolerated. Further review of the care plan failed to include the interventions to monitor Resident 11's left hand for complications related to the splint device or to perform skin checks when the splint device was applied. On 6/16/26 at 1030 hours, Resident 11 was observed sitting in the wheelchair with the splint applied to her left hand. Review of Resident 11's Restorative Nursing Flowsheet for June 2026 showed the following documentation for the application and removal times of the splint device to Resident 11's left hand:- on 6/1/26: on at 0900 hours and off at 1300 hours,- on 6/2/26: on at 0915 hours and off at 1315 hours,- on 6/4, 6/5, 6/6, and 6/8/26: on at 0900 hours and off at 1300 hours,- on 6/9/26: on at 0915 hours and off at 1315 hours,- on 6/11/26: on at 0920 hours and off at 1320 hours,- on 6/12 and 6/13/26: on at 0930 hours and off at 1330 hours, and- on 6/15 and 6/16/26: on at 0900 hours and off at 1300 hours. On 6/18/26 at 0845 hours, an interview and concurrent medical record review for Resident 11 was conducted RNA 1. RNA 1 stated Resident 11 had a physician's order to apply the splint device to Resident 11's left hand five times a week for four hours, or as tolerated. RNA 1 stated the splint was usually applied at around 0900 hours and removed around 1300 hours. RNA 1 reviewed Resident 11's RNA 1 treatment flowsheet and verified the RNA staff documented the time the splint device was applied and removed from Resident 11's left hand. RNA 1 stated the skin was checked every two hours when the splint device was applied. When RNA 1 was asked where the skin checks were documented, RNA 1 verified there was no documented evidence Resident 11's skin was checked every two hours on the days when the splint device was applied to Resident 11's left hand. On 6/18/26 at 0905 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 3. RN 3 verified there was no physician's order to assess the resident's skin while the splint was applied to the left hand. RN 3 stated when the splint device was applied there could be potential complications of the skin including irritation or redness, blister, swelling, and/or (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain, if the splint device was applied too tight. RN 3 stated the resident's skin should be checked when the splint device was applied for more than two hours. RN 3 verified Resident 11's care plan for the risk for further joint contractures did not include the interventions for the skin assessment of Resident 11's left hand when the splint device was in use. RN 3 further verified there was no other care plan to address the use of splint device for Resident 11's left hand. On 6/18/26 at 1000 hours, an interview was conducted with the DON. The DON stated the splint devices were applied by the RNAs, as per the physician's order for the ordered duration. The DON stated if the splint device was applied for more than two hours, the staff who applied the splint device should check the resident's skin for any skin breakdown or complications related to the application of the splint device. The DON stated the checking of the residents skin should be done every two hours and documented. The DON further stated for the use of the splint device, there should be specific interventions in the plan of care for the use of the splint and the checking for complications related to use of splint device. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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 facility P&P review, the facility failed to ensure two of two final sampled residents (Residents 4 and 56) were evaluated for nutrition status, to receive the appropriate services needed to maintain acceptable parameters of nutritional status. * The facility failed to obtain Resident 4's weekly weights as per the physician's order and care plan. Resident 4 experienced a seven-pound weight loss in one month and the facility failed to ensure the resident was seen and evaluated by the RD as per the physician's order. * The facility failed to ensure Resident 56 was seen and evaluated by the RD for the weight loss of 7lbs in one week. These failures had the potential for further weight loss and for Residents 4 and 56 to not meet their nutritional needs. Findings: Review of the facility's P&P titled Weight Variance Committee revised 10/2018 showed screening of weights for variances will be done on a regular basis per nursing (DON or designee) and dietary (RD in-house or consultants RD/Supervisor). A list of residents with weight variances will be established and shall be referred to the interdisciplinary committee members. These residents will be reviewed at the next Weight Variance Committee meeting. The recommendations from the committee will be carried out by the designated discipline responsible. The residents with weight variances will continue to be reviewed at the Committee meeting until the IDT determines whether the problem has been resolved or is unable to be impacted, due to the resident's diagnosis or condition. Documentation, including assessments and care planning, will be maintained the resident's medical record. Any weight gain/loss of greater than three pounds per week should be reviewed by the IDT for cause and further recommendations. 1. Medical record review for Resident 4 was initiated on 6/15/26. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 4's H&P examination dated 5/31/26, showed Resident 4 was unable to make independent medical decisions. Review of Resident 4's Order Summary Report showed the following physician's orders: - Dated 5/2/26, for the RD evaluation, - Dated 6/1/26, to refer to the RD for weight loss, - Dated 6/1/26, to obtain weekly weights for four weeks related to weight loss, and - Dated 6/3/26, for enteral feedings, to administer Jevity 1.2 (enteral feeding formula) 1.2 at 50 ml/hr for 20 hours to provide 1000 ml/1200 kcal per day. Review of Resident 4's RD readmission Nutritional assessment dated [DATE], showed Resident 4 was readmitted after transfer to the hospital on 4/3/26. Resident 4's current weight was 124 lbs (as (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 4/21/26) and the resident returned with the diagnosis of CHF (congestive heart failure) exacerbation, dysphagia, and new GT placement. Resident 4 was NPO and received Jevity 1.2 at 48 ml/hr for 20 hours. Further review showed the RD documented Resident 4 showed a significant 12 lbs (8.8%) weight loss in 14 days. Weight maintenance or gradual weight decrease to decrease BMI to 23 will be supported. Review of Resident 4's Weights and Vitals Exceptions showed the following weights for Resident 4: - On 4/1/26, 135 lbs, - On 4/15/26, 123 lbs (readmission weight), - On 5/5/26, 124 lbs, - On 5/26/26, 121 lbs, - On 6/1/26, 117 lbs (5.6% change in one month, comparison weight 5/5/26, - 7 lbs), and - On 6/16/26, 116 lbs. Review of Resident 4's plan of care showed the following care plan problems: - Dated 4/14/26, addressing Resident 4's risk for dehydration and weight loss. The interventions included dietary evaluation as needed, to refer to the weight variance for close monitoring of weight. On 6/1/26, the interventions included to refer to the RD, and to obtained weekly weights for four weeks. - Dated 5/2/26, addressing Resident 4's nine-pound weight loss in one month. The approach showed to continue the weekly weights and the RD evaluation. - Dated 6/1/26, addressing Resident 4's seven pounds weight loss in one month. The approach showed to refer Resident 4 to the RD, to obtain weekly weights for four weeks, and to increase the GTF to Jevity 1.2 at 50 ml/hr for 20 hours. Review of Resident 4's IDT Weight Variance Progress Notes dated 5/7/26, showed Resident 4 had weight loss with acute hospitalization and CHF exacerbation. The IDT team documented the body weight was stable since readmission and the expected weight loss due to fluid diuresis. The IDT team recommended monthly weights monitoring. Review of Resident 4's SBAR Communication Form dated 6/1/26, addressing Resident 4's weight loss of seven pounds in one month showed the physician was notified and recommended the referral to the RD and weekly weights for four weeks. Review of the Weight Variance Meeting dated 6/4/26, showed the IDT team discussed Resident 4's seven-pound weight loss since 5/1/26 (one month). The documentation showed the RD recommended (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Jevity 1.2 at 50 ml/hr for 20 hours to provide 1000 ml/1200 kcal/day. The physician was notified of the recommendations and carried out. Review of Resident 4's medical record failed to show Resident 4's weight was obtained for the week of 6/8/26. Further review of the medical record failed to show the documented evidence Resident 4 was seen and evaluated by the RD as per the physician's orders on 5/2/26 and 6/1/26. On 6/17/26 at 1520 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON stated when a resident had a 3% weight loss in one week, or a 5% weight loss in one month, the physician, resident/representative party, and the RD would be informed. The DON stated the RD was responsible for assessing the residents and attending the IDT weight variance meeting to discuss the resident's plan of care and the RD recommendations. The DON reviewed Resident 4's medical records and verified the above findings. The DON stated there was no documentation Resident 4 was seen and evaluated by the RD as above findings. On 6/18/26 at 1000 hours, a follow-up interview was conducted with the DON. The DON stated for the residents with weight loss, the RD was expected to assess and evaluate the residents and document in the medical record. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Weight Variance Committee revised 10/2018, showed it is the policy of the facility to review and monitor residents with weight variances, at an interdisciplinary team (IDT) meeting in a regular scheduled basis. This committee shall be referred to as the Weight Variance Committee. In order to provide an initial and on-going assessment of weight status, all newly admitted residents should be weighed upon admission, then weekly four (4) times, and then monthly thereafter. Medical record review for Resident 56 was initiated on 6/15/26. Resident 56 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 56's H&P examination dated 5/21/26, show Resident 56 did not have the capacity to understand and make decisions. Review of Resident 56's Weight Summary showed the following dates and weights: - On 5/21/26, 156 lbs; - On 5/26/26, 149 lbs; a weight loss of 7 lbs from 5/21/26; - On 6/2/26, 147 lbs; a weight loss of 9 lbs from 5/21/26; and - On 6/9/26, 146 lbs, a weight loss of 10 lbs from 5/21/26. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 56's Order Summary report showed the following physician's order: - Dated 5/21/26, weekly weight times four (4); and - Dated 5/26/26, to refer to the RD for weight loss. Review of Resident 56's RD readmission Nutritional assessment dated [DATE], showed Resident 56 was readmitted after transferring to the hospital on 5/21/26. Resident 56 was admitted to the facility with both lower extremity edema. Review of Resident 56's medical records failed to show Resident 56's weight was obtained for the week of 6/16/26. In addition, there was no documented evidence to show Resident 56 was seen and evaluated by the RD as per the physician's orders on 5/26/26. On 6/15/26 at 1005 hours, an observation of Resident 56 and concurrent interview with CNA 2 was conducted. Resident 56 was in bed with breakfast tray at the overbed table. When asked, CNA 2 stated Resident 56 had only eaten 25% of the breakfast. On 6/17/26 at 1121 hours, an interview and concurrent medical record review for Resident 56 was conducted with RN 1. RN 1 verified the above findings and stated the RD should have assessed Resident 56 for the weight loss on 5/26/26. On 6/17/26 at 1402 hours, an interview was conducted for Resident 56 with RN 2. RN 2 stated Resident 56 was reweighed at 139 lbs, with a weight loss of 7 lbs from 6/9/26. On 6/18/26 at 0802 hours, a telephone interview was conducted for Resident 56 with Family Member 1. Family Member 1 stated being aware of Resident 56 weight loss, and brought in Korean foods for the resident. On 6/18/26 at 0844 hours, an interview was conducted with the DON. The DON verified the above findings. The DON stated the RD was expected to assess and evaluate Resident 56 and document in the medical record. The DON further stated facility did not have any Vietnamese nor Korean menu and the facility have the American menu to offer to the residents. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate dialysis care was provided for one of 22 final sampled residents (Resident 47) reviewed for dialysis services. * The facility failed to ensure the emergency dialysis kit was kept at Resident 47's bedside. In addition, the facility failed to ensure Resident 47's AV shunt was assessed every shift and the blood pressure was not taken on the resident's left upper arm where the AV shunt located. These failures had the potential for the Resident 47 to not receive the necessary and/or immediate interventions to manage the dialysis access site and prevent possible medical complications. Findings: Review of the facility's P&P titled Dialysis Care revised 2/2018 showed it is the policy of the facility to provide standards for the resident receiving shunt care. Blood pressure and venous punctures will not be performed on the extremity where the shunt is located. In case of an emergency, at the bedside of a dialysis resident, there should be a clamp, tape, 4x4s and kerlix. Information that the shunt is to be checked once a shift for bruit and thrill, no injections, venous punctures or restraints on the extremity with the shunt. Medical record review for Resident 47 was initiated on 6/15/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's MDS 5-day PPS assessment dated [DATE], showed Cognitive Skills for Daily Decision Making was moderately impaired (decisions poor; cues/supervision required). Review of Resident 47's admission Record showed Resident 47 had a diagnosis of ESRD (end stage renal disease) and was dependent on renal dialysis. Review of Resident 47's Pre and Post Dialysis Communication dated 6/15/26, show Resident 47 had dialysis access site on the left arm AV shunt and right upper chest perma-catheter. Review of Resident 47's Order Summary Report for June 2026 showed a physician's order dated 3/19/26, for hemodialysis every Monday, Wednesday, and Friday at the dialysis facility. Further review of the Order Summary Report failed to show an order to monitor left arm AV shunt and order no blood pressure, no venipuncture to the left arm. Review of Resident 47's documentation of BP for June 2026 showed the following:- dated 6/11/26 at 1212 hours, a BP reading of 122/60 mmHg on the left arm;- dated 6/12/26 at 0808 hours, a BP reading of 104/56 mmHg on the left arm;- dated 6/12/26 at 1258 hours, a BP reading of 96/56 mmHg on the left arm;- dated 6/12/26 at 1655 hours, a BP reading of 114/59 mmHg on the left arm;- dated 6/13/26 at 0835 hours, a BP reading of 122/54 mmHg on the left arm;- dated 6/13/26 at 1238 hours, a BP reading of 138/56 mmHg on the left arm;- dated 6/13/26 at 1626 hours, a BP reading of 112/60 mmHg on the left arm; - dated 6/14/26 at 0847 hours, a BP reading of 114/54 mmHg on the left arm;- dated 6/14/26 at 1606 hours, a BP reading of 110/68 mmHg on the left arm;- dated 6/15/26 at 0945 hours, a BP reading of 126/78 mmHg on the left arm; - dated 6/15/26 at 1322 hours, a BP reading of 128/68 mmHg on the left arm;- dated 6/15/26 at 1751 hours, a BP reading of 132/74 mmHg on the left arm;- dated 6/16/26 at 0949 hours, a BP reading of 128/70 mmHg on the left arm; - dated 6/16/26 at 1247 hours, a BP reading of 122/74 mmHg on the left arm; and- dated 6/17/26 at 0812 hours, a BP reading of 104/54 mmHg on the left arm; a. On 6/15/26 at 1513 hours, an observation was conducted for Resident 47. Resident 47 was sitting in his wheelchair and observed to have the right upper chest perma-catheter dressing. On 6/15/26 at 1614 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated Resident 47 had the right upper chest perma-catheter dialysis access site. RN 1 further stated Resident 47 was a high risk for bleeding and needed an emergency kit supplies kept at the resident's bedside in case of an emergency. RN 1 checked and verified there were no supplies at Resident 47's bedside. b. On 6/17/26 at 0931 hours, an interview and concurrent medical record review for Resident 47 was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with RN 1. RN 1 verified Resident 47 had dialysis access site on the left forearm and right upper chest perma-catheter. RN 1 stated Resident 47 should have an order for no blood pressure taking on the left arm for risk of access damage and clotting. RN 1 verified the blood pressure was taken on the left arm on the above dates and times. On 6/17/26 at 1339 hours, an interview and concurrent medical record review for Resident 47 was conducted with RN 2. RN 2 verified he was taking the blood pressure of Resident 47 and was not aware Resident 47 had a left arm AV shunt. On 6/18/26 at 0844 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated all resident who had a dialysis access site should have and emergency kit at bedside and the licensed nurse should have not taken Resident 47's blood pressure on the left arm for risk of clot. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure safe and effective pharmaceutical services for one of 22 final sampled residents (Resident 47) and one nonsampled resident (Resident 108). * Resident 47's Controlled Drug Record (CDR) failed to show documentation of an Ativan (medication to manage anxiety) 0.5 mg as wasted (disposed) by two licensed nurses when the medication was logged out of the CDR but not administered to Resident 47. * The facility failed to clarify Resident 108's physician order for famotidine (medication to treat heartburn) 40 mg and the medication's indication for use prior to the administration of the medication to Resident 108. These failures had the potential for inaccurate controlled medication accountability, drug diversion, or loss; and had the potential for the residents to receive unnecessary medications and other adverse outcomes. Findings: 1. Review of the facility's P&P titled Controlled Medications dated 4/2008 showed when a dose of controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record on the line representing that dose. Medical record review for Resident 47 was initiated on 6/16/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's Order Summary Report showed a physician's order dated 4/2/26, for Ativan 0.5 mg tablet by mouth in the morning on Monday, Wednesday, and Friday. Review of Resident 47's CDR showed an Ativan 0.5 mg oral tablet was popped out of the bubblepack (narcotic supply container) on Tuesday, 6/9/26. On 6/17/26 at 1401 hours, an interview and concurrent medical record review for Resident 108 was conducted with the DON. The DON verified Resident 47's CDR showed an Ativan 0.5 mg oral tablet was popped out of Resident 47's narcotic supply container on Tuesday, 6/9/26, when the prescriber's medication order showed the Ativan 0.5 mg dose was scheduled for Monday, Wednesday, and Friday. On 6/18/26 at 0935 hours, an interview was conducted with the DON. The DON stated RN 4 stated they popped the Ativan oral tablet out of Resident 47's medication bubblepack (narcotic supply container) and then RN 4 realized the controlled substance was not ordered on 6/9/26, when they reviewed the MAR. The DON stated RN 4 told the DON that they wasted the controlled substance but there was no second witness for Resident 47's Ativan medication waste disposal. The DON stated RN 4 did not follow the medication disposal protocol. The DON stated the expectation was to document narcotic waste with a licensed witness. 2. Review of the facility's P&P titled Prescriber Medication Orders dated 1/2025 showed any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified with the attending physician. Further review of the P&P showed the prescriber is contacted to verify or clarify an order. Medical record review for Resident 108 was initiated on 6/15/26. Resident 108 was admitted to the facility on [DATE]. Review of Resident 108's Order Summary Report showed a physician's order dated 6/3/26, for famotidine 40 mg tablet by mouth in the morning for supplement. Review of Resident 108's MAR from 6/4 to 6/17/26, showed the famotidine medication was administered to Resident 108 daily for the indication of supplement. On 6/17/26 at 1401 hours, an interview and concurrent medical record review for Resident 108 was conducted with the DON. The DON verified Resident 108's medication order showed the indication for the famotidine medication was for supplement. On 6/18/26 at 0928 hours, an interview was conducted with the DON. The DON verified the findings and stated the expectation was that each medication order had an appropriate indication for use.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the observation, interview, facility document review, and facility P&P review, the facility failed to ensure safe medication labeling practices were followed for two of three medication carts inspected (Medication Carts A and B); failed to ensure the medications were not left unattended at the bedside for one nonsampled resident (Resident 109); and failed to ensure the medications were stored at the proper temperature range in accordance with the accepted standards of practice and/or manufacturer's instructions for one of one Central Supply storage area. * Two inhaler mouthpieces and an opened bottle of artificial tears eye drops were not properly labeled with sufficient information to clearly identify the specific resident for Residents 42, 65, and 75 stored inside Medication Carts A and B. * The Central Supply storage area had no room temperature monitoring log to demonstrate the medications were stored within the specified temperature range. * The facility failed to ensure a medication cup containing zinc oxide (topical medicated cream) was not left at Resident 109's bedside unattended. In addition, the facility failed to dispose the zinc oxide in the proper disposal bin. These failures posed the risk of unsafe practice and unauthorized access to the medications, cause medication errors and preventable infections from cross-contamination from other residents if accidentally mixed up with other residents similar or same drugs, and placed the residents at risk for receiving ineffective medications and the potential for adverse clinical 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. 1.a. On 6/16/26 at 1034 hours, an inspection of Medication Cart A and concurrent interview was conducted with RN 3. When Medication Cart A was inspected, there was an unlabeled and opened bottle of artificial tears observed inside the opened medication carton of the artificial tears. There was no label to show the resident-specific information. RN 3 verified the unlabeled artificial tears bottle was for Resident 42. RN 3 verified the unlabeled artificial tears bottle without the resident-specific information could be used for another resident resulting in infection control outcomes. b. On 6/16/26 at 1052 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 3. When Medication Cart B was inspected, one unlabeled Symbicort (maintenance drug for breathing problems) inhaler mouthpiece for Resident 65, and one unlabeled Incruse Ellipta (maintenance drug for breathing problems) inhaler mouthpiece for Resident 75 were stored inside the opened medication inhaler cartons. RN 3 verified both inhaler mouthpieces for Residents 65 and 75 had no label with the resident-specific information. RN 3 stated the unlabeled inhaler mouthpieces could be used for another resident leading to infection control outcomes. On 6/17/26 at 1410 hours, an interview was conducted with the IP. The IP stated if unlabeled residents' medications were mixed up, it could lead to cross contamination with the other residents. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/26 at 0931 hours, an interview was conducted with the DON. The DON was informed of the finding and verified the findings. The DON stated the expectation was for the medication to be labeled with the resident's name when the medication carton was opened. 2. Review of the facility's P&P titled Storage of Medications dated 1/2025 showed medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. Further review of the facility's P&P showed medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified. Review of the facility's Central Supply Room temperature logs showed the room temperature was last documented in January 2026. On 6/16/26 at 0944 hours, an inspection of the Central Supply Room and concurrent interview was conducted with the Central Supply Clerk. Medications were stored in the Central Supply Room. The product labeling of a medication carton containing 12 bisacodyl (medication to treat constipation) suppositories showed to store the drug at temperatures below 25 C (77 F) degrees. The product labeling of a medication carton containing 12 acetaminophen (medication to reduce fever and relieve pain) suppositories showed to store the drug at temperatures 20 to 25 C (68 to 77 F) degrees or in a cool place. The product labeling of a bulk medication bottle containing docusate sodium (medication to treat constipation) liquid showed to store at room temperature 15 to 30 C (59 to 86 F) degrees. The Central Supply Clerk stated the last time they documented the Central Supply Room temperature on the temperature log was in January 2026. On 6/18/26 at 0926 hours, an interview was conducted with the DON. The DON stated the room temperature log for the Central Supply Room was to be completed. If the room temperature was below or above the temperature range specified on the product labeling on the drug containers, then the staff had to let the management know. 3. Review of the facility's P&P titled Medication Storage in the Facility: Storage of Medication revised 1/2025 showed medications and biologicals are stored safely, accurately, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. On 5/15/26 at 0855 hours, during the initial tour of the facility, Resident 109 was observed asleep in bed . A medication cup containing white cream was observed on top of Resident 109's bedside drawer with no label. On 6/15/26 at 0956 hours, an observation and concurrent interview for Resident 109 was conducted with LVN 5 at Resident 109's bedside. When LVN 5 was asked what was the white cream inside the medication cup observed on top of Resident 109's bedside drawer, LVN 5 stated it was the topical cream for Resident 109's skin problem. LVN 5 then took the medication cup containing white cream observed on top of the resident's drawer and disposed in a regular trash can. When asked if she (continued on next page)		

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: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually disposed of medication in a regular trash, LVN 5 stated the medication should be disposed in the medication trash bin inside the medication room. LVN 5 was observed going back to the trash can and retrieved the medication cup she threw in the regular trash can, and went inside the medication room. Medical record review for Resident 109 was initiated on 6/15/26. Resident 109 was admitted to the facility on [DATE]. Review of Resident 109's H&P examination dated 6/8/26, showed Resident 109 had no capacity to understand and make decisions. Review of Resident 109's Order Summary Report dated 6/17/26, showed a physician's order dated 6/8/26, to cleanse with normal saline the sacral redness pressure injury, pat dry, apply zinc oxide (topical medicated cream) and cover with foam dressing daily. Further review of Resident 109's Order Summary Report failed to show a documented evidence a physician's order was obtained for the self-administration of medication. On 6/18/26 at 1104 hours, an interview and concurrent medical record review for Resident 109 was conducted with RN 3. RN 3 verified Resident 109 was unable to self-administer medications. RN 3 also verified there was no physician's order for Resident 109 to self-administer medications. RN3 was informed of Resident 109's zinc oxide inside a medication found on top of the resident's drawer which was thrown in the regular trash container and retrieved after being thrown by LVN 5. RN 3 verified the findings and stated the medication should have been kept in the treatment cart. On 6/18/26 at 1117 hours, an interview and concurrent medical record review for Resident 109 was conducted with the DON. The DON was informed and verified the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - Few	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 for two nonsampled residents (Residents 29 and 95) reviewed for therapeutic diet. * The facility failed to ensure Residents 29 and 95 were served with the cappuccino mousse dessert as per the menu for the lunch meal on 6/15/26. This failure had the potential to not meet Resident 29 and 95's nutritional needs and negatively impact the residents' nutritional health. Findings: Review of the facility's document titled Diet Texture dated 6/15/26, showed 97 of 105 residents in the facility received food prepared in the kitchen. Review of the facility's P&P titled Dietary- Menus, Food, and Drinks revised 10/2017 showed menus will meet the nutritional needs of the residents in accordance with established national guidelines, be prepared in advance, and be followed. Review of the facility's document titled Good For Your Health Menus (undated) showed the lunch menu for Monday 6/15/26, was French dip on a roll, au jus (a light, savory sauce made from the natural juices and drippings of cooked meat), sweet potatoes fries, corn coleslaw, and cappuccino mousse. a. Medical record review for Resident 29 was initiated on 6/15/26. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's H&P examination dated 9/30/25, showed Resident 29 had no capacity to understand and make decisions. Review of Resident 29's Order Summary Report for June 2026 showed a physician's order dated 1/29/25, to provide Resident 29 with a large portion, fortified, no added salt (NAS) pureed texture diet and regular/thin liquid consistency. b. Medical record review for Resident 95 was initiated on 6/15/26. Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 8/1/25, showed Resident 95 had no capacity to understand and make decisions. Review of Resident 95's Order Summary Report for June 2026 showed a physician's order dated 7/19/24, to provide Resident 95 with a fortified, no added salt (NAS) pureed texture diet and regular/thin liquid consistency. Review of the facility document titled Summer Menus (undated) Week 3- Monday 6/15/26, under pureed- IDDSI Level 4, showed the following items: pureed French dip roast beef, pureed soft sandwich roll, pureed sweet potato fries, pureed corn coleslaw, and cappuccino mousse. On 6/15/26 at 1155 hours, during the lunch meal observation in the dining room, the facility staff were observed assisting Residents 29 and 65 with their lunch. The following were observed:- Resident 29 was observed with the following items on her lunch tray: double portion of puree beef, one scoop of puree bread, one scoop of puree sweet potatoes fries, a cup of pureed corn, cup of milk, water, juice, and vanilla health shake. Resident 29 was not observed served with the cappuccino mousse.- Resident 95 was observed with the following items on his lunch tray: a scoop of puree beef, one scoop of puree bread, one scoop of puree sweet potatoes fries, two cups of pureed corn, a carton of milk, a cup of water, a 4 oz vanilla health shake, and a 4 oz cup of yogurt. Resident 95 was not observed served with the cappuccino mousse. On 6/15/26 at 1217 hours, an interview and concurrent observation for Residents 29 and 95 was conducted with the IP. The IP verified the above findings. The IP stated the residents on a pureed diet should also receive the cappuccino mousse dessert for the lunch meal. On 6/18/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(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 - 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 interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of 22 final sampled residents (Resident 47) was accurate. * The facility failed to ensure Resident 47's information on the H&P and Physician Progress Note was accurate. This failure had the potential for the resident's care needs not being met as their medical information was inaccurate. Findings: Review of facility's P&P titled Physician Services revised 1/2018 showed a physician, MD (Medical Doctors) or DO (Doctor of Osteopathy), must personally approve in writing a recommendation that an individual be admitted to the facility. Medical record review for Resident 47 was initiated on 6/15/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination show a documentation Resident 47 was admitted to Facility A (a different facility name and not this actual facility) for continued skilled nursing care, coordination of dialysis, rehabilitation, and management of chronic disease. Review of Resident 47's Physician Progress Notes showed documentation on the following dates:- On 3/26/26 - Resident 47 was admitted at Facility A;- On 4/2/26 - Resident 47 was admitted at Facility A;- On 4/10/26 - Resident 47 was admitted at Facility A;- On 4/16/26 - Resident 47 was admitted at Facility A;- On 4/23/26 - Resident 47 was admitted at Facility A;- On 5/7/26 - Resident 47 was admitted at Facility A;- On 5/14/26 - Resident 47 was admitted at Facility A;- On 5/21/26 - Resident 47 was admitted at Facility A;- On 5/28/26 - Resident 47 was admitted at Facility A; and- On 6/12/26 - Resident 47 was admitted at Facility A. On 6/17/26 at 0955 hours, an interview and concurrent medical record review was conducted with the MRD. The MRD verified the above findings. On 6/18/26 at 0844 hours, an interview was conducted with the DON. The DON verified the above findings, and stated the MD was aware of the inaccurate documentation on the admitting facility in the H&P and Physician Progress Note. On 6/18/26 at 1249 hours, an interview was conducted with the Assistant Administrator and DON. The Assistant Administrator and DON were informed and acknowledged the above findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Leisure Court Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1135 Leisure Court 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to complete the MDS assessments accurately for one of 22 final sampled residents (Resident 11). * The facility failed to code Resident 11 for the application of the left hand splint. This failure posed the risk of Resident 11 not receiving the individualized plan of care based on the resident's specific needs. Findings: Medical record review for Resident 11 was initiated on 6/15/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's H&P examination dated 5/31/26, showed Resident 11 was unable to make independent medical decisions. Review of Resident 11's Order Summary Report showed a physician's orders dated 7/22/25, for the RNA to apply the hand splint to the left hand five times a week or as tolerated every Monday, Tuesday, Thursday, Friday, and Saturday. Review of Resident 11's MDS assessment dated [DATE], under Section O0500, Restorative Nursing Programs showed Resident 11 was coded for none or less than 15 minutes a day for splint assistance. Review of Resident 11's Restorative Nursing documentation for April 2026 showed documentation the hand splint was applied to Resident 11's left hand on 4/3, 4/4, 4/6, 4/7, 4/9, and 4/10/26 for four hours. On 6/18/26 at 1100 hours, an interview and concurrent medical record review for Resident 11 was conducted with the DON. The DON reviewed Resident 11's medical record and verified the above findings.		