STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555536	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Regency Care Center	1770 W. LA Habra Blvd. LA Habra, CA 90631

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of three sampled residents (Residents 1 and 3) remained free from accident hazards. * The facility failed to assess Residents 1 and 3's ability to handle containers and consume the hot beverages as per the facility's P&P. In addition, Resident 1 spilled a cup of hot chocolate on her left shoulder extending down to the posterior back causing redness and blisters to Resident 1's left shoulder and left upper back. These failures posed the risk of injury to the other residents who were consuming hot liquids in the facility. Findings: Review of the facility's P&P titled Hot Liquid Safety revised 12/19/22, showed all the residents are assessed for their ability to handle containers and consume hot liquids. Residents with difficulties will receive appropriate supervision and use of assistive devices to drink hot liquids. Interventions will be individualized and noted on the resident's plan of care. Interventions include, but are not limited to: a. Wide based cups; b. Cups with lids and handles; c. Aprons; and d. Disallow hot liquids while lying in bed. General safety precautions when serving hot liquids include, but are not limited to: a. Make sure resident is alert and in proper positioning to consume hot liquids; b. Use cups, mugs, or other containers that are appropriate for hot beverages; c. Do not overfill containers; d. Regulate temperature of hot liquids to which residents have direct access; (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 1130 hours, a concurrent observation and interview was conducted with Resident 1. Resident 1 was observed awake and lying in bed with the head of the bed elevated at 45 degrees. Resident 1 was asked to describe her spillage incident on 11/15/24. Resident 1 stated she would only have the hot chocolate or coffee in the morning, and on 11/15/24, she was offered with the hot chocolate that morning. Resident 1 stated she had just woken up and she was in the same position as she was now. Resident 1 stated she was not sitting in an upright position in bed. Resident 1 stated when she received thehot chocolate, she tried sipping the hot drink with the straw maybe twice. Resident 1 then placed the cup on the table in front of her after trying to sip it twice. Resident 1 further stated the next thing she remembered was screaming in pain because she spilled the hot chocolate on herself but could not remember if she fell asleep. On 12/5/24 at 1330 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 1 was assigned to her most of the times. CNA 2 stated Resident 1 was alert but confused at times. CNA 2 was asked to describe Resident 1's hot beverage spillage incident on 11/15/24. CNA 2 stated when she gave Resident 1 the hot chocolate, Resident 1 was awake and started drinking the hot chocolate. CNA 2 then went to see another resident. CNA 2 stated 15 minutes after she left Resident 1, she heard Resident 1 screaming so she went to see Resident 1 right away. CNA 2 stated she found the hot chocolate was spilled on Resident 1's left shoulder and her back. CNA 2 stated she observed Resident 1 crying because she was in pain. CNA 2 stated she started wiping Resident 1's body and called the nurse. CNA 2 further stated Resident 1 could eat by herself but would fall asleep at times and needed cuing. CNA 2 stated when she was not busy, she would sit with Resident 1 for the whole meal. On 12/5/24 at 1400 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 1 was assigned to him when Resident 1 had the hot liquid spillage incident. LVN 1 stated Resident 1 sustained redness on the left shoulder and back, and eventually developed blisters on those body parts. LVN 1 stated Resident 1 needed partial to moderate assistance with eating. LVN 1 stated Resident 1 needed to be cued multiple times and at times Resident 1 would fall asleep during meals. LVN 1 further stated Resident 1 should have a helper throughout the meal. LVN 1 stated there was no assessment done for Resident 1 regarding her ability to consume hot liquids. On 12/5/24 at 1620 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated the nurses assessed the residents' ability to eat by themselves but did not perform an assessment specifically regarding the residents ' ability to handle a container and consume hot liquids. RN 1 verified Resident 1's medical record failed to show documented evidence the assessment was completed to determine Resident 1's ability to handle containers and consume hot liquids. On 12/5/24 at 1645 hours, an interview and concurrent medical record review was conducted with the OT 1. OT 1 stated the OT evaluation dated 9/6/24, showed Resident 1 had impairment in both upper extremities due to the resident's shoulder pain and the section under Self-Feeding showed Resident 1 was independent. OT 1 stated he only assessed in general how Resident 1 ate, handled the utensils and the cup. OT 1 stated the OT did not do a specific assessment of the residents' ability to handle and consume hot liquids. 2. Medical record review for Resident 3 was initiated on 12/5/24. Resident 3 was admitted in the facility on 3/30/22 and was readmitted on [DATE]. Review of Resident 3's H&P examination dated 11/18/23, showed Resident 3 had the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 3's medical record showed no evidence Resident 3 was assessed for her ability to handle containers and consume hot liquid. On 12/5/24 at 1620 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no assessment performed to assess Resident 3's ability to handle containers and consume hot liquids as per the facility's P&P.