STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER: Park Regency Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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** 52559 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided for three of three sampled residents (Residents 1, 2, and 3). * Residents 1 and 2's care plan failed to properly address the use of floor mats for safety. * Residents 2 and 3's post fall neurological assessments were incomplete. These failures had the potential for adverse events related to falls to happen. Findings: 1. Review of the facility's P&P titled Fall Prevention Program dated 12/28/23, showed the nurse and/or interdisciplinary team will initiate interventions on the resident's care plan. a. Medical record review for Resident 1 was initiated on 3/27/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. On 3/27/25 at 0817 hours, there were bilateral floor mats observed by Resident 1's bed. On 3/27/25 at 1215 hours, Resident 1 was observed in bed. The resident's bed was in the lowest position and the bilateral floor mats were still beside the resident's bed. Review of Resident 1's eINTERACT SBAR Summary for Providers dated 3/12/25 at 1630 hours, showed the resident had an unwitnessed fall and was sent to the hospital for evaluation. Review of Resident 1's care plan last revised 3/27/25, failed to show the floor mats were included as part of the resident's care. An interview with LVN 2 was conducted on 3/27/25 at 1358 hours. LVN 2 stated the bilateral floor mats were ordered by a physician for fall risk residents. LVN 2 stated Resident 1's bilateral floor mats were placed when the resident was readmitted to the facility. (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	b. Medical record review for Resident 2 was initiated on 3/27/25. Resident 2 was admitted to the facility on [DATE]. On 3/27/25 at 0944 hours, one floor mat was observed by Resident 2's bed. Resident 2 was lying in bedand the bed was at the lowest position. Review of Resident 2's eINTERACT SBAR Summary for Providers dated 3/15/25 at 0540 hours, showed the resident had an unwitnessed fall and was sent to the acute care hospital for evaluation. Review of Resident 2's nurses progress note dated 3/16/25 at 0313 hours, showed the resident was transferred back to the facility. Review of Resident 2's care plan dated 3/15/25, failed to include the information for the staff to identify which side of the bed the floor mat should be placed. On 3/27/25 at 1358 hours, an interview with LVN 2 was conducted. LVN 2 stated the bilateral floor mats were ordered by a physicianfor fall risk residents. On 3/27/25 at 1421 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated a physician's order was not needed for the floor mats because it was considered a nursing intervention for the residents. The DON further stated during a post-fall IDT meeting, the members would discuss and decide if the floor mats were needed and would update the resident's care plan. The DON stated Residents 1 and 2's floor mats were placed when the residents were readmitted to the facility. The DON reviewed Residents 1 and 2's care plans and verified the care plan did not address the use of the floor mat. 2. Review of the facility's P&P titled, Fall Prevention Program dated 12/28/23, showed to monitor the vital signs in accordance with facility policy, monitor for changes in resident cognition, and when any resident experiences a fall, the facility will document all assessments and actions. a. Medical record review for Resident 2 was initiated on 3/27/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's neurological flowsheet dated 3/15/25, showed the neurological assessment for item number 17 was missing. Review of Resident 2's eINTERACT SBAR Summary for Providers dated 3/15/25 at 0540 hours, showed the resident had an unwitnessed fall and was sent to the acute care hospital for evaluation. Review of Resident 2's Nurse Progress Note dated 3/16/25, showed at 0313 hours, the resident was transferred back at the facility. An interview and concurrent medical record review was conducted with the DON on 3/27/25 at 1421 hours. The DON stated the neurological assessments should be done for the residents with unwitnessed falls and should be documented on the neurological flowsheets. The DON reviewed Resident 2's neurological flowsheets and verified neurological assessment, Item Number: 17 was not completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Medical record review for Resident 3 was initiated on 3/27/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's eINTERACT SBAR Summary for Providers dated 3/2/25 at 2051 hours, showed the resident had an unwitnessed fall. The primary care provider's recommendation was to conduct the neurological checks. Review of Resident 3's neurological flowsheet dated 3/2/25, showed the neurological assessment, Item Numbers: 6, 7, 12, 14, 15, and 18 were missing. On 3/27/25 at 1421 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the neurological assessments should be done for the residents with unwitnessed falls and should be documented on the neurological flowsheets. The DON reviewed Residents 2 and 3's neurological flowsheets and verified the neurological assessments were incomplete.