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	08/27/2025

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 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. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop a plan of care to reflect the individual care needs for two of three sampled residents (Residents 1 and 2). * The facility failed to develop a care plan to address Resident 1's wandering behavior by attempting to enter to other female rooms. * The facility failed to develop a care plan to address Resident 2's elopement risk. These failures posed the risk of the residents not receiving the appropriate treatment and services.Findings: Review of the facility's P&P titled Comprehensive Care Plans reviewed/revised 12/2022 showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. According to the Fundamentals of Nursing 10th edition, Communicating and Recording the Nursing Care Plan, a well written care plan is prepared by the nurse who best knows the patient and is recorded on the day the patient presents for treatment and care, according to facility policy, with modifications to the initial plan signed and dated. 1. Closed medical record review for Resident 1 was initiated on 8/26/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/24/25. Review of Resident 1's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 8/13/25, showed the resident attempted to enter other female rooms. Further review of Resident 1's medical record failed to show documented evidence the care plan for the wandering behavior of attempting to enter to other female rooms was developed before the resident eloped on 8/17/25. On 8/27/25 at 1401 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with RN 2. RN 2 verified Resident 1 had wandering behavior by attempting to enter to other female rooms on 8/13/25, and the care plan was not initiated until 8/17/25, when the resident eloped. RN 2 stated the licensed nurse should have started the care plan on 8/13/25. On 8/27/25 at 1632 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have initiated the care plan as soon as Resident 1's wandering behavior was observed. 2. Medical record review for Resident 2 was initiated on 8/26/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Elopement Risk - V 3 assessment dated [DATE], showed the resident was at risk for elopement. Review of Resident 2's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Further review of Resident 2's medical record failed to show documented evidence a care plan was developed to address the resident's elopement risk before 8/18/25. The care plan for Resident 2's elopement risk was created on 8/18/25. On 8/27/25 at 1340 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 2's Elopement Risk - V 3 assessment dated [DATE], showed the resident was at risk for elopement and there was no care plan to address the resident's elopement risk before 8/18/25. RN 2 acknowledged the care plan for Resident 2's elopement risk was created on 8/18/25. RN 2 stated Resident 2's care plan should have been initiated right away. On 8/27/25 at 1625 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated Resident 2's care plan should have been created as soon as the resident was identified as an elopement risk. On 8/27/25 at 1644 hours, the Administrator and DON were informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on interview, closed medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accident hazards for one of three sampled residents (Resident 1). * The facility failed to ensure Resident 1 did not eloped from the facility. This failure had the potential to place Resident 1 at risk of serious injury.Findings: Review of the facility's P&P titled Elopements and Wandering Residents reviewed/revised 12/2022 showed this facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The Policy Explanation and Compliance Guidelines section showed alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 1. Closed medical record review for Resident 1 was initiated on 8/26/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/24/25. Review of Resident 1's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 8/13/25, showed the resident attempted to enter other female rooms. Further review of Resident 1's medical record failed to show documented evidence the Elopement Risk - V 3 assessment was done on 8/13/25. The elopement risk assessment included the question does the resident wander? Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 8/17/25, showed elopement and wanderer. In addition, the evaluation showed Resident 1's body assessment was done and noted with skin discoloration 3 cm (length) x 4 cm (width) at the left forearm. On 8/26/25 at 1315 hours, an interview was conducted with CNA 1. CNA 1 verified Resident 1 eloped from the facility on 8/17/25. CNA 1 stated the elopement occurred on 8/17/25 at around 0930 hours. CNA 1 stated Resident 1 was in his wheelchair at 0830 hours and could move himself. CNA 1 further stated she was busy and did not hear the door alarm. CNA 1 stated she told the supervisor she did not see Resident 1 leaving the facility. On 8/26/25 at 1340 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 verified Resident 1 eloped from the facility on 8/17/25. RN 2 stated the CNA reported to him Resident 1 eloped at 0930 hours. RN 2 stated when the CNA reported she could not find Resident 1, the facility staff started looking for Resident 1 in every room. RN 2 further stated Resident 1 had a history of attempting to enter female rooms. RN 2 stated he initiated the elopement protocol when the facility staff could not find Resident 1. RN 2 stated the police found Resident 1 by the [NAME] church at 1000 hours. On 8/27/25 at 1051 hours, an interview was conducted with the Laundry Staff. The Laundry Staff stated she was having her lunch break when she heard the door alarm. The Laundry staff stated she did not get up and checked the door because she was on her lunch break and assumed somebody else would check the door alarm. On 8/27/25 at 1555 hours, a follow-up interview and concurrent medical record review was conducted with RN 2. RN 2 acknowledged Resident 1 had change in condition evaluation dated 8/13/25, for wandering by attempting to enter other female rooms. RN 2 verified the Elopement Risk - V 3 assessment was not done on 8/13/25. RN 2 stated the licensed nurse should have done the elopement risk assessment for Resident 1 to prevent episode of elopement. On 8/27/25 at 1632 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have initiated an elopement assessment to identify Resident 1 was an elopement risk. The DON stated the facility staff should have attended to the door alarm immediately. On 8/27/25 at 1644 hours, the Administrator and DON were informed and acknowledged the above findings.