

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/18/2026
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 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 observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of three sampled residents (Resident 1). * The facility failed to complete an assessment for the change in condition, notification of physician and responsible party, and documentation of administration of oxygen and its effectiveness for Resident 1. The facility failed to monitor resident's change of condition after the episodes of low oxygen levels. In addition, there was no care plan developed for the oxygen use. These failures posed the risk of the resident not receiving the appropriate care and the potential for a delay in providing care to the resident. Findings: Review of the facility's P&P titled Notification of Changes revised 12/19/22, showed the following:- the facility must inform the resident, consult with the resident's physician and/or notify the resident's family or legal representative when there is a change requiring such notification like significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. Review of the facility's P&P titled Medication Administration revised 12/19/22, showed the following:- sign the MAR after administered. For those medications, requiring vital signs, record the vitals onto the MAR Review of the facility's P&P titled Documentation in Medical Record revised 12/19/22, showed the following:- documentation can be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred; and- documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or response to care. Medical record review for Resident 1 was initiated on 6/17/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/25/26, showed Resident 1 had the capacity to understand and make decisions. Resident 1's admission diagnoses included bladder cancer and interstitial pulmonary disease (a group of conditions that cause inflammation and scarring in the lungs). Review of Resident 1's oxygen saturation levels and oxygen use showed the following:- On 5/28/26 at 2352 hours, 88% on room air;- On 5/29/26 at 2352 hours, 85% on room air;- On 5/30/26 at 2323 hours, 84% on room air;- On 5/31/26 at 1840 hours, 95% with oxygen via nasal cannula;- On 5/31/26 at 2323 hours, 92% with oxygen via nasal cannula;- On 6/1/26 at 2356 hours, 90% with oxygen via nasal cannula; and- On 6/2/26 at 1014 hours, 90% with oxygen via nasal cannula. Review of Resident 1's Order Summary Report dated 5/22-6/3/26, showed a physician's order dated 5/31/26, for oxygen via nasal cannula at two to four liters per minute, may titrate oxygen up to five liter per minute to maintain pulse oximeter greater or equal to 92%. Notify the physician if the pulse oximeter is less than 92% at maximum titration as needed for SOB or wheezing. Review of Resident 1's Progress Notes dated 5/31/26 at 1612 hours, showed LVN 3's documentation of Resident 1 receiving oxygen at two liters per minute via nasal cannula while Family Member 1 was present at the bedside. Review of Resident 1's monitor record for May 2026 failed to show documentation of oxygen administration and its effectiveness on 5/31/26. On 6/17/26 at hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 1. Resident 1's low oxygen saturation levels below 89% and oxygen use on the dates of 5/28-6/2/26, progress notes documented on 5/31/26 at 1612 hours, and monitor record for oxygen administration and its (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effectiveness on 5/31/26 were reviewed with LVN 1. LVN 1 verified the above findings and stated there was no assessment for the change of condition for Resident 1's low oxygen levels, failed to complete SBAR for low oxygen level or shortness of breath, no notification made to the physician and responsible party, no monitoring of the resident's change in condition, and no care plan for the oxygen use. In addition, LVN 1 stated the low oxygen level, shortness of breath, or any change from resident's baseline were considered a change in condition. On 6/17/26 at 1343 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated the abnormal vital signs including the low oxygen levels below 91% were considered change in condition. The DON stated the licensed nurses must assess the resident, notify the physician and responsible party, carry out any physician's orders, administer medications as ordered, complete SBAR, initiate or update care plan, and document monitoring in the residents' progress notes every shift for 72 hours. In addition, the DON stated if the medications were ordered as needed, the licensed nurses must document the administration of the medication and its effectiveness. Resident 1's medical record was reviewed with the DON and she verified the abnormal oxygen levels and oxygen use, verified there was no SBAR and assessment completed for Resident 1's change in condition with the low oxygen levels and the physician's order for oxygen as needed on 5/31/26 at 0224 hours by LVN 2. Furthermore, the DON verified the oxygen was administered on 5/31-6/2/226. However, there was no documentation of the oxygen administration on the MAR monitoring record and its effectiveness. On 6/18/26 at 1218 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		