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	12/12/2025

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **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 for four of five final sampled residents (Resident 8, 12, 38, and 55) reviewed for the use of the side rails. * The facility failed to obtain the physician's order, to provide the least restrictive alternatives, and to conduct a bed rail assessment for Resident 12's use of the side rails. * The facility failed to provide documented evidence the manufacturers' recommendations and specifications for installing and maintaining bed rails were conducted for Resident 8, 38, and 55 bed rails. In addition, the facility failed to conduct a bed rail assessment for Resident 38's bed rails. These failures had the potential to place the residents at risk for entrapment and serious injuries.Findings: Review of the facility's P&P titled Proper Use of Bed Rails revised 12/19/22, showed it is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Further review of the facility's P&P showed the resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. In addition, the resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. 1. On 12/09/2025 at 1104 hours, Resident 8 was observed awake in bed with her upper one half bed rails elevated. Resident 8 was observed to have a low air loss mattress. Medical record review for Resident 8 was initiated on 12/9/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 10/11/25, showed Resident 8 had no capacity to understand and make decisions. On 12/12/25 at 1054 hours, an interview and concurrent facility record review was conducted with the Maintenance Director. When asked about Resident 8's bed manuals for bed rails, the Maintenance Director stated he would provide the manuals. Review of the information provided for Resident 8's bed manuals failed to show documented evidence of the manufacturer's' recommendations and specifications for installing and maintaining the bed rails for Resident 8's bed. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 12/12/2025 at 926 hours, Resident 38 was observed in a bariatric bed awake, with his bilateral upper one half bed rails elevated. Medical record review for Resident 38 was initiated on 12/12/25. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's bed rail assessment dated [DATE], showed the bed rails were not indicated for Resident 38. Review of Resident 38's H&P examination dated 11/3/25, showed Resident 38 had the capacity to understand and make decisions. On 12/12/25, at 1015 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified an assessment for Resident 38's bed rails was not completed. On 12/12/25, at 1054 hours, an interview and concurrent facility record review was conducted with the Maintenance Director. When asked about Resident 38's bed manuals for the bed rails, the Maintenance Director stated he would provide the manuals. Review of the information provided for Resident 38's bed manuals failed to show documented evidence of the manufacturer's' recommendations and specifications for installing and maintaining the bed rails for Resident 38's bed. 3. On 12/9/25 at 0920 hours, Resident 55 was observed awake in a low air loss mattress bed with his bilateral mid, one-half bed rails elevated. Medical record review for Resident 55 was initiated on 12/9/25. Resident 55 was readmitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 7/2/25, showed Resident 55 had the capacity to understand and make decisions. On 12/12/25, at 1054 hours, an interview and concurrent facility record review was conducted with the Maintenance Director. When asked about Resident 55's bed manuals for the bed rails, the Maintenance Director stated he would provide the manuals. Review of the information provided for Resident 55's bed manuals failed to show documented evidence of the manufacturer's' recommendations and specifications for installing and maintaining the bed rails for Resident 55's bed. 4. On 12/9/25 at 0937 hours, during the initial tour of the facility, Resident 12 was observed lying in bed, with bilateral 1/4 (quarter) side rails elevated. Resident 12 was observed holding on to the right 1/4 side rail while being changed by CNA 1. Medical record review for Resident 12 was initiated on 12/9/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 9/19/25, showed Resident 12 had no capacity to understand and make decisions. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 12's MDS dated [DATE], showed Resident 12 required partial/moderate to substantial/maximal assistance from staff member for bed mobility. Review of Resident 12's Order Summary Report showed a physician's order dated 10/28/25, for bilateral 1/4 side rails for bed mobility and enabler use. Further review of Resident 12's medical record failed to show documented evidence the least restrictive alternatives were attempted and bed rail assessment was conducted prior to the use of the side rails for Resident 12. On 12/11/25 at 0904 hours, an interview for Resident 12 was conducted with CNA 1. CNA 1 stated when Resident 12 was in bed, the bilateral 1/4 side rails were elevated at all times. CNA 1 further stated Resident 12 grabbed on the side rails when being assisted with turning. On 12/12/25 at 0841 hours, Resident 12 was observed lying in bed, with bilateral 1/4 side rails elevated. On 12/12/25 at 0853 hours, an interview and concurrent medical record review for Resident 12 was conducted with RN 2. RN 2 stated prior to the use of the side rails, the resident should be assessed initially for the need for the side rails by the therapist, and whether the resident could benefit from the use of the side rails and would also recommend which side rail to use. RN 2 further stated the least restrictive alternatives should be attempted first prior to the use of the side rails, such as the use of the bilateral bolsters. RN 2 verified there were no documentation the least restrictive alternatives were attempted, and no bedrail assessment by the therapy department was conducted prior to Resident 12's use of the bilateral 1/4 side rails. On 12/12/25 at 0926 hours, an interview and concurrent medical record review for Resident 12 was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated the therapist would conduct an assessment or PT/OT evaluation, and then a rehabilitation screening for the residents who could benefit from the use of the grab bars. The Director of Rehabilitation further stated they only have grab bars in the facility. When asked if the residents with the side rails were also assessed and screened by the therapy department, the Director of Rehabilitation stated the long-term residents were reassessed for the side rails by the nursing department. On 12/12/25 at 1224 hours, an interview and concurrent medical record review for Resident 12 was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 12. The DON stated the therapy department will do the assessment initially to determine whether the resident could benefit from the side rails, then the nursing department would attempt an alternative measures, obtain the physician's order, initiate care plan, and inform the maintenance for the use of the side rails. Cross reference to F909

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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. * Boxed food items in the walk-in refrigerator and freezer were observed placed within two to three inches from the ceiling, blocking the spray of the fire sprinklers. * A floor tile next to the facility's ice machine was observed missing a piece of the tile. * Station 2 Residents' refrigerator did not have a thermometer inside the freezer, and half-a-gallon ice cream was observed with ice build along the top outer edges of the ice cream's lid. * A ceiling tile inside the facility's dining room was observed with a hole in it. These failures posed the risks of the fire sprinklers not releasing their full spray in the event of an emergency, posed the risk of harboring the growth of microorganism; posed the risk of causing food borne illnesses to the residents, and posed the risk of unsanitary conditions for the residents.Findings: Review of the facility's Diet Type Report dated 12/10/25, showed 91 residents received meals prepared in the kitchen. 1.a. According to the USDA Food Code 2022, Section 6-201.11, floors, floor covering, walls, wall covering, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. On 12/9/25 at 0745 hours, an initial tour of the kitchen was conducted with the Dietary Supervisor. The following was observed during the tour: - A floor tile next to the facility's ice machine was observed missing a piece of the tile. The Dietary Supervisor verified the findings. On 12/09/2025 at 1218 hours, a dining room observation was conducted. A ceiling tile, located above the area where meal trays were uncovered and checked, was observed with a hole in it. The Dietary Supervisor verified the findings. b. According to the USDA Food Code 2022, Section 3-305.11, food shall be stored where it is not exposed to splash. According to the Occupational Safety and Health Standards, Section 1910.159(c)(10), Sprinkler Spacing, the employer shall assure that sprinklers are spaced to provide a maximum protection area per sprinkler, a minimum of interference to the discharge pattern by building or structural members or building contents and suitable sensitivity to possible fire hazards. The minimum vertical clearance between sprinklers and material below shall be 18 inches (45.7 cm). On 12/9/25 at 0745 hours, an initial tour of the kitchen was conducted with the Dietary Supervisor. The following was observed during the tour: - Inside the walk-in refrigerator and the walk-in freezer, multiple boxed food items were observed placed about two to three inches from the ceiling. The boxes were observed blocking the spray of the fire sprinklers. The Dietary Supervisor verified the findings. c. According to the USDA Food Code 2022, Section 4-203.12, Temperature Measuring Devices, Ambient Air and Water, a temperature measuring device is used to measure the air temperature in a refrigeration unit. On 12/9/25, at 0815 hours, during a tour of Station A with the Dietary Supervisor, the residents' refrigerator was inspected. The freezer compartment of the refrigerator was observed missing a thermometer. In addition, a half-gallon container of ice cream was observed with ice buildup surrounding the top edges of the container. The Dietary Supervisor verified all findings. d. According to the USDA Food Code 2022, Section 2-302.11 and Section 2-302.11, food employees shall keep their fingernails trimmed. On 12/10/25, at 1135 hours, a trayline preparation observation was conducted inside the facility's kitchen. The Dietary Supervisor was observed with artificial fingernails extending about one-half inch beyond her fingertips. On 12/10/25 at 1535 hours, the above finding was verified with the Dietary Supervisor.

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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, facility document review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infections were implemented. * The facility failed to initiate an infection tracking surveillance for the residents with signs and symptoms of infection who were not prescribed with antibiotic treatment. * CNA 7 was observed with artificial nails, extending beyond her fingertips. * Resident 76's drape was observed with a black substance along the bottom of the drape. These failures posed the risk of not preventing the spread of infection in the facility, posed the risk of causing an injury to residents' skin, and posed the risk of unsanitary environment.Findings: Review of the facility's P&P titled Infection Surveillance revised 12/19/22, showed in part a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections. Definitions: Infection Surveillance refers to an ongoing systemic collection, analysis, interpretation, and dissemination of infection-related data. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. The licensed nurses participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. Examples of notification triggers include, but are not limited to: a. Resident develops signs and symptoms of infection. b. A resident is started on an antibiotic. c. A microbiology test is ordered. d. A resident is placed on isolation precautions, whether empirically or by physician order. e. Microbiology test results show drug resistance. On 12/11/25 at 1251 hours, an interview and concurrent review of the facility's Infection Control Surveillance tracking was conducted with the IP. The IP showed the tracking surveillance of the residents with signs and symptoms of infection and the antibiotics prescribed by the physician. However, the IP was not able to provide evidence of the tracking for the residents with signs and symptoms without prescribed antibiotics. The IP further stated and verified, We have documentation in the COC (Change of Condition) notes but there is no tracking. Moving forward I will include it in the tracking surveillance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/25 at 1319 hours, an interview was conducted with the DON. The DON verified the findings and stated moving forward the facility will include the tracking surveillance of the residents with signs and symptoms of infection who were not prescribed antibiotic treatments. 2. Review of the facility's Employee Handbook showed employees were prohibited from any form of artificial fingernails that have been found to increase the colonization and transmission of pathogens to patients. Therefore, only nails of reasonable length (no longer than1/4 beyond the fingertip) were permitted for health care workers with direct patient contact or contact with patient food or medical supplies. According to the CDC.gov website, healthcare workers who wear artificial nails are more likely to harbor pathogens on their fingertips. Medical record review for Resident 103 was initiated on 12/9/25. Resident 103 was admitted to the facility on [DATE]. Review of Resident 103's H&P examination dated 12/10/25, showed Resident 103's diagnoses included leukemia (cancer of the blood and bone marrow), status post surgery to her abdomen. Resident 103 had no capacity to understand or make decisions. Review of Resident 103's December 2025 MAR showed Resident 103 was receiving Imbruvica (medication used in chemotherapy) oral tablet 420 mg one tablet by mouth daily at 0900 hours for leukemia. On 12/9/2025 at 1023 hours, CNA 7 was observed going to provide a bed bath to Resident 103. CNA 7 was observed with artificial nails extending approximately 1/2 (half) inch beyond her fingertips. When asked about CNA 7's artificial nails, CNA 7 acknowledged she was not supposed to have artificial fingernails per facility's policy. On 12/10/25 at 1600 hours, an interview was conducted with the IP regarding staff wearing artificial nails. The IP stated if the staff was doing direct care, the staff had to keep their nails trimmed and short. The IP was informed regarding one kitchen staff and one direct care staff observed with artificial fingernails extending beyond fingertips. The IP acknowledged the above findings. 3. Medical record review for Resident 76 was initiated on 12/9/25. Resident 76 was admitted to the facility on [DATE]. Review of Resident 76's H&P examination dated 9/28/25 showed Resident 76 had the capacity to understand and make decisions. On 12/09/2025 at 1445 hours, an observation and concurrent interview was conducted with Resident 76. CNA 7 was also present in the room. Resident 76 verbalized concerns with not wanting to be in her room because she did not like staring at the dirty drape on her window. The drape was observed with a black substance along the bottom of the drape. According to Resident 76, she had complained to a staff about the black substance on the drape. The window was located right next to Resident 76's bed. The finding was verified with CNA 7; however, CNA 7 was not aware of the dirty drape on Resident 76's window. On 12/10/25 at 0900 hours, an interview was conducted with the Maintenance Supervisor. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance Supervisor stated the staff had to notify the janitor for change of curtains if soled, as needed, otherwise the change of curtains was done monthly during deep cleaning rooms as scheduled. According to the Maintenance Supervisor, she was not aware Resident 76's drape had a black substance on it. The resident's room was last deep cleaned by the housekeeping department on 11/22/23, and was scheduled for a complete room cleaning on the 22nd of the month, including curtains.

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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, and facility P&P review, the facility failed to ensure one of four final sampled residents reviewed for side rails (Resident 12) and one of one final sampled resident reviewed for physical restraint (Resident 76) were provided the right to self-determination regarding the use of side rails and physical restraints. * The facility failed to ensure the informed consent was obtained prior to the use of side rails for Resident 12. * The facility failed to obtain the informed consent prior to having Resident 76's bed against the wall. These failures posed the risk of the residents and their responsible party not understanding the risks and benefits regarding the use of side rails, physical restraints, and having the resident's bed against the wall. Findings: 1. Review of the facility's P&P titled Informed Consent dated 3/25/24, showed the following: - When situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, but not limited to, administration of psychotherapeutic medications, application of physical restraint or prolonged use of a device that may lead to inability to regain use of a normal body function and for transfer and discharge; and - It is the responsibility of the healthcare professional who proposes any medical intervention or treatment that requires informed consent to provide information to the resident/resident representative regarding the resident's condition and circumstances that are pertinent to a decision to accept or refuse the proposed intervention or treatment. On 12/9/25 at 0937 hours, during the initial tour of the facility, Resident 12 was observed lying in bed with the bilateral 1/4 (quarter) side rails elevated. Medical record review for Resident 12 was initiated on 12/9/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 9/19/25, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Order Summary Report showed a physician's order dated 10/28/25, for the bilateral 1/4 side rails for bed mobility and enable use. Further review of Resident 12's medical record failed to show an informed consent for the bilateral 1/4 side rails was obtained from the resident's responsible party. On 12/12/25 at 0853 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated after the resident had been assessed by the therapist and determined to benefit from the use of the side rails, the licensed nurses would contact the physician to obtain an order for the side rails. RN 2 further stated the licensed nurses would then verify the informed consent had been obtained from the resident or the responsible party. RN 2 stated the resident or their responsible party would sign the informed consent form to show they agreed and understood the purpose, risks and benefits of the side rails. RN 2 reviewed Resident 12's medical record and was unable to find documentation to show the informed consent was obtained from the resident's responsible party prior to Resident 12's use of the side rails. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/25 at 1224 hours, an interview and concurrent medical record review for Resident 12 was conducted with the DON. The DON verified the above findings. The DON stated Resident 12 might have been transferred from another bed to her current bed with the side rails installed, and the licensed nurse only obtained the physician's order for side rails, and initiated the care plan. The DON further stated the licensed nurse did not follow all the steps required for utilizing the side rails, such as verifying if the physician had obtained the informed consent from the resident's responsible party prior to the use of side rails. 2. On 12/9/25 at 1445 hours, Resident 76 was observed in bed. Resident 76's bed was observed against the wall. Medical record review for Resident 76 was initiated on 12/9/25. Resident 76 was admitted to the facility on [DATE]. Review of Resident 76's H&P examination dated 9/28/25, showed Resident 76's diagnoses included dementia (general term referring to loss of mental function such as thinking, memory, and reasoning skills), psychosis (a serious mental disorder characterized by impaired thinking and emotions), anxiety (a feeling of fear, dread or uneasiness), and history of falls. Further review of Resident 76's medical record failed to show the informed consent was obtained for having Resident 76's bed against the wall. On 12/11/25 at 1406 hours, an interview was conducted with CNA 7. When asked about Resident 76's bed against the wall, CNA 7 stated she did not know why Resident 76's bed was against the wall. On 12/12/25 at 1050 hours, Resident 76 was observed in bed with the bed against the wall. On 12/12/25 at 1052 hours, an interview was conducted with LVN 8. When asked about Resident 76's bed against the wall, LVN 8 stated she thought Resident 76 preferred the bed against the wall. On 12/12/25, at 1230 hours, an interview was conducted with RN 1. When asked about Resident 76's bed against the wall, RN 1 stated this was the first time RN 1 noticed Resident 76's bed was against the wall. RN 1 stated she did not know how Resident 76's bed got against the wall. RN 1 verified there was no informed consent for having Resident 76's bed against the wall. Cross reference F604 and F656, example # 3.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 determine if it was safe to self-administer the medications left at the bedside for one of 19 final sampled residents (Resident 54). * Resident 54 was observed with a bottle of Systane (artificial tears) eyedrops at the bedside, and an orange bottle containing two nebules of Systane eyedrops. However, Resident 54 was not assessed to determine if she could self-administer medications. In addition, there were no physician's orders for the Systane eyedrops, and to self-administer medication, and no care plan problem addressing the resident's self-administration of the medication. These failures had the potential for Resident 54 to administer the medications inaccurately and could affect their well-being. Findings: Review of the facility's P&P titled Self-Administration of Medications revised 12/19/22, showed the following:- It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the IDT has determined which medications may be self-administered safely;- The results of the IDT assessment are recorded on the electronic health record;- Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration of the MAR;- The following conditions are met for bedside storage to occur: (a) the manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective, and (b) the medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy; and- All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible part. On 12/9/25 at 0959 hours, Resident 54 was observed sitting in a wheelchair in the room. A bottle of Systane eyedrops and an orange bottle containing two nebules of Systane eyedrops were observed on her overbed table. Resident 54 stated she administered the eyedrops to herself twice a day. Medical record review for Resident 54 was initiated on 12/9/25. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's medical record failed to show a physician's order for the administration of the eyedrops to self-administer medications. Review of Resident 54's plan of care failed to show a care plan problem was developed to address Resident 54's self-administration of the eyedrops. Further review of Resident 54's medical record failed to show an assessment was conducted by the IDT to determine if Resident 54 was safe to self-administer medications. On 12/9/25 at 1447 hours, an observation and concurrent interview for Resident 54 was conducted with LVN 5. LVN 5 verified a bottle of Systane eyedrops and an orange bottle containing Systane eyedrops were on Resident 54's overbed table. LVN 5 also verified there was no physician's order to administer Systane eyedrops. LVN 5 further verified there were no physician's order to self-administer the medications and care plan addressing the resident's self-administration of the medications. On 12/11/25 at 0947 hours, an interview and concurrent medical record review for Resident 54 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated when a resident has been taking a medication at home and wanted to continue taking the medication while at the facility, the nurses had to notify the physician to get an order to administer a medication. RN 1 stated the facility did not allow the residents to have any medications at bedside. On 12/12/25 at 1229 hours, an interview and concurrent medical record review for Resident 54 was conducted with the DON. The DON verified the above findings. The DON stated the nurses were responsible for educating the residents and family members to inform the nurses if any medication were brought in from home. The DON stated if the resident requested to self-administer the medications, the IDT would have to assess the resident to determine whether it was safe for the resident to self-administer, then the nurses would obtain physician's order for the medication, and to self-administer the medication, initiate a care plan to address the medication and the self-administration of medications, and document the self-administration of medication in the MAR.

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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 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 offer information on how to formulate an advanced directive (a legal document stating a person's wishes about receiving medical care if the person is no longer able to make medical decisions) and/or maintain a copy of the advanced directive for two of nine final sampled residents reviewed for advanced directives (Resident 50). * Resident 50 was not offered information on how to formulate an advanced directive. * The facility failed to obtain a copy of Resident 54's advanced directive. These failures had the potential for Resident 50 and 54's decisions regarding their healthcare and treatment options not communicated to the healthcare staff and honored.Findings: Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advanced Directives revised 12/19/22, showed in part, it is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advanced directive. The P&P further showed on admission, the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advanced directive. In the event the resident is unable to formulate an Advanced Directive due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. The facility will provide the resident or resident representative with information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive. 1. Medical record review for Resident 50 was initiated on 12/10/25. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's POLST dated 11/2/25, showed the resident did not have an advanced directive. Review of Resident 50's H&P examination dated 11/3/25, showed the resident had the capacity to understand and make medical decisions. On 12/10/25 at 1403 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD was asked if there was documented discussion or education provided to the resident or their responsible party regarding the formulation of an advanced directive. The SSD verified there was no documentation to show the facility provided information on how to formulate an advanced directive. The SSD stated she would speak to the resident's responsible party to discuss the formulation of an advanced directive. On 12/12/25 at 1328 hours, interview was conducted with the DON. The DON verified the above findings. 2. Medical record review for Resident 54 was initiated on 12/9/25. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's POLST under section D dated 10/25/25, showed Resident 54 had capacity, but the form did not indicate whether Resident 54 had an advance directive or not. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 54's Social Service Assessment – V5 dated 10/27/25, showed the boxes for the advanced directive and POLST selections were checked. Under the Additional Notes section, showed the SSD asked the resident if she had an advance directive and Resident 54 stated she did, the SSD requested for a copy of the advanced directive, and the resident stated she would ask her daughter to look for it. However, further review of Resident 54's medical record failed to show documentation the social services staff followed up to obtain a copy of Resident 54's advanced directive. On 12/10/25 at 1433 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated during the social services assessment, Resident 54 stated she had an advanced directive, but she did not have a copy at the time. The SSD failed to show documentation to show if the social services staff had followed up with Resident 54's responsible party to obtain a copy of Resident 54's advanced directive.

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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 ensure one of one final sampled resident reviewed for physical restraints (Resident 76) remained free of the physical restraints. * The facility failed to ensure Resident 76's bed was not against the wall per the facility's P&P. This failure had the potential for Resident 76 not being able to get out of bed on both sides and the potential for Resident 76 to sustain injury.Findings: Review of the facility's P&P titled Restraint Free Environment revised 12/19/22, showed the physical restraints including placing a bed close enough to a wall that the resident was prevented from rising out of the chair or voluntarily getting out of bed was prohibited. On 12/9/25 at 1445 hours, Resident 76 was observed in bed. Resident 76's bed was observed against the wall. Medical record review for Resident 76 was initiated on 12/9/25. Resident 76 was admitted to the facility on [DATE]. Review of Resident 76's H&P examination dated 9/28/25, showed Resident 76's diagnoses included dementia, psychosis, anxiety, and history of falls. On 12/11/25 at 1406 hours, an interview was conducted with CNA 7. When asked about Resident 76's bed against the wall, CNA 7 stated she did not know why Resident 76's bed was against the wall. CNA 7 stated Resident 76 could get out of her bed independently. On 12/12/25 at 1050 hours, Resident 76 was observed in bed with her bed against the wall. On 12/12/25 at 1052 hours, an interview was conducted with LVN 8. When asked about Resident 76's bed against the wall, LVN 8 stated she thought Resident 76 preferred the bed against the wall. On 12/12/25, at 1230 hours, an interview was conducted with RN 1. When asked about Resident 76's bed against the wall, RN 1 stated this was the first time RN 1 noticed Resident 76's bed was against the wall. RN 1 stated she did not know how Resident 76's bed got against the wall.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one of five final sampled residents reviewed for unnecessary medications (Resident 2) and two final sampled residents (Residents 5 and 54) were free from the unnecessary psychotropic drugs (any drug that affects brain activity associated with mental processes and behavior). * The facility failed to ensure Resident 2's orthostatic blood pressure (measure the blood pressure while laying, sitting and standing) was monitored as ordered by the physician related to the use of the antipsychotic medication. * Resident 5's mirtazapine (antipsychotic medication) medication dose was increased. The facility failed to ensure the physician assessed and evaluated Resident 5 prior to increasing the dose of the medication and failed to document the reason for the increased dose of the medication. In addition, the facility failed to ensure Resident 5's monthly behavior summary was completed for the use of mirtazapine medication. * The facility failed to ensure Resident 54's monthly behavior summary was completed for the use of the mirtazapine medication. These failures had the potential to place the residents at risk of receiving unnecessary medications and increased risk of serious medication adverse reactions. Findings: Review of the facility's P&P titled Use of Psychotropic Medication revised 3/17/25, showed the psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team. 1. Medical record review for Resident 5 was initiated on 12/10/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 2/13/25, showed Resident 5 could make needs known but could not make medical decisions. Review of Resident 5's MAR for the month of November 2025 showed a physician's order dated 7/30/25, to administer mirtazapine15 mg one tablet by mouth at bedtime for depression manifested by poor oral intake less than 50% of meal and was discontinued on 12/3/25. Review of Resident 5's Psychiatric Progress Note dated 11/12/25, showed Resident 5 had a diagnosis of depression. Review of Resident 5's Order Summary Report for December 2025 showed the following physician's orders: - dated 12/10/25, to administer mirtazapine 30 mg one tablet by mouth at bedtime for depression manifested by poor oral intake. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/3/25, to monitor for depression manifested by poor oral intake of less than 50% with meals. Further review of Resident 5's medical record failed to show documented evidence of the physician's evaluation and assessment of Resident 5 prior to the increased dosage of the mirtazapine medication. Review of Resident 5's Monitor Record for November and December 2025 showed the resident's recorded meal percentage intake. However, further review of Resident 5's medical record failed to show documented evidence of the summary for the total number of episodes the resident had less than 50% of the meals. On 12/11/25 at 1039 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 verified Resident 5's physician's order for the mirtazapine medication dose was increased from 15 mg to 30 mg. When RN 1 was asked if the physician assessed and evaluated Resident 5 before increasing the dosage of the mirtazapine medication, RN 1 stated yes. However, RN 1 was unable to show documentation of the physician's evaluation/assessment. In addition, RN 1 verified there was no monthly behavior summary for the monitoring of Resident 5 behavior of consuming less than 50% of meals. 2. Medical record review for Resident 2 was initiated on 12/10/25. Resident 2 was admitted to the facility on [DATE]. Review of the Order Summary Report dated 12/11/25, showed the following physician's orders: - dated 4/18/25, to administer Zoloft 50 mg (antidepressant medication) one tablet by mouth one time a day for depression manifested by verbalization of feeling depressed. - dated 10/22/25, to administer Zyprexa 2.5 mg (antipsychotic medication) one tablet by mouth in the morning for psychosis manifested by yelling for no apparent reason. - dated 4/25/25, to administer Zyprexa 5 mg (antipsychotic medication) one tablet by mouth at bedtime for psychosis manifested by yelling for no apparent reason. - dated 5/29/25, to administer clonazepam 0.5 mg (antianxiety medication) one and half tablet by mouth one time a day for anxiety manifested by verbalization of anxiousness. - dated 5/5/25, to check for the orthostatic hypotension by checking the blood pressure in three positions (sitting, standing and lying) once a day every Monday related to the use of the psychotropic medications. Review of the Resident 2's Monitor Record for October, November, and December 2025 showed the orthostatic blood pressures (sitting, standing and lying) were scheduled to be monitored every Monday. However, the blood pressure readings for the three positions (sitting, standing and lying) were the same data readings as follows: - On 10/6/25, the blood pressure readings were 126/74 mmHg for the sitting, standing and lying position. - On 10/27/25, the blood pressure readings were 126/72 mmHg for the sitting, standing and lying position. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 11/3/25, the blood pressure readings were 124/68 mmHg for the sitting, standing and lying position. - On 11/10/25, the blood pressure readings were 121/61 mmHg for the sitting, standing and lying position. - On 11/17/25, the blood pressure readings were 118/70 mmHg for the sitting, standing and lying position. - On 11/24/25, the blood pressure readings were 126/64 mmHg for the sitting, standing and lying position. - On 12/1/25, the blood pressure readings were 124/76 mmHg for the sitting, standing and lying position. - On 12/8/25, the blood pressure readings were 125/73 mmHg for the sitting, standing and lying position. On 12/11/25 at 1059 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 verified Resident 2's physician's order for the psychotropic medication uses and the monitoring of the orthostatic hypotension. RN 1 was informed about the blood pressure readings and verified the findings. On 12/11/25 at 1345 hours, an interview and concurrent medical record review for Residents 2 and 5 was conducted with the DON. The DON was informed and verified the above findings. 3. Medical record review for Resident 54 was initiated on 12/9/25. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's Order Summary Report showed the following physician's orders dated: - On 10/29/25, to administer mirtazapine 7.5 mg one tablet by mouth at bedtime for depression manifested by poor oral intake; and - On 10/29/25, to monitor depression manifested by poor oral intake less than 50% with meals. Review of Resident 54's MAR for November and December 2025 showed Resident 54 was administered the mirtazapine medication from 11/1 to 12/10/25 at 2100 hours. Review of Resident 54's Monitoring Record for November and December 2025 showed Resident 54 had less than 50% meal intake on the following meals: - 40% meal intake on 11/19/ at 1000 hours; - 25% meal intake on 11/16/25 at 1800 hours; - 40% meal intake on 11/22/25 at 1800 hours; - 40% meal intake on 12/4/25 at 1800 hours; and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 30% meal intake on 12/9/25 at 1000 hours. However, further review of Resident 54's medical record failed to show a monthly behavior summary was completed for November 2025 related to the use of the mirtazapine medication. On 12/11/25 at 0947 hours, an interview and concurrent medical record review for Resident 54 was conducted with RN 1. When asked what the licensed nurses considered as poor intake, RN 1 stated poor intake was when a resident consumed less than 50% of the meal tray. RN 1 stated Resident 54's meal intake was documented by the CNAs under the Task Documentation, and by the LVNs under the Monitor Record. RN 1 verified the documentation of Resident 54's meal intake as documented by the CNAs and LVNs did not match. When asked what the facility should do when Resident 54 consumed less than 50% of his meal tray, the RN 1 stated the licensed nurses, or the CNAs would offer a supplement or an alternative meal. When asked about the monthly behavior summary for the mirtazapine medication monitoring, RN 1 verified the monthly behavior summary related to the use of the mirtazapine medication for Resident 54 was not completed. RN 1 stated the physicians, and the pharmacist accessed the Task Documentation if they wanted to check Resident 54's meal intake, but if they asked for the behavior summary, the physicians and the pharmacist accessed the Monitor Record documentation. On 12/12/25 at 1229 hours, an interview and medical record review for Resident 54 was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated ideally the CNA documentation of Resident 54's meal intake should be followed. The DON stated she used the CNA documentation of the resident's meal intake during the behavior management meeting for Resident 54.

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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 interview, medical record review, and the facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for two of 19 final sampled residents (Residents 35 and 76) and one nonsampled resident (Resident 81). * The facility failed to develop a comprehensive care plan to address Resident 35's fall on 12/9/25, to include interventions aimed to prevent future incident of falls. * The facility failed to develop a comprehensive care plan problem to address Resident 76's bed against the wall. * The facility failed to develop a comprehensive care plan problem to address Resident 81's fluid restrictions. These failures posed the risk of not providing appropriate, consistent, and individualized care to these residents.Findings: Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed the comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. The P&P further showed residents' care plans were to be developed for each resident that reflected the resident's needs and preferences. 1. Medical record review for Resident 81 was initiated on 12/10/25. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's Order Summary Report for December 2025 showed a physician's order dated 11/26/25, for fluid restrictions of 1500 ml per day; nursing total equal to 660 ml and dietary total equal to 840 ml. Review of Resident 81's comprehensive care plans failed to show an individualized care plan problem was developed to address Resident 81's fluid restrictions. On 12/11/25 at 1106 hours, an interview and concurrent medical record review for Resident 81 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified there was no care problem to address Resident 81's fluid restrictions. RN 1 stated there should be care plan problems specific to Resident 81's fluid restriction. On 12/11/25 at 1345 hours, an interview and concurrent medical record review for Resident 81 was conducted with the DON. The DON was informed and verified the above findings. Cross Reference to F692, example number # 2. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 35 was initiated on 12/9/25. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's eInteract Change of Condition Evaluation – V5.1 dated 12/9/25, showed Resident 35 was in the activity room when the resident lost balance and fell onto the floor. Review of Resident 35's plan of care showed a care plan problem initiated on 12/9/25, to address Resident 35's fall on 12/9/25. The interventions included reminding Resident 35 to use his call light for assistance whenever possible and reminding Resident 35 to ask for assistance when he needed assistance outside of his room. No other interventions were documented. On 12/11/25 at 1023 hours, an interview and concurrent medical record review for Resident 35 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified there were only two interventions included on Resident 35's care plan problem to address Resident 35's fall on 12/9/25. RN 1 stated the care plan should be comprehensive and individualized. On 12/11/25 at 1220 hours, an interview and concurrent medical record review for Resident 35 was conducted with the DON. The DON was informed and verified the above findings. 3. On 12/9/25 at 1445 hours, Resident 76 was observed in bed. Resident 76's bed was observed against the wall. Medical record review for Resident 76 was initiated on 12/9/25. Resident 76 was admitted to the facility on [DATE]. Review of Resident 76's H&P examination dated 9/28/25, showed Resident 76's diagnoses included dementia, psychosis, anxiety, and history of falls. Further review of Resident 76's medical record failed to show a care plan problem was developed to address the resident's bed against the wall. On 12/11/25 at 1406 hours, an interview was conducted with CNA 7. When asked about Resident 76's bed against the wall, CNA 7 stated she did not know why Resident 76's bed was against the wall. CNA 7 stated Resident 76 could get out of her bed independently. On 12/12/25 at 1050 hours, Resident 76 was observed in bed with her bed against the wall. On 12/12/25, at 1230 hours, an interview was conducted with RN 1. When asked about Resident 76's bed against the wall, RN 1 stated this was the first time RN 1 noticed Resident 76's bed was against the wall. RN 1 stated she did not know how Resident 76's bed got against the wall. RN 1 verified Resident 76's plan of care did not include a care plan problem to address Resident 76's bed against the wall.

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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, facility document review, and facility P&P review, the facility failed to ensure the nutritional interventions were followed for one nonsampled resident (Resident 81) reviewed for nutrition. * The facility failed to ensure the physician's order for fluid restriction was followed and documented properly for Resident 81. This failure had the potential to negatively affect the resident's health and well-being. Findings: On 12/9/25 at 0910 hours, during the initial tour of the facility, Resident 81 was observed in bed awake. A posted signage for fluid restriction on the wall of Resident 81's head of bed was observed. A water pitcher and a half full bottle of colored drink were observed on top of the over the bed table. Medical record review for Resident 81 was initiated on 12/10/25. Resident 81 was admitted to the facility on [DATE]. a. Review of Resident 81's Order Summary Report for December 2025 showed a physician's order dated 11/26/25, for fluid restrictions of 1500 ml per day: nursing to provide a total 660 ml (7 AM to 3 PM shift to provide 270 ml, 3 PM to 11 PM shift to provide 270 ml and 11 PM to 7 AM shift to provide 120 ml) of fluids and dietary to provide a total 840 ml (breakfast: 360 ml, lunch: 240 ml, and dinner: 240 ml) of fluids per day for a total of 1500 ml. On 12/10/25 at 1506 hours, an interview for Resident 81 was conducted with CNA 4. CNA 4 stated Resident 81 ate independently and drank a lot of water. CNA 4 stated she refilled Resident 81's water pitcher. CNA 4 was asked about the posted signage for the fluid restriction in Resident 81's bedroom. CNA 4 stated she was not aware Resident 81 was on fluid restriction. CNA 4 verified and acknowledged there were a lot of fluid containers and water pitchers on Resident 81's table. On 12/10/25 at 1520 hours, an observation and concurrent interview was conducted with LVN 8 at Resident 81's bedside. LVN 8 verified the posted signage for fluid restriction in Resident 81's bedroom. LVN 8 stated she was not aware of Resident 81's fluid restrictions. LVN 8 verified and acknowledged there were a lot of fluids and water pitcher containers on Resident 81's table. On 12/11/25 at 0805 hours, an observation and concurrent interview was conducted with Resident 81. Resident 81 was observed in bed eating breakfast. Resident 81 was asked about the posted signage on the wall for the fluid restriction. Resident 81 stated she was told that she could not have a water pitcher on her table. When asked if she was aware of how much fluid she could have, Resident 81 stated she was not aware of how much fluid she could drink but stated she could ask anytime if she wanted to have water from the facility staff. Resident 81 was asked why she needed to limit her fluid intake, she stated her legs would swell up if she had too many fluids. b. Review of Resident 81's Monitor Record for the months of November and December 2025 showed the inaccurate documentation of the licensed nurses record for the amount of fluids given to Resident 81 every shift, for example: - On 11/27/25, Resident 81 was provided 870 ml of fluids for the 7 AM to 3 PM shift, 180 ml of fluids for the 3 PM to 11 PM shift and 120 ml of fluids for the 11 PM to 7 AM shift, for a total of 1,170 ml. The total amount of fluids limit for the nursing department to provide was 660 ml per the physician's order. The 1,170 ml amount of fluid was almost double the amount of fluid allotted for nursing staff to (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide. Review of Resident 81's Nutrition – Amount Eaten for 11/27/25, showed a total of 260 ml of fluids were provided for breakfast, lunch, and dinner. The physician's order was for the dietary department to provide a total of 840 ml of fluids per day. On 12/11/25 at 1106 hours, an interview and concurrent medical record review for Resident 81 was conducted with RN 1. RN 1 verified Resident 81 had a physician's order for fluid restriction. RN 1 stated the fluid should be monitored to follow the physician's order for the fluid restriction and documented properly. RN 1 showed the amount of fluids in the recorded log documented by the CNAs and stated the amount was the total for a 24-hour period. RN 1 verified the amount entered for the fluid intake was inaccurate due to the amount not meeting the total fluids required for the resident. On 12/11/25 at 1345 hours, an interview and concurrent medical record review for Resident 81 was conducted with the DON. The DON was informed and verified the above findings. Cross Reference to F 656, example number 1.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 two final sampled residents (Residents 38 and 78) investigated for respiratory status were provided with the appropriate respiratory care and services. * The facility failed to ensure Resident 38 had a physician's order for the resident's oxygen use. * Resident 78's nasal cannula was observed on the floor, and undated. In addition, the resident's nebulizer mask and tubing were observed on top of the drawer, uncovered. These failures had the potential to affect the respiratory health and well-being of the residents in the facility.Findings: Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed to verify there is a physician's order for this procedure and review the physician's order or facility protocol for oxygen administration. The facility staff shall change the oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. 1. On 12/9/25 at 0900 hours and 0959 hours, during the initial tour of the facility, Resident 78 was observed on her bed. Resident 78 was observed receiving oxygen at two liters per minute via nasal cannula, which was attached to an oxygen machine. Resident 78's oxygen nasal cannula tubing was observed unlabeled, undated, and touching the floor. In addition, the nebulizer mask and tubing were placed on top of the bedside drawer uncovered. Medical record review for Resident 78 was initiated on 12/10/25. Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's Order Summary Report dated 12/10/25, showed the following physician's orders: - dated 3/25/25, to administer ipratropium-albuterol (breathing treatment medication) inhalation solution 0.5 to 2.5 (3) mg/3 ml, inhale orally at bedtime for shortness of breath; - dated 10/11/25, to change the oxygen nasal cannula weekly on Saturday every night shift; and - dated 12/9/25, to administer oxygen at two liters per minute via nasal cannula, to maintain the oxygen saturation greater or equal to 92%. On 12/9/25 at 0959 hours, an observation, interview, and concurrent medical record review for Resident 78 was conducted with LVN 7. LVN 7 verified Resident 78's oxygen nasal cannula tubing was unlabeled, undated, and touching the floor. In addition, LVN 7 verified the nebulizer mask and tubing were placed on top of the bedside drawer uncovered. LVN 7 stated the oxygen nasal cannula tubing should be dated, labeled with the resident's name, changed routinely every Saturday, and not touching the floor. LVN 7 further stated the nebulizer mask and tubing should have been placed inside the clear plastic bag when not in use. On 12/11/25 at 1056 hours, an interview and concurrent medical record review for Resident 78 was conducted with RN 1. RN 1 verified the physician's order for Resident 78's use of oxygen and breathing treatment medication. RN 1 was informed of the above findings. RN 1 stated the oxygen tubing was changed on a weekly basis and labeled with the date and resident's name. In addition, RN 1 stated the nebulizer tubing and mask were labeled and placed in a clear plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 1 verified the above findings. On 12/11/25 at 1345 hours, an interview for Resident 78 was conducted with the DON. The DON was informed and verified the above findings. 2. On 12/9/25, at 0918 hours, Resident 38 was observed receiving oxygen via nasal cannula. The oxygen concentrator was observed set at three liters per minute. Medical record review for Resident 38 was initiated on 12/9/25. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's H&P examination dated 11/3/25, showed Resident 38's had the capacity to understand and make decisions. Further review of Resident 38's medical record failed to show a physician's order for Resident 38's use of oxygen. On 12/12/25 at 0926 hours, an observation and concurrent interview was conducted with Resident 38. When asked about his oxygen, Resident 38 stated he used his oxygen on a long-term basis to help him breathe. Resident 38 stated he was diagnosed with COPD. When asked if he knew how many liters of oxygen he was administered, Resident 38 stated he did not know. On 12/12/25 at 927 hours, an interview and concurrent medical record review was conducted with LVN 8. When asked about Resident 38's oxygen use, LVN 8 verified Resident 38 did not have a physician's order for Resident 38's oxygen use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medication label review, facility P&P review, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.69%. Two of three licensed nurses (LVNs 1 and 3) who were observed during medication administration were found to have errors. * LVN 1 failed to ensure Macrobid (urinary antibiotic) medication was administered to Resident 77 with food and not crushed. * LVN 3 failed to ensure ursodiol (gastrointestinal agent) medication was administered to Resident 47 with food. These failures created the risk for the residents to have potential side effects or complications related to the medications. Findings: 1. Review of the FDA label dated 2021 for Macrobid showed the following:- Each Macrobid capsule contains two forms of nitrofurantoin, 25% is macrocrystalline nitrofurantoin, which has slower dissolution and absorption than nitrofurantoin monohydrate. The remaining 75% is nitrofurantoin monohydrate contained in a powder bled which, upon exposure to gastric and intestinal fluid, forms a gel matrix that releases nitrofurantoin over time; and- To take Macrobid with food (ideally breakfast and dinner) to further enhance tolerance and improve drug absorption. Review of the facility's P&P titled Crushed Medication revised 12/19/22, showed the medications shall be crushed in accordance with standards of practice for safety and accuracy in medication administration On 12/10/25 at 1008 hours, a medication administration observation for Resident 77 was conducted with LVN 1. LVN 1 prepared one capsule of Macrobid 100 mg medication. The medication label on the bubble pack for Macrobid showed to Take medication with food. LVN 1 was observed opening the Macrobid capsule, placing it in a small clear pouch, crushing the medication, and mixing it with an apple sauce. On 12/10/25 at 1011 hours, Resident 77 was observed sitting in bed. There was no meal tray or food items at bedside. LVN 1 was observed administering the crushed Macrobid medication to Resident 77 without any food, nor asking Resident 77 if she had eaten. Medical record review for Resident 77 was initiated on 12/10/25. Resident 75 was readmitted to the facility on [DATE]. Review Resident 77's Order Summary Report showed the following physician's orders dated:- On 6/3/25, to crush all crushable medication. - On 12/8/25, to administer Macrobid 100 mg one capsule by mouth two times a day. On 12/10/25 at 1057 hours, an interview and concurrent medical record review for Resident 77 was conducted with LVN 1. LVN 1 verified she crushed the Macrobid medication and administered it to Resident 77 without food. When asked about crushing the Macrobid medication, LVN 1 stated there was a physician's order to crush all crushable medications. When asked if Macrobid medication was a crushable medication, LVN 1 stated she did not get any information the Macrobid medication should not be crushed. When asked about giving the Macrobid medication without food, LVN 1 stated the order did not say to give the medication with food. LVN 1 was shown the bubble pack for the Macrobid medication showing to take the medication with food. LVN 1 stated Resident 77 had breakfast at 0800 hours. 2. Review of the FDA label revised 6/2013 for ursodiol (medication used to treat certain liver and gallbladder conditions) showed the recommended adult dosage and to administer with food. On 12/9/25 at 1638 hours, a medication administration observation for Resident 47 was conducted with LVN 3. LVN 3 prepared the medications including one capsule of ursodiol 300 mg. The medication label on the bubble pack for the ursodiol medication showed to take medication with food. On 12/9/25 at 1648 hours, Resident 47 was observed sitting in bed. There was no meal tray or food items at bedside. LVN 3 was observed administering the medications including the ursodiol medication to Resident 4 without any food, nor asking Resident 47 if she had eaten. On 12/9/25 at 1652 hours, an interview and concurrent medical record review for Resident 47 was conducted with LVN 3. LVN 3 verified he administered the ursodiol medication to Resident 47 without food. LVN 1 verified the physician's order and the bubble pack for the ursodiol medication showed to take the medication with food. Medical record review for Resident 47 was initiated on 12/10/25. Resident 75 was admitted to the facility on [DATE]. Review Resident 47's (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order Summary Report showed a physician's order dated 10/7/25, to administer ursodiol 300 mg one capsule by mouth with meals. On 12/12/25 at 1245 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the nurses should be aware of the crushable and non-crushable medications, and the medications to be given with food.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 one nonsampled resident (Resident 77) was free from significant medication error. * The facility failed to ensure the Macrobid (urinary antibiotic) medication was administered to Resident 77 with food and the medication was not crushed. This failure placed Resident 77 at risk for significant side effects and medical complications. Findings: Review of the FDA label dated 2021 for the Macrobid medication showed the following:- Each Macrobid capsule contains two forms of nitrofurantoin, 25% is macrocrystalline nitrofurantoin, which has slower dissolution and absorption than nitrofurantoin monohydrate. The remaining 75% is nitrofurantoin monohydrate contained in a powder bled which, upon exposure to gastric and intestinal fluid, forms a gel matrix that releases nitrofurantoin over time;- To take Macrobid with food (ideally breakfast and dinner) to further enhance tolerance and improve drug absorption. Review of the facility's P&P titled Crushed Medication revised 12/19/22, showed medications shall be crushed in accordance with standards of practice for safety and accuracy in medication administration On 12/10/25 at 1008 hours, a medication administration observation for Resident 77 was conducted with LVN 1. LVN 1 prepared one capsule of Macrobid 100 mg. The medication label on the bubble pack for Macrobid showed to Take medication with food. LVN 1 was observed opening the Macrobid capsule, placing it in a small clear pouch, crushing the medication, and mixing it with an apple sauce. On 12/10/25 at 1011 hours, Resident 77 was observed sitting in bed. There was no meal tray or food items at bedside. LVN 1 was observed administering the crushed Macrobid medication to Resident 77 without any food, nor asking Resident 77 if she had eaten. Medical record review for Resident 77 was initiated on 12/10/25. Resident 77 was readmitted to the facility on [DATE]. Review Resident 77's Order Summary Report showed the following physician's orders dated:- On 6/3/25, to crush all crushable medication; and- On 12/8/25, to administer Macrobid 100 mg one capsule by mouth two times a day. Review of Resident 77's MAR for December 2025 showed Resident 77 was administered the Macrobid medication on 12/9/25 at 0900 and 2100 hours, and 12/10/25 at 0900 hours. On 12/10/25 at 1057 hours, an interview and medical record review for Resident 77 was conducted with LVN 1. LVN 1 verified she crushed the Macrobid medication and administered it to Resident 77 without food. On 12/10/25 at 1609 hours, a follow-up interview for Resident 77 was conducted with LVN 1. LVN 1 stated she had been crushing the Macrobid medication when administering the medication to Resident 77 because the resident cannot take whole pills. When asked what was done after administering the crushed Macrobid medication to Resident 77 without food, LVN 1 stated she would talk to the pharmacy consultant. LVN 1 stated she was monitoring Resident 77 for the side effects of the Macrobid medication. On 12/11/25 at 1639 hours, a telephone interview for Resident 77 was conducted with the Pharmacy Consultant. The Pharmacy Consultant stated the Macrobid medication should not be crushed and should be given to Resident 77 with food. The Pharmacy Consultant stated the nurses should know what crushable medications were, and if a resident who could not swallow whole pills was prescribed with a medication that could not be crushed, they should inform the prescribing physician and the pharmacy as well. On 12/12/25 at 1245 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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. Based on observation, interview, and facility P&P review, the facility failed to ensure the staff implemented the proper storage, labeling, and disposal of medications in a safe manner. * The facility failed to dispose of the expired medications in Medication Room A. * The facility failed to dispose of the expired medications inside Treatment Cart A. * The facility failed to ensure Medication Cart B was not left unlocked and unattended. These failures had potential to result in unsafe medication administration, cross-contamination of the medications, and posed the risk for non-licensed staff to have access to the medications.Findings: Review of the facility's P&P titled Medication Storage dated 12/19/22, showed the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with facility policy. 1. On 12/10/25 at 0955 hours, an inspection of Medication Room A medication refrigerator was conducted with LVN 4. The following was observed: - one opened vial of acetylcysteine 20 % (cough medication) inhalation vial, no open date and with a label to discard 96 hours after opening. - one opened vial of tuberculin PPD (skin test for Tuberculosis) with an open date of 11/8/25. Per label, discard after 30 days from opening date. - one medication incinerator bin was open, with multiple whole oral meds, not dissolved. LVN 4 verified the above findings. 2. On 12/10/25 at 1417 hours, an inspection of Treatment Cart A was conducted with LVN 6, the following was observed: - One bottle of nystatin powder (antifungal medication) with an open date of 11/2/25, and with a label to discard after 14 days of opening. LVN 6 verified the finding. On 12/11/25 at 1448 hours, an interview was conducted with the DON. The DON was informed and verified the findings. 3. On 12/9/25 at 1613 hours, LVN 11 was observed in front of Medication Cart B preparing the glucometer (a machine to test blood sugar level) machine. LVN 11 was then observed going inside a resident's room, and closed the resident's door. Medication Cart B parked facing the hallway was observed to be unlocked and unattended. Staff were observed passing by. On 12/9/25 at 1617 hours, an observation of Medication Cart B and concurrent interview was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with LVN 11. LVN 11 was observed coming out of the room. LVN 11 verified he left Medication Cart B unlocked and unattended. On 12/9/25 at 1245 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **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 personal food policy for one of 19 final sampled residents (Resident 76) was followed. * Resident 76 had a personal ice chest observed soiled and with food items inside. This failure posed the resident at risk of storing the food items which may cause food borne illnesses.Findings: On 12/09/2025 at 1445 hours, an observation and concurrent interview was conducted with Resident 76. CNA 7 was also present in the room. A purple ice chest was observed inside Resident 76's room. The ice chest was observed with brownish and yellowish stains scattered inside the ice chest, and contained two bananas and two melted ice packs. The findings were verified with CNA 7. When asked about the cleaning of the ice chest, CNA 7 acknowledged the staff were responsible for cleaning it. CNA 7 stated the ice chest had only been inside Resident 76's room one day. However, Resident 76 stated the ice chest had been in her room for a while. On 12/11/2025 at 1026 hours, a telephone interview was conducted with Resident 76's Responsible Party. When asked about the purple ice chest inside Resident 76's room, the responsible party stated it was brought to Resident 76's room about one month ago. Medical record for Resident 76 was initiated on 12/9/25. Resident 76 was admitted to the facility on [DATE]. Review of Resident 76's H&P examination dated 9/28/25, showed Resident 76 had the capacity to understand. Review of Resident 76's Personal Inventory Update and Resident Clothing and Possessions inventory dated 9/25 and 10/3/25, failed to show the ice chest was included in the inventory lists. On 12/12/25 at 1230 hours, an interview was conducted with RN 1. When asked about Resident 76's personal ice chest, RN 1 stated the family brought in the ice chest. According to RN 1, Resident 76's family member was aware the facility had a refrigerator to store all the perishable foods for three days or until expiration date. RN 1 verbalized Resident 76's family member was educated about the facility's policy to check with the nursing staff prior to bringing food items for the resident. RN 1 was informed the ice chest was not included in Resident 76's inventory list and the ice chest was soiled with stains.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to conduct a regular bed inspection as part of a regular maintenance program to identify areas of possible entrapment for one of five residents (Resident 12) reviewed for side rails. * Resident 12's medical record failed to show documented evidence the entrapment assessment was conducted prior to the use of side rails. This failure had the potential to negatively impact the resident resulting in possible entrapment, serious injuries, and death.Findings: On 12/9/25 at 0937 hours, during the initial tour of the facility, Resident 12 was observed lying in bed, with the bilateral 1/4 (quarter) side rails elevated. Resident 12 was observed holding on to the right 1/4 (quarter) side rail while being changed by CNA 1. Medical record review for Resident 12 was initiated on 12/9/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's MDS dated [DATE], showed Resident 12 required partial/moderate to substantial/maximal assistance from staff member for bed mobility. Review of Resident 12's H&P examination dated 9/19/25, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Order Summary Report showed a physician's order dated 10/28/25, for bilateral 1/4 side rails for bed mobility and enabler use. Further review of Resident 12's medical record failed to show documented evidence the entrapment assessment was conducted prior to the use of side rails for Resident 12. On 12/12/25 at 0853 hours, an interview and concurrent medical record review for Resident 12 was conducted with RN 2. RN 2 stated he was not familiar with the zones of entrapment, but the maintenance department measured and checked the beds. On 12/12/25 at 1048 hours, an interview and concurrent facility document review for Resident 12 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the monthly bed inspection in the facility and installation of the side rails. The Maintenance Director stated the DON would inform him if the side rails were needed to be installed, and the maintenance staff installed the side rails. When asked about the entrapment assessment, the Maintenance Director stated he was familiar with the different zones of entrapment and performed the entrapment assessment prior to the use of side rails, and quarterly as part of the monthly bed inspection. The Maintenance Director verified there was no documentation the entrapment assessment was conducted prior to Resident 12's use of the bilateral 1/4 side rails.

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	12/12/2025

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

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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 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 interview, medical record review, and facility document review, the facility failed to ensure the MDS assessment contained accurate resident information for one of 19 final sampled residents (Resident 59). * The facility failed to ensure the accurate height and weight measurements were documented on Resident 59's MDS assessment. This failure had the potential for resident not to have an individualized plan of care for the resident's needs. Findings: Medical record review for Resident 59 was initiated on 12/10/25. Resident 59 was admitted to the facility on [DATE]. Review of Resident 59's Mini Nutritional assessment dated [DATE], showed the resident's height of 73 inches and weight of 169 lbs. Review of Resident 59's progress note dated 10/10/25, showed the Dietary Supervisor documented the resident's height was 73 inches and weight was 169 lbs. However, review of Resident 59's admission MDS assessment dated [DATE], showed the resident's height was 61 inches and weight as 86 lbs. On 12/10/25 at 1133 hours, an interview and concurrent medical record review was conducted with the MDS Nurse. The MDS Nurse verified the Resident 56's admission MDS assessment under section K dated 10/13/25, showed the resident's height was 61 inches and weight was 86 lbs. The MDS Nurse stated the documentation for the resident's height and weight was not accurate. The MDS Nurse stated he did not know where the incorrect height and weight came from, but the correct height and weight should have been documented on the MDS assessment. On 12/11/25 at 1132 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated she was not aware the resident's height and weight documentation on the admission MDS assessment was inaccurate for Resident 59. RN 1 verified the documented height of 61 inches and weight of 86 lbs. were in accurate and did not match the right height and weight documented in Resident 59's medical record. RN 1 further stated the MDS staff had to make sure the height and weight were documented accurately. On 12/12/2025 at 1350 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555536	A. Building B. Wing	12/12/2025

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

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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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interview, medical record review, and facility P&P review, the facility failed to revise the comprehensive care plan for one of 19 final sampled residents (Resident 11). * The facility failed to revise the comprehensive care plan to reflect Resident 11's use of temazepam (used to help promote sleep) medication from PRN to routine administration. This failure posed the risk of Resident 11 not receiving the appropriate care and treatment.Findings: Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed in part, it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in resident's comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Medical record review for Resident 11 was conducted on 12/10/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Order Summary Report dated 12/11/25, showed a physician's order dated 10/14/25, to administer temazepam oral capsule 15 mg, give one capsule by mouth at bedtime for insomnia (common sleep disorder making it hard to fall asleep, to stay asleep) manifested by inability to sleep. Review of Resident 11's Care Plan Report showed a care plan problem dated 7/31/25, addressing the resident's use of the temazepam medication every 24 hours as needed for insomnia for 14 days manifested by inability to sleep. However, further review of Resident 11's care plan problem for the temazepam medication failed to show the care plan was revised to reflect Resident 11's use of the temazepam medication from PRN to routine administration. On 12/10/25 at 1103 hours, an interview and concurrent medical record review for Resident 11 was conducted with DON. The DON stated the care plan to administer the temazepam medication still reflected the PRN use of the medication, while the current physician's order was to give the medication routinely. The DON verified the resident's care plan was not revised.

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	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 19 final sampled residents (Resident 9) was accurate. * The facility failed to document Resident 9's weight accurately. This failure had the potential for the resident's care needs not being met as their medical information was inaccurate.Findings: Review of the facility's P&P titled Weight Management Policy dated 11/1/24, showed the facility will ensure that all the residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Medical record review for Resident 9 was initiated on 12/10/25. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's recorded weight for October and December 2025 showed the following: - on 10/28/25, Resident 9's weight was 240 lbs.- on 10/31/25 1233 hours, Resident 9's weight was 108 lbs., a 132 lbs. weight loss from 10/28/25.- on 10/31/25 2231 hours, Resident 9's weight was 240 lbs. - on 12/5/25, Resident 9's weight was 230 lbs.- on 12/7/25, Resident 9's weight was 308 lbs., a 78 lbs. weight gain from 12/5/25.- on 12/8/25, Resident 9's weight was 229 lbs. On 12/11/25 at 1013 hours, an interview and concurrent medical record review was conducted with RNA1. RNA 1 stated the RNAs were responsible to obtain the weights of the residents and if there was a three-pound weight gain or weight loss, these changes were reported to the charge nurses or supervisors. RNA 1 further stated he was unable to remember if he weighed Resident 9 on 10/31 or 12/7/25. On 12/11/25 at 1040 hours, an interview and concurrent medical record review was conducted with LVN 9. LVN 9 stated the RNAs weighed the residents and if there were any issues, the RNAs brought it to the licensed nurses' attention. LVN 9 stated Resident 9 weighed herself with the facility staff present. LVN 9 verified the above findings and stated she did not know what happened with the documented weights on 10/31 and 12/7/25. LVN 9 stated the weights was probably documented in kilograms versus into pounds. LVN 9 verified the weights should be accurately documented. On 12/11/25 at 1118 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 9 had her own weighing scale, and if there was a discrepancy, the facility staff would check the weighing scale. RN 1 stated the resident's weight had been stable. RN 1 reviewed Resident 9's weight discrepancies for 10/31 and 12/7/25, and stated the weights recorded for 10/31and 12/7/25, were mistakenly documented. On 12/12/25 at 1350 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.