STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555667	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Park Care Center	12681 Haster Street Garden Grove, CA 92840

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49258 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure themedical records were complete and accurately maintained for two of ten sampled residents (Residents 9 and 10). * Residents 9 and 10's medical records failed to show the monitoring of the residents' locations was completed on 3/9, 3/10, and 3/12/25. These failures had the potential for the residents' care needs to not be met as their medical information was inaccurate and incomplete. Findings: Review of the facility's P&P titled Falling Star Program dated 8/1/18,showed the resident safety committee/interdisciplinary team will determine placement of the residents into the Falling Star Program to reduce the incidence of falls/injury for each resident in the program. Nursing staff will do every hour monitoring as followed and log completion. 1. Medical record review for Resident 9 was initiated on 3/13/25. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had moderate cognitive impairment and needed substantial/maximal assistance with mobility. Review of Resident 9's Order Summary Report showed a physician's order dated 2/19/25, for the resident to be on the falling star program. Review of Resident 9's Care Plan revised on 3/13/25, showed a care plan focus problem addressing Resident 9's high risk for falls. The interventions included the falling star program and to follow facility's fall protocol. Review of Resident 9's Progress Note dated 2/15/25, showed Resident 9 was found on the floor at 1506 hours lying on his left side with head on the blanket. Resident 9 sustained a two centimeters abrasion on top of the head with minimal bleeding. Review of Resident's 9's Falling Star record for March 2025 showed no documented evidence Resident 9 was monitored for the resident's location on the following dates: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/9/25, from 0000 hours to 0300 hours; - 3/10/25, from 0000 hours to 0600 hours; and - 3/12/25, from 0800 hours to 2300 hours. On 3/13/25 at 1330 hours, an observation of Resident 9 and concurrent interview was conducted with FM 1. Resident 9 was observed awake and lying in the bed. There was a pink sign with star and letter A observed posted outside Resident 9's room. FM 1 stated Resident 9 fell last February. On 3/13/25 at 1455 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 9 was confused at times and needed assistance with mobility. CNA 6 stated the facility had the falling star program for residents who were high risk for fall and who fell . CNA 6 stated the CNAs had to check the resident every hour and record in the falling star form the location of the resident. CNA 6 stated they had been doing the monitoring for a long time. CNA 6 stated the falling star record could either be given to the CNA by the nurses at the start of the shift or the outgoing CNAcould pass it to the incoming CNA to continue recording the monitoring of the resident. CNA 6 further stated CNAs would be reminded during the huddle of the residents who were in the falling star program and there was a pink signage with the star and the resident's bed identifier outside the room. CNA 6 verified he worked on 3/12/25. CNA 6 stated he did not fill up the falling star record for his shift on 3/12/25 because he did not receive the form from the charge nurse. CNA 6 stated he checked the resident every hour during his shift on 3/12/25, but did not document it. 2. Medical record review for Resident 10 was initiated on 3/13/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P evaluation dated 1/29/25, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's MDS assessment dated [DATE], showed Resident 10 needed substantial/ maximal assistance with mobility. Review of Resident 10's Order Summary Report showed a physician's order dated 1/30/25, for the falling star program. Review of Resident 10's Care Plan revised on 2/3/25, showed a care plan focus problem addressing Resident 10's high risk for falls. The interventions included the falling star program and to follow facility's fall protocol. Review of Resident 10's Progress Note dated 2/1/25 at 0624 hours, showed Resident 10 was found by the housekeeping sitting on the floor in front of the closet. Resident 10 was observed with discoloration to right side of the forehead without any bleeding or swelling. Review of Resident's 10's Falling Star record for March 2025 showed no documented evidence Resident 10 was monitored for the resident's location on the following dates: - 3/9/25, from 0000 hours to 0300 hours; (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	- 3/10/25, from 0000 hours to 0600 hours; and - 3/12/25, from 0800 hours to 2300 hours. On 3/13/25 at 1405 hours, an observation was conducted with Resident 10. Resident 10 was awake and sitting in the wheelchair inside the room. The pink signage with the star and letter B was observed outside the room of Resident 10. On 3/13/25 at 1425 hours, an interview was conducted with CNA 5. CNA 5 stated Resident 10 could be confused at times and would not follow instructions. CNA 5 stated Resident 10 was in the falling star program. CNA 5 stated when the resident was in the falling star program, she had to check the resident every hour and record the resident's location in the falling star record paper. CNA 5 stated after the shift she would pass it to the next shift's CNA. CNA 5 further stated if she knew the resident was high risk for fall and did not get the form, she would ask the charge nurse for the form. CNA 5 stated she was not assigned to Resident 10 on 3/12/25. CNA 5 verified the missing documentation for monitoring in the Falling Star record for March 2025. CNA 5 stated it could mean the CNA did not check the resident or forgot to fill in the form. On 3/13/25 at 1520 hours, an interview and concurrent facility documentreview was conducted with LVN 3 for Residents 9 and 10. LVN 3 stated the falling star program was implemented for those residents who had a fall incident or who were high risk for fall. LVN 3 stated part of the falling star program was for the CNAs to monitor the resident every hour and to record the resident's location in the falling star paper form. LVN 3 stated the CNA also had to sign their initial in each hour. LVN 3 stated all CNAs were aware of this responsibility. LVN 3 verified the missing monitoring in the falling star records for Resident 9 and 10. LVN 3 further stated if the monitoring was not documented it could mean the CNA did not check the resident or forgot to fill in the form. On 3/14/25 at 1536 hours, an interview was conducted with the DON. The DON stated the falling star program was implemented in 2018 as part of the facility's fall prevention program. The DON stated the falling star program was implemented for those residents who had a fall incident or who were high risk for fall. The DON stated the pink signage with the star and the resident's bed identifier should be posted outside the room of the resident and the CNA will fill in the falling star form. The DON stated the CNAs had to check and record every hour the location of the resident and sign with their initial each hour. The DON further stated if the falling star record was left blank, the CNA did not do the monitoring and the CNA had to be given an in-service training regarding the falling star program. The DON was notified and acknowledged the above findings for Residents 9 and 10.