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	06/26/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of five final sampled residents (Resident 4) attained and maintained their highest practicable well-being. * The facility failed to continuously monitor Resident 4 after the resident had a witnessed fall. This failure had the potential for not providing the necessary care and services if the residents had a change in condition. Findings: Review of the facility's P&P titled Fall Prevention Program revised 12/28/23, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. When any resident experiences a fall, the facility will assess the resident and document all assessments and actions. Medical record review for Resident 4 was initiated on 6/25/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 4/10/25, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 had severe cognitive impairment and needed substantial/maximal assistance with mobility. Review of Resident 4's SBAR Communication Form dated 5/13/25, showed Resident 4 was being wheeled by the CNA to go to the dining area and the wheelchair got stuck in the carpet by the door to the patio which caused Resident 4 to slide off the wheelchair and fall forward. Resident 4 did not hit her head on the ground and did not sustain any injuries. The carpet was taken off the dining room right away. Review of Resident 4's plan of care initiated on 5/13/25, showed a care plan problem addressing Resident 4's fall incident on 5/13/25. The interventions included to monitor Resident 4 for pain or discomfort, vital signs, change in level of consciousness and notify the physician as needed. Further review of Resident 4's medical record failed to show documented evidence of continued monitoring/assessment for Resident 4 by the licensed nurses after the fall incident on 5/13/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1108 hours, an observation and concurrent interview was conducted for Resident 4. Resident 4 was awake and sitting in the wheelchair inside the room. Resident 4 was unable to verbalize anything when asked about the fall incident happened on 5/13/25. Resident 4 was smiling and stated she was ok. On 6/25/25 at 1510 hours, a telephone interview for Resident 4 was conducted with CNA 2. CNA 2 verified the fall incident of Resident 4 on 5/13/25. CNA 2 stated Resident 4 was confused, could not follow the instructions, and was always trying to get out of the wheelchair. CNA 2 stated she was wheeling Resident 4 to the dining room and Resident 4 tried to stand up and because it was too fast, she could not grab Resident 4 right away. CNA 2 stated it was either the wheelchair or Resident 4's feet which got stuck in the door mat. CNA 2 stated everything happened so fast. CNA 2 stated Resident 4 did not hit her head on the ground and the nurse was there and came right away to assist. On 6/25/25 at 1630 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. RN 1 stated she witnessed Resident 4's fall incident on 5/13/25. RN 1 stated the wheelchair in which Resident 4 was seating got stuck in the door mat while being wheeled by CNA 2 in the dining area. RN 1 stated Resident 4 fell forward but did not hit her head on the ground. RN 1 stated a fall incident was considered a change in condition. RN 1 stated for a change in condition, the licensed nurse needed to monitor the resident every shift for 72 hours. RN 1 stated the licensed nurse should monitor the resident who had a fall for any changes in the resident's condition, vital signs, pain, and level of consciousness. RN 1 further stated it was important to continuously monitor the resident when there was a change in condition because based on the assessment, they could provide the proper care to the resident and would be able to notify the physician of any changes. RN 1 verified Resident 4 was not continuously monitored on 5/14 and 5/15/25 after Resident 4 fell on 5/13/25. On 6/26/25 at 1634 hours, an interview was conducted with the DON. The DON stated for any change in condition, the licensed nurses had to monitor the resident every shift for 72 hours for any changes in the mental status, vital signs, pain or discomfort, and skin. The DON further stated the importance of monitoring the resident continuously after a change in condition like fall was to assess right away if there were any changes in the resident's status, to be able to report to the physician, and to provide the necessary care to the resident. The DON was notified and acknowledged the above findings.