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	09/22/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to thoroughly investigate an allegation of facility staff to resident physical abuse for one of three sampled residents (Resident 1) when * Resident 1 alleged that her caregiver (CNA) physically abused her. The facility staff tasked with conducting potential resident witness interviews, failed to provide the facility's Abuse Coordinator with an interview conducted with Resident 1's roommate (Resident 2), who was present during the time Resident 1 alleged to have been physically abused. This failure potentially inhibited the facility's ability to determine if resident abuse occurred and posed the risk for further abuse. Findings: Review of the facility's P&P titled Abuse, Neglect and Exploitation revised 12/19/22, showed it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation occurs. Procedures for investigations include identifying and interviewing all involved people, including the alleged victim, alleged perpetrator, and witnesses who might have knowledge of the allegation. Medical record review for Resident 1 was initiated on 9/17/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderately impaired cognition. On 9/17/25 at 1550 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed in her room lying in her bed. Resident 1 stated approximately two weeks ago, on the night shift, her caregiver slapped her on the face, choked her, and squeezed her hands, resulting in pain to her hands. Resident 1 described the caregiver as being a female with blonde hair. Resident 1 stated she reported the incident to the facility staff. Resident 1 stated her roommate (Resident 2) was present during the incident. Medical record review for Resident 2 was initiated on 9/17/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 had moderately impaired cognition. On 9/17/25 at 1600 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed in her room lying on her bed. Resident 2 was asked if she witnessed any person slap or choke her roommate (Resident 1) or squeeze her roommate's hands. Resident 2 stated she had poor vision and had not seen anyone slap or choke Resident 1 or squeeze Resident 1's hands. Resident 2 stated she did hear Resident 1 yelling about being hit. On 9/17/25 at 1738 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator stated he served as the facility's Abuse Coordinator. The Administrator stated the facility conducted an investigation specific to Resident 1's allegation that a facility staff member choked, slapped, and squeezed Resident 1's feet. The Administrator stated the SSD and Social Services Assistant (SSA) conducted interviews of the facility staff and residents during the course of the facility's investigation. The Administrator stated at the conclusion of the facility's investigation, the facility was unable to substantiated Resident 1's allegation. Review of the facility's investigation was then conducted with the Administrator. The facility's investigation failed to show documentation Resident 1's roommate (Resident 2) was interviewed, or an attempt was made to interview Resident 2, specific to Resident 1's allegations. The Administrator verified the findings and stated an interview with Resident 2 should have been included as a component of the facility's investigation. The Administrator stated he had not realized (when reviewing the facility's investigation) Resident 2's interview was not included. The Administrator stated Resident 2 was a potential witness and in accordance with the facility's Abuse P&P, needed to be interviewed. The Administrator stated interviewing potential witnesses would help the facility determine whether abuse may have occurred. On 9/18/25 at 1121 hours, an interview, medical record review, and concurrent facility document review was conducted with the SSD. The SSD stated her assistant, the SSA, conducted the interviews of the Vietnamese speaking residents, specific to the facility's investigation of Resident 1's allegations. The SSD was asked if Resident 2 (Vietnamese speaking) was interviewed during the course of the facility's investigation of Resident 1's allegations. The SSD stated the SSA had interviewed Resident 2, however, the SSD did not provide Resident 2's interview to the Administrator (Abuse Coordinator). The SSD stated she had asked the MDS Coordinator if Resident 2 had the capacity to be interviewed. The SSD stated the MDS Coordinator told her Resident 2 had no capacity. The SSD stated she then placed the SSA's documentation of the interview the SSA conducted with Resident 2 in the facility's shred box. The SSD stated she did not