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	04/28/2026

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 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 interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the appropriate use of restraints including consent, physician's order, skin assessment, removal of restraint, and ROM exercises were provided for one of six sampled residents (Resident 2) reviewed for restraints. * Resident 2 did not have a physician's order, informed consent, assessment, or monitoring for the use of the bilateral soft mittens. In addition, there was no documentation of the mittens removal, and if the hands were assessed and exercised every two hours. These failures had the potential for the increased risk of resident's skin and soft tissue injury as well as the decrease in the ROM functions related to the restraint use.Findings: Review of the facility's P&P titled Restraint Free Environment dated 12/2022 showed the following: The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the residents medical symptoms.Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment question. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraintBehavioral interventions should be used and exhausted prior to the application of a physical restraintA physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint.Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine:How the use of restraints would treat the medical symptom;The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released;The type of direct monitoring and supervision that will be provided during the use of restraint;How the resident will request staff assistance and how his/ her needs will be met while the restraint is in place;How to assist the resident in attaining or maintaining his or her highest practical level of physical and psychosocial well-being. Review of the facilities P&P titled Informed Consent dated 3/2024 showed the following:Prior to initiating the administration of a psychotherapeutic medication or physical restraint or a device, licensed nursing staff shall verify with the resident or surrogate decision maker that he/she has given informed consent for the proposed psychotherapeutic medication or physical restraint or device to the prescriber. Psychotherapeutic medications may not be administered until the informed consent has been verified.Licensed nursing staff shall document either 1) in the order for the psycho therapeutic medication or physical restraint or device, when the order is given by the physician, that the informed consent was obtained by the physician and the name/ or relationship of the individual to the resident giving informed consent, or, 2) on a separate verification form.Initiation of a psychotherapeutic medication or physical restraint without informed consent may be necessary if there is documentation in the residence health record by the license nursing staff that an emergency existed when there was an unanticipated condition in which immediate action was necessary to prevent serious bodily harm or emotional distress to the (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident or others. Informed consent will be obtained within 72 hours of administration of the medication, application of the restraint or use of a device that may lead to the inability to regain use of a normal bodily function by the ordering physician. Medical record review for Resident 2 was initiated on 4/22/26. Resident 2 was readmitted to the facility on [DATE], transferred to an acute care facility on 4/15/26, and returned on the same day. Review of the facility document titled 1500-2200 hours Shift Assignment dated 4/13/26, showed LVN 1 was assigned to Resident 2. Review of Resident 2's MAR dated 4/13/26, showed LVN 1 administered medications to Resident 2 at 2100 hours. Review of Resident 2's Medication Administration Record dated 4/14/26, showed LVN 4 administered medications to Resident 2 at 0900 hours. Review of the facility document titled 0700-1500 hours Shift Assignment dated 4/14 and 4/15/16, showed LVN 4 was assigned to Resident 2. Review of Resident 2's medical record failed to show a signed informed consent, monitoring, assessment, physician's order, care plan, or any documentation addressing the use of soft mitten restraints on bilateral hands. On 4/23/26 at 1050 hours, a telephone interview was conducted with LVN 1. When asked if Resident 2 was observed with hand mittens, LVN 1 stated Resident 2 arrived to the facility with the bilateral hand mittens. When asked if Resident 2 had an informed consent signed for the hand mittens, LVN 1 stated, Not that I'm aware of. When asked if Resident 2's hands and wrists were assessed while he had the mittens on, LVN 1 stated no. On 4/28/26 at 0819 hours, an interview was conducted with LVN 4. When asked if Resident 2 was observed with hand mittens, LVN 4 stated the resident came back to the facility with mittens. LVN 4 further stated that would be considered a restraint, and there were no orders for restraints; therefore, she instructed a CNA to remove the restraints. On 4/28/26 at 0901 hours, an interview was conducted with CNA 1. When asked if he was instructed to the remove mittens from Resident 2's hands, CNA 1 stated, no. When asked if Resident 2 was seen with hand mittens on, CNA 1 stated he had seen the mittens inside Resident 2's closet last week. On 4/28/26 at 1351 hours, an interview was conducted with the DON. The DON stated she was unaware if Resident 2 was admitted with mittens and stated, Absolutely not, we don't do mittens. The DON stated if a resident was admitted with a soft mitten restraints, there should be documentation showing that there were physician's orders, consent, assessments, removal of the restraint every two hours to assess for circulation, and a care plan. On 4/28/26 at 1533 hours, the Administrator and DON acknowledged the above findings.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 prevent or minimize injuries from a fall for three of six sampled residents (Residents 2, 3, and 6) reviewed for falls. * Resident 2 had a history of a fall, however, the care plan for the floor mats were not resident centered for Resident 2's fall. * Resident 3 had a history of falls, however, the facility failed to ensure the 72-hour neurological assessments (assessment of the brain, and nervous system used to detect, manage, and track neurological changes or damage) were conducted completely. In addition, the facility failed to ensure the bilateral floor mats were provided, and the 24-hour orthostatic blood pressures (sudden drop in blood pressure that occurs when standing up) were conducted. * Resident 6 had a history of a fall, however, the facility failed to ensure the 72-hour neurological assessments were conducted completely, and the 72-hour orthostatic blood pressures were conducted as per physician's orders. These failures had the potential to place the residents at risk for injuries.Findings: Review of the facility's P&P titled Documentation in Medical Record revised 12/2022 showed the licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the residence medical record in accordance with state law and facility policy. Review of the facility's P&P titled Care Plan Revisions Upon Status Change dated 12/2022 showed the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Review of the facility's P&P titled Fall Prevention Program revised 12/2023 showed the nurse and/or the interdisciplinary team will initiate inter4ventiosn on the resident's care plan, in accordance with the resident's level of fall risk. Fall interventions include but not limited to:a. Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to:a clear pathway to the bathroom and bedroom doors;bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed;call light and frequently used items are within reach;adequate lighting; andwheelchairs and assistive devices are in good repair;b. Monitor for changes in residence cognition, gait, ability to rise/sit, and balance; andc. Monitor vital signs in accordance with facility policy. 1. Medical record review for Resident 2 was initiated on 4/22/26. Resident 2 was readmitted to the facility on [DATE], transferred to an acute care facility on 4/15/26, and returned on the same day. Review of Resident 2's Nurses Progress Notes dated 4/15/26, showed resident was found with body horizonal to the left side of the bed. Review of Resident 2's Interdisciplinary Care Conference dated 4/15/26, showed Resident 2 had an unwitnessed fall on 4/15/26 at 1230 hours. Further review of the note showed recommendations for a big boy bed, and falling star program. Review of Resident 2's Rehab Screen Progress Notes dated 4/16/26, showed bed lowered to lowest setting recommended. Bedside mats and additional mattress on right side of bed in place. Review of Resident 2's Care Plan Report dated 4/16/26, showed a care plan problem for Resident 2's fall with bump on the left forehead . Further review of the care plan did not show any interventions addressing the bilateral floor mats. On 4/22/26 at 0818 hours, an observation of Resident 2 was conducted. Resident 2 was lying in bed with a fall mattress on the right side of the bed, and floor mat on the left side of the bed. On 4/22/26 at 1105 hours, an observation of Resident 2 was conducted. Resident 2 was lying in bed with a fall mattress on the right side of the bed, and floor mat on the left side of the bed. On 4/28/26 at 1351 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON verified Resident 2 did not have physician's order for floor mats, and there were no care plan interventions addressing the floor mats. The DON stated Resident 2 was not supposed to have the floor mats as a big boy bed was implemented instead. 2. Medical record review for Resident 3 was initiated on 4/22/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/23/26, showed a physician's order dated 8/14/25, for Clopidogrel Bisulfate (antiplatelet medication, acts as a blood thinner) oral tablet one time a day for cerebral vascular accident (stroke) prophylaxis (measures taken to prevent diseases before they occur). a. Review of Resident 3's SBAR Communication Form dated 3/11/26, showed around 0000 hours, the resident was on the floor on the right side of the bed. Resident was noted with a skin tear on the right side of the eye with swelling, resident is on a blood thinner. Review of Resident 3's Care Plan Report dated 3/11/26, showed a care plan problem addressing resident's fall with minor injury. The care plan interventions included obtaining vital signs every shift, take blood pressure lying, sitting, standing times one in the first 24 hours. Review of Resident 3's Neurological Flowsheet dated 3/11/26, showed the following:- at 0000 hours, blood pressure 140/60 mmHg, position: lying;- at 0015 hours, blood pressure 145/72 mmHg, position: lying; - at 0030 hours, blood pressure 136/54 mmHg, position: lying;- at 0045 hours, blood pressure 138/66 mmHg, position: lying;- at 0100 hours, blood pressure 140/66 mmHg, position: lying;- at 0130 hours, blood pressure 139/74 mmHg, position: lying;Further review of the Neurological Flow Sheet showed Resident 3 was transferred to an acute care facility, and vital signs were resumed on 3/11/26 at 1649 hours.- at 1649 hours, blood pressure 123/26 mmHg, position: lying;- at 2000 hours, blood pressure 127/74 mmHg, position: lying; and- at 0000 hours, blood pressure 118/74 mmHg, position: lying b. Review of Resident 3's Change in Condition Progress Note dated 4/11/26, showed the resident was noted lying on the floor on the left side of the bed in supine position. Review of Resident 3's medical record dated 4/11/26, did not show Resident 3's orthostatic blood pressure readings were obtained as care plan interventions. Review of Resident 3's Neurological Flowsheet dated 4/11/26, showed the following blank entries for vital signs, pupil response, motor response, consciousness, speech, and patient response:- 4/11/26 at 1430 hours;- 4/11/26 at 1630 hours;- 4/11/26 at 2030 hours; and- 4/12/26 at 0330 hours c. Review of Resident 3's Order Summary Report dated 4/12/26, showed a physicians order to apply bilateral floor mats to prevent further injury. Review of Resident 3's Interdisciplinary Care Conference dated 4/12/26, showed a fall incident care conference recommendations for low bed with bilateral floor mats. On 4/22/26 at 0827 hours, an observation was made of Resident 3 lying in bed, with one floor mat on the right side of the bed. On 4/23/26 at 0741 hours, an observation was made of Resident 3 lying in bed, with one floor mat on the right side of the bed. On 4/23/26 at 1308 hours, an observation and concurrent interview for Resident 3 was conducted with LVN 4. LVN 4 verified Resident 3 had one floor mat on the right side of the bed, and stated the resident's physician's orders showed bilateral floor mats. On 4/28/26 at 1351 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated Resident 3 was transferred to an acute care facility on 3/11/26 at 0148 hours, and returned on 3/11/26 at 1324 hours (approximately 11 and half hours later). The DON verified Resident 3's care plan for orthostatic blood pressures should have been continued upon return since it was still within the 24-hour time frame, or revised to reflect residents current condition. The DON verified Resident 3 had one floor mat, and stated the resident needed the bilateral floor mats, and verified the neurologic assessments were incomplete. 3. Medical record review for Resident 6 was initiated on 4/23/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's eINTERACT Change in Condition Evaluation dated 4/9/26 at 2315 hours, showed a change in condition for a fall and skin wound. Further review showed the provider notifications recommendations were to keep ice on the forehead, monitor blood pressures for 72 hours, and notify the physician. Review of Resident 6's Nurses Progress Notes dated 4/9/26 at 2315 hours, showed CNA went to answer residents call light but resident already noted sitting on the floor with bump and laceration to the left side of the forehead. Review of Resident 6's MAR dated 4/10/26, showed a physician's order for Orthostatic Hypotension - monitor blood pressure every week: lying, sitting, standing, every shift for three days. Further review of the MAR showed a check mark indicating the task was completed, however, the MAR did not show the orthostatic blood pressure results. Review of Resident 6's Interdisciplinary Care Conference dated 4/10/26, showed a fall incident care conference. The recommendations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed to monitor orthostatic hypotension for 72 hours. Review of Resident 6's Care Plan Report dated 4/10/26, showed a care plan problem addressing Resident 6's fall with bump/laceration to left side of the forehead. The interventions included neurocheck per facility protocol, and to monitor orthostatic blood pressure as ordered. Review of Resident 6's Neurological Flowsheet Dated 4/10/26 showed the following blank entries for vital signs, pupil response, motor response, consciousness, speech, and patient response:- 4/10/26 at 1555 hours;- 4/10/26 at 1955 hours;- 4/10/26 at 2355 hours;- 4/11/26 at 0755 hours; and- 4/11/26 at 2355 hours On 4/23/26 at 1345 hours, interview and concurrent medical record review for Resident 6 was conducted with RN 2. When asked what the check mark indicated in the MAR, RN 2 stated the task was completed. When asked how the facility would monitor the orthostatic blood pressure readings if there were no data for monitoring, RN 2 stated she could not see it. RN 2 verified Resident 6's neurological assessments had blanks and incomplete data, and the orthostatic blood pressure readings were not obtained per order. On 4/28/26 at 1351 hours, the DON verified the above findings. On 4/28/26 at 1533 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.