

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Garden Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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 was accurate for two of three sampled residents (Residents 1 and 2). * The facility failed to ensure Resident 1 and 2's Fall Risk assessment were accurate. These failures posed the risk for the residents to not receive the necessary care and interventions. Findings: Review of the facility's P&P titled Fall Prevention Program revised 4/20/26, 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. Review of the facility's P&P titled Documentation in Medical Record revised 12/19/22, showed each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. Under the Policy Explanation and Compliance Guidelines showed documentation shall be factual, objective, and resident centered. 1. Medical record review for Resident 1 was initiated on 7/21/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1C dated 6/22/26, showed Resident 1 had a fall. However, review of Resident 1's Fall Risk - V4 dated 6/22/26, showed Resident 1 had no falls in the past three months. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's cognition was moderately impaired. On 7/22/26 at 1123 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 1 fell on 6/22/26, and the Fall Risk - V4 assessment dated [DATE], showed Resident 1 had no falls in the past three months. RN 2 stated the licensed nurse should have updated Resident 1's history of falls because the resident fell that day. 2. Medical record review for Resident 2 was initiated on 7/21/26. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was cognitively intact. Review of Resident 2's eINTERACT Change in Condition Evaluation - V 5.1C dated 6/26/26, showed Resident 2 had a fall. However, review of Resident 2's Fall Risk - V4 dated 6/26/26, showed Resident 2 had no falls in the past three months. On 7/22/26 at 1613 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 2 fell on 6/26/26, and the Fall Risk - V4 assessment dated [DATE] showed Resident 2 had no falls in the past three months. RN 2 stated the licensed nurse should put one fall if the resident fell that day. On 7/22/26 at 1647 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings.		

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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