STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555729	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Center	1601 S Baldwin Ave. Arcadia, CA 91007

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 interview, and record review, the facility failed to ensure licensed nurses (in general) monitored the right thigh wound Jackson Pratt drain (JP, a soft, flexible, bulb-shaped suction device that gently draws fluid from a wound to help speed up healing time and reduce risk of an infection), and monitored and changed the right lower quadrant (RLQ) abdominal wound vacuum canister (a medical device that uses continuous or intermittent suction to accelerate healing of wounds) when it was full for one of three sampled residents (Resident 3).These deficient practices resulted in delayed interventions and services for monitoring the wound and JP drain and had the potential to delay Resident 3's wound healing.During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 1/21/2026 with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a weakness or partial paralysis affecting one side of the body) following cerebral infarction (damage to brain tissue caused by loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 3's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/22/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. The H&P indicated Resident 3 had undergone surgery on a right thigh tumor and the plan for Resident 3 while in the facility was to receive wound care for right thigh ulcer with monitoring for drainage.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2026, the MDS indicated Resident 3 was dependent (helper does all the effort to complete the activity) on staff for eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene.During a review of Resident 3's admission Initial Assessment (AIA), dated 1/21/2026 and timed at 5:10 PM, the AIA indicated Resident 3 had a wound vacuum within the RLQ of abdomen to the perineal area (area between the genitals and anus) and a JP drain on the right thigh.During a review of Resident 3's Order Summary Report (OSR), dated 1/21/2026, the OSR indicated there was no physician's order to monitor Resident 3's right thigh JP drain, and to empty and record the output from the JP drain. The OSR indicated there was no order to monitor and to change the canister for Resident 3's RLQ abdominal wound vacuum.During a review of Resident 3's medical record, there was no evidence found in the record that Resident 3's JP drain and wound vacuum were monitored on the evening shift (from 3 PM to 11 PM) on 1/21/2026 and on the night shift (from 11 PM to 7 AM) on 1/22/2026.During a review of Resident 3's Nursing Progress Note (NPN), dated 1/22/2026 and timed at 1:01 PM, the NPN indicated Resident 3's physician ordered to transfer and to admit Resident 3 to General Acute Care Hospital (GACH) 1 for further evaluation of excessive wound vacuum drainage.During a review of Resident 3's NPN, dated 1/23/2026 and timed at 9:34 PM, the NPN indicated Resident 3 was readmitted to the facility from GACH 1.During a review of Resident 3's OSR, dated 2/1/2026, the OSR indicated there was an order to drain and record output (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for right medial thigh with JP drain, which was ordered and started on 1/22/2026. The OSR indicated there was no order to monitor the wound vacuum and change the canister.During a review of Resident 3's Treatment Administration Record (TAR), dated 1/1/2026 to 1/31/2026, the TAR indicated monitoring for JP drain on right thigh and recording of JP drainage amount every shift started 1/22/2026 and discontinued on 1/22/2026. The TAR indicated there was no monitoring for the JP drain and recording of JP drainage on 1/21/2026 evening shift and on 1/22/2026 night shift. The TAR indicated monitoring for JP drain stoma site on right lateral and medial thigh every shift started 1/22/2026 until 1/27/2026. There is no monitoring for JP drain stoma site on right lateral and medial thigh on 1/21/2026 evening and night shift. The TAR indicated continuing wound vacuum on right quadrants to right inner thigh and monitoring for any adverse change every shift started 1/22/2026 until 1/27/2026. There are no continuing wound vacuum and monitoring for any adverse change on 1/21/2026 evening shift and night shift after the resident's admission on [DATE].During a concurrent interview and record review on 2/9/2026 at 3:11 PM with Treatment Nurse (TN) 1 and TN 2, Resident 3's OSR and TAR were reviewed. TN 1 and TN 2 stated there was no order to monitor, drain, and record the drainage amount of the JP drain and to monitor, continue, and change the wound vacuum canister when it is full on 1/21/2026 upon resident's admission.During a concurrent interview and record review on 2/9/2026 at 4:52 PM with Licensed Vocational Nurse (LVN) 2, Resident 3's OSR was reviewed. LVN 2 stated that there was no order to monitor, drain, and record the drainage amount of the JP drain and monitor and change the wound vacuum on 1/21/2026. LVN 2 stated LVN 2 did not monitor, drain, and record the drainage amount for the JP drain and the wound vacuum on 1/21/2026 evening shift.During an interview on 2/9/2026 at 4:59 PM with Registered Nurse (RN) 1, RN 1 stated RN 1 assessed Resident 3 on 1/21/2026 upon admission and Resident 3 was admitted with JP drain and wound vacuum. RN 1 stated RN 1 did not verify and obtain an order with Resident 3's physician to monitor, drain, and record the drainage amount of the JP drain and monitor and change the wound vacuum on 1/21/2026.During a phone interview on 2/11/2026 at 11:12 AM with LVN 5, LVN 5 stated LVN 5 did not monitor, drain, and record the drainage amount of the JP drain for Resident 3 on 1/21/2026 evening shift.During an interview on 2/10/2026 at 3:42 PM with the Director of Nursing (DON), the DON stated the facility should monitor, drain, and record the drainage amount of the JP drain and monitor, continue, and change the wound vacuum canister after admission for resident who had JP drain and wound vacuum.During a review of the facility's policy and procedure (P&P) titled, admission Assessment and Follow Up: Role of the Nurse, undated, the P&P indicated the admitting nurse needs to contact the resident's Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The P&P indicated that the orders obtained from the physician should be recorded in the resident's medical records. The P&P also indicated that the nurse should notify the supervisor and the Attending Physician of immediate needs that the resident may have and report other information in accordance with facility policy and professional standards of practice.

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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. Based on interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 4 completed documentation of the physician's order to perform the bladder scan (a non-invasive, painless ultrasound procedure used to measure the volume of urine in the bladder) and insert a straight catheter (a flexible, single-use, or intermittent tube inserted to the bladder to drain the urine and empty the bladder) for one of three sampled residents (Resident 2) on 12/8/2025.This deficient practice resulted in inaccurate documentation in Resident 2's medical record and had the potential for delaying interventions and services for Resident 2.During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 11/15/2025 with diagnoses which included neuromuscular dysfunction of bladder (nerve damage from disease or injury disrupts communication between the brain, spinal cord, and bladder muscles, causing overactive [leaking/frequency of urination] or underactive [retention of urine] bladder function), and extrarenal uremia (a buildup of waste products in blood that occurs as a result of untreated kidney failure).During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 11/16/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort to complete the activity) with toileting hygiene, showering/bathing, and lower body dressing. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort to complete the activity) with eating, oral hygiene, and personal hygiene.During a review of Resident 2's Order Summary Report (OSR), dated 11/15/2025 and 12/1/2025, the OSRs indicated there was no physician's order to perform a bladder scan and insert a straight catheter as needed for Resident 2.During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 12/8/2025, the SBAR indicated LVN 4 performed a bladder scan on Resident 2, notified Resident 2's physician, and received physician's order to insert a straight catheter as needed for Resident 2 on 12/8/2025 at 12:45 PM.During a concurrent interview and record review on 2/11/2026 at 9:28 AM with LVN 4, Resident 2's OSR, dated 11/15/2025, and SBAR, dated 12/8/2025, were reviewed. LVN 4 stated LVN 4 performed a bladder scan on Resident 2 and received a physician's order to insert straight catheter for Resident 2 to drain urine as needed on 12/8/2026. LVN 4 stated there was no documented order to perform the bladder scan and insert the straight catheter on 12/8/2025. LVN 4 stated LVN 4 should have documented the order to perform the bladder scan and insert straight catheter.During an interview on 2/11/2026 at 2:50 PM with the Director of Nursing (DON), the DON stated the nurse should have obtained and documented a physician's order to perform the straight catheter for Resident 2.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, undated, the P&P indicated, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. The P&P indicated, 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. 2. Entries may only be recorded in the residents' clinical record by licensed personnel (e.g. RN, LPN/L VN, physicians, therapists, etc.) in accordance with state law and facility policy. 3. All incidents, accidents, or changes in the resident's condition must be recorded.During a review of the facility's P&P titled, Electronic Signatures and Electronic Orders, revised 4/2021, the P&P indicated, The time and date of orders entered or changed made to electronic records are recorded.