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	03/03/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call lights be kept within reach for two of five sampled residents (Resident 3 and Resident 5) in accordance with the facility's policy and procedure (P&P), titled, Call Lights.These deficient practices had the potential for Resident 3 and Resident 5 to receive delayed care and services necessary to meet the residents' needs.a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 10/3/2025 with diagnoses including 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 (the blood supply to part of the brain is blocked or reduced, which leading to brain tissue death), generalized muscle weakness, and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 3's Care Plan (CP), dated 11/7/2025, the CP indicated that the resident is at fall risk and the intervention to reduce the risk is to maintain call light within reach.During a review of Resident 3's History and Physical (H&P), dated 11/26/2025, the H&P indicated that the resident had the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 1/9/2026, the MDS indicated Resident 3 was moderate impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident was dependent (Helper does all of the effort. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene.During a review of Resident 3's CP, dated 3/1/2026, the CP indicated the intervention to improve functional ability when in bed is to place call light and frequently used items within reach.During a concurrent observation and interview on 3/2/2026 at 1:12 PM with Resident 3 in Resident 3's room, Resident 3 was awake and lying on the bed. Resident 3's call light was hanging on the left side bedrail, and the call light pad was hanging under the bed. Resident 3 stated Resident 3 can barely move hands and arms and cannot reach the call light pad.During a concurrent observation and interview on 3/2/2026 at 1:31 PM with Certified Nursing Assistant (CNA) 2 in Resident 3's room, Resident 3's call light pad was hanging under the bed. CNA 2 stated that Resident 3 was unable to touch the call light pad which was hanging under the bed. CNA 2 stated staff should have placed the call light pad within Resident 3's reach.b. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to facility on 1/5/2026 with diagnoses including malignant neoplasm of prostate (prostate cancer- is cancer that develops in the prostate, a small, walnut-shaped gland located below the bladder and in front of the rectum in males), secondary malignant neoplasm of bone (bone cancer- aggressive, cancerous growths that destroy bone tissue and can spread to other body parts), difficulty in walking, generalized muscle weakness, and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 5's CP, dated 1/6/2026, the CP indicated the intervention to improve functional ability when in bed is to place call light and frequently used items within reach. The CP indicated that the resident is at fall risk and the intervention to reduce the risk is to maintain call light within reach.During a review of Resident 5's H&P, dated 1/7/2026, the H&P indicated that (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident has the capacity to understand and make decisions.During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had intact cognitive skills. The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, and upper and lower body dressing. The MDS indicated the resident required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, and personal hygiene.During a concurrent observation and interview on 3/3/2026 at 9:48 AM with Resident 5 in Resident 5's room, Resident 5 was awake and sitting on the left edge of his bed with feet on floor. Resident 5's call light was on the floor next to the right side of the bed. Resident 5 stated Resident 5 cannot use the call light to call for help because he cannot reach the call light.During a concurrent observation and interview on 3/3/2026 at 9:52 AM with Licensed Vocational Nurse (LVN) 1 in Resident 5's room, Resident 5's call light was on the floor. LVN 1 stated that Resident 5 was unable to reach the call light because the call was on the floor and at the other side of bed where the resident was sitting. LVN 1 stated staff should have kept the call light within Resident 5's reach.During an interview on 3/3/2026 at 3:44 PM with the Director of Nursing (DON), the DON stated the facility should ensure the call light was always kept within resident's reach.During a review of the facility's policy and procedure (P&P) titled, Call Light, revised October 2010, the P&P indicated When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, revised March 2021, the P&P indicated, facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The P&P indicated, The resident's individual needs and preferences are accommodated to the extent possible.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure the physician ordered medication Nystatin (a medication used to treat fungal or yeast infections of the skin, such as diaper rash) not left at bedside for one of three sampled residents (Resident 1) in accordance with the facility's policy and procedure (P&P), titled, Storage of Medications.This deficient practice resulted in Resident 1's medication was left at Resident 1's bedside and had the potential for Resident 1 not to receive appropriate medication administration following the physician's orders to meet the residents' needs.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/25/2025 with diagnoses including muscle wasting and atrophy, generalized muscle weakness, liver cell carcinoma (the most common type of liver cancer), secondary malignant neoplasm (is a cancerous tumor, an abnormal growth that can grow uncontrolled and spread to other parts of the body) of other parts of nervous system, and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 1 had intact cognitive skills (ability to make daily decisions). The MDS indicated the resident was dependent (Helper does all of the effort. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated that the resident required substantial/maximal assistance (Helper does more than half the effort) with personal hygiene.During a review of Resident 1's Treatment Administration Record (TAR), dated 3/2026, the TAR indicated Resident 1 had scrotum MASD need to be treated as: cleanse with NS, pad dry, apply Nystatin powder every shift for 14 days and recorded in the TAR. The order date is 2/26/2026.During a concurrent observation and interview on 3/2/2026 at 2:03 PM with Resident 1 and family member at Resident 1's bedside, there was a bottle of physician ordered Nystatin powder with the order label on the top of the bedside drawer. Resident 1 and the family member stated the Nystatin was kept at Resident 1's bedside and everyone can get it.During a concurrent observation and interview on 3/2/2026 at 2:55 PM with Treatment Nurse (TN) 1, the Treatment Cart (a mobile, organized, and lockable unit used by healthcare professionals to store, transport, and administer medical supplies, medications, and equipment) was observed. There was no Nystatin powder, which was ordered on 2/26/2026 to apply for the scrotum MASD every shift for 14 days for Resident 1, in the Treatment Cart. TN 1 stated the Nystatin powder ordered on 2/26/2026 to apply for the scrotum MASD (moisture associated skin damage caused from prolonged exposure to moisture) every shift for 14 days for Resident 1 should be stored in the Treatment Cart instead of at the resident's bedside. TN 1 stated only licensed nurses should get and apply the ordered Nystatin powder to Resident 1.During an interview on 3/3/2026 at 3:44 PM with the Director of Nursing (DON), the DON stated the facility should keep all ordered medications in a locked place and ensure only licensed nurses can access the medication.During a review of Resident 1's Order Summary Report (OSR), dated 3/3/2026, the OSR indicated there was a treatment order to treat scrotum MASD as follow: cleanse with NS (normal saline- a saltwater solution), pat dry, apply Nystatin powder, every shift for 14 days. The order is active on 2/26/2026.During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, revised April 2019, the P&P indicated the facility should store all drugs and biologicals in a safe, secure, and orderly manner. The P&P indicated, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. The P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.