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	06/30/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an individualized care plan (a document that outlines a person's health needs and the care they require) was developed and implemented for one of four sampled residents (Resident 1) medical condition of constipation (fewer than three bowel movements per week or experiencing difficult, painful, and incomplete passages of stool). This deficient practice had the risk to negatively affected Resident 1's care and create an immediate risk to Resident 1's health, safety, and quality of life. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included cervical spinal stenosis (narrowing of the spinal canal in the neck) and diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 5/12/2026, the H&P indicated Resident 1 was alert and oriented x 4 (a medical term meaning a patient is fully conscious and correctly aware of four key aspects of their identity and surroundings: person, place, time, and event/situation). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making were intact. The MDS indicated Resident 1 was independent for all activities of daily living. During a review of Resident 1's Order Summary Report, dated 5/11/2026, the order summary report indicated Resident 1 had an order for milk of magnesia oral suspension 400 milligrams/5 milliliters, ([mg] one thousand of a gram used for medication dosage and/or amount/[ml] a metric unit of fluid volume used in medicine to measure the total amount of liquid medication), give 30 ml by mouth every six hours as needed for constipation. During a review of Resident 1's Order Summary Report, dated 5/11/2026, the order summary report indicated Resident 1 had an order for polyethylene glycol 3350 oral powder 17 grams ([gm] metric unit of measurement, used for medication dosage and/or amount), give polyethylene 17 gm by mouth one time a day for bowel management (consistent routine to prevent constipation and fecal incontinence [accidental leakage of solid or liquid stool, or gas]). Hold for loose stools. Mix with 8 ounces of water. During a review of Resident 1's Order Summary Report, dated 5/11/2026, the order summary report indicated Resident 1 had an order for senna oral table 8.6 mg, give one tablet by mouth two times a day for bowel management. Hold for loose stools. During a review of Resident 1's Order Summary Report, dated 5/19/2026, the order summary report indicated Resident 1 had an order for polyethylene glycol 3350 oral powder 17 gm, give polyethylene 17 gm by mouth two times a day for bowel management. Hold for loose stools. Mix with 8 ounces of water. During a review of Resident 1's Order Summary Report, dated 5/19/2026, the order summary report indicated Resident 1 had an order for senna oral table 8.6 mg, give two tablet by mouth two times a day for bowel management. Hold for loose stools. During a review of Resident 1's Medication Administration Audit Report (MAR), dated 5/1/2026 - 5/31/2026, the MAR indicated Resident 1 had an order to receive milk of magnesia oral suspension 400mg/5ml, give 30 ml by mouth every six hours as (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed for constipation. The MAR indicated Resident 1 received medication on 5/21/2026 and 5/24/2026. During a review of Resident 1's MAR, dated 5/1/2026 - 5/31/2026, the MAR indicated Resident 1 had an order to receive polyethylene glycol 3350 oral powder 17 grams/scoop, give one scoop by mouth one time a day for bowel management. The MAR indicated Resident 1 received medication on 5/12/2026, 5/13/2026, 5/16/2026 - 5/19/2026. During a review of Resident 1's MAR, dated 5/1/2026 to 5/31/2026, the MAR indicated Resident 1 had an order to receive polyethylene glycol 3350 oral powder 17 grams/scoop, give one scoop by mouth two times a day for bowel management. The MAR indicated Resident 1 received medication on 5/19/2026 - 5/25/2026. During a review of Resident 1's MAR, dated 5/1/2026 - 5/31/2026, the MAR indicated Resident 1 had an order to receive [NAME] oral tablet 8.6 mg, give one tablet by mouth two times a day for bowel management. The MAR indicated Resident 1 received medication on 5/12/2026, 5/13/2026, 5/16/2026 - 5/19/2026. During a review of Resident 1's MAR, dated 5/1/2026 - 5/31/2026, the MAR indicated Resident 1 had an order to receive [NAME] oral tablet 8.6 mg, give two tablets by mouth two times a day for bowel management. The MAR indicated Resident 1 received medication on 5/19/2026 - 5/25/2026. During a review of Resident 1's electronic medical record, unable to locate Resident 1's care plan for Resident 1's constipation. During an interview on 6/30/2026 at 10:06 a.m. with Minimum Data Set (MDS) Nurse 1 (clinical leader who manages comprehensive patient assessments), MDS Nurse 1 stated a care plan indicated residents' problems, goals and interventions to treat a problem and prevent the problem from getting worse. MDS Nurse 1 stated residents changes of conditions should be implemented in the care plan. MDS Nurse 1 stated if a resident's medical condition required medication it should be in residents care plan because it would indicate plan of care for residents' medical condition. During an interview on 6/30/2026 at 3:11 p.m. with Director of Nursing (DON), the DON stated a care plan indicated interventions that nursing staff must practice to care for residents. The DON stated resident's medications, diagnosis, behaviors, and change of conditions must get care planned. The DON stated a resident suffering from constipation must have a care plan for constipation. The DON stated it was important to develop a care plan for constipation because constipation can cause sepsis (body's extreme, life-threatening response to an infection), stomach distension (visible swelling, expansion, or increase in the size of the abdomen beyond its normal girth), nausea, vomiting, and could lead to fecal impaction (a serious, potentially life-threatening condition that occurs when severe, chronic constipation causes a large, dry mass of hardened stool to get stuck in the colon [main part of the large intestine, which helps digest food and remove waste from the body] or rectum [final portion of large intestine, temporarily stores stool until expelled from the body]). The DON stated the risk of not having a care plan for constipation was Resident 1 would not be accurately monitored and cared for. During a review of facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated care plan would include: 1. Measurable objectives and timeframes. 2. Describe services that are to be furnished to attain or maintain the resident's higher practicable physical, mental, and psychosocial well-being. 3. Incorporate identified problem areas. 4. Incorporate risk factors associated with identified problems.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility reviewed, updated, and/or revised new interventions for one of three sampled residents (Resident 1) care plan (a document that outlines a person's health needs and the care they require) for falls that occurred on 6/19/2026, 6/20/2026, and 6/26/2026. This deficient practices caused subsequent falls to Resident 2, potentially placing Resident 2 at risk for great bodily injury. During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included malignant neoplasm of brain (cancerous brain tumor) and diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). During a review of Resident 2's History and Physical Examination (H&P), dated 5/12/2026, the H&P indicated Resident 2 could make needs known but could not make medical decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 5/11/2026, the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 required supervision for eating. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for upper body dressing. The MDS indicated Resident 2 was dependent on staff for toileting hygiene, shower/bathing, lower body dressing and putting on/taking off footwear. MDS indicated Resident 2 had falls since admission with no injuries. During a review of Resident 2's Fall Risk Evaluation form, dated 4/29/2026, the Fall Risk Evaluation form indicated a total score of 10 or above represented a high risk for falls. The Fall Risk Evaluation form indicated Resident 2's total score was 12. During a review of Resident 2's Fall Risk Evaluation form, dated 5/8/2026, the Fall Risk Evaluation form indicated a total score of 10 or above represented a high risk for falls. The Fall Risk Evaluation form indicated Resident 2's total score was 21. During a review of Resident 2's Situation, Background, Assessment, Recommendation form ([SBAR] a communication tool used by healthcare workers when there is a change of condition among residents), dated 6/19/2026, the SBAR indicated Resident 2 had an unwitnessed fall on 6/19/2026. The SBAR indicated Resident 2 was found lying on the floor next to Residents 2's bed. The SBAR indicated Resident 2 lost balance as Resident 2 was reaching for an item. The SBAR indicated Resident 2 had no injuries from the fall. During a review of Resident 2's SBAR, dated 6/20/2026, the SBAR indicated Resident 2 had an unwitnessed fall on 6/20/2026. The SBAR indicated Resident 2 was found on floor mat while bending his knees. The SBAR indicated Resident 2 had no injuries from the fall. During a review of Resident 2's SBAR, dated 6/26/2026, the SBAR indicated Resident 2 had an unwitnessed fall on 6/26/2026. The SBAR indicated Resident 2 had an unwitnessed fall while ambulating in the hallway by nurses' station. The SBAR indicated Resident 2 had no injuries from the fall. During a review of Resident 2's Care Plan for falls, dated 5/1/2026, the care plan indicated Resident 2 was at risk for falls related to impaired cognition, lack of coordination, history of falls, and not calling for help. Resident 2's fall risk care plan was not revised after 6/19/2026, 6/20/2026, and 6/26/2026 falls. Resident 2's care plan did not include fall incidents' and new interventions were not developed. During an interview on 6/30/2026 at 10:06 a.m., with Minimum Data Set Nurse 1 (MDS Nurse 1, clinical leader who manages comprehensive patient assessments), MDS Nurse 1 stated a care plan indicated residents' problems, goals and interventions to treat a problem and prevent the problem from getting worse. MDS Nurse 1 stated recurrent falls are part of a long-term goal care plan. MDS Nurse 1 stated long-term goal care plans must be revised after each fall. MDS Nurse 1 stated if care plan did not get revised there would be a risk for resident falling again. MDS Nurse 1 stated MDS Nurse 1 revised Resident 2's fall risk (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan yesterday (6/29/2026). MDS Nurse 1 received Interdisciplinary Team (IDT) notes yesterday (6/29/2026) and added fall incidents and interventions. During an interview on 6/30/2026 at 10:46 a.m., with MDS Nurse 2, MDS Nurse 2 stated a care plan was tailored to each resident's diagnosis with goals and interventions for nursing to practice during resident care. MDS Nurse 2 stated care plans must be revised and updated after a resident had a fall. MDS Nurse 2 stated care plans must get revised to implement new interventions to prevent future falls. MDS Nurse 2 stated MDS Nurse 2 reviewed Resident 2's care plan for falls on 6/29/2026 and the care plan was not updated after Resident 2's falls. MDS Nurse 2 stated MDS Nurse 2 updated Resident 2's fall risk care plan on 6/29/2026. MDS Nurse 2 stated a care plan revision must be completed after each fall and staff must develop new interventions with each revision. During a concurrent interview and record review on 6/30/2026 at 11:16 a.m., with MDS Nurse 2, Resident 2's fall risk care plan, dated 5/1/2026 was reviewed. The care plan indicated no new interventions were developed after Resident 2's fall on 6/19/2026 and 6/20/2026. The care plan indicated Resident 2's fall on 6/26/2026 was not implemented in Resident 2's care plan and new interventions were not developed. The MDS Nurse 2 stated Resident 2's falls should have been care planned with new interventions. MDS Nurse 2 stated all license nurses could have developed new interventions after Resident 2's fall but they did not do it. MDS Nurse 2 stated interventions for a fall risk care plan should be to assign resident to a room close to nurses' station, involve Resident 2 in activities, and answer Resident 2's call light quickly. During an interview on 6/30/2026 at 2:50 p.m., with the Director of Nursing (DON), the DON stated a care plan indicated interventions that nursing staff must practice to care for residents. The DON stated resident's medications, diagnosis, behaviors and change of conditions must get care planned. The DON stated residents needed a care plan for falls to minimize the recurring of falls. The DON stated after a resident had another fall, resident's care plan had to be updated. The DON stated the care plan got updated by developing new interventions. The DON stated if care plan did not get revised after each fall, it created the risk for resident to fall again. The DON stated if new interventions were not developed after a recurring fall, it was a system failure. The DON stated staff needed to review interventions and find out why Resident 2 continued to experience falls. During a review of facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The P&P indicated the interdisciplinary team must review and update the care plan:a. When there has been a significant change in the residents' condition.b. When desired outcome was not met. During a review of facility P&P titled, Falls-Clinical Protocol, dated 3/2018, the P&P indicated staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The P&P indicated if underling causes cannot be readily identified or corrected, staff would try various relevant interventions based on assessments of the nature or category of falling, until falling reduces, stops or until a reason is identified for its continuation. During a review of facility P&P titled, Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated the staff and attending physician would implement resident-centered fall prevention plan to reduce the specific risk factor of falls for each resident at risk or with a history of falls. The P&P indicated if falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff demonstrated and maintained competency to safely provide care and services in accordance with professional standards for one of three sampled residents (Resident 1) when:1. Licensed Vocational Nurse (LVN) 1 failed to follow Resident 1's doctor's order for oxycodone (a potent, semi-synthetic pain medication prescribed to treat moderate to severe pain) on 5/11/26 to 5/13/26 and on 5/23/26. 2. LVN 1 did not have the knowledge of medication parameters (specific rules, clinical limits, and measurable values that guide how a drug is given, adjusted, or stopped). These deficient practices placed Resident 1 and other residents at risk for unsafe medication administration including complications such as medication over sedation, medication toxicity, and the medication would not help for the medication purpose and residents' diagnosis. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included cervical spinal stenosis (narrowing of the spinal canal in the neck) and diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine. During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 5/12/2026, the H&P indicated Resident 1 was alert and oriented X 4 (a medical term meaning a patient is fully conscious and correctly aware of four key aspects of their identity and surroundings: person, place, time, and event/situation). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 1 was independent for all activities of daily living. During a review of Resident 1' s Order Summary Report, dated 5/11/2025, the Order Summary Report indicated Resident 1 had an order to receive oxycodone tablet 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) by mouth every three hours as needed for severe pain (7-10 pain level- 0 means no pain, and 10 means the worst pain). During a review of Resident 1' Medication Administration Record (MAR), dated 5/1/2026 - 5/31/2026, the MAR indicated Resident 1 was scheduled to receive oxycodone tablet 5 mg, one tablet by mouth every three hours as needed for severe pain. The MAR indicated on 5/11/2026, 5/12/2026, and 5/23/2026 Resident 1 had a pain scale of 4 and received oxycodone 5 mg. The MAR indicated on 5/13/2026 Resident 1 had a pain scale of 2 and received oxycodone 5mg. During a concurrent observation and interview on 6/29/2026 at 3:37 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 used cellphone to search information to answer the question of what a medication parameter was used for. LVN 1 read off LVN 1's cell phone and stated a medication parameter was used for medication ranges, it provided guidance of when to give certain medications. LVN 1 stated it was not a safe practice not to follow medication parameters. LVN 1 was not able to explain what the medication administration process was when a medication had medication parameters. LVN 1 was not able to explain what LVN 1 would do if a resident was not within a medication parameter. LVN 1 stated the pain scale for medication oxycodone was 5-10 [pain level]. LVN 1 stated if resident were under the medication parameter LVN 1 would administer a medication alternative and LVN 1 stated LVN 1 did not do that. During a concurrent interview and record review on 6/29/2026 at 4:16 p.m. with LVN 1, Resident 1's MAR, dated 5/1/2026 - 5/31/2026 was reviewed. The MAR indicated on 5/11/2026, 5/12/2026, 5/13/2026 and 5/23/2026 Resident 1's pain scale was less than the medication parameter for oxycodone yet medication was administered to Resident 1. LVN 1 stated LVN 1 administered medication to Resident 1 because Resident 1 and Resident 1's family requested the medication. LVN 1 was not able to answer if a pain scale of 2 or 4 was within oxycodone medication parameter. LVN 1 stated a pain scale of 4 was higher than the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	range of 7 -10 pain scale. LVN 1 stated Resident 1 stated Resident 1 was in excruciating pain. LVN 1 was unable to explain if a pain of 2 and 4 was excruciating pain. LVN 1 stated administering oxycodone to Resident 1 for a pain of 2 and 4 was following doctor orders. During an interview on 6/30/3036 at 3:22 p.m. with the Director of Nursing (DON), the DON stated medication parameters were used for resident safety. The DON stated if medication parameters were not followed it would cause complications, medication toxicity and medication would not help for the medication purpose and residents' diagnosis. The DON stated not following a medication parameter was not following doctor's order because medication was not administered as doctor's order. The DON stated the risk in having staff that were not competent had the potential of harming residents. The DON stated hiring a nurse that did not speak English would increase the risk of miscommunication with residents and doctors and it would create a risk in medication errors. During a review of facility's Policy and Procedure (P&P) titled, Competency of Nursing Staff,, dated 5/2019, the P&P indicated competency in skills and techniques necessary to care for residents' needs include but is not limited to competencies in areas such as: communication, medication management and pain management.