STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	1550 North Park Avenue Pomona, CA 91768

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to ensure a copy of the Notice of Proposed Transfer and Discharge (NPTD- informs the resident and the resident's representative of the transfer or discharge and the reasons for the move) for a facility-initiated discharge for one of 10 sampled residents (Resident 4) was sent to the Ombudsman (OMB- an advocate for residents of nursing homes, board and care centers, and assisted living facilities) before the resident was discharged from the facility on 12/23/24. This failure had the potential for Resident 4 to not be protected from being inappropriately discharged from the facility. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included aphasia (a disorder that makes it difficult to speak), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness in the arm, leg, and face on one side of the body) following a cerebral infarction (damage to tissues in the brain which occurs because of disrupted blood flow to the brain). During a review of Resident 4's History and Physical (H&P, physician's clinical evaluation and examination of the resident) dated 5/15/24, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment and care planning tool) dated 12/23/24, the MDS indicated Resident 4 did not have memory problems and only had some difficulty making decisions in new situations. The MDS indicated Resident 4 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying assistance as resident completed the activity) with walking, oral and toileting hygiene and required partial/moderate assistance (helper does less than half the effort) with showering/bathing, upper and lower body dressing, with putting on/taking off footwear, and with personal hygiene. During a review of Resident 4's Discharge Planning Review Form (DPRF), created by Registered Nurse Supervisor 3 (RNS 3) on 12/23/24, and reviewed and signed by the Quality Assurance Nurse (QAN) on 12/30/24, the DPRF indicated Resident 4's discharge was facility-initiated. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's NPTD dated 12/23/24, the NPTD indicated Resident 4's representative signed the NPTD on 12/23/24 and the discharge effective date was on 12/23/24. During a review of the facsimile (fax, transmission of a scanned printed material to a telephone number connected to a printer or other output device) Transmission Log, dated 12/31/24, the Transmission Log indicated the NPTD was sent to the OMB on 12/31/24. During a telephone interview on 1/27/25 at 10:02 am with the OMB, the OMB stated the OMB did not receive the NPTD for Resident 4's discharge until 12/31/24 but Resident 4 was discharged on [DATE]. During an interview on 1/27/25 at 3:54 pm with the facility's Social Services Director (SSD), the SSD stated the SSD, the Case Manager (CM), and/or Nursing sends the NPTD to the OMB within 30 days after discharge. The SSD stated the SSD could not remember who and when the NPTD for Resident 4's discharge was sent to the OMB. During a review of the facility's Policy and Procedure (P&P) titled, Notice of Transfer/Discharge, dated 10/2017, the P&P indicated the NPTD applies to transfers or discharges that are initiated by the facility, not by the resident. The P&P indicated, when the resident is being discharged home or to another facility, the facility representative will complete the Notice of Proposed Transfer and Discharge form, and provide it to the resident, responsible party, and Ombudsman prior to the transfer or discharge. Social Service will document discharge plans and services in accordance with the discharge planning policies and procedures .

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NAME OF PROVIDER OR SUPPLIER Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 North Park Avenue Pomona, CA 91768	

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to ensure the clinical record for 2 of 10 sampled residents (Resident 1 and Resident 3) was complete and accurate when: 1. Licensed Vocational Nurse (LVN) 1 did not accurately document Resident 1's condition in the Change in Condition Evaluation (CIC), dated [DATE] and timed at 7:30 am. 2. The names of staff who responded to the Rapid Response (facility emergency code that indicates someone is experiencing a medical emergency or critical change in health condition), what time the Rapid Response Team (RRT) got to Resident 1's room, and the names of staff who provided cardiopulmonary resuscitation (CPR, emergency lifesaving procedure, consisting of chest compressions and mouth-to-mouth or mechanical breaths, performed when the heart stops beating or beats ineffectively and/or to restore breathing) to Resident 1 on [DATE] were not documented in Resident 1's clinical record. 3. The names of staff who responded to the Rapid Response, what time the RRT got to Resident 3's room, the names of staff who provided CPR to Resident 3, and the name of staff who tried to start an intravenous catheter (IV - a soft, flexible tube placed inside a vein, usually in the hand or arm, and used by health care providers to give a person medicine or fluids) on Resident 3 on [DATE] were not documented in Resident 3's clinical record. These failures had the potential for Resident 1's and Resident 3's care to not be accurately evaluated for procedural and guidelines compliance, and the need for staff education and training to be evaluated. Findings: a. During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility with diagnoses which included acute posthemorrhagic anemia (a condition that develops when an individual loses a large amount of blood quickly). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool)), dated [DATE], the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 1 was able to communicate Resident 1's needs. The MDS indicated Resident 1 was independent with toileting hygiene and required set-up or clean-up assistance (helper sets up or cleans up but resident completes activity) with eating, oral hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's CIC, dated [DATE] and timed at 7:30 am, the CIC indicated Resident 1 was unresponsive, did not have a pulse, and was not breathing. The CIC indicated Certified Nursing Assistant (CNA) 2 reported to LVN 1 Resident 1 was not responding and when LVN 1 went to check on Resident 1 in the room, Resident 1 did not respond to painful stimuli. The CIC indicated Resident 1 did not have a pulse and was not breathing, and rapid response was called. Upon arrival of the rapid response team (RRT), the RRT initiated CPR until paramedics arrived. The CIC did not indicate the names of the staff who responded to the rapid response and the names of the staff who provided CPR to Resident 1. The CIC did not indicate Resident 1 was bleeding from both nostrils. During an interview on [DATE] at 7:45 pm with LVN 1, LVN 1 stated CNA 2 reported on [DATE] at 7:20 am that Resident 1 was not responding. LVN 1 and CNA 2 went to Resident 1's room right away and found Resident 1 in bed with blood coming out from Resident 2's both nostrils. LVN 1 stated LVN 1 called Resident 1's name and touched Resident 1's hands and arms and Resident 1 did not respond. LVN 1 stated Resident 1's skin was not pale. LVN 1 stated Rapid Response was called and the RRT got to Resident 1's room and initiated CPR. LVN 1 did not state LVN 1 applied painful stimuli to Resident 1. During a follow-up interview on [DATE] at 8:40 pm with LVN 1, LVN 1 stated when CNA 2 and LVN 1 checked on Resident 1 on [DATE] at 7:20 am, Resident 1 had weak and shallow breathing. LVN 1 stated LVN 1 and CNA 2 did not initiate CPR because Resident 1 still had a pulse. During an interview on [DATE] at 9:21 pm with the Director of Nursing (DON), the DON stated the DON reviewed Resident 1's clinical record and was unable to find documentation of what time the RRT got to Resident 1's room, the names of staff who responded to the rapid response, and the names of staff who provided CPR to Resident 1 on [DATE]. The DON stated the only documentation the DON found in Resident 1's clinical record regarding Resident 1's change in condition on [DATE] was the CIC created by LVN 1 dated [DATE] and timed at 7:30 am. The DON stated it was important to document accurately in the Resident 1's clinical record to prove that we did everything we can for this patient. The DON stated licensed nurses (in general) must document details of care provided to the resident in the progress notes or in the CIC. The DON stated upon review of Resident 1's CIC, dated [DATE] and timed at 7:30 am, the CIC indicated Resident 1 had no pulse. The DON stated the DON spoke to LVN 1 and LVN 1 told the DON that LVN 1 created the CIC, dated [DATE] and timed at 7:30 am, after Resident 1 already lost Resident 1's pulse. The DON stated LVN 1 told the DON that LVN 1 did not create a CIC for when Resident 1 was unresponsive but still had a pulse. The DON stated LVN 1 must document on the CIC all the details from the start of Resident 1's change in condition. The DON stated, LVN 1 should have captured (Resident 1) being unresponsive with a pulse and breathing until Resident 1 became pulseless and stopped breathing. During a telephone interview on [DATE] at 10:05 pm with CNA 2, CNA 2 stated CNA 2 and CNA 3 went to Resident 1's room on [DATE] at 7:28 am and they found Resident 1 unresponsive and Resident 1's skin was yellow and not (Resident 1's) usual color. CNA 2 stated CNA 2 looked at Resident 1's chest to check Resident 1's respirations and Resident 1's chest did not go up and down. CNA 2 stated CNA 2 notified LVN 1 about Resident 1's change in condition and CNA 2 and LVN 1 went inside Resident 1's room to check on Resident 1. CNA 2 stated after LVN 1 checked on Resident 1, CNA 2 followed LVN 1 to the nurse's station and LVN 1 paged for rapid response. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 1:33 pm with CNA 3, CNA 3 stated on [DATE] at 7:25 am, CNA 3 brought Resident 1's tray inside Resident 1's room and CNA 3 found Resident 1 in bed pale, with yellow skin. CNA 3 stated CNA 3 did not call Resident 1's name, CNA 3 went outside the room right away to ask CNA 2 to check on Resident 1. CNA 3 and CNA 2 went inside Resident 1's room and tried to wake up Resident 1 by calling Resident 1's name. CNA 3 stated Resident 1 did not respond to CNA 3 and to CNA 2. CNA 3 stated CNA 3 did not see Resident 1's stomach moving like breathing but Resident 1 had a blanket on. b. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired, and Resident 3 was able to communicate but had difficulty communicating some words or finishing thoughts. The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort) with eating and oral hygiene, and was dependent on others with toileting hygiene, showering/bathing, upper and lower body dressing, and with putting on/taking off footwear. During a review of Resident 3's CIC, dated [DATE] and timed at 5:51 pm, the CIC indicated Resident 3 was unresponsive and was not breathing. The CIC indicated staff (unidentified) was unable to obtain Resident 3's vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature). The CIC did not indicate the names of staff who responded to the Rapid Response, what time the RRT got to Resident 3's room, the names of staff who provided CPR to Resident 3, and the name of staff who tried to start an intravenous catheter (IV - a soft, flexible tube placed inside a vein, usually in the hand or arm, and used by health care providers to give a person medicine or fluids) on Resident 3. During a review of Resident 3's Health Status Progress Notes (HSPN) created by Registered Nurse Supervisor (RNS) 3 on [DATE] and timed at 5:51 pm, the HSPN indicated RNS 3 was alerted by Resident 3's nurse that Resident 3 was found unresponsive, not breathing, rapid response and CPR was initiated, and 911 was called immediately. The HSPN did not indicate the names of staff who responded to the Rapid Response, what time the RRT got to Resident 3's room, the names of staff who provided CPR to Resident 3, and the name of staff who tried to start an IV on Resident 3. During an interview on [DATE] at 2:24 pm with RNS 3, RNS 3 stated when Resident 3's nurse alerted RNS 3 on [DATE] at 5:51 pm that Resident 3 was not breathing, RNS 3 told Resident 3's nurse to start CPR. RNS 3 paged code blue (facility emergency code that indicates a resident is requiring resuscitation) and called 911. RNS 3 stated after RNS 3 called 911, RNS 3 went inside Resident 3's room and multiple LVNs, 2 registered nurses (RNs), and 2 respiratory therapists (RTs) were providing CPR on Resident 3. RNS 3 stated an RN from the subacute unit tried to insert an IV into Resident 3 but was unsuccessful. RNS 3 stated RNS 3's practice was to document on a note pad and transcribe what was documented on the note pad in the resident's clinical record. RNS reviewed Resident 3's clinical record and was unable to find documentation of the names of staff who responded to the Rapid Response, what time the RRT got to Resident 3's room, the names of staff who provided CPR to Resident 3, and the name of staff who tried to start an IV on Resident 3. RNS 3 stated it was important to document accurately to prove everything that was done for the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Medical Emergencies - Code Blue, dated [DATE], the P&P indicated, using the Code Blue Cart Checklist from the emergency cart and/or the AED case, the nurse will assure that the following tasks have been completed .document the event in the resident record, charting of time and condition of the resident at the time of discovery, CPR initiated, when Code Blue called, when physician and family notified, and when nursing staff responded .All documentation will be maintained in the resident's medical record. During a review of the facility's policy and procedure (P&P) titled, Medical Record Content, dated [DATE], the P&P indicated the purpose of the P&P was to ensure adequate and accurate documentation of care provided to each resident while at the facility. The P&P indicated, the facility will maintain a medical record for each resident admitted to the facility that will contain sufficient information to identify the resident, support the diagnosis, justify the medical necessity for treatment, and facilitate continuity of care among health care providers .