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	03/28/2025

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 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. 46687 Based on interview and record review, the facility failed to ensure licensed nurses (LN) developed and implemented a care plan (CP) for one of three sampled residents (Resident 2) with interventions to help prevent a fall after Resident 2 was determined to be a high-fall risk based off Resident 2 ' s Fall Risk Assessment (FRA) dated 1/11/2025, based on the facility ' s policy and procedure (P&P) titled, Fall Management Program, and Comprehensive, Person-Centered Care Planning. As a result of this failure, on 3/8/2025 at 4:15 pm, Resident 2 fell out of bed and was found on the floor by Certified Nurse Assistant (CNA) 2. Resident 2 sustained a left elbow skin tear (a wound that happens when the layers of skin separate or peel back). Cross Reference: F689 Findings: During a review of Resident 2 ' s Admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/11/2025 with diagnoses that included lack of coordination (uncoordinated movement due to muscle control that causes an inability to coordinate movements) and osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones gradually wears away, leading to pain, stiffness, and reduced movement) of the right hip and right knee. During a review of Resident 2 ' s FRA dated 1/11/2025, timed at 5:10 pm, the FRA indicated Resident 2 was at high-risk for falls. During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool) dated 1/18/2025, the MDS indicated Resident 2 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 2 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, rolling left and right (in bed), sitting to lying, lying to sitting on side of the bed, and chair/bed-to-chair transfers. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with eating, oral and personal hygiene, and upper body dressing. The MDS indicated walking 10 feet was not attempted due to medical condition or safety concerns. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s eINTERACT/change in condition(CIC- a change in the resident ' s health or functioning that requires further assessment and intervention) Evaluation (CICE) dated 3/8/2025, timed at 4:15 pm, the CICE indicated the CNA (not identified) alerted Registered Nurse (RN) 2 that Resident 2 had fallen out of bed. The CICE indicated Resident 2 was found on Resident 2 ' s back, next to the bed. The CICE indicated Resident 2 had a skin tear to the left elbow. During a concurrent interview and record review on 3/25/2025 at 2:08 pm, with the MDS Nurse (MDSN), Resident 2 ' s FRA dated 1/11/2025 and care plans (CP) were reviewed on the facility's computer program, Point-Click Care (PPC- cloud-based Electronic Health Record (EHR) platform specifically designed for long-term care providers, including skilled nursing, assisted living, and senior living communities). The FRA indicated a score of 10 or higher indicated the resident is at high risk of fall. The MDSN stated Resident 2 ' s FRA on PCC indicated Resident 2 was at high-risk for falls based on Resident 2's score of 14. The MDSN stated (in general) when a FRA indicated a Resident was high risk for falls, the FRA will prompt the licensed nurse to complete a CP indicating, at high-risk for falls. The MDSN stated without a CP, the staff did not have a road map for what interventions needed to be done for the resident. The MDSN stated Resident 2 did not have a CP made on 1/11/2025 indicating Resident 2 was at high- risk for falls. The MDSN stated it was possible that if a CP had been made for Resident 2 on 1/11/2025, Resident 2 ' s fall and injury on 3/8/2025 could have been avoided. During a telephone interview on 3/25/2025 at 3:25 pm, with CNA 2, CNA 2 stated CNA 2 started the shift around 3 pm on 3/8/2025 and was doing rounds on the residents. States he heard a noise coming from Resident 2 ' s room, then heard Resident 2 shout for help. CNA 2 stated CNA 2 found Resident 2 on the floor lying on the side of the bed closest to the door, with Resident 2 ' s head near the foot of the bed, and Resident 2 ' s legs on the floor. CNA 2 stated CNA 2 immediately asked for help. CNA 2 stated CNA 2 could not tell if Resident 2 was bleeding, and was shouting, I want to go home! CNA 2 stated CNA 2 thinks Resident 2 cannot walk because CNA 2 had never seen Resident 2 walk. CNA 2 stated CNA 2 did not know Resident 2 was at high-risk for falls before the fall on 3/8/2025. CNA 2 stated CNA 2 did not know how often CNA 2 was supposed to check on Resident 2 before Resident 2 fell . CNA 2 stated if assigned residents at high-risk for falls, CNA 2 would check on them every 10 minutes. During a telephone interview on 3/25/2025 at 3:40 pm, with Registered Nurse (RN) 2, RN 2 stated Resident 2 was at high-risk for falls before falling on 3/8/2025. RN 2 stated there should have been a CP indicating Resident 2 was at high-risk for falls and that it was important because a CP guided the care to help Resident 2 prevent falls and keep Resident 2 safe. RN 2 stated without a CP, staff would not be aware of Resident 2 ' s high-risk for falls status and what interventions to take with Resident 2. RN 2 stated it was possible Resident 2 ' s fall and injury on 3/8/2025 could have been prevented if staff knew the appropriate interventions to take with a CP. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 1:38 pm, with the Director of Nursing (DON), the DON stated (in general) all residents who were considered at high-risk for falls needed a CP. The DON stated a CP was important to address the safety concerns and the risk for falls. The DON stated without a CP, there are no interventions in place to be able to prevent an incident. The DON stated the facility had a fall management program for residents who were considered at high-risk for falls and/or have previously fallen. The DON stated those residents ' names ' go on a list and were monitored more frequently to prevent falls and the recurrence of falls. The DON stated Resident 2 was not added to the fall management program list until 3/8/2025 when Resident 2 fell out of bed. The DON stated Resident 2 should have been added to the list on 1/11/2025 when the FRA indicated Resident 2 was at high-risk for falls. the DON stated it was possible Resident 2 ' s fall and injury on 3/8/2025 could have been prevent had Resident 2 been added to the fall management program, a CP be developed and interventions in place. During a review of the facility ' s P&P titled, Fall Management Program, revised 3/13/2021, the P&P indicated the purpose was to provide residents a safe environment that minimized complications associated with falls. The P&P indicated the facility would implement a fall management program that supposed providing an environment free from all hazards. The P&P indicated as part of the admission assessment, LNs would complete a FRA. The P&P indicated if a fall risk factor was identified, document interventions on the resident ' s care plan. The P&P indicated the interdisciplinary team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) and/or the licensed nurse would develop a CP according to the identified risk factors and root cause(s) per Care Area Assessment (CAA) guidelines. The P&P indicated the IDT would initiate, review, and update the resident ' s fall risk status and care plan at the following intervals: on admission, quarterly, upon identification of significant CIC, post fall, and as needed. During a review of the facility ' s P&P titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated within seven days from the completion of the comprehensive MDS assessment, the comprehensive CP would be developed. The P&P indicated all goals, objectives, interventions, etc, from the current baseline CP would be included in the resident ' s comprehensive CP. The P&P indicated additional changes or updates to the resident ' s comprehensive CP would be made based on the assessed needs of the resident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46687 Based on interview and record review, the facility failed to provide care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) for one of three sampled residents (Resident 2) as indicated in the facility ' s policy and procedure (P&P) titled, Fall Management Program, by failing to: 1. Ensure licensed nurses (LN) developed and implemented a care plan (CP) for Resident 2 with interventions to help prevent a fall after Resident 2 was determined to be a high-fall risk based off Resident 2 ' s Fall Risk Assessment (FRA) dated 1/11/2025. 2. Ensure LNs made Resident 2 part of the fall management program on 1/11/2025 when Resident 2 was assessed to be at high-risk for falls. As a result of this failure, on 3/8/2025 at 4:15 pm, Resident 2 fell out of bed and was found on the floor by Certified Nurse Assistant (CNA) 2. Resident 2 sustained a left elbow skin tear (a wound that happens when the layers of skin separate or peel back). Cross Reference: F656 Findings: During a review of Resident 2 ' s Admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/11/2025 with diagnoses that included lack of coordination (uncoordinated movement due to muscle control that causes an inability to coordinate movements) and osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones gradually wears away, leading to pain, stiffness, and reduced movement) of the right hip and right knee. During a review of Resident 2 ' s FRA dated 1/11/2025, timed at 5:10 pm, the FRA indicated Resident 2 was at high-risk for falls. During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool) dated 1/18/2025, the MDS indicated Resident 2 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 2 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, rolling left and right (in bed), sitting to lying, lying to sitting on side of the bed, and chair/bed-to-chair transfers. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with eating, oral and personal hygiene, and upper body dressing. The MDS indicated walking 10 feet was not attempted due to medical condition or safety concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s eINTERACT/change in condition (CIC- a change in the resident ' s health or functioning that requires further assessment and intervention) Evaluation (CICE) dated 3/8/2025, timed at 4:15 pm, the CICE indicated the CNA (not identified) alerted Registered Nurse (RN) 2 that Resident 2 had fallen out of bed. The CICE indicated Resident 2 was found on Resident 2 ' s back, next to the bed. The CICE indicated Resident 2 had a skin tear to the left elbow. During a concurrent interview and record review on 3/25/2025 at 2:08 pm, with the MDS Nurse (MDSN), Resident 2 ' s FRA dated 1/11/2025 and care plans (CP) were reviewed on the facility's computer program, Point-Click Care (PPC- cloud-based Electronic Health Record (EHR) platform specifically designed for long-term care providers, including skilled nursing, assisted living, and senior living communities). The FRA indicated a score of 10 or higher indicated the resident is at high risk of fall. The MDSN stated Resident 2 ' s FRA on PCC indicated Resident 2 was at high-risk for falls based on Resident 2's score of 14. The MDSN stated (in general) when a FRA indicated a Resident was high risk for falls, the FRA will prompt the licensed nurse to complete a CP indicating, at high-risk for falls. The MDSN stated without a CP, the staff did not have a road map for what interventions needed to be done for the resident. The MDSN stated Resident 2 did not have a CP made on 1/11/2025 indicating Resident 2 was at high- risk for falls. The MDSN stated it was possible that if a CP had been made for Resident 2 on 1/11/2025, Resident 2 ' s fall and injury on 3/8/2025 could have been avoided. During a telephone interview on 3/25/2025 at 3:25 pm, with CNA 2, CNA 2 stated CNA 2 started the shift around 3 pm on 3/8/2025 and was doing rounds on the residents. States he heard a noise coming from Resident 2 ' s room, then heard Resident 2 shout for help. CNA 2 stated CNA 2 found Resident 2 on the floor lying on the side of the bed closest to the door, with Resident 2 ' s head near the foot of the bed, and Resident 2 ' s legs on the floor. CNA 2 stated CNA 2 immediately asked for help. CNA 2 stated CNA 2 could not tell if Resident 2 was bleeding, and was shouting, I want to go home! CNA 2 stated CNA 2 thinks Resident 2 cannot walk because CNA 2 had never seen Resident 2 walk. CNA 2 stated CNA 2 did not know Resident 2 was at high-risk for falls before the fall on 3/8/2025. CNA 2 stated CNA 2 did not know how often CNA 2 was supposed to check on Resident 2 before Resident 2 fell . CNA 2 stated if assigned residents at high-risk for falls, CNA 2 would check on them every 10 minutes. During a telephone interview on 3/25/2025 at 3:40 pm, with Registered Nurse (RN) 2, RN 2 stated Resident 2 was at high-risk for falls before falling on 3/8/2025. RN 2 stated there should have been a CP indicating Resident 2 was at high-risk for falls and that it was important because a CP guided the care to help Resident 2 prevent falls and keep Resident 2 safe. RN 2 stated without a CP, staff would not be aware of Resident 2 ' s high-risk for falls status and what interventions to take with Resident 2. RN 2 stated it was possible Resident 2 ' s fall and injury on 3/8/2025 could have been prevented if staff knew the appropriate interventions to take with a CP. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 1:38 pm, with the Director of Nursing (DON), the DON stated (in general) all residents who were considered at high-risk for falls needed a CP. The DON stated a CP was important to address the safety concerns and the risk for falls. The DON stated without a CP, there are no interventions in place to be able to prevent an incident. The DON stated the facility had a fall management program for residents who were considered at high-risk for falls and/or have previously fallen. The DON stated those residents ' names ' go on a list and were monitored more frequently to prevent falls and the recurrence of falls. The DON stated Resident 2 was not added to the fall management program list until 3/8/2025 when Resident 2 fell out of bed. The DON stated Resident 2 should have been added to the list on 1/11/2025 when the FRA indicated Resident 2 was at high-risk for falls. the DON stated it was possible Resident 2 ' s fall and injury on 3/8/2025 could have been prevent had Resident 2 been added to the fall management program, a CP be developed and interventions in place. During a review of the facility ' s P&P titled, Fall Management Program, revised 3/13/2021, the P&P indicated the purpose was to provide residents a safe environment that minimized complications associated with falls. The P&P indicated the facility would implement a fall management program that supposed providing an environment free from all hazards. The P&P indicated as part of the admission assessment, LNs would complete a FRA. The P&P indicated if a fall risk factor was identified, document interventions on the resident ' s care plan. The P&P indicated the interdisciplinary team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) and/or the licensed nurse would develop a CP according to the identified risk factors and root cause(s) per Care Area Assessment (CAA) guidelines. The P&P indicated the IDT would initiate, review, and update the resident ' s fall risk status and care plan at the following intervals: on admission, quarterly, upon identification of significant CIC, post fall, and as needed.

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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** 46687 Based on interview and record review, the facility failed to ensure accurate documentation on the Fall Risk Assessment (FRA) for one of three sampled residents (Resident 2), according to the facility ' s policy and procedure (P&P) titled, Completion and Correction, by failing to: Ensure Registered Nurse (RN) 2 accurately assessed and documented Resident 2 ' s FRA on 3/8/2025, after Resident 2 sustained a fall. As a result of this failure, after Resident 2 fell on [DATE], Resident 2 ' s revised FRA was completed, and indicated Resident 2 was not at high-risk for falls. This failure had the potential for Resident 2 to not receive the care and services needed to prevent another fall from happening and could lead to Resident 2 not being monitored appropriately. Findings: During a review of Resident 2 ' s Admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/11/2025 with diagnoses that included lack of coordination (uncoordinated movement due to muscle control that causes an inability to coordinate movements) and osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones gradually wears away, leading to pain, stiffness, and reduced movement) of the right hip and right knee. During a review of Resident ' s FRA dated 1/11/2025, timed at 5:10 pm, the FRA indicated Resident 2 was at high-risk for falls. The FRA indicated Resident 2 did not have a history of falls in the past three months. During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool) dated 1/18/2025, the MDS indicated Resident 2 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 2 was dependent (helper does ALL the effort. Resident does none of the effort to completely the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, rolling left and right (in bed), sitting to lying, lying to sitting on side of the bed, and chair/bed-to-chair transfers. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with eating, oral and personal hygiene, and upper body dressing. The MDS indicated walking 10 feet was not attempted due to medical condition or safety concerns. During a review of Resident 2 ' s eINTERACT/change in condition(CIC- a change in the resident ' s health or functioning that requires further assessment and intervention) Evaluation (CICE) dated 3/8/2025, timed at 4:15 pm, the CICE indicated the CNA (not identified) alerted Registered Nurse (RN) 2 that Resident 2 had fallen out of bed. The CICE indicated Resident 2 was found on Resident 2 ' s back, next to the bed. The CICE indicated Resident 2 had a skin tear to the left elbow. (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 2 ' s FRA dated 3/8/2025, timed at 5:53 pm, the FRA indicated Resident 2 did not have a history of falls in the past three months. The FRA indicated Resident 2 was not at high-risk for falls. During a concurrent interview and record review on 3/25/2025 at 2:08 pm, with the MDS Nurse (MDSN), Resident 2's FRA was reviewed on the facility's computer program Point-Click Care (PPC- cloud-based Electronic Health Record (EHR) platform specifically designed for long-term care providers, including skilled nursing, assisted living, and senior living communities). The MDSN stated (in general) when a resident has fallen, it generally increases the FRA score. The MDSN stated an FRA score of 10 or higher indicated a resident was at high-risk for falls. The MDSN stated Resident 2 ' s initial FRA score was 14. The MDSN stated when Resident 2 ' s FRA was completed on 3/8/2025 after Resident 2 fell , the FRA score was nine. The MDSN stated Resident 2 ' s FRA from 3/8/2025 should have indicated Resident 2 had a fall within the past three months, which would have kept Resident 2 at high-risk for falls. The MDSN stated it was important to ensure all assessments were accurate to ensure Resident 2 was receiving appropriate care. The MDSN stated because Resident 2 ' s FRA dated 3/8/2025 was not accurate, there could be a discrepancy with Resident 2 ' s care. During a telephone interview on 3/25/2025 at 3:40 pm, with RN 2, RN 2 stated RN 2 completed Resident 2 ' s FRA 3/8/2025, but did not complete the FRA correctly. RN 2 stated Resident 2 ' s FRA should have indicated Resident 2 had a fall within the past three months. RN 2 stated if Resident 2 ' s FRA would have been documented correctly, the FRA would have prompted RN 2 to create a care plan indicating Resident 2 was at high-risk for falls. RN 2 stated it was important to ensure RN 2 ' s documentation was accurate for patient safety. RN 2 stated because Resident 2 ' s FRA 3/8/2025 was not accurate, it did not prompt RN 2 to make a CP and could affect how safely Resident 2 was cared for and may lead Resident 2 to not being monitored appropriately. During an interview on 3/26/2025 at 3:28 pm, with the Director of Nursing (DON), the DON stated (in general) it was important to accurately document an FRA to know the true score because it could affect a resident ' s level of risk. The DON stated if a resident ' s FRA score was lowered because of inaccurate documentation, it could cause a resident to not receive services or be monitored the same if the FRA score reflected a high-risk for falls. During a review of the facility ' s P&P titled, Completion and Correction, revised 1/1/2012, the P&P indicated the purpose was to ensure that medical records were complete and accurate, and that the facility would work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. The P&P indicated entries would be complete, legible, descriptive, and accurate.