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	06/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify Resident 3's doctor of Resident 3's refusals to allow the nurse to perform accu checks (sampling a drop of blood from the finger to determine the blood glucose [sugar] level) on 5/5, 5/8, 5/11, and 5/12/2025. These failures had the potential to result in Resident 3 to not receive treatment to address Resident 3's risks for hypoglycemia (a condition where the level of glucose in the blood drops below a healthy range) or hyperglycemia (having too much glucose in the blood) which could negatively affect Resident 3's health and wellbeing. (Cross Reference F656) Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 11/28/2023 and readmitted Resident 3 on 3/28/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 3's untitled care plan, initiated on 1/3/2024, the care plan indicated Resident 3 was resistive to care and had a history of refusing treatment, including accu checks and insulin. The care plan indicated facility staff should notify Resident 3's doctor if Resident 3 continues to refuse after 3 attempts. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 2/24/2025, the MDS indicated Resident 3 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 required partial/moderate (helper does less than half the effort) from staff for bathing, lower body dressing, and toileting hygiene. During a review of Resident 3's Order Summary Report (OSR), dated 6/3/2025, the OSR indicated a physician order for Resident 3 to receive Humulin R injection Solution (Insulin as a medication, insulin is any pharmaceutical preparation of the protein hormone insulin that is used to treat high blood glucose) as per a sliding scale (the amount of insulin given is based on Resident 3's blood glucose [sugar] level). The OSR indicated the facility should check Resident 1's blood glucose level, and administer Humulin R if needed, before meals and at bedtime. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555852	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Healthcare & Wellness Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/3/2025 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 3's Medication Administration Record (MAR), for May 2025, was reviewed. The MAR indicated LVN 2 documented that Resident 3 refused to let LVN 2 check Resident 3's blood sugar level with an accu check on 5/8 and 5/12/2025. LVN 2 stated LVN 2 did not notify Resident 3's doctor of Resident 3's refusals for the accu checks on 5/8 and 5/12/2025. LVN 2 stated if a resident (in general) was refusing treatments, the facility staff should attempt two more times and then notify the residents' (in general) doctor of the refusal of treatment. During a concurrent interview and record review on 6/3/2025 at 1:02 p.m. with the Quality Assurance Nurse (QAN), Resident 3's MAR, for May 2025, was reviewed. The MAR indicated Resident 3 refused accu checks on 5/5, 5/8, 5/11, and 5/12/2025. The QAN confirmed that the facility staff failed to notify Resident 3's doctor of the refusals on 5/5, 5/8, 5/11, and 5/12/2025. During a review of the facility's Policy and Procedure (P&P) titled, Refusal of Treatment revised 1/1/2012, the P&P indicated, .The Attending Physician will be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal.

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to implement the comprehensive person-centered care plan for one of three sampled residents (Residents 3) when the facility staff failed to notify Resident 3's doctor of Resident 3's refusals of accu checks (sampling a drop of blood from the finger to determine the blood glucose [sugar] level) as indicated in Resident 3's untitled care plan, initiated on 1/3/2024. This failure had the potential to result in Resident 3 to not receive treatment to address Resident 3's risks for hypoglycemia (a condition where the level of glucose in the blood drops below a healthy range) or hyperglycemia (having too much glucose in the blood) which could negatively affect Resident 3's health and wellbeing. (Cross Reference F580) Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 11/28/2023 , and readmitted Resident 3 on 3/28/2025 with diagnoses including metabolic encephalopathy (brain disease that alters brain function or structure), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 3's untitled care plan, initiated on 1/3/2024, the care plan indicated Resident 3 was resistive to care and had a history of refusing treatment, including accu checks and insulin. The care plan indicated facility staff should notify Resident 3's doctor if Resident 3 continues to refuse after 3 attempts. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 2/24/2025, the MDS indicated Resident 3 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 required partial/moderate (helper does less than half the effort) assistance from staff for bathing, lower body dressing, and toileting hygiene. During a review of Resident 3's Order Summary Report (OSR), dated 6/3/2025, the OSR indicated a physician order for Resident 3 to receive Humulin R injection Solution (Insulin as a medication, insulin is any pharmaceutical preparation of the protein hormone insulin that is used to treat high blood glucose) as per a sliding scale (the amount of insulin given is based on Resident 3's blood glucose [sugar] level). The OSR indicated the facility should check Resident 1's blood glucose level, and administer Humulin R, if needed, before meals and at bedtime. During a concurrent interview and record review on 6/3/2025 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 3's Medication Administration Record (MAR), for May 2025, was reviewed. The MAR indicated LVN 2 documented that Resident 3 refused to let LVN 2 check Resident 3's blood sugar level with an accu check on 5/8 and 5/12/2025. LVN 2 stated LVN 2 did not notify Resident 3's doctor of Resident 3's refusals for the accu checks on 5/8 and 5/12/2025. LVN 2 stated if a resident (in general) was refusing treatments, the facility staff should attempt two more times and then notify the residents' (in general) doctor of the refusal of treatment. (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 a concurrent interview and record review on 6/3/2025 at 1:02 p.m. with the Quality Assurance Nurse (QAN), Resident 3's MAR, for May 2025, was reviewed. The MAR indicated Resident 3 refused accu checks on 5/5, 5/8, 5/11, and 5/12/2025. The QAN confirmed facility staff failed to notify Resident 3's doctor of the refusals on 5/5, 5/8, 5/11, and 5/12/2025. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning revised November 2018, the P&P indicated, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial wellbeing.

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	555852	A. Building B. Wing	06/03/2025

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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 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 observation, interview, and record review, the facility failed to ensure one of 10 sampled residents (Resident 5) had a written physician's order to go out on pass (temporary permission of a resident to leave the facility within a specified time) before Resident 5 left the facility to go on an overnight pass on 5/23/2025. This failure had the potential for Resident 5 and other residents to be allowed out of the facility without being properly assessed for safety awareness, decision-making capacity, physical disabilities, and the ability to call for medical assistance if required and when indicated. Resident 5 left the faciity on 5/23/2025 and came back on 5/24/2025 with abrasions and bruises on both arms and legs, and bleeding in the back of the head. (Cross reference F842) Findings: During a review of Resident 5's Face Sheet, the FS indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (when the space inside the spine [backbone] gets too small. This can put pressure on the spinal cord and the nerves that travel through the spine) and difficulty walking. The FS indicated Resident 5 was self-responsible. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 5's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 5 had decreased movement on both upper extremities (shoulders, elbows, wrists, hands) and had decreased movement on one lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, dressing, putting on/taking off footwear, personal hygiene, moving around in bed, transferring, and with walking 50 feet with two turns. During a review of Resident 5's active Physician's Orders (POs) as of 6/2/2025, the POs indicated there was no written PO for Resident 5 to go on an overnight out on pass on 5/23/2025. During a review of Resident 5's late entry Progress Notes (PN) written by Licensed Vocational Nurse (LVN) 4, dated 5/23/2025 and timed 1 for p.m., the PN indicated Resident 5 went on an overnight pass with Family Member (FM) 1. During a review of a Change in Condition (CIC) PN, dated 5/24/2025 and timed for 9:15 a.m., the CIC indicated Resident 5 returned to the facility on 5/24/2025 at 5:50 a.m. with bruises on both arms and legs, and bleeding in the back of the head. The CIC indicated Resident 5 appeared to be intoxicated. (continued on next page)

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	555852	A. Building B. Wing	06/03/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the PN, dated 5/24/2025 and timed for 1:06 p.m., the PN indicated Resident 5 returned from General Acute Care Hospital (GACH) 1 with the following diagnoses: alcohol intoxication and closed head injury without change in level of consciousness. The PN indicated Resident 5's CT of the head showed mild left frontal scalp swelling. During a review of the PN, dated 5/24/2025 and timed for 2:27 pm, the PN indicated Resident 5 had abrasions on both elbows and both knees. During a review of the PN, dated 5/24/2025 and timed for 3:57 p.m., the PN indicated the Director of Nursing (DON) spoke with Medical Doctor (MD) 1 to confirm MD 1 gave a nurse (unidentified) an overnight out on pass telephone order for 5/23/2025 to 5/24/2025. During a concurrent observation and interview on 6/2/2025 at 11:59 a.m. with Resident 5, Resident 5 stated Resident 5 fell off the sidewalk while walking back to the facility and scratched up Resident 5's arms and hit Resident 5's head. Resident 5 was observed with multiple scabbed abrasions on both forearms. Resident 5 denied any other injuries and refused a body check. During an interview on 6/3/2025 at 10:17 a.m. with the DON, the DON stated LVN 4 took care of Resident 5 when Resident 5 left for an overnight pass on 5/23/2025. During a subsequent interview on 6/3/2025 at 11:43 a.m. with the DON, the DON stated LVN 4 told the DON, on 5/23/2025, LVN 4 had obtained an order from MD 1 for Resident 5 to go out on an overnight pass from 5/23/2025 to 5/24/2025, but LVN 4 was in a hurry and forgot to write down and carry out MD 1's order. The DON stated the expectation was for licensed nurses to document a physician's order as soon as possible. During a phone interview on 6/3/2025 at 3:03 p.m. with MD 1, MD 1 stated he would not order an overnight out on pass. MD 1 stated MD 1 did not want to give Resident 5 another out on pass order because Resident 5 abused Resident 5's previous out on pass order. During a subsequent phone interview on 6/3/2025 at 4:14 p.m. with MD 1, MD 1 called to clarify that MD 1 could not remember if MD 1 gave the nurse (unidentified) an overnight pass order for Resident 5 on 5/23/2025. During a review of the facility's P&P titled, Out on Pass, with a revision date of 12/1/2014, the P&P indicated, If the Attending Physician and Psychiatrist (if applicable) determine that the resident may participate in activities outside the facility, the Attending Physician will write/give an order for a pass on the physician order sheet. The Attending Physician's order should indicate whether the resident needs to be accompanied by a responsible person while out on pass . During a review of the facility's P&P titled, Physician Orders, with a revision date of 8/21/2020, the P&P indicated, A licensed nurse will record telephone orders with the date, time, and signature of the person receiving the order .The telephone order is transcribed onto the Physician's Order form at time the order is taken .Whenever possible, the licensed nurse receiving the order will be responsible for documenting and carrying out the order .

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	555852	A. Building B. Wing	06/03/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was provided wound care treatment as ordered by Resident 1's physician. This failure had the potential for Resident 1's wound to become infected and/or for Resident 1's wound to not heal. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/7/2025 with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra), and pressure ulcer (also known as bed sore or pressure injury, localized injuries to the skin and underlying tissue caused by prolonged pressure) of the left buttock. During a review of Resident 1's Wound Assessment and Plan (WAP), dated 5/13/2025, the WAP indicated Resident 1 had a pressure injury related to a medical device located on Resident 1's penis. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene and bathing. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for dressing and personal hygiene. The MDS indicated Resident 1 had an indwelling catheter (Foley catheter, a type of urinary catheter that remains inside the bladder and is connected to a drainage bag to continuously collect urine). During a review of Resident 1's Order Summary Report (OSR), dated 6/2/2025, the OSR indicated Resident 1 had an open wound to the penis caused by a medical device (Foley catheter). The OSR indicated the physician ordered a treatment for Resident 1's open wound on the penis to be done daily. The treatment order indicated to cleanse the open wound with normal saline (used to cleanse wounds), apply hydro gel (a gel used to encourage wound healing), and to cover the open wound with a dry dressing. During a concurrent observation and interview on 6/2/2025 at 11:10 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 was observed lying in the bed. LVN 1 stated Resident 1 had a sore on Resident 1's penis. LVN 1 stated the Treatment Nurse (TN) was responsible to change the dressing over the sore on Resident 1's penis. LVN 1 removed the diaper from Resident 1's groin area which revealed there was no bandage covering the sore on Resident 1's penis. An open wound was noted at the bottom section near the tip of Resident 1's penis where the catheter tube entered Resident 1's penis. LVN 1 stated a dressing needed to cover the sore on Resident 1's penis. LVN 1 stated if the dressing comes off, LVN 1, should be notified so the dressing could be replaced. LVN 1 stated a dressing needed to cover the wound in order for the wound to heal. (continued on next page)

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	555852	A. Building B. Wing	06/03/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/2/2025 at 11:15 a.m. with TN 1, TN 1 was observed applying the treatment order to the open wound on Resident 1's penis. LVN1 confirmed a dressing was not covering the open sore as indicated in Resident 1's physician orders. TN 1 stated the open wound was caused by the Foley catheter. TN 1 stated the wound should have a dressing always covering the wound. TN 1 stated if the wound was not kept covered, the healing of the wound would be delayed. TN 1 stated there was a risk the open wound would become infected if the wound was not kept covered with a dressing. During an interview on 6/2/2025 at 2:44 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to care for Resident 1 on 6/2/2025. CNA 1 stated CNA 1 had changed Resident 1's diaper around 10 a.m. on 6/2/2205. CNA 1 stated Resident 1 did not have a bandage over the open sore of the penis when CNA 1 had changed Resident 1's diaper earlier in the morning. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Injury and Skin Integrity Treatment, revised 8/12/2016, the P&P indicated, Treatments to pressure injuries and other skin integrity problems will be provided as ordered by the physician.

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	555852	A. Building B. Wing	06/03/2025

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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** Based on interview and record review, the facility failed to ensure the clinical record for one of 10 sampled residents (Resident 5) was complete and accurate when there was no written physician's order to go out on pass (temporary permission of a resident to leave the facility within a specified time) before Resident 5 left the facility to go on an overnight pass on 5/23/2025. This failure had the potential for Resident 5's whereabouts to not be known to facility staff and for Resident 5 to be allowed out of the facility without being properly assessed for safety awareness, decision-making capacity, physical disabilities, and the ability to call for medical assistance if required and when indicated. Resident 5 left the faciity on 5/23/2025 and came back on 5/24/2025 with abrasions and bruises on both arms and legs, and bleeding in the back of the head. Cross reference F684 Findings: During a review of Resident 5's Face Sheet, the FS indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (when the space inside the spine [backbone] gets too small. This can put pressure on the spinal cord and the nerves that travel through the spine) and difficulty walking. The FS indicated Resident 5 was self-responsible. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 5's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 5 had decreased movement on both upper extremities (shoulders, elbows, wrists, hands) and had decreased movement on one lower extremity (hip, knee, ankle, foot). The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, dressing, putting on/taking off footwear, personal hygiene, moving around in bed, transferring, and with walking 50 feet with two turns. During a review of Resident 5's active Physician's Orders (POs) as of 6/2/2025, the POs indicated there was no written PO for Resident 5 to go on an overnight out on pass on 5/23/2025. During a review of Resident 5's late entry Progress Notes (PN) written by Licensed Vocational Nurse (LVN) 4, dated 5/23/2025 and timed for 1 pm, the PN indicated Resident 5 went on an overnight out on pass with Family Member (FM) 1. During a review of a Change in Condition (CIC) PN, dated 5/24/2025 and timed for 9:15 a.m., the CIC indicated Resident 5 returned to the facility on 5/24/2025 at 5:50 a.m. with bruises on both arms and legs, and bleeding in the back of the head. The CIC indicated Resident 5 appeared to be intoxicated. (continued on next page)

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	555852	A. Building B. Wing	06/03/2025

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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	During a review of the PN, dated 5/24/2025 and timed for 1:06 pm, the PN indicated Resident 5 returned from General Acute Care Hospital (GACH) 1 with the following diagnoses: alcohol intoxication and closed head injury without change in level of consciousness. The PN indicated Resident 5's CT of the head showed mild left frontal scalp swelling. During a review of the PN, dated 5/24/2025 and timed for 2:27 p.m., the PN indicated Resident 5 had abrasions on both elbows and both knees. During a review of the PN, dated 5/24/2025 and timed for 3:57 p.m., the PN indicated the Director of Nursing (DON) spoke with Medical Doctor (MD) 1 to confirm MD 1 gave a nurse (unidentified) an overnight out on pass order for 5/23/2025 to 5/24/2025. During a concurrent observation and interview on 6/2/2025 at 11:59 a.m. with Resident 5, Resident 5 stated Resident 5 fell off the sidewalk while walking back to the facility and scratched up Resident 5's arms and hit Resident 5's head. Resident 5 was observed with multiple scabbed abrasions on both forearms. Resident 5 denied any other injuries and refused a body check. During an interview on 6/3/2025 at 10:17 a.m. with the DON, the DON stated LVN 4 took care of Resident 5 when Resident 5 left for an overnight pass on 5/23/2025. During a subsequent interview on 6/3/2025 at 11:43 a.m. with the DON, the DON stated LVN 4 told the DON, on 5/23/2025, LVN 4 obtained an order from MD 1 for Resident 5 to go out on an overnight pass from 5/23/2025 to 5/24/2025, but LVN 4 was in a hurry and forgot to write down and carry out MD 1's order. The DON stated the expectation was for licensed nurses to document a physician's order as soon as possible. During a phone interview on 6/3/2025 at 3:03 p.m. with MD 1, MD 1 stated he would not order an overnight out on pass. MD 1 stated MD 1 did not want to give Resident 5 another out on pass order because Resident 5 abused Resident 5's previous out on pass order. During a subsequent phone interview on 6/3/2025 at 4:14 p.m. with MD 1, MD 1 called to clarify that MD 1 could not remember if MD 1 gave the nurse (unidentified) an overnight pass order for Resident 5 on 5/23/2025. During a review of the facility's P&P titled, Out on Pass, with a revision date of 12/1/2014, the P&P indicated, If the Attending Physician and Psychiatrist (if applicable) determine that the resident may participate in activities outside the facility, the Attending Physician will write/give an order for a pass on the physician order sheet. The Attending Physician's order should indicate whether the resident needs to be accompanied by a responsible person while out on pass . During a review of the facility's P&P titled, Physician Orders, with a revision date of 8/21/2020, the P&P indicated, A licensed nurse will record telephone orders with the date, time, and signature of the person receiving the order .The telephone order is transcribed onto the Physician's Order form at time the order is taken .Whenever possible, the licensed nurse receiving the order will be responsible for documenting and carrying out the order .