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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>555852 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>12/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Park Avenue Healthcare & Wellness Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1550 North Park Avenue<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation and interview, the facility failed to ensure a safe and clean environment for one of three sampled residents (Resident 2) when:</p> <p>a. The wall in Resident 2's room was observed with brown spots.</p> <p>b. The recliner chair in Resident 2's room was observed with brown smears on the seat of the recliner. These failures resulted in Resident 2 living in an unclean environment and had the potential to result in psychosocial decline to Resident 2.</p> <p>Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 12/3/2025 with diagnoses including encephalopathy (a disturbance of brain function) and chronic obstructive pulmonary disease (a group of lung diseases that cause long-term breathing problems). During a review of Resident 2's History and Physical (H&amp;P), dated 12/5/2025, the H&amp;P indicated Resident 2 did not have the capacity to understand and make decisions. During an observation on 12/8/2025 at 1:30 PM in Resident 2's room, raised round brown spots were observed on the wall next to the wall mounted television above Bed 2. During a concurrent observation and interview on 12/8/2025 at 1:45 PM with Certified Nursing Assistant (CNA) 1 in Resident 2's room, a brown smear was observed on the seat of the recliner chair located next to Bed 2. CNA 1 stated the recliner chair was dirty. During a concurrent observation and interview on 12/9/2025 at 10:50 AM with the Director of Nursing (DON) in Resident 2's room, round brown spots were observed on the wall next to the wall mounted television set above Bed 2 and brown smears were observed on the seat of the recliner located in Resident 2's room. The DON stated it was important for the walls and recliner chair in Resident 2's room to [remain] clean. During a review of the facility's Policy and Procedure (P&amp;P) titled, Housekeeping-General, revised 1/1/2012, the P&amp;P's purpose indicated, To ensure that the Facility is clean, sanitary, and in good repair at all times so as to promote the health and safety of residents, staff, and visitors. The P&amp;P's policy indicated, All rooms of the Facility are kept clean and as free as possible of germs and other contaminating agents at all times, while maintaining a pleasant and homelike atmosphere for our residents. During a review of the facility's P&amp;P titled, Housekeeping-Resident Rooms, revised September 2016, the P&amp;P's purpose indicated, To promote the quality of life for residents by providing clean and sanitary living spaces. The P&amp;P's procedure indicated chairs (except cloth upholstered) were to be damp wiped (using a sponge or cloth dipped in a cleaning solution to clean surfaces) on a regular basis. Additionally, the P&amp;P's procedure indicated all surfaces in the room including walls were to be thoroughly cleaned and disinfected after resident discharge.</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to obtain medication admission orders for one of three sampled residents (Resident 1) when the medical doctor (MD)1 did not respond to Registered Nurse (RN) 1's request for medication admission orders. This failure resulted in Resident 1's medications not being obtained timely and had the potential to result in adverse medical outcomes for Resident 1. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 12/3/2025 with diagnoses including metabolic encephalopathy (brain dysfunction due to illness), acute (sudden) and chronic (persistent or long-lasting) respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen [colorless, odorless gas]), type 2 diabetes mellitus (a chronic disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production) with hyperglycemia (high blood sugar levels), and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness). During a review of Resident 1's History and Physical (H&amp;P), dated 12/5/2025, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Progress Note titled Q [every] Shift 72 Hour admission Note, dated 12/3/2025, timed at 5:30PM, the Progress Note indicated, Notified [MD 1] [regarding] [Resident 1] doesn't have discharge medication order[s] from [General Acute Care Hospital (GACH) 1]. During a review of Resident 1's Order Summary Report (OSR), dated active as of 12/9/2025, the OSR indicated Resident 1 had the following orders: a. Amiodarone (a medication used to treat irregular heart rhythms) one tablet two times a day with a start date of 12/4/2025. b. Insulin Lispro (a fast-acting insulin used to lower blood sugar) to be given before meals and at bedtime with a start date of 12/4/2025. c. Ipratropium-albuterol (a medication used to treat lung disease) three milliliters (ml-a unit of measurement) to be given every six hours with a start date of 12/4/2025. d. Keppra (a medication used to treat and prevent seizures) oral tablet 1500 milligrams (mg-a unit of measurement) two times a day for seizures with a start date of 12/4/2025. e. Olanzapine (a medication used to treat mental health disorders) one tablet to be given two times a day for psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) with a start date of 12/4/2025. f. Pantoprazole sodium (a medication used to treat gastroesophageal reflux disease [GERD-a medical condition where stomach acid flows back into the tube connecting the mouth and stomach) one tablet one time a day for GERD with a start date of 12/5/2025. During an interview on 12/8/2025 at 4:27 PM with RN 1, RN 1 stated MD 1 did not respond to RN 1's text on 12/3/2025 requesting medication admission orders for Resident 1. RN 1 stated that since MD 1 did not respond to RN 1's text, RN 1 should have notified the Medical Director. RN 1 stated RN 1 did not follow up with the Medical Director. RN 1 stated it was important for the MD to be aware of Resident 1's medical needs to ensure Resident 1's safety. During an interview on 12/9/2025 at 2:25 PM with the Director of Nursing (DON), the DON stated Resident 1 was admitted to the facility on [DATE] and Resident 1's medications were not ordered until 12/4/2025 around 12 PM. The DON stated since MD 1 did not reply to RN 1's notification text on 12/3/2025 RN 1 should have called the Medical Director. Additionally, the DON stated it was important to notify the MD to ensure Resident 1 was stable and in good [health] condition. During a review of the facility's Policy and Procedure (P&amp;P) titled, admission and Orientation of Residents, revised October 2017, the P&amp;P's purpose indicated, To facilitate the admission and readmission process of residents while ensuring that residents and families are properly oriented to the Facility. The P&amp;P's procedure indicated, Upon admission, the resident's Attending Physician will provide the following information to the Admissions Office: Medication orders.</p> |   |  |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>Based on interview and record review the facility failed to ensure the recommended therapeutic diet (a diet ordered by a physician or a delegated registered or licensed dietitian as part of treatment for a disease or clinical condition) was ordered for one of three sampled residents (Resident 1) when Registered Nurse (RN) 1 did not order a diabetic diet (an eating plan that helps control blood sugar levels) for Resident 1. This failure had the potential to result in Resident 1 experiencing adverse health effects such as hyperglycemia (high blood sugar levels). Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 12/3/2025 with diagnoses including metabolic encephalopathy (brain dysfunction due to illness), acute (sudden) and chronic (persistent or long-lasting) respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen [colorless, odorless gas]), type 2 diabetes mellitus (a chronic disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production) with hyperglycemia (high blood sugar levels), and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness). During a review of Resident 1's History and Physical (H&amp;P), dated 12/5/2025, the H&amp;P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report (OSR), dated active as of 12/9/2025, the OSR indicated a regular standard portion diet (a diet that is not a restrictive medical diet but follows general health guidelines) was ordered for Resident 1 on 12/4/2025 with a start date of 12/4/2025. During a concurrent interview and record review on 12/8/2025 at 4:27 PM with Registered Nurse (RN) 1, Resident 1's General Acute Care Hospital (GACH) records, titled After Visit Summary, (a patient-focused document given after a hospital visit to provide discharge instructions) dated 11/21/2025-12/3/2025 were reviewed. The GACH record indicated Resident 1 had discharge instructions for a diabetic diet. RN 1 stated Resident 1 should have had a diabetic diet ordered but on 12/4/2025 RN 1 mistakenly ordered a regular diet for Resident 1. RN 1 stated it was important for Resident 1 to receive the correct diet for Resident 1's safety and to prevent medical complications such as hyperglycemia. During an interview on 12/9/2025 at 2:25 PM with the Director of Nursing (DON), the DON stated it was important for Resident 1 to have the correct diet ordered so that Resident 1's medical needs could be addressed. During a review of the facility's Policy and Procedure (P&amp;P) titled, Therapeutic Diets, revised 6/1/2014, the P&amp;P's purpose indicated, To ensure that the Facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders. The P&amp;P's policy indicated, Therapeutic diets are diets that deviate from the regular diet and require a physician order. Per the physician order, therapeutic diets are planned, prepared and served in consultation with the Dietician.</p> |   |  |