

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  12/11/2025
NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to maintain complete and accurate clinical records by failing to document required meal intake percentages for one of three sampled residents (Resident 1). This failure resulted in incomplete/inaccurate nutritional records and had the potential to negatively affect Resident 1's health and well-being. Findings: During a review of Resident 1's admission Record (AR- face sheet), the AR indicated the facility admitted Resident 1 on 4/16/2024 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical (H&amp;P) dated 12/20/2025, the H&amp;P indicated Resident 1 did not have the mental capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 1/6/2025, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 1 required moderate assistance with eating, maximal assistance with oral hygiene and upper body dressing and was dependent to staff on toileting, shower/bathing self and lower body dressing. During a review of Resident 1's POC Nutrition - Amount Eaten documentation from January 3, 2025 through January 31, 2025, the documentation indicated a pattern of incomplete documentation on the following dates: January 6, 2025: No documentation of breakfast intake percentage and No documentation of lunch intake percentage. January 7, 2025: No documentation of dinner intake percentage. January 8, 2025: No documentation of dinner intake percentage. January 9, 2025: No documentation of breakfast intake percentage. January 10, 2025: No documentation of dinner intake percentage. January 11, 2025: No documentation of breakfast intake percentage. No documentation of lunch intake percentage. January 14, 2025: No documentation of breakfast intake percentage. No documentation of lunch intake percentage. No documentation of dinner intake percentage. January 15, 2025 - January 18, 2025: No documentation of dinner intake percentage. January 19, 2025: No documentation of breakfast intake percentage. No documentation of lunch intake percentage. No documentation of dinner intake percentage. January 21, 2025: No documentation of breakfast intake percentage. No documentation of lunch intake percentage. January 23, 2025- January 24, 2025: No documentation of dinner intake percentage. January 26, 2025- January 29, 2025: No documentation of breakfast intake percentage. No documentation of lunch intake percentage. During an interview on 12/11/2025 at 10 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated meal intake percentages needed to be documented for each resident's meal. During an interview on 12/11/2025 at 2: 45 PM with the facility's Director of Nursing (DON), the DON stated resident records were required to be complete and accurate. During a review of the facility's Policy and Procedure (P&amp;P) titled, ADL Documentation revised July 1, 2014, the P&amp;P indicated the facility will ensure documentation of care provided to the residents for completion of ADL by nursing staff.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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