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	02/05/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Cross Reference F 563Based on interview and record review the facility failed to ensure the Responsible Party (RP-an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making) did not make undelegated decisions for one of three sampled residents (Resident 2) when facility staff did not ask Resident 2 if Family Members (FM) 1 and 2 could receive a medical update for Resident 2.This failure resulted in Resident 2 experiencing feelings of sadness and had the potential for psychosocial (the emotional and social requirements that individuals have to feel safe, supported, and capable of functioning well in their environment) distress and feelings of decreased self-worth.Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 9/2/2025 with diagnoses including urinary tract infection (an infection that affects any party of the urinary system including the kidneys, ureters, bladder, and urethra) and unspecified dementia (the loss of the ability to think, remember, and reason that affect daily life and activities). The AR indicated Resident 2 had an RP.During a review of Resident 2's History and Physical (H&P), dated 9/2/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 2's cognitive (the ability to think and process information) skills for daily decision making was impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 2 required partial to moderate assistance with toileting, showering, and walking.During a telephone interview on 2/3/2026 at 3:15 PM with FM 1, FM 1 stated on 1/21/2026 while visiting Resident 2 at the facility FM 1 and Resident 2's spouse (FM 2) requested a medical update regarding Resident 2 from the Social Service Director (SSD). FM 1 stated the SSD informed FM 1 and FM 2 that Resident 2's RP was Resident 2's Power of Attorney (POA-a legal document that gives one person the authority to act on behalf of another person) and had denied FM 1 and FM 2 a medical update regarding Resident 2.During a telephone interview on 2/3/2026 at 4:50 PM with the RP, the RP stated on 1/21/2026 a facility staff member called the RP and asked if FM 1 and FM 2 had permission to receive a medical update for Resident 2. The RP stated the RP instructed the facility not to give FM 1 and FM 2 any medical updates regarding Resident 2.During an interview on 2/4/2026 at 9:30 AM with the Social Service Coordinator (SSC) 1, SSC 1 stated FM 1 and FM 2 visited the facility on 1/21/2026 and asked for a medical update regarding Resident 2. SSC 1 stated since FM 1 and FM 2 were not listed on Resident 2's AR, FM 1 and FM 2 were not provided with the requested medical update for Resident 2. SSC 1 stated SSC 1 did not ask Resident 2's permission to give a medical update to FM 1 and FM 2.During an interview on 2/4/2026 at 1 PM with Resident 2, Resident 2 stated Resident 2 was unaware FM 1 and FM 2 were denied medical updates regarding Resident 2 which made Resident 2 feel sad. Resident 2 stated FM 1 and FM 1 could receive medical updates regarding Resident 2. Resident 2 stated, My [family members] are my life, with tears observed in Resident 2's eyes.During a concurrent interview and record review on 2/4/2026 at 3:10 PM with the SSD, Resident 2's POA (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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 9/14/2022 was reviewed. The POA indicated Resident 2's RP was a financial POA. The SSD stated the POA was a financial POA and not a medical POA. The SSD stated the financial POA does not give the POA the right to make medical decisions for Resident 2. The SSD stated the facility should have asked Resident 2 if FM 1 and FM 2 could receive a medical update regarding Resident 2. The SSD stated it was important to ask Resident 2 about Resident 2's wishes because it was Resident 2's right.During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised January 2012, the P&P's purpose indicated, To promote and protect the rights of all residents at the Facility. The P&P's policy indicated, Residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect those rights. Residents have freedom of choice, as much as possible, about how they wish to live their everyday live and receive care, subject to the Facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety. The R&P's Procedure indicated, In order to facilitate resident choices, Facility Staff will Inform (and regularly remind) the resident and family members of the resident's right to self-determination and participation in preferred activities.

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Cross Reference F551Based on interview and record review the facility failed to provide immediate access by family members (FMs) for one of three sampled residents (Resident 2) when Resident 2's FM 1 and FM 2 were denied further visitation access to Resident 2.This failure resulted in Resident 2 not receiving visits from FM 1 and FM 2, made Resident 2 feel sad, violated Resident 2's right, and had the potential to result in Resident 2 experiencing psychosocial (the emotional and social requirements that individuals have to feel safe, supported, and capable of functioning well in their environment) distress and feelings of decreased self-worth.Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 9/2/2025 with diagnoses including urinary tract infection (an infection that affects any party of the urinary system including the kidneys, ureters, bladder, and urethra) and unspecified dementia (the loss of the ability to think, remember, and reason that affect daily life and activities). The AR indicated Resident 2 had a Responsible Party (RP-an individual chosen by the resident to act on behalf of the resident to support the resident in decision-making).During a review of Resident 2's History and Physical (H&P), dated 9/2/2025, the H&P indicated Resident 2 could make needs known but could not make medical decisions.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 2's cognitive (the ability to think and process information) skills for daily decision making was impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 2 required partial to moderate assistance with toileting, showering, and walking.During a telephone interview on 2/3/2026 at 3:15 PM with Family Member (FM) 1, FM 1 stated on 1/21/2026 while visiting Resident 2 at the facility FM 1 and Resident 2's spouse (FM 2) requested a medical update regarding Resident 2 from the Social Service Director (SSD). FM 1 stated the SSD informed FM 1 and FM 2 after speaking with Resident 2's RP on 1/21/2026 that Resident 2's RP had denied FM 1 and FM 2 further visitation of Resident 2 at the facility.During an interview on 2/3/2026 at 3:50 PM with Resident 2, Resident 2 stated FM 1 and FM 2 had permission to visit Resident 2 at the facility. Additionally, Resident 2 stated any of Resident 2's family members could visit Resident 2 at the facility.During a telephone interview on 2/3/2026 at 4:50 PM with the RP, the RP stated on 1/21/2026 a facility staff member called the RP and asked if FM 1 and FM 2 had permission to receive a medical update for Resident 2. The RP instructed the facility not to give FM 1 and FM 2 any medical updates or allow them further visitation of Resident 2 at the facility.During an interview on 2/4/2026 at 1 PM with Resident 2, Resident 2 stated Resident 2 was unaware FM 1 and FM 2 were denied further visitation for Resident 2 which made Resident 2 feel sad. Resident 2 stated, My [family members] are my life, with tears observed in Resident 2's eyes.During an interview on 2/4/2026 at 3:10 PM with the SSD, the SSD stated it is the policy of the facility to let any family members visit when the residents (in general) permit it. The SSD stated the facility should have asked Resident 2 if FM 1 and FM 2 were allowed to visit Resident 2. The SSD stated it was important to ask Resident 2 about Resident 2's wishes because it is Resident 2's right. Additionally, the SSD stated it was important for Resident 2's quality of life to be allowed access to Resident 2's family members.During a review of the facility's Policy and Procedure (P&P) titled, Visitation Rights, revised January 2016, the P&P's purpose indicated, To ensure that residents are able to exercise their rights with regard to visitation. The P&P's policy indicated, The Facility permits resident to receive visitors subject to the resident's wishes and the protection of the rights of other resident in the facility. The P&P's procedure indicated, Resident's right to visitors: The resident may visit with immediate family or relatives any time, so long as the protection of the rights and safety of other residents is (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not jeopardized.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a care plan for one of two sampled residents (Resident 1) regarding the implementation of a pacemaker monitoring system as indicated on the facility's policy. This deficient practices had the potential for Resident 1 to receive improper care and monitoring of the resident's heart rhythms. Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis that included heart failure (heart muscle is too weak or stiff to pump blood efficiently), hypertension (elevated blood pressure) and presence of a Cardiac Pacemaker. During a review of Resident 1's care plan, titled The resident has altered cardiovascular (a change in the normal structure or function of the heart) status related to history of pacemaker placement, initiated on 8/26/2025, the care plan indicated to monitor/document/report for chest pain or pressure.During a review of Resident 1's History and Physical (H&P), dated 8/28/2025, the H&P indicated Resident 1 was able to make decisions.During a review of Resident 1's Minimum Date Set (MDS, an assessment and care planning tool), dated 11/18/2025, the MDS indicated Resident 1's was cognitively intact, had the ability to understand and be understood by others. The MDS indicated Residents 1 needed setup or clean up with assistance from staff with eating, oral and personal hygiene, and from sit to lay position.During a review of Resident 1's Progress Notes (PN), dated 11/25/2025 at 6:18 PM, the PN indicated on 11/25/2025, the PN indicated Resident 1's Family Member (FM) brought in a heart monitor and FM instructed staff to plug-in and place close to the resident. During an interview and concurrent record review of Resident 1's paper and electronic medical record, with the Assistant Director of Nursing (ADON), on 2/3/2026 at 4:32 PM, the was no care plan related to Resident 1's pacemaker monitoring system available for review. The ADON stated the resident's care plan was not updated and it did not indicate the use of a pacemaker monitoring system. The ADON stated updated care plans were important to ensure proper care was provided and appropriate interventions were in place for Resident 1. During an interview with Registered Nurse 2 (RN 2), on 2/3/2026 at 4:47 PM, RN 2 stated RN 2 did not update Resident 1's care plan regarding the use of a pacemaker monitoring system. RN 2 stated RN 2 should have updated the care-plan because it was important information regarding Resident 1's heart. During an interview with the Director of Nursing (DON), on 2/5/20026 at 11:42 AM, the DON stated the care-plan should be updated because it (care-plans) was a guide for staff to follow to ensure appropriate interventions were in place like a map.During a review of a policy, titled Completion & Correction, revised 1/1/2012, indicated to ensure that medical records are complete and accurate. Entries will be recorded promptly as the events or observations occur. Entries will be complete, legible, descriptive and accurate. Any person making observations or rendering direct services to the resident will document in the record. During a review of a policy, titled Pacemaker - Management, effective 8/19/2025, indicated for Care Plan Development: incorporate pacemaker care into the resident's care plan, including specific interventions, monitoring frequency, and safety precautions.

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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 record review and interview, the facility failed toInform and obtain orders from Resident 1's physician regarding the use and implementation of a pacemaker monitoring Device (PMD, bedside or mobile app devices that securely transmit data from an implanted cardiac device to a healthcare team).Place Resident 1's cardiac pacemaker (CP, small battery-operated device that helps the heartbeat in a regular rhythm) information readily accessible in the resident's paper or electronic chart as indicated in facility policy titled Pacemaker - Management, and lesson plan titled Pacemaker Management. Program type: Education for Licensed Nurses. These failure had the potential to place Resident 1 at risk for delay of care and monitor of the PMD. Findings: 1.During a review of an admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis that included heart failure (heart muscle is too weak or stiff to pump blood efficiently), hypertension (elevated blood pressure) and presence of a Cardiac Pacemaker. During a review of Resident 1's History and Physical (H&P), dated 9/13/2025, the H&P indicated Resident 1 was able to make decisions.During a review of Resident 1's Minimum Date Set (MDS, an assessment and care planning tool), dated 11/18/2025, the MDS indicated Resident 1's was cognitively intact, had the ability to understand and to be understood by others. The MDS indicated Residents 1 needed setup or clean up with assistance from staff with eating, oral and personal hygiene, and from sit to lay position.During a review of Resident 1'a progress notes (PN) written by Registered Nurse 2 (RN 2), dated 11/25/2026 at 8:18 PM, the PN indicated Resident 1's Family Member 3 (FM 3) brought in a heart monitor (PMD). Per FM, the heart monitor is being monitored by the resident's cardiologist and FM instructed RN 2 to just plug in and place close (to) the resident.During an interview with RN 2, on 2/3/2026 at 4:47 PM, RN stated on 11/25/2025, upon Resident 1 and Resident 1's FM returned to the facility from a cardiologist appointment, FM gave RN 2 a heart monitor and the FM instructed RN 2 to plug the monitor in and place it close to the resident for monitoring. RN 2 stated RN 2 did not call Resident 1's Physician or cardiologist to obtain an order to use the PMS and an instruction on how to use the PMD. RN 2 stated RN 2 should have called Resident 1's Physician to ensure the residents' heart was working well.During an interview with Registered Nurse 3 (RN 3), on 2/4/2026 at 10:24 AM, RN 3 stated, when a resident returned to the facility with a new device without orders or instructions, RN 3 would call the physician for orders for instructions regarding the new device, especially pacemakers.During an interview and concurrent record review of Resident 1's paper and electronic medical record, with the Director of Nursing (DON), on 2/5/2026 at 11:42 AM, there was no orders or instructions regarding the use of the PMD. The DON stated there were no orders or instructions regarding PMD. The DON stated RN 2 should have obtained orders from Resident 1's Physician and validate instructions on how to use the PMD - acceptable distance range for transmission, how long should the device be on, how the device is charged and what to-do if the device alarms.During a review of the facility's policy titled Pacemaker - Management, effective 8/19/2025, indicated residents with pacemakers shall receive appropriate, individualized care that prioritizes safety, monitoring, education, and prompt response to any pacemaker- related complications. To establish standardized guidelines for the safe and effective nursing care of residents with pacemakers in compliance with state regulations and facility standards.2. During a review of Resident 1's care plan, titled The resident has altered cardiovascular (a change in the normal structure or function of the heart) status related to history of pacemaker placement, initiated on 8/26/2025, the care plan indicated to monitor/document/report for chest pain or pressure.During an interview and concurrent record review of Resident 1's paper and electronic chart with the Assistant Director of Nursing (ADON), on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/3/2026 at 4:32 PM, the ADON stated the ADON did not find any documentation or paperwork regarding Resident 1's pacemaker; the model type or any information regarding upkeep such as battery changes, etc.During an interview with the Director of Nursing (DON), on 2/5/2026 at 11:42 AM, the DON stated no documentation regarding Resident 1's pacemaker (make/model/location/battery change) was found in the resident's paper and electronic charts. DON stated it was important to have basic pacemaker information in case of an emergency; the information will help ensure the best care for the residents was provided. During a review of the facility's policy and procedure titled Pacemaker - Management, dated 8/19/2025, indicated to document the type of pacemaker, date of insertion, manufacturer (if available), and physician.During are review of a Lesson Plan, titled Pacemaker Management: Education for Licensed Nurses, dated 5/26/2025, the Lesson Plan indicated document the pacemaker type, date of insertion, manufacturer (if available), and implanting physician. Obtain a copy of the pacemaker identification card in the resident's medical record.