

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025
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NAME OF PROVIDER OR SUPPLIER FRENCH PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 E WASHINGTON AVENUE , SANTA ANA, California, 92701
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F0000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the concurrent Recertification, Relicensing, and Abbreviated Surveys for Complaint Numbers: 2402606 and 2561207.</p> <p>The survey team entered the facility on 7/15/25 at 0730 hours.</p> <p>The facility identified the census as 182.</p> <p>The survey final sample size was 35.</p> <p>FOR COMPLAINT NUMBER: 2402606, DEFICIENCIES WERE IDENTIFIED AND CITED AT F684 and F842.</p> <p>FOR COMPLAINT NUMBER: 2561207, DEFICIENCIES WERE IDENTIFIED AND CITED AT F684.</p> <p>GLOSSARY AND DEFINITIONS:</p> <p>% - percentage</p> <p>7-3 shift - 0700- 1500 hours</p> <p>7 am - 7 pm shift - 0700 - 1900 hours</p> <p>3-11 shift - 1500 - 2300 hours</p> <p>11-7 shift - 2300 - 0700 hours</p> <p>ADON - Assistant Director of Nursing</p> <p>ADL - Activities of Daily Living</p> <p>Advance Directive - legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions</p> <p>AFO - Ankle-foot Orthoses, device that help align the</p>	F0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider to the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907.</p>	08/23/2025
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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 reverse for further 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 Administrator	(X6) DATE 8/10/2025
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POC Accepted

9/4/25

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F0000	Continued from page 1 ankle and foot AMA - Against Medical Advise Antibiotic time out- a formal process where healthcare providers reassess a patient's antibiotic treatment, typically 48-72 hours after initiation. Antidepressants- medications used to treat depression and other mental health conditions Antipsychotics- a class of medications primarily used to manage symptoms of psychosis (symptoms that happen when a person is disconnected from reality) Anxiolytics- medication that reduces anxiety AV Shunt - Arteriovenous shunt (surgically created connection between an artery and vein for hemodialysis) BIMS - Brief Interview for Mental Status (a cognitive screening tool used to assess the cognitive function of individuals in long-term care facilities) BiPAP - Bilevel Positive Airway Pressure (a non-invasive ventilation device that helps individuals with breathing difficulties by delivering pressurized air through a mask or nasal plugs, used to treat sleeping disorder and other respiratory issues where breathing assistance is needed) bpm - beat(s) per minute Bruit - sound heard over AV shunt indicating good blood flow (to assess functionality) CA- California CAI - Community Acquired Infection CAUTI - Catheter Associated Urinary Tract Infection CDC - Center for Disease Control and Prevention cc - cubic centimeter(s) CMS - Centers for Medicare and Medicaid Services CNA - Certified Nursing Assistant Covid-19 - viral infection affecting the respiratory system Depression - mood disorder that causes a persistent	F0000		

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F0000	<p>Continued from page 2 feeling of sadness and loss of interest</p> <p>Dialysis - a life-sustaining treatment that filters blood removing waste and fluids, and maintaining electrolyte balance</p> <p>DON - Director of Nursing</p> <p>DS - Double Strength</p> <p>DSD - Director of Staff Development</p> <p>DSS - Dietary Services Supervisor</p> <p>d/t - due to</p> <p>DVT - Deep Vein Thrombosis (blood clot forms in a deep vein)</p> <p>EBP - Enhanced Barrier Precautions</p> <p>End stage renal disease - condition when the kidneys can no longer adequately filter waste and excess fluids from the blood</p> <p>EHR - Electronic Health Record</p> <p>ER - Emergency Room</p> <p>Facility Assessment - a document describing resident population and needs to determine staff and other resources necessary to competently care for residents</p> <p>FDA - Food and Drug Administration</p> <p>Foley catheter - a type of indwelling urinary catheter</p> <p>FR- French (a standard used to measure the diameter of catheters)</p> <p>GT - Gastrostomy Tube (tube inserted through the abdominal wall into the stomach and used to deliver nutrition or medication)</p> <p>HAI - Healthcare Acquired Infection (an infection developed 48 hours after admission to the facility)</p> <p>H&P - History and Physical</p> <p>Hemodialysis - a medical treatment that uses a machine to filter waste products, excess fluids, and toxins from the blood when the kidneys are no longer able to do so</p>	F0000		

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F0000	<p>Continued from page 3</p> <p>Hypnotics- medication to treat insomnia and other sleep disorders by promoting sleep</p> <p>I&O - Intake and Output</p> <p>ID - Infectious Disease</p> <p>Indwelling urinary catheter - thin, flexible tube inserted into the bladder through the urethra to drain urine</p> <p>Infiltrates- the presence of substance denser than air within the lung tissue, such as pus, blood, or protein, that appear abnormal on imaging tests.</p> <p>IP - Infection Preventionist</p> <p>IU - International unit, a standard measure of the biological activity of certain substances like vitamins, hormones, and medications</p> <p>IV - intravenous</p> <p>kcal - kilocalorie(s)</p> <p>LAL - Low Air Loss {a type of medical mattress designed to prevent and treat pressure ulcers (also known as bed sores)}</p> <p>Loeb Minimum Criteria - a set of minimum clinical criteria used to guide the initiation of antibiotic therapy for suspected infections in residents of long term care facilities.</p> <p>LTC - Long Term Care</p> <p>LVN - Licensed Vocational Nurse</p> <p>MAR - Medication Administration Record</p> <p>McGeer's criteria - a set of criteria used in long term care facilities to identify if residents' symptoms meet the criteria of a true infection</p> <p>MDRO - Multidrug Resistant Organism (bacteria that are resistant to multiple antibiotics)</p> <p>MDS - Minimum Data Set (a standardized assessment tool)</p> <p>Medication Room- a room for storage, preparation or dispensing of drugs and medications.</p> <p>mcg - microgram(s)</p>	F0000		

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F0000	<p>Continued from page 4</p> <p>mg - milligram(s)</p> <p>ml - milliliter(s)</p> <p>ml/hr - milliliter(s) per hour</p> <p>mmHg - millimeter(s) of mercury</p> <p>MRI - Magnetic Resonance Imaging (medical imaging technique that uses strong magnetic fields and radio waves to create detailed images of the body's internal structures)</p> <p>N/A - not applicable</p> <p>Narcotic Logbook- provides a tool to keep track of narcotics usage by patients.</p> <p>Nasal cannula - a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help</p> <p>Nebulizer - a small machine that turns liquid medicine into a mist that can be easily inhaled</p> <p>Neurogenic bladder- a condition where nerve damage disrupts the normal communication between the brain and the bladder, leading to problems with bladder control and emptying.</p> <p>NH - Nursing Home</p> <p>NHSN- National Healthcare Safety Network</p> <p>Oxygen concentrator- a machine that delivers oxygen</p> <p>Ombudsman - advocates for residents of long-term care facilities, such as nursing homes.</p> <p>OT - Occupational Therapy/Therapist</p> <p>Oxygen saturation level - amount of oxygen in the blood</p> <p>P&P - Policy and Procedure</p> <p>PICC line - Peripheral Inserted Central Catheter (intravenous access used for a prolonged period of time)</p> <p>Pneumonia- an infection that causes inflammation in the air sacs of the lungs, often filling them with fluid or pus</p> <p>POLST - Physician Orders for Life-Sustaining Treatment</p>	F0000		

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F0000	Continued from page 5 PPE - Personal Protective Equipment PRN- as needed QAPI - Quality Assessment and Performance Improvement QSO - Quality, Safety, and Oversight RN - Registered Nurse RNA - Restorative Nursing Assistant ROM - Range of Motion RT - Respiratory Therapy/Therapist SB - Senate Bill SNF - Skilled Nursing Facility SSD - Social Services Director ST - Speech Therapy/ Therapist TAR - Treatment Administration Record Thrill - vibration felt over AV shunt indicating good blood flow (to assess functionality) TV - television u/ml - units per milliliter(s) USDA - United States Department of Agriculture UTI - Urinary Tract Infection (an infection involving any part of the urinary system including urethra bladder uterus and kidney)	F0000	F0558 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 63 was affected by this deficient practice. Immediately, both RNA 1 and CNA 1 put the call light next to resident. DSD provided 1:1 education to RNA 1 and CNA 1 about call light placement and making sure call light are within reach. On 7/25/2025 and 8/4/2025-8/8/2025, DON and DSD in-serviced all staff regarding call light placement and making sure they are within resident reach. In-serviced included frequent monitoring of call light within resident reach for resident has tendency to push the call light away and making sure nursing supervisor is made aware and plan of care is updated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All resident were potentially affected by this deficient practice. On 7/24/2025, All department heads did a room rounds to check if any other resident was affected and found no other resident with issue. On 8/4/2025, Administrator and Maintenance Director checked all call lights to make sure it has clip to keep call light next to resident reach and no other issue noted. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: Administrator and designee will oversee this process. Department heads and designee will do daily room rounds to check for call light placement and report to daily morning meetings for any non-compliance x 4 weeks.	8/23/2025
F0558 SS = B	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide	F0558		

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F0558 SS = B	<p>Continued from page 6</p> <p>the reasonable accommodations to meet the needs for one of 35 final sampled residents (Resident 63). The facility failed to ensure the call light for Resident 63 was within the residents' reach. This failure had the potential to negatively impact the resident's physical and psychosocial well-being or would result in delayed provision of care.</p> <p>Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely Response dated 12/19/22, showed the facility was adequately equipped with a call light. The facility staff will ensure the call light is within reach of resident and secured as needed. On 7/15/25 at 1016 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 63. Resident 63 was observed in bed, awake, and stated he needed assistance. When asked how he could call for the facility staff's assistance, Resident 63 stated he pressed the red button but he was unable to find it. Resident 63 added he just yelled and called the licensed nurse. Resident 63's call light button was observed on the floor. On 7/15/25 at 1016 hours, summoned RNA 1 to Resident 63's room and informed RNA 1 that Resident 63 needed an assistance. RNA 1 checked the resident and the resident made RNA 1 known that he needed assistance. RNA 1 was asked where the call light button was for the resident. RNA 1 verified the call light button was on the floor. RNA 1 stated the call light button should have been with the resident while in bed. Medical record review for Resident 63 was initiated on 7/16/25. Resident 63 was admitted to the facility on 5/8/25. On 7/21/25 at 0923 hours, an observation and concurrent interview with Resident 63 was conducted. Resident 63 was in bed awake and stated he needed his nurse because he was in pain. When Resident 63 was asked where his call light button was, Resident 63 was unable to find the call light button. The call light button was observed on the floor, not within the reach of the resident. Summoned CNA 1 to the resident's room, who was assigned to Resident 63 and informed CNA 1 Resident 63 needed assistance. CNA 1 was observed asking the resident what he needed and the resident informed CNA 1 he needed pain medication for his leg pain. CNA 1 was asked how Resident 63 called for the licensed nurse, CNA 1 stated Resident 63 was able to use the call light button and sometimes he called out the name of his licensed nurse. When CNA 1 was asked where the call light button of Resident 63 was, CNA 1 verified and acknowledged Resident 63's call light button was on the floor. CNA 1 stated Resident 63 kept moving in the bed and sometimes the call light button fell from the bed. CNA 1 stated the call light button usually had a clip to hold onto the bed sheet,</p>	F0558	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>Administrator will monitor effectiveness of the process and any findings will be presented to the Monthly QA&A meeting. The Plan of Correction will presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months.</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0558 SS = B	Continued from page 7 to prevent the call light from being misplaced. CNA 1 was observed placing the call light button near the resident and attached the clip on the resident's bedsheet. On 7/22/2025 at 1453 hours, an interview for Resident 63 was conducted with RN 2. RN 2 was asked about the call light button of the residents. RN 2 stated the call light buttons should always be within the reach of the resident for them to call the facility staff when they needed an assistance. RN 2 was informed of the observation of Resident 63's call button found in the floor. RN 2 verified and acknowledged the above findings.	F0558	F0578	8/23/2025
F0578 SS = B	Request/Refuse/Discontinue Treatment; Form for Advance Directive CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F0578	1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 51 was affected by this deficient practice. Immediately, social Service Director updated resident 51 advance directive record to reflect current wishes of the resident. On 8/5/2025-8/8/2025, Administrator in-serviced all Social Services and Licensed Nurse regarding Advance directive and making sure a copy of resident advance directive was placed in the resident medical records and making sure it reflects current resident's wishes. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All resident has potentially affected by this deficient practice. On 8/5/2025, Medical record and social services audited all residents' advance directive to make sure it reflects current treatment plan and wishes of resident and if advance directive is applicable, a copy of advance directive was placed in residents' medical record and found no other issue was noted. Social Services will review Advance directive with resident during quarterly care plan meeting and as needed for any significant changes or if responsible party or resident's desired to make changes to their Advance Directive. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: DON and Social Services director or designee will oversee this process. Social services will review and discuss advance directive to all all new admission and re-admission and if a copy of advance directive is available, it will be placed in resident's medical records. Social Services will do quarterly audit of resident's advance directive and update plan of care. Medical record will audit all new admission and re-admission medical record to make sure a copy of advance directive is in medical record, if available.	

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F0578 SS = B	<p>Continued from page 8</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the copy of the advance directive was maintained in the resident's medical record for one of 35 final sampled residents (Resident 51). This had the potential for the facility to provide treatment and services against the resident's wishes.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directives revised date 12/19/22, showed on admission the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. In the event the resident is unable to formulate an advance directive due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.</p> <p>Review of Resident 51's medical record was initiated on 7/16/25. Resident 51 was admitted to the facility on 1/25/24, and readmitted on 5/27/25.</p> <p>Review of Resident 51's H&P examination dated 5/29/25, showed Resident 51 had the capacity to understand and make decisions.</p> <p>Review of Resident 51's Admission MDS assessment dated 6/2/25, showed Resident 51 had a BIMS score of 14, indicating intact cognition.</p> <p>Review of Resident 51's Physician Orders for Life Sustaining Treatment (POLST) dated 5/27/25, showed</p>	F0578	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON and social services will monitor effectiveness of the process. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0578 SS = B	Continued from page 9 under Section D for Information and Signatures, Resident 51 had an advance directive. Review of Resident 51's Advance Directive Acknowledgment form dated 5/27/25, showed Resident 51 had executed an advance directive however, there was no copy of the advance directive in Resident 51's medical records. On 7/23/25 at 1249 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the findings and stated a copy of the resident's advance directive should be in the resident's chart to confirm the resident's wishes.	F0578	F0605 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 89 was identified as affected by this concern. Resident is currently receiving a routine antidepressant medication. It was noted during an interview on 7/22/2025 that the LVN 2 was unable to readily identify where non-pharmacological interventions (NPI) were documented in the medical record. On 7/22/2025, DON educated LVN on how to locate NPIs in the care plan and the importance of documenting NPIs when resident behaviors are observed. Resident 89 plan of care was updated to include NPI for depression and making sure Licensed nurse is documenting Resident 89 behavior it occurs and when NPI was provided.	8/23/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any ... chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- ...	F0605	2. Identify Other Residents Who May Have Been Affected by the Deficient Practice: Residents receiving psychotropic medications may have been impacted by this issue. On 8/4/2025, DON and Unit manager audited 10 random residents medical records receiving psychotropic medication and found no other issue noted. From 8/5/2025-8/8/2025, the Director of Nursing (DON) or designee in-serviced all Licensed Nurses about resident receiving psychotropic medication, in particular routine psych medication to include NPI and recording behavior per facility policy and procedure. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: The DON or designee will oversee ongoing education and compliance monitoring. All residents on psychotropic medications will continue to have care plans that include individualized NPIs. From 8/5/2025, licensed staff received continued education on documenting behavioral observations and corresponding NPIs in the medical record.	

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F0605 SS = D	<p>Continued from page 10</p> <p>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.</p> <p>....</p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic;</p> <p>(ii) Anti-depressant;</p> <p>(iii) Anti-anxiety; and</p> <p>(iv) Hypnotic.</p> <p>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p>	F0605	<p>Medical records or designee will review all new psychotropic medication orders daily, including new admissions and re-admission, and report findings to the DON. New orders will be reviewed in clinical meetings to ensure NPIs are considered and included in the resident's care plan by the interdisciplinary team (IDT), as appropriate. Resident's Plan of care will be updated per facility policy and procedure.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON or designee will monitor effectiveness of the process. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0605 SS = D	<p>Continued from page 11</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 89) was free from the unnecessary psychotropic drugs (any drug that affects brain activity associated with mental processes and behavior).</p> <p>* The facility failed to ensure non-pharmacological interventions were implemented for the depression and behaviors exhibited by Resident 89.</p> <p>This failure had the potential to place the residents at risk of receiving unnecessary medications and an increased risk of serious medication adverse reactions.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Use of Psychotropic Medication use revised 3/17/25, showed in part, a psychotropic drug is any drug that affects the brain activities associated with the mental processes and behavior, which includes the antipsychotics,</p>	F0605		

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F0605 SS = D	<p>Continued from page 12 anxiolytics, hypnotics, and antidepressants... non pharmacological interventions must be attempted unless contraindicated to minimize the need for psychotropic medication, use the lowest possible dose, or discontinue the medication.</p> <p>Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was admitted to the facility on 7/26/25, and readmitted on 3/19/25.</p> <p>Review of Resident 89's MDS dated 5/22/25, showed Resident 89 had a memory problem and severely impaired cognitive skills for daily decision making.</p> <p>Review of Resident 89's Order Summary Report showed a physician's order dated 3/19/25, for mirtazapine (antidepressant medication) 30 mg oral tablet one tablet by mouth at bed time for depression as manifested by crying.</p> <p>Review of Resident 89's Monitor Record for July 2025 showed from 7/1 to 7/22/25, Resident 89 had 56 episodes of depression as manifested by crying spells related to the use of mirtazapine.</p> <p>Review of Resident 89's medical record did not show the non-pharmacological interventions were identified or documented as an option to be implemented when Resident 89 had episodes of depression as manifested by crying spells related to the use of mirtazapine medication.</p> <p>On 7/22/25 at 1426 hours, an interview and concurrent medical record review for Resident 89 was conducted with LVN 2. LVN 2 verified Resident 89 was receiving the mirtazapine medication. LVN 2 also verified Resident 89 had 56 episodes of depression as manifested by crying spells. LVN 2 was not able to show the non-pharmacological interventions documentation when Resident 89 had episodes of depression as manifested by crying spells.</p> <p>On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings.</p>	F0605	<p>F0628</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 194 was affected by this deficient practice. Resident 194 was no longer in the facility. On 7/22/2025, Medical Record Director sent a copy of the resident 194 Notification of discharge to ombudsman.</p> <p>On 8/5/2025, Administrator in-serviced Medical Records, Social Services and Case Manager the process of notifying ombudsman of any resident transfer or discharge per facility protocol. On 8/5/2025-8/8/2025, DON in-service all licensed nurses about facility policy and process for notifying ombudsman about resident's discharge and transfer.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents that was discharged was potentially affected by this deficient practice. On 8/5/2025, Medical records audited transfer and discharge of last 30 days to make sure notification of ombudsman was done and found no other issue noted.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>Administrator or designee will oversee the process. Social Services and Case manager will notify ombudsman for any resident discharge to community and Medical records will notify ombudsman for any resident transferred to acute setting. Medical record will audit resident's medical record when discharged or transferred and make sure notification of ombudsman was completed. Administrator or designee will review notification of ombudsman log monthly x 3 months to make sure it's completed.</p>	8/23/2025
F0628 SS = D	<p>Discharge Process</p> <p>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)</p> <p>§483.15(c)(2) Documentation.</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(I)(A) through (F) of this section, the facility</p>	F0628		

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F0628 SS = D	<p>Continued from page 13 must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>§483.15(c)(3) Notice before transfer.</p> <p>Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is</p>	F0628	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON and Administrator will monitor the effectiveness of the process, any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0628 SS = D	<p>Continued from page 14 transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental</p>	F0628		

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F0628 SS = D	<p>Continued from page 15 Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice.</p> <p>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(f).</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p>	F0628		
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F0628 SS = D	<p>Continued from page 16 (iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to send a copy of the notice of discharge to the representative of the Office of the State Long Term Care Ombudsman for one of three sampled residents (Resident 194) reviewed for closed records. This failure posed the risk of the LTC (Long term Care) Ombudsman not being aware of the circumstances of the resident's transfer/discharge should the resident and their representative believe the transfer or discharge was inappropriate or involuntary.</p> <p>Findings: Review of the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, showed the facility will maintain evidence that the notice was sent to the Ombudsman. For Non-Emergency Transfers or Discharges - Initiated by the facility, return not anticipated...(b.) Provide transfer/discharge notice to the resident/representative and Ombudsman as</p>	F0628		

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F0628 SS = D	Continued from page 17 indicated. Closed medical record review for Resident 194 was initiated on 7/15/25. Resident 192 was admitted to the facility on 5/22/25, and discharged to home on 6/14/25. Review of Resident 194's Order Summary Report showed a physician's order dated 6/9/25, to discharge the resident to home with medications on 6/10/25. Review of Resident 194's Licensed Progress Notes dated 6/14/25, showed the discharge instructions were given to the resident's caregiver and the resident was discharged home. Further review of Resident 194's closed medical record did not show any documentation the State LTC Ombudsman was notified of the resident's discharge. On 7/21/25 at 1538 hours, an interview and concurrent closed medical record review was conducted with the Medical Records Director. The Medical Records Director was asked to show documentation of the Ombudsman notification regarding Resident 194's discharge. The Medical Records Director verified she could not find any documentation of the Ombudsman notification in the resident's medical record. However, the Medical Records Director stated she would follow-up with the SSD if their department have a separate log book for the Ombudsman notifications upon a resident's transfer or discharge. On 7/22/25 at 1310 hours, an interview and concurrent closed medical record was conducted with the SSD. The SSD was asked to show documentation of the Ombudsman notification regarding Resident 194's discharge to home. The SSD verified she could not provide a copy of the Ombudsman notification when Resident 194 was discharged home. On 7/23/25 at 1124 hours, the Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.	F0628	F0656 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 86 was affected by this deficient practice. Immediately, Unit manager updated resident's 86 care plan to reflect Oxygen administration parameter. On 8/5/2025-8/8/2025, DON provided 1:1 education to LVN 12 and in-serviced all Licensed Nurses about facility policy and procedure of developing comprehensive care plan for each resident, in particular care plan for oxygen administration. DON inserviced also about policy and procedure for assessing resident's medical needs to make sure plan of care was updated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents receiving Oxygen could potentially affected by this deficient practice. DON and Unit managers audited all residents care plan who were receiving oxygen and found no other issue. DON will provided ongoing education and training to Licensed nurses about developing comprehensive care plan for individual resident. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: DON or Designee will oversee this process. DON or designee will review all new admission and re-admission for oxygen order and will make sure comprehensive care plan was done to include oxygen parameter, especially for resident receiving oxygen, Any finding will be reviewed and reported during clinical meeting. Medical record will audit oxygen order to make sure plan of care reflects resident's oxygen administration parameters x 3 months and report to DON for any non-compliance.	8/23/2025
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (f) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F0656		

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F0656 SS = D	<p>Continued from page 18</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure a comprehensive care plan was developed for one of 35 final sampled residents (Resident 86).</p> <p>* Resident 86's care plan specific to oxygen administration failed to include the oxygen administration parameters. The nursing staff failed to attempt to administer the lowest amount of oxygen required to maintain Resident 86's oxygen saturation level at 92 % or greater, in accordance with the physician's order. This failure placed the resident at risk for not being provided appropriate, consistent, and individualized care.</p> <p>Findings:</p>	F0656	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON or designee will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months.</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025
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F0656 SS = D	<p>Continued from page 19</p> <p>Medical record review for Resident 86 was initiated on 7/15/25. Resident 86 was admitted to the facility on 11/12/23.</p> <p>Review of Resident 86's physician's order dated 6/18/25, showed an order for oxygen to be administered at two liters per minute via nasal cannula, may titrate (oxygen rate) to maintain an oxygen saturation greater than or equal to 92%.</p> <p>On 7/15/25 at 1050 hours, an observation and concurrent interview was conducted with Resident 86. Resident 86 was observed lying in her bed and receiving continuous oxygen therapy via a nasal cannula, at a rate of six liters per minute. Resident 86 stated a past COVID-19 infection had caused damage to her lungs, having resulted in her need for oxygen therapy. Resident 86 stated she did not know the rate of oxygen she was receiving as the nursing staff had set the rate.</p> <p>On 7/15/25 at 1554 hours, an observation, interview, and concurrent medical record review, was conducted with LVN 12. Resident 86 was observed lying in her bed. Resident 86 was observed receiving continuous oxygen via a nasal cannula, at a rate of six liters per minute. LVN 12 was asked the maximum rate of oxygen she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation greater than or equal to 92%, in accordance with the physician's order. LVN 12 stated she was uncertain, as the order failed to specify a maximum rate of oxygen. LVN 12 then stated she would consult with Resident 86's RN (RN 5).</p> <p>On 7/15/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with RN 5. RN 5 verified Resident 86's medical record failed to show documentation specific to the rate of oxygen Resident 86 was receiving. RN 5 was informed that Resident 86 had received continuous oxygen therapy via a nasal cannula, at a rate of six liters per minute, from 1050 hours to 1604 hours. RN 5 reviewed and verified Resident 86's medical record showed documentation Resident 86's oxygen saturation level was 98% (on 7/15/25 at 0908 hours) and 97% (on 7/15/25 at 1557 hours). RN 5 was asked the maximum rate of oxygen that she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation level greater than or equal to 92 percent, in accordance with the</p>	F0656		

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F0656 SS = D	Continued from page 20 physician's order. RN 5 stated in accordance with the facility's P&P for oxygen administration, Resident 86 could receive oxygen at a maximum rate of five liters per minute via nasal cannula. RN 5 stated the oxygen administered at a rate greater than five liters per minute would be administered via an oxygen mask to ensure optimal oxygen absorption. RN 5 stated the nursing staff should have attempted to titrate Resident 86's oxygen to the lowest rate possible between 1050 and 1604 hours, while maintaining Residents 86's oxygen saturation level at 92% or greater. On 7/17/25 at 1016 hours, an interview and concurrent medical record review was conducted with the ADON. Review of Resident 86's care plan addressing oxygen therapy initiated 4/11/24, showed Resident 86 had impaired gas exchange. Resident 86's care plan failed to show information specific to the maximum rate in which nursing staff could titrate Resident 86's oxygen, via the nasal cannula. The ADON stated Resident 86's care plan should have included the oxygen administration parameters and the nursing staff should have attempted to administer the lowest amount of oxygen required to maintain Resident 86's oxygen saturation level at 92% or greater, in accordance with the physician's order.	F0656	F0657 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 104 was affected by this deficient practice. Immediately, Unit manager removed resident 104's nebulizer machine at bedside and updated care plan. On 8/6/2025-8/8/2025, DON in-serviced all licensed nurses about facility policy and procedure for timing and revision of resident's plan of care, in particular updating plan of care when an order was discontinued and making sure any equipment related to the plan of care was removed from resident's bedside. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All resident were potentially affected by this deficient practice. DON and Unit managers audited 10 random resident to make sure plan of care is up-to-date and found no other issue.	8/23/2025
F0657 SS = B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be: (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical	F0657	3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: DON will oversee the process of revising and updating plan of care. Unit Manager or designee will review 24-hours and 72-hours audit to make sure all discontinued treatment will reflect on the plan of care. Medical records will audit all new and discontinued orders to make sure plan of care was updated and will report during clinical meeting for any non-compliance (M-F) x 3 months.	

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F0657 SS = B	<p>Continued from page 21 record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(lii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 35 final sampled residents (Resident 104) was revised to reflect the resident's current care needs and interventions. The facility failed to ensure Resident 104's plan of care was revised to address Resident 104's breathing treatment. This posed the risk of not providing Resident 104 with individualized and person-centered care.</p> <p>Findings:</p> <p>Findings: Review of the facility's P&P titled Comprehensive Care Plans dated 12/19/22, showed the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment. On 7/15/25 at 1006 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 104. Resident 104 stated she used the nebulizer machine (medical device used to treat respiratory conditions) at bedside when she needed it due to her breathing problem. Resident 104's nebulizer mask was observed on top of the nebulizer machine undated. Medical record review for Resident 104 was initiated on 7/17/25. Resident 104 was admitted to the facility on 7/2/25. Review of Resident 104's physician's order dated 3/24/24, with the discontinued date of 4/1/25, showed to administer ipratropium-Albuterol solution (inhaler medication) 0.5 to 2.5 mg/3 ml via inhalation orally every six hours for shortness of breath for 14 days. Review of Resident 104's plan of care showed a care plan problem dated 9/24/24, addressing Resident 104's breathing treatment use for shortness of breath. However, the plan of care was not revised to reflect the discontinued physician's order for the breathing treatment. On 7/23/25 at 1528 hours, an interview was conducted with the DON for Resident 104. The DON was</p>	F0657	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0657 SS = B	Continued from page 22 informed and verified the above findings. Cross reference F695, example #7.	F0657	F0684	8/23/2025
F0684 SS = D	<p>Quality of Care</p> <p>CFR(s): 483.25</p> <p>§ 483.25 Quality of care</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure necessary care and services were provided to two out of 35 final sampled residents (Residents 85 and 195).</p> <p>* The facility failed to ensure Resident 85's Infectious Disease Physician's recommendation dated 5/17/25, for an urgent MRI of the right hip was communicated to the ordering Physician and arranged in a timely manner.</p> <p>* The facility failed to ensure Resident 195's Intake and Output (I&O) were documented.</p> <p>These failures had the potential to affect Resident 85 and 195's well-being.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Provision of Physician Ordered Services dated 5/15/23, showed for Diagnostic tests: a.) Facility will maintain a schedule of diagnostic tests in accordance with physician's orders. b.) Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to appropriate entity. c.) Qualified nursing personnel will receive the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the</p>	F0684	<p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 85 and 195 was affected by this deficient practice. Resident 195 was no longer in the facility.</p> <p>Resident 85 has scheduled MRI was completed on 7/28/2025 and no negative outcome was noted.</p> <p>On 8/5/2025-8/8/2025, DON in-serviced all licensed nurse about facility policy and procedure when resident coming from an appointment and scheduling any follow-up order such as an MRI to prevent any delay of treatment.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All resident were potentially affected by this deficient practice. RN supervisor and Unit manger audited all residents that came back from an appointment in last 90 days and found no other issue noted with follow up order or plan of care.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON or designee will oversee this process. RN supervisor or designee will review all resident's medical record when coming back from an appointment and follow up at medical office to make sure all follow up order or procedure was noted in resident's medical record. DON or designee will review 24-hours and 72-hours summary report during clinical meeting (M-F) to make necessary care and services was being followed-up and plan of care was updated.</p>	

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F0684 SS = D	<p>Continued from page 23 reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Ordering physician will be notified of results upon receipt if deemed "critical" and/or require immediate attention. d.) Documentation of consultations, diagnostic tests, the results and date/time of Physician notification will be maintained in the resident's clinical record. e.) In instances where diagnostic testing or consultations are not available to be performed onsite or the physician has requested that the services be performed at an offsite facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments. For follow-up appointments: Facility staff will assist residents in scheduling and attending follow-up appointments as ordered by the physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p>Review of the facility's P&P titled Physician Services dated 12/19/22, showed the resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility.</p> <p>Medical Record Review for Resident 85 was initiated on 7/15/25. Resident 85 was admitted to the facility on 5/7/25.</p> <p>Review of Resident 85's MDS assessment dated 6/3/25, showed Resident 85 had a BIMS Score of 12, indicating moderate cognitive impairment.</p> <p>Review of Resident 85's Order Summary Report showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 6/20/25, for MRI of the right hip with/without contrast. Needs to be scheduled. - dated 7/11/25, for MRI of the right hip without contrast, scheduled for 7/28/25 at 1335 hours. <p>On 7/17/25 at 0943 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was asked to show documentation of Resident 85's appointment with an outside physician for May 2025. RN 1 showed a faxed documentation dated 6/5/25, for</p>	F0684	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; integrate QA Process:</p> <p>The DON and Administrator will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0684 SS = D	<p>Continued from page 24</p> <p>Resident 85's telemedicine appointment with the Infectious Disease physician with a date of service on 5/17/25. The faxed documentation showed Resident 85's Infectious Disease physician's recommended for urgent MRI of the right hip to assess the size of the abscess (pus collection). RN 1 was asked to show documentation from the licensed staff reviewed the Infectious Disease physician's telemedicine progress notes and notified Resident 85's ordering physician about the recommendation for the urgent MRI. RN1 verified there was no documentation in the resident's medical record from the licensed staff about the telemedicine appointment on 5/17/25, and if the Infectious Disease physician's progress notes and recommendations were reviewed and relayed to the resident's ordering physician. RN 1 was also asked about the facility's process when making arrangements for Resident 85's recommended urgent MRI of the right hip. RN 1 stated the facility had a calendar for communicating the residents' needed appointments. However, RN 1 verified there was no documentation on the facility's calendar to show the request to make arrangements for Resident 85's urgent MRI of the right hip or if the MRI was scheduled. RN 1 verified Resident 85 had a physician's order dated 6/20/25, to schedule the MRI of the right hip with/without contrast and a physician's order dated 7/11/25, to show the MRI was scheduled for 7/28/25. When RN 1 was asked if the appointment for the urgent MRI should have been arranged sooner, since the Infectious Disease physician's recommendation was dated 5/17/25, RN 1 acknowledged the urgent MRI should have been arranged sooner and communicated among the licensed staff.</p> <p>On 07/17/2025 at 1318 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD was asked if there was a communication relayed by the licensed staff for Resident 85's Infectious Disease recommendation for the urgent MRI of the right hip from 5/17/25. The SSD verified she could not find any documentation to show the licensed staff communicated with the Social Services department about Resident 85's need for the urgent MRI of the right hip.</p> <p>On 7/17/25 at 1335 hours, an interview and concurrent medical record review was conducted with the Case Manager. The Case Manager was asked about the facility's process when a resident needed an urgent MRI scheduled as recommended by a physician outside of the facility. The Case Manager stated the licensed staff would communicate to the Social Services department or to the facility's case managers once there was be a</p>	F0684		

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F0684 SS = D	<p>Continued from page 25</p> <p>physician's order. The Case Manager stated when a resident needed an urgent procedure, the facility could contact the resident's insurance company for immediate authorization and arrangement. When the Case Manager was asked to show documentation when she was notified Resident 85 needed an urgent MRI of the right hip recommended from the Infectious Disease physician's on 5/17/25, the Case Manager acknowledged she was not able to find documentation of the communication regarding Resident 85's need to arrange for an urgent MRI of the right hip. The Case Manager stated the request for the urgent MRI should have been communicated so the appointment could be arranged, however, it was not endorsed to her.</p> <p>On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p> <p>2. Closed medical record review for Resident 195 was initiated on 7/15/25. Resident 195 was admitted to the facility on 12/16/22, and discharged to acute care hospital on 1/22/23.</p> <p>Review of Resident 195's H&P examination dated 12/28/22, showed Resident 195 had capacity to understand and make decisions.</p> <p>Review of Resident 195's Order Summary Report dated 12/16/22, showed a physician's order to record the intake and output (I&O) every shift for 30 days. Reassess continuation of the intake and output after 30 days.</p> <p>Further review of Resident 195's medical record failed to show documented evidence Resident 195's I&O values were documented as ordered.</p> <p>On 7/18/25 at 1017 hours, an interview and concurrent closed medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 verified there was no documented evidence Resident 195's I&O values were documented.</p> <p>On 7/21/25 at 1409 hours, an interview and concurrent closed medical record review for Resident 195 was</p>	F0684		

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F0684 SS = D	Continued from page 26 conducted with RN 3. RN 3 verified Resident 195 had a physician's order to monitor the I&O for 30 days, however, RN 3 verified there was no documentation of the resident's I&O values. On 7/22/25 at 0900 hours, an interview was conducted with the Medical Records Director. The Medical Records Director verified Resident 195 had a physician's order to monitor the resident's I&O for 30 days, however, the Medical Records Director verified there was no documented evidence Resident 195's I&O were documented. On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated if there was a physician's order to monitor the I&O, the nursing staff should have documented the resident's I&O. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.	F0684	F0686 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Residents 98, 122, 28, and 131 were identified as impacted by this concern. On 7/17/2025, the Director of Nursing (DON) and Unit Manager assessed and adjusted all low air loss (LAL) mattress settings to correspond with each resident's weight. For residents able to communicate, staff inquired about comfort level, and settings were adjusted based on resident preference as needed. For residents unable to clearly express comfort level, mattresses remained set according to weight-based recommendations. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents using LAL mattresses were considered potentially affected. On 7/16/2025, the DON and designee compiled a list of all residents with LAL mattresses and ensured settings were reviewed and adjusted to align with each resident's current weight. For those who could communicate, adjustments were made based on individual feedback regarding comfort. Residents unable to verbalize preferences remained on weight-based settings. All mattress settings were reviewed and reflected in the residents' care plans. On 8/5/2025-8/8/2025, DON in-serviced all licensed nurses about facility policy and procedure for Low air loss mattress (LAL) setting and to update resident's plan of care if resident's has preferred setting based on their comfort level. On 7/21/2025-7/25/2025, DSD in-serviced all CNA about policy and procedure for low air loss mattress setting to consult licensed nurse if LAL needed to be adjusted during care.	8/23/2025
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development and worsening of pressure injuries and promote the healing of existing pressure injuries four of five final sampled residents (Residents 28, 98, 122, and 131) reviewed for pressure injuries.	F0686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0686 SS = D	<p>Continued from page 27</p> <p>* The facility failed to ensure the low air loss (LAL) mattress setting was consistent with the residents' weight. This had the potential for the residents to not receive the appropriate care and services to promote healing or prevent the development and worsening of pressure injuries.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility P&P titled Use of Support Surfaces revised date 9/12/23, showed support surfaces will be chosen by matching the potential therapeutic benefit with the resident's specific situation. Further review of the P&P showed support surfaces will be utilized in accordance with manufacturer recommendations. Considerations for utilizing specialized support surfaces: <ol style="list-style-type: none"> a. Medical condition. b. Size and weight. c. Mobility and activity levels. d. Need for microclimate control or shear reduction. e. Presence of pressure injuries, including severity and location. f. Risk for developing a pressure injury or at high risk for additional pressure injuries. g. Pain or discomfort. h. Bottoms out on the current surface. <p>On 7/15/25 at 1056 hours, during the initial tour of the facility, Resident 98 was observed positioned on her back and lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at four. Review of the LAL mattress device showed level four setting was for a weight of 175 pounds.</p> <p>Medical record review for Resident 98 was initiated on 7/15/25. Resident 98 was admitted to the facility on 10/3/22, and readmitted on 8/16/24.</p>	F0686	<p>3. Measures Put into Place to Provide Systemic Changes in the Facility:</p> <p>The DON or designee will oversee ongoing monitoring of LAL mattress settings. Treatment nurses or designee will ensure that mattress settings are initially established based on resident weight. Adjustments will be made if a resident communicates discomfort. For residents unable to communicate, settings will remain at weight-based recommendations unless otherwise directed. A current list of residents with LAL mattresses and corresponding settings will be maintained and reviewed weekly. Updates to orders and care plans will be made as necessary.</p> <p>4. How the Facility Plans to Continue Monitoring:</p> <p>The DON or designee will review mattress settings and related documentation on an ongoing basis. Any discrepancies or concerns will be addressed promptly. Findings and compliance status will be reported during the monthly Quality Assurance (QA) meetings on 8/14/2025 and for a minimum of three months.</p> <p>5. Corrective action completion date:</p> <p>8/23/2025</p>	8/23/2025

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F0686 SS = D	<p>Continued from page 28 Review of Resident 98's H&P examination dated 8/20/24, showed Resident 98 had the capacity to understand and make decisions.</p> <p>Review of Resident 98's Quarterly MDS assessment dated 7/2/25, showed Resident 98 had a BIMS score of 15, indicating intact cognition.</p> <p>Review of Resident 98's Order Summary Report for July 2025 showed a physician's order dated 8/16/24, for the LAL mattress: check device function and pressure setting set per the resident's weight every shift.</p> <p>On 7/17/25 at 1351 hours, an observation and concurrent interview was conducted with Resident 98 inside the resident's room. Resident 98 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at three. Review of the LAL mattress device showed level three setting was for a weight of 140 pounds. When Resident 98 was asked if the LAL mattress she was lying on was comfortable, the resident stated she was more comfortable, and the LAL mattress was better after it the pressure level was adjusted. In addition, the resident stated the past few days her back hurt when the pressure level was set at four.</p> <p>On 7/17/25 at 1530 hours, an interview was conducted with LVN 3. LVN 3 was informed of the above findings and stated the LAL mattress was monitored by the Treatment nurse, but she also conducted a quick visual check by looking at the numbered pressure setting based on the resident's weight to provide comfort.</p> <p>On 7/22/25 at 1502 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed and acknowledged the above findings. The ADON stated the LAL mattress setting was based on the resident's weight and it was important to have the correct setting to achieve the therapeutic level and comfort for the residents.</p> <p>2. On 7/15/25 at 1513 hours, during the initial tour of the facility, Resident 122 was observed positioned on her back and lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at five. Review of the LAL mattress device showed level five setting was for a</p>	F0686		

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F0686 SS = D	<p>Continued from page 29 weight of 210 pounds.</p> <p>Medical record review for Resident 122 was initiated on 7/16/25. Resident 122 was admitted to the facility on 4/30/25.</p> <p>Review of Resident 122's H&P examination dated 5/2/25, showed Resident 122 had the capacity to understand and make decisions.</p> <p>Review of Resident 122's Admission MDS assessment dated 5/6/25, showed Resident 122 had a BIMS score of 14, indicating intact cognition.</p> <p>Review of Resident 122's Care Plan dated 5/15/25, showed an intervention for the LAL mattress for comfort, with the setting to be per resident comfort level or weight every shift for skin maintenance.</p> <p>Review of Resident 122's Order Summary Report for July 2025 failed to show a physician's order for the use of the LAL mattress.</p> <p>On 7/16/25 at 1652 hours, an interview was conducted with LVN 15. LVN 15 was informed of the above findings. LVN 15 stated the LAL mattress was monitored by the Treatment nurse and the pressure setting should be reevaluated due to the weight setting discrepancy.</p> <p>On 7/22/25 at 1526 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed of the above findings and acknowledged there was no physician's order for the LAL mattress prior to the resident's use. Furthermore, the ADON stated the LAL mattress setting was based on the resident's weight and it was important to have the correct setting to achieve the therapeutic level and comfort for the residents.</p> <p>3. Review of the Owner's Operator and Maintenance Manual for MicroAir MA60 Alternating Pressure System and MA65 Alternating Pressure On-Demand Low Air Loss System revised 2/2008 showed the resident comfort pressure ranges from Soft (level zero) to Firm (level nine). The Comfort Control LED (light-emitting diode) displays the resident comfort pressure levels from zero</p>	F0686		

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F0686 SS = D	<p>Continued from page 30 to nine and provides a guide to the caregiver to set approximate comfort pressure level depending on the resident weight.</p> <p>Medical record review for Resident 28 was initiated on 7/15/25. Resident 28 was admitted to the facility on 12/6/21, and readmitted on 7/2/25.</p> <p>Review of Resident 28's Quarterly MDS assessment dated 4/25/25, showed Resident 28 had a BIMS score of 7, indicating severe cognitive impairment.</p> <p>Review of Resident 28's Order Summary Report for July 2025 showed a physician's order dated 7/15/25, for LAL mattress: Check for device function and for the pressure setting set per the resident's comfort every shift for skin maintenance.</p> <p>On 7/15/25 at 1042 hours, an observation and concurrent interview was conducted with Resident 28 inside the resident's room. Resident 28 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at six. Review of the LAL mattress device showed level six setting was for a weight of 245 pounds. When Resident 28 was asked if the LAL mattress she was lying on was comfortable, the resident stated she was not comfortable and replied, "the mattress is too hard."</p> <p>On 7/15/25 at 1050 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2 inside Resident 28's room. LVN 2 verified the above findings. When LVN 2 asked Resident 28 if she wanted the LAL mattress at a softer or firmer level, Resident 28 replied she wanted the LAL mattress to be "softer." LVN 2 verified Resident 28 weight was 134 pounds on 7/3/25, and the mattress setting should have been set at a comfort pressure level of three, which was the setting was for a weight of 140 pounds.</p> <p>On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated the LAL mattress should be set according to the resident's weight and then with the resident's comfort. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p>	F0686		

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F0686 SS = D	<p>Continued from page 31</p> <p>4. On 7/15/25 at 1222 and 1627 hours, and 7/16/25 at 0835 and 1134 hours, Resident 131 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at eight. Review of the LAL mattress device showed comfort pressure level eight corresponded to the weight of 315 pounds.</p> <p>On 7/17/25 at 1351 hours, Resident 131 was observed lying on a LAL mattress (MicroAir 65 Alternating Pressure with Low Air Loss) with the comfort pressure level set at four. Review of the LAL mattress device showed comfort pressure level four corresponded to the weight of 210 pounds.</p> <p>Medical record review for Resident 131 was initiated on 7/15/25. Resident 131 was admitted to the facility on 5/14/25, and readmitted on 6/6/25.</p> <p>Review of Resident 131's MDS assessment dated 5/21/25, showed Resident 131 had memory problem and severely impaired cognitive skills for daily decision making. Further review of the MDS assessment showed Resident 131 was dependent on the facility staff for his activities of daily living.</p> <p>Review of Resident 131's Order Summary Report showed a physician's order dated 6/8/25, for LAL mattress for wound healing and comfort.</p> <p>Review of Resident 131's Braden Scale for Predicting Pressure Ulcer Risk dated 6/19/24, showed Resident 131 was at a very high risk for pressure ulcer.</p> <p>Review of Resident 131's Weights and Vitals Summary showed on 7/3/25, Resident 131 had the weight of 103 pounds.</p> <p>On 7/16/25 at 1143 hours, an observation, interview, and concurrent medical record review for Resident 131 was conducted with LVN 13. LVN 13 stated Resident 131 was nonverbal and unable to express his comfort level or show facial features of discomfort. LVN 13 verified the observation of Resident 131's LAL mattress set at a comfort level of eight, which corresponded to the weight of 315 pounds. LVN 13 verified Resident 131's</p>	F0686		

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F0686 SS = D	Continued from page 32 most recent weight of 103 pounds. On 7/17/25 at 1353 hours, an observation, interview and concurrent medical record review for Resident 131 was conducted with LVN 14. LVN 14 stated Resident 131 was at a very high risk for developing pressure ulcers and the LAL mattress was provided to Resident 131 to prevent development of the pressure ulcer. LVN 14 stated Resident 131 was nonverbal and unable to express his comfort level or show facial features of discomfort, so the LAL mattress should be set as per Resident 131's weight. LVN 14 verified the observation of Resident 131's LAL mattress set at a comfort level of four, which corresponded to the weight of 210 pounds. LVN 14 stated Resident 131's LAL mattress should have been set as per the resident's weight, which was 103 pounds and the comfort level for Resident 131 should have been set to two and not four or eight. On 7/22/25 at 1503 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.	F0686	F0688 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 5 was affected by this deficient practice. Resident 5 is currently not in the facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents with splint were potentially affected by this deficient practice. DON, ADON and Unit managers conducted audit on all residents receiving splints, braces, and ROM devices and found no other issue noted. On 8/5/2025, DON in-serviced all licensed nurse about facility policy and procedure of splint, braces, and ROM devices assessment and to add monitoring for skin integrity at least every 2 hours and as needed. On 8/6/2025-8/8/2025, DSD in-serviced all CNA and RNA about facility policy and procedure of application of ROM devices, splint and braces to report immediately to licensed nurses if skin breakdown was noted beneath the devices. Plan of care was updated for all residents with medical devices application for splinting, braces and ROM devices to include monitoring of skin breakdown at least every 2 hours and as needed when devices were applied on the resident. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: DON or designee will oversee this process. All new medical devices order will be review during clinical meeting to make sure RNA is following treatment plan and monitoring for skin integrity was included in the plan of care. IDT will review monthly and as needed all residents with medical devices application and update plan of care.	8/23/2025
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided to prevent the decline in	F0688		

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F0688 SS = D	<p>Continued from page 33 the ROM functions for one of six final sampled residents (Resident 5) reviewed for ROM functions.</p> <p>* The facility failed to ensure the physician's orders to apply the left AFO and bilateral elbow splints to Resident 5's extremities were followed. In addition, Resident 5's skin was not assessed when the left AFO and bilateral elbow splints were applied. This failure had the potential for Resident 5 to sustain a decline in ROM functions, leading to muscle atrophy (loss of muscle mass and strength) and decrease in functioning.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Restorative Nursing Programs dated 12/19/22, showed the restorative care will be provided to help promote optimal safety and independence. The RNA was performed daily to the residents by maintaining a good body alignment and proper positioning. Residents identified during comprehensive assessment process will receive the RNA services including the application of splint or brace assistance.</p> <p>On 7/15/25 at 1007 hours, during the initial tour of the facility, Resident 5 was observed awake in the activity room and had contractures (shortening and hardening of muscles, tendons or other tissues, leading to a deformity) on both the upper and lower extremities. A splint device was applied on both arms.</p> <p>Medical record review for Resident 5 was initiated on 7/16/25. Resident 5 was admitted to the facility on 5/7/25.</p> <p>Review of Resident 5's plan of care showed a care plan problem dated 5/29/25, addressing the Restorative Nursing Program for the application of the splint/brace. The interventions included the application of the bilateral elbow splints for two to four hours or as needed and the application of the left AFO. The interventions also included the assessment of the skin before applying and removing the splints. However, there were no interventions included in the care plan to perform Resident 5's skin assessment when the bilateral elbow splints and left AFO were applied to the resident.</p> <p>Review of Resident 5's Documentation Survey Report for</p>	F0688	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0688 SS = D	<p>Continued from page 34</p> <p>June 2025 showed two entries/ times where the RNA documented the application and removal of the left AFO and bilateral elbow splints during the 7 AM-3 PM shift. However, the report only showed one time/ entry was documented for either the application or removal of the left AFO on the following dates: 6/2, 6/16, 6/17, 6/20, 6/21, 6/24, 6/25, 6/26, 6/27, 6/29, and 6/30/25, and for the bilateral splints on the following dates: 6/2, 6/3, 6/16, 6/17, 6/20, and 6/24/25. It was unclear whether the entries on the listed dates were documented for the application or removal of the left AFO and bilateral elbow splints, since the report did not specify. Further review of the report failed to show documented evidence the skin assessment was completed when the left AFO and bilateral elbow splints were applied to Resident 5.</p> <p>Review of Resident 5's Documentation Survey Report for July 2025 showed two entries/ times where the RNA documented the application and removal of the left AFO and bilateral elbow splints during the 7 AM-3 PM shift. However, the report only showed one time/ entry was documented for either the application or removal of the left AFO on the following dates: 7/2-7/4, 7/6-7/9, and 7/11-7/20/25, and for the bilateral splints on the following dates: 7/6, and 7/15-7/20/25. It was unclear whether the entries on the listed dates were documented for the application or removal of the left AFO and bilateral elbow splints, since the report did not specify. Further review of the report failed to show documented evidence the skin assessment was completed when the left AFO and bilateral elbow splints were applied to Resident 5. On 7/21/25 at 1047 hours, an interview and concurrent medical record review for Resident 5 was conducted with RNA 1. RNA 1 verified Resident 5 had RNA services ordered for the application of the left AFO and bilateral elbow splints. RNA 1 was asked what time the left AFO and bilateral elbow splints were applied to Resident 5. RNA 1 reviewed the medical record and verified there was documentation of the time when the left AFO and bilateral elbow splints were applied and removed from Resident 5. However, the record was inaccurate and missing entries. RNA 1 was asked about Resident 5's skin when the left AFO and bilateral elbows were applied. RNA 1 stated the RNAs checked the resident's skin before the application and after the removal from Resident 5. RNA 1 verified and acknowledged there was no documentation about the skin assessment of Resident 5 when the left AFO and bilateral elbow splints were applied.</p> <p>On 7/21/25 at 1503 hours, an interview and concurrent medical record review for Resident 5 was conducted with</p>	F0688		

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F0688 SS = D	Continued from page 35 the RN 2. RN 2 stated the licensed nurses were responsible for the supervision of the RNA during the application of the splints and devices to the residents. RN 2 verified Resident 5's physician's order for the RNA application of the left AFO and bilateral elbow splints. RN 2 verified and acknowledged the missing documentation of the times when the left AFO and bilateral elbow splints were applied and removed from Resident 5 on the above listed dates. In addition, RN 2 verified and acknowledged there was no documentation about the skin assessment of Resident 5 when the left AFO and bilateral elbow splints were applied. On 7/23/25 at 1528 hours, an interview for Resident 5 was conducted with the DON. The DON was informed and verified the above findings.	F0688	F689 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 4 was identified as affected by this concern. On 7/21/25, the Director of Nursing (DON) or designee reviewed the use of floor mats for the resident with the interdisciplinary team (IDT). After evaluation, it was determined that floor mats were no longer indicated. The recommendation to discontinue use was communicated to the physician, and the order was discontinued. The resident's care plan was updated accordingly.	8/23/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent an accidents for one of four final sampled residents (Resident 4) reviewed for prevention of accident hazards. The facility failed to implement the floor mats on both sides of Resident 4's bed for safety, in accordance with the physician's order. This failure put the resident at high risk of serious injuries from a fall. Findings: Review of the facility's P&P titled Falls Prevention Program dated 12/19/22, showed the facility's fall prevention on all residents should be assessed for fall risk and receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The fall interventions included to provide additional interventions as directed by the	F0689	2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All fall risks residents using were considered potentially impacted. On 8/4/2025, Don and unit manager reviewed all resident with floor mats order and found no other issue. On 8/4/2025, the DON and designee created a list of all residents using floor mats. The IDT reviewed each case to determine ongoing need. For residents where use was no longer clinically indicated, recommendations were made to discontinue use, and care plans were updated to reflect current interventions. On 8/5/2025-8/8/2025, DON in-services all Licensed nurses about facility policy and procedure for placing floor mats for resident at risks for fall, in particular assessing residents who are no longer on fall risks and has order for floor mats to discontinue the devices as it is potentially an accidental hazard. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: The DON or designee will oversee this process. Unit managers and designee will conduct routine audits to ensure appropriate placement and condition of mats, accurate documentation in the care plan, and use in accordance with current physician orders and clinical justification.	

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F0689 SS = D	<p>Continued from page 36 resident's assessment including assistive devices.</p> <p>During the initial tour of the facility on 7/15/25 at 0816 hours, Resident 4 was observed in bed with the bed in lowest position. However, there was no floor mat observed on the side of the resident's bed.</p> <p>Medical record review for Resident 4 was initiated on 7/16/25. Resident 4 was admitted to the facility on 1/31/24.</p> <p>Review of Resident 4's H&P examination dated 2/4/25, showed Resident 4 had no capacity to understand and make decisions.</p> <p>Review of Resident 4's Fall Risk Evaluation dated 2/17/25, showed Resident 4 was considered to be at risk for falls.</p> <p>Review of Resident 4's MDS assessment dated 4/17/25, showed Resident 4 had moderate cognitive impairment.</p> <p>Review of Resident 4's plan of care showed a care plan problem revised 7/18/25, addressing Resident 4's risk of fall or injury. The interventions included to place bilateral floor mats for safety precaution.</p> <p>Review of Resident 4's Order Summary Report dated 7/23/25, showed a physician's order dated 2/1/24, to place bilateral floor mats for safety precaution every shift. On 7/21/25 at 0935 hours, an observation and concurrent interview for Resident 4 was conducted with CNA 2. CNA 2 stated Resident 4 had weakness on the left side of his body and needed total assist on all ADL care. CNA 2 stated the resident was unable to turn and reposition himself in bed. However, CNA 2 stated the resident was able to grab the side rail when turned to his right side and unable to grab the bar when turning to his left side. When CNA 2 was asked if there were floor mats on both sides of the bed while inside Resident 4's room, CNA 2 verified and acknowledged there were no floor mats at the sides of the bed. On 7/21/25 at 1407 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 2. RN 2 was asked about Resident 4's floor mats. RN 2 stated she was made aware by the facility staff about the resident's floor mats and stated the physician</p>	F0689	<p>IDT will review all residents with order for floor mats quarterly to ensure it is still appropriate for the resident and update plan of care accordingly. Department heads and designee will do room rounds daily to make sure floor mats was in placed for resident with orders x 3 months</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025
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F0689 SS = D	Continued from page 37 should have been made aware to discontinue the order for the floor mats, since the resident was not able to move independently in the bed. RN 2 stated she notified the resident's physician.	F0689	F0690 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 12, 63 and 89 was affected by this deficient practice. Immediately, Licensed nurse put a basin underneath the indwelling catheter bag to prevent from touching the floor. For resident 89, on 7/17/2025, RN updated the plan of care for resident to include indwelling catheter care in resident's order. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents with indwelling catheter were potentially affected by this deficient practice. On 7/17/2025, RN supervisor and unit manager audited all residents with indwelling catheter to make they have an order for indwelling catheter care and no indwelling bag was touching the floor and found no other issue noted. On 8/5/2025-8/8/2025, DON in-serviced all licensed nurses and CNA about facility policy and procedure for indwelling catheter care, in particular making sure resident with indwelling catheter has an order for indwelling catheter care to prevent resident from developing UTI and to update plan of care. DON also emphasize on making sure all indwelling catheter bag and medical tubing were not touching the floor. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: DON or designee will oversee this process. Unit manager and designee will review all new admission and re-admission to make sure resident with indwelling catheter will have an order for indwelling catheter care order. IDT will review during clinical meeting to make sure plan of care for resident with indwelling catheter is being followed. Medical Records will audit all new admission and re-admission medical records to make sure resident with Indwelling catheter care and care plan is updated. any noncompliance will report to DON x 3 months.	8/23/2025
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services to prevent UTIs for	F0690		

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F0690 SS = D	<p>Continued from page 38 three of three final sampled residents (Residents 12, 63, and 89) reviewed for the use of indwelling urinary catheter (thin, flexible tube inserted into the bladder through the urethra to drain urine).</p> <p>* The facility failed to ensure the urinary catheter tubing was not touching the floor for Residents 12 and 63.</p> <p>* The facility failed to ensure indwelling urinary catheter care was provided as per the care plan to Resident 89.</p> <p>These failures had the potential for the residents to develop UTIs.</p> <p>Findings:</p> <p>1. Review of the Centers for Disease Control and Prevention's article (undated) titled Catheter-Associated Urinary Tract Infection (CAUTI) showed a UTI is an infection in the urinary tract system (including the bladder and the kidneys). Germs can travel along the catheter, and if they enter the urinary tract, may cause an infection in the bladder or kidneys. Prevention of the CAUTIs include proper catheter insertion techniques, regular monitoring, and prompt removal of the catheter when no longer needed.</p> <p>Review of the facility's P&P titled Catheter Care dated 12/19/22, showed it was the policy of the facility to ensure that the residents with indwelling catheter receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Further review of the P&P showed catheter care will be performed every shift and as needed by nursing personnel.</p> <p>On 7/15/25 at 1436 hours, Resident 89 was observed lying on her bed, and the indwelling urinary catheter was observed hanging on the right lower side of her bed.</p> <p>Review of Resident 89's plan of care dated 3/4/25, showed a care plan problem addressing the resident's use of an indwelling urinary catheter. The goal showed the resident would not show signs and symptoms of</p>	F0690	<p>Department heads and designee will do daily room rounds to make sure no indwelling catheter bag is touching the floor, any non-compliance will be address immediately and report to morning meeting.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0690 SS = D	<p>Continued from page 39 urinary tract infection, and the interventions included to provide a Foley catheter (a type of an indwelling catheter) care as ordered.</p> <p>Review of Resident 89's Order Summary Report showed a physician's order dated 3/19/25, for indwelling urinary catheter sized FR 16, balloon sized 10 cc, as needed for neurogenic bladder (medical condition where nerve damage affects the bladder's ability to store and release urine), change for blockage, leaking, pulled out, excessive sedimentation, and change the urinary catheter drainage bag as needed and with every change of the indwelling urinary catheter.</p> <p>Further review of the physician's orders did not show the order for urinary catheter care.</p> <p>Review of Resident 89's MDS assessment dated 5/22/25, showed Resident 89 had a memory problem and severely impaired cognitive skills for daily decision making.</p> <p>Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was admitted to the facility on 7/26/25, and readmitted on 3/19/25, with an indwelling urinary catheter.</p> <p>Review of Resident 89's Admission Record dated 7/16/25, showed Resident 89 had a history of UTI.</p> <p>On 7/17/25 at 1435 hours, an observation, interview, and concurrent medical record review for Resident 89 was conducted with RN 1. RN 1 stated the facility provided urinary catheter care to the residents who had indwelling urinary catheter to prevent UTI. RN 1 stated the indwelling urinary catheter care required a physician's order, and the licensed nurses provided the urinary catheter care to the residents. RN 1 verified Resident 89 had the indwelling urinary catheter. RN 1 verified the resident's plan of care showed to provide indwelling urinary catheter care as ordered. However, Resident 89 had no physician's order for the catheter care. RN 1 further stated she was not able to find the documentation to show if the indwelling urinary catheter care was provided to Resident 89. RN 1 stated the physician's order should have been obtained and the indwelling urinary catheter care should have been provided to Resident 89 as per the care plan.</p>	F0690		

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F0690 SS = D	<p>Continued from page 40</p> <p>On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings.</p> <p>2. On 7/15/25 at 1455 hours, during the initial tour of the facility, an observation was conducted for Resident 12. Resident 12 was observed laying on the bed. Resident 12's indwelling urinary catheter drainage bag was observed without sediments. However, Resident 12's indwelling urinary catheter drainage bag was observed touching the floor.</p> <p>Medical record review for Resident 12 was initiated on 7/15/25. Resident 12 was admitted to the facility on 4/30/24, and was readmitted on 3/3/25.</p> <p>Review of Resident 12's MDS assessment dated 5/5/25, showed the resident had a BIMS score of 7, which indicated severe cognitive impairment.</p> <p>Record Review of Resident 12's Order Summary Report dated 7/21/25, showed a physician's order dated 3/3/25, for an indwelling urinary catheter to change for blockage, leaking, pulling out, excessive sedimentation, and to change catheter drainage bag as needed and with every change of indwelling urinary catheter.</p> <p>On 7/15/25 at 1508 hours, an observation of Resident 12's indwelling urinary catheter drainage bag and concurrent interview was conducted with LVN 9. LVN 9 verified the resident's indwelling urinary catheter drainage bag was touching the floor. LVN 9 stated when Resident 12's bed was placed in low position, the indwelling urinary catheter drainage bag should be placed inside a basin, to prevent the drainage bag from touching the floor. LVN 9 was observed getting a basin for the indwelling urinary catheter drainage bag.</p> <p>On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p> <p>3. On 7/15/25 at 1123 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 63. Resident 63 was</p>	F0690		

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F0690 SS = D	<p>Continued from page 41 observed awake in bed. Resident 63's indwelling urinary catheter drainage bag was observed placed on the side of the bed and touching the floor.</p> <p>Medical record review for Resident 63 was initiated on 7/16/25. Resident 63 was admitted to the facility on 5/28/25.</p> <p>Review of Resident 63's Order Summary Report dated 7/17/25, showed a physician's order dated 5/8/25, for an indwelling urinary catheter to change the catheter drainage bag as needed and with every change of indwelling urinary catheter.</p> <p>On 7/17/2025 at 1048 hours, an observation and concurrent interview for Resident 63 was conducted with LVN 3. LVN 3 was asked about Resident 63's catheter drainage bag and LVN 3 verified Resident 63 had a catheter. LVN 3 was informed about the observation of the resident's indwelling urinary catheter drainage bag touching the floor. LVN 3 verified and acknowledged the resident's indwelling urinary catheter drainage bag was placed at the side of the bed and touching the floor. LVN 3 stated she instructed her CNA to place the indwelling urinary catheter drainage bag in a basin in order for the drainage bag to not directly touch the floor.</p> <p>On 7/17/2025 at 1126 hours, an interview for Resident 63 was conducted with the DON. The DON was informed and verified the above findings.</p>	F0690	<p>F0695</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 36, 54, 69, 80, 86, 89, 104, 122 were affected by this deficient practice. Immediately, Licensed nurse updated plan of care for resident 36, 86, 89, 104, 122. Licensed nurse immediately replaced oxygen tubing that was touching the floor for resident 69 and replaced tubing of 80 with no label.</p> <p>On 7/18/2025, Respiratory Therapist supervisor reviewed BIPAP user guide manual and provided 1:1 education to RT 1 about BIPAP cleaning guidelines and documentation.</p> <p>On 7/16/2025, DON provided 1:1 education to LVN 2 and 12 regarding oxygen administration and making sure to document when providing PRN order.</p> <p>On 8/5/2025-8/8/2025, DON in-serviced all Licensed Nurses about facility policy and procedure of developing comprehensive care plan for each resident, in particular care plan for oxygen administration. DON in-serviced also about policy and procedure for assessing resident's medical needs to make sure plan of care was updated and documenting when providing Oxygen as needed. DON also in-service about oxygen setting monitoring and following physician orders.</p> <p>On 8/5/2025-8/8/2025, RT supervisor in-serviced all Licensed Nurses about facility policy and procedure for manging and maintaining BIPAP machine which included cleaning schedule and making sure it was documented when cleaning and replacing parts of the BIPAP, such as tubings and mask.</p>	8/23/2025
F0695 SS = D	<p>Respiratory/Tracheostomy Care and Suctioning</p> <p>CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, medical record review, and facility's P&P review, the facility failed to</p>	F0695	<p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents receiving Oxygen could potentially affected by this deficient practice. DON and Unit managers audited all residents care plan who were receiving oxygen and found no other issue. DON will provided ongoing education and training to Licensed nurses about developing comprehensive care plan for individual resident.</p>	

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F0695 SS = D	<p>Continued from page 42 ensure the respiratory care and services were provided for six of nine final sampled residents (Residents 36, 54, 86, 89, 104, and 122) and two nonsampled residents (Residents 69 and 80).</p> <p>* The facility failed to ensure the oxygen was administered as per the physician's order for Resident 89. In addition, there was no documentation for the PRN administration of the oxygen and the reason why the oxygen was administered to Resident 89.</p> <p>* Resident 86 had a physician's order to administer continuous oxygen via a nasal cannula and to titrate the oxygen rate to maintain an oxygen saturation level of 92% or greater. Resident 86 received continuous oxygen therapy at a rate of six liters per minute via nasal cannula for approximately five hours. The facility failed to attempt to titrate the oxygen to a lower rate to maintain Resident 86's oxygen saturation level at 92% or greater. Additionally, the facility had exceeded the maximum rate of oxygen (five liters per minute) allowed to be administered to Resident 86 via nasal cannula, in accordance with the facility's P&P.</p> <p>* The facility failed to ensure Resident 69's oxygen tubing was not touching the floor.</p> <p>* The facility failed to ensure Resident 80's oxygen tubing was dated and labeled.</p> <p>* The facility failed to ensure Resident 104's physician's order for nebulizer breathing treatment was carried out. The breathing treatment was discontinued; however, the nebulizer machine, mask, and tubing were observed at the bedside undated and not placed inside a clear plastic bag when not in use.</p> <p>* The facility failed to ensure Resident 54's BIPAP (Bilevel Positive Airway Pressure, a non-invasive ventilation device that helps individuals with breathing difficulties by delivering pressurized air through a mask or nasal plugs, used to treat sleeping disorder and other respiratory issues where breathing assistance is needed) tubing assembly, water tub and mask were regularly cleaned to prevent the growth of germs as indicated on Resident 54's BIPAP user guide.</p> <p>* The facility failed to follow the physician's order for Residents 36 and 122's oxygen therapy.</p> <p>These failures had the potential for the residents to not receive the appropriate respiratory care and increase risks of the infection.</p>	F0695	<p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON or Designee will oversee this process. DON or designee will review all new admission and re-admission for oxygen order and will make sure comprehensive care plan was done to include oxygen parameter, especially for resident receiving oxygen, Any finding will be reviewed and reported during clinical meeting.</p> <p>Department Heads and designee will do daily room rounds to make sure all oxygen tubings were label and not touching the floor, any issue will be address immediately and reported to morning meeting x 3 months.</p> <p>Medical record will audit oxygen order to make sure plan of care reflects resident's oxygen administration parameters x 3 months and report to DON for any non-compliance.</p> <p>Respiratory Therapist will review BIPAP cleaning and maintenance log monthly to make sure RT are following the user guide manual for cleaning and maintenance of BIPAP, any non-compliance will be reported to the DON x 3 months.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON and Administrator will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0695 SS = D	<p>Continued from page 43 Findings:</p> <p>1. Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician, except in the case of an emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. Further Review of the P&P showed the staff shall notify the physician of any changes in resident condition, including changes in vital signs, oxygen concentration, or evidence of complications associated with the use of oxygen. Types of oxygen delivery systems include nasal cannulas (where oxygen is administered through plastic cannulas in the nostrils). Effective for low oxygen concentrations, less than 40 percent (equivalent to a rate of five liters per minute).</p> <p>On 7/15/25 at 1048 hours, Resident 89 was observed lying in her bed. Resident 89 was observed receiving oxygen via nasal cannula at five liters per minute.</p> <p>On 7/15/25 at 1627 hours, Resident 89 was observed lying in her bed. Resident 89 was observed receiving oxygen via nasal cannula at four liters per minute.</p> <p>On 7/16/25 at 1053 hours, Resident 89 was observed lying in her bed. Resident 89 was observed receiving oxygen at 3.5 liters per minute.</p> <p>Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was admitted to the facility on 7/26/25, and readmitted on 3/19/25.</p> <p>Review of Resident 89's MDS assessment dated 5/22/25, showed Resident 89 had a memory problem and severely impaired cognitive skills for daily decision making.</p> <p>Review of Resident 89's Order Summary Report showed the physician's order dated 7/16/25, to administer PRN oxygen via nasal cannula at 2-4 liters per minute. May titrate oxygen up to 5 liters per minute to maintain oxygen saturation level greater or equal to 92 % at maximum titration, as needed.</p> <p>Further review of Resident 89's medical record did not show the documented reason why the oxygen was being administered to Resident 89. In addition, Resident 89's medical record did not show the documentation of the oxygen administration.</p>	F0695		

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F0695 SS = D	<p>Continued from page 44</p> <p>On 7/16/25 at 1104 hours, an observation and concurrent medical record review for Resident 89 was conducted with LVN 2. LVN 2 stated if the resident required the PRN administration of the oxygen, then the reason for PRN administration of the oxygen should be documented; and if the resident's condition required continuous administration of the oxygen, then the physician should be notified and the order for continuous oxygen administration should be obtained. In addition, the PRN administration of the oxygen should be documented and indicate the amount of oxygen being delivered to the resident. LVN 2 verified the above observation and stated Resident 89 had been receiving continuous oxygen administration since she started working at the facility for the last two months. LVN 2 reviewed Resident 89's medical record and stated she was not able to find a documented reason why the oxygen was being administered to Resident 89. LVN 2 reviewed the oxygen saturation levels of Resident 89 for July 2025 and verified there was no documentation of the oxygen saturation levels below 92 %. In addition, LVN 2 verified there was no documentation of the amount of oxygen being administered to Resident 89.</p> <p>On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings.</p> <p>2. Medical record review for Resident 86 was initiated on 7/15/25. Resident 86 was admitted to the facility on 11/12/23.</p> <p>Review of Resident 86's physician's order dated 6/18/25, showed an order for the oxygen to be administered at two liters per minute via nasal cannula, may titrate (oxygen rate) to maintain an oxygen saturation greater than or equal to 92 %.</p> <p>Review of Resident 86's plan of care showed a care plan problem initiated 4/11/24, addressing the resident's oxygen therapy. The care plan showed Resident 86 had impaired gas exchange.</p> <p>On 7/15/25 at 1050 hours, an observation and concurrent interview was conducted with Resident 86. Resident 86 was observed lying in her bed. Resident 86 was observed receiving continuous oxygen therapy via a nasal cannula at a rate of six liters per minute. Resident 86 stated a past COVID-19 infection had caused damage to her lungs, having resulted in her need for oxygen therapy. Resident 86 stated she did not know the rate of the oxygen she was receiving as nursing staff had set the rate.</p>	F0695		

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F0695 SS = D	<p>Continued from page 45</p> <p>On 7/15/25 at 1554 hours, an observation, interview, and concurrent medical record review was conducted with LVN 12. Resident 86 was observed lying in her bed. Resident 86 was observed receiving continuous oxygen via a nasal cannula at a rate of six liters per minute. LVN 12 was asked the maximum rate of oxygen that she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation level greater than or equal to 92 %, in accordance with the physician's order. LVN 12 stated she was uncertain, as the order failed to specify a maximum rate of oxygen. LVN 12 obtained Resident 86's oxygen saturation level (while receiving six liters of oxygen) which yielded a result of 97 %. LVN 12 then stated she would consult with Resident 86's RN (RN 5).</p> <p>On 7/15/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with RN 5. RN 5 verified Resident 86's medical record failed to show documentation specific to the rate of oxygen Resident 86 was receiving. RN 5 was informed Resident 86 had received continuous oxygen therapy via a nasal cannula at a rate of six liters per minute, from 1050 hours to 1604 hours. RN 5 reviewed and verified Resident 86's medical record showed documentation that Resident 86's oxygen saturation level was 98 % (on 7/15/25 at 0908 hours) and 97 % (on 7/15/25 at 1557 hours). RN 5 was asked the maximum rate of oxygen she could administer to Resident 86 (via nasal cannula) to maintain an oxygen saturation level greater than or equal to 92 %, in accordance with the physician's order. RN 5 stated in accordance with facility's P&P for oxygen administration, Resident 86 could receive oxygen a maximum rate of five liters per minute via nasal cannula. RN 5 stated the oxygen administered at a rate greater than five liters per minute would be administered via an oxygen mask, to ensure optimal oxygen absorption. RN 5 stated the nursing staff should have attempted to titrate Resident 86's oxygen to the lowest rate possible between 1050 and 1604 hours, while maintaining Residents 86's oxygen saturation level at 92 % or greater. RN 5 stated Resident 86's physician should have been informed if Resident 86 required continuous oxygen at a rate of six liters per minute via nasal cannula, to maintain an oxygen saturation level of 92 % or greater. RN 5 stated she would inform Resident 86's physician and seek clarification specific to Resident 86's oxygen therapy order.</p> <p>Cross reference to F656.</p> <p>3. On 7/15/25 at 0804 hours and 7/17/25 at 1031 hours, Resident 69 was observed in bed with the oxygen at two</p>	F0695		

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F0695 SS = D	<p>Continued from page 46 liters per minute via nasal cannula. Resident 69's oxygen tubing was observed touching the floor.</p> <p>Medical record review for Resident 69 was initiated on 7/16/25. Resident 69 was admitted to the facility on 7/17/25.</p> <p>Reviewed of Resident 69's Order Summary Report dated 7/17/25, showed a physician's order dated 7/16/25, to administer oxygen via nasal cannula at 2 to 4 liters per minute.</p> <p>On 7/17/25 at 1031 hours, an observation and concurrent interview for Resident 69 was conducted with LVN 4. LVN 4 verified Resident 69's oxygen tubing was touching the floor. LVN 4 stated the oxygen tubing should not be touching the floor.</p> <p>On 7/17/25 at 1101 hours, an interview for Resident 69 was conducted with the DON. The DON was informed and verified the findings.</p> <p>4. On 7/15/25 at 0911 hours, during the initial tour of the facility, Resident 80 was observed in bed awake. Resident 80 was observed with oxygen at three liters per minute via nasal cannula and the oxygen tubing was unlabeled and undated.</p> <p>Medical record review for Resident 80 was initiated on 7/16/25. Resident 80 was admitted to the facility on 7/19/18.</p> <p>Review of Resident 80's Order Summary Report dated 7/17/25, showed a physician's order dated 7/16/25, to administer oxygen via nasal cannula at 2 to 5 liters per minute.</p> <p>ON 7/17/25 at 1045 hours, an observation and concurrent interview for Resident 80 was conducted with LVN 3. LVN 3 was asked about Resident 80's use of the oxygen via nasal cannula. LVN 3 verified and acknowledged the oxygen tubing was unlabeled and undated. LVN 3 stated the night shift nurse changed the oxygen tubing once a week every Sunday and usually labeled and dated the oxygen tubing.</p> <p>On 7/17/25 at 1112 hours, an interview for Resident 80 was conducted with the DON. The DON was informed and</p>	F0695		

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F0695 SS = D	<p>Continued from page 47 verified the findings.</p> <p>5. On 7/15/25 at 1006 hours, during the initial tour of the facility, Resident 104 stated she was using the nebulizer machine at beside when she needed it due to her breathing problem. Resident 104's nebulizer mask was observed on top of the nebulizer machine undated.</p> <p>Medical record review for Resident 104 was initiated on 7/17/25. Resident 104 was admitted to the facility on 7/2/25.</p> <p>Review of Resident 104's physician's order dated 3/24/24, to administer ipratropium-albuterol solution (Inhaler medication) 0.5 to 2.5 mg/3 ml via inhalation orally every six hours for shortness of breath for 14 days. However, the physician's order for breathing treatment was discontinued 4/1/25.</p> <p>On 7/21/25 at 1330 hours, an interview and concurrent medical record review for Resident 104 was conducted with LVN 5. When LVN 5 was asked about Resident 104's breathing treatment, LVN 5 verified Resident 104 was receiving a breathing treatment. LVN 5 then accessed the resident's electronic medical record when LVN 5 was asked about the medication for the breathing treatment. LVN 5 verified and acknowledged the breathing treatment via nebulizer was discontinued on 4/1/25. LVN 5 verified the nebulizer machine was at the bedside and the nebulizer tubing was placed on top of the nebulizer machine. LVN 5 stated the nebulizer machine should have been removed and cleaned when the physician's order for breathing treatment was discontinued. LVN 5 stated the nebulizer tubing and mask should have been placed on the clear plastic bag when not in use.</p> <p>On 7/23/25 at 1528 hours, an interview for Resident 104 was conducted with the DON. The DON was informed and verified the findings.</p> <p>Cross reference to F657.</p> <p>6. Review of the BiPAP AirCurve 10 VAUTO S ST user guide manual showed the ResMed AirCurve 10 VAUTO, AirCurve 10 S and AirCurve 10 ST are bilevel positive airway pressure devices. Under the About your device section showed: 1. Air outlet 2. Air filter cover 3.</p>	F0695		

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F0695 SS = D	<p>Continued from page 48</p> <p>Power inlet 4. Serial number and device number 5. Water tub 6. Screen 7. Adapter cover 8. SD card cover. Setup. Caution. Do not overfill the water tub as water may enter the device and air tubing. 1. Place the device on a stable level surface. 2. Plug the power connector into the rear of the device. Connect one end of the power cord into the power supply unit and the other end into the power outlet. 3. Connect the air tubing firmly to the air outlet located on the rear of the device. 4. Open the water tub and fill it with distilled water up to the maximum water level mark. Do not fill the water tub with hot water. 5. Close the water tub and insert it into the side of the device. 6. Connect the free end of the air tubing firmly onto the assembled mask. Caring for your device. It is important that you regularly clean your AirCurve 10 device to make sure you receive optimal therapy... Regularly clean your tubing assembly, water tub and mask to receive optimal therapy and to prevent growth of germs that can adversely affect your health. The website of ResMed AirCurve 10 VAUTO S ST, www.resmed.com, showed it is generally recommended to clean the BIPAP mask daily to maintain its quality and prevent the growth of germs that could adversely affect your health. Disassemble the mask components and clean them gently with warm water and mild soap each day. Regularly cleaning is vital to ensure effective therapy and comfort during use.</p> <p>On 7/15/25 at 1143 hours, during the initial tour of the facility, Resident 54 was observed with a BIPAP machine, tubing and mask by his bedside table. Resident 54's BIPAP tubing and mask were observed in a clear bag labeled with Resident 53's name and dated with 6/29/25.</p> <p>Medical record review was for Resident 54 was initiated on 7/15/25. Resident 54 was admitted to the facility on 4/16/25, and readmitted on 5/27/25.</p> <p>Review Resident 54's Order Summary Report showed a physician's order dated 5/25/25, for the BIPAP use every evening and night shift monitoring of mask placement.</p> <p>Review of Resident 54's MAR for June 2025 showed the BIPAP was administered from June 1 through June 30 2025. However, there was no specific documentation to show Resident 54's BIPAP machine, tubing, and mask were cleaned.</p>	F0695		

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F0695 SS = D	<p>Continued from page 49</p> <p>Review of Resident 54's TAR and Respiratory Administration Record (RESP) did not show specific documentation when Resident 54's BiPAP machine, tubing, and mask were cleaned.</p> <p>Review of Resident 54's Respiratory Therapist record log on the SNF BiPAP monthly changes (changes are to be done as needed when soiled or malfunctioning) showed the following:</p> <ul style="list-style-type: none"> - Circuit (First Monday) showed the dates for 5/29, 6/2, N/A, 7/1/25 and N/A; - Mask (First Monday) showed the dates for 5/29, 6/2, N/A, 7/1/25 and N/A; - Bacterial Filter (First and Third Monday) showed the dates for 5/29, 6/2, 6/16, 7/1, and 7/15/25; and - Air Filter (Six Months) showed the dates for 5/29/25, N/A, N/A, N/A, and N/A. <p>On 7/15/25 at 0922 hours, an observation, interview, and concurrent medical record review on Resident 54 was conducted with LVN 2. LVN 2 was asked who was responsible for checking and cleaning Resident 54's BiPAP machine, tubing, and mask. LVN 2 stated for Resident 54, the Respiratory Therapists were responsible for cleaning and checking Resident 54's BiPAP machine, tubing, and mask. LVN 2 was informed Resident 54's BiPAP tubing and mask were placed in a clear bag dated 6/29/25. LVN 2 checked and verified the BiPAP tubing and mask were stored in a clear bag dated 6/29/25. LVN 2 was also asked if she could show any documentation on the resident's electronic medical record when Resident 54's BiPAP machine, tubing assembly and mask were last cleaned. LVN 2 verified she was not able to find documentation on the resident's electronic medical record, however would reach out to Resident 54's RT if there was a separate record log for the cleaning.</p> <p>On 7/15/25 at 1202 hours, an observation and a concurrent interview was conducted with RT 1. RT 1 verified Resident 54's BiPAP tubing and mask were stored in a clear bag dated 6/29/25. When RT 1 was asked if he was assigned to Resident 54 and the process on cleaning Resident 54's BiPAP machine, tubing, and mask, RT 1 stated he was assigned to Resident 54 and Resident 54's BiPAP machine, tubing, and mask were</p>	F0695		

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F0695 SS = D	<p>Continued from page 50 cleaned monthly. RT 1 was also asked to provide a copy of Resident 54's ResMED AirCurve 10 VAUTO S ST user guide manual and to show documentation in the resident's electronic medical record when Resident 54's BiPAP machine, tubing, and mask were cleaned. RT 1 stated he would provide a copy of Resident 54's BiPAP user guide manual and show the documentation when Resident 54's BiPAP machine, tubing, and mask were last cleaned.</p> <p>On 7/18/25 at 0912 hours, an interview and a concurrent medical record review was conducted with the RT 1. RT 1 verified Resident 54's MAR for June 2025 showed Resident 54 was administered breathing/ventilation treatment using Resident 54's BiPAP machine, tubing, and mask from June 1 through June 30, for the evening and night shift. RT 1 was asked to show specific documentation showing Resident 54's BiPAP tubing assembly, water tub, and mask were cleaned regularly to receive optimal therapy and prevent the growth of germs as instructed by Resident 54's BiPAP user guide manual. RT 1 showed the SNF BiPAP monthly changes record log; however, there was no specification on when Resident 54's BiPAP tubing assembly, water tub, and mask were cleaned. RT 1 further verified the BiPAP equipment cleaning should have been documented.</p> <p>On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p> <p>7. On 7/15/25 at 1035 hours, during the initial tour of the facility, Resident 36 was observed lying in bed and receiving oxygen at 3.5 liters per minute via nasal cannula, which was attached to the oxygen machine concentrator.</p> <p>Medical record review for Resident 36 was initiated on 7/15/25. Resident 36 was admitted to the facility on 4/27/19, and readmitted on 5/3/19.</p> <p>Review of Resident 36's H&P examination dated 9/3/24, showed Resident 36 had no capacity to understand and make decisions.</p> <p>Review of Resident 36's Order Summary Report for July 2025 showed a physician's order dated 5/30/25, to</p>	F0695		

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F0695 SS = D	<p>Continued from page 51 administer oxygen at two liters per minute via nasal cannula every shift for low oxygen saturation levels.</p> <p>On 7/16/25 at 1614 hours, an observation, interview, and concurrent medical record review was conducted with LVN 7. LVN 7 verified Resident 36's oxygen machine concentrator was set at 3.5 liters per minute and the physician's order for the resident's oxygen was to be administered at two liters per minute every shift. LVN 7 acknowledged the findings and stated the facility staff should follow the physician's order for the oxygen administration for Resident 36.</p> <p>On 7/21/25 at 1554 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed of the above findings and stated the physician's order for oxygen administration should have been followed.</p> <p>8. On 7/15/25 at 1513 hours, during the initial tour of the facility, Resident 122 was observed lying in bed and asleep with eyes closed. There was no oxygen signage nor oxygen concentrator in the resident's room.</p> <p>Medical record review for Resident 122 was initiated on 7/16/25. Resident 122 was admitted to the facility on 4/30/25.</p> <p>Review of Resident 122's H&P examination dated 5/2/25, showed Resident 122 had the capacity to understand and make decisions.</p> <p>Review of Resident 122's Order Summary Report for July 2025 showed a physician's order dated 4/30/25, to administer oxygen at 2-3 liters per minute via nasal cannula, may titrate oxygen to maintain oxygen saturation levels greater than or equal to 91% every shift.</p> <p>On 7/16/25 at 1600 hours, an observation and concurrent interview was conducted with Resident 122. Resident 122 stated she had not used oxygen for awhile in the past two to three months.</p> <p>On 7/16/25 at 1604 hours, an observation, interview, and concurrent medical record review was conducted with</p>	F0695		

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F0695 SS = D	Continued from page 52 LVN 15. LVN 15 verified Resident 122 had a physician's order for oxygen to be administered at 2-3 liters per minute every shift and was discontinued on 7/16/25 at 1124 hours.	F0695	F0698	8/23/2025
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to ensure dialysis care was provided for one of 35 final sampled residents (Resident 9). * The facility failed to assess Resident 9's dialysis access site (AV shunt) for a bruit and thrill every shift in accordance with the facility's P&P. This failure had the potential for the facility staff failing to identify impaired functionality of Resident 9's AV shunt, and posed the risk for negative health outcomes in the event Resident 9's dialysis access site was to become inoperable. Findings: Review of the facility's P&P titled hemodialysis revised 6/5/23, showed the nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist.	F0698	1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 9 was affected by this deficient practice. Immediately on 7/23/2025, RN Supervisor assessed Resident 9's dialysis access site and found to be in working order with no issue noted--bruit and thrill were present on assessment. Resident's 9 plan of care was updated by RN supervisor to make sure dialysis access site was being assess every shift. On 7/23/2025, DON provided 1:1 education to LVN 8 about facility policy and procedure for assessing dialysis access site and to make sure it was being documented in resident's medical record. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All dialysis resident were potentially affected by this deficient practice. RN supervisor and Unit managers reviewed all dialysis residents and found no other issue noted. On 8/5/2025-8/8/2025, DON in-serviced all Licensed nurses about facility policy and procedure for assessing dialysis access site and making sure it was being assess every shift and as needed for functionality and any issue should be reported to primary physician. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: DON or designee will oversee this process. RN supervisor or designee will review all new dialysis resident to make sure dialysis access site is being assess every shift. IDT team will review during clinical meeting to make sure plan of care was being followed. Medical record will audit care plan and MAR for assessing dialysis access site, any non-compliance will be reported to the DON x 3 months.	

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F0698 SS = D	<p>Continued from page 53</p> <p>Medical record review for Resident 9 was initiated on 7/15/25. Resident 9 was admitted to the facility on 1/22/25.</p> <p>Review of Resident 9's physician's order dated 12/23/24, showed an order for hemodialysis on Tuesday, Thursday, and Saturday.</p> <p>Further review of Resident 9's medical record failed to show documentation Resident 9's dialysis access site was assessed every shift during the month of June 2025 and from 7/1 through 7/17/25.</p> <p>On 7/23/25 at 1024 hours, an interview was conducted with LVN 8. LVN 8 stated Resident 9 had hemodialysis on Tuesday, Thursday, and Saturdays. LVN 8 stated Resident 9's dialysis access site consisted of a left upper arm AV shunt. LVN 8 was asked about the facility's process for assessing Resident 9's dialysis access site. LVN 8 stated on Resident 9's dialysis days, the facility nursing staff would assess Resident 9's dialysis site for a bruit and thrill and document the assessment on the facility's Dialysis Communication Form.</p> <p>On 7/23/25 at 1106 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated in accordance with the facility's P&P, Resident 9's dialysis access site should have been assessed for the bruit and thrill every shift to ensure functionality, rather than only being assessed on dialysis days. The DON verified Resident 9's medical record failed to show documentation Resident 9's dialysis access site was assessed every shift during the month of June 2025 and from 7/1 through 7/17/25.</p>	F0698	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DO will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p> <p>F0755</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 9 was affected by this deficient practice. Immediately on 7/23/2025, RN supervisor clarified resident's 9 medication administration order with primary physician to administer daily medication, scheduled in morning, after resident returned from dialysis.</p> <p>All residents receiving narcotic medication in cart A, B and C were affected by this deficient practice. Immediately on 7/17/2025, Unit manager and Licensed nurse in charge of the Cart A, B and C reviewed narcotic logs to make sure all narcotics were accounted for and narcotic log sheet was being signed by incoming and outgoing nurses.</p>	8/23/2025
F0755 SS = D	<p>Pharmacy Srvcs/Procedures/Pharmacists/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p>	F0755	<p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents were potentially affected by this deficient practice. RN supervisor and Unit manager reviewed all dialysis residents and found no other issue with medication administration during dialysis days. Unit manager reviewed all narcotic logs and found no other issue on other carts.</p>	

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NAME OF PROVIDER OR SUPPLIER FRENCH PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 E WASHINGTON AVENUE , SANTA ANA, California, 92701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	<p>Continued from page 54</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmacy services in accordance with the physician's orders and the facility's P&P for one of six residents (Resident 9) reviewed for unnecessary medications and three of four medication carts observed.</p> <p>* The facility failed to ensure Resident 9's scheduled morning medications were administered after Resident 9 had returned to the facility from his dialysis appointment.</p> <p>* The facility failed to ensure the narcotic log sheets were signed by the licensed nurses during the controlled medication reconciliation for Medication Carts A, B, and C.</p> <p>These failures had the potential for negative health outcomes and posed the risk for diversion of controlled medications.</p> <p>Findings:</p>	F0755	<p>On 8/6/2025-8/8/2025, DON in-serviced all licensed nurses about facility policy and procedure for administration of medication to resident during their dialysis treatment days. DON emphasize on clarifying with resident's primary physician any medication administration order that will be conflicted with resident's dialysis treatment time and to make sure to update plan of care. DON also in-serviced all licensed nurse about policy and procedure of narcotic reconciliation, including making sure signing the narcotic log sheet for incoming and outgoing nurse, and its importance to prevent narcotic diversion.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON or designee will oversee this process. RN supervisor or designee will review all new dialysis resident to make sure all their medication administration time does not conflicts with their dialysis treatment schedule, and if it does, it will be clarified with primary physician immediately and update plan of care. IDT will review during clinical meeting (M-F) to make sure plan of care was being followed. Medical record will audit orders and MAR for non-compliance and will report to DON x 3 months.</p> <p>Unit manager or designee will review narcotic log sheet daily x 4 weeks, then weekly thereafter. Any noncompliance with narcotic log sheet will be reported to the DON.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0755 SS = D	<p>Continued from page 55</p> <p>Review of the facility's P&P titled Medication Administration revised 12/19/22, showed the medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as order by the physician and in accordance with professional standards of practice. Administer medications within 60 minutes prior or after scheduled time unless otherwise ordered by the physician.</p> <p>1. Medical record review for Resident 9 was initiated on 7/15/25. Resident 9 was admitted to the facility on 1/22/25.</p> <p>Review of Resident 9's physician's order dated 12/23/24, showed an order for hemodialysis on Tuesday, Thursday, and Saturday.</p> <p>Review of Resident 9's Order Summary Report dated 7/23/25, showed the following medications were ordered to be administered on 7/8/25 at 0900 hours:</p> <ul style="list-style-type: none"> - calcium acetate (phosphate binder medication) 667 mg orally for end stage renal disease; - docusate sodium (stool softener) 100 mg orally for bowel management; - Eliquis (anticoagulant medication) 2.5 mg orally for DVT prophylaxis; - escitalopram oxalate (antidepressant medication) 20 mg orally for depression; - gabapentin (neuropathic pain medication) 300 mg orally for neuropathy; - glipizide (diabetes medication) 5 mg orally for diabetes mellitus; - Rena-Vite (B-complex vitamin & folic acid) one tablet orally for supplement; and - sevelamer (phosphate binder medication) 800 mg orally for hyperphosphatemia. <p>Review of Resident 9's MAR dated July 2025 showed documentation the above listed medications were not administered on 7/8/25 at 0900 hours, in accordance with the physician's order and the facility's P&P.</p>	F0755		

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F0755 SS = D	<p>Continued from page 56</p> <p>Review of Resident 9's Dialysis Communication Form dated 7/8/25, showed Resident 9 had returned to the facility from his dialysis appointment on 7/8/25 at 0940 hours.</p> <p>On 7/23/25 at 1024 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 reviewed Resident 9's Dialysis Communication Form dated 7/8/25, and verified Resident 9 returned to the facility from his dialysis appointment on 7/8/25 at 0940 hours. LVN 8 then reviewed Resident 9's MAR dated 7/8/25, and verified the documentation which showed the above listed medications were not administered on 7/8/25 at 0900 hours, as ordered by Resident 9's physician. LVN 8 stated in accordance with the facility's P&P for medication administration, when Resident 9 returned to the facility from his dialysis appointment on 7/8/25 at 0940 hours, Resident 9's scheduled 0900 hours medications should have been administered as ordered by the physician.</p> <p>2.a. Review of the facility's P&P titled Controlled Substance Administration & Accountability revised 6/5/23, showed it is the policy of this facility to promote safe, high-quality care, compliant with state and federal regulations regarding monitoring the use of controlled substance. This facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. Under Policy Explanation and Compliance Guidelines, for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.</p> <p>Review of Medication Cart C's Narcotic Logbook showed multiple missing licensed nurses' signatures on the following days and shifts:</p> <ul style="list-style-type: none"> - for the outgoing licensed nurse on 6/12/25, for the 7 am - 7 pm shift; - for the outgoing licensed nurse on 6/17/25, for the 7 am - 7 pm shift; and - for the outgoing and incoming licensed nurses on 7/11/25, for the 7 am - 7 pm shift. <p>On 7/17/25 at 0915 hours, an interview and concurrent facility document review was conducted with RN 4. RN 4</p>	F0755		

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F0755 SS = D	<p>Continued from page 57</p> <p>verified multiple licensed nurses' signatures were missing in the Narcotic Logbook. RN 4 stated the licensed nurses must make sure the logbooks were signed by two licensed nurses during the outgoing and incoming shifts, to ensure the narcotic medications were accounted for the day.</p> <p>b. Review of Medication Cart A's Narcotic Logbook showed multiple missing licensed nurses' signatures on the following days and shifts:</p> <ul style="list-style-type: none"> - for the incoming licensed nurse on 6/15/25, for the 11-7 shift; - for the incoming licensed nurse on 6/27/25, for the 3-11 shift; - for the outgoing licensed nurse on 6/27/25, for the 11-7 shift; and - for the outgoing licensed nurse on 6/30/25, for the 7-3 shift. <p>On 7/17/25 at 1025 hours, an interview and concurrent facility document review was conducted with LVN 10. LVN 10 verified the missing licensed nurses' signatures on the above dates and shifts on the Narcotic Logbook.</p> <p>c. Review of Medication Cart B's Narcotic Logbook showed multiple missing licensed nurses' signatures on the following days and shifts:</p> <ul style="list-style-type: none"> - for the incoming licensed nurse on 4/29/25, for the 7-3 shift; and - for the outgoing licensed nurse on 4/29/25, for the 3-11 shift. <p>On 7/17/25 at 1042 hours, an interview and concurrent facility document review was conducted with LVN 8. LVN 8 verified the missing licensed nurses' signatures on the Narcotic Logbook.</p> <p>On 7/23/25 at 1125 hours, an interview and concurrent facility document review was conducted with DON. The DON verified the above findings. The DON stated the licensed nurses should have signed the Narcotic Logbook to ensure the controlled medications were accounted for when they came and/or left work.</p>	F0755		

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F0755 F0761 SS = D	<p>Label/Store Drugs and Biologicals</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage and labeling of the residents' medications, for one of four medication rooms, two of eight medication carts, and one of 35 final sampled residents (Resident 1) and one nonsampled resident (Resident 171).</p> <p>* Resident 171's olanzapine (antipsychotic medication) medication bottle was labeled with the incorrect administration time.</p> <p>* The physician's order for ferrous sulfate liquid and the ferrous sulfate liquid supplement medication bottle label failed to show the prescribed dose to be administered to Resident 171.</p> <p>* The facility failed to ensure the orally administered medications were kept separate from externally used medications, e.g., eye drops and suppositories</p>	F0755 F0761	<p>F0761</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 1 and resident 171 were affected by this deficient practice.</p> <p>Resident 1 is currently not in the facility.</p> <p>On 7/21/2025 and 7/24/2025, Unit manger clarified Medication order for resident 171 of Olanzapine and Ferrous sulfate with primary physician and notified pharmacy for correct medication label.</p> <p>All residents were affected by facility failure to separate oral medication vs external use medication in the medication room and medication cart. Immediately on 7/16/2025, RN supervisor and Charge nurse organized the storage to make sure there is a separation between oral medication and external use medication.</p> <p>On 7/17/2025, RN 4 removed the insulin that was opened for more than 28 days per facility P&P, and re-ordered the medication.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents were potentially affected by this deficient practice. On 8/4/2025, DON and Unit mangers review all 10 random resident to make sure all medication label and order was correct and found no other issue. On 7/24/2025, Unit manager and RN supervisor checked all medication cart and medication storage to make sure there is a separation between oral medication and external use medication such as suppositories, eye drops, etc. and found no other issues.</p> <p>On 8/5/2025-8/8/2025, DON in-serviced all licensed nurses about facility P&P for Medication label management and storage, in particular physician order and medication label is matching. DON also emphasize on storage and separation of oral medication and externally use medications and its importance to prevent cross contamination.</p>	8/23/2025

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F0761 SS = D	<p>Continued from page 59 (medication given, inserted rectally or vaginally).</p> <p>* The facility failed to ensure the opened insulin (medication to lower down blood sugar level) pen or vial labeled with an open date more than 28 days was immediately removed from the medication cart.</p> <p>* One opened bottle of Remedy Anti-fungal Powder (used to treat common fungal infections) was observed on Resident 1's bedside table. However, Resident 1 did not have a physician's order for the Remedy Anti-fungal Powder.</p> <p>These failures had the potential to result in medication administration errors, potential for medication to lose stability and effectiveness, and had the potential to negatively impact the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Labeling of Medications and Biologicals revised 12/19/22, showed all the medications used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications.</p> <p>1. Medical record review for Resident 171 was initiated on 7/15/25. Resident 171 was admitted to the facility on 2/17/25.</p> <p>Review of Resident 171's physician's order dated 7/10/25, showed to administer olanzapine zydys 5 mg orally at noon for psychosis manifested by auditory hallucinations, aggressive behavior, and pulling on the GT.</p> <p>On 7/21/25 at 1030 hours, an inspection of Medication Cart D was conducted with LVN 8. Medication Cart D contained Resident 171's olanzapine medication. The label affixed to Resident 171's medication bottle, which contained Resident 171's olanzapine zydys 5 mg tablets, showed to give one tablet by mouth in the morning (however, the physician's order showed to administer at noon) for psychosis manifested by auditory hallucinations, aggressive behavior, and pulling on the GT. LVN 8 verified the label was inaccurate as Resident 171's physician ordered the</p>	F0761	<p>DON also in-serviced licensed nurse about facility P&P for medication at bedside and making sure to check new admission and readmission for any medication when they arrived from acute care and the importance of reconciling all their medications with the resident or responsible party.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON or designee will oversee this process. RN supervisor or designee will review all new admission and readmission order and verify order with physician, charge nurse will make sure all medication label from pharmacy is matching current physician order and notify pharmacy for any discrepancy. IDT will review All admission during clinical meeting (M-F) to make sure all plan of care is in placed and all orders were verified.</p> <p>Unit managers or designee will do daily medication storage check x 4 weeks and weekly thereafter to make sure all oral medication and external use medication were stored separately. Any non-compliance will be reported to DON.</p> <p>Department heads and designee will do daily room rounds to check for any medication at bedside and address any issue immediately and report to morning meeting x 3 months.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0761 SS = D	<p>Continued from page 60 olanzapine zydis 5 mg tablet to be administered at noon.</p> <p>2. Review of Resident 171's physician's order dated 4/3/25, showed to administer ferrous sulfate liquid solution 220 mg/5 ml, give 7.5 ml via GT one time a day for supplement.</p> <p>On 7/21/25 at 0839 hours, a medication administration observation, interview, and concurrent medical record review was conducted with LVN 8. LVN 8 was observed preparing and administering Resident 171's prescribed morning medications. LVN 8 prepared and administered Resident 171's ferrous sulfate liquid solution. LVN 8 was asked the dose of the ferrous sulfate liquid solution she administered to Resident 171. LVN 8 stated she administered 7.5 ml. However, LVN 8 was unable to state the total dose (in mg) she administered to Resident 171. LVN 8 then verified Resident 171's physician's order for ferrous sulfate liquid solution and the ferrous sulfate supplement bottle label failed to show the prescribed total dose to be administered to Resident 171.</p> <p>3. Review of the facility's P&P titled Medication Storage, revised date 12/19/22, showed in part, it is the policy of this facility to ensure all the medications housed in our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light ventilation, moisture control, segregation, and security. Under Policy Explanation and Compliance Guidelines, Internal products: Medications to be administered by mouth are stored separately from other formulations (i.e., eye drops, ear drops injectables). External Products: disinfectants and drugs for external use are stored separately from internal and injectable medications.</p> <p>On 7/16/25 at 1520 hours, an inspection of Medication Room A and concurrent interview was conducted with LVN 7. The following was observed stored together on the upper shelf attached to the wall:</p> <ul style="list-style-type: none"> - four boxes of Pure Gentle Enema Saline Laxative; - two boxes of hemorrhoidal suppositories; - one box of Styte sterile lubricant eye ointment; and 	F0761		

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F0761 SS = D	<p>Continued from page 61 - multiple bottles of oral/ tablet medications.</p> <p>LVN 7 verified the above findings.</p> <p>On 7/16/24 at 1555 hours, an observation and concurrent interview was conducted with DON. The DON verified the three different routes of medications were stored together in one shelf. The DON stated the medications should be separated by compartments.</p> <p>4. Review of the facility's P&P titled Labeling of Medications and Biologicals revised 12/19/22, showed in part, all the medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. Biologicals are made from a variety of natural sources and are used to treat, prevent, and diagnose diseases and medical conditions. They may include a wide range of products such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues and recombinant therapeutic proteins. Labels for multi-use vials must include all opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.</p> <p>On 7/17/25 at 0915 hours, an inspection of Medication Cart C and concurrent interview was conducted with RN 4. The following was observed:</p> <p>- one opened vial of IIspro Insulin 100 u/ml (type of insulin injected to lower the blood sugar level) labeled with an opened date of 6/18/25, which is more than 28 days, per facility's P&P. RN 4 verified the finding and stated the insulin should have been discarded on 7/16/25, and a new vial should have been ordered.</p> <p>5. Review of the facility's P&P titled Medication Storage, revised 12/19/22, showed all drugs and biologicals will be stored in locked compartments (such as medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.</p> <p>Medical record review for Resident 1 was initiated on 7/15/25. Resident 1 was admitted to the facility on 6/23/25, and readmitted on 6/29/25.</p>	F0761		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = D	<p>Continued from page 62</p> <p>Review of Resident 1's H&P examination dated 6/30/25, showed Resident 1 had the capacity to understand and make decisions.</p> <p>Review of Resident 1's Order Summary Report on 7/15/25, showed no documented evidence the resident had a physician's order for the Remedy Anti-fungal Powder medication.</p> <p>On 7/15/25 at 1147 hours, an observation and concurrent interview was conducted with Resident 1 inside the resident's room. One opened bottle of Remedy Anti-fungal Powder was observed on Resident 1's bedside table. When Resident 1 was asked if the nursing staff applied the powder on her, Resident 1 verified the nursing staff had applied the antifungal powder before. Resident 1 stated the antifungal powder was applied on her under breasts and abdomen.</p> <p>On 7/15/25 at 1201 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1 inside Resident 1's room. LVN 1 verified the above findings. LVN 1 verified the bottle of Remedy Anti-fungal Powder was opened. LVN 1 also verified there was no physician's order for the antifungal powder. LVN 1 stated the medications needed a physician's order prior to administering the medication and the nursing staff would contact the physician for an order.</p> <p>On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated the antifungal powder was considered a medication and should have a physician's order. The DON stated the nursing staff obtained a physician's order and the resident now had orders for the antifungal powder. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p>	F0761	<p>F0808</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 93 was affected by this deficient practice. Immediately on 7/15/2025, RN supervisor assessed and observed resident for any adverse reaction and no issue was noted.</p> <p>On 7/15/2025, Registered Dietitian in-serviced all dietary staff about P&P for therapeutic diet and making sure all residents diet slip was being followed.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents receiving consistent carbohydrate diet were potentially affected by this deficient practice. On 7/15/2025, RD and Dietary supervisor audited all resident receiving Consistent carbohydrate diet and found no other issue noted.</p> <p>On 7/25/2025, RD and Dietary supervisor implemented new process of putting label for all dessert appropriate for resident with consistent carbohydrate diet order to make it easier for floor staff to recognize and address the issue if resident received inappropriate meal.</p>	8/23/2025
F0808 SS = D	<p>Therapeutic Diet Prescribed by Physician</p> <p>CFR(s): 483.60(e)(1)(2)</p> <p>§483.60(e) Therapeutic Diets</p> <p>§483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.</p>	F0808		

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F0808 SS = D	<p>Continued from page 63</p> <p>§483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure one sampled resident (Resident 93) received the appropriate consistent carbohydrate diet as ordered by the physician. This failure had the potential to cause elevation of the resident's blood sugar.</p> <p>Findings:</p> <p>On 7/15/25 at 1201 hours, Resident 93 was observed eating lunch in the first floor dining room. Review of Resident 93's meal ticket (used to identify the resident's diet and food preferences for meal service) showed Resident 93 required a consistent carbohydrate diet with no added salt (a diet intended to reduce blood sugar variations). Resident 93 had a blueberry streusel dessert on her meal tray.</p> <p>Review of the facility menu spreadsheet dated 7/15/25, showed the desert for the consistent carbohydrate diet for lunch was two pear halves, not blueberry streusel dessert.</p> <p>On 7/15/25 at 1201 hours, a concurrent interview and observation was conducted with LVN 6 who was in the dining room. LVN 6 verified Resident 93 was supposed to receive a consistent carbohydrate diet from her meal ticket. LVN 6 verified the dessert served to Resident 93 was the blueberry streusel. LVN 6 stated he was only comparing the meal tray ticket to the diet list and did not have the menu spreadsheet to determine if the food items served were the correct ones.</p> <p>Medical record review for Resident 93 was initiated on 7/15/25. Resident 93 was admitted to the facility on 5/13/25. Review of the Physician Order Report showed a physician's order dated 5/13/25, to provide Resident 93 with a consistent carbohydrate diet with no added salt.</p> <p>On 7/15/25 at 1430 hours, an interview and concurrent medical record review was conducted with the DSS. The DSS verified the above findings and stated Resident 93 required a consistent carbohydrate diet and should have received two pear halves for dessert.</p>	F0808	<p>On 7/25/2025, 7/28/025-7/31/2025, RD and Dietary supervisor in-serviced all Dietary staff, and Nursing department regarding P&P for therapeutic diet and the implementation of new process for recognizing dessert for resident with consistent carbohydrate diet order.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON and Registered Dietitian or designee will oversee this process. RN supervisor or designee will review all new admission and readmission diet order and RD will follow up for therapeutic diet. IDT team will discuss all new resident with therapeutic diet during clinical meeting (M-F) making sure plan of care was in placed. Dietary supervisor will make sure diet order and diet slip is accurate during meal tray line daily and Licensed nurse on the floor will double check every meal to make sure resident is receiving correct meal based on their physician therapeutic diet order.</p> <p>Any non-compliance will be reported to DON daily x 3 months.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025
F0812	Food Procurement, Store/Prepare/Serve-Sanitary	F0812		

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F0812 SS = D	<p>Continued from page 64</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure sanitary requirements were met in the kitchen as evidenced by: 1. Two of three ice scoop holders were not clean and one of three ice scoop holders contained standing water.</p> <p>2. The plate cover rack was not clean.</p> <p>3. More than ten plate covers did not have a smooth and cleanable surface.</p> <p>These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population of 145 who consumed food prepared in the kitchen and ice from the ice machines.</p> <p>Findings:</p> <p>Review of the facility document titled Diet Count by</p>	F0812	<p>F0812</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>145 of 180 residents were affected by this deficient practice.</p> <p>On 7/17/25, immediately the maintenance director and designee removed identified soiled ice machine scoop holders and replaced soiled with brand new clean and sanitized ice scoop holders</p> <p>On 7/18/25, the Dietary Service Supervisor (DSS) and designee removed and discarded all identified worn and frayed meal plate covers, and replaced with smooth, cleanable and brand new plate covers.</p> <p>On 7/18/25, the Dietary Supervisor and designee removed soiled plate cover rack and replaced with properly cleaned and sanitized plate cover rack.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents have the potential to be affected by this deficient practice. On 7/18/25, the Registered Dietitian, Dietary Service Supervisor (DSS), and designee conducted a facility wide audit for kitchen equipment, including plate cover, plate cover rack, and ice machine scoop holders and found no other noncompliance.</p> <p>On 8/5/2025-8/7/2025, Administrator in-serviced Dietary staff about the facility P&P for food procurement and maintaining all equipment used in kitchen were cleaned and sanitized and to throw away and replaced any uncleanable equipment such as plate cover rack that was worn out or frayed.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>Administrator and Dietary Service Supervisor (DSS) or designee will oversee the process. Dietary supervisor or designee will check all kitchen equipment daily for cleanliness and sanitation, Administrator or designee will check kitchen equipment randomly and weekly to</p>	

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F0812 SS = D	<p>Continued from page 65 Diet report dated 7/15/25 showed, 145 of 180 residents in the facility received food prepared in the kitchen.</p> <p>1. Review of the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A. Equipment, food-contact surfaces and utensils shall be clean to sight and touch.</p> <p>On 7/15/25 at 1056 hours, a concurrent interview and observation of the ice machine scoop holders located in the first floor ice machine room was conducted with the Maintenance Director. Three ice scoop holders were observed to be visibly soiled, and the standing water was observed inside one of the scoop holders. The Maintenance Director verified the findings and stated the housekeeping staff was responsible to clean the ice scoop holders.</p> <p>On 7/15/25 at 1120 hours, a concurrent interview and observation of the ice machine scoop holders located in the second floor ice machine room was conducted with the Maintenance Director. The inside of ice scoop holders were visibly soiled and had a pink residue. The Maintenance Director verified the ice scoop holders were not clean.</p> <p>On 7/17/25 at 0928 hours, a concurrent interview and review of the ice scoop holder photographs was conducted with the Housekeeping Director. The Housekeeping Director stated the ice scoop holders were cleaned daily with soap and water. When shown photographs of the visibly soiled ice scoop holders with standing water, the Housekeeping Director verified the ice scoop holders were not clean and they must be free of standing water.</p> <p>2. According to the USDA Food Code 2022 Section 4-101.19 Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling or that require frequent cleaning shall be constructed of a corrosion-resistant, nonabsorbent, smooth material.</p> <p>On 7/15/25 at 0845 hours, a concurrent interview and kitchen observation was conducted with the Assistant DSS. More than 20 plate covers were observed to be visibly worn and frayed. The Assistant DSS verified the</p>	F0812	<p>make sure all kitchen equipment were clean and not worn or frayed, and dietary staff were following sanitation process. Any noncompliance will be reported during morning meetings. Dietary supervisor or designee will be responsible for ordering and replacing any kitchen equipment that is not up to standard per facility P&P.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The Administrator or designee will be responsible for ensuring the monitoring process remains in place. Any findings and noncompliance will be immediately corrected and presented to the monthly Safety Committee meetings and the Quality Assurance (QA&A) committee meetings. The Plan of Correction was presented at the QA&A meeting on 8/14/25. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings x 3 months</p> <p>5. Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0812 SS = D	Continued from page 66 meal tray covers were visibly worn and frayed.	F0812		8/23/2025
F0813 SS = D	<p>3. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A. Equipment, food-contact surfaces and utensils shall be clean to slight and touch.</p> <p>On 7/15/25 at 0845 hours, a concurrent interview and kitchen observation was conducted with the assistant DSS. The plate cover rack was observed to be visibly soiled with a sticky residue. The Assistant DSS verified the visibly soiled, sticky residue on the plate cover rack. The Assistant DSS stated the plate cover racks must be cleaned and sanitized and further verified that the meal tray covers must have a smooth, cleanable surface.</p> <p>Personal Food Policy CFR(s): 483.60(l)(3) §483.60(l)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, facility document review, and facility P&P review, the facility failed to implement a safe food handling policy to ensure outside foods brought into the facility for residents by visitors were properly prepared and stored for safe consumption. * The facility failed to ensure the residents' foods inside Refrigerator A were labeled with the residents' names. * The facility failed to provide specific documentation on Resident 49's care plan addressing the problem of risk on storage of food in Resident 49's restroom bathtub. * The facility failed to ensure the facility's P&P for the use and storage of foods brought in by the family or visitors included any food safety related concerns such as time and temperature control and safe food</p>	F0813	<p>F0813</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 49 were affected by this deficient practice. On 7/21/2025, Unit manager and Social Services met with resident regarding his food storage and explained to resident the risk of storing food item in a resident shared bathtub. Resident 49 understand the risks and IDT team updated the plan of care.</p> <p>All residents receiving outside food from family or visitors were affected by this deficient practice. On 8/5/2025, RD and Dietary supervisor provided facility P&P to all residents receiving food from outside and educational flier for food handling was given to family and visitor bringing food from outside.</p> <p>On 7/15/2025, food found unlabeled in refrigerator A was discarded by the IP nurse.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents were potentially affected by this deficient practice. IP nurse checked all refrigerator for resident and found no other issue noted.</p> <p>On 8/5/2025-8/8/2025, Registered Dietitian in-service all staff regarding facility P&P for personal food policy, in particular making sure any food from outside will be labeled and store appropriately, and to educate resident, family member and visitor about food handling and risk of bringing food from outside. Plan of care should be updated accordingly.</p>	

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F0813 SS = D	<p>Continued from page 67 handling and preparation.</p> <p>These failures had the potential to result in foodborne illnesses in a highly susceptible resident population.</p> <p>Findings:</p> <p>1. On 7/15/25 at 1021 hours, an observation and concurrent interview was conducted with the IP. An observation was conducted of the residents' refrigerator (Refrigerator A). Four Tai Pei shrimp fried rice packages were observed inside of Refrigerator A. The shrimp fried rice packages were labeled with a room number; however, the packages were not labeled with the resident's name. Additionally, a four-ounce container of chocolate chip ice cream was observed inside of a plastic bag inside of Refrigerator A. The ice cream container was labeled with a room number; however, the container was not labeled with the resident's name. The ice cream was leaking from the top of the container and into the plastic bag.</p> <p>The IP verified the above findings and stated the resident food items needed to be labeled with the residents' name, to identify whom the items belonged to. The IP stated labeling food items with only a room number was insufficient, as residents may change rooms within the facility. The IP stated the ice cream needed to be discarded as it was leaking and touching the inside of the plastic bag in which it was stored. The IP stated the ice cream should not be served to the residents for infection control.</p> <p>2. Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 8/5/24, showed it is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. All food items brought in that are manufactured and does not require refrigeration, may be kept in the resident room inside a lock tight container that is provided by the resident. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative. If any part of this policy is not followed, the facility reserves the right to protect others by not allowing food items to be brought into the facility for a resident. The facility staff will assist the residents in accessing and consuming food that is brought in by resident and family or</p>	F0813	<p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>Administrator and RD or designee will oversee this process. RD and dietary supervisor will discuss to all new admission and their responsible party during initial care plan meeting about personal food policy and will provide education about food handling if family or visitors plan to bring food from outside.</p> <p>Department heads and designee will do daily room rounds to check for any food stored in area that is not appropriate for food storage and educate resident of facility P&P for storing food.</p> <p>Any non-compliant resident will be reported during morning meeting and IDT will meet with resident for plan of care.</p> <p>Dietary Supervisor or designee will check resident refrigerator daily to make sure food were properly labeled per facility P&P, any non-compliant food label will be discarded.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>Administrator will monitor the effectiveness of the process and any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months.</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0813 SS = D	<p>Continued from page 68 visitors if the resident is not able to do so on their own.</p> <p>On 7/15/25 at 1055 hours, during the initial tour of the facility, an observation was conducted inside Residents 49 and 146's shared restroom. The bathtub inside Residents 49 and 146's restroom was observed with seven boxes of Knotts Berry Farm raspberry and strawberry cookies.</p> <p>Medical record review for Resident 49 was initiated on 7/15/25. Resident 49 was admitted to the facility on 11/1/22, and readmitted on 8/23/24.</p> <p>Record Review of Resident 49's MDS assessment dated 4/11/25, showed Resident 49 had a BIMS score of 13, indicating intact cognition.</p> <p>Review of Resident 49's progress notes and plan of care did not show specific documentation that education was provided to Resident 49 regarding the risk of storing food items in a shared restroom's bathtub.</p> <p>Medical record review for Resident 146 was initiated on 7/15/25. Resident 146 was admitted on 4/16/25</p> <p>Review of Resident's 146's MDS assessment dated 7/7/25, showed Resident 146 had a BIMS score of 13, indicating intact cognition.</p> <p>On 7/21/25 at 0941 hours, a follow up observation of Residents 49 and 146's shared restroom and concurrent interview was conducted with Residents 49 and 146. Seven boxes of Knotts Berry Farm raspberry and strawberry cookies and boxes of chicken noodles were observed in the shared restroom's bathtub. Resident 49 was asked if all the food items in the bathtub belonged to him. Resident 49 stated he stored all his food items in the bathtub. When Resident 49 was asked if the facility staff provided him education regarding safe food handling and storage, Resident 49 refused to answer.</p> <p>On 7/21/25 at 1332 hours, an observation, interview and concurrent medical record review was conducted with the RN 2. RN 2 was informed of the observation regarding Resident 49's food items stored in the shared resident</p>	F0813		

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F0813 SS = D	<p>Continued from page 69 restroom's bathtub. RN 2 was asked if Resident 146 was using the restroom. RN 2 stated Resident 146 was not using the restroom, however, the shared restroom was also used for washing the washcloths used for Resident 146's personal hygiene. RN 2 was observed checking Residents 49 and 146's shared restroom and verified Resident 49's food items in the bathtub. RN 2 verified there was no documentation to show Resident 49 was provided education regarding safe food handling and storage of food items, and the risk when storing food items in the restroom.</p> <p>On 7/21/25 at 1341 hours, an interview and concurrent medical record review was conducted with Social Services Assistant 2. Social Services Assistant 2 was informed of the above findings. Social Services Assistant 2 stated Resident 49 had hoarding tendencies and noticed the resident's food items in the resident's room and in the shower. Social Services Assistant 2 stated she spoke with Resident 49 on 7/17/25, to clean all the food excess but Resident 49 declined. When Social Services Assistant 2 was asked to show documentation Resident 49 was provided with education about the risk of storing food in the restroom's bath tub, Social Services Assistant 2 verified there was no documentation.</p> <p>On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the findings.</p> <p>3. Review of the facility's P&P titled Use and Storage of Food Brought In By Family and Visitors revised 8/5/24, showed all the food brought in by visitors should be checked by nursing to ensure compatibility with the resident's diet. However, there P&P did not address any food safety related concerns such as time and temperature control and safe food handling and preparation.</p> <p>On 7/17/25 at 0959 hours, an interview and concurrent facility's document review was conducted with the IP. The IP verified the facility's outside food policy did not address for safe food handling, preparation, and time and temperature controls.</p> <p>On 7/17/25 at 1113 hours, an interview and concurrent facility's document review was conducted with the</p>	F0813		

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F0813 SS = D	Continued from page 70 Admission Director. When the Admission Director was asked to review the facility's outside food policy, the Admission Director verified there was no mention in the facility's outside food policy of safe food handling, preparation, storage, and appropriate time and temperature controls.	F0813		8/23/2025
F0836 SS = B	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to comply with CA State law SB 1383 dated 1/1/22, which mandated the facilities to separate the organic waste from their waste stream. This failure had the potential to increase the environmental impact of the facility thus adversely impacting the residents' health and	F0836	F836 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: All resident were affected by this deficient practice. On 7/18/25, immediately maintenance director contacted waste management provider to initiate and coordinate organic waste bin service and delivery. On 7/23/25, appropriate organic waste bins were placed in designated waste disposal area. Maintenance Director in-serviced all dietary staff about facility P&P for organic waste disposal per regulatory requirements. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. On 7/23/25, the Maintenance Director and designee verified with contracted waste management provider of compliance and conducted a facility wide waste audit to ensure waste disposal practices are met per SB 1383; no other deficiency were identified. On 7/25/2025, 8/4/2025-8/8/2025, Administrator in-serviced all staff regarding organic waste regulation under SB 1383. 3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur. Administrator and Dietary Supervisor or designee will oversee the process. Dietary supervisor or designee will monitor compliance making sure dietary staff is following the regulation under SB 1383, for separation of organic waste from waste stream. Administrator will check randomly to make sure staff is compliant with SB 1383 regulation x 3 months	

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NAME OF PROVIDER OR SUPPLIER FRENCH PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 E WASHINGTON AVENUE , SANTA ANA, California, 92701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0836 SS = B	Continued from page 71 well-being. Findings: On 7/16/25 at 0906 hours, an observation and concurrent interview was conducted with the DSS and Maintenance Director for the facility's trash area. The facility did not have separate bins for separating the organic waste from the facility's waste stream per the CA SB 1383. The DSS and Maintenance Director both verified the facility did not separate the organic waste from the facility's waste stream. The DSS and Maintenance Director further verified the facility did not have the required organic waste bins.	F0836	4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process: The Administrator or designee will be responsible for ensuring the monitoring process remains in place to confirm compliance. Any findings and noncompliance will be immediately corrected and presented to the monthly Safety Committee meetings and the Quality Assurance (QA&A) committee meetings. The Plan of Correction was presented at the QA&A meeting on 8/14/25. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings x 3 months	8/23/2025
F0838 SS = D	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed	F0838	5. Corrective action completion date: 8/23/2025 F838 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: All residents were affected by this deficient practice. On 8/4/2025, Administrator and IDT team met and updated facility assessment in accordance with CMS QSO-24-13-NH and included inputs from direct staff, inputs received during resident and resident's family and representative during care plan meeting and addressed contingency staffing needs. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents were potentially affected by this deficient practice. On 8/5/2025, Facility consultant in-service administrator and IDT team about new facility assessment regulation and making sure facility assessment was updated annually, when significant change happened or when regulation changes.	

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F0838 SS = D	<p>Continued from page 72 for the resident population;</p> <p>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</p> <p>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.</p> <p>§483.71(a)(2) The facility's resources, including but not limited to the following:</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).</p> <p>§ 483.71(b) In conducting the facility assessment, the facility must ensure:</p> <p>§ 483.71(b)(1) Active involvement of the following participants in the process:</p> <p>(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the</p>	F0838	<p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>Administrator or designee will oversee this process. Administrator will make sure any changes to facility assessment regulation, facility assessment will be updated. Annually, IDT team will update facility assessment with inputs from required representative. Administrator will present facility assessment for approval annually and when changes was made during monthly QA meeting.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>Administrator will monitor the effectiveness of the process Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025 for approval.</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0838 SS = D	<p>Continued from page 73 medical director, an administrator, and the director of nursing; and</p> <p>(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.</p> <p>(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>§483.71(c) The facility must use this facility assessment to:</p> <p>§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).</p> <p>§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.</p> <p>§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.</p> <p>§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.</p> <p>§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following:</p> <p>1. Active involvement of required individuals in developing the Facility Assessment;</p>	F0838		

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F0838 SS = D	<p>Continued from page 74</p> <p>2. A plan to maximize recruitment and retention of direct care staff; and</p> <p>3. A contingency plan for staffing needs.</p> <p>This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.</p> <p>Findings:</p> <p>According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan.</p> <p>Review of the Facility's Assessment dated 5/14/25, did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs.</p> <p>On 7/23/25 at 1443 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment was dated 5/14/25, and verified there were no direct care staff, direct care representatives, residents, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were plan to maximize recruitment and retention of the direct care staff or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.</p>	F0838		
F0842 SS = B	<p>Resident Records - Identifiable Information</p> <p>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-Identifiable information.</p>	F0842		

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F0842 SS = B	Continued from page 75 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F0842	F842 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 171 and 195 were affected by this deficient practice. On 07/21/2025, Unit manager clarified medication scheduling record and notified pharmacy to send medication with correct label. Resident 195 is no longer residing in the facility. On 7/16/2025, Administrator provided 1:1 education to Activity director about facility p&P for making sure to complete and have accurate documentation on the resident council agenda/minutes record, in particular reviewing and following up on resident's council grievances. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents were potentially affected by this deficient practice. On 8/4/2025, DON and Unit manager audited 10 random residents Medication Administration records and found no other issue noted. On 8/4/2025, Medical records audited last 30 days transfer and discharge record and found no other issue with completion of notification of transfer/ discharge record. On 7/16/2025, Activity director reviewed all resident council meeting minutes in the last 4 months and followed up on any grievances and all grievances was addressed. On 8/5/2025-8/8/2025, the Director of Nursing (DON) or designee in-serviced all Licensed Nurses about facility P&P for accuracy of documentation and making sure any medication label were accurate based on physician order. On 8/5/2025, Administrator in-serviced Social services and case manager about the facility P&P for making sure proposed notification of discharge/ transfer form were completed and signed.	8/23/2025

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F0842 SS = B	<p>Continued from page 76</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(h)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure complete and accurate resident medical records and facility records were maintained for one of three sampled residents reviewed for closed records (Resident 195), one nonsampled resident (Resident 171), and the Resident Council record.</p> <p>* Resident 171's scheduling details for the administration of olanzapine zydys (antipsychotic medication) showed conflicting information specific to the medication administration time.</p> <p>* The facility failed to ensure complete and accurate documentation on the Resident Council Agenda/ Minutes record for the months of March, April, May, and June 2025.</p>	F0842	<p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON and Administrator or designee will oversee this process. RN supervisor or designee will review all new admission and re-admission to make all orders were verified with primary physician, in particular the medication administration time and notify pharmacy for any label discrepancy. Unit manager or designee will review 24-hours and 72-hours summary report and report during clinical meeting for any non-compliance.</p> <p>Administrator or designee will review all resident council agenda minutes to make sure it was completed accurately and all grievances was addressed and followed up before signing.</p> <p>Medical records will audit all proposed notice of discharge and transfer daily after resident discharge/ transfer to make sure all necessary information was completed and signed. All non-compliance will be reported to the administrator and DON in the morning meeting (M-F) x 3 months.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON and Administrator will monitor the effectiveness of the process and report any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0842 SS = B	<p>Continued from page 77</p> <p>* The facility failed to ensure the Notice Proposed Transfer/Discharge form was accurately completed and signed for Resident 195.</p> <p>These failures had the potential for the residents' care needs not being met as the facility records and resident medical records were inaccurate.</p> <p>Findings:</p> <p>1. Medical record review for Resident 171 was initiated on 7/15/25. Resident 171 was admitted to the facility on 2/17/25.</p> <p>Review of Resident 171's physician's order dated 7/10/25, showed to administer olanzapine zydys 5 mg orally at noon for psychosis manifested by auditory hallucinations, aggressive behavior, and pulling the GT.</p> <p>Review of Resident 171's Scheduling Details dated 7/14/25, showed the olanzapine zydys 5 mg was to be administered orally in the morning at 0900 hours. However, further review of Resident 171's Scheduling Details dated 7/14/25, showed a conflicting administration time (of 1200 hours) for the olanzapine zydys 5 mg to be administered to Resident 171.</p> <p>On 7/21/25 at 0839 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 171's Scheduling Details dated 7/14/25, showed to administer the olanzapine zydys 5 mg both in the morning at 0900 and at 1200 hours. LVN 8 stated the time of 0900 hours was inaccurate, as Resident 171's physician ordered the medication to be administered at 1200 hours.</p> <p>Cross reference F761 example #1.</p> <p>2. On 7/16/25 at 0834 hours, an interview was conducted with the Activities Director. The Activities Director was asked how many times the residents met for the Resident Council and to show the Resident Council Minutes from March – July 2025. The Activities Director stated the Resident Council committee usually meet once a month, every last Wednesday of the month or when the</p>	F0842		

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F0842 SS = B	<p>Continued from page 78 residents agreed to reschedule the meeting. The Activities Director provided the facility's Resident Council Agenda/Minutes from March through July 2025.</p> <p>Review of the facility's document titled Resident Council Agenda/ Minutes for March through June 2025 showed the issues identified by the Resident Council. The response from the department to those issues was also documented, however, the sections to show if the issues had been resolved to the residents'/family's reasonable satisfaction were left unchecked (yes or no) on 3/26, 4/30, 5/12, and 6/9/25.</p> <p>On 7/16/25 at 1032 hours, an interview was conducted during the Resident Council meeting with Residents 18, 125, 130, 141, 144, and 152. Residents 18, 125, 130, 141, 144 and 152 were asked if their concerns/issues were followed up or resolved by the facility. All the residents stated their previous concerns/issues had been resolved.</p> <p>On 7/18/25 at 0820 hours, an interview and concurrent facility document review was conducted with the Activities Director. The Activities Director was informed of the incomplete documentation on the Resident Council Agenda/ Minutes for March through June 2025 as mentioned above. The Activities Director verified she was responsible for following up and ensuring the issues were resolved and document on the Resident Council Agenda/ Minutes. The Activities Director verified the above findings.</p> <p>On 7/23/25 at 1124 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p> <p>3. Closed medical record review for Resident 195 was initiated on 7/15/25. Resident 195 was admitted to the facility on 12/16/22, and discharged to the acute care hospital on 1/22/23.</p> <p>Review of Resident 195's H&P examination dated 12/28/22, showed Resident 195 had no capacity to understand and make decisions.</p> <p>Review of Resident 195's Notice Proposed</p>	F0842			

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F0842 SS = B	<p>Continued from page 79</p> <p>Transfer/Discharge form dated 1/22/23, failed to show documented evidence of a Resident and/or Representative's Signature. Further review showed Resident 195 was transferred and/or discharged to Hospital A.</p> <p>Review of Resident 195's physician's order dated 1/22/23, showed a physician's order to transfer the resident to Hospital B's ER via 911 ambulance for further evaluation d/t (due to) low oxygen saturation.</p> <p>On 7/18/25 at 1017 hours, an interview and concurrent closed medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated the information on the Notice Proposed Transfer/Discharge form should accurately match with the physician's transfer orders. LVN 6 also stated the form should be completed. LVN 6 verified there was no signature of the resident or resident's representative on the form.</p> <p>On 7/21/25 at 1409 hours, an interview and concurrent closed medical record review was conducted with RN 3. RN 3 verified the above findings. RN 3 stated Resident 195's Notice Proposed Transfer/Discharge form showed the resident was transferred or discharged to Hospital A. However, RN 3 verified the physician's order showed the resident was to transfer to Hospital B. RN 3 stated the Notice Proposed Transfer/Discharge form should have been updated to accurately reflect the physician's transfer order to document where the resident was transferred or discharged to from the facility.</p> <p>On 7/23/25 at 1125 hours, an interview was conducted with the Administrator, Administrator Assistant, and DON. The DON stated she expected the licensed nurses to accurately complete the Notice Proposed Transfer/Discharge form, to include the correct location of the transfer or discharge and signature of the resident or resident's representative. The Administrator, Administrator Assistant, and DON were informed and acknowledged the above findings.</p>	F0842	<p>F880</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 120 was affected by staff not performing hand hygiene in between glove changes during treatment.</p> <p>On 7/18/2025, DON provided 1:1 education to LVN 11 about facility policy and procedure for infection control and prevention, especially doing hand hygiene in between glove changes during wound treatment to prevent cross contamination.</p> <p>Resident 162 was affected by this deficient practice. Immediately on 7/15/2025, LVN 9 changed the isolation signed from EBP to contact isolation.</p> <p>All resident were affected by soiled laundry stored in the clean laundry area.</p> <p>On 7/18/2025, IP nurse in-serviced all laundry staff about facility P&P for cross contamination and proper separation and storage of clean and soiled laundry.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents were potentially affected by this deficient practice.</p> <p>On 7/18/2025, IP nurse check laundry area to make sure soiled and clean area were separated and no soiled laundry were crossing the clean laundry area.</p> <p>On 7/25/2025, 8/4/2025-8/8/2025, DON, DSD, and IP nurse in-serviced all staff regarding facility P&P for infection control and prevention. The in-service focuses on hand hygiene, cross contamination, making sure clean and soiled laundry were separated, isolation precaution.</p> <p>On 8/5/2025-8/8/2025, DON in-serviced all Licensed Nurses about facility P&P for resident with new order of isolation and to put appropriate isolation sign immediately.</p>	8/23/2025
F0880 SS = D	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a</p>	F0880		

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F0880 SS = D	<p>Continued from page 80 safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff</p>	F0880	<p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON and IP Nurse or designee will oversee this process. IP nurse will do random check of laundry area to make sure soiled laundry is not stored in the clean area. any non-compliance will be addressed by training staff and reported to DON.</p> <p>IP will provide ongoing training and education to all staff about hand hygiene monthly x 3 months and random hand hygiene compliance will be completed and results will be reported monthly during infection control committee meeting.</p> <p>IP nurse will review all isolation signage to make sure resident in isolation has proper isolation sign. any new isolation order received by Charge nurse will be reported to IP nurse and discuss during Clinical meeting to make sure plan of care was updated.</p> <p>Any noncompliance will be reported to DON x 3 months</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>DON and IP nurse will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A and infection control meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0880 SS = D	<p>Continued from page 81 involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections.</p> <p>* The facility failed to ensure the soiled laundry was not stored in the clean laundry area.</p> <p>* The facility failed to ensure the facility staff performed hand hygiene before and after wearing gloves during the wound treatment observation for one nonsampled resident (Resident 120).</p> <p>* The facility failed to ensure the appropriate transmission-based precaution door signage was placed for one final sampled resident (Resident 162).</p> <p>These failures had the potential for cross-contamination and spread of infectious organisms in the facility.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Handling Soiled Linen dated 12/19/22, showed it is the policy of the facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Further review of the P&P showed used or soiled linen shall be collected at the bedside (or point of use such as dining room) and placed in a linen bag or designated linen receptacle. When the task is</p>	F0880		

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F0880 SS = D	<p>Continued from page 82 complete, the bag shall be closed securely and placed in the soiled utility room. Further review of the P&P showed soiled linen shall be kept separate from the clean linen.</p> <p>On 7/18/25 at 1029 hours, an observation of the laundry area and concurrent interview was conducted with the House Keeping Supervisor and DSD Assistant. Two soiled laundry bin, one with soiled mops and the other one with soiled towels were observed uncovered in the clean laundry area. The House Keeping Supervisor verified the observation and stated the two soiled laundry bin should not have been stored in the clean laundry area. The House Keeping Supervisor was observed taking soiled laundry bin out of the clean linen area.</p> <p>2. Review of the facility's P&P titled Hand Hygiene revised 12/19/22, showed all the staff will perform proper hand hygiene procedures to prevent the spread of the infection to other personnel, residents and visitors. Further review of the P&P showed the use of the gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Under the section Hand Hygiene Table showed to perform hand hygiene with either soap and water or alcohol-based hand rub, before applying and after removing personal protective equipment (PPE), including gloves.</p> <p>Medical record review for Resident 120 was initiated on 7/18/25. Resident 120 was admitted to the facility on 5/13/25.</p> <p>Review of Resident 120's Order summary Report showed a physician's order dated 7/8/25, to cleanse the coccyx (tailbone) pressure injury with normal saline, pat dry, apply xeroform (non adhering dressing), apply zinc (used to treat or prevent skin irritation like cuts, burns or diaper rash), and cover with a silicone dressing daily and as needed for soilage every day shift for wound management.</p> <p>On 7/18/25 at 0918 hours, a wound care observation for Resident 120 was conducted with LVN 11. Resident 120 was observed being awake in bed. LVN 11 was observed performing hand hygiene and wearing a gown and a clean pair of gloves. LVN 11 began by cleaning Resident 120's wound on the coccyx area with normal saline. LVN 11 then changed to a clean pair of gloves without</p>	F0880		

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F0880 SS = D	<p>Continued from page 83 performing hand hygiene and proceeded to pat the wound dry. Subsequently, LVN 11 changed to a second clean pair of gloves, again without performing hand hygiene, and applied the xeroform to the wound. LVN 11 then donned a third clean pair of gloves, still without performing hand hygiene, and applied the zinc ointment to the wound. Lastly, LVN 11 changed into a fourth pair of gloves, once more without performing hand hygiene, and applied the silicone dressing.</p> <p>On 7/18/25 at 0935 hours, an interview was conducted with LVN 11. LVN 11 was informed and verified of the above observation. LVN 11 stated she should have performed hand hygiene before donning each pair of clean gloves.</p> <p>On 7/22/25 at 1503 hours, the DON was informed and acknowledged the above findings.</p> <p>3. Review of the facility's P&P titled Infection Prevention and Control Program revised 12/19/22, showed in part, this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. Isolation signs are used to alert staff, family members, and visitors of transmission-based precautions.</p> <p>Medical record review for Resident 162 was initiated on 7/15/25. Resident 162 was admitted to the facility on 3/4/24, and readmitted on 3/19/25.</p> <p>Review of Resident 162's physician's orders showed the following orders:</p> <ul style="list-style-type: none"> - dated 6/26/25, for ID consult (Infectious Disease doctor) due to Multidrug Resistant Infection; and - dated 7/14/25, to administer Zyvox (antibiotic) 800 mg on tablet by mouth two times a day for UTI for seven days, and Bactrim DS (antibiotic) 800-160 mg one tablet by mouth two times a day for seven days for infection. 	F0880		

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F0880 SS = D	Continued from page 84 On 7/15/25 at 1515 hours, an observation, interview, and concurrent medical record review was conducted with LVN 9 for Resident 162. Resident 162's room door was closed. There was an EBP signage posted on the entrance door. Review of Resident 162's physician's order dated 7/11/25, showed an order for contact isolation: MDRO urine. LVN 9 verified the resident had an order for contact isolation and should have a contact isolation signage on the door instead of the EBP signage. LVN 9 was observed changing the door signage to a contact isolation and removed the EBP signage. On 7/15/25 at 1555 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.	F0880	F881 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 89 was affected by this deficient practice. On 7/18/2025, DON provided 1:1 education to IP nurses about facility P&P for antibiotic stewardship program, in particular following the McGeer's criteria and Loeb minimum criteria and notifying primary physician of resident's signs and symptoms for appropriate use of antibiotic medication.	8/23/2025
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview, facility document review, and facility P&P review, the facility failed to accurately monitor and address the use of the antibiotics when the resident's condition did not meet the McGeer's criteria (a set of criteria used in long term care facilities to identify if residents' symptoms meet the criteria of a true infection) or Loeb minimum criteria (a set of minimum clinical criteria used to guide the initiation of antibiotic therapy for suspected infections in residents of long term care facilities) for one of five final sampled residents (Resident 89) reviewed for antibiotic stewardship. This failure had the potential risk for continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics and the development of antibiotic	F0881	2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents were potentially affected by this deficient practice. on 8/4/2025, DON and IP nurse reviewed residents in the last 30 days who received antibiotic and making sure McGeer's and Loeb criteria was followed and verified with primary physician and no other issue was noted. On 8/5/2025-8/8/2025, DON in-serviced all Licensed Nurses about facility P&P for Antibiotic Stewardship program and identifying signs and symptoms in line with McGeer's Criteria and Loeb minimum criteria and verifying with primary physician for appropriate usage of antibiotic medication, especially if resident does not meet McGeer's or Loeb criteria. DON emphasize on documenting in resident's medical record if primary physician insisted on continuing the Antibiotic even if resident infection does not meet McGeer's or Loeb Criteria for unnecessary use of Antibiotic. Resident plan of care will also be updated.	

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F0881 SS = D	<p>Continued from page 85 resistant bacteria.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Antibiotic Stewardship Program revised 12/19/22, showed it is the policy of the facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The program included antibiotic use protocols as a system to monitor antibiotic use...the facility uses the (CDC's NHSN Surveillance Definition, updated McGeer's criteria, or other surveillance tool) to define infection. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics.</p> <p>Review of the facility's document titled Infection Surveillance Monthly Report for June 2025 showed Resident 89 was admitted to the facility on 3/19/25. Resident 89 had a productive cough with purulent sputum, and fever on 6/28/25. Resident 89 was prescribed Zithromax (antibiotic) 250 mg oral tablet.</p> <p>Further review of the Infection Surveillance Monthly Report did not show if the above symptoms met the McGeer's criteria for true infection or Loeb's minimum criteria to treat the infection with antibiotics.</p> <p>Medical record review for Resident 89 was initiated on 7/15/25. Resident 89 was readmitted to the facility on 3/19/25.</p> <p>Review of Resident 89's Infection Screening Evaluation dated 6/28/25, showed Resident 89 was afebrile (no fever), had unproductive new or increased cough, and had recent chest x-ray showing new infiltrates consistent with pneumonia. Further review of the Infection Screening Evaluation failed to show if the symptoms experienced by Resident 89 met the McGeer's criteria for true infection or Loeb's minimum criteria to treat the infection with antibiotics.</p> <p>However, review of Resident 89's Antibiotic Time Out dated 7/1/25, showed Zithromax oral tablet 250 mg two tablets via GT one time only for presenting clinical</p>	F0881	<p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>DON and IP nurse or designee will oversee this process. If a resident developed signs and symptoms of possible infection, RN supervisor or charge nurse will notify primary care physician (PCP) for the COC. If PCP ordered antibiotic, RN supervisor or charge nurse will initiate appropriate use of antibiotic and might suggest to PCP for additional testing, such as labs before initiating antibiotic use. If PCP insisted to start antibiotic, RN supervisor or charge nurse will document in resident medical records and initiate McGeer's criteria or loeb minimum criteria and reported to IP nurse. IP nurse will re-evaluate Antibiotic use and if McGeer's Criteria or Loeb criteria was not met, IP nurse would verify with primary physician for antibiotic use and suggest antibiotic timeout. IP nurse would update plan of care based on PCP order.</p> <p>IP Nurse will report antibiotic use monthly to infection control committee and any PCP not complaint with McGeer's and Loeb Criteria will be discuss with Medical Director.</p> <p>Medical record will audit all new antibiotic order for compliance to antibiotic stewardship program and report to DON x 3 months.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The DON will monitor the effectiveness of the process and report to the Administrator. Any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0881 SS = D	<p>Continued from page 86 symptoms of fever, and increased sputum. Under the section narrative notes, showed physician was notified Resident 89 was afebrile and had mild secretion, antibiotic time out was suggested, and Resident 89's infection met the McGeer's criteria.</p> <p>Further review of the Resident 89's medical record failed to show if Resident 89 had a fever or increased sputum or productive cough.</p> <p>On 7/18/25 at 1417 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked about the facility's antibiotic stewardship program. The IP stated the facility used the McGeer's criteria. The IP stated if a resident did not meet the criteria for a true infection using the McGeer's criteria, the physician would be notified. The IP verified the above findings and stated Resident 89 did not have a fever and purulent sputum. The IP verified the symptoms Resident 89 experienced on 6/28/25 did not meet the McGeer's criteria for true infection. The IP stated she should have accurately notified the physician regarding Resident 89's symptoms that did not meet the McGeer's Criteria for a true infection when the antibiotic was ordered.</p> <p>On 7/22/25 at 1503 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>	F0881		
F0908 SS = E	<p>Essential Equipment, Safe Operating Condition</p> <p>CFR(s): 483.90(d)(2)</p> <p>§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and manufacturer document review, the facility failed to maintain the essential equipment in the safe operating conditions when:</p> <p>* The facility failed to maintain three of three ice machines in sanitary working condition.</p> <p>* The facility failed to ensure the manufacture specifications were followed for one of three ice machines.</p>	F0908	<p>F0908</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>145 residents were affected by this deficient practice</p> <p>On 7/15/25, all three ice machines were immediately taken out of service by the maintenance director and designee; certified vendor inspected, served, and thoroughly sanitized the ice machines following the manufacturer's specific cleaning and scale removal instructions.</p> <p>On 7/16/25, Dietary Supervisor and designee contacted certified vendor to initiate replacement of identified non-compliant ice machines and vendor confirmed delivery and installation of new ice machines on 8/1/25.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 8/1/2025, Administrator and Maintenance Director checked all ice-handling processes and related equipment. All ice machine equipments were cleaned and sanitized. Ice machine inside the kitchen was replaced on 8/1/2025. No other noncompliance were found.</p>	8/1/2025

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F0908 SS = E	<p>Continued from page 87</p> <p>These failures had the potential to cause contamination of ice in a highly vulnerable population of 145 residents who received ice from the ice machines.</p> <p>Findings:</p> <p>Review of the Diet Count by Diet report completed by the facility on 7/15/25, showed 145 residents in the facility received an oral diet.</p> <p>Review of the USDA Food Code 2022, Section 4-501.11, Good Repair and Proper Adjustment showed equipment shall be maintained in a state of good repair and sanitary working condition.</p> <p>Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. A. Equipment, food contact surfaces and utensils shall be clean to sight and touch.</p> <p>1.a. On 7/15/25 at 1033 hours, an observation of Ice Machine 1 and concurrent interview was conducted with the Maintenance Director. Upon inspection of the internal components of the ice machine, a brown residue was found on the ice machine evaporator (the part of the ice machine where ice was made), a yellow residue was found on the water curtain (a panel that directs the ice from the evaporator to the ice storage bin), a gray residue was found in the ice chute, (the part of the ice machine that directs ice from the harvester to the ice storage bin), and a yellow residue was found on the ice storage bin deflector (a device that directs the ice into the bin). The Maintenance Director verified the findings.</p> <p>b. On 7/15/25 at 1033 hours, an observation of Ice Machine 2 and concurrent interview was conducted with the Maintenance Director. Observed were two metal screws located in the ice storage bin held the ice bin deflector in place. Red and brown stains were noted on the metal screws and the sides of the ice storage bin. The Maintenance Director verified the findings.</p> <p>c. On 7/15/25 at 1120 hours, an observation of Ice Machine 3 and concurrent interview was conducted with the Maintenance Director. Upon inspection of the internal ice machine components, brown and black</p>	F0908	<p>On 8/1/2025, Ice machine technician in-serviced maintenance department on how to clean and sanitized the ice machine, making sure deep cleaning was done including compartments not easily visible using approved chemical for cleaning ice machine.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>Administrator or designee will oversee this process. and compliance. Maintenance will do monthly deep cleaning and sanitation of ice machine. The dietary supervisor and designee would do daily ice machine cleaning and inspection will be recorded. Vendor will perform quarterly service and cleaning to ensure cleanliness and compliance with equipment and sanitation protocols.</p> <p>Administrator or designee will check ice machine weekly and randomly x 3 months to make sure cleaning and sanitation compliance is being followed.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>The Administrator or designee will be responsible for ensuring the monitoring process remains in place to confirm compliance. Any findings and noncompliance will be immediately corrected and presented to the monthly Safety Committee meetings and the Quality Assurance (QA&A) committee meetings. The Plan of Correction was presented at the QA&A meeting on 8/14/25. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings x 3 months</p> <p>5. Corrective action completion date: 8/1/2025</p>	8/1/2023

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F0908 SS = E	<p>Continued from page 88 residues were noted on the evaporator, and black and gray residues were noted on the water curtain of the evaporator. The Maintenance Director verified the findings.</p> <p>2. Review of the manufacturer guidelines found on the inside panel of Ice Machine 1 showed: Scale Removal and Sanitizing Instructions: 6. Pour eight ounces of Scotsman Clear 1 ice machine scale remover into the reservoir.</p> <p>On 7/16/25 at 0916 hours, an observation of Ice Machine 1 and concurrent interview was conducted with Vendor 1. Vendor 1 stated he used Nucalgon nickel safe ice machine cleaner to clean the internal components of the ice machines. Vendor 1 stated the Nucalgon nickel safe ice machine cleaner was equivalent to Scotsman Clear 1. Vendor 1 further stated the ice machine company raised the prices of the cleaners so the company he worked for used a generic cleaner. Vendor 1 stated he cleaned many different brands of ice machines and it was not possible to use the appropriate cleaner for each brand of ice machine.</p>	F0908	<p>F0909</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Residents 35, 36, 49, 51, 85, 122, 146, and 153 were affected by this deficient practice.</p> <p>On 7/23/2025, Maintenance Director re-assessed all resident 35, 36, 49, 52, 85, 122, 146, and 153 for entrapment to make sure measurement of zone 7 reflected on the form being use.</p> <p>On 7/23/2025, Administrator provided 1:1 in-serviced to Maintenance director for facility policy and procedure for measuring entrapment and using form that reflects zone 7 to show if it pass or fails.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p>	
F0909 SS = E	<p>Resident Bed</p> <p>CFR(s): 483.90(d)(3)</p> <p>§483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate, complete, and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of bed side rails for seven of 10 final sampled residents (Residents 35, 36, 49, 51, 85, 122, and 153) and one nonsampled resident (Resident 146) reviewed for siderails.</p> <p>* The facility failed to ensure the residents' entrapment assessments were accurately completed for</p>	F0909	<p>All residents were potentially affected by this deficient practice. On 7/23/2025, Maintenance director audited all residents bed for entrapment measurement of zone 7 and all 182 residents were found to have issue related to the form use not reflecting zone 7 if it fails or pass the entrapment measurement. Maintenance team immediately re-measured all zone 7 in resident beds and entrapment measurement form was revised to reflect zone 7 measurement of fail or pass. All zone 7 entrapment measurement passed.</p> <p>3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur:</p> <p>Administrator or designee will oversee this process and compliance. Maintenance will measure zone 7 for entrapment and make sure it reflect on the measurement for entrapment form. Any bed not in compliant with zone 7 entrapment will be removed. Administrator will review entrapment records randomly for compliance x 4 weeks and monthly thereafter.</p>	

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F0909 SS = E	<p>Continued from page 89 Residents 35, 36, 49, 51, 122, and 153.</p> <p>* The facility failed to ensure Residents 85 and 146 's bilateral grab bars bed entrapment assessment was accurate and completed.</p> <p>These failures had the potential to negatively impact the residents, resulting in possible entrapment, serious injury, and death.</p> <p>Findings:</p> <p>According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are:</p> <ul style="list-style-type: none"> - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. <p>Review of the facility's P&P titled Proper Use of Side Rails revised date 12/19/22, showed entrapment was an event in which a resident is caught, trapped, or entangles in the space in or about the bed rail. The resident assessment should assess the resident's risk</p>	F0909	<p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>Administrator will monitor the effectiveness of the process and report any findings will be presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 08/14/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/23/2025</p>	8/23/2025

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F0909 SS = E	<p>Continued from page 90 of entrapment between the mattress and bed rail or in bed rail itself. The Maintenance Director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. Further review of the P&P showed as part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs:</p> <ul style="list-style-type: none"> a. Medical diagnosis, conditions, symptoms, and/ or behavioral symptoms b. Size and weight c. Sleep habits d. Medications e. Acute medical or surgical interventions f. Underlying medical conditions g. Existence of delirium h. Ability to toilet self safely i. Cognition j. Communication k. Mobility (in and out of bed) l. Risk of falling <p>1. On 7/15/25 at 1035 hours, during the initial tour of the facility, Resident 36 was observed asleep in the bed with the bilateral grab bars elevated at the head of the bed.</p> <p>Medical record review for Resident 36 was initiated on 7/15/25. Resident 36 was admitted to the facility on 4/27/19, and readmitted on 5/3/19.</p> <p>Review of Resident 36's H&P examination dated 9/3/24, showed Resident 36 had no capacity to understand and make decisions.</p> <p>Review of Resident 36's Order Summary Report for July 2025 showed a physician's order dated 3/17/25, for</p>	F0909		

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F0909 SS = E	<p>Continued from page 91 bilateral grab bar every shift for bed mobility and turning.</p> <p>Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 36 dated 3/18/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed.</p> <p>2. On 7/22/25 at 1021 hours, during an observation with the Maintenance Director, Resident 49's bed was observed with the bilateral grab bars elevated at the head of the bed.</p> <p>Medical record review for Resident 49 was initiated on 7/21/25. Resident 49 was admitted to the facility on 11/1/22, and readmitted on 8/23/24.</p> <p>Review of Resident 49's H&P examination dated 8/24/24, showed Resident 49 had the capacity to understand and make decisions.</p> <p>Review of Resident 49's Order Summary Report for July 2025 showed a physician's order dated 6/6/25, for bilateral grab bar every shift for enabler for bed mobility and transfers.</p> <p>Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 49 dated 1/7/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed.</p> <p>3. On 7/15/25 at 1106 hours, during the initial tour of the facility, Resident 51 was observed in bed with the bilateral grab bars elevated at the head of the bed.</p> <p>Medical record review for Resident 51 was initiated on 7/16/25. Resident 51 was admitted to the facility on 1/25/24, and readmitted on 5/27/25.</p> <p>Review of Resident 51's H&P examination dated 5/29/25, showed Resident 51 had the capacity to understand and make decisions.</p>	F0909		

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F0909 SS = E	<p>Continued from page 92</p> <p>Review of Resident 51's Admission MDS assessment dated 6/2/25, showed Resident 51 had a BIMS score of 14, indicating intact cognition.</p> <p>Review of Resident 51's Order Summary Report for July 2025 showed a physician's order dated 5/30/25, for bilateral grab bar every shift for bed mobility and transfers.</p> <p>Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 51 dated 6/12/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed.</p> <p>4. On 7/15/25 at 1513 hours, during the initial tour of the facility, Resident 122 was observed in bed with the bilateral grabs bar elevated at the head of the bed.</p> <p>Medical record review for Resident 122 was initiated on 7/16/25. Resident 122 was admitted to the facility on 4/30/25.</p> <p>Review of Resident 122's H&P examination dated 5/2/25, showed Resident 122 had the capacity to understand and make decisions.</p> <p>Review of Resident 122's Admission MDS assessment dated 5/6/25, showed Resident 122 had a BIMS score of 14, indicating intact cognition.</p> <p>Review of Resident 122's Order Summary Report for July 2025 showed a physician's order dated 5/1/25, for bilateral grab bar every shift for bed mobility and transfers.</p> <p>Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 122 dated 5/30/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show Zone 7 was measured and if it passed or failed.</p> <p>5. On 7/17/25 at 0857 hours, an observation and concurrent interview was conducted with Resident 153.</p>	F0909		

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F0909 SS = E	<p>Continued from page 93</p> <p>Resident 153 was observed sitting up in a wheelchair and the resident's bed was observed with the bilateral grab bars elevated at the head of the bed.</p> <p>Medical record review for Resident 153 was initiated on 7/16/25. Resident 153 was admitted to the facility on 2/13/23, and readmitted on 7/14/24.</p> <p>Review of Resident 153's H&P examination dated 9/8/24, showed Resident 153 had the capacity to understand and make decisions.</p> <p>Review of Resident 153's Quarterly MDS assessment dated 6/27/25, showed Resident 153 had a BIMS score of 12, indicating moderately impaired cognition.</p> <p>Review of Resident 153's Order Summary Report for July 2025 showed a physician's order dated 3/18/25, for bilateral grab bar every shift for bed mobility and transfers.</p> <p>Review of the facility's Bed System Measurement Device Test Results Worksheet for Resident 153 dated 1/7/25, showed Zones 1, 3, and 6 were measured and passed; however, the form failed to show if Zone 7 was measured and if it passed or failed.</p> <p>On 7/22/25 at 1006 hours, an observation, interview, and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated the measurements of the bed, spaces in between the mattress, grab bars, and headboards were taken using a tape measure. The Maintenance Director verified there were discrepancies between the assessments of the Zones and Zone 7, which was not reflected in the Bed System Measurement Device Test Results Worksheets. In addition, the Maintenance Director stated the measurements were done to prevent entrapment and Zone 7 should have been reflected and added on the form.</p> <p>On 7/22/25 at 1548 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings.</p> <p>6. On 7/15/25 at 1035 and 1625 hours, and on 7/16/25 at 1101 hours, Resident 35 was observed lying on his bed</p>	F0909		

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F0909 SS = E	<p>Continued from page 94 with the 1/2 (half) siderail elevated on the right side of the bed and the 3/4 siderail elevated on the left side of the bed.</p> <p>Medical record review for Resident 35 was initiated on 7/15/25. Resident 35 was admitted to the facility on 9/30/03, and readmitted on 4/24/25.</p> <p>Review of Resident 35's Bed System Measurement Device Test Results Worksheet dated 4/29/25, did not show if Zone 7 was measured and if Resident 35's side rail had passed the Zone 7 entrapment assessment for the use of the siderails.</p> <p>Review of the Resident 35's Order Summary Report showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 7/16/25, for the 1/2 right bed rail when in bed for positioning and ease of mobility, secondary to generalized weakness. - dated 4/24/25, for the 3/4 left bed rail while in bed to self-assist with turning and repositioning due to left upper extremity paraparesis (partially unable to move) related to spinal cord injury and to promote sense of security. <p>Review of Resident 35's plan of care showed a care plan revised on 7/16/25, addressing the siderail management for the risk of entrapment and impairment in skin discoloration. The goal showed Resident 35 would be provided with the safe use of the side rails. The interventions included to check the siderails regularly to ensure they were securely attached and in good working condition. Further review of the P&P showed to visually check bed the mattress and rail for appropriateness of the resident's dimensions.</p> <p>On 7/22/25 at 1006 hours, an observation, interview, and concurrent medical record review for Resident 35 was conducted with the Maintenance Director. Resident 35 was observed lying on his bed with the 1/2 siderail elevated on the right side of the bed and the 3/4 siderail elevated on the left side of the bed. The Maintenance Director verified the above observation and stated Resident 35 had the 1/2 siderail on the right side of the bed and the 3/4 siderail on the left side of the bed. The Maintenance Director reviewed the Bed System Measurement Device Test Results Worksheet dated</p>	F0909		

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F0909 SS = E	<p>Continued from page 95 4/29/25, and verified the document did not show if Zone 7 was measured, and if Resident 35 passed the Zone 7 measurement for the use of the sideralls.</p> <p>On 7/22/25 at 1503 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p> <p>7. On 7/15/25 at 1057 hours, an observation was conducted for Resident 85's bed. Resident 85 was observed lying on the bed and watching TV with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 85 was initiated on 7/15/25. Resident 85 was admitted to the facility on 5/7/25.</p> <p>Review of Resident 85's Order Summary Report showed a physician's order dated 5/14/25, for the bilateral grab bars for turning and repositioning.</p> <p>On 7/22/25 at 1043 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director was asked to show the documentation for Resident 85's bilateral grab bars bed entrapment assessment. The Maintenance Director showed the facility's document titled Bed System Measurement Device Test Results Worksheet dated 5/25/25, for Resident 35. The worksheet showed the following zones were assessed and measured:</p> <p>for Zone 1, passed, four inches</p> <p>for Zone 2, passed, two inches.</p> <p>for Zone 3, passed one and one eighth.</p> <p>for Zone 4, passed two inches.</p> <p>for Headboard Zone 6, passed, half.</p> <p>However, there was no documentation to show the assessment, measurement, and result (passed or failed) for Zone 7. In addition, there was no specified unit of measurement used for Zones 3 and 6.</p>	F0909		

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F0909 SS = E	<p>Continued from page 96</p> <p>8. On 7/15/25 at 1113 hours, during the initial tour of the facility, an observation was conducted for Resident 146's bed. Resident 146 was not observed his room. However, Resident 146's bed was observed with the bilateral grab bars elevated.</p> <p>Medical record review for Resident 146 was initiated on 7/15/25. Resident 146 was admitted to the facility on 4/3/24, and readmitted on 4/16/25.</p> <p>Review of Resident 146's Order Summary Report showed a physician's order dated 6/12/25, for the bilateral grab bars for bed mobility and repositioning.</p> <p>On 7/22/25 at 1041 hours, an interview and concurrent medical record review was conducted with the Maintenance Director. The Maintenance Director was asked to show the documentation for Resident 146's bilateral grab bars bed entrapment assessment. The Maintenance Director showed the facility's document titled Bed System Measurement Device Test Results Worksheet dated 3/18/25, for Resident 146. The worksheet showed the following zones were assessed and measured:</p> <p>for Zone 1, passed, four inches.</p> <p>for Zone 2, passed, one and 1/8.</p> <p>for Zone 3, passed, one and 1/8.</p> <p>for Zone 4, passed, one inch.</p> <p>for Headboard Zone 6, passed and 1/2.</p> <p>However, there was no documentation to show the assessment, measurement and result for Zone 7. In addition, there was no specified unit of measurement used for Zones 2, 3, 4, and 6. The Maintenance Director verified there was inaccuracy in completion of the entrapment assessments for Residents 85 and 146.</p>	F0909		