

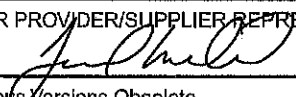
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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 08/14/2025	
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
F0000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Number: 2589185.</p> <p>The survey team entered the facility on 8/14/25 at 0835 hours.</p> <p>The facility identified the census as 183.</p> <p>The survey sample size was 3.</p> <p>Inspection was limited to the complaint investigated and did not represent the findings of a full inspection of the facility.</p> <p>* FOR COMPLAINT NUMBER: 2589185, DEFICIENCIES WERE IDENTIFIED AND CITED AT F628.</p> <p>GLOSSARY AND DEFINITIONS:</p> <p>AMA - Against Medical Advice (when a resident chooses to leave the facility before the physician recommends discharge)</p> <p>H&P - History and Physical</p> <p>P&P - Policy and Procedure</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> <p>F628</p> <p>1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice:</p> <p>Resident 1 was affected by this deficient practice. Resident 1 is still residing in the facility. On 8/25/2025, IDT team notify primary care physician about discharge planning for resident 1.</p> <p>On 8/25/2025, Administrator in-serviced IDT team about facility policy and procedure for discharge planning and process. Administrator emphasize the need to involve primary care physician during discharge process to make sure PCP can assess and document resident's care needs and if safe for discharge.</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 discharged residents were potentially affected by this deficient practice. On 8/25/2025, Medical records audited all residents discharged in the last 30 days for physician documentation and found no other issue.</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>		08/30/2025
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 must ensure that the transfer or discharge is</p>			F0628	<p>Administrator or designee will oversee the discharge planning and process. IDT team will initiate discharge planning during initial care plan meeting and notify PCP of the initial plan. Any resident found by IDT that indicated their health significantly improved, PCP will be notified and assess if resident is safe for discharge and document in their progress notes and order for discharge. If PCP agreed and documented that resident is safe for discharge, IDT team will start discharge process and notify the resident or responsible party. Medical record will</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 08/29/2025
--	-------------------------------	--------------------------------

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 08/14/2025	
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
F0628 SS = D	<p>Continued from page 1 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 transferred or discharged.</p>			F0628	<p>audit all discharge residents medical record to make sure compliance x 3 months. Any non-compliance will be reported to the Administrator.</p> <p>4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process:</p> <p>Administrator will report any findings and presented to the Monthly QA&A meeting. The Plan of Correction was presented at the Quality Assurance (QA&A) committee meeting on 09/11/2025. Ongoing findings from audits will be reported to the QAPI/QAA monthly meetings for at least three months</p> <p>Corrective action completion date: 8/30/2025</p>		08/30/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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 08/14/2025	
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		
F0628 SS = D	<p>Continued from page 2</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 Disabilities Assistance and Bill of Rights Act of 2000</p>	F0628					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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 08/14/2025	
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
F0628 SS = D	<p>Continued from page 3 (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(l).</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> <p>(iv) The information specified in paragraph (e)(1) of</p>			F0628			

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 08/14/2025	
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
F0628 SS = D	<p>Continued from page 4 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, and facility P&P review, the facility failed to ensure the discharge process was properly followed for one of three sampled residents (Resident 1).</p> <p>* The failed to ensure Resident 1's medical record showed the physician's documentation indicating the resident's health improved sufficiently and ready to be discharged from the facility. This failure had the potential for Resident 1 to unsafely discharge from the facility.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Transfer or Discharge (including AMA) revised 12/19/22, showed the physician shall document medical reasons for the transfer or discharge in the medical record, when the</p>			F0628			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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 08/14/2025	
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
F0628 SS = D	<p>Continued from page 5</p> <p>reason for transfer or discharge is for any reason other than nonpayment of the stay or the facility ceasing to operate. A copy of the physician's order for discharge should be attached to the discharge notice.</p> <p>Medical record review for Resident 1 was initiated on 8/14/25. Resident 1 was admitted to the facility on 11/01/22.</p> <p>Review of Resident 1's H&P examination dated 8/24/24, showed Resident 1 had the capacity to understand and make decisions.</p> <p>Review of Resident 1's physician's order dated 6/18/25, showed for Resident 1 to possibly discharge on 6/23/25, to Program A with home health for safety evaluation.</p> <p>Further review of Resident 1's medical record failed to show Resident 1's physician documented the resident's health had improved sufficiently and no longer needed the facility's services prior to 6/23/25. There was no documented evidence Resident 1 was assessed for a safe discharge by the physician for the planned possible discharge.</p> <p>On 8/15/25 at 1400 hours, a telephone interview was conducted with the Administrator. The Administrator was informed and verified the above findings for Resident 1.</p>			F0628			