STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent further falls and/or injuries for two of four sampled residents (Residents 3 and 7). * The facility failed to ensure Resident 3's post fall neurological assessment and monitoring were completed. Additionally, Resident 3's attending physician and responsible party were not notified after the resident had sustained a fall on 4/15/25. * Thefacility failed to provide the necessary care and services Resident 7 post fall sustaining injury and documented abnormal findings from neurological assessment. In addition, Resident 7's post fall assessment was not completed accurately. These failures posed the risk of the residents to not receive timely interventions to address their post fall status. Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised 4/1/2015 showed the following: - The facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition. - It is the responsibility of the person who observes the change to report the change to the Licensed Nurse. - The Licensed Nurse will assess the COC and determine what nursing interventions are appropriate before notifying the Attending Physician. - The Licensed Nurse must observe and assess the overall condition utilizing a physical assessment and chart review. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Fall Management Program revised on 3/13/21, showed the following: - Following every resident fall, the licensed nurse will perform a post-fall evaluation and update, initiate or revise the Resident's care plan as necessary. - For an unwitnessed fall or a witnessed fall with suspected or known head injury, the licensed nurse will complete neurological checks for 72 hours following the fall incident: i. Perform neurological checks at the ordered frequency or as the listed below equaling 72 hours; and - The attending physician will be informed if there is a deviation from the Resident's baseline status for further instructions. - The licensed nurse will notify the DON and /or the Administrator regarding the fall incident as soon as possible. - The licensed nurse will notify the Resident's attending physician and Resident's responsible party of the fall incident. 1. Medical record review for Resident 3 was initiated on 4/21/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3's BIMS score was 5, indicating severe cognitive impairment. Review of Resident 3's Discharge Summary Progress Note on 4/15/25 at 1037 hours, showed Resident 3 was transferred to the acute care hospital at 0930 hours. Review of Resident 3's Admission Progress Note dated 4/19/25 at 1828 hours, showed the resident was readmitted back to the facility with an admitting diagnosis of traumatic injury. Resident 2 was admitted with an acute fracture of the tip of the odontoid (bony element of the neck, allowing for side-to-side movement). Review of Resident 3's care plan initiated 4/24/25, showed Resident 3 rolled out of bed on 4/15/25, with a scrape on right eyebrow/tiny drop of blood prior to being transferred to the acute care hospital. The interventions included 1:1 (one staff to one resident) supervision in place, reporting to CDPH L&C Program, and reeducating regarding documentation including notifying the physician, responsible party, and the DON for an event of a fall. On 4/23/25 at 0855 hours, a concurrent interview and medical record review was conducted with CNA 6. CNA 6 stated Resident 3 rolled out of bed with both knees landingon the floor. The resident's head was up and not touching the floor. CNA 6 stated henoticed minimal bleeding to the right eyebrow. CNA 6 stated CNA 10 notified LVN 9 and RN 2 right after the fall incident and LVN 9 assessed Resident 3. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 0942 hours, a telephone interview was conducted with CNA 10. CNA 10 stated he was assigned as the 1:1 sitter for Resident 3's roommate. CNA 10 stated at approximately 0300 hours, he witnessed Resident 3 wake up and quickly rollout of bed. The resident's knees wereon the floor and there was slight bleeding on his right eyebrow. CNA 10 stated LVN 9 and RN 2 were notified immediately regarding Resident 3's fall incident. Review of Resident 3 medical record failed to show documentation of the post fall monitoring and COC assessment after Resident 3's roll out of bed with minor injury. On 4/23/25 at 1345 hours, a telephone interview was conducted with LVN 9. LVN 9 was asked regarding the facility's fall policy. LVN 9 stated when resident has a fall either witnessed or unwitnessed, a COC assessment which includes post fall assessments, neurological assessments for 72 hours and risk management assessments must be completed. Furthermore, LVN 9 stated the licensed nurse will notify the resident'sattending physician and resident's responsible party of the fall incident. LVN 9 was asked regarding Resident 3's fall incident on 4/15/25. LVN 9 stated she was not informed by CNAs 6or 10. LVN 9 stated it was the responsibility of the staff who observed the fall incident to report the fall incident to the Licensed Nurse. LVN 9 stated the post fall monitoring and documentation from the licensed nurses must be documented on the resident's progress notes every shift for 72 hours. LVN 9 verified a COC assessment/documentation, post fall monitoring,and notification to the MD/resident's responsible party was not done for Resident 3 for the fall on 4/15/25. On 4/23 at 1310 hours, a telephone interview was conducted with RN 2. RN 2 verified the above findings. RN 2 stated the post fall monitoring must be documented to monitor the resident's condition and status. Furthermore, RN 2 stated the monitoring for the COC which includedpost fall, must be documented in the resident 's medical record every shift for 72 hours and the Neurological Assessment must be completed to monitor the resident's neurological status. RN 2 was asked regarding Resident 3's fall incident on 4/15/25. RN 2 stated she was not informed regarding Resident 3's fall incident by any of the 1:1 CNA sitters. On 4/23/25 at 1530 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the Neurological Assessments must be completed by the licensed nurses to assess Resident's 3 neurological status post fall. Furthermore, the DON stated the post fall monitoring and documentation must be completed every shift for 72 hours. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 7 was initiated on 4/22/25. Resident 7 was readmitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 4/9/25, showed Resident 7 had the capacity to understand and make decisions. In addition, it showed Resident 7 was a full code. Review of Resident 7's MDS assessment dated [DATE], showed Resident 7's BIMS score was 14, indicating cognitively intact. Review of Resident 7's MDS Section B for Speech clarity coded 0, indicating clear speech with distinct intelligible words. Review of Resident 7's Social Service assessment dated [DATE],showed Resident 7 was a full code, however declined to formulate an Advance Directives. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 0905 hours, Resident 7 was observed sitting in her bed. Resident 7 was awake, alert and verbally responsive. Resident 7's bed was in low position and surrounding areas was clutter free. Resident 7 was observed to be on 1:1 supervision with the facility sitter. Resident 7 refused to be interviewed. Review of Resident 7's COC/SBAR dated 3/29/25 at 0914 hours, showed Resident 7 had a witnessed fall incident when Resident 7 lost her balance and hit the overbed table on the way down. Review of Resident 7's Neurological Check List dated 3/29/25 showed the following: - Pupils equal, marked ' No'. - Left Pupil reactive to light, marked ' No'. - Right Pupil reactive to light, marked ' No'. - Responds to simple commands, marked ' No'; and - Verbalizes appropriately, marked ' No.' Review of Resident 7's Neurological Flow Sheet dated 3/29/25,showed the key for Speech were 1 for Clear, 2 for Slurred, 3 for Rambling, and 4 for Aphasic. The following were the assessment results for Resident 7's speech post fall: - at 0915, 0930, and 0945 hours, Speech was marked 2, indicating slurred. Review of Resident 7's Post Fall Evaluation dated 3/29/25,failed to show the sections for Contributing factors, Medication changes, and Clinical Suggestions were completed accurately. Review of Resident 7's Physician's Order dated 3/29/25 at 1146 hours, showed may transfer to the acute care hospital for further evaluation status postfall. Review of Resident 7's Progress Note dated 3/29/25 at 1311 hours, showed Resident 7 left the facility via gurney assisted by three EMTs in stable condition and still noted with discoloration on her right face with complain of pain/discomfort. On 4/22/25 at 1056 hours, an interview was conducted with RN 3. RN 3 was asked regarding the facility's fall policy and process post fall. RN 3 stated when resident had a fall either witnessed or unwitnessed, assessments included post fall, neurological checks for 72 hours, risk management, inform the physician, and responsible party. Furthermore, RN 3 stated if the neurological assessments had an abnormal finding, the facility must transfer the resident via paramedics immediately. On 4/22/25 at 1320 hours, a telephone interview was conducted with LVN 2. LVN 2 stated he witnessed the fall during the medication administration. Resident 7 tried to get up from the bed, lost her balance, and hit her right side of the face against the bedside table. LVN 2 stated he completed the post fall assessments and documentation with RN 2's assistance. Furthermore, LVN 2 stated Resident 7 was transferred via non-urgent transport to the acute care hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 1500 hours, a concurrent interview and medical record review was conducted with the DON. The DON was asked of the facility's process for witnessed or unwitnessed falls. The DON stated for all the witnessed or unwitnessed fall incidents, the charge nurse and RN must complete the post fall assessment, document SBAR/COC, inform the physician, update care plan, neurological assessment in medical recordsand flowsheet. The DON stated if an abnormal finding from the Neurological assessments was noted, the resident must be transferred via paramedics immediately then inform the physician. The DON stated the Medical Records Director and DON checked for completion of assessments and documentations post fall, however, the DON was responsible in checking for the accuracy. Medical record review of Resident 7's Neurological Check List and Flow Sheet dated 3/29/25,showed an abnormal finding and the Post fall assessment was incomplete. The DON verified Resident 7's Neurological Check List and Flow Sheet dated 3/29/25,showed for an abnormal finding and the Post fall assessment was incomplete. The DON stated Resident 7 should been transferred via paramedics immediately due to abnormal findings of Neurological assessment post fall. Furthermore, the DON stated Resident 7's post fall assessment must be completed to formulate the plan of care. On 4/23/25 at 1259 hours, a telephone interview was conducted with RN 2. RN 2 was asked of Resident 7's baseline prior to the witnessed fall on 3/29/25. RN 2 stated Resident 7's baseline was alert, oriented to name, place, time and situation. RN 2 added Resident 7's base line for speech was clear. RN 2 was asked regarding the facility's process and policy when a resident was observed to have an abnormal finding in the neurological assessment. Furthermore, RN 2 stated if a resident had an abnormal finding in the neurological assessment, the facility must transfer the resident via paramedics immediately especially post fall or any sustained head injury. On 4/23/25 at 1504 hours, an interview was conducted with the DON and Administrator. The DON and Administrator was informed and acknowledged the above findings.