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	06/16/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse by a resident for one of four final sampled residents (Resident 117) investigated for abuse. * Resident 117 was hit on the right eyebrow by another resident (Resident 113), resulting in a superficial skin tear. In addition, the facility failed to monitor Resident 113 as per facility's abuse protocol after a resident to resident physical altercation. These failures had the potential for not protecting the resident and negatively impact the resident's well-being. Findings: Review of the facility's P&P titled P-AN01 Abuse Prevention and Management revised 5/30/24, showed the facility does not condone any form of resident abuse, neglect, misappropriation of resident property, exploitation, and/or mistreatment. Abuse is defined as the willful, deliberate infliction of injury, unreasonable confinement, involuntary seclusion, and physical or chemical restraint not required to treat symptoms, and/or imposed for the purposes of discipline or convenience, intimidation, exploitation, misappropriation of resident's property, mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. Physical abuse is defined as, but not limited to, hitting, slapping, punching, and/or kicking. It also includes corporal punishment, which is physical punishment used to correct and/or control behavior. Review of the facility's P&P titled NP23 Change of Condition Notification dated 8/25/22, under the Documentation section showed the licensed nurse will communicate any changes in required interventions to the care team members involved in the resident's care. The licensed nurse will document each shift for at least 72 hours when there is a change in the resident's condition. 1. Review of the facility's SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 6/2/25, showed a resident to resident altercation between Residents 113 and 117 reported by RN 1. Resident 117 was reported using foul racial slurs and screaming loudly at Resident 113 when both residents were at the supervised smoke break. The activities personnel who was in the supervised smoking area was unable to intervene on time. Resident 113 struck Resident 117 one time above the right eyebrow which resulted in a superficial skin tear with minimal bleeding. The activities personnel and other staff immediately responded and separated Residents 113 and 117. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Investigative Summary report dated 6/6/25, showed the facility had substantiated the allegation of abuse for Residents 113 and 117, however, the incident was unavoidable. a. Medical record review for Resident 117 was initiated on 6/10/25. Resident 117 was admitted to the facility on [DATE]. Review of Resident 117's H&P examination dated 4/26/25, showed Resident 117 had fluctuating capacity to understand and make decisions, and had a significant diagnosis of schizoaffective-bipolar type disease. Review of Resident 117's MDS assessment dated [DATE], showed Resident 117 was cognitively intact. Further review of the MDS assessment showed Resident 117 had no behavioral symptoms exhibited such as physical behavioral symptoms directed toward others (for example-hitting, kicking, pushing, scratching, grabbing, or abusing others sexually) and verbal behavioral symptoms directed toward others (for example-threatening others, screaming at others, or cursing at others). Review of the facility's Interview Record regarding the resident to resident altercation dated 6/2/25 at 1226 hours, showed Resident 117 stated he was talking to another resident during the smoke break and Resident 113 jumped up, came over him, and hit him one time on the right side of his face. Resident 117 stated he did not say anything to Resident 113 until after Resident 113 hit him. Resident 117 stated right after Resident 113 hit him, the staff rushed in between them and removed Resident 113 from the smoke break patio. Review of Resident 117's Nursing Note dated 6/2/25, showed at 1130 hours, Resident 117 was observed to be verbally aggressive towards all individuals in the smoking patio including other residents and facility staff during the monitored smoke break. Resident 117 was loud, directing verbal racial slander continuously which prompted Resident 113 to approach Resident 117 and inadvertently struck Resident 117 above the right eyebrow which resulted in a superficial skin tear before the interaction could be prevented by the activity and nursing staff. The two residents were separated immediately and both were assessed. Resident 117's verbal racial slander and foul loud abusive language did not stop towards all the residents and staff. The physician was notified of Resident 117's verbally abusive behavior with a new order for 1:1 supervision (one staff to supervise one resident) for behavior monitoring and to send Resident 117 to an acute care hospital for the abusive verbal behavior when the bed was available. Resident 117 was being monitored for emotional distress due to a resident to resident altercation. Further review of Resident's 117's Nursing Note showed Resident 117 continued to exhibit the verbal aggression behavior toward the facility staff and being followed up by the psychiatric nurse practitioner. Resident 117 was transferred to an acute care hospital in a behavioral or psychiatric department on 6/6/25. b. Medical record review for Resident 113 was initiated on 6/10/25. Resident 113 was readmitted to the facility on [DATE]. Review of Resident 113's H&P examination dated 5/15/25, showed Resident 113 could make needs known, however, could not make medical decisions due to schizophrenia. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 113's MDS assessment dated [DATE], showed Resident 113 had moderate impaired cognition. Further review of the MDS assessment showed Resident 113 had exhibited delusional behavior and verbal behavioral symptoms directed toward others occurred one to three days. Review of the facility's Interview Record regarding the resident to resident altercation dated 6/2/25 at 1249 hours, showed Resident 113 verbalized he got upset and slapped someone. Resident 113 stated he was smoking and Resident 117 started calling the staff in foul language. Resident 113 stated he told Resident 117 to shut up and Resident 117 started calling him in foul language. Resident 113 stated he slapped Resident 117 in the face and the staff came right away, stopped him and took him out of the patio. Review of Resident 113's eInteract Change in Condition Evaluation dated 6/2/25, showed at 1130 hours, Resident 113 was in the supervised smoking patio and Resident 117 was also in the smoking patio. Resident 117 was witnessed using racial slurs and screaming to Resident 113. Resident 113 struck at Resident 117 as the activity personnel who was in the smoking patio was about to intervene. The activities personnel and other facility staff responded and immediately separated both residents. Resident 113 was being monitored for emotional distress due to a resident-to-resident altercation. Review of Resident 113's plan of care revised on 10/23/23, showed a care plan problem addressing Resident 113's risk for harm, self-directed or other-directed related impaired thought processes, bipolar disorder and depression. The interventions included to monitor Resident 113 for signs and symptoms of aggression, provide verbal feedback to Resident 113 regarding the behavior, and if Resident 113 poses a potential threat to injure self or others to notify the provider. On 6/11/25 at 1000 hours, an interview was conducted with Resident 113. Resident 113 was asked to describe the physical altercation between himself and Resident 117 which happened on 6/2/25. Resident 113 stated he remembered the black resident yelling foul language to the facility's staff and the residents in the smoking patio. Resident 113 stated this happened just this month of June but could not recall exactly which day. Resident 113 stated he got upset and did not want Resident 117 to hurt the people in the smoking patio, so he told Resident 117 to shut up. Resident 113 stated Resident 117 continued to yell foul words so he hit Resident 117 in the face. Resident 113 stated the facility staff stopped him immediately and he was brought out of the smoking patio. Resident 113 further stated he was so angry during the incident because of the behavior of Resident 117 toward the staff and all of them in the smoking patio. Resident 113 stated he did not see Resident 117 smoking anymore in the patio. On 6/11/25 at 1045 hours, an interview was conducted with CNA 12. CNA 12 stated he was familiar with both Residents 113 and 117. CNA 12 stated Resident 113 would have episodes of yelling at other residents; however, he never witnessed Resident 113 being physically aggressive to the staff or other residents. CNA 12 stated he heard report Resident 117 would initiate fight with other residents, but he had never witnessed the behavior. CNA 12 further stated, however, Resident 117 could be verbally aggressive to the staff and other residents like yelling at them using foul language. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 1205 hours, an interview was conducted with RN 1. RN 1 stated the resident to resident altercation between Residents 113 and 117 happened on 6/2/25 at around 1130 hours, in the supervised smoking patio during the residents' smoke break. RN 1 stated Resident 117 was using foul racial slander and screaming loudly at Resident 113. Activities personnel who was in the supervised smoking area was unable to intervene on time. Resident 113 struck Resident 117 one time above the right eyebrow which resulted in a superficial skin tear with minimal bleeding. Activity personnel and other staff immediately responded and separated Residents 113 and 117. RN 1 stated both Residents 113 and 117 were assessed. Resident 117's skin tear was treated by the treatment nurse. RN 1 stated she followed the proper protocol of reporting to the CDPH, Ombudsman, and called the police department. RN 1 stated with the kind of residents they had in the facility who the majority were with psychiatric illness, it was hard to prevent resident to resident altercation which was why they used 1:1 supervision as needed and ordered, continuing to monitor the residents who had history of abusive behavior by both nursing and social services staff, make sure the plan of care was implemented, and monitoring the effects of the medications as well as using the non-pharmacological interventions to lessen the behavior. 2. Review of the facility's Daily Charting showed for the new behavioral problem to chart a minimum of 72 hours. The facility document showed for Resident 113 the charting reason was for emotional distress with the start date of 6/2/25, and stop date of 6/5/25. Review of the Order Summary Report showed a physician's order dated 6/2/25, to monitor Resident 113 for signs and symptoms of emotional distress such sadness, crying, poor meal intake, self-isolation, poor motivation, decreased participation in ADLs care, inability to sleep, etc. every day shift for 14 days. Report promptly to the physician. Further medical record review for Resident 113 failed to show documented evidence of continued monitoring/assessment for Resident 113 by the licensed nurses post resident to resident altercation incident. On 6/11/25 at 1130 hours, an interview and concurrent facility document review was conducted with LVN 5. LVN 5 stated any new behavioral problem exhibited the resident was considered change in condition. LVN 5 stated both residents involved in the resident to resident altercation would be monitored every shift for 72 hours. LVN 5 stated whenever there was a change of condition for the resident, the nurses would document it in the Daily Charting green book to remind the nurses of the assessment to be done. LVN 5 stated the monitoring assessment was documented in the nursing progress notes such as if the resident had changes in vital signs, feeling of sadness, poor meal intake, any changes in the skin, or changes in sleeping pattern. On 6/11/25 at 1205 hours, an interview and concurrent medical record review for Resident 113 was conducted with RN 1. RN 1 stated any type of abuse incident was considered a change in condition for both residents involved. RN 1 stated both residents would be monitored by the licensed nurses for any emotional distress such as changes in moods, angry outburst, changes in vital signs, poor meal intake, inability to sleep, not participating in ADLs care, or significant skin changes if the resident was hit, every shift for 72 hours and it would be continued as needed or as ordered by the physician. RN 1 stated the social services staff would do their separate assessment and follow up with the residents involved in the altercation. RN 1 verified the continued monitoring for Resident 113 by the licensed nurses was not completed post resident to resident altercation incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/22 at 1622 hours, an interview and concurrent medical record review and facility record review was conducted with the DON. The DON stated the facility substantiated the resident to resident altercation between Residents 113 and 117. Resident 117 was verbally abusive to the staff and the residents on 6/2/25, during the supervised smoke break in the smoking patio. The DON stated Resident 113 struck Resident 117 even before the facility staff was able to intervene. The DON stated after the incident, the staff were in-serviced to be more vigilant and aware of behavior symptom changes of the residents. The DON stated both Residents 113 and 117 were monitored for any signs and symptoms of emotional distress. The DON acknowledged there was an order for Resident 113 to be monitored for emotional distress every day shift, however, the facility's protocol and policy was to monitor the resident for any change in condition every shift for 72 hours. The DON stated the order was incorrectly entered. The DON verified the continued monitoring for Resident 113 by licensed nurses was not completed post resident to resident altercation incident. The DON stated it was very important to monitor the resident to identify if the change in condition had been escalated, to provide the necessary care to the resident as needed, and to report to the physician any changes in the resident's condition promptly and as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to follow their protocol for written notification of transfer or discharge for four of four final sampled residents reviewed for hospitalization (Residents 10, 15, 86, and 122), one of three residents (Resident 117) reviewed for closed records, and one of three residents (final sampled resident, Resident 122) reviewed for hospice and end of life. * Resident 137's medical record did not show the resident received a discharge summary and a recapitulation of their stay when they discharged to the community. * Resident 10's Notice of Proposed Transfer and Discharge form was not completed for three acute care transfers, and the resident's record failed to show the Ombudsman was notified of the resident's acute care transfer for one of two completed Notice of Proposed Transfer and Discharge forms. * Resident 117's Notice of Proposed Transfer and Discharge form failed to show who was notified of the transfer and Ombudsman notification. * Resident 15's written Notice of Proposed Transfer and Discharge was not completed upon transfer to acute care. * Resident 86's written Notice of Proposed Transfer and Discharge was not completed upon transfer to acute care * Resident 122's written Notice of Proposed Transfer and Discharge was not completed upon transfer to acute care. These failures had the potential for the residents not receiving the accurate information about their transfer/discharge status and their rights to appeal. Findings: Review of facility's P&P titled Notice of Transfer/Discharge revised 10/2017 showed before a resident's transfer or discharge occurs, the facility must notify the resident, the responsible party, and Ombudsman of the transfer, the reason for transfer, and document in the resident's medical record. Review of facility's P&P titled P-NP03 Discharge and Transfer of Residents effective 3/21/25, showed the facility will provide the resident or responsible party with a Notice of Proposed Transfer and Discharge document, and a copy will be placed in the resident's medical record as well as faxed to the Ombudsman. For discharged residents, the facility will provide the resident or their responsible a copy of an evaluation of the resident's discharge needs and discharge plan. 1. Closed medical record review for Resident 137 was initiated on 6/12/25. Resident 137 was admitted to the facility on [DATE], and discharged to the community on 3/18/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 137's medical records failed to show the resident received a copy of the recapitulation of the resident's stay including home health services information, follow-up appointments, and a medication list with instructions. On 6/12/25 at 1537 hours, the MRD stated she was unable to locate a signed discharge summary in Resident 137's medical records. On 6/13/25 at 0740 hours, an interview and concurrent closed medical record review for Resident 137 was conducted with the DON. The DON stated when the resident was discharged from the facility, the nurse should print and explain the Discharge Planning Review Form with a medication list, and provide the resident the form with a copy being placed in the resident's medical record. The DON verified they were unable to locate a signed copy of Resident 137's Discharge Summary. 2. Medical record review for Resident 10 was initiated on 6/10/25. Resident 10 admitted to the facility on [DATE]. Review of Resident Census showed the resident was on a acute care hospital leave for the following dates: - On 8/23/24, and returned to the facility on 8/26/25. - On 9/3/24, and returned to the facility on 9/6/24. - On 10/6/24, and returned to the facility on [DATE]. - On 11/17/24, and returned to the facility on [DATE]. - On 4/22/25, and returned to the facility on 5/6/25. Review of Resident 10's Notice of Proposed Transfer and discharge date d 11/17/24, failed to show a copy of the notice was faxed to the office of the Ombudsman. Review of Resident 10's medical records failed to show a written notification of transfer was provided to the resident or the resident's responsible party, and faxed to the Ombudsman for 8/23, 9/3, and 10/6/24. On 6/10/25 at 0801 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated the facility was not sending them all the required notifications of the residents' transfers. On 6/11/25 at 1541 hours, an interview and concurrent medical record review for Resident 10 was conducted with the MRD. The MRD stated she was unable to find the Notice of Proposed Transfer and Discharge forms for 8/23, 9/3, and 10/6/24. The MRD stated she was unable to find the documentation of the Notice of Proposed Transfer and discharge date d 11/17/24, was faxed to the Ombudsman. The MRD stated the nursing staff should complete the notification form and fax it to the Ombudsman, and attach the fax confirmation form to the notification and place it in the resident's medical record. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1438 hours, an interview was conducted with RN 2. RN 2 stated the process for a resident who was discharged or transferred out of the facility was to complete the Notice of Proposed Transfer and Discharge form, fax the form to the Ombudsman, and attach the fax confirmation with the form in the resident's medical record. 3. Closed medical record review for Resident 117 was initiated on 6/10/25. Resident 117 was admitted to the facility on [DATE], and was discharged to an acute care hospital on 6/6/25. Review of Resident 117's Notice of Proposed Transfer and discharge date d 6/6/25, failed to show the reason for the resident's transfer/discharge, and who was notified of the transfer/discharge. On 6/10/25 at 0801 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman stated the facility was not sending them all the required notifications of the residents transfers. On 6/12/25 at 1403 hours, an interview and concurrent closed medical record review for Resident 117 was conducted with the MRD. The MRD verified Resident 117's Notice of Proposed Transfer and discharge date d 6/6/25, failed to show the reason for the resident's transfer/discharge, and who was notified of the transfer/discharge. On 6/12/25 at 1438 hours, an interview was conducted with RN 2. RN 2 stated the process for a resident who was discharged or transferred out of the facility, was to complete the Notice of Proposed Transfer and Discharge form, fax the form to the ombudsman, and attach the fax confirmation with the form in the resident's medical record. 6. Medical record review for Resident 122 was initiated on 6/10/25. Resident 122 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 122's medical record titled eINTERACT Transfer Form V5 and eINTERACT Change in Condition Evaluation - V 5.1 showed Resident 122 was transferred to the acute care facility on the following dates: - On 9/9/24, - On 4/1/25; and - On 4/10/25. Further review of Resident 122's medical record failed to show a copy of the Notice of Proposed Transfer and Discharge was faxed to the Ombudsman on 9/9/24, 4/1, and 4/10/25. On 6/12/25 at 1515 hours, an interview and concurrent medical record review for Resident 122 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated upon a hospital transfer or discharge to home, the facility's protocol was to fax a copy of the Notice of Proposed Transfer and Discharge to the Ombudsman. RN 2 verified the Notice of Proposed Transfer and Discharge should have been faxed to the Ombudsman on the dates Resident 122 was transferred to the acute care hospital; however, RN 2 verified it was not done. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 1534 hours, an interview was conducted with the MRD. The MRD verified she reviewed Resident 122's medical record and did not have copies of the resident's Notice of Proposed Transfer and Discharge from 9/9/24, 4/1, and 4/10/25. The MRD further stated the nursing staff were responsible for faxing the form to the Ombudsman. On 6/16/25 at 1200 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Closed medical record review for Resident 15 was initiated on 6/11/25. Resident 15 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 2/24/25. Review of Resident 15's medical record failed to show documented evidence the resident and/or his responsible party were provided with the written notice of the resident's transfer to an acute care facility. Additionally, Resident 15's medical record failed to show documentation the Notice of Proposed Transfer was sent to the Ombudsman as required. On 6/11/25 at 0826 hours, an interview and concurrent closed medical record review for Resident 15 was conducted with RN 1. RN 1 verified the facility was required to complete the Notice of Proposed Transfer when the residents were transferred to an acute care facility and the notice should be in the resident's medical record unless the the resident's medical record had been thinned in which case it would be stored in the medical records. RN 1 further stated a copy was required to be sent to the Ombudsman and documented. RN 1 then provided a blank copy of the facility's Notice of Proposed Transfer for reference purposes. On 6/11/25 at 1541 hours, the MRD verified there was no Notice of Proposed Transfer for Resident 15's transfer to an acute care facility on 2/24/25, either in the resident's chart or medical records. On 6/12/25 at 0814 hours, RN 2 verified there was no Notice of Proposed Transfer for Resident 15's transfer to an acute care facility on 2/24/25, in the resident's closed medical record. 5. Closed medical record review for Resident 86 was initiated on 6/11/25. Resident 86 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 4/28/25. Review of Resident 86's medical record failed to show documented evidence the resident and/or his responsible party were provided with a written notice of the resident's transfer to an acute care facility. Additionally, Resident 86's medical record failed to show documentation the Notice of Proposed Transfer was sent to the Ombudsman as required. On 6/11/25 at 0826 hours, an interview and concurrent closed medical record review for Resident 86 was conducted with RN 1. RN 1 verified the facility was required to complete the Notice of Proposed Transfer when the residents were transferred to an acute care facility and the notice should be in the resident's medical record unless the medical record had been thinned in which case it would be stored in the medical records. RN 1 further stated a copy was required to be sent to the Ombudsman and documented. RN 1 then provided a blank copy of the facility's Notice of Proposed Transfer for reference purposes. On 6/11/25 at 1541 hours, the MRD verified there was no Notice of Proposed Transfer for Resident 86's transfer to an acute care facility on 4/28/25, either in the resident's chart or medical records. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 0814 hours, RN 2 verified there was no Notice of Proposed Transfer for Resident 86's transfer to an acute care facility on 4/28/25, in the resident's closed medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure one of three final sampled residents (Resident 22) reviewed for pressure injury was provided the necessary care and services when the LAL mattress was set incorrectly for Resident 22. In addition, Resident 22 was left lying on multiple layers of bedding, absorbent pad, and an incontinent brief. These failures had the potential for the resident not to receive the appropriate care and services to promote skin healing. Findings: Review of the facility's P&P titled Mattresses revised 1/1/12, under the Procedure section showed for the facility staff to make sure the mattress is inflating properly, check air mattress routinely to ensure that it is working properly, and alternating air mattress are used to relieve pressure as indicated by the resident's physical condition. May use an incontinent pad, if necessary, between resident and bottom sheet to maximize the effect. a. On 6/10/25 at 0857 hours, during the initial tour of the facility, Resident 22 was observed in the room and lying in bed. Resident 22's LAL mattress was set to static mode while the weight range was set to 200 to 250 pounds. Medical record review for Resident 22 was initiated on 6/10/25. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's plan of care initiated on 2/20/25, showed a care plan problem addressing Resident 22's left hip pressure injury. The interventions included the use of LAL mattress for wound management with setting - static mode when doing ADL care and alternate mode when not providing ADL care, and one bar above 90. Review of Resident 22's Order Summary Report showed a physician's order dated 4/16/25, for LAL mattress for wound management and monitor for functioning - setting mode when doing ADL care and alternate mode when not providing ADL care, and one bar above 90 pounds every shift. Review of Resident 22's H&P examination dated 4/20/25, showed Resident 22 could make needs known, however, could not make medical decisions. Review of Resident 22's MDS assessment dated [DATE], showed Resident 22 had severe cognitive impairment and was dependent with the ADLs care and mobility. Review of Resident 22's Weights and Vitals Summary showed Resident 22's weight on 6/8/25, was 107 pounds. Review of Resident 22's Wound Assessment and Plan dated 6/9/25, showed Resident 22 had an unstageable pressure injury in the left hip with wound measurement of 3 cm in length x 3 cm in width x depth was unable to determine. Resident 22's wound status was healing and no signs and symptoms of infection. (continued on next page)

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	06/16/2025

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 1040 hours, an observation of Resident 22 and concurrent staff interview was conducted with the DON. The DON verified the LAL mattress was in static mode and the weight range setting was set to 200 to 250 pounds. The DON stated he was not sure what the static mode meant, and he would verify with the treatment nurse. On 6/10/25 at 1050 hours, an interview was conducted with RN 1. RN 1 stated the static mode for LAL mattress meant a consistent even air distribution and the facility usually use the static mode setting per resident's request. On 6/10/25 at 1059 hours, an interview was conducted with LVN 10. LVN 10 verified Resident 22 had an unstageable pressure injury in the left hip. LVN 10 stated they had always set the LAL mattress in static mode for Resident 22's comfort. LVN 10 verified Resident 22's weight was 107 pounds, and the weight range setting was set to 200 to 250 pounds. LVN 10 stated the weight range could have been set to lesser than 200 pounds. LVN stated she would verify with the DME Personnel who in-serviced them regarding the LAL mattress. LVN 10 further stated the treatment nurses checked the LAL mattress if it was functioning well, however, it was the responsibility of all the licensed nurses and CNAs to make sure the setting was set correctly. On 6/10/25 at 1354 hours, a concurrent interview and facility document review was conducted with LVN 10. Review of the facility's document titled [NAME] Air Manual (undated) showed the users can adjust the pressure setting to the most suitable level according to the weight and height of the resident. LVN 10 verified the LAL mattress for Resident 22 should be set to alternate mode since the ADL care was not being provided to Resident 22. LVN 10 set Resident 22's LAL mattress to alternate mode and the weight range dial was adjusted to one bar above 90 pounds. b. On 6/11/25 at 1110 hours, a follow-up observation was conducted for Resident 22. Resident 22 was observed lying in bed with the LAL mattress with multiple layers of bedding, incontinent pad and wearing an incontinent brief. On 6/11/25 at 1115 hours, an interview for Resident 22 was conducted with LVN 2. LVN 2 verified Resident 22 had multiple layers of bedding, incontinent pad, and incontinent brief. LVN 2 stated there should be only one layer of sheet because if the resident was laying on multiple layers of sheets while on LAL mattress, it defeated the purpose of the LAL mattress. LVN 2 verified Resident 22 had a pressure injury. LVN 2 stated the CNAs should know they could not have the resident lay in multiple layers of bedding and incontinent pads when the resident was using LAL mattress. On 6/11/25 at 1145 hours, an interview was conducted with LVN 1. LVN 1 stated the wound doctor checked Resident 22's wound every Monday. LVN 1 stated Resident 22 was readmitted to the facility with unstageable pressure injury. LVN 1 stated Resident 22's wound size was the same from when the resident was admitted to the facility. LVN 1 stated Resident 22 should only have the bottom sheet and either the incontinent pad or the incontinent brief. LVN 1 stated if the resident was lying in multiple bedding, incontinent pad and incontinent brief in the LAL mattress, the wound might not heal. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/25 at 1330 hours, an interview was conducted with the DON. The DON stated the treatment nurses primarily checked the setting and functioning of the LAL mattress on their shift and document in the MAR, however, the CNAs should be able to check it too. The DON stated for the residents with pressure injuries, the licensed nurses and CNAs should make sure the residents were not lying in multiple bedding, incontinent pads and briefs, whether the residents were using a specialty mattress or not. The DON stated the residents would have the potential to develop more moisture and it could affect the skin integrity and wound healing, and if the residents were using the specialty bed or mattress, it would defeat the purpose of the equipment. The DON stated the treatment nurses were educating the residents regarding this as well but some residents who were alert and oriented were requesting for the use of several bed linens or pads. The DON stated the treatment nurses were being trained by the corporate consultant regarding wound management as well and the facility's wound physician also provided educational training during the weekly visits. The DON stated the DME supplier would come to the facility as well to provide in-service training for the use of the medical equipment like the LAL mattress and specialty bed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure to follow the puree recipe for puree vegetables for 21 residents on puree diet. This failure posed the risk of the residents not receiving food prepared by methods that conserve nutritive value. Findings: Review of the Diet Type Report dated 6/11/25, showed 21 of 133 residents received puree food prepared from the kitchen. Review of the facility's P&P titled Standardized Recipes date revised 7/1/14, showed the food products prepared and served by the dietary department will utilize standardized recipes. On 6/11/25 at 1045 hours, an observation of the puree meals preparation was conducted with [NAME] 1. [NAME] 1 stated she was preparing to puree the vegetables for a total of 21 residents and would prepare the vegetables for 24 servings. During the puree preparation for the broccoli and carrots, [NAME] 1 was observed measuring three cups of cold milk poured into a measuring cup and adding the cold milk to the cooked broccoli and carrots while the recipe showed for 24 servings to add one half cup to one- and one-half cups of warm fluid such as milk or low sodium broth. The DDS verified the findings and stated [NAME] 1 did not follow the recipe for the puree vegetables and the recipe should have been followed.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of three garbage dumpsters. This failure had the potential to attract pest/rodents that carried diseases. Findings: Review of the facility's P&P titled Waste Management revised 4/21/22, showed to maintain appropriate waste containers. The container must be closable, puncture resistant, and leak-proof. Dispose of non-regulated waste in appropriate, non-combustible waste containers. When waste bags are ¾ full, close bag and remove from area. Dispose bag into large, covered waste bin or cart in soiled utility. Discard soiled, disposable incontinence products in covered waste bin or cart in the soiled utility room. Food waste will be placed in covered garbage and trash cans. According to the 2022 FDA Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 6/10/25 at 0735 hours, an observation of the garbage dumpsters was conducted. One of the three outside garbage dumpsters was observed with the lid fully propped open by the bulky boxes, preventing the lid from closing. The Maintenance Supervisor was informed of the above observation with a photograph of the garbage dumpster taken on 6/10/25 at 0735 hours. On 6/11/25 at 1151 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor of the facility's two of three outside garbage dumpsters. The garbage dumpsters were observed with the lids partially propped open by the trash bags and bulky boxes, preventing the lids from fully closing. The Maintenance Supervisor verified the above findings and stated the dumpster lids should be completely closed at all times, to prevent flies from getting in and out of the trash and for infection control purposes.