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	04/24/2026

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 Note: The nursing home is disputing this citation.	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, and facility P&P review, the facility failed to ensure one of six sampled residents (Resident 4) reviewed for abuse was free from abuse. * The facility failed to protect Resident 4's right to be free from physical abuse by another resident (Resident 5). Resident 4's right foot was punched twice by Resident 5. Resident 4 had two right dorsal (top) foot superficial scratches. This failure had the potential for Resident 4 to be seriously injured or have negative psychosocial outcomes. Findings: Review of the facility's P&P titled 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. The facility develops policies, procedures, training programs, and screening and prevention systems. The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. Review of the facility's P&P titled P-AN01 Abuse Prevention and Management revised 5/30/24, under Definitions section showed:- 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 property, mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. Abuse includes the neglect and deprivation of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse also includes verbal abuse, sexual abuse, physical abuse, mental abuse, or abuse facilitated or enabled by the use of technology that causes physical harm, pain, or mental anguish.- Willful, as related to abuse, is defined as the individual acting deliberately (not inadvertent or accidental) and not that the individual must have intended to inflict injury or harm. a. Medical record review for Resident 4 was initiated on 4/23/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 4's eINTERACT Change in Condition Evaluation - V 5.1 dated 4/17/26, showed an alleged abuse. Review of Resident 4's N Adv - Skin Check dated 4/17/26, showed Resident 4 had right dorsal foot superficial scratches. Resident 4 was noted with superficial scratches to right dorsal foot (site 1) measuring 0.1 cm, no swelling noted, minimal bleeding. Site 2 (dorsal foot) measuring 0.1 cm, no swelling noted, no bleeding. Surrounding skin intact. Review of Resident 4's eINTERACT SBAR Summary for Providers Progress Notes dated 4/17/26, showed the staff responded to a loud verbal discussion between Resident 5 and Resident 4 each in wheelchair outside of Room A in the hallway. As staff was in the process to intervene when Resident 5 was observed reaching forward from wheelchair extending left arm and struck Resident 4 on the right lower leg. The staff immediately separated both residents from each other. b. Medical record review for Resident 5 was initiated on 4/23/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's MDS assessment dated [DATE], showed the resident was cognitively intact. During the investigation, Resident 5 was not available for an interview. Resident 5 was sent to the acute care hospital. On 4/23/26 at 1410 hours, an interview (continued on next page)

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 Note: The nursing home is disputing this citation.	was conducted with Resident 4. Resident 4 stated she was in front of Room A and a man was sitting in front of Room B and singing a song before the incident happened. Resident 4 stated the man stopped singing and moved in the hallway towards her. Resident 4 stated she was setting up her food when the incident happened. Resident 4 stated the man called her black bitch and she replied, your Momma is one. Resident 4 stated the man got mad and hit her right foot with his fist two times. Resident 4 further stated she threw her soda at him but did not hit him. Resident 4 stated the man got mad and hit her left leg. Resident 4 stated she had a small cut and a scratch on her right foot. Resident 4 stated her wound has been healed for a while. On 4/24/26 at 0950 hours, an interview was conducted with LVN 2. LVN 2 stated, I assessed Resident 4 after the alleged abuse incident happened. LVN 2 stated Resident 4 had two small scratches on her foot. LVN 2 stated Resident 4's wounds were superficial scratches with very minimal bleeding. On 4/24/26 at 1636 hours, a telephone interview was conducted with CNA 3. When CNA 3 was asked if Resident 5 punched Resident 4's right foot twice, CNA stated yes. On 4/24/26 at 1651 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. The DON stated Resident 5 had a long history of mental illness which included schizophrenia and dementia. The DON stated prior to Resident 5's event with Resident 4, they never had unusual interaction including any type of verbal and physical altercation. The DON stated before that event, Resident 5 was not manifesting any kind of unusual behavior. The DON further stated Resident 5 was immediately placed on one-on-one supervision and was transferred to a psychiatric acute care hospital. The DON stated on transfer, Resident 5 denied hitting Resident 4. The DON stated Resident 5 was laughing for no reason and talking loudly to himself.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to report an abuse allegation to CDPH, L&C Program for one of six residents (Resident 4) reviewed for abuse. * The facility failed to ensure SOC 341 was sent to CDPH, L&C Program. The facility faxed the SOC 341 form for Resident 4's abuse allegation to CDPH, L&C Program's phone number, instead of CDPH, L&C Program's fax number. This failure had the potential for the abuse allegation going unreported and uninvestigated.Findings: Review of the facility's P&P titled 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. The facility develops policies, procedures, training programs, and screening and prevention systems. The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies. Review of the facility's P&P titled P-AN01 Abuse Prevention and Management revised 5/30/24, under Notification of Outside Agencies for All Allegations of Abuse section showed the Administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practicably possible, but no longer than two hours of an initial report and send a written SOC 341 report to the ombudsman, law enforcement, and CDPH Licensing and Certification within two hours. Medical record review for Resident 4 was initiated on 4/23/26. Resident 4 was admitted to the facility on [DATE]. Review of the facility's SOC 341 dated 4/17/26, showed a staff responded to a loud verbal discussion between the residents each in wheelchair outside of Room A hallway. As the staff was in the process to intervene, Resident 5 was observed reaching forward from wheelchair extending left arm and struck Resident 4 on right lower leg. The staff immediately separated both residents. Further review of the facility's SOC 341 dated 4/17/26, showed the facility faxed the SOC 341 form to CDPH, L&C Program's telephone number instead of CDPH, L&C Program's fax number. On 4/24/26 at 1447 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator verified the SOC 341 form was faxed to CDPH, L&C Program's phone number instead of CDPH, L&C Program's fax number. The Administrator stated the fax result showed success and it was an honest mistake. The Administrator stated the staff should have double checked the fax number. On 2/24/26 at 1651 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.