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	05/29/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **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 fully inform the resident or resident's responsible party and obtain a completed informed consent prior to the use of the psychotropic medications for two of four sampled residents (Residents 1 and 4) reviewed for unnecessary psychotropic medications. * The facility failed to ensure the informed consent was obtained from Resident 1 or the resident's representative before administering the buspirone hydrochloride (antianxiety medication) medication to Resident 1. * The facility failed to ensure the informed consent was obtained from Resident 4 or the resident's representative before administering the Clozaril (atypical antipsychotic medication) and Depakote (mood stabilizer medication) medications to Resident 4. These failures had the potential for the residents and their responsible party to be unaware of the risks associated with the use of the psychotropic medications and the potential side effects. Findings: Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the facility's P&P titled NP67 Informed Consent dated 1/3/24, showed except in emergencies, informed consent must be obtained prior to the proposed treatment or procedure. Where possible, consent should be obtained sufficiently in advance to allow the resident or their surrogate decision-maker time to consider and make an informed decision. Review of the facility's P&P titled P-NP67 Informed Consent dated 1/30/26, showed under the verification of informed consent the licensed nurse will contact the healthcare practitioner to request the practitioner obtain the informed consent, if the licensed nurse is unable to verify that the Healthcare Practitioner obtained informed consent from the resident or decision-maker. 1. Medical record review for Resident 1 was initiated on 5/27/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 1's Order Summary Report dated 5/27/26, showed a physician's order dated 2/6/26, for buspirone hydrochloride oral tablet 10 mg. Give one tablet by mouth three times a day for anxiety manifested by verbalization of anxiousness. Nonpharmacological interventions: 1. Music/TV, 2. Redirect/divert, 3. Call family/responsible party, 4. Toilet, 5. 1:1 Conversation, 6. Reassure/orient, 7. Assess pain/infection, 8. Offer drink/snack, 9. Quiet environment, 10. Walk/wheel resident, 11. Activity/exercise, 12. Massage/back rub. Further review of Resident 1's medical record did not show documented evidence of an informed consent for Resident 1's buspirone hydrochloride medication. On 5/29/26 at 1148 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 4. RN 4 verified Resident 1 had no informed consent for the buspirone hydrochloride medication ordered on 2/6/26. RN 4 stated the licensed nurse should have informed Resident 1 of the need for informed consent for the buspirone hydrochloride medication and informed Resident 1's physician. RN 4 stated the informed consent was important so Resident 1 would be aware of the medication and treatment being given. RN 4 stated Resident 1 should have been informed of the risk and benefits of the psychotherapeutic medication. 2. Medical record review for Resident 4 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was initiated on 5/28/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 2/2/26, showed the resident had the mental capacity to make decisions. Review of Resident 4's Order Summary Report dated 5/28/26, showed the following physician's orders: - dated 1/30/26, to administer Clozaril oral tablet 200 mg (clozapine). Give one tablet by mouth at bedtime for schizophrenia manifested by angry outburst as exhibited by yelling/screaming for no apparent reason. Nonpharmacological interventions: 1. Music/TV, 2. Redirect/divert, 3. Call family/responsible party, 4. Toilet, 5. 1:1 Conversation, 6. Reassure/orient, 7. Assess pain/infection, 8. Offer drink/snack, 9. Quiet environment, 10. Walk/wheel resident, 11. Activity/exercise, 12. Massage/back rub; - dated 1/30/26, to administer Clozaril oral tablet 25 mg (clozapine). Give three tablets by mouth one time a day for schizophrenia manifested by angry outburst as exhibited by yelling/screaming for no apparent reason. Nonpharmacological interventions: 1. Music/TV, 2. Redirect/divert, 3. Call family/responsible party, 4. Toilet, 5. 1:1 Conversation, 6. Reassure/orient, 7. Assess pain/infection, 8. Offer drink/snack, 9. Quiet environment, 10. Walk/wheel resident, 11. Activity/exercise, 12. Massage/back rub; and - dated 1/30/26, to administer Depakote (mood stabilizer medication) oral tablet delayed release (divalproex sodium). Give 750 mg by mouth two times a day for mood stabilizer as exhibited by from being calm to sudden irritability. Nonpharmacological interventions: 1. Music/TV, 2. Redirect/divert, 3. Call family/responsible party, 4. Toilet, 5. 1:1 Conversation, 6. Reassure/orient, 7. Assess pain/infection, 8. Offer drink/snack, 9. Quiet environment, 10. Walk/wheel resident, 11. Activity/exercise, 12. Massage/back rub. Further review of Resident 1's medical record failed to show documented evidence of informed consent for Resident 1's Clozaril and Depakote medications. On 5/29/26 at 1257 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 4. RN 4 verified Resident 4 had no informed consent for the Clozaril and Depakote medications ordered on 1/30/26. RN 4 stated the licensed nurse should have checked the files to make sure the resident had the updated informed consent. On 5/29/26 at 1527 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated in January 2026 the facility decided to renew all the psychotropic informed consents every six months, specifically in February and September, to make tracking the renewal dates easier. The DON stated the facility renewed all the residents' informed consents in February 2026 and acknowledged the informed consents for Residents 1 and 4 were missed.