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	06/25/2026

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 - 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 interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of six sampled residents (Resident 1) was protected from sexual abuse. * On 5/30/26, Resident 2 was found on top of Resident 1, in Resident 1's room. Residents 1 and 2 were face to face in bed and Resident 2 was observed humping on top of Resident 1. Resident 1 lacked the cognitive capacity to provide informed consent or make reasonable decisions regarding personal safety. Considering Resident 1's cognitive ability, a reasonable person would consider this as severe emotional trauma and may go through post traumatic issues, violation of personal rights, and potential physical injury due to the unsafe positioning of Resident 2 on top of Resident 1. * The facility failed to ensure the facility's P&P for abuse protocols were followed when the CNA changed the resident's diaper after the alleged abuse incident and prior to the police officers being onsite to conduct an abuse investigation. This failure prevented the preservation of possible evidence, hinder the investigative process, and violating the established abuse response procedures. 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. Sexual abuse is defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault. 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. Further review of the P&P showed the purpose of the policy is to address the health, safety, welfare, dignity, and respect of residents. Reports of resident abuse, mistreatment, neglect, exploitation, injuries of an unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated. The P&P further showed Sexual abuse is defined as non-consensual sexual contact of any type, sexual harassment, sexual coercion, or sexual assault. Immediate actions included: If the suspected perpetrator is another resident, separate the resident so they do not interact with each other until the circumstances of the reported incident can be clarified. The resident will be assessed by the licensed nurse for any physical injuries or emotional distress. Notify the physician and provide treatment as ordered, if applicable. Notify the responsible party of the incident and results of assessment finding. If an abuse allegation involves forced sexual penetration, the Administrator or designated representative will notify the Attending Physician to promptly examine the resident or obtain an order to transfer the resident to the acute care hospital for examination. Immediately notify law enforcement. Do not bathe the resident or wash the resident's clothes of linen. Do not take items from the area in which the incident is alleged to have occurred. On 6/1/26, CDPH received an SOC 341 (Report of Suspected Dependent Adult/Elder Abuse) from the facility dated 5/30/26. The SOC 341 (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 - Actual harm Residents Affected - Few	showed Resident 2 was found in female resident's room (Resident 1) in her bed. On 6/11/26 at 1220 hours, CDPH initiated an onsite investigation regarding the allegation of sexual abuse involving Residents 1 and 2. Review of the facility's summary of findings dated 6/4/26, showed on 5/30/26 at approximately 1100 hours, the Maintenance Director saw Resident 2 in Resident 1's room, on top of Resident 1. Resident 2's pants were pulled down towards his knees. Resident 1's gown was half off, chest exposed. Residents 1 and 2 were face to face and Resident 2 was moving in a humping motion. The Maintenance Director pulled Resident 2 off Resident 1 and yelled into the hallway, to the nurses' station approximately 10 feet away. The RN supervisor and LVNs in the station immediately went to assist. Upon approaching Resident 1's room, Resident 2 was observed exiting the room wearing his pants. The LVNs directed Resident 2 out of Resident 1's room. The RN supervisor visually assessed Resident 1 and was observed with the left side of the brief undone. Resident 1 was noted to be calm with no signs of distress noted. The facility's summary showed Resident 2 was in the activity room from 1005 to 1050 hours and had attended activities with the other residents and left the dining room to go for the 1100 hours smoke break with no unusual behaviors noted. Further review of the facility's summary of findings showed the Maintenance Director who was the witness to the alleged incident was interviewed on 5/30/26. The Maintenance Director reported as he walked by Resident 1's room, he saw Resident 2 on top of Resident 1, with his pants down. Resident 2 was moving in a humping motion. The Maintenance Director attempted to pull Resident 2 off from the waist, who was hugging Resident 1. Resident 2 attempted to push the Maintenance Director away. The Maintenance Director called into the hallway for help; not leaving the residents in the room. By that time, Resident got off the bed and pulled on his pants. The Maintenance Director reported that Resident 1 was exposed at the chest area, saw brief on for Resident 1, but did not notice if the brief was removed or not. In addition, facility's summary of findings also showed Officers B and C came to the facility on 5/30/26 at approximately 1755 hours, to conduct an investigation regarding the incident, interviewed Resident 2, and interviewed Resident 1 at bedside. Following the interview, a skin assessment was completed in the presence of Officer 3, who was a female officer, and contacted the forensic RN to discuss their findings; and based on their assessment and investigation findings, Resident 1's transfer to the acute hospital was not indicated to avoid further trauma to the resident. The PA for Resident 1's primary physician was notified and the order for transfer was discontinued. The facility's summary failed to show if a sexual abuse was committed by Resident 2 against Resident 1. a. Medical record review for Resident 1 was initiated on 6/11/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 1/6/26, showed Resident 1 had no mental capacity to make decisions, and had a diagnosis of Traumatic Brain Injury (TBI) with spastic hemiparesis. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) with self-care which included eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 5/30/26, showed the staff reported a male resident (Resident 2) was found in the resident's room (Resident 1) in the resident's bed. The staff immediately responded and found the resident (Resident 1) lying supine in her bed, with her button up pajama blouse unbuttoned exposing her chest area and wearing her diaper. Resident 1 was immediately covered with a blanket and privacy curtains closed. Resident 1 was not able to state the event, with no signs or symptoms of emotional distress such as crying, facial expressions of fear or pain. The PA for Resident 1's primary physician was notified and noted with orders for may transfer to an acute hospital setting for further evaluation and treatment, and bed hold for seven days if admitted . Police Department A was notified through Officer A and stated an officer will be dispatched to the facility to investigate the incident. Closed medical record review for Resident 2 was initiated on 6/11/26. Resident 2 was readmitted to the facility on [DATE], and was transferred to an acute care hospital on 5/30/26. Review of Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2's H&P examination dated 5/7/26, showed Resident 2 had the mental capacity to make decisions. Review of Resident 2's Plan of Care showed a care plan problem focus initiated on 5/11/26, which showed Resident 2 was observed with flashlight, aiming light towards female CNA's buttocks; speaking to licensed nurse stating, I want to take you out, marry you, and I want you to move in with me. The interventions included to monitor inappropriate behavior towards female residents, to educate the resident regarding respecting a female residents' personal boundaries, inappropriate behavior was not acceptable in the facility, and to notify and responsible party. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was independent on ambulation. Further review of Resident 2's MDS assessment showed Resident 2 had no functional limitation in range of motion on upper extremities and lower extremities. On 6/11/26 at 1220 hours, an interview was conducted with the Administrator. The Administrator stated Resident 2 was transferred to the acute care hospital shortly after the incident and the facility would not be accepting Resident 2 back to the facility. On 6/11/26 at 1315 hours, an interview and concurrent observation was conducted with Resident 1. Resident 1 was observed lying down in bed with head slightly elevated, and her body was covered with a blanket. Resident 1 stated there were good days and bad days in the facility. When asked to describe what the bad days were, Resident 1 stated nothing. Resident 1 further stated she did not remember the incident which occurred on 5/30/26. On 6/11/26 at 1346 hours, an interview was conducted with the Maintenance Director. When asked about his knowledge of the alleged incident involving Residents 1 and 2 on 5/30/26, the Maintenance Director stated the resident in Room A asked him for a closet lock and he did not have anything at the time that was compatible for Room A's closet. The Maintenance Director stated he went and searched in different rooms which included Resident 1's room where the door was partially closed and privacy curtains were partially drawn; and when he entered the room, he saw Resident 2 on top of Resident 1 with the arms around Resident 1's upper torso and was doing humping motion. Resident 2's bottom was exposed, and his pants were down and was wearing a shirt. The Maintenance Director stated he attempted to pull Resident 2 from Resident 1, but Resident 2 was resistant and wanted to hit him. The Maintenance Director further stated he yelled for help and the staff immediately came and assisted. When the staff came in, Resident 2 got off from Resident 1 and walked away from the room. Resident 1's upper torso was exposed with her breast exposed. Resident 1's diaper was lowered down with the front diaper down, her genital was exposed. There was no reaction noted from Resident 1. On 6/12/26 at 0910 hours, an interview and concurrent medical record review for Residents 1 and 2 was conducted with the SSD. The SSD stated Resident 1 was not cognitively intact and Resident 1 was dependent with the staff on ADLs. The SSD stated Resident 2 was independent on ADLs and Resident 2 was walking independently. The SSD further stated Resident 2 had behavior of verbal aggression toward the staff and wrote inappropriate things on the wall. When asked about the incident that happened on 5/30/26, as witnessed by the Maintenance Director, the SSD verified the incident was considered sexual abuse. On 6/12/26 at 1039 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 1 was dependent with the staff on ADLs and had weaknesses on her left arm. CNA 1 stated in the morning of the alleged incident, CNA1 put on button up pajama blouse, a diaper, and a pair of shorts to Resident 1. CNA1 further stated it would not be possible for Resident 1 to unbutton her pajama blouse and lower her shorts by herself. On 6/12/26 at 1233 hours, a telephone interview was conducted with LVN1. When asked about her knowledge of the alleged incident on 5/30/26, involving Residents 1 and 2, LVN 1 stated the maintenance man (referring to the Maintenance Director) came out of the hall and asked for help. Resident 2 was coming out of Resident 1's room. Resident 1's breast was exposed, and her diaper was exposed. Resident 1's left diaper strap was undone and can see her pubic area because the diaper was folded on the side. LVN 1 stated she asked Resident 1 if she was OK; however, Resident 1 cannot really say what happened. LVN 1 further stated she and LVN 4 conducted visual check on Resident 1 and they did not see any blood or bodily fluids. According to LVN 1, the CNA changed Resident 1 but not immediately and the police took some time before they came to the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	of penetration occurred between Residents 1 and 2. The P&P regarding abuse prevention was reviewed with the Administrator and DON over the phone. Page 3 of 4 showed.Do not bathe the resident or wash the resident's clothes or linen. Do not take items from the area in which the incident is alleged to have occurred. When the Administrator was asked if she was aware the alleged victim was changed prior to the police officers being onsite, the Administrator stated she was not aware of the situation and she has conducted several interviews, and nothing was mentioned Resident 1 was changed prior to the police officers' arrival to the facility. The Administrator further stated she instructed the staff not to change Resident 1 prior to the police officers' arrival to the facility to conduct the investigation. The Administrator further stated the facility assessed Resident 1 immediately after the incident occurred, and days post the incident. Resident 1 did not have signs of trauma, distress, and skin injuries. Resident 1 was at her baseline and did not complain of anything. Resident 1 was not transferred to an acute care hospital based on the decision/recommendation from the police officers and forensic nurse who conducted their investigation post notification of the alleged incident and felt there was no penetration occurred between Residents 1 and 2 and was not necessary to avoid further trauma to Resident 1. The Administrator and DON acknowledged the findings.