STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055252	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orange Healthcare & Wellness Centre, LLC	920 West LA Veta Street Orange, CA 92868

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services to prevent UTI for two of two sampled residents (Residents 1 and 2) reviewed for catheter care. * The facility failed to ensure proper positioning of Residents 1 and 2' s urinary drainage bag to prevent urine from flowing back into the residents' bladder. * The staff member failed to monitor or assess the color of Resident 2's urinary output. These failures posed the risk for Residents 1 and 2 to develop CAUTI. Findings: Review of the facility's P&P titled Care of Catheter revised 6/10/21,showed the residents with Foley catheters will be cared for utilizing the most current CDC Guidelines to prevent Urinary Tract Infections. Nursing Staff will assess urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and amount of urine. The catheter tubing, bag or spigot will be anchored to not touch the floor. The catheter and collecting tube will be kept free from kinking and the collection bag will be kept below the level of the bladder. 1. On 12/4/24 at 1035 hours, an observation was conducted with Resident 1. Resident 1 was observed lying in bed with the bed in a low position. Resident 1's urinary catheter drainage bag was observed on the top of Resident 1 ' s bed without a dignity bag. Resident 1's urinary output was visible from the hallway and from the opened patio door, which lead to facility's patio. There were other residents and visitors observed in the facility's patio. Medical record review for Resident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10/5/24, showed Resident 1 had no capacity to make medical decisions. Review of Resident 1's Order Summary Report showed the following physician'sorders: (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/19/24, for an indwelling urinary catheter size 16 Fr with 10 cc balloon via gravity. - dated 10/4/24, for urinary Foley catheter care to be provided every shift and to assess the urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and the amount of urine output. Review of Resident 1's plan of care showed a care plan problem dated 10/20/24, addressing Resident 3's urinary catheter use. The interventions included to position the urinary catheter bag and tubing below the level of the bladder and away from the entrance door. On 12/4/24 at 1106 hours, a follow up observation was conducted with Resident 1. Resident 1's urinary catheter bag was observed on top of Resident 1's bed and not covered with a dignity bag. Family Member 1 was observed at the bedside, and she stated she did not touch the urinary catheter bag and no staff had come in to check the resident's urinary catheter bag. On 12/4/24 at 1130 hours, an observation and concurrent interview was conducted with the DON. The DON verified Resident 1's urinary catheter bag should be covered with a dignity bag and positioned below Resident 1's bladder. 2. On 12/5/24 at 1020 hours, an observation of Resident 2 and concurrent interview was conducted with the DON. Resident 2 was observed lying on his back with the urinary catheter bag on top of Resident 2's bed and not covered with a dignity bag. The urinary catheter bag was visible from the hallway and the patio door, which was facing the facility's outdoor sidewalk near the handicap parking lot. Resident 2's urine color output was also observed to be dark yellow brown in color. Medical record review for Resident 2 was initiated on 12/4/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/7/24, showed Resident 2 could make needs known but could not make medical decisions. Review of Resident 2's Order Summary Report showed the following physician's orders dated 5/8/24: - for an indwelling urinary catheter size 16 Fr via gravity drainage for obstructive uropathy. - Foley catheter care to be provided every shift and assess the urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and amount the of urine output every shift. Review of Resident 2's plan of care showed a care plan problem dated 2/22/24, addressing Resident 2's indwelling urinary catheter use. The interventions included to position the urinary catheter bag and tubing below the level of the bladder and away from the entrance door. On 12/5/24 at 1030 hours, an observation and concurrent interview was conducted with Treatment Nurse 2. Treatment Nurse 2 acknowledged Resident 2's urinary bag should be covered with a dignity bag and positioned below Resident 2's bladder. Treatment Nurse 2 further stated Resident 2's urinary output should not be dark yellow brown in color, and instead, the urine should be clear yellow. Treatment Nurse 2 stated Resident 2's urine output should be properly monitored. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 1513 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings.

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview and medical record review, the facility failed to ensure the medical records for two of sixsampled residents (Residents 1 and 2) were complete and accurately documented. * The licensed nurses failed to ensure documentation on the TAR for Residents 1 and 2 were complete and accurate. This failure had the potential for the residents' care needs not being met as their medical information was incomplete. Findings: 1. Medical record review for Resident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's TAR for November 2024 showed the following: a. Missing documentation of the assessment of the resident's urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and the amount of urine output every shift as per the physician's order dated 10/4/24, on the following dates: - 11/3/24, for the night shift; - 11/4/24, for the evening shift; - 11/15/24, for the night shift; and - 11/28/24, for the evening shift. b. Missing documentation for the Foley catheter care to be provided to the resident every shift as per the physician's order dated 10/4/24, on the following dates: -11/3/24, for the night shift; -11/4/24, for the evening shift; -11/15/24, for the night shift; and -11/28/24, for the evening shift. 2. Medical record review for Resident 2 was initiated on 12/4/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's TAR for November 2024 showed the following: (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	a. Missing documentation for the assessment of the resident's urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and the amount of urine output every shift as per the physician's order dated started 5/8/24, on the following dates: -11/7/24, for the evening shift; and -11/15/24, for the night shift. b. Missing documentation for the Foley catheter care to be provided every shift as per the physician's order dated 5/8/24, on the following dates: -11/7/24, for the evening shift; and -11/15/24, for the night shift. c. Missing documentation to monitor/record/report to the MD for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns every shift as per the physician's order dated 7/23/24, on the following dates: - 11/7/24, for the evening shift; and - 11/15/24, for the night shift. On 12/5/24 at 1030 hours, an interview and concurrent medical record review for Residents 1 and 2 was conducted with Treatment Nurse 2. Treatment Nurse 2 verified all the above missing documentation in Residents 1 and 2's TAR. On 12/5/24 at 1513 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings.