

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Orange Healthcare & Wellness Centre, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**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 the abuse protocol during the facility investigation process for one of eight sampled residents (Resident 1).</p> <p>* The facility failed to suspend CNA 1 from work when Resident 1 reported an allegation of physical abuse against CNA 1 on 6/17/25. This failure had the potential to place Resident 1 and other residents at risk of not being protected against the alleged abuser.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Reporting Abuse revised 1/8/14, showed upon an allegation of abuse by a facility staff member, the facility staff member will be suspended and removed from the premises during the investigation.</p> <p>On 6/17/25, the CDPH, Licensing and Certification Program received a report from the facility regarding Resident 1's allegation of physical abuse by CNA 1.</p> <p>Medical record review for Resident 1 was initiated on 6/26/25. Resident 1 was admitted to the facility on [DATE], and readmitted to the facility on [DATE].</p> <p>Review of Resident 1's H&P examination dated 5/27/25, showed Resident 1 had capacity to make his own medical decisions.</p> <p>Review of the facility's investigation documents for Resident 1's allegation of abuse showed the interviews and statements of the facility's staff members and residents. However, further review of the documents failed to show CNA 1 was suspended immediately after Resident 1 had voiced concerns about an alleged physical abuse to LVN 4 on 6/17/25 at 0140 hours.</p> <p>On 6/26/25 at 1055 hours, a telephone interview was conducted with CNA 1. CNA 1 verified she worked with Resident 1 on 6/17/25, during the night shift from 2300 to 0700 hours. CNA 1 reported Resident 1's allegation of abuse to LVN 4 on 6/17/25 at 0140 hours. When asked if she was suspended immediately after the reporting of the alleged abuse, CNA 1 stated that LVN 4 and RN 1 gave her a different assignment to not work directly with Resident 1 that night.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/25, at 0900 hours, a telephone interview was conducted with LVN 4. LVN 4 stated that Resident 1 was assessed immediately after reporting of the alleged physical abuse. There was no injury indicated. LVN 4 stated CNA 1 was asked to take another assignment. At around 0215 hours, an officer was called to the facility by Resident 1. RN 1 accompanied the officer, and the officer concluded there were no signs of elder abuse.</p> <p>On 6/27/25 at 0930 hours, a telephone interview was conducted with RN 1. RN 1 acknowledged he failed to inform the Administrator immediately after the allegation of abuse was reported. RN 1 further stated the alleged staff should also be suspended pending the investigation to ensure the safety of Resident 1 and other residents in the facility.</p> <p>On 6/27/25 at 1430 hours, an interview was conducted with the Administrator. The Administrator acknowledged the findings.</p>