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	09/03/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the failed to provide the reasonable accommodations to meet the care needs for two of 13 sampled residents (Residents 2 and 3). * The facility failed to ensure Residents 2 and 3's call lights were answered in a timely manner. This failure had the potential to negatively impact the resident's psychosocial well-being or result in a delay to provide care and services to the residents.Findings: Review of facility's P&P titled Communication-Call System dated 1/1/2012, showed the facility will provide a call system to enable residents to alert the nursing staff from their rooms. The nursing staff will answer the call bells promptly, in a courteous manner. In answering to request, the nursing staff will return to resident with the item or reply promptly. a. On 8/28/25 at 0925 hours, during the initial tour of the facility, an observation and concurrent interview for Resident 3 was conducted with CNA 1. Resident 3's call light was turned on from hallway and there was an audible beeping sound on the call light panel at the nurses station. There were two facility staff in the hallway who passed by Resident 3's room without answering the call light. Resident 3 started screaming and was heard in the hallway. No facility staff answered the call light to assist Resident 3. On 8/28/25 at 0945 hours, 20 minutes after Resident 3's call light was on, CNA 1 answered Resident 3's call light. In a concurrent interview, CNA 1 stated Resident 3 needed to be changed. CNA 1 stated she needed to answer the call light right away and if she could not answer the call light, she would ask other staff to answer the call light. Medical record review for Resident 3 was initiated on 8/28/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had severe cognitive impairment and needed substantial to maximum assistance for ADL care from the staff. b. On 8/28/25 at 1025 hours, an observation and concurrent interview for Resident 2 was conducted with CNA 1. Resident 2's call light was turned on from hallway and there was an audible beeping sound on the call light panel at the nurses station. LVNs 2 and 3 were sitting at the nurses station. RNA 1 passed by Resident 2's room without answering the resident's call light. No facility staff answered the call light to provide assistance to Resident 2. On 8/28/25 at 1045 hours, 20 minutes after Resident 2's call light was on, CNA 1 answered Resident 2's call light. In a concurrent interview, CNA 1 stated Resident 2 wanted the lunch tray removed from her room. On 8/28/25 at 1050 hours, an interview was conducted with LVNs 2 and 3, and RNA 1. LVN 2 verified she heard the beeping sound of the call light for Resident 2. LVN 2 stated they needed to answer the call light right away when it was turned on. LVN 2 verified she did not answer the call light of Resident 2 right away. LVN 3 verified he heard the beeping sound of the call light for Resident 2. LVN 3 verified he did not answer the call light of Resident 2 right away. RNA 1 verified the call light of Resident 2 was turned on when he passed by the room and acknowledged he did not answer the call light of Resident 2 right away. RNA 1 stated the call light of Resident 2 should have been answered right away. On 9/3/25 at 1655 hours, an interview was conducted with the Administrator and DON was conducted. The Administrator and the DON were informed and verified the findings.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview, medical record review, and facility P&P review, the facility failed to maintain an accurate and complete medical record for two of 13 sampled residents (Residents 12 and 13). * The facility failed to ensure the licensed nurses documented their initials on Residents 12 and 13's TARs (indicating the treatments were provided) as per the facility's P&P. This failure had the potential for the residents' care needs not being met as their medical record information was inaccurate and/or incomplete.Findings: Review of the facility's P&P titled Completion and Correction revised 1/1/2012, showed the facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. The facility will ensure the medical records are complete and accurate. Entries will be recorded promptly as the event occurs. 1. Medical record review for Resident 12 was initiated 8/29/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed a physician's order dated 5/20/25, to cleanse Resident 12's sacrum fragile scar tissue with soap and water, pat dry, then apply zinc oxide (skin barrier cream), every shift for skin maintenance. Review of Resident 12's TAR (Treatment Administration Record) for 7/2025 failed to show documentation the licensed nurse performed Resident 12's treatment on 7/7, 7/18, 7/19, and 7/28/25, on the evening shift. The licensed nurse failed to document their initials on the TAR for the cleansing of Resident 12's sacrum and the application of her barrier cream. 2. Medical record review for Resident 13 was initiated on 8/29/25. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed an order dated 7/12/25, to cleanse Resident 13's MASD (sacrococcyx and right left buttocks) with normal saline, pat dry, then apply moisture barrier cream every shift. Review of Resident 13's TAR for 7/2025 failed to show documentation the licensed nurse performed Resident 13's treatment on 7/18/25 and 7/19/25, on the evening shift. The licensed nurse failed to document their initials on the TAR for the cleansing of Resident's 13 MASD (sacrococcyx and right left buttocks) and the application of her barrier cream. On 9/2/25 at 1550 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the findings and stated after a licensed nurse provided resident treatment, the licensed nurse would then document the treatment provided in the resident's medical record (TAR). The DON stated she would contact the nurses who failed to document Resident 12 and 13's treatments were provided and determine whether the nurses failed to provide the treatments or had provided the residents' treatments, however, forgot to document in the residents' medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 the infection control practices were observed. * LVN 1 failed to follow the EBP infection control practices while performing the wound care for Resident 1. * LVN 2 failed to follow the infection control practices on wearing PPE in the hallway. These failures posed the risk for transmission of disease-causing microorganisms and infections. Findings: Review of the facility's P&P titled Enhanced Barrier Precaution dated 5/28/24, showed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. EBP are indicated for residents with any of the following: wounds (e. g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers). In addition, to facilitate compliance with EBP, gowns and gloves are to be donned before each high contact task, not prior to entering the room. Health care personnel should not routinely wear gowns and gloves in the hallway. Review of the facility's Enhanced Standard Precaution signage showed everyone must perform hand hygiene before entering the room. Anyone participating in any of these six moments must also don gown and gloves for morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, cleaning and disinfecting the environment, and mobility assistance and preparing to leave room. a. On 8/28/25 at 0900 hours, during the initial tour of the facility, an observation and concurrent interview for Resident 1 was conducted with LVN 1. An EBP signage was observed outside of Resident 1's room. There was a small drawer on Resident 1's door which contained gloves, gowns, and a bottle of alcohol-free wipes. LVN 1 was observed providing wound care to Resident 1 in bed without wearing the gown. LVN 1 verified Resident 1 was on EBP for wound. LVN 1 verified he was not wearing a gown while providing wound care to Resident 1. Medical record review for Resident 1 was initiated on 8/28/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 6/17/25, for low air loss mattress for wound management re-opened right buttock pressure injury stage four every shift for wound management. b. On 8/28/25 at 0930 hours, an observation and concurrent interview for Resident 2 was conducted with LVN 2. Resident 2's room was closed and had a sign for COVID-19 isolation. There was a small drawer on Resident 2's door which contained gloves, gowns, and a bottle of alcohol-free wipes. LVN 2 was observed preparing medication from the medication cart in front of Resident 2's room. LVN 2 donned PPE and went to the medication room in the hallway wearing PPE. LVN 2 stated she did not enter Resident 2's room because she needed medication inside the medication room. On 8/28/25 at 1520 hours, an interview was conducted with the IP. The IP was informed of the observation and verified the findings. IP stated LVN 1 should have been wearing a gown while providing wound care to Resident 1 and LVN 2 should not be wearing any PPE when in the hallway. On 8/28/25 at 1630 hours, an interview was conducted with the Administrator. The Administrator was informed and verified the findings.