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	04/08/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **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 implement their policy to provide medical records for one of three sampled residents (Resident 1). * Resident 1 did not receive the requested medical records timely. This failure resulted in the violation of Resident 1's right to access his medical records. Findings: Review of the facility's P&P titled Resident Access to Protected Health Information (PHI) revised 11/1/15, showed the following:- if the resident and/or their personal representative requests a copy of the resident's medical record, the HIPAA Privacy Officer will provide the resident and/or their personal representative with a copy of the medical record within two working days after receiving the written request. Medical record review for Resident 1 was initiated on 4/8/26. Resident 1 was admitted to the facility on [DATE]. Review of the facility's document titled Request for Access to Protected Health Information (PHI) dated 1/29/26, showed Resident 1 requested for the whole chart and signed by Resident 1 for the second request. Review of the facility's document titled Resident Records Request Intake form dated 1/29/26, under Potential Issues Noted in Request/Chart for Legal showed the box for family raised concerns was checked. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's Brief Interview for Mental Status (BIMS) score was 13, which meant the resident had intact cognition. Review of the facility's document from the MRD's printed email sent from the corporate legal team HIS (Health Information Specialist) dated 3/31/26 at 1702 hours, showed Resident 1's medical record request was approved for release. On 4/8/26 at 0826 hours, an interview was conducted with Resident 1. Resident 1 stated he had signed several request forms to have access and copy his entire medical record since 1/2026 and submitted them to the MRD. In addition, Resident 1 stated it had been several months since he had requested a copy of his entire medical record from the MRD and still he had not received the requested copy. Furthermore, Resident 1 stated they were his medical record and Resident 1 and the complainant had the rights to access and copy all his medical and billing records. On 4/8/26 at 1118 hours, an interview and facility document review was conducted with the MRD. The MRD verified Resident 1 requested for the whole chart on 1/29/26, as a second request, as shown on the form titled Resident Request for Access to Protected Health Information. The MRD verified the above findings. In addition, the MRD stated the facility's policy was to provide access or requested medical records within 48 to 72 business hours. The MRD stated until now Resident 1 and the complainant have not received the copy of Resident 1's entire medical record as requested on 1/29/26. On 4/8/26 at 1352 hours, an interview and facility document review was conducted with the MRD. The MRD verified the form titled Resident Records Request Intake form dated 1/29/26, under the section Potential Issues Noted in Request/Chart for Legal Review, showed the resident's family raised concerns was checked. The printed document from the MRD's email from the corporate legal team HIS dated 3/31/26 at 1702 hours, was also reviewed with the MRD. The MRD verified the email showed Resident 1's request for records was approved for release. The MRD stated after he received Resident 1's request for the copy of the entire medical record on 1/29/26, he sent the request for review to the corporate legal team; then the corporate legal team would review the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested medical records. However, there was no timeframe for how long it would take to receive release of approval of requested medical records. The MRD stated he received the approval to release Resident 1's requested medical record on 3/31/26, via email from the corporate legal team HIS, however; he did not provide the requested medical record to Resident 1. On 4/8/26 at 1615 hours, an interview and facility document review was conducted with the DON. Resident 1's request form titled Resident Request for Access to Protected Health Information requesting for the whole chart was reviewed with the DON. The DON verified Resident 1's request. The DON stated the facility cannot deny the residents' rights to access their medical record. In addition, the DON stated the negative outcome if facility was denying or delaying access to the resident's medical record would be the residents and family members would be suspicious of the facility could be hiding something from them. Furthermore, the DON acknowledged it was not until the nurse surveyor came into the facility for investigation when the MRD provided the requested medical record for Resident 1. On 4/8/26 at 1655 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. On 4/15/26 at 1259 hours, a telephone interview was conducted with Resident 1's family member. The family member stated Resident 1 and her were not informed by facility for the required fees in requesting a copy of Resident 1's entire medical records. In addition, Resident 1's family member stated Resident 1 and her did not sign any forms showing they declined to pay the required fees for the copy of the requested medical records. On 4/15/26 at 1456 hours, a telephone interview was conducted with the Administrator. The Administrator stated she informed Resident 1 and the resident's family member verbally regarding the required fees in requesting a copy of the medical records prior to providing them. Furthermore, the Administrator stated there was no documentation of Resident 1 or Resident 1's family member declining to pay the required fees for the requested copy of the entire medical records.