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	09/12/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, and medical record review, the facility failed to ensure care was provided in a manner which promoted dignity and respect for one of four sampled residents (Resident 76) reviewed for the use of indwelling urinary catheter (flexible tube used to empty the bladder and collect urine in a drainage bag). The facility failed to ensure Resident 76's urinary catheter collection bag was inside the privacy bag. This failure had the potential to negatively impact Resident 76's emotional well-being. Findings: On 9/9/24 at 0849 hours, during the initial tour of the facility, Resident 76 was observed lying in bed with an indwelling urinary catheter draining yellow urine into a urine collection bag. The urine collection bag was observed hanging on the right side of Resident 76's bed, not inside the privacy bag. On 9/9/24 at 0853 hours, an interview and concurrent observation was conducted with CNA 2. CNA 2 verified the above finding. CNA 2 stated the urine collection bag should be inside the privacy bag for the resident's privacy. CNA 2 was then observed donning gloves and placing the urine collection bag inside the privacy bag. Medical record review for Resident 76 was initiated on 9/9/24. Resident 76 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 76's H&P examination dated 11/28/23, showed Resident 76 was able to make some of his needs known, but he was not able to make his own decisions. Review of Resident 76's Order Summary for September 2024 showed a physician's order dated 7/18/24, for the placement of a 16 Fr indwelling/suprapubic catheter (a tube used to drain urine from the bladder through a small incision in the lower abdomen) with balloon via gravity drainage for benign prostatic hyperplasia (a noncancerous condition that occurs when the prostate gland enlarges). On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated for all the residents with the indwelling urinary catheters, she expected all the catheter collection bags to be inside the privacy bag to provide the residents with dignity. The DON was informed and acknowledged the above findings.

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

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	09/12/2024

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 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** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the call light was within reach for three of 19 final sampled residents (Residents 16, 38, and 76) and two nonsampled residents (Residents 39 and 61). This failure had the potential to negatively impact the residents' psychosocial well-being or result in a delay to provide care and services to the residents. Findings: Review of the facility's P&P titled Communication-Call System revised 1/1/12 showed the facility will provide a call system to enable the residents to alert the nursing staff from their rooms and toileting/bathing facilities. Call cords will be placed within the resident's reach in the resident's room. 1. Medical record review for Resident 16 was initiated on 9/9/24. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. On 9/9/24 at 0800 hours, Resident 16 was observed with the call light clipped on edge of the head of the bed. When asked if she could reach the call light to ask for staff assistance, Resident 16 stated she could not reach it. 2. Medical record review for Resident 38 was initiated on 9/9/24. Resident 38 was admitted to the facility on [DATE], and readmitted on [DATE]. On 9/9/24 at 0820 hours, Resident 38 was observed with the call light placed underneath the pillow. When asked if he could reach call light to ask for staff assistance, Resident 38 state he could not reach it. On 9/9/24 at 0925 hours, an observation and concurrent interview was conducted with LVN 7 for Residents 16 and 38. Resident 16 was observed with the call light clipped on the head of the bed and out of Resident 16's reach. Resident 38 was observed with the call light underrneath the pillow. LVN 7 verified the findings. 48882 3. On 9/9/24 at 0849 hours, during the initial tour of the facility, Resident 76 was observed lying in bed. Resident 76's call light was observed on top of the bedside drawer, to the left side of Resident 76's bed. Medical record review for Resident 76 was initiated on 9/9/24. Resident 76 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 76's H&P examination dated 11/28/23, showed Resident 76 was able to make some of his needs known, but he was not able to make his own decisions. (continued on next page)

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	09/12/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 79's MDS dated [DATE], showed Resident 76 required dependent assistance for bed mobility, which included rolling from left to right, sit to lying, and lying to sitting on the side of the bed. On 9/9/24 at 0853 hours, an interview and concurrent observation was conducted with CNA 2. CNA 2 verified Resident 76's call light was on top of the bedside drawer. CNA 2 stated the call light should be within the resident's reach. CNA 2 was observed placing Resident 76's call light within the resident's reach. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated she expected the call lights to be placed within the residents' reach. The DON was informed and acknowledged the above findings. 39670 4. On 9/10/24 at 0845 hours, Resident 39 was observed awake and in bed. Resident 39's call light button was observed on the top of the bedside drawer. The call light button was not within Resident 39's reach. When Resident 39 asked about his call light button, he was made aware the call light button was on the top of the bedside drawer and he was not able to reach it. On 9/10/24 at 0847 hours, MDS Coordinator 3 was summoned inside Resident 39's room. MDS Coordinator 3 verified the call light button for Resident 39 was placed on top of the bedside drawer. MDS Coordinator 3 stated the call light button should have been placed near the resident so he could call the staff when he needed assistance. 5. On 9/9/24 at 0808 hours and 9/10/24 at 0853 hours, Resident 61 was observed awake and in bed. Resident 61's call light cord was clipped to the wire cord on the wall at the head of the bed with the call light button hanging. The call light button was not within Resident 61's reach . On 9/10/24 at 1331 hours, an observation and concurrent interview was conducted with CNA 5. CNA 5 verified the call light button was not within Resident 61's reach. On 9/12/24 at 1417 hours, an interview for Resident 39 and 61 was conducted with the DON. The DON was informed and acknowledged the above findings.

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	09/12/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to provide the written information regarding the advance directives (legal document of a person's wishes regarding medical care when the person is no longer able to make medical decisions), and obtain and/or maintain copies of the advance directives in the medical records for five of 19 final sampled residents (Residents 17, 45, 76, 351, and 601). These failures had the potential for the residents' decisions regarding their healthcare and treatment not being honored. Findings: Review of the facility's P&P titled Advance Directive revised 7/25/24, showed upon admission, the admissions staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. During the Social Service Assessment process, the Director of Social Services or designee will also ask the resident if they have a written advance directive. If the resident has an advance directive, the facility shall request a copy of the document from the resident or resident's representative. If the resident does not have an advance directive and additional information was requested, the SSD or designee may provide the resident with a copy of the advance directive form for their review. 1. Medical record review for Resident 17 was initiated on 9/9/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Social Services assessment dated [DATE], under the Advance Directive section, showed Resident 17 had an advance directive and a copy from the resident/resident representative was requested. Review of Resident 17's medical record failed to show a copy of Resident 17's advance directive. Review of Resident 17's Progress Notes failed to show documentation the facility had followed up to obtain a copy of Resident 17's advance directive. On 9/11/24 at 1215 hours, an interview was conducted with the SSD. The SSD stated upon admission the resident/resident representatives were asked if the resident had an advance health care directive in place. If the resident did, the facility would request for a copy to keep in the resident's medical records. On 9/11/24 at 1600 hours, a follow-up interview and concurrent record review for Resident 17 was conducted with the SSD. The SSD verified the above findings. The SSD reviewed the Social Service Notes and stated there was no documentation to show the facility had followed up to obtain Resident 17's advance directive. The SSD further stated the facility did not have a system and should establish a system to notify the facility of the residents who required a follow-up to obtain their advance directive. (continued on next page)

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	09/12/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated upon admission, if the resident had an advance directive, the facility would request a copy and the Social Services department would be responsible to follow-up to obtain the copy. The DON further stated the Social Services department should continue to follow up and document their attempts until they were able to obtain the residents' advance directive. When asked about the importance of obtaining the residents' advance directive, the DON stated the advance directive was the wishes of the residents and the facility should ensure the residents' wishes were honored. The DON was informed of and acknowledged the above findings. 2. Medical record review for Resident 76 was initiated on 9/9/24. Resident 76 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 76's H&P examination dated 11/28/23, showed Resident 76 was able to make some of his needs known, but he was not able to make his own decisions. Review of Resident 76's Social Services Assessments dated 12/6/23 and 7/24/24, under the section for Advance Directive, showed none of the options was selected. Review of Resident 76's medical record failed to show documentation Resident 76 or his representative was offered literature on how to formulate an advance directive. On 9/11/24 at 1215 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated upon admission, the residents/resident representatives were asked if the resident had an advance directive in place. If the resident did not have an advance directive and had no capacity to make decisions but wished to formulate an advance directive, the facility would still provide information about advance directions and how to formulate one. The SSD further stated each resident should have an Advance Health Care Directive (AHCD) Acknowledgement form in their medical record to indicate the resident received information regarding advance directives. The SSD verified the above findings. The SSD reviewed Resident 76's medical record and verified Resident 76 did not have an AHCD Acknowledgement form in his medical record. On 9/11/24 1559 hours, a follow-up interview and concurrent medical record review for Resident 76 was conducted with the SSD. The SSD stated there was no documentation in the resident's medical record to show the facility had followed up regarding whether Resident 76 had an advance directive or wanted additional information to be provided. On 9/12/24 at 1421 hours, and interview was conducted with the DON. The DON was informed and acknowledged the above findings. 43119 3. Medical record review for Resident 45 was initiated on 9/9/24. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 45's H&P examination dated 6/13/24, showed Resident 45 had the capacity to understand and make decisions. Review of Resident 45's Quarterly MDS dated [DATE], showed Resident 45 was cognitively intact. (continued on next page)

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	09/12/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 45's Physician Orders for Life Sustaining Treatment (POLST) dated 2/14/22, showed under Section D, Resident 45 had no advance directive. However, review of Resident 45's Advance Directive Acknowledgment form, (undated), showed Resident 45 had no advance directive and would like more information. Review of the Social Services progress notes from 12/21 to 7/24, failed to show documented evidence when Resident 45 was offered information on how to formulate an advance directive. On 9/11/24 at 1224 hours, an interview and concurrent medical record review was conducted the SSD. The SSD verified the Advance Directive Acknowledgment form was undated and stated it should have been dated to verify when the information on how to formulate an advance directive was offered to Resident 45. On 9/11/24 at 1240 hours, a follow-up interview and concurrent medical record review was conducted with the SSD. The SSD verified there was no documentation to show when Resident 45 was offered information on how to formulate an advance directive. 47476 4. Medical record review for Resident 601 was initiated on 9/9/24. Resident 601 was readmitted to the facility on [DATE]. Review of Resident 601's Advance Healthcare Directive (AHCD) Acknowledgement Form dated 1/31/22, showed Resident 601 had an AHCD in place and a copy was requested by the facility. Review of Resident 601's medical record failed to show a copy of the AHCD was maintained in the resident's medical record. On 9/11/24 at 1214 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated she was responsible for completing the Advance Healthcare Directive Acknowledgement Forms and if the resident had an AHCD in place, she would request for a copy to keep in their medical record. On 9/11/24 at 1601 hours, a follow-up interview was conducted with the SSD. The SSD verified Resident 601 did not have a AHCD maintained in her medical record and there was no follow up to obtain a copy of Resident 601's AHCD. 39670 5. Medical record review for Resident 351 was initiated on 9/9/24. Resident 351 was admitted to the facility on [DATE]. Review of Resident 351's MDS dated [DATE], showed Resident 351 had severe cognitive impairment. Review of Resident 351's POLST form prepared on 8/24/24, under Section D, failed to show if Resident 351 had or did not have an advance directive. (continued on next page)

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	09/12/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further medical record review for Resident 351 failed to show documented evidence the formulation of an advance directive was offered to Resident 351's representative. On 9/11/24 at 1215 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified the above finding and stated there should have been documented evidence the advance directive information was offered and if the resident representative accepted or denied the formulation of an advance directive. On 9/12/24 at 1417 hours, an interview and concurrent medical record review for Resident 351 was conducted with the DON. The DON was informed and verified the above findings.

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	09/12/2024

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 0661 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the reconciliation of medications was thoroughly performed and documented in the medical record upon discharge for one of two closed records reviewed (Resident 99). This failure posed the risk for not identifying discrepancies or differences in Resident 99's pre-discharge and post-discharge medication orders, which had the potential to negatively affect Resident 99's well-being. Findings: Review of the facility's P&P titled Discharge and Transfer of Residents revised 2/2018 showed the following: - The discharge summary/post discharge plan of care will contain a summary of the resident's status, including a description of the resident's: Drug therapy, licensed nurse's discussion with the resident/resident representative regarding his/her pre-SNF placement medications, and reconciliation to post discharge medication regimen. - The discharge summary/post discharge plan will include documentation from the IDT regarding transfers or discharges, and the following information: Medications, including all prescription and over-the-counter medications to be taken by the resident with information on dosage, frequency of administration, and recognition of common significant side-effects. Closed medical record review for Resident 99 was initiated on 9/10/24. Resident 99 was admitted to the facility on [DATE], and discharged home on 6/14/24. Review of Resident 99's Order Summary Report dated 9/11/24, showed the physician's orders for medications that Resident 99 was receiving in the facility. The physician's orders included medications such as apixaban (blood thinner), atorvastatin (medication to lower cholesterol), furosemide (medication to decrease fluid retention), insulin, and several medications to lower blood pressure. Review of Resident 99's medical record failed to show documented evidence a medication reconciliation had been completed upon Resident 99's discharge on 6/14/24. On 9/11/24 at 1143 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator 2. The MDS Coordinator 2 was informed and verified the above findings. The MDS Coordinator 2 verified the discharge nurse would complete and document the medication reconciliation.

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	09/12/2024

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for two of two residents reviewed for IV access (Residents 89 and 600). * The facility failed to ensure the PICC line external catheter measurements were performed and documented in the medical record upon admission for Resident 600. * The facility failed to ensure the IV antibiotic medication was properly labeled for Resident 89. These failures had the potential to delay the identification of catheter related complications for the residents. Findings: Review of the facility's P&P titled PICC Dressing Change dated 3/2023 showed in part, the length of the external catheter is obtained upon admission, during dressing changes, if signs or symptoms of complications are present. Documentation in the medical record includes but is not limited to date and time, site assessment, length of external catheter . 1. Medical record review for Resident 600 was initiated on 9/9/24. Resident 600 was admitted to the facility on [DATE]. Review of Resident 600's Order Summary Report dated 9/11/24, showed the following physician's orders: - dated 9/11/24, for TPN at 150 ml/hr for 12 hours via PICC line. - dated 8/21/24, to measure the arm circumference and external lumen catheter weekly every day shift, every seven days. Further review of Resident 600's medical record failed to show documented evidence the measurement of the external catheter length for Resident 600's PICC line was obtained upon admission. On 9/12/24 at 1018 hours, an interview and concurrent record review was conducted with RN 2. RN 2 verified he was responsible for the IV maintenance in the facility. RN 2 was informed and verified Resident 600's medical record did not show the PICC line external catheter measurement was obtained upon admission. 39670 2. Review of the facility's P&P titled Administration of an Intermittent Infusion dated 3/23 showed the RN should label the IV container and administration set with date, time and nurses initials when administering IV medications to the residents with an IV medication physician's order. (continued on next page)

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	09/12/2024

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour of the facility on 9/9/24 at 0809 hours, Resident 89 was observed in bed awake, receiving IV antibiotic medication at a rate of 150 ml/hr via a rotary dial regulator. However, Resident 89's IV medication bag was unlabeled and undated. On 9/9/24 at 0907 hours, an observation and concurrent interview for Resident 89 was conducted with RN 2. RN 2 was summoned to Resident 89's bedside and asked about the IV antibiotic medication for the resident. RN 2 verified Resident 89 was receiving an IV antibiotic medication. RN 2 verified the IV antibiotic medication bag was undated and unlabeled. RN 2 stated he forgot to place the label on the IV medication bag. Medical record review for Resident 89 was initiated on 9/10/24. Resident 89 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 89's Order Summary Report dated 9/11/24, showed a physician's order dated 8/8/24, to administer cefoxitin sodium (antibiotic medication) intravenously 2 gm three times a day for discitis of the lumbosacral region (infection of the spine). On 9/12/24 at 1417 hours, an interview and concurrent medical record review for Resident 89 was conducted with the DON. The DON was informed and verified the above findings.

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	09/12/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 19 final sampled residents (Residents 58, and 351) and three nonsampled residents (Resident 69, 75, and 352) were provided with the appropriate respiratory care when: * The facility failed to ensure Resident 58's oxygen nasal cannula (flexible tube to deliver oxygen into the nose) tubing was dated as per the facility's P&P and stored in a set up bag when not in use. * The facility failed to ensure Resident 351's nebulizer mask and tubing were stored in a set up bag when not in use. In addition, the facility failed to formulate a plan of care for the use of the nebulizer therapy. * The facility failed to ensure Resident 352's oxygen tubing was not touching the floor. * The facility failed to ensure Resident 75's nebulizer mask and tubing were stored in a set up bag when not in use * The facility failed to ensure Resident 69's CPAP mask was stored in a set up bag when not in use. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Therapy revised November 2017 showed the facility to ensure a safe storage and administration of oxygen to the residents with a physician's order. It is the facility's protocol to administer oxygen under safe and sanitary conditions to meet the residents need. In addition, the oxygen tubing, mask, and cannulas will be changed every seven days and as needed, the supplies will be dated each time they are changed. 1. During the initial tour of the facility on 9/9/24 at 0906 hours, Resident 58 was observed receiving oxygen therapy at 2 liters per minute via nasal cannula attached to an oxygen machine. A portable oxygen tank at the back of Resident 58's wheelchair with an oxygen nasal cannula tubing attached was observed undated, unlabeled, and not placed inside a set up bag. On 9/10/24 at 1355 hours, Resident 58 was not in his room. However, the oxygen machine was turned on and the oxygen tubing nasal cannula was observed on top of Resident 58's bed . Medical record review for Resident 58 was initiated on 9/10/24. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's Order Summary Report dated 9/11/24, showed a physician's order dated 1/13/24, to administer oxygen at 2 liters per minute via nasal cannula to keep the oxygen saturation level above 92% every shift. (continued on next page)

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	09/12/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 1356 hours, an observation and concurrent interview for Resident 58 was conducted with LVN 1. LVN 1 verified Resident 58's use of oxygen therapy. LVN 1 verified Resident 58's nasal cannula tubing was unlabeled, undated, and not placed inside a set up bag when not in use. 2. On 9/9/24 at 1010 hours and 9/10/24 at 0810 hours, Resident 351 was observed in bed receiving oxygen therapy at 2 liters per minute via nasal cannula attached to an oxygen machine. Resident 351's nebulizer machine was observed on top of the bedside drawer and with the nebulizer mask placed on top of the machine. On 9/10/24 at 1351 hours, an observation and concurrent interview with LVN 1. LVN 1 verified Resident 351's use of the nebulizer machine as needed for shortness of breath. LVN 1 stated after the administration of the breathing treatment via the nebulizer machine, the mask and tubing were placed in a set up bag at the bedside of the resident. LVN 1 verified the findings and stated the nebulizer mask and tubing should have been placed inside a set up bag. Medical record review for Resident 351 was initiated on 9/10/24. Resident 351 was admitted to the facility on [DATE]. Review of Resident 351's Order Summary Report dated 9/11/24, showed a physician's order dated 9/5/24, to administer ipratropium-albuterol (bronchodilator -opening the airways in the lungs medication) inhalation solution 0.5-2.5 (3) mg/3 ml orally every four hours as needed for shortness of breath/wheezing for 30 days. Review of Resident 351's plan of care failed to show documented evidence a care plan problem was developed to address Resident 351's use of the breathing treatment medication via nebulizer machine. On 9/11/24 at 1459 hours, an interview and concurrent medical record review for Resident 351 was conducted with LVN 1. LVN 1 stated the charge nurses and the RNs were responsible in formulating a plan of care on each resident condition. LVN 1 verified Resident 351's use of nebulizer machine for breathing treatment. LVN 1 verified there was no plan of care for the use of the breathing treatment for shortness of breath/coughing. 3. On 9/10/24 at 1322 hours, an observation and concurrent interview for Resident 352 was conducted with RN 2 at the bedside. Resident 352's oxygen tubing was observed on the floor. RN 2 verified Resident 352's use of oxygen therapy. RN 2 was observed removing the nasal cannula tubing and replaced it with a new oxygen tubing. Medical record review for Resident 352 was initiated on 9/11/24. Resident 352 was admitted to the facility on [DATE]. Review of Resident 352's Order Summary Report dated 9/11/24, showed a physician's order dated 9/7/24, to administer oxygen at 2 liters per minute via nasal cannula to keep the oxygen saturation level above 95% every shift for shortness of breath. On 9/12/24 at 1417 hours, an interview and concurrent medical record review for Residents 58, 351, and 352 was conducted with the DON. The DON stated she expected the residents' oxygen tubing, nebulizer masks and tubing to be labeled and placed inside a set up bag when not in use. The DON was informed and verified the above findings. (continued on next page)

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	09/12/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47476 4. On 9/9/24 at 1617 hours, and 9/10/24 at 1430 hours, Resident 75 was observed lying in bed. Resident 75's nebulizer mask and tubing were observed undated and placed on top of the nebulizer machine on her bedside table. Medical record review for Resident 75 was initiated on 9/9/24. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's Order Summary Report dated 9/10/24, failed to show the physician's orders for medications which required the use of a nebulizer. On 9/10/24 at 1439 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 75's nebulizer mask and tubing should have been labeled and stored inside a plastic bag. 32179 5. Medical record review for Resident 69 was initiated on 9/9/24. Resident 69 was admitted to the facility on [DATE], and readmitted on [DATE]. On 9/9/24 at 0845 hours, Resident 69 was observed lying in bed. Resident 69's CPAP (continuous positive airway pressure- machine used to provide air to gently keep the airway open during sleep) inner mask was observed touching the bedside table and the tubing was undated. On 9/9/24 at 1240 hours, MDS Coordinator 1 was summoned to the room. Resident 69's CPAP inner mask was observed touching the bedside table and the tubing was undated. MDS Coordinator 1 verified the finding. On 9/9/24 at 1400 hours, an interview was conducted with the Director of Central Supply. The Director of Central Supply stated the CPAP tubing and mask were replaced every Wednesday and the CPAP tubing should be dated. The Director of Central Supply stated the CPAP mask should be placed inside a plastic bag.

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	09/12/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to offer or provide adequate and appropriate pain management for one of one resident reviewed for pain management (Resident 600). The facility failed to ensure Resident 600 was monitored for side effects related to the use of the narcotic pain medication. Additionally, the facility failed to consistently provide non-pharmacological interventions for pain prior to the administration of a narcotic pain medication to Resident 600. These failures had the potential for not effectively managing the resident's pain. Findings: Review of the facility's P&P titled Pain Management revised 11/2016 showed the facility staff will help the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain to the extent possible. The nursing staff will also utilize non-pharmacological interventions to address possible issues contributing to pain. Residents receiving medications for pain management will be monitored for side effects of the medication ordered. 1. Medical record review for Resident 600 was initiated on 9/9/24. Resident 600 was admitted to the facility on [DATE]. Review of Resident 600's H&P examination dated 8/22/24, showed Resident 600 had the capacity to understand and make decisions. Review of Resident 600's Order Summary Report dated 9/11/24, showed the following physician's orders: - dated 8/21/24, for Norco (a narcotic medication) 5-325 mg one tablet by mouth every four hours as needed for moderate pain. - dated 8/21/24, for Norco 5-325 mg two tablets by mouth every four hours as needed for severe pain. Further review of Resident 600's physician's orders failed to show an active order for non-pharmacological interventions nor a physician's order to monitor for the side effects of the Norco medication. Review of Resident 600's MAR for September 2024 showed Resident 600 had received the Norco medication on 9/2, 9/6, 9/7, and 9/10/24. The MAR showed non-pharmacological interventions were being implemented only until 9/3/24. (continued on next page)

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	09/12/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 1018 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 600 was receiving Norco medication for pain management. RN 2 stated non-pharmacological interventions should be given as long as the resident was receiving the narcotic medication. RN 2 verified the non-pharmacological interventions were stopped on 9/3/24, and stated when the facility did a reassessment of the pain management after 14 days, the non-pharmacological interventions were not reinstated. RN 2 verified there was no side effect monitoring ordered by the physician or completed for the Norco medication.

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	09/12/2024

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, medical record review, and facility P&P review, the facility failed to complete the assessments, attempt the least restrictive alternative measures, obtain the physician's orders and informed consents, and initiate care plans for the use of side rails for five of six sampled residents reviewed for side rail use (Residents 45, 47, 64, 78, and 601). This failure had the potential to put the residents at risk for serious injuries. Findings: Review of the facility's P&P titled Bed Rails revised 5/2024 showed the facility will use bed rails as mobility enablers. Prior to the use of a bed rail, staff will attempt the use of appropriate alternatives. If the alternatives were not adequate to meet the resident's needs, the resident will be evaluated for the use of bed rails. Prior to the installation of bed rails, alternatives will be attempted. An evaluation of the tried alternatives and how they failed to meet the Resident's needs will be documented in the medical record. Prior to the installation of bed rails, the ordering physician will obtain informed consent from the resident or their representative. The licensed nurse will initiate a care plan around the use of bed rails. 1. On 9/9/24 at 1054 hours, and 9/11/24 at 0831 hours, Resident 64's bed was observed to have bilateral grab bars. Medical record review for Resident 64 was initiated on 9/9/24. Resident 64 was readmitted to the facility on [DATE]. Review of Resident 64's H&P examination dated 7/9/24, showed Resident 64 had the capacity to understand and make decisions. Review of Resident 64's Order Summary Report failed to show a physician's order for the use of bilateral bed grab bars. Review of Resident 64's Comprehensive Care Plan failed to show a care plan problem was developed addressing the use of bilateral bed grab bars. Review of Resident 64's Bed Rail assessment dated [DATE] and 7/9/24, showed there were no side rail or assist bars indicated at this time for Resident 64. Further medical record review for Resident 64 failed to show documented evidence the least alternative measures were attempted; physician's order was obtained; informed consent was obtained; and assessment was completed prior to the use of the bilateral bed grab bars. (continued on next page)

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	09/12/2024

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 0913 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 64 used the bilateral bed grab bars for repositioning and turning. LVN 1 stated prior to using the grab bars, an assessment would be completed, and the rehabilitative staff would make a recommendation for the need of grab bars. LVN 1 stated for the use of grab bars, they needed a physician's order, informed consent, and care plan. LVN 1 was informed of and verified the above findings. On 9/11/24 at 0934 hours, an interview and concurrent medical record review was conducted with MDS Coordinator 2. MDS Coordinator 2 stated Resident 64 needed partial assistance for his mobility. MDS Coordinator 2 was informed and verified the above findings. On 9/12/24 at 1710 hours, the DON and Administrator were informed and acknowledged the above findings. Cross reference to F700, example #1. 48844 2. On 9/12/24 at 0902 hours, Resident 45 was observed in bed with bilateral grab bars elevated. Medical record review for Resident 45 was initiated 9/12/24. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's H&P examination dated 6/13/24, showed Resident 45 had the capacity to understand and make decisions. Review of Resident 45's Order Summary Report dated 9/12/24, showed a physician's order dated 6/14/24, for bilateral grab bars for bed mobility and repositioning. Review of Resident 45's Bed Rail assessment dated [DATE], showed the side rails/assist bar were indicated and served as an enabler to promote independence. Resident 45 had expressed a desire to have side rails/assist bar. Review of Resident 45's Care Plan revised 8/13/24, showed a care plan problem adressing the requested grab bars. The interventions included the bilateral grab bars for bed mobility assistance. Further medical record review for Resident 45 failed to show an informed consent was obtained from the resident and/or representative prior to the use of grab bars. On 9/12/24 at 0910 hours, an interview was conducted with LVN 3. LVN 3 stated Resident 45 used the grab bars to hold on to during the diaper changes. On 9/12/24 at 1349 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified there was no informed consent for the use of bilateral grab bars. Cross reference to F700, example #2. 3. On 9/12/24 at 0921 hours, Resident 47 was observed in bed with bilateral grab bars elevated. (continued on next page)

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	09/12/2024

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 47 was initiated on 9/12/24. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination dated 6/13/24, showed Resident 47 had the capacity to understand and make decisions. Review of Resident 47's Order Summary Report dated 9/12/24, showed a physician's order dated 7/16/24, for bilateral grab bars to aid in bed mobility and repositioning. Review of Resident 47's Bed Rail assessment dated [DATE], showed Resident 47 did not express a desire to have side rails/assist bar for safety and/or comfort and the side rails/assist bar were not indicated. Review of Resident 47's care plan failed to show a care plan problem or intervention was developed for Resident 47's use of bilateral grab bars. Further medical record review for Resident 47 failed to show an informed consent was obtained from the resident and/or representative prior to the use of bilateral grab bars. On 9/12/24 at 1349 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified there was no informed consent for the use of bilateral grab bars. On 9/12/24 at 1410 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 verified Resident 47's bed rail assessment did not match with the physician's order. Cross reference to F700, example #3. 4. On 9/12/24 at 1002 hours, Resident 78 was observed in bed with grab bar on the left side of the bed elevated. Medical record review for Resident 78 was initiated on 9/12/24. Resident 78 was readmitted to the facility on [DATE]. Review of Resident 78's H&P examination dated 1/22/24, showed Resident 78 had the capacity to understand and make medical decisions. Review of Resident 78's Order Summary Report dated 9/12/24, showed a physician's order dated 4/17/24, for grab bar on the left side of bed to aid with bed mobility and repositioning. Review of Resident 78's Bed Rail assessment dated [DATE], showed Resident 78's left side rail placement was indicated and served as an enabler to promote independence. Resident 78 had expressed a desire to have side rails/assist bar. Review of Resident 78's Care Plan initiated on 4/17/24, showed an intervention for the use of left grab bar to maximize independence with turning and repositioning in bed. Further medical record review for Resident 78 failed show an informed consent was obtained from the resident and/or representative prior to the use of left grab bar. (continued on next page)

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	09/12/2024

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 1002 hours, an interview was conducted with CNA 3. CNA 3 stated the grab bar at the left side of the bed of Resident 78 was used for repositioning. On 9/12/24 at 1349 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified there was no informed consent for the use of left grab bar. Cross reference to F700, example #5. 5. On 9/12/24 at 1016 hours, Resident 601 was observed in bed with bilateral grab bars elevated. Medical record review for Resident 601 was initiated on 9/12/24. Resident 601 was readmitted to the facility on [DATE]. Review of Resident 601's H&P examination dated 1/24/24, showed Resident 601 had the capacity to understand and make decisions. Review of Resident 601's Order Summary Report dated 9/12/24, showed a physician's order dated 7/12/24, for bilateral grab bars to aid in bed mobility and repositioning. Review of Resident 601's Bed Rail assessment dated [DATE], showed Resident 601 did not express a desire to have side rails/assist bar for safety and/or comfort and side rails/assist bar were not indicated Review of Resident 601's care plan failed to show a care plan problem or intervention was developed for Residen 601's use of the bilateral grab bars. Further medical record review for Resident 601 failed to show an informed consent was obtained from the resident and/or representative prior to the use of bilateral grab bars. On 9/12/24 at 1349 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified there was no informed consent for the use of bilateral grab bars. On 9/12/24 at 1452 hours, a concurrent interview and medical record review was conducted with the DON. The DON acknowledged the above findings. Cross reference to F700, example #6.

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	09/12/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50126 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs of the residents when: * The facility failed to ensure proper accounting and safeguarding of the controlled medications when the incoming and outgoing licensed nurses were not consistently signing the controlled count each shift for Medication Carts 1 and 3. This failure had the potential for drug diversion. Findings: Review of the facility's P&P titled Medication Storage in the Facility dated 8/2014 showed at each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medications accountability record. Review of the facility's Narcotic Book Guide titled Using the Brigg's Narcotic Record Book dated 2/2021 showed the oncoming licensed nurse will perform a narcotic inventory count at the change of shifts with the off-going licensed nurse according to the facility's policy and procedure. The two licensed nurses will: -Verify and count each medication as listed according to the Index of the Narcotic Record Book -Refer to the individual Narcotic Record page for the remaining amount for each listed resident and medication. -Verify that the remaining amount recorded on the individual narcotic record page is consistent with the actual amount in the medication card or medication bottle. -The on-coming Licensed Nurse and off-going Licensed Nurse will both sign the Controlled Drugs-Count Record located in the back of the Narcotic Record Book. a. On 9/10/14 at 1420 hours, a medication cart inspection of Medication Cart 3 was conducted with LVN 8. During the medication cart inspection, the binder for controlled drugs count record for Medication Cart 3 was reviewed. During the review of the Controlled Drugs-Count Record log, the following dates were observed with missing signatures from the outgoing and incoming licensed nurses: 8/21, 8/22, 9/1, and 9/7/24. LVN 8 verified the above findings. b. On 9/10/14 at 1430 hours, a medication cart inspection of Medication Cart 1 was conducted with LVN 1. During the medication cart inspection, the binder for controlled drugs count record for Medication Cart 1 was reviewed. During the review of the Controlled Drugs-Count Record log, the following dates were observed with missing signatures from the outgoing and incoming licensed nurses: 8/6, 8/18, 8/22, 8/24, 8/31, and 9/1/24. LVN 1 verified the above findings. (continued on next page)

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	09/12/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at 1453 hours, an interview and concurrent facility document review was conducted with the DON. The DON was informed and verified the above findings. The DON stated there should be signatures from both licensed nurses in the narcotic count book.

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	09/12/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one for five residents (Resident 17) reviewed for unnecessary medications was free from unnecessary psychotropic drugs. The facility failed to ensure Resident 17's orthostatic blood pressure was monitored as ordered by the physician related to the use of an antipsychotic medication. This failure had the potential for Resident 17 to have adverse complications from the medications. Findings: Review of the facility's P&P titled Behavior/Psychoactive Drug Management revised 1/25/24, showed when a resident is admitted with an antipsychotic medication(s), or a resident is prescribed an antipsychotic medication(s), the resident's orthostatic blood pressure is monitored weekly. Depending on the specific classification of psychoactive medication the resident should be observed and/or monitored for side effects and adverse consequences. All complications and side effects should be reported to the healthcare practitioner. Review of the facility's P&P titled Orthostatic Hypotension revised 1/1/12, showed orthostatic vital signs will be taken and recorded when ordered by the physician, and when a sudden drop in blood pressure is suspected as the cause of resident falls, vertigo, feelings of dizziness, and similar occurrences. The procedure for taking orthostatic blood pressure is as follows: a. In a lying down position use the appropriate size of BP cuff on the resident's arm and take his/her BP and heart rate. Record the numbers. b. Have the resident stand up, taking precautions to ensure he/she does not fall. c. Immediately take the resident's blood pressure and heart rate. Record the numbers. d. Ask whether the resident is experiencing divineness. Record the response. If the resident has a drop in systolic blood pressure greater than 10 mmHg and an increase in heart rate of 10 beats per minute when standing, check his/her medications for possible side effects. Notify the physician for possible medication adjustment. Medical record review for Resident 17 was initiated on 9/9/24. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report dated 9/12/24, showed the following physician's orders dated 8/28/24: - to administer risperidone (antipsychotic medication) 0.25 mg one tablet by mouth in the morning for psychosis (a mental condition that causes people to lose touch with reality, making it hard to distinguish what's real and what's not) manifested by paranoid feelings causing fear; (continued on next page)

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	09/12/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- to administer risperidone 0.5 mg one tablet by mouth at bedtime for psychosis manifested by paranoid feelings causing fear; - to monitor the orthostatic blood pressure in the lying position, every Wednesday during the day shift; - to monitor the orthostatic blood pressure in the sitting position, every Wednesday during the day shift; and - to monitor the orthostatic blood pressure in the standing position, every Wednesday during the day shift. Review of Resident 17's MAR for September 2024 showed Resident 17 was administered risperidone 0.25 mg daily from 9/1/24 through 9/12/24 at 0900 hours, and risperidone 0.5 mg daily at bedtime from 9/1/24 through 9/12/24 at 2100 hours. Further review of the MAR for September 2024 showed orthostatic blood pressures (lying, sitting, and standing) were scheduled to be monitored every Wednesday. However, the blood pressure readings were documented as follows: - On 9/4/24: the blood pressure readings were recorded as NA for the lying and sitting positions, and 121/60 mmHg for the standing position. - On 9/11/24: the blood pressure readings were recorded as 121/67 mmHg for the lying position, 119/74 mmHg for the sitting position, and NA for the standing position. On 9/12/24 at 0929 hours, an interview and concurrent medical record review for Resident 17 was conducted with LVN 4. LVN 4 reviewed the medical record for Resident 17 and verified the above findings. LVN 4 stated there was no documentation in Resident 17's medical record to show why the nurses documented NA for the blood pressure readings for the above dates. LVN 4 further stated the blood pressure readings should not be documented as NA, and the blood pressure should have been obtained and compared as per the physician's order to monitor the blood pressure for orthostatic hypotension. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated the residents on antipsychotic medications should be monitored for potential side effects such as orthostatic hypotension. The DON stated monitoring for orthostatic hypotension was done by measuring the resident's blood pressure in different positions, and the blood pressures were then compared to determine if there was a drastic drop in the blood pressure, which could indicate orthostatic hypotension. When asked, the DON stated the staff should not document NA and the blood pressure reading should be obtained in the indicated positions and compared. The DON was informed and acknowledged the above findings.

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	09/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage in three of three medication storage rooms inspection when: * The facility failed to ensure the discharged resident's syringes with needles were discarded and removed from Medication room [ROOM NUMBER]. * Four bottles of lactulose (medication to treat constipation) solution was stored next to 30 lidocaine patches in Medication room [ROOM NUMBER]. * The temperatures for three of three medication room refrigerators used to store medications in Medication rooms [ROOM NUMBER] were out of range. These failures had the potential for the residents to receive ineffective medication dosages and negatively impact their well-being. Findings: Review of the facility's P&P titled Medication Storage in the Facility dated 8/2014 showed the following: - Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medications, and recorded from the pharmacy if an order exists. - Orally administered medications are kept separate from externally used medications. - Medications requiring refrigeration or temperature between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit) are kept in a refrigerator with a thermometer to allow temperature monitoring. 1. On 9/9/24 at 1024 hours, during the inspection of Medication room [ROOM NUMBER] with IP 1 and RN 2 the following was observed: -59 3 ml-syringes with 25-gauge needles in an open plastic bag labeled for Resident 603 were found on the medication room shelf. -Four bottles of lactulose solution for Resident 88 was stored next to 30 patches of lidocaine 4 % for Resident 73 on the medication room shelf. (continued on next page)

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	09/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IP 1 and RN 2 verified the above findings. IP 1 verified Resident 603 was discharged from the facility on 7/5/24. IP 1 and RN 2 stated the syringes with needles should have been discarded in the pharmaceutical waste bin when Resident 603 was discharged . In addition, IP 1 and RN 2 stated the oral solution medication should not be stored next to the lidocaine patches. 2.a. On 9/9/24 at 1055 hours, an observation of the medication refrigerator temperature in Medication room [ROOM NUMBER] was conducted with IP 1 and RN 2. When IP 1 opened the medication refrigerator to check the temperature inside, IP 1 stated the medication refrigerator temperature was 64 degrees Fahrenheit. The following medications were observed in the refrigerator: - TPN dextrose clinsol clinlipid IV parental - 1 bottle of Vancomycin (antibiotic) 50 mg - 18 capsules of dronabinol (an orally active cannabinoid) 5 mg capsules - 3 Lantus insulin pen 100 u/ml - 2 vials of Aplisol 5TU (purified protein derivation) 0.1 ml - 2 vials of MVI (multivitamin supplement) 30 ml to be added to TPN - 2 vials of Novulin R 100 units per vial - 24 packets of Velstassa (for hypercholemia) oral suspension 8.4 grams - 2 Insulin e-kits 2 - humlin N and humlin R humlog, 3 ml each, quantity=8 total, expiration date of 11/24 According to Lexicomp (pharmaceutical resource online), Aplisol, Lantus, and Velstassa are to be stored at 36-46 degrees Fahrenheit; and dronabinol is to be stored at 46 - 59 degrees Fahrenheit. Review of the Medication Fridge and Room Temp Log inside Medication room [ROOM NUMBER] showed the medication refrigerator temperature range was 36 - 46 degrees Fahrenheit. The log also showed the temperature on 9/9/24, for the 7-3 (0700 hours to 1500 hours) shift was 38.1 degrees Fahrenheit. IP 1 stated she checked the medication refrigerator temperature at 0730 hours on 9/9/24. When asked, IP 1 did not know when the medication refrigerator was last opened. IP 1 stated the medication refrigerator temperature was too high and not within the range. RN 2 verified the findings. b. On 9/9/24 at 1059 hours, an observation of the medication refrigerator temperature in Medication room [ROOM NUMBER] was conducted with IP 1, LVN 9, and RN 2. When IP 1 opened the medication refrigerator to check the temperature inside, IP 1 stated the medication refrigerator temperature was 55 degrees Fahrenheit. The following medications were observed in the refrigerator: - 1 bottle of Vancomycin 50 mg, 80 ml in the bottle - 2 injectable Ozempic (antidiabetic) 0.25 - 00.5 mg (continued on next page)

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	09/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2 injectable Ozempic 2 mg - 1 injectable Ozempic 2 mg - 1 injextable Ozempic 0.25-.0.5 mg - 2 injectable pens of Wegovy (for weight loss) 0.25 mg - 2 injectable Trulicity (antidiabetic) 1.5 mg - 3 injectable pens of lispro (antidiabetic) 100 mg - 1 injectable pen of Lantus 100 unit - 1 injextable pen of Humilin R insulin 500 units - 1 injectable pen of Lantus 100 units According to Lexicomp, Ozempic, Wegovy, Trulicity, lispro, Lantus, and Vancomycin are to be stored at 36 to 46 degrees Fahrenheit. Review of the Medication Fridge and Room Temp Log inside Medication room [ROOM NUMBER] showed the medication refrigerator temperature range was 36 - 46 degrees Fahrenheit. The log also showed the temperature on 9/9/24 for the 7-3 shift was 38 degrees Fahrenheit. LVN 9 stated she checked the medication refrigerator temperature at 0730 hours on 9/9/24, and the temperature was within the range. When asked, LVN 9 did not know when the medication refrigerator was last opened. Infection Preventionist 1 stated the medication refrigerator temperature was too high and not within the range. RN 2 verified the medication refrigerator temperature was too high and not within the range. c. On 9/9/24 at 1115 hours, an observation of the medication refrigerator temperature in Medication room [ROOM NUMBER] was conducted with IP 1 and LVN 8. When IP 1 opened the medication refrigerator to check the temperature inside, IP 1 stated the medication refrigerator temperature was 50 degrees Fahrenheit. The following medications were observed in the refrigerator: - 3 boxes of acetylcysteine (to relieve chest congestion) 20% vials (quantity 90 ml total per box) - 2 injectable pens of Lantus insulin 50 units - 6 injectable pens of basaglar insulin 100 unit - 1 vial of Lantus insulin 100 mg - 1 vial of lorazpam (antianxitey) 20 mg per 10 ml - 1 injectable pen of bydureon BCISE (antidiabetic) 2 mg According to Lexicomp, acetylcysteine is to be store at 68 to 77 degrees Fahrenheit and Lantus is to be stored at 36 to 46 degrees Fahrenheit. (continued on next page)

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	09/12/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviw of the Medication Fridge and Room Temp Log inside Medication room [ROOM NUMBER] showed the medication temperature range was 36 - 46 degrees Fahrenheit. The log also showed the temperature on 9/9/24 for the 7-3 shift was 40 degrees Fahrenheit. IP 1 verified the medication refrigerator temperature was too high. LVN 8 stated she checked the medication refrigerator temperature around 0745 - 0750 hours on 9/9/24, and the temperature was within the range. When asked, LVN 8 did not know when the medication refrigerator was last opened. On 9/9/24 at 1130 hours, an interview was conducted with the Administrator. The Administrator was informed of the above findings and stated all of the medication refrigerators out of the temperature range would be replaced. On 9/10/24 at 1036 hours, an interview was conducted with the Pharmacist. The Pharmacist stated the nurses and Pharmacy Consultants made rounds in the facility monthly and checked the medication refrigerator temperatures. The Pharmacist further stated the medication refrigerator temperature during these monthly checks were not logged. Review of the Skilled Nursing Pharmacy Summary of Nurse Consultant Services dated 8/7/24, was conducted with the DON. Under the Services Provided section, showed the following: - Med Pass done with AM Nurse; - Med Cart and Med Room audited, Med Refrigerator; and - E-kits (emergency kits) and required logs checked. The DON verified the medication refrigerator temperature was checked by the Pharmacy Nurse Consultant but not logged.

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	09/12/2024

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review, and the facility P&P review, the facility failed to ensure food preferences were honored for one nonsampled resident (Resident 30). Resident 30 disliked Brussels sprouts and preferred nonfat milk but was served Brussels sprouts and low fat milk for lunch. This had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Dietary Profile and Resident Preference Interview revised 4/21/22, showed resident preferences would be reflected in the medical record and tray-card and updated in a timely manner. The Dietary Department would provide residents with meals consistent with their preferences and physician order as indicated on the tray card. If a preferred item was not available, a suitable substitute should be provided. Medical record review for Resident 30 was initiated on 9/9/24. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's H&P examination dated 6/16/24, showed Resident 30 had the capacity to understand and make decisions. On 9/9/24 at 1302 hours, a lunch observation was conducted in Resident 30's room. Resident 30's meal tray was observed with mashed potatoes with gravy, ground meat, and Brussels sprouts. An open carton of reduced fat milk was also observed on Resident 30's tray. However, review of Resident 30's meal ticket showed Resident 30 disliked Brussels sprouts and preferred nonfat milk. When asked, Resident 30 stated she did not like Brussels sprouts. On 9/9/24 at 1305 hours, an interview and concurrent observation was conducted with MDS Coordinator 2. MDS Coordinator 2 verified the above findings and stated Resident 30 should have had an alternative vegetable on her tray. MDS Coordinator 2 was observed asking Resident 30 about her choice for alternative vegetable and left to place the order. MDS Coordinator 2 was then observed entering Resident 30's room with a carton of nonfat milk. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated the resident's food preferences and dislikes should be honored. The DON was informed and acknowledged the above findings.

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	09/12/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39856 Based on observation, interview, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed when: * A food preparation sink did not have a backflow prevention. * A rack used to dry plate covers was not clean. * Resident 64's room was observed with perishable food items brought from the outside. These failures posed the risk for cross contamination which could lead to food poisoning in the 83 residents who consumed food from the kitchen. Findings: Review of the facility matrix showed 83 of 93 residents consumed food from the kitchen. 1. According to the USDA Food Code 2022 Section 5-402.11 Backflow Prevention, (A) .a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 9/9/24 at 1140 hours, an observation of the plumbing of a food preparation sink located adjacent to the DSS's office and concurrent interview was conducted with the Maintenance Assistant. The drain pipe of the food preparation sink did not have backflow prevention. The Maintenance Assistant verified the finding and stated the drain previously had backflow prevention but it had been removed. 2. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 9/9/24 at 0910 hours, an observation of a rack used to dry plate covers and concurrent interview was conducted with the DSS. The drying rack had a greasy residue and food debris. The DSS verified the finding and asked the kitchen staff to clean the drying rack. 47476 3. Review of the facility's P&P titled Food Brought in by Visitors revised 6/2018 showed perishable food requiring refridgeration will be discarded after two hours at bedside. On 9/9/24 at 1054 hours, an observation and concurrent interview was conducted with Resident 64. Resident 64's bedside table, nightstand, and cart to the left side of his bed were observed filled with food items, including opened cans of soda, bagged bread, and a block of cheese. Resident 64 stated the cheese on his bedside table needed to be in the refrigerator. (continued on next page)

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	09/12/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 0911 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 64's family provided Resident 64 with food from the outside. LVN 1 stated for food items in the room, the items should be sealed and kept in the refrigerator if they needed to keep it in the refrigerator. LVN 1 was informed and acknowledged the above findings. LVN 1 stated the cheese should be refrigerated. On 9/11/24 at 0925 hours, a follow-up observation was conducted for Resident 64. The block of cheese was observed on Resident 64's bedside table. On 9/11/24 at 0944 hours, an interview was conducted with MDS Coordinator 2. MDS Coordinator 2 was informed and acknowledged the above findings.

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	09/12/2024

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 39856 Based on observation, interview and facility P&P review, the facility failed to ensure the facility employees and visitors who brought food from the outside to the facility were educated on safe food handling practices. This failure posed the risk for residents who consumed food brought from the outside to be exposed to unsafe food handling which could lead to food borne illness. Findings: Review of the facility P&P titled Food Brought by Visitors revised June 2018, showed in part, B. Ensuring safe food handling once the food is brought to the facility, including safe reheating and hot/cold food holding, and handling of leftovers. On 9/10/24 at 853 hours, an interview was conducted with RN 2. RN 2 was asked how the facility ensured safe food handling practices were followed when the visitors brought food to the facility from the outside. RN 2 stated he was not sure how the facility ensured safe food handling practices were followed. RN 2 was asked if he had received education on safe food handling practices. RN 2 stated he could not recall if he received education on safe food handling practices. When asked if RN 2 was aware of what safe food handling practices included, RN 2 stated he was not sure. RN 2 was asked if the visitors received any information regarding safe food handling. RN 2 verified the facility did not provide the visitors with information on safe food handling practices. On 9/10/24 at 900 hours, an interview was conducted with the DSD. The DSD stated she had worked at the facility for two months and verified she had not educated the facility staff on safe food handling practices, but she would check the education records for any training given in the past. On 9/10/24 at 910 hours, an interview and concurrent facility P&P review was conducted with the DON. The policy titled Food Brought by Visitors revised June 2018 was reviewed with the DON. The DON was asked how the facility ensured safe food handling practices were followed when the visitors brought food to the facility from the outside. The DON stated the food must be clean and in a sealed container. The DON was not able to state how the facility ensured safe food handling practices were followed when the visitors brought food to the facility from the outside. On 9/10/24 at 1126 hours, an interview was conducted with the DSD. The DSD verified the facility had not given the facility employees training regarding safe food handling practices.

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	09/12/2024

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 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** 47476 Based on interview and medical record review, the facility failed to ensure the medical records for two of 19 final sampled residents (Residents 63 and 64) were accurate and complete. * The facilty failed to ensure Resident 64's POLST form was complete. * The facility failed to ensure Resident 63's POLST form was updated to reflect Resident 63 had an advance directive and a designated Health Care Agent. These failures had the potential for the residents' care needs not being met as their medical information was incomplete. Findings: 1. Medical record review for Resident 64 was initiated on 9/9/24. Resident 64 was readmitted to the facility on [DATE]. Review of Resident 64's POLST dated 7/9/24, under Section D, showed no information checked whether Resident 64 had an advance directive or health care agent. Review of Resident 64's Advance Healthcare Directive (AHCD) Acknowledgement form dated 7/9/24, showed Resident 64 did not have an AHCD. On 9/11/24 at 1214 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD acknowledged Resident 64's POLST was incomplete and should have been updated. 48882 2. Medical record review for Resident 63 was initiated on 9/9/24. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 63's POLST dated 10/8/22, under Section D, showed Resident 63 did not have an advance directive. Review of Resident 63's Advance Healthcare Directive (AHCD) Acknowledgement Form dated 7/5/21, showed on 8/14/21, an advance directive was executed. Review of Resident 63's Progress Notes showed an entry dated 8/14/21 at 0913 hours, documenting an advance directive was executed for Resident 63, and the Ombudsman and a witness at bedside. The note showed a copy of the advance directtive was placed in the resident's chart. (continued on next page)

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	09/12/2024

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 9/11/14 at 1215 hours, an interview and concurrent medical record review for Resident 63 was conducted with the SSD. The SSD stated the POLST form including Section D was completed by the nursing staff. The SSD stated if the resident formulated an advance directive, or an advance directive was obtained after the resident's admission, the Social Services would update the AHCD Acknowledgement Form. When asked, the SSD stated she did not inform the nursing staff of the update, and she did not update the POLST. The SSD verified the above findings and stated the POLST was inaccurate and should have been updated. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated as soon as the facility was aware and had obtained a copy of the resident's advance directive, the facility should update the POLST immediately to accurately reflect the resident's advance directive. The DON was informed and acknowledged the above findings.

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	09/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their infection control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable disease and infections. * The facility failed to maintain an accurate infection control surveillance program for the months of January 2024 through August 2024. The facility conducted surveillance only on the residents who exhibited signs and symptoms of an infection and were prescribed antimicrobial medications (medications used to treat infections). The facility failed to ensure the residents who exhibited signs and symptoms of an infection but were not prescribed antimicrobial medications were included in the facility's infection control surveillance log. The facility failed to ensure the Surveillance Data Collection Form was complete and accurate to determine whether the resident's infection met the McGeer's criteria for true infection. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room. * The facility failed to ensure RN 2 wore the appropriate PPE when entering a COVID-19 isolation room for Resident 75. These failures have the potential risk for not identifying, managing, containing, and controlling the transmission of communicable disease within the facility. Findings: 1. Review of the facility's P&P titled Infection Control- Policies & Procedures revised 1/1/12, showed the Quality Assessment and Assurance Committee, through the Infection Control Committee, oversees the implementation of infection control policies and procedures, and helps department heads ensure that they are implemented and followed. The objective of the facility's infection control policies and procedures is to prevent, detect, investigate, and control infections in the facility. Review of the facility's P&P titled Infections Caused by Delivery of Healthcare Services-Identification revised 1/1/12, showed when an infection is identified the infection control coordinator confirms that the infection meets the criteria for an infection and works to identify if the infection developed in the facility. Review of the facility's P&P titled Infection Control Surveillance revised 3/1/14, showed the licensed nurse would initiate the gathering of the surveillance data for each resident and document on Section A of the appropriate Surveillance Data Collection Form. The Infection Preventionist would review the Surveillance Data Collection Form initiated by the licensed nurse and determine if the infection was HAI or CAI. The IP would document accordingly on Section B of the appropriate Surveillance Data Collection Form. (continued on next page)

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	09/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of the facility's monthly Infection Control Surveillance Logs from January 2024 through August 2024 showed the following resident infection surveillance data for HAIs, CAIs, and Criteria Not Met. - January 2024: a total of 35 cases, including 15 HAIs and 18 CAIs, - February 2024: a total of 27 cases, including 14 HAIs and 10 CAIs, - March 2024: a total of 41 cases, including 15 HAIs, 21 CAIs, and 1 Criteria Not Met, - April 2024: a total of 30 cases, including 7 HAIs, 20 CAIs, and 3 Criteria Not Met, - May 2024: a total of 24 cases, including 7 HAIs, 13 CAIs, and 3 Criteria Not Met, - June 2024: a total of 32 cases, including 10 HAIs, 20 CAIs, and 1 Criteria Not Met, - July 2024: a total of 25 cases, including 8 HAIs, 16 CAIs, and Criteria Not Met, - August 2024: a total of 27 causes, including 14 HAIs, 11 CAIs and 2 Criteria Not Meet. Further review of the facility's monthly Infection Control Surveillance Logs from January through August 2024 showed all residents determined to have either an HAI, CAI, or Criteria Not Met were also prescribed antimicrobial medications. There was no documented evidence the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications were included in the monthly surveillance logs. On 9/11/24 at 1420 hours, a concurrent interview, medical record review, and facility document review was conducted with IP 1. IP 1 stated she was responsible for conducting the surveillance of the resident infections in the facility. When asked about the facility's infection surveillance program, IP 1 stated a Surveillance Data Collection Form was completed for the residents admitted to the facility currently on antibiotics and for the residents at the facility with signs and symptoms of an infection and was prescribed antibiotics. IP 1 stated the Surveillance Data Collection Form was a two-part form, with Section A specific to the McGeer's criteria. IP 1 further stated once Section A of the form was completed, the IP would complete Section B, which determined whether the infection was a hospital-acquired infection (HAI, nosocomial infection), or a community-associated infection (CAI), and whether the infection met the McGeer's criteria for a true infection. IP 1 stated the information on the Surveillance Data Collection Form would then be documented into the monthly Infection Control Surveillance Log for tracking of infections. IP 1 was asked if the residents who exhibited signs and symptoms of an infection but were not prescribed antimicrobial medications were included in the facility's infection surveillance logs. IP 1 stated only the residents with infections and were prescribed antimicrobial medications were on the facility's monthly infection surveillance logs. The Surveillance Data Collection Form for Residents 16, 47, 48, 77, 87, and 603 were reviewed with IP 1. The residents' Surveillance Data Collection Form showed the following documentation: * For Resident 48, the report was completed on 7/23/24, and showed the following: (continued on next page)

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	09/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The antibiotic treatment prescribed for Resident 48 was vancomycin (antibiotic) 10 ml four times a day for 10 days for c-diff (clostridium difficile, a bacteria which causes diarrhea and inflammation of the colon), started on 7/23/24, and the type of isolation documented was enhanced precautions - Section B of the form was not completed by the IP to indicate whether the infection was an HAI, CAI, or DNMC (did not meet criteria). * For Resident 47, the report was completed on 7/16/24, and showed the following: - the antibiotic treatment prescribed for Resident 47 was Macrobid oral capsule 100 mg for urinary tract infection started on 7/7/24. - Section B of the form was not completed by the IP to indicate whether the infection was an HAI, CAI, or DNMC. * For Resident 16, the reports were completed on 5/29 and 6/27/24. The 5/29/24 report showed the following: - The antibiotic treatment prescribed for Resident 16 was meropenem intravenous 500 mg every eight hours for seven days for urinary tract infection, started on 5/26/24 - Section B of the form was not completed by the IP to indicate whether the infection was an HAI, CAI, or DNMC. The 6/27/24 report showed the following: - The antibiotic treatment prescribed for Resident 16 was Bactrim oral tablet 800-160 mg two times a day for 30 days for urinary tract infection started on 6/24/24. - Section A, the McGeer's criteria tool was not filled out; however, it was determined to be an CAI. * For Resident 603, the report was completed on 6/27/24, and showed the following: - The antibiotic treatment prescribed for Resident 603 was Levaquin oral tablet 500 mg daily for pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making breathing difficult and painful) until 6/25/24. - Under Section A, the McGeer's criteria tool was incomplete, indicating Resident 603 only met two out of three required criteria; however, it was determined to be a CAI. * For Resident 77, the report was completed on 6/25/24, and showed the following: - The antibiotic treatment prescribed for Resident 77 was azithromycin oral tablet 250 mg daily for five days for possible lung infiltration until 6/24/24. (continued on next page)

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	09/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Under Section A, the McGeer's criteria tool was incomplete, indicating Resident 77 only met two out of three required criteria; however, it was determined to be a CAI. * For Resident 87, the report was completed on 6/21/24, and showed the following: - The antibiotic treatment prescribed for Resident 87 was meropenem intravenous 500 mg every eight hours for seven days for urinary tract infection, started on 6/14/24. - Under Section A, the McGeer's criteria tool was incomplete, indicating Resident 87 only met one out of two required criteria; however, it was determined to be a HAI. IP 1 verified the Surveillance Data Collection Form for Residents 16, 47, 48, 77, 87, and 603 were incomplete. IP 1 also verified the infections for Residents 77, 87, and 603 did not meet the McGeer's criteria for a true infection. IP 1 stated the Surveillance Data Collection Form completed for each resident should be complete and accurate and if results were pending, the IP should follow-up to ensure the form was completed. On 9/11/24 at 1445 hours, an interview and concurrent record review for Resident 48 was conducted with IP 1. IP 1 was asked about the isolation for a resident being treated for c.diff. IP 1 stated if the resident was being treated for c.diff, then the resident should be on contact isolations. IP 1 verified Resident 48 was placed only on enhanced precaution. IP 1 was asked if Resident 48 was placed on contact precautions in July 2024. IP 1 reviewed Resident 48's medial record and stated there was no physician's order to place Resident 48 on contact isolation for c.diff infection in July 2024. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated the purpose of the facility's Infection Control Surveillance Log was for tracking and surveillance purposes. The DON stated the log should also include the residents with signs and symptoms of infection and were not prescribed antibiotics. The DON was informed and acknowledged the above findings. Cross reference to F881. 2. On 9/10/24 at 0920 hours, an inspection of the laundry area and concurrent interview with Laundry Services Personnel 1 was conducted. The following was observed: - two eyeglasses and an employee phone were on top of the clean table area where the clean clothes or linens were folded. Laundry Services Personnel 1 verified the above finding and stated the items should not be on the table used to fold the clean laundry. Laundry Service Personnel 1 was observed removing the employee belongings from the table. On 9/11/24 at 1544 hours, an interview was conducted with IP 1. IP 1 stated the clean laundry should be folded on the clean laundry table. IP 1 further stated the clean laundry table should be cleaned routinely and should not have any personal items on it. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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	09/12/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47476 3. According to the CDC's Infection Control Guidance: SARS-CoV-2 dated 6/24/24, the health care providers who enter the room of a patient with suspected or confirmed COVID-19 should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Medical record review for Resident 75 was initiated on 9/9/24. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's Order Summary Report dated 9/10/24, showed a physician's order dated 9/1/24, for Standard, Droplet and Contact precautions for COVID-19 positive. Review of Resident 75's Change in Condition Evaluation dated 9/1/24, showed Resident 75 was noted to have labored breathing and hoarseness. Upon testing Resident 75 for COVID-19, Resident 75 was COVID-19 positive. On 9/10/24 at 1435 hours, RN 2 was observed entering Resident 75's room without wearing an N95 mask. RN 2 stated Resident 75's COVID-19 isolation was completed the day prior. On 9/10/24 at 1448 hours, a follow-up interview was conducted with RN 2. RN 2 acknowledged he did not don an N95 while entering Resident 75's room and stated he knew he was required to wear an N95 mask. On 9/11/24 at 1038 hours, an interview was conducted with IP 1. IP 1 stated Resident 75 was on COVID-19 isolation for 10 days and 9/10/24 was the 10th day. IP 1 stated the required PPE for COVID-19 isolation was to wear the N95 mask, face shield, goggles, gown, and gloves. The IP was informed and acknowledged the above findings.

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	09/12/2024

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48882 Based on interview, facility document review, and facility P&P review, the facility failed to inform the physician of the residents prescribed antibiotics with signs and symptoms not meeting McGeer's Criteria (criteria used by long-term care facilities to determine a true infection) for one of 19 final sampled residents (Resident 87) and three nonsampled residents (Residents 59, 77, and 603). This failure had the potential risk for continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics and the development of antibiotic resistant bacteria. Findings: According to the Centers for Disease Control and Prevention (CDC), antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile (a type of bacteria that can cause diarrhea and inflammation of the colon), increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review the facility's P&P titled Antibiotic Stewardship revised 5/20/21, showed the facility will promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for Residents. The IP (Infection Preventionist) will collect and analyze infection surveillance data, coordinate data collection, and monitor adherence to infection control policies and procedures. Further review of the facility's P&P showed the facility had chosen to use Revisited McGeer"s Criteria (2012) for surveillance. Antibiotic time-outs (ATO, a review process for all antibiotics prescribed in the facility, which prompts clinicians to reassess the ongoing need for an antibiotic after culture results are available) would be utilized when appropriate. The IP is responsible for tracking the following antibiotic stewardship processes: - Surveillance and multi drug resistant organism (MDRO) tracking - The antibiotic ordered, dose, route and ordering physician as well as the cost of the drug - Whether or not the Resident's condition met McGeer's Criteria when the antibiotic was ordered - If cultures were ordered - Any changes in antibiotic orders during therapy - Outcomes of antibiotic therapy (continued on next page)

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	09/12/2024

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 1420 hours, a concurrent interview and facility document review was conducted with IP 1. IP 1 stated she was responsible for conducting surveillance of residents with infections in the facility. IP 1 stated a Surveillance Data Collection Form was completed for each resident with signs and symptoms of an infection and were prescribed antibiotics at the facility, and also completed for the residents admitted to the facility on antibiotics. IP 1 stated Section A of the Surveillance Data Collection Form was used to determine if the residents' signs and symptoms of infection met the McGeer's criteria as a true infection. IP 1 stated the Infection Preventionist was responsible for completing Section B of the form to indicated whether the infection was an HAI, CAI, or DNMC (did not meet criteria). IP 1 further stated if the residents' signs and symptoms did not meet the McGeer's criteria and antibiotics were prescribed, then the physician would be notified to determine if the antibiotic should be discontinued or continued. IP 1 stated once the physician was informed, the IP nurse would document in the Antibiotic Time Out form. Review of the facility's Monthly Antibiotic Stewardship Reports for June 2024 showed the following documentation: - 9.3% HAI, census of 96 residents, - 1 case of residents prescribed antibiotic who did not meet McGeer's criteria for infection. Review of the facility's Monthly Antibiotic Stewardship Reports for July 2024 showed the following documentation: - 9.2% HAI cases, census 98 residents, - 1 case of residents prescribed antibiotic who did not meet McGeer's criteria for infection. Review of the residents' Surveillance Data Collection Form for the months of June and July 2024 was conducted with IP 1. After reviewing the resident's Surveillance Data Collection Forms, the IP verified Residents 77 and 87 (June 2024) and Resident 603 (July 2024) did not meet Mc Geer's criteria for a true infection, were prescribed antibiotics, and were not indicated as DNMC in Section B of the Residents' Surveillance Data Collection Forms. Furthermore, Resident 87's Surveillance Data Collection Form was completed on 6/21/24. Resident 87 had been started on antibiotics on 6/14/24, and Resident 87's Surveillance Data Collection Form showed a urine culture was not obtained. IP 1 also verified Resident 59 (July 2024) did not meet McGeer's criteria for a true infection and the resident was prescribed antibiotics. IP 1 was asked to show the documentation that the physicians had been notified when the infection criteria were not met for the above residents. IP 1 reviewed the medical records for the above residents and stated she was unable to provide the documentation. On 9/12/24 at 1421 hours, an interview was conducted with the DON. The DON stated the purpose of the facility's Infection Control Surveillance Form was for tracking and surveillance purposes and the monthly Surveillance Logs should be complete and accurate to reflect the numbers of HAIs, CAIs, and infections that did not meet criteria in the facility. The DON was informed and acknowledged the above findings.

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	09/12/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39856 Based on observation and interview, the facility failed to ensure essential kitchen equipment was maintained in proper working condition when: * The ice machine located in the kitchen was not clean and the manufacturer guidelines were not followed. * The walk-in freezer floor was not in a cleanable condition. * The facility failed to ensure the low air loss matress for Resident 69 was functioning properly. These failures had the potential for essential equipment to not function in the way it was intended. Findings: According to the USDA Food Code 2022 Section 4-601. 11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, food-Contact surfaces, and utensils shall be clean to the sight and touch. Review of the ice machine manufacturer guidelines (undated) located on the interior cover of the ice machine showed in part, Scale Removal and Sanitizing Instructions: .7. Mix a cleaning solution of one ounce ice machine scale remover [Scotsman Clear 1 ice machine scale remover] to 12 ounces of water. 8. Locate curtain, push in on edge of curtain by pivot pin to release it. Pull curtain out of machine .10. Locate ice thickness sensor. Squeeze mounting legs together to release sensor. 11. Wash the sensor and the adjustment screw with ice machine scale remover solution, rinse with clean water. Also wash the water distributor and curtain with the ice machine cleaner solution. 12. Locate water level sensor. Squeeze catches together and pull up to remove sensor. 13. Separate probes from housing and wash all surfaces with ice machine scale remover solution. Rinse and return probes to holder. 14. Create a solution of sanitizer by mixing one gallon or four-liter solution of locally approved sanitizer and clean, warm water. Use an EPA approved food equipment sanitizer at the solution mix recommended by the sanitizer manufacturer .15. Thoroughly wash all surfaces of the ice thickness sensor, water level sensor, curtain and water distributor with the sanitizer solution. 16. Wash all interior surfaces of the freezing compartment, including evaporator cover and right-side panel liner with the sanitizing solution. 17. Return water level sensor, ice thickness sensor, water distributor and curtain to their normal positions. Be sure water level sensor and ice thickness sensor are completely dry. 18. Push and release the Clean button. The yellow Clean light will blink, and the display will show C. The machine will go through a harvest cycle, drain the reservoir and begin to refill it .20. Pour the sanitizing solution into the reservoir until it is full. The unit will circulate the sanitizer, then drain and flush it. This will take 35 minutes . (continued on next page)

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	09/12/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 0829 hours, an observation of the ice machine located in the kitchen and concurrent interview was conducted with the Maintenance Assistant (MA) using the DSS as a translator. The MA stated he cleaned the ice machine monthly. Upon removal of the ice machine harvester curtain (a plastic panel that directed ice from the ice harvester to ice storage bin) a rubber strip attached to the harvester curtain was observed not intact. The rubber strip had a white residue that was flaking off. The MA stated the white residue was dried glue that was used to attach the rubber strip to the harvester curtain. The MA confirmed the rubber strip should be replaced. The ice machine chute (section of the ice machine that directs the ice from the ice harvester to the ice storage bin) was observed with a grayish, white residue. The DSS and MA agreed the ice machine chute was not clean and the ice machine would be taken out of service. The MA was asked to describe the process he used to clean the ice machine. The MA stated he mixed one ounce of [Scotsman Clear 1 ice machine scale remover] with 32 ounces of water then ran the cleaning solution through the machine on the clean cycle. The MA stated he removed the internal components of the ice machine and sprayed the internal components with hot water. The MA stated he also sprayed the ice storage bin and ice chute with hot water. The MA was asked if he had read the ice machine manufacturer's instructions located on the inside cover of the ice machine. The MA stated he had not read the ice machine manufacturer's instructions because they were in English. The MA stated he used the kitchen sanitizing solution to clean the ice storage bin. The MA stated he added water to the kitchen sanitizing solution once it was dispensed from the sanitizing solution dispensing nozzle. The MA stated after rinsing the ice storage bin with the diluted kitchen sanitizing solution, he rinsed the ice storage bin with hot water. 1. According to the USDA Food Code 2022 Annex 3 Section 4-201.11 Equipment and Utensils showed, Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents. On 9/09/24 at 0758 hours, an observation of the walk-in freezer was conducted with the DSS. The floor of the walk-in freezer had black anti-slip tape on the small ramp leading to the freezer floor. The black anti-slip tape was not intact which exposed the metal floor underneath. The metal floor underneath the black anti-slip tape had a hard thick brown residue which resembled rust. The walk-in freezer floor beyond the small ramp was composed of linoleum. The linoleum was cracked with a brown residue and not intact. The DSS confirmed the observation and stated the maintenance was aware of the problem. On 9/09/24 at 0930 hours, an observation of the walk-in freezer floor and concurrent interview was conducted with the Maintenance Director. The Maintenance Director stated he was not aware of the freezer floor. 32179 2. Medical record review for Resident 69 was initiated on 9/9/24. Resident 69 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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	09/12/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 0845 and 1010 hours, Resident 69 was observed lying on a low air loss mattress bed and the pump had a red light blinking. Resident 69 had alternating pump of low air loss mattress malfunctioned and the alarm was muted. On 9/9/24 at 1240 hours, MDS Coordinator 1 was summoned to Resident 69's room. Resident 69's alternating pump for the low air loss mattress was malfunctioned and the alarm was muted. MDS Coordinator 1 was tried to unmute the alarm and the alarm kept beeping. MDS coordinator verified the finding. On 9/12/24 at 1110 hours, an interview was conducted with LVN 2. LVN 2 stated he checked all the low air loss mattress every morning. LVN 2 stated he was not aware of any low air loss mattress pump malfunction or any muted alarms.

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	09/12/2024

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate, complete, and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of bed rails for six of six residents (Residents 45, 47, 63, 64, 78, and 601) who were reviewed for grab bar use. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Rails revised 11/16/22, showed the facility's maintenance team is responsible for installing the bed rails. The entrapment zone review will focus on the following: any gaps that exist between the mattress, bed frame or bed rail that is wide enough to entrap the resident's head, body, arm or legs. The maintenance department will routinely inspect the beds and bed rails for preventive maintenance, safety standards and assess for need for repair. Annual bed measurement inspections to review and document entrapment areas in accordance with the FDA's Potential Zones. 1. Medical record review for Resident 64 was initiated on 9/9/24. Resident 64 was readmitted to the facility on [DATE]. (continued on next page)

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	09/12/2024

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 64's H&P Examination dated 7/9/24, showed Resident 64 had the capacity to understand and make decisions. Review of Resident 64's Order Summary Report failed to show a physician's order for the use of bilateral bed grab bars. Review of Resident 64's Bed Rail assessment dated [DATE] and 7/9/24, showed there were no siderail or assist bars indicated at this time for Resident 64. However, on 9/9/24 at 1054 hours and 9/11/24 at 0831 hours, Resident 64's bed was observed to have bilateral grab bars installed on the bed. On 9/11/24 at 0913 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 64 used the bilateral bed grab bars for repositioning and turning. LVN 1 was informed of and verified the above findings. On 9/11/24 at 0947 hours, an interview and concurrent facility document review for Resident 64 was conducted with the Maintenance Director. The Maintenance Director stated he was responsible for the entrapment assessment of the facility's beds with side rails. The Maintenance Director stated he checked the entrapment zones on the bed once a year and would use the Bed System Measurement Device Test Results Worksheet for the beds with side rails. The Maintenance Director stated he did not measure or document the entrapment zones for the use of grab bars and would only check the gap between the mattress space and the grab bar. On 9/12/24 at 1710 hours, the DON and Administrator were informed and acknowledged the above findings. Cross reference to F700, example #1. 48844 2. On 9/12/24 at 0902 hours, Resident 45 was observed in bed with bilateral grab bars elevated. Medical record review for Resident 45 was initiated on 9/12/24. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's Bed Rail assessment dated [DATE], showed the side rails/assist bar were indicated and served as an enabler to promote independence. Resident 45 had expressed a desire to have side rails/assist bar. However, further review of the medical record for Resident 45 failed to show a documentation for the entrapment assessment prior to Resident 45's use of bilateral grab bars. Cross reference to F700, example #2. 3. On 9/12/24 at 0921 hours, Resident 47 was observed in bed with bilateral grab bars elevated. (continued on next page)

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	09/12/2024

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 47 was initiated on 9/12/24. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's Bed Rail assessment dated [DATE], showed Resident 47 did not express a desire to have side rails/assist bar for safety and/or comfort and side rails/assist bar are not indicated at this time. Further medical record review for Resident 47 failed to show a documentation for the entrapment assessment prior to Resident 47's use of the bilateral grab bars. Cross reference to F700, example #3. 4. On 9/12/24 at 0945 hours, Resident 63 was observed in bed with a grab bar on the left side of the bed elevated. Medical record review for Resident 63 was initiated on 9/12/24. Resident 63 was admitted on [DATE]. Review of Resident 63's Bed Rail assessment dated [DATE], showed the side rails/assist bar were indicated and served as an enabler to promote independence. Resident 63 had expressed a desire to have side rails/assist bar. However, further review of the medical record for Resident 63 failed to show documentation for the entrapment assessment completed for the use of grab bar on the left side of the bed. 5. On 9/12/24 at 1002 hours, Resident 78 was observed in bed with a grab bar on the left side of the bed elevated. Medical record review for Resident 78 was initiated on 9/12/24. Resident 78 was readmitted to the facility on [DATE]. Review of Resident 78's Bed Rail assessment dated [DATE], showed Resident 78's left side rail placement was indicated and served as an enabler to promote independence. Resident 78 had expressed a desire to have side rails/assist bar. Further medical record review for Resident 78 failed to show a documentation of the entrapment assessment prior to Resident 78's use of the grab bar on the left side of the bed. Cross reference to F700, example #4. 6. On 9/12/24 at 1016 hours, Resident 601 was observed in bed with bilateral grab bars elevated. Medical record review for Resident 601 was initiated on 9/12/24. Resident 601 was readmitted to the facility on [DATE]. Review of Resident 601's Bed Rail assessment dated [DATE], showed Resident 601 did not express a desire to have side rails/assist bar for safety and/or comfort and the side rails/assist bar were not indicated at this time. (continued on next page)

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	09/12/2024

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further medical record review for Resident 601 failed to show a documentation of the entrapment assessment prior to Resident 601's use of the bilateral grab bars. On 9/11/24, an interview was conducted with the Maintenance Director. The Maintenance Director verified there was no documentation of measurements for the grab bars. The DON acknowledged the above findings. Cross reference to F700, example #5.