STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055674	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Center of Orange County	9021 Knott Ave Buena Park, CA 90620

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive person-centered care plan was revised for one of three sampled residents (Resident 2). * The facility failed to revise Resident 2's care plan when Resident 2 had a fall. This failure placed the resident at risk of not being provided appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Care Planning Interdisciplinary Team revised 9/2013 showed the assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Medical record review for Resident 2 was initiated on 10/1/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's eINTERACT Change in Condition Evaluation dated 8/23/25, showed Resident 2 was found lying on the floor on the right side of the bed holding the siderail. Review of Resident 2's Fall Risk Evaluation dated 8/23/25, showed Resident 2 was at a high risk for falls. Review of Resident 2's plan of care dated 8/23/25, showed a care plan problem addressing Resident 2's moderate risk for falls. In addition, the care plan showed Resident 2 had a fall on 8/23/25. However, the care plan was not revised to show Resident 2's high risk for fall based on the resident's Fall Risk Evaluation dated 8/23/25. On 10/3/25 at 1139 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 2 was at high risk for fall and the resident's care plan was not revised to show the resident's high risk for fall after his fall incident on 8/23/25. On 10/3/25 at 1420 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for one of three sampled residents (Resident 1). * LVN 1 delayed contacting emergency services after Resident 1 who was on an anticoagulant, had an unwitnessed fall and injury to his forehead. This failure had the potential to negatively affect the resident's well-being as the necessary care and services were not provided.Findings: Medical record review for Resident 1 was initiated on 10/1/25. Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses which included anoxic brain damage, diffuse traumatic brain injury, and epilepsy. Review of Resident 1's H&P examination dated 4/24/25, showed Resident 1 had no capacity to make medical decisions. Review of Resident 1's eINTERACT Change of Condition Evaluation - V 5.1 dated 9/18/25 at 0840 hours, showed Resident 1 had an unwitnessed fall, where he was found on the floor next to his bed. Resident 1 was noted to have a bump on his right forehead. The physician was notified at 0905 hours and recommended to transfer Resident 1 to the acute care hospital for an evaluation and treatment. Review of Resident 1's progress note showed a late entry dated 9/18/25 at 1000 hours, showing the licensed staff called 911 and the paramedics arrived at 0950 hours. Resident 1 left the facility via gurney at 0958 hours. Review of Resident 1's admission H&P note from Acute Care Hospital A dated 9/18/25, showed Resident 1 fell around two feet from the bed onto the ground and striking his head. The CT of the head result showed a small 2 mm right frontal subdural hematoma. On 10/1/25 at 1600 hours, an interview was conducted with LVN 1. LVN 1 stated on 9/18/25 at around 0840 hours, she found Resident 1 on the floor near the right side of his bed. LVN 1 stated she assessed Resident 1 and saw a bump on his forehead, before placing him back on his bed with CNA 1's assistance. LVN 1 stated the physician ordered to transfer Resident 1 to the acute care hospital for an evaluation. LVN 1 stated she contacted a regular ambulance but was told by the ambulance company that since Resident 1 was on a blood thinner medication and had a bump on his head, she should contact 911. LVN 1 stated she attempted to contact another regular ambulance but was told the same instructions. LVN 1 then contacted 911 for Resident 1. On 10/2/25 at 1548 hours, an interview was conducted with the DON. The DON stated if the resident had an unwitnessed fall and was on blood thinner medications, the resident would be transferred to the acute care hospital for an evaluation via a regular ambulance or 911. When asked what would determine the licensed staff to contact 911, the DON stated if the resident had a bump or a headache. The DON verified Resident 1 had a bump on his head due to the unwitnessed fall incident. In addition, the DON stated the licensed staff should have contacted 911 for Resident 1. On 10/10/25 at 1607 hours, a telephone interview was conducted with the DON and Medical Records Director. The DON and Medical Records Director were informed and acknowledged the above findings. Cross reference F689.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of three sampled residents (Resident 1) was free from accident hazards. * Resident 1 had an unwitnessed fall incident on 9/18/25. The facility failed to investigate Resident 1's family member's grievance regarding Resident 1's position near the edge of the bed on 9/16/25. Resident 1's fall risk assessment was inaccurate resulting in an incorrect fall risk score status. In addition, the facility failed to update Resident 1's care plan addressing the resident's risk for fall and his behavior of dangling his legs off the bed prior to his fall incident. These failures resulted in Resident 1 sustaining a subdural hematoma (a collection of blood that accumulates between the brain and the inner layer of the skull) and hospitalization.Findings: Review of the facility's P&P titled Grievance/Complaint Log revised 4/2008 showed the Social Services will be responsible for the grievance log. The following information as a minimum must be recorded:a) The date the grievance/complaint was received;b) The name and room number of the resident following the grievance complaint;c) The name and relationship of the person filing the grievance/complaint in behalf of the resident;d) The date the alleged incident took place;e) The name of the person (s) investigating the incident;f) The disposition of the grievance (i.e., resolved, dispute, etc.,).Review of the facility's Fall Program: Falling (Yellow) Star Program (undated) showed the IDT (Interdisciplinary Team) will review appropriate interventions for the residents identified as a fall risk; interventions will be based on the resident's fall risk factors from assessments, history of falls, and other fall risk determinants. The DON and DSD will re-educate the nursing staff about the Falling Star Program which will include the frequency of monitoring the residents and interventions to minimize injuries from a potential fall. a. Medical record review for Resident 1 was initiated on 10/1/25. Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses which included diffuse traumatic brain injury (a disruption in the normal function of the brain that can be caused by a bump, blow or jolt to the head), history of falling, and anoxic brain damage (a condition where the brain was deprived of oxygen for a period of time). In addition, Resident 1 was hospitalized on [DATE], and returned to the facility on 9/25/25. Review of Resident 1's H&P examination dated 4/24/25, showed Resident 1 was nonverbal and had no capacity to make medical decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was dependent on the facility staff assistance to roll from lying on his back, to the left and right sides, and return to lying on his back on the bed. Further review of Resident 1's MDS assessment showed to code the resident dependent when the resident did not provide any effort to complete the activity, or the assistance of two or more helpers were required for the resident to complete the activity. In addition, the MDS assessment showed Resident 1 had an impairment on both upper and lower extremities that interfered with daily functions. Review of Resident 1's Grievance / Complaint Report Form dated 9/16/25, showed the department manager would investigate the allegations and submit a written report of the findings to the Administrator within five working days of receiving the grievance. Resident 1's grievance form showed Resident 1's family member complained regarding the resident's legs positioned towards the edge of the bed and informing a CNA to reposition the resident. Under the sections for witnesses and employees to describe the incident and to describe the findings of the incident showed N/A was documented. Under the Recommendations/Corrective Action Taken section showed an in-service was initiated for the licensed nurses and CNAs on 9/17/25, about proper positioning in bed. However, further review of Resident 1's medical record failed to show documentation the facility monitored and/or provided additional interventions to prevent the resident from falling after the grievance from the resident's family member was filed. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 9/18/25, showed Resident 1 had an unwitnessed fall incident, where he was found lying on the floor near the right side of his bed. Resident 1 was noted to have a bump on the right side of his forehead. Resident 1 was on an anticoagulant (blood thinner) medication and the physician ordered to transfer Resident 1 to the acute care hospital for an evaluation and treatment. Review of Resident 1's admission H&P note from Acute Care Hospital A dated 9/18/25, showed Resident 1 fell around two feet from the bed onto the ground and striking his head. The CT of the head (computed tomography scan of the head is an imaging test that uses X-rays to create detailed cross-sectional images of the brain, skull, and sinuses) result showed a small 2 mm (size) right frontal subdural hematoma. b. Review of the facility's P&P titled Falls - Clinical Protocol revised 3/2018 showed the staff will identify the resident's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the residents needs for two of three sampled residents (Residents 1 and 2). * The facility failed to administer Resident 1's medications scheduled. In addition, the facility documented Resident 1's medications were administered on 9/19/25 at 1700, 1800, 1900, and 2100 hours, after the resident was transferred to the acute care hospital. * The facility failed to administer Resident 2's medications scheduled on 9/15 and 9/22/25 at 2100 hours. These failures had the potential to negatively affect the residents health conditions and posed the risk for diversion of the medications.Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in a safe and timely manner and as prescribed. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. If a medication is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the appropriate line on the resident's MAR. Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective, complete, and accurate. 1. Medical record review for Resident 1 was initiated on 10/1/25. Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses which included anoxic brain damage, epilepsy, tachycardia, dysphagia and chronic respiratory failure with hypoxia. Review of Resident 1's H&P examination dated 4/24/25, showed Resident 1 had no capacity to make medical decisions and had a GT. Review of Resident 1's Order Summary Report showed the following physician's orders:- dated 4/23/25 and discontinued on 9/25/25, to administer gabapentin (antiseizure) 300 mg one capsule via GT three times a day for seizure disorder and methocarbamol (used as a muscle relaxant) 750 mg one tablet via GT three times a day for muscle spasm;- dated 4/24/25 and discontinued on 9/25/25, to administer docusate sodium (stool softener) 100 mg one tablet via GT at bedtime for bowel management, multivitamin-minerals (supplement) one tablet via GT at bedtime for supplement, 10 ml of levetiracetam (antiseizure) 100 mg/ml via GT two times a day for seizure disorder, metoprolol tartrate (antihypertensive) 50 mg one tablet via GT every twelve hours for hypertension/tachycardia, and two drops of artificial tears solution in both eyes four times a day for dry eyes;- dated 5/5/25 and discontinued on 9/25/25, to swab povidone-iodine (used to prevent infections in minor cuts and burns) 10 % external swab in each nostril every twelve hours every two weeks on Monday, Tuesday, Wednesday, Thursday, and Friday for decolonization (process aimed to reduce or eliminate the presence of bacteria or microorganisms on the body or environment);- dated 5/17/25 and discontinued on 9/25/25, to administer vitamin D (supplement) 25 mcg one tablet via GT one time a day for supplement, and magnesium oxide (supplement) 400 mg one tablet via GT two times a day for magnesium supplement;- dated 6/3/25 and discontinued on 9/25/25, to administer sodium chloride (supplement) 1 g two tablets via GT three times a day for hyponatremia;- dated 6/16/25 and discontinued on 9/25/25, to administer melatonin (supplement) 5 mg one tablet via GT at bedtime for circadian rhythm disruption; - dated 7/5/25 and discontinued on 9/25/25, to inject enoxaparin sodium (blood thinner) 30mg/0.3 ml subcutaneously two times a day for DVT prophylaxis, - dated 7/23/25 and discontinued on 9/25/25, to administer amantadine HCl (used to treat stiffness, tremors and slowness of movement) 100m g via GT two times a day for dyskinesia;- dated 8/4/25 and discontinued on 9/25/25, to administer 1.25 mg of levalbuterol HCl (prevents and treats shortness of breath) 1.25 mg/3 ml via nebulizer four times a day for respiratory failure; -dated 9/25/25, to administer gabapentin (anticonvulsant medication) 300 mg one capsule via GT three times a day for seizure disorder; and- dated 9/26/25, to administer 2 ml of budesonide (used to treat shortness of breath) 0.5 mg/2 ml orally every twelve hours for respiratory failure, acetaminophen (pain reliever) 325 mg two tablets via GT three times a day for pain management, 10 ml of levetiracetam 100 mg/ml via GT every twelve hours for seizure, enoxaparin sodium 30 mg/0.3 ml subcutaneously two times a day for DVT prophylaxis, magnesium oxide 400 mg one tablet via GT two times a day for magnesium supplement, metoprolol tartrate 50 mg one tablet via GT every twelve hours for hypertension/tachycardia, amantadine HCl 100 mg one tablet via GT three times a day for involuntary movements, and methocarbamol 750 mg one tablet via GT three times a day for muscle spasm. a. Review of Resident 1's MAR for 9/2025 failed to show documented evidence the following medications were administered:- the ratification tears medication on 9/9/25 at 1700 hours;- the enoxaparin, levetiracetam, magnesium oxide, and vitamin D medications on 9/9/25 at 1800 hours;- the levalbuterol HCl

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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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the residents' medical record were complete and accurate for two of three sampled residents (Residents 2 and 3). * Resident 2's fall risk assessments were incomplete. * Resident 3's fall risk assessments were incomplete. These failures posed the risk for the residents care needs not being met as their medical record information were inaccurate and incompleteFindings: Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Medical record review for Resident 2 was initiated on 10/1/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Fall Risk Evaluation dated 6/19/25, showed blank entries for the following sections: systolic blood pressure, and vision status. Review of Resident 2's Fall Risk Evaluation dated 8/23/25, showed blank entries for the following sections: ambulation, and systolic blood pressure. 2. Medical record review for Resident 3 was initiated on 10/1/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report dated 10/1/25, showed the following physician's orders: - dated 2/16/25, to administer benazepril (antihypertensive) 20 mg one tablet orally one time a day for hypertension;- dated 2/16/22, to administer hydralazine HCl (antihypertensive) 100 mg one tablet orally three times a day for hypertension;- dated 2/16/22, to administer hydrochlorothiazide (diuretic) 12.5 mg one capsule orally in the evening for CHF; - dated 2/16/22, to administer metoprolol tartrate (antihypertensive) 25 mg one tablet orally two times a day; and- dated 4/26/23, to inject Humulin R (hypoglycemic/lowers blood sugar) 100 unit/ml subcutaneously per sliding scale one time a day for diabetes. Review of Resident 3's MAR for July 2025 showed Resident 3 was administered the benazepril, Humulin R, hydrochlorothiazide, hydralazine, and metoprolol medications. Review of Resident 3's Fall Risk Evaluation dated 7/21/25, showed Resident 3 took one to two classes of medications listed on the evaluation form (anesthetics, antihistamines, antihypertensive, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics and sedative/hypnotics) currently or within the last seven days. However, Resident 3 was taking three classes of the medications listed (antihypertensive, diuretic, and hypoglycemic). On 10/2/25 at 1256 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified Resident 2 and 3's Fall Risk Evaluations had blank entries and were inaccurate. On 10/8/25 at 1150 hours, an interview was conducted with the DON. The DON stated the responses checked off on the Fall Risk Evaluation should be filled out completely, as the responses affected the overall fall risk score for the residents.