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	04/15/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the care plan intervention for fall prevention for one of three sampled residents (Resident 3) reviewed for falls. * The facility failed to ensure Resident 3 was provided with a yellow wristband as per the resident's care plan intervention for fall. This failure had the potential to affect the facility staff's ability to provide appropriate supervision and implement timely fall prevention measures. Findings: Review of the facility's P&P titled Falls - Clinical Protocol revised 3/2018 showed the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. Medical record review for Resident 3 was initiated on 4/14/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's Progress Notes showed the following Health Status Note:- dated 2/3/26 at 0045 hours, showed Resident 3 was found on the floor, on the left side of the bed; and- dated 2/6/26 at 0613 hours, showed Resident 3 was found kneeling on the floor mat next to the left side of the bed. Review of Resident 3's Plan of Care showed a care plan problem to address Resident 3's actual fall dated 2/6/26. The interventions included providing a yellow wrist band to Resident 3 per the facility's Falling Star Program. On 4/14/26 at 0900 hours, Resident 3 was observed in bed, and asleep. Resident 3 was not observed with a yellow wristband as per the facility's Falling Star Program. On 4/14/26 at 1350 hours, a medical record review and concurrent interview was conducted with RN 1. RN 1 stated Resident 3 had fallen in the facility on 2/3 and 2/6/26. RN 1 verified Resident 3's plan of care fall interventions included for Resident 3 to have a star by her name on the door, and a yellow wristband per the Falling Star Program to indicate Resident 3 was a high risk for fall and had a history of falling in the facility. On 4/14/26 at 1418 hours, an observation for Resident 3 and concurrent interview was conducted with RN 1. RN 1 verified Resident 3 did not have a yellow wristband.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one of six sampled residents (Resident 3) received the appropriate care and services for pressure injury prevention. * The facility failed to offload Resident 3's bilateral heels per the physician's orders. This failure had the potential to place Resident 3 at risk to develop pressure injury on her heels. Findings: On 4/14/26 at 0900, 0911, and 1227 hours, Resident 3 was observed asleep and lying in bed with both heels touching the bed. Medical record review for Resident 3 was initiated on 4/14/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed the following physician's orders:- dated 11/5/25, to offload bilateral heels with pillows at all times while in bed for skin maintenance; and- dated 11/29/25, to apply bilateral heel protector at all times for skin management. May release during patient (resident) care. On 4/14/26 at 1243 hours, an observation for Resident 3 and concurrent interview was conducted with CNA 2. Resident 3 was observed asleep and lying in bed with both heels touching the bed. CNA 2 stated she was not sure if there was a physician's order to apply heel protectors for the resident or to offload her heels from the bed. On 4/14/26 at 1255 hours, an observation for Resident 3 and concurrent interview and medical record review was conducted with LVN 1. LVN 1 was observed getting a pair of heel protectors for Resident 3. LVN 1 verified Resident 3's heels should be offloaded from the bed with a pillow or heel protectors as per the physician's order. LVN 1 stated Resident 3 did not have any skin issues and no pressure injuries on her heels.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the appropriate care and services to prevent UTIs for one of one of six sampled residents (Resident 4) with an indwelling urinary catheter (a flexible, sterile tube which drains the urine from the bladder into a bag outside of the body). * The facility failed to ensure Resident 4's indwelling urinary catheter drainage bag was not touching the floor. This failure posed the risk for Resident 4 to develop UTIs and complications from UTIs.Findings: On 4/14/26 at 0834 and 0845 hours, Resident 4 was observed in bed with an indwelling urinary catheter attached to a urinary drainage bag. The urinary drainage bag was observed on the floor. A pink basin was observed underneath the resident's bed. Medical record review for Resident 4 was initiated on 4/14/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 3/19/26, to maintain indwelling urinary catheter drainage bag below the bladder at all times. On 4/14/26 at 0917 hours, an observation for Resident 4 and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 4's indwelling urinary catheter drainage bag was touching the floor, and a pink basin was underneath the resident's bed. CNA 1 was observed placing Resident 4's indwelling urinary catheter drainage bag hook into the bedframe, and throwing away the basin. On 4/14/26 at 1350 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. When asked about the proper positioning of the indwelling urinary drainage bag, RN 1 stated if the bed was on the lowest position, the indwelling urinary drainage bag should still be hanging on the bed frame, and the pink basin should be placed underneath the drainage bag to prevent the drainage bag and indwelling urinary catheter tubing from touching the floor.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one sampled resident (Resident 3) reviewed for side rail use was free from accident hazards related to the use of side rails. * The facility failed to ensure Resident 3's use of side rails as per the resident's plan of care for fall prevention were indicated in Resident 3's bed rail assessment. This failure had the potential to place Resident 3 at risk for entrapment and serious injury from the side rail use.Findings: Review of the facility's P&P titled Bed Safety revised 12/2007 showed the following:- The resident's sleeping environment shall be assessed by the IDT, considering the resident's safety, medical conditions, comfort and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment; and- Side rails maybe used if assessment and consultation with the attending physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. On 4/14/26 at 0900, 0911, and 1227 hours, Resident 3 was observed lying in bed and asleep with the bilateral upper grab rails elevated. Medical record review for Resident 3 was initiated on 4/14/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had severe cognitive impairment, no impairment to upper and lower extremities, and needed supervision from the facility staff for bed mobility. Review of Resident 3's Progress Notes showed the following Health Status Note:- dated 2/3/26 at 0045 hours, showed Resident 3 was found on the floor, on the left side of the bed; and- dated 2/6/26 at 0613 hours, showed Resident 3 was found kneeling on the floor mat next to the left side of the bed. Review of Resident 3's Plan of Care showed a care plan problem to address Resident 3's actual fall dated 2/6/26. The interventions included providing side rails used as grab bars. Review of Resident 3's Bed Rail Assessment - V 1 dated 2/3/26, showed the side rails or assist bars were not indicated for Resident 3. Further review of Resident 3's medical record did not show a bed rail entrapment risk assessment was conducted on 2/3/26. On 4/14/26 at 1243 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 verified Resident 3 was lying in bed and asleep with the bilateral upper grab rails elevated. CNA 2 stated Resident 3 was able to hold on to the grab rails to help when turning and repositioning. On 4/14/26 at 1350 hour, a medical record review and concurrent interview was conducted with RN 1. RN 1 stated Resident 3 had fallen in the facility on 2/3 and 2/6/26. RN 1 verified Resident 3's plan of care fall interventions included for Resident 3 to have a grab bars. RN 1 further verified the bed rail assessment conducted for Resident 3 showed grab rails were not indicated for the resident.