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	06/25/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 ensure the bed hold policy was carried out for one of four sampled residents (Resident 3). * The facility failed to ensure Resident 3's previously assigned room and bed were provided when the resident returned to the facility from the acute care facility, during the seven-day bed hold period. This failure had the potential for the resident to have an inappropriate discharge.Findings: Review of the facility's P&P titled Bed Holds and Returns dated 3/2017 showed the residents may return and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy. Medical record review for Resident 3 was initiated on 6/12/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 3's Bed Hold Informed Consent dated 3/13/26 at 1400 hours, showed a Yes response to the item, I desire up to seven days bed hold by resident's Family Member 1. Review of Resident 3's Progress Notes dated 3/13/26, showed the dialysis clinic called the facility to inform Resident 1 was being sent to the acute care facility. The Progress Notes further showed all the resident's medications were stored and locked in the medication room, resident's personal belongings were bagged and stored as per the facility's protocol. Review of Resident 3's Order Listing Report dated 3/18/26, showed a physician's order for seven day bed hold if admitted . Review of Resident 3's Progress Notes dated 3/19/26, showed Resident 3 was readmitted back to the facility. On 6/12/26 at 1106 hours, an interview was conducted with Resident 3. Resident 3 stated a couple months ago, she went to the acute care facility for six days and when she returned, all her belongings were boxed up, and she was provided with a different room and bed. Resident 3 stated, Why do they make you sign a paper showing a seven-day bed hold? On 6/25/26 at 1049 hours, an interview was conducted with the DON. The DON stated the seven-day bed hold policy required the facility to accept the resident back in the same room and same bed within the seven-day period. On 6/25/26 at 1338 hours, an interview was conducted with the Marketing Director and DON. The Marketing Director stated on 3/19/26, she received a referral for the resident to be readmitted on [DATE], when she was to be discharged from the acute care facility. When asked what happened when she returned on 3/19/26, the Marketing Director stated the resident was to be expected back to the facility on 3/20/26, as per acute care facility's physician's orders. The DON verified the day one of the bed hold would start on the day the resident was transferred, and end on 3/19/26. The DON acknowledged the bed should have been held until 3/19/26, for Resident 3.

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 ensure one of four sampled residents were provided the necessary care and services to maintain their highest practicable well-being. * The facility failed to ensure Resident 1 was provided an escort to an outpatient appointment as instructed by the staff from physician's office. This failure had the potential to delay resident's care.Findings: Review of the facility's P&P titled Transportation, Social services dated 12/2008 showed except in emergencies of the resident and or his representative (sponsor) shall be expected to arrange transportation (e.g., to go outside physician or clinic appointments or a planned transfer or discharge from the facility. Social services will help the resident as needed to obtain transportation. Inquiries concerning transportation should be referred to social services. Medical record review for Resident 1 was initiated on 6/12/26. Resident 1 was admitted to the facility on [DATE]. Resident 1 had a diagnosis of End Stage Renal Disease (ESRD). Review of Resident 1's Social Service History and Initial assessment dated [DATE], showed the following:- spouse or domestic partner, none;- list children names,. none; and- other support members, no one at this time. Review of Resident 1's Order Listing Report dated 3/6/26, showed a physician's order for dialysis (life-sustaining treatment for people with kidney failure) every Mondays, Wednesdays, and Fridays, and a right upper chest Permacath (specialized central venous catheter used primarily for hemodialysis. Review of Resident 1's Dialysis Center Communication Record dated 4/29/26, showed for Resident 1 had an appointment for vein mapping for AVF (arteriovenous fistula - an abnormal connection between an artery and a vein that allows blood to flow directly between them, bypassing the tiny capillaries) creation. Resident 1 will need a family member or friend to escort him to the appointment.Review of Resident 1's Order Listing Report showed a physician's order for the following appointments for vein mapping (a non-invasive ultrasound test that creates a visual blueprint of the size, depth, and health of your blood vessels. It is primarily used to prepare for surgeries like dialysis access):- appointment for vein mapping on 5/21/26 at 1500 hours, will need a family or friend to escort to the appointment;- appointment for vein mapping on 6/4/26 at 1415 hours, will need a family or friend to escort to the appointment;- appointment for vein mapping on 6/25/26 at 1300 hours, transportation to be arranged SSD. Accompanied by CNA/RNA; and- appointment for vein mapping on 6/25/26 at 1515 hours, please ensure that staff/family accompanies the patient to the appointment, this is the third reschedule for the patient. Review of Resident 1's Progress note dated 6/4/26 at 1528 hours, showed the resident left at 1400 hours, came back at 1500 hours via wheelchair assisted by one transporter. Resident 1 was not seen by the physician due to unavailable escort. Review of Resident 1's Care Plan Report dated 6/4/26, showed the resident left at 1400 hours and came back at 1500 hours via wheelchair assisted by one transporter. Resident 1 was not seen by the physician due to unavailable escort. Review of Resident 1's Progress Note dated 6/12/26, showed the appointment was rescheduled three times due to no staff came with the resident. The progress note also showed the facility was not aware the past appointments and resident dis not have any family member to accompany for vein mapping on 6/25/26 at 1300 hours. On 6/12/26 at 1553 hours, an interview was conducted with Resident 1. Resident 1 stated he had two appointments for the vein mapping, and stated no one could take him there. Resident 1 stated he did not have any family or friends as he was not from here. Resident 1 stated he had gone to the appointment and was turned away due to not having an escort. On 6/24/26, at 1611 hours, an interview was conducted with the SSD. The SSD stated her responsibilities would include to set up the transportation. When asked if she was aware if Resident 1 had any family or friends in this state, the SSD stated she conducted the initial admission assessment and was aware Resident 1 had no family or friends here. When asked who assisted in providing the escort if the resident had no one to escort, the SSD stated whoever made the appointment will inform the DSD, and the DSD will find someone to escort the resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/25/26 at 1013 hours, an interview was conducted with the DSD. The DSD stated she was not aware until 6/17/26, that Resident 1 needed an escort. On 6/25/26 at 1049 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings, and stated, We need to create a process.

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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** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of four sampled residents were provided with dietary preferences. * The facility failed to ensure Resident 1's documented allergy to lactose was carried out. This failure had the potential for the resident to have an intolerance or allergic reaction to food.Findings: Review of the facility's P&P titled Food Allergies and Intolerances dated 8/2017 showed the residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment. Residents with food intolerances and allergies are offered appropriate substitutions for food that they cannot eat period the dietitian will determine whether food allergies or intolerances are interfering with the residents overall nutrition status and make recommendations regarding appropriate food substitutions and or dietary supplements. Nursing staff and food service employees are trained in the signs and symptoms of allergic reactions to food and basic first aid measures in the event of food allergy emergency. Medical record review for Resident 1 was initiated on 6/12/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's medical record showed Resident 1 had an allergy to lactose. On 6/12/26 at 1428 hours, Resident 1 was observed eating his lunch meal tray which contained rice with peas, fish, and bread. On 6/12/26 at 1432 hours, an interview and concurrent observation was conducted with the DSS. The DSS stated the bread was a piece of cake. When asked what was used to make the cake, the DSS showed a white cake mixture bag with ingredients that listed whey (from milk) and non-fat dry milk. Further review of the cake mixture showed contains milk, soy and wheat. On 6/12/26 at 1553 hours, an interview was conducted with Resident 1. Resident 1 stated he suffered from the food at the facility since he was lactose intolerant. When asked what happened when he ate dairy, Resident 1 proceeded to state he just did not like it, since he was a child. When asked what he ate for lunch, Resident 1 stated fish, rice, and coffee. When asked if he ate the cake on the meal tray, Resident 1 stated yes he ate a small sweet bread. On 6/24/26 at 1111 hours, an interview and concurrent medical record review for Resident 1 was conducted with the RD. When asked what Resident 1's allergy was listed as, the RD stated lactose. The RD stated a lactose allergy would include milk or milk products. When shown the cake mix batter ingredients, the RD verified the cake mixture contained lactose. On 6/25/26 at 1049 hours, an interview was conducted with the DON. When asked how the facility ensured the resident did not receive food the resident was allergic to, the DON stated it will be screened in the kitchen and they (nursing) double checked. On 6/25/26 at 1530 hours, the Administrator and DON were notified and acknowledged the above findings.