STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555259	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainplace Post Acute	1835 West LA Veta Avenue 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 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. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was developed to reflect the individual care needs for one of six sampled residents (Resident 1). * There was no care plan developed for Resident 1's refusals to shower or bathe. This failure had the potential for the resident to not be provided with appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 12/2023 showed the following:- it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment;- the resident has the right to refuse or discontinue treatment. In the event that a resident refusescertain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk; and Medical record review for Resident 1 was initiated on 11/24/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10//9/24, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's BIMS score was 13, indicating he was cognitively intact. On 11/24/25 at 1310 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was lying in bed awake, oriented times three (refers to the resident being alert and oriented to person, place and time) with periods of forgetfulness, and verbally responsive. Resident 1 had short facial hair and a strong body odor. Resident 1 stated he has refused showers when his football game was on television. Review of Resident 1's Tasks for Shower/Bathing showed the resident refused a shower/bath on the following dates:- on 10/30/25 on the pm shift- on 11/3/25 on the pm shift- on 11/10/25 on the pm shift- on 11/13/25 on the pm shift- on 11/17/25 on the pm shift- on 11/20/25 on the pm shift; and- on 11/24/25 on the pm shift. Review of Resident 1's plan of care failed to show a care plan was developed for the resident's refusals to shower or bathe. On 11/25/25 at 0925 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed Resident 1's medical record and verified there was no documented evidence of the resident's refusal to shower or bathe in the progress notes. RN 1 further verified there was no care plan developed for Resident 1's refusal to shower or bathe. RN 1 stated the assigned CNA must fill out a shower sheet for every resident scheduled to shower. RN 1 stated if the resident refused or if the CNA observed any skin issues, the CNA must report to the assigned licensed nurses for follow up. RN 1 further stated if a resident refuses to shower, the licensed nurse must document under progress notes the refusal after two scheduled showers in a week under despite encouragement or offer attempts provided and initiate a care plan. Furthermore, if the resident continued to refuse shower or bed bath for two weeks, the licensed nurses must complete a change of condition assessment, inform the resident's physician and responsible party, monitor documentation every shift for 72 hours, and develop a care plan. On 11/25/25 at 1115 hours, an interview and concurrent medical record review for Resident 1 was conducted with the IP. Review of Resident 1's Shower Sheets for October and November 2025 showed the resident had refused showers on the following dates: - on 10//9/25- on 10/13/25- on 10/23/25; and - on 11/6/25. Additionally, there were missing shower sheets for the dates of 10/30, 11/3, 11/10, 11/13, 11/17, 11/20, and 11/24/25. The IP reviewed Resident shower schedule and stated Resident 1's shower was scheduled every Monday and Thursday during the pm shift. The IP verified the above findings. The IP stated the medical record staff and DSD should have followed up Resident 1's missing shower sheets. The IP stated the shower sheets served as a communication for any significant changes with resident's refusal of showers and skin condition and must be accurately completed to reflect the resident's plan of care. On 12/1/25 at 1153 hours, a telephone interview was conducted with LVN 1. LVN 1 stated Resident 1 had refused showers for the past three months. LVN 1 verified he did not document the refusals in Resident 1's progress notes, and verified there was no care plan for the refusal. LVN 1 stated care plan was important because it is a guide for the resident's care while in the facility. On 12/1/25 at 1257 hours, an interview was conducted with the DON. The DON stated if a resident refused showers, the CNAs could offer and provide full body bath or bed bath. The DON clarified the sponge bath was not an equivalent or replacement to a shower and full body or bed bath. The DON was informed and acknowledged the above findings.

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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. (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 0684 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 observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of six sampled residents (Resident 1). * The facility failed to ensure a change in condition assessment and monitoring was completed for Resident 1's rash on the bilateral hands. This failure posed the risk of the resident to not receive appropriate care.Findings: Review of the facility's P&P titled Significant Change of Condition Response revised 1/2022 showed the following:- if, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware;- the Nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions;- the resident will then be placed on the 24 Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions. An attempt to identify the cause for decline, when it occurs, needed assist and resident behavior / acceptance of increased need of assistance will be monitored;- the nurse will communicate the change to other departments as appropriate and updatedcommunications will be available during morning report;- there will be certain circumstances where immediate attention will be warranted and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his / her clinical judgment and shall contact the physician based on the urgency of the situation. The Medical Director shall be notified in the event that the Attending Physician or on-call Physician cannot be reached. The resident / resident representative will be notified of the change of condition and any changes in the resident's medical or nursing care;- each department notified will perform their own evaluation and assessment to determine if thechange requires further intervention and implement actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR); and- the interdisciplinary team (IDT) shall collaborate with the attending physician, resident, and/orresident representative to review risk indicators and the plan of care. The IDT will document thiscollaboration in the EMR in the next scheduled Comprehensive Care Plan Meeting or sooner if deemed necessary by the IDT. Medical record review for Resident 1 was initiated on 11/24/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10//9/24, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's BIMS score was 13, indicating he was cognitively intact. Review of Resident 1's Order Summary Report showed a physician's order dated 11/18/25, for miconazole nitrate (an antifungal medication used to treat fungal infections) external cream 2 % ,to apply on bilateral hands topically in the morning for rash for 14 days. Further review of Resident 1's medical record failed to show a change in condition assessment and monitoring was completed for the resident's rash on the bilateral hands. On 11/25/25 at 1509 hours, an interview and concurrent medical record review was conducted with RN 2. RN 1 verified there was no documented evidence a change of condition assessment and monitoring was completed for the rash on the bilateral hands. RN 2 verified the above findings. In addition, RN 2 stated skin changes were considered a change in condition; the licensed nurses must complete a change of condition assessment, inform the physician and responsible party, document a progress notes monitoring every shift for 72 hours, and initiate or revise the care plan. On 12/1/25 at 1153 hours, a telephone interview was conducted with LVN 1. LVN 1 stated he received Resident 1's order for miconazole nitrate from the physician on 11/18/25, however, he failed to complete a change of condition assessment and monitoring documentation. LVN 1 stated accurate and timely assessment and documentation are important to show resident's condition or problems are monitored by licensed staff, interventions were implemented, and medical records were updated. On 12/1/25 at 1257 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.