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	04/27/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurate for one of four sampled residents (Resident 1). * The facility failed to ensure Resident 1's physician's progress notes were accurate and did not contain information of other residents. * The facility failed to ensure Resident 1's skin assessments were documented by the licensed staff. These failures had the potential for the resident's care needs not to be met as their medical information was inaccurate and incomplete.Findings: Review of the facility's P&P titled Nursing Clinical: Documentation revised 5/2007 showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. Medical record review for Resident 1 was initiated on 4/23/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P dated 3/11/26, showed Resident 1 had the capacity to make medical decisions. a. Review of Resident 1's Progress Notes showed a Physician's Progress Note dated 3/16/26 at 0427 hours, listing a detailed summary of Resident 1's status and plan of care. However, upon further review, the Physician's Progress Note also listed a detailed summary and plan of care for Residents 5 and 6. On 4/23/26 at 1457 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated the Physician's Progress Notes were not reviewed after entry unless there was a new order to review. The DON verified the medical information for Residents 5 and 6 should not be listed in the medical record for Resident 1. b. Review of the facility's P&P titled Change in Condition revised 4/2025 showed 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. Review of Resident 1's CNA Skin Observation, also referred to as the shower sheet, showed the following:- dated 3/12/26, CNA 1 indicated redness to the bilateral groin/inner thigh area. LVN 1 indicated assessment done.- dated 3/19/26, CNA 2 indicated redness to the right groin/inner thigh area. LVN 2 indicated assessment done.- dated 3/23/26, CNA 3 indicated red areas to the lower back and the groin area. LVN 3 indicated assessment done. On 4/23/26 at 1305 hours, an interview and concurrent medical record review for Resident 1 was conducted with Treatment Nurse 1. Treatment Nurse 1 stated for any new findings there should be a documented assessment, change of condition documented, and the physician should be notified if necessary. Treatment Nurse 1 verified there were no assessments, progress notes or change of condition documented to correspond with the findings on the shower sheets dated 3/12, 3/19, and 3/23/26. On 4/23/26 at 1457, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified there were no assessments, progress notes or change of condition documented to correspond with the findings on the shower sheets dated 3/12, 3/19, and 3/23/26. The DON further verified nurses should be documenting their skin assessments.

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