

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  New Orange Hills		STREET ADDRESS, CITY, STATE, ZIP CODE  5017 E. Chapman Avenue Orange, CA 92869	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</b></p> <p>Based on observation, interview, medical record review, facility document review, and facility P&amp;P review, the facility failed to ensure the necessary wound care and services were provided for three of five sampled residents (Residents 2, 3, and 5).</p> <p>* The facility failed to ensure Resident 2's wound care treatment orders were clarified and communicated when there were two physicians providing two different wound care orders.</p> <p>* The facility failed to ensure Resident 3 was provided with the appropriate bed mattress to promote healing of the pressure injury.</p> <p>* The facility failed to ensure the physician's order for the correct sequence of Resident 5's wound care treatment was followed.</p> <p>These failures had the potential for Residents 2, 3, and 5 to not receive the appropriate care and services to promote wound healing.</p> <p>Findings:</p> <p>1. Medical record review for Resident 2 was initiated on 2/25/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's Physician Order Summary showed the following physician's orders:</p> <ul style="list-style-type: none"> <li>- dated 12/10/24, to apply mupirocin (antibiotic) external ointment 2%, apply to the affected area topically every day shift for infection for 30 days until 1/10/25</li> <li>- dated 1/10/25, to cleanse the incision site with sterile saline and Q-tip's BID and follow up in three weeks for re-evaluation of wound or sooner if sign of infection was observed.</li> </ul> <p>Review of Resident 2's Neurosurgeon Progress Note dated 1/17/25, showed Resident 2 was status post cranioplasty on 5/8/24. The physician recommended for wound care evaluation and management, cleaning of the incision site twice a day with sterile saline and Q-tips and following up in four weeks for re-evaluation of the wound or sooner if there were signs of infection.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's Wound Specialist Progress Notes dated 1/8, 1/15, 1/22, and 1/29, 2/5, 2/12, and 2/19/25, showed Resident 2 was seen for the scalp wound evaluation and treatment. The treatment plans showed to cleanse with NSS, pat dry, apply mupirocin ointment, cover with the ABD pad, wrap with Kerlix gauze, and secure with tape QD for 14 days.</p> <p>Review of Resident 2's TAR for January 2025 showed Resident 2 received the following wound treatments:</p> <ul style="list-style-type: none"> <li>- for mupirocin external ointment 2%, apply to the affected area topically every day for skin infection from 1/1 - 1/9/25, and</li> <li>- to cleanse the incision with sterile saline and Q-tips BID from 1/10 - 1/31/25.</li> </ul> <p>Review of Resident 2's TAR for February 2025 showed Resident 2 received the wound treatment as ordered to cleanse the incision with sterile saline and Q-tips BID from 2/1 - 2/25/25.</p> <p>However, further review of Resident 2's TAR failed to show if Resident 2 received the wound treatments as recommended by the wound specialist to apply the mupirocin ointment after 1/9/25.</p> <p>On 2/26/25 at 1359 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated the mupirocin ointment was being used to treat Resident 2's scalp abscess per the wound specialist's recommendations since 12/10/24, however the order in the EHR did not reflect the order. LVN 1 stated the mupirocin ointment order was discontinued on 1/10/25. LVN 1 verified the TAR treatments reflected the incorrect order and did not show the mupirocin ointment. LVN 1 verified there were two separate orders for Resident 2, and he should have clarified the orders with the neurosurgeon.</p> <p>On 2/28/25 at 1603 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the wound care specialists recommendations were not changed in the EHR to reflect the current treatment plan, and the expectations were to follow the physician's orders, communicate and clarify between the two physicians providing the wound care orders, and carry out the recommendations by the neurosurgeon.</p> <p>2. Review of the User's Manual for Med-Aire 8 Alternating Pressure Mattresses Replacement System with Low Air Loss, showed the system is a high-quality powered air support surface that is specifically designed for the prevention and treatment of pressure injuries while optimizing patient support.</p> <p>Review of the facility's P&amp;P titled Skin and Wound Monitoring and Management revised 1/2023 showed a resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.</p> <p>Medical record review for Resident 3 was initiated on 2/25/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident Plan of Care initiated on 2/20/25, showed a care plan problem addressing Resident 3's actual impairment to the skin integrity relate to the unstageable pressure injury to the sacral lumbar area.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Order Audit Report showed a physician's order dated 2/20/25, to provide a LAL mattress for the skin management.</p> <p>On 2/26/25 at 1356 hours, an observation and concurrent interview was conducted with the DON. Resident 3 was observed in bed, lying on the Direct Supply Air overlay mattress. The DON verified Resident 3 was not lying on an LAL mattress.</p> <p>3. Medical record review for Resident 5 was initiated on 2/26/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 5's Order Summary Report showed a physician's order dated 2/5/25, for the chronic right and left lower leg venous ulcers, to cleanse the areas with normal saline, pat dry, apply the collagen sheet, then the xeroform or adaptic dressing, cover with the absorbent pad, wrap with Kerlix, and secure with tape every day shift on Mondays, Wednesdays, and Fridays for skin management.</p> <p>On 2/26/25 at 0951 hours, a wound care observation for Resident 5 was conducted with LVN 1. LVN 1 treated Resident 3's left leg venous ulcer first then treated the right leg venous ulcers doing the same sequence of wound treatment. LVN 1 cleansed the right and left leg venous ulcers with normal saline and patted the ulcers dry, then LVN 1 was observed applying the xeroform first, then the collagen sheet to the leg venous ulcers, then applied ABD pad, wrapped with Kerlix and taped.</p> <p>On 2/26/25 at 1035 hours, an interview was conducted with LVN 1. LVN 1 verified Resident 3's physician's order for the right and left leg venous ulcers were, after cleaning the wounds to apply the collagen sheet first then the xeroform or adaptic dressing. LVN 1 acknowledged he applied the xeroform first then the collagen sheet on Resident 3 during the wound care treatment.</p> <p>On 2/28/25 at 1603 hours, an interview and concurrent medical record review was conducted with the DON. The DON was made aware and acknowledged the above findings.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49348</p> <p>Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of five sample residents (Resident 2) remained free from accident hazards.</p> <p>* The facility failed to provide the bilateral floor mats at Resident 2's bedside as ordered by the physician for safety. This failure had the potential to place Resident 2 at risk for serious injury.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Falls Prevention revised 8/2020 showed the following:</p> <ul style="list-style-type: none"> <li>- A post fall assessment including recommendations and care plan changes will be completed for all residents who have experienced a fall.</li> <li>- If appropriate, interventions will be initiated by per ID Team member recommendation and when necessary, physician's orders for any fall related incident.</li> <li>- The falls team will generate recommendations which may include but are not limited to nursing interventions.</li> </ul> <p>Medical record review for Resident 2 was initiated on 2/25/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's Order Summary Report showed a physician's order dated 6/26/24, to place the bilateral floor mats at the resident's bedside for safety.</p> <p>Review of Resident 2's Plan of Care initiated on 6/21/24, showed a care plan problem to address Resident 2's actual fall on 6/21/24. The interventions included to place the bilateral floor mats at the resident's bedside.</p> <p>Review of Resident 2's Quarterly Fall Risk Evaluation dated 12/19/24, showed the resident was a high risk for falls.</p> <p>On 2/26/25 at 1443 hours, an observation and concurrent interview was conducted with the ADON. Resident 2 was observed lying in bed with no floor mats at bedside for safety as ordered and care planned. The ADON verified Resident 2 did not have the bilateral floor mats at bedside as ordered and care planned for safety due to the risk for falls.</p> <p>On 2/28/25 at 1603 hours, an interview was conducted with the DON. The DON was made aware and verified the above findings.</p>		