STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Orange Hills	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for two of eight sampled residents (Residents 1 and 2). * The facility failed to ensure Resident 1 was seen for the outpatient physician's follow-up appointments. * The facility failed to ensure Resident 2's wound care was followed as ordered by the physician. These failures had the potential to negatively affect the residents' well-being as the necessary care and services were not provided. Findings: 1. Review of Resident 1's medical record was initiated on 4/25/25. Resident 1 was admitted to the facility on [DATE]. Resident 1 had a diagnosis of acute and chronic respiratory failure, tracheostomy, and congenital malformation of skull and facial bones. Review of Resident 1's Order Summary Report showed the following physician's orders for the following: -dated 4/3/25, showed appointment speech evaluation MD on 4/7/25 -dated 4/2/25, showed appointment for plastic surgeon on 4/9/25 Review of Resident 1's Social Services Progress Notes dated 4/7/25, showed Resident 1 had an appointment for speech evaluation at 1430 hours. Further review of the medical record showed the appointment was cancelled per the SSD. Review of Resident 1's Social Services Progress Note dated 4/7/25, showed the SSA reached out to the transportation company, and they could not accommodate the doctor's appointment and would have to be private pay. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/25 at 0846 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated if a resident had an outpatient appointment, the facility would arrange the transportation and pay out of pocket if needed. When the DON was asked if a follow-up appointment should have been made for Resident 1, the DON stated, yes. On 5/9/25 at 0925 hours, an interview and concurrent medical record review for Resident 1was conducted with the SSD and DON. The SSD stated Resident 1 had a speech evaluation appointment scheduled for 4/7/25 at 1430 hours. The SSD stated she attempted to arrange transportation for the appointment scheduled for 4/7/25; however, the transportation could not be arranged due to Resident 1's insurance. The DON stated Resident 1 had a plastic surgery appointment scheduled. When asked if Resident 1 went to the appointment, the DON stated the resident did not go to any appointments. 2. Closed medical record review for Resident 2 was initiated on 4/25/25. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 2's Order Summary Report dated 3/6/25, showed for the right lower extremity, to remove Prevena Dressing (wound management system used after surgery to manage closed surgical incison) on 3/7/25, one time only. Review of Resident 2's Progress Notes dated 3/7/25, showed Prevena dressing removed per PCP orders, no complaints of pain or discomfort before, during and post procedure. Slight ss drainage noted on sections of the surgical incision to the right hip, ecchymosis also noted during procedure. Right hip surgical incision noted with 65 staples measuring 35.0 x 1.0 cm. Areas werecleanse with betadine, covered with dry dressing, Tx as ordered. On 5/8/25 at 1451 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 1. LVN 1 verified there wasno physician's order to apply betadine to Resident 2's wound care, and it would require a physician's order. On 5/14/25 at 1335 hours, an interview was conducted with the DON. The DON verified the betadine wound care would require a physician's order. On 5/14/25 at 1437 hours, the Administrator and the DON acknowledged the above findings.

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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** 49348 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent the development or worsening of pressure injuries for one of eight sampled residents (Resident 7). * The facility failed to apply barrier cream to Resident 7's sacrum during the wound care as ordered by the physician. * Resident 7's wound care assessment failed to reflect Resident 7 had underminingto the sacrococcyx pressure injury. * The facility failed to ensure the low air loss mattress settings for Resident 7 were set correctly. These failures had the potential for Resident 7 to not receive the appropriate care and services to promote healing of the pressure injury. Findings: Review of the facility P&P titled Skin and Wound Monitoring and Management revised 1/2023 showed the following: 1. A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not be limited to: - measuring the skin injury; - staging the skin injury (when the cause is pressure); - describing the nature of the injury; - describing the location of the skin alteration; - describing the characteristics of the skin alteration 2. Suggestions for measuring: assessment of the pressure injury for tunneling, and undermining is an important part of the complete pressure injury assessment. 3. If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative note documenting that notification. 4. Monitoring: daily via medication administration and treatment administration records; confirm all orders have implemented as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Communication of Changes: any changes in the condition of the resident's skin as identified daily, weekly, monthly or otherwise, must be communicated to: resident/responsible party, the resident's physician, others as necessary to facilitate healing. 1. Review of Resident 7's medical record was initiated on 5/8/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 7 had a diagnosis of anoxic brain damage. Review of Resident 7's H&P examination dated 5/8/25, showed Resident 7 was able to open eyes occasionally with tracking, non-verbal, and unable to follow commands. Review of Resident 7's Order Summary Report showed the following orders dated: - 5/6/25, apply barrier cream to perineal and sacral areas everyday shift for skin management and as needed; - 5/8/25 Santyl (medication to treat wounds) external ointment, apply to sacrum topically every day shift for wound management for 30 days. On 5/8/25 at 0941 hours, an observation was made of LVNs 1 and 2 performing wound care to Resident 7's sacrococcyx pressure injury. During the observation, Resident 7 had undermining from 8 o'clock to 12 o'clock. LVN 2 performed woundcare to the exposed tissue areas and did not perform wound care to the undermining areas. On 5/8/25 at 1100 hours, an interview was conducted with LVN 2. When LVN 2 was askedif Resident 7 had any undermining present, LVN 2 stated, I didn't notice, didn't see any loose skin. On 5/8/25 at 1139 hours, a concurrent observation of Resident 7 and interview was conducted with LVNs 1 and 2. LVN 2 verified Resident 7's sacrococcyx pressure injury had undermining from 8 o'clock to 12 o'clock of 3 cm. On 5/8/25 at 1148 hours, an interview was conducted with LVN 1. LVN 1 stated he did not notice the undermining upon initial assessment but will notify the physician regarding the undermining. 2. Review of Resident 7's LN-Initial Admission Record dated 5/6/25, showed Resident 7 had a coccyx pressure injury. Further review of the Initial Admission Record did not show the measurements or staging of the pressure injury. Review of Resident 7's LN Skin Evaluation PRN/Weekly document dated 5/7/25, did not address Resident 7 had undermining to the sacrococcyx pressure injury. Review of Resident 7's Care Plan Report showed the following: - dated 5/6/25, hadpressure ulcer of the sacrum related to been immobile, incontinent. The interventions included to assess/record/monitor wound healing; assess and document status of the wound perimeter, wound bed and healing progress; report improvements and declines to the MD; to administer treatments as ordered; and to monitor for effectiveness. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 1100 hours, an interview and concurrent observation of Resident 7 was conducted with LVNs 1 and 2. When LVN 2 was asked if Resident 7 was observed to have undermining, LVN stated she did not see any undermining. On 5/9/25 at 1006 hours, an interview was conducted with the DON. The DON stated the undermining areas for Resident 7's sacrococcyx pressure injury would also require cleaning the wound and applying the treatment as ordered by the physician. 3. Review of Resident 7's Weights and Vitals Summary dated 5/7/25, showed Resident 7's weight was 116 pounds. Review of Resident 7's MDS assessment dated [DATE], showed the following assessment in section GG Functional Abilities: - roll left and right 1 , indicating dependent - sit to lying 88 , indicating not applicable due to medical condition or safety concerns. -l [NAME] to sitting on side of bed 88 indicating not applicable due to medical condition or safety concerns. - sit to stand, 88 indicating not applicable due to medical condition or safety concerns. Review of Resident 7's Order Summary Report dated 5/6/25, showed to use the LAL mattress for wound management and check the placement and settings every shift. Review of Resident 7's Care Plan Report dated 5/7/25, showed Resident 7 had Stage 4pressure injury to the sacrum. The interventions included to use the LALM for wound management and check the placement and settings every shift. Review of the Med-Air 8 Alternating Pressure Mattress Replacement System with Low Air Loss User Manual showed for the pressure range selection, the users can adjust the pressure levels of the air mattress using the analog pressure dial to a desired firmness based on personal comfort or weight settings. On 5/8/25 at 0952 hours, a concurrent observation of Resident 7 and interviewwas conducted with LVN 1. LVN 1 verified Resident 7's LALM setting was set to 180 pounds, and Resident 7 weighs 116 pounds. On 5/9/25 at 1006 hours, an interview was conducted with the DON. The DON stated the LALM setting would be dependent on the resident'sweight. The DON verified the LALM setting for Resident 7 was not set according to Resident 7's weight of 116 pounds. On 5/14/25 at 1437 hours, the Administrator and the DON acknowledged the above findings.

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	555286	A. Building B. Wing	05/14/2025

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to maintain the accurate medical records for one of eight sampled residents(Resident 2). This failure had the potential for the resident's record not maintained to show accurate information. Findings: Review of the facility's P&P titled Documentation (undated) 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. Closed medical record review for Resident 2 was initiated on 4/25/25. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 2's MAR for March 2025 showed the following were checked off as completed on 3/13/25, when the resident had been discharged from the facility the day before: - heel protectors daily; - monitor apical pulse every shift, heart rate of 80 beats per minute; - monitor for signs and symptoms of pacemaker malfunction; - monitor pacemaker site to left side every shift for protrusion, bleeding, tenderness, redness, drainage, and discomfort; and - potassium chloride ER (extended release) oral tablet (potassium supplement). On 5/8/25 at 1451 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 1. LVN 1 verified Resident 2's MAR showed the task was completed on 3/13/25. On 5/9/25 at 0846 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON stated the check marks on Resident 2's MAR indicated as administered. The DON acknowledged and verified the above findings. On 5/14/25 at 1437 hours, the Administrator and the DON acknowledged the above findings.

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	555286	A. Building B. Wing	05/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the infection control practices were followed for one of eight sampled residents (Resident 1). * The facility failed to ensure the isolation gown found in the clean linen's drawer outside Resident 1's room was free from the soiled gloves. * The facility failed to change the soiled tracheostomy tie after performing the neck wound care for Resident 1. These failures posed the risk for transmission of infection and the development of disease-causing microorganisms. Findings: Review of the facility's P&P titled Infection Prevention and Control Program revised 10/2022 showed the following: a. Facility personnel will conduct themselves and provide care in a way that minimizes the spread of infection. b. Facility personnel will handle, store, process, and transport linens so as to prevent the spread of infection. c. The facility personnel will use effective methods for safe storage, transport, and disposal of garbage, refuse and infectious waste, consistent with all applicable local, state, and federal requirements for such disposal. Review of the facility's P&P titled Securing Tracheostomy Tubes (undated), showed all the tracheostomy tube ties shall be changed after the resident had a shower/bath, per trach tube tie change schedule, and as needed if soiled. 1. Review of Resident 1's medical record was initiated on 4/25/25. Resident 1 was admitted to the facility on [DATE]. Resident 1 had a diagnosis of acute and chronic respiratory failure, tracheostomy, and congenital malformation of skull and facial bones. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderate cognitive impairment with a BIMS score of 10, indicating moderate cognitive impairment. On 5/7/25 at 1004 hours, an observation of Resident 1's wound care treatment was conducted with LVN 1. During the observation, an isolation cart containing clean yellow folded isolation gowns was observed outside Resident 1's room. During the surveyor's donning of the yellow isolation gown, the wadded up gloves were found inside the left sleeve of the gown. LVN 1 verified the findings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 1312 hours, an interview was conducted with the IP nurse. When asked about the facility's process when gloves were found inside the isolation gown, the IP nurse stated the isolation gown should be checked before placing them in the clean linen drawers. On 5/7/25 at 1344 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the process for washing the isolation gowns was to take out the gloves and wash the gowns separately from the other linens; however, sometimes the gloves got stuck in the gowns, and since the gloves were plastic, it melted, but the laundry staff tried to check the gowns two to three times to make sure there were no gloves in the gowns. The Maintenance Director stated the best thing they coulddo to resolve the situation was to conduct an in-service. On 5/9/25 at 1006 hours, an interview was conducted with the DON. The DON stated she believed the gloves found inside the gown was an isolated incident and stated,I have no explanations, except that it shouldn't be there. 2. Review of Resident 1's Order Summary Report showed a physician's order for the following dates: - dated 3/11/25, to provide trach care every day and night shift. - dated 5/2/25, cleanse right neck wound with normal saline, pat dry, collagen powder, xeroform gauze (a wound dressing to maintain a moist wound environment), place abdominal dressing under trach tie, every day shift for wound management for 14 days until finished. Review of Resident 1's eINTERACT Change in Condition Evaluation V4.2 dated 4/20/25, showed Resident 1 had a 5 cm x 2.3 cm laceration to the right side of the neck inflicted by trach tie. The recommendations of the primary clinician showed the following: consult with the wound MD, treatment order received from the wound MD to cleanse right neck with NS (normal saline), pat dry, apply xeroform, cover with abdominal dressing under trach tie for support. Review of Resident 1's Respiratory Ventilation Records dated from 5/2-5/4/25, showed an order dated 5/4/25, equipment change 1 Further review of the Respiratory Ventilation Records dated from 5/2-5/4/25,showed the Equipment Change Code legend was coded as trach tie, 1. On 5/7/25 at 1004 hours, an observation was conducted with LVN 1 performing the wound care to Resident 1's right side neck wound. Resident 1 was observed to be present with a tracheostomy tube and a wound to the right side of the neck, and right sided facial and neck mass. LVN 1 began performing the wound care to Resident 1's right side of the neck. LVN 1 was observed to cleanse the wound with normal saline, patted dry, while working around the trach tie moving it up to gain access to the wound. LVN 1 was observed to walk to the restroom to wash his hands. LVN 1 returned to Resident 1, donned gloves, and applied xeroform, and an abdominal pad. LVN 1 completed the wound care and the same trach tie remained on Resident 1. On 5/7/25 at 1048 hours, LVN 1 verified Resident 1's trach tie was soiled. RT 1 and LVN 1 began changing the trach tie. After removal of the trach tie, the inner trach tie lining was observed with curled strands of hair, and shades of light brown, dark brown, bright red, dark red, and black to the inner lining of the trach tie and dated 5/4. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 1102 hours, an interview was conducted with RT 1. RT 1 stated the trach tie for Resident 1 was soiled and would require the trach tie to be changed. On 5/7/25 at 1104 hours, an interview was conducted with Resident 1. Resident 1stated the trach ties were changed once a week to one and half weeks. On 5/7/25 at 1127 hours, an interview was conducted with the IP nurse. The IP nurse stated the trach ties were changed every seven days, and if soiled. On 5/7/25 at 1440 hours, an interview was conducted with the DON. The DON stated if thetrach ties were visibly soiled, they should be changed regardless of if they were just recently changed. On 5/14/25 at 1437 hours, the Administrator and the DON were informed andacknowledged the findings.