

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 11/10/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for one of three sampled residents (Resident 1). * The facility failed to ensure Residents 1's bed was in a low position as per the resident's care plan. Resident 1 fell from the bed and sustained a fracture on left lower leg. This failure contributed in Resident 1 sustaining serious injuries from fall and suffering from pain. Findings: According to the National Institute of Health publication titled Biomechanical Evaluation of Injury Severity Associated with Patients Falls from Bed published on 11/15/2008, showed falling from a high bed is dangerous, with potential effects ranging from sprains to severe injuries like fractures, concussions, traumatic brain injuries, and spinal cord injuries. The risk and severity of injury increase with the height of the bed and the hardness of the landing surface. Risk factors included the height of the bed. Higher beds increase the risk of more severe injury. Preventing falls from high beds include using low beds to minimize fall height. Review of the facility's P&P titled Falls Prevention dated 02/2023 showed residents identified at risk for falls would have appropriate interventions. Each resident fall, the facility would implement actions to reduce the incidence of falls and minimize potential injury from fall. The CDPH, L&C Department received a Letter from the facility dated 11/3/25, to report an Unusual Occurrence (fall with fracture). The facility Letter showed on 10/31/25 at approximately 1500 hours, Resident 1 sustained an unwitnessed fall. The report showed Responsible Party 1 was present at the facility and observed Resident 1 fall from the bed. The Letter further showed Resident 1 was transferred to the acute care hospital and returned at 0045 hours with fracture to the left lower extremity. On 11/6/25 at 1015 hours, an observation of Resident 1 and concurrent interview was conducted with Family Member 1 at bedside. Resident 1 was observed in bed as awake, alert and able to respond by gestures. Resident 1 was observed with a cast on the left lower leg with skin discoloration above the cast. Family Member 1 stated on 10/31/25 at around 1500 hours, he visited Resident 1 in the facility. Family Member 1 stated he looked at Resident 1's bed but Resident 1 was not in bed, and he noticed the bed was elevated high. Family Member 1 stated he thought maybe the staff got Resident 1 up in the wheelchair to attend the holiday party in the activity room. Family Member 1 stated when he was about to go to the activity room, he heard someone was calling for help. Family Member 1 found Resident 1 on the floor, on the left side of the bed, lying on her left side in a curl-ball-like position, crying, and in a lot of pain. Family Member 1 stated he yelled for assistance from the staff. Family Member 1 stated he accompanied Resident 1 to the hospital and was informed Resident 1 had a fracture on her lower left leg in three different bones. Family member 1 further stated Resident 1 had fallen hard from the bed and suffered pain and broken bones. Medical record review for Resident 1 was initiated on 11/6/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/5/25, showed Resident 1 had a diagnosis of Alzheimer's Dementia and a history of fall, and had no capacity to understand and make decisions. Review of Resident 1's Fall Risk Evaluation dated 7/21/25, showed Resident 1 was at risk for falls and had a history of fall in the past three months. Review of Resident 1's Physician Order Summary showed the following physician's orders:- dated 7/21/25, for the use of bilateral bolster pillows while in bed for postural support and proper body alignment, and- 10/6/25, for the use of bilateral floor mats to minimize risk of injury. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had severe cognitive impairment, dependent on staff on all ADLs, and had a history of fall. Review of Resident 1's Care Plan Report showed a care plan problem initiated on 5/4/25, addressing the risk for falls related to late effects of nontraumatic intracerebral hemorrhage, generalized body weakness, left hemiplegia, seizure disorder, impaired vision, Alzheimer's disease and medication side effects. The interventions included were to place the floor mats to minimize risk of injury and place the bed in low position. Review of Resident 1's Progress Notes dated 10/31/25 at 1608 hours, showed at around 1515 hours, Responsible Party 1 informed the licensed nurse Resident 1 was on the floor. The note further showed during the assessment Resident 1 complained of pain to the left lower extremity, noted with bump on top of anterior (front) part of the ankle, and light blue discoloration to the left side of foot. Review of Resident 1's Change of Condition Evaluation showed the following:- dated 7/21/25, Resident 1 had a fall; and- dated 10/31/25, Resident 1 had a fall. The Review Findings And Provider Notification - Summary section showed the nurse was notified Resident 1 was on the floor, and Resident 1 was side lying on the left side of the bed. The documentation further showed bump on left ankle noted</p>		