

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  11/26/2025
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 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)

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, medical record review, and facility P&amp;P review, the facility failed to ensure quality care and services were provided for two of ten sampled residents (Residents 4 and 6). * The facility failed to ensure Resident 4 was monitored for the side effects and the effectiveness of the diabetic medication, and for signs and symptoms of hyperglycemia (high blood glucose). * The facility failed to ensure Resident 6's glucose monitoring was performed as ordered by the physician. These failures had the potential for the residents to not receive the necessary care and services to maintain their highest physical well-being. Findings: Review of the facility's P&amp;P titled Guidelines for Medication Administration (undated) showed to observe the resident/patient for immediate reaction and any reactions that occur during the hours following administration. Record relevant and required information on the appropriate documentation record. Review of the facility's P&amp;P titled Comprehensive Resident Centered Care Plan revised January 2021 showed it is the policy of this facility that the IDT shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 1. Closed medical record review for Resident 4 was initiated on 11/19/25. Resident 4 was admitted to the facility on [DATE], and discharged on 11/14/25. Review of Resident 4's Order Summary Report showed a physician's order dated 11/6/25, for insulin glargine-yfgn (a long-acting biosimilar insulin) subcutaneous (under the skin) solution 100 units/ml. Inject 15 units subcutaneously at bedtime for DM. Review of Resident 4's LTC admission H&amp;P examination dated 11/7/25, showed the resident had no decision making capacity and had diagnoses including DM Type 2. Review of Resident 4's care plan for DM dated 11/7/25, showed the following interventions:- Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.- Monitor/document/report to MD PRN for signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Further review of Resident 4's medical record failed to show documented evidence the resident was monitored for the side effects and effectiveness of the diabetic medication and for the signs and symptoms of hyperglycemia (high blood glucose). On 11/25/25 at 1347 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 verified Resident 4 was not monitored for the side effects and effectiveness of the diabetic medication and for the signs and symptoms of hyperglycemia. RN 2 stated the licensed nurse should have asked Resident 4's physician upon admission for an order to monitor the signs and symptoms of hypoglycemia (low blood glucose) and hyperglycemia. RN 2 further stated the licensed nurse should have also asked Resident 4's physician if he could order for blood sugar checks. RN 2 stated it was important to check the resident's blood sugar to know if it was high or low and to prevent further complications. On 11/25/25 at 1501 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have clarified to Resident 4's physician with regards to diabetic medication and blood sugar monitoring. The DON stated the resident needed monitoring to make sure that the current treatment is effective. 2. Medical record review for Resident 6 was initiated on 11/19/25. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's Order Summary Report showed a physician's order dated 3/4/24, for Accucheck one time daily in the morning AC. Review of Resident 6's MDS assessment dated [DATE], showed Resident 6 was cognitively intact. Review of Resident 6's MARs from October to November 2025 failed to show glucose monitoring was completed on 10/28, 11/14, 11/19, and 11/22/25. On 11/25/25 at 1427 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 6's glucose monitoring was not completed on 10/28, 11/14, 11/19, and 11/22/25. RN 2 stated the licensed nurse should have charted the reason why Resident 6's glucose monitoring was not done so whatever happens to the resident, it was documented. On 11/25/25 at 1540 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated if Resident 6 refused, the licensed nurse should have put refused or document in the progress notes. The DON stated it was important to check the blood sugar to ensure the blood sugar was within normal limits and the resident was not having symptoms of hypoglycemia or hyperglycemia</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure the medical record was accurate for one of ten sampled residents (Resident 4). * The facility failed to ensure Resident 4's Fall Risk Evaluation was accurate. This failure posed the risk for Resident 4 not to receive the accurate and necessary care. Findings: Review of the facility's P&amp;P titled Falls Prevention revised February 2023 showed a post fall assessment including the rehabilitation department staff designee and care plan changes will be completed for all residents who have experienced a fall. Review of the facility's P&amp;P titled Documentation (undated) showed the resident's 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 4 was initiated on 11/19/25. Resident 4 was admitted to the facility on [DATE], and discharged on 11/14/25. Review of Resident 4's LTC admission H&amp;P examination dated 11/7/25, showed the resident had no decision making capacity. Review of Resident 4's SBAR Communication Form dated 11/12/25, showed the resident had a fall and no changes were observed. However, review of Resident 4's Fall Risk Evaluation dated 11/12/25, showed the resident had no falls in the past three months. On 11/25/25 at 1410 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 verified Resident 4 fell on [DATE], and the Fall Risk Evaluation dated 11/12/25 showed Resident 4 had no falls in the past three months. RN 2 stated the licensed nurse who did Resident 4's Fall Risk Evaluation did not include the current fall. RN 2 stated the licensed nurse should have chosen one to two falls in the past three months because Resident 4 fell. On 11/25/25 at 1525 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified Resident 4's Fall Risk Evaluation was inaccurate. The DON acknowledged Resident 4 had a fall on 11/12/25, and the Fall Risk Evaluation showed no falls in the past three months. The DON stated the licensed nurse did not count the present fall and should have included the fall as part of the history of fall.</p>		