

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Advanced Rehab Center of Tustin		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 E. First Street Santa Ana, CA 92705	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on interview and medical record review, the facility failed to send a copy of the notice of the transfer/discharge to the representative of the Office of the State Long-Term Care Ombudsman for two of three sampled residents (Residents 1 and 2). This failure posed the risk of the Ombudsman not being aware of the circumstances of the residents' transfer/discharge should the appeal be filed or requested by the residents or their representatives regarding the transfers.</p> <p>Findings:</p> <p>1. Medical record review for Resident 1 was initiated on 1/10/25. Resident 1 was admitted to the facility on [DATE], transferred to the acute care hospital on 12/12/24, and readmitted to the facility on [DATE].</p> <p>Review of Resident 1's H&P examination dated 12/30/24, showed Resident 1 had impaired judgment and did not have mental capacity to make decisions.</p> <p>Review of Resident 1's progress note dated 12/12/24, showed the physician assessed Resident 1 and ordered for Resident 1's transfer to the acute care hospital.</p> <p>Further review of Resident 1's medical record failed to show the copy of the written notice of transfer/discharge was sent to the LTC Ombudsman on 12/12/24.</p> <p>2. Medical record review for Resident 2 was initiated on 1/15/25. Resident 2 was admitted to the facility on [DATE], transferred to the acute hospital on 12/26/24 and readmitted to the facility on [DATE].</p> <p>Review of Resident 2's H&P examination dated 1/13/25, showed Resident 2 had mental capacity to make decisions.</p> <p>Review of Resident 2's SBAR Communication Form-General dated 12/26/24, showed under the nursing notes, the physician assessed the resident and ordered to transfer Resident 2 to the acute care hospital.</p> <p>Further review for Resident 2's medical record failed to show the copy of the written notice of transfer/discharge was sent to the LTC Ombudsman.</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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 1/15/25 at 1040 hours, an interview and concurrent medical review was conducted with RN 1. RN 1 stated the RN or charge nurse will handle the transfer of the resident including completing the notice of transfer/discharge. Furthermore, RN 1 stated whoever transferred the resident will forward a copy of the notice to the Ombudsman.</p> <p>On 1/15/25 at 1425 hours, an interview and concurrent medical review was conducted with the DON. The DON stated the notice of transfer/discharge should be faxed or forwarded to the Ombudsman within 24 hours.</p> <p>On 1/15/25 at 1615 hours, an interview was conducted with DON and ADON. Both the DON and ADON confirmed there was no documentation or evidence the notice of transfer/discharge was sent to the Ombudsman.</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) and/or the resident's representative was provided a written bed hold policy prior to the transfer. This failure had the potential for the resident or resident's representative to not be informed of their rights to return to the facility following a hospitalization .</p> <p>Findings:</p> <p>Review of the facility's P&P titled Bed-holds and Returns revised 3/2017 showed prior to the transfers, the residents or residents' representatives will be informed in writing of the bed hold and return policy.</p> <p>Medical record review for Resident 1 was initiated on 1/10/25. Resident 1 was admitted to the facility on [DATE], transferred to the acute care hospital on 12/12/24, and readmitted to the facility on [DATE].</p> <p>Review of Resident 1's H&P examination dated 12/30/24, showed Resident 1 had impaired judgment and did not have mental capacity to make decisions.</p> <p>Review of Resident 1's progress notes dated 12/12/24, showed the physician assessed Resident 1 and ordered for Resident 1's transfer to the acute care hospital.</p> <p>Further review of Resident 1's medical record failed to show Resident 1 and/or the resident's representative was informed of the facility's bed hold policy before transferring to the acute care hospital.</p> <p>On 1/15/25 at 1425 hours, an interview and concurrent medical record review was conducted with the DON. The DON confirmed the admission part on the bed hold informed consent on admission for Resident 1 was blank. Furthermore, the DON stated the bed hold informed consent should be explained to the resident or resident's representative on admission.</p>