STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055330	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab Center of Tustin	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)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the preparation for a safe and orderly discharge for one of two sampled residents (Resident 1). * Resident 1 was transferred to an acute care hospital without the hospital being notified and without the medical records being sent. * Resident 1 was transferred to an acute care hospital without the transferring nurse providing any report to the nurse at the receiving facility. * Resident 1's personal and demographic information, H&P examination, medication list, physician's orders, and POLST were not provided to Acute Care Hospital 1. These failures posed the resident at risk for not meeting the resident's medical needs when the receiving facility did not receive the needed documents for the transfer with the necessary medical information. Findings: Review of the facility's P&P titled Transfer or Discharge, Emergency revised 8/2018 showed if it is necessary to make an emergency transfer or discharge to a hospital or other related institution, the receiving facility must be notified that the transfer was being made. The P&P also showed the residents medical records must be forwarded to the medical records office of the receiving facility within 24 hours of the transfer or discharge. Closed medical record review for Resident 1 was initiated on 2/24/25. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's H&P examination dated 1/29/25, did not address Resident 1's capacity to understand and make medical decisions. Resident 1 had diagnoses including PTSD and a TBI from an MVA. Review of Resident 1's MDS dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 1's Change in Condition Evaluation dated 2/6/25 at 2100 hours, showed the resident had increased confusion, combative behaviors, and required a one-to-one sitter. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Order Summary Report showed a physician's order dated 2/6/25, for Resident 1 to transfer to Acute Care Hospital 1 for combative behavior, increased confusion, attempting to get out of bed with a history of recurrent falls. Review of Resident 1's transfer form dated 2/6/25, signed by RN 2 showed a verbal health information exchange was done. Resident 1's transfer form failed to show the name and title of the nurse who called in the report to Acute Care Hospital 1. Additionally, Resident 1's transfer form failed to show the name and title of the nurse who received the report. On 2/24/25 at 1429 hours, an interview was conducted with RN 2. RN 2 stated when the report was called to another facility and the name and title of the nurse who received the report is supposed to be documented. RN 2 stated she could not remember who she spoke to at Acute Care Hospital 1 or if it was another nurse who called in the report. RN 2 stated Resident 1's face sheet, H&P, medications list, orders, and POLST were supposed to be printed from the electronic charting record and handed to the ambulance personnel. RN 2 stated she thought she had given the medical records to the ambulance personnel. RN 2 stated the ambulance personnel kept a record on their iPad. RN 2 stated they did not keep a record of which medical records were sent because they were printed from the electronic record system. On 2/24/25 at 1609 hours, a concurrent interview and closed medical record review was conducted with the DON. The DON stated the transferring nurse must call the report to the nurse at the receiving facility for continuity of care. The DON stated it was an expectation that the transferring nurse complete a transfer discharge form. The nurse calling to give the report from our facility should document the name of the nurse they called report to. The DON acknowledged there was no documentation to show the acute care hospital was provided with Resident 1's medical information during the transfer. On 2/25/25 at 1550 hours, a concurrent interview and closed medical record review was conducted with the Administrator and DON. The Administrator stated he was notified on 2/7/25, via email by Acute Care Hospital 1 they had not been notified of the transfer, there were no medical records sent, and there was no accepting MD. The Administrator stated their medical records department staff did not send Resident 1's medical record to Acute Care Hospital 1, and they had not received a request for medical records from Acute Care Hospital 1. The DON stated the medical records were supposed to be sent with the resident when the resident was transferred to the acute care hospital. The Administrator and DON verified the findings.