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	07/09/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse by a resident for one of five sampled residents (Resident 1). * Resident 1 was hit on the nose by another resident (Resident 2), which resulted in Resident 1 having a nasal fracture (broken nose). This failure had the potential to negatively impact Resident 1's well-being.Findings:Review of the facility's P&P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 4/2021 showed the residents have the right to be free from abuse, this includes but not limited to freedom of physical abuse, protect residents from abuse by anyone including other residents. Review of the facility's SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 6/24/25, showed a report of a resident-to-resident altercation between Residents 1 and 2 by the ADON. Medical record review for Resident 1 was initiated on 7/9/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a BIMS score of 14 (cognitively intact). Review of Resident 1's H&P examination dated 4/15/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's SBAR Communication Form dated 6/24/25, showed at approximately 1300 to 1310 hours Residents 1 and 2 were in the patio socializing when RN 1 heard a commotion from the patio. RN 1 immediately went to the patio and tried to intervene the altercation from happening, but it was too late. Resident 2 had punched Resident 1 on her nose. RN 1 separated both residents. Resident 1 was assessed for pain, and an ice pack was applied to Resident 1's nose. Resident 1's primary physician ordered to transfer Resident 1 to the acute care hospital for further evaluation due to the bleeding of the nose post resident to resident altercation. Review of Resident 1's acute care hospital record showed Resident 1 was admitted to the acute care hospital on 6/24/25, for face and nose pain status post being punched in the face twice in the skilled nursing facility. The CT scan performed on 6/24/25, showed the small left frontal (front of the brain, behind the forehead) and supraorbital (the region of the skull directly above the eye socket) scalp hematoma and acute nasal bone fracture (broken nose).On 7/7/25 at 0912 hours, an interview was conducted with Resident 3 (who had the mental capacity to make decisions based on the H&P examination dated 7/6/25). Resident 3 verified she was in the patio when the altercation between Residents 1 and 2 happened. Resident 3 stated she heard Resident 2 pounding on the table saying he had to be in the facility for 180 days and suddenly got mad. Resident 1 asked Resident 2 to leave and suddenly Resident 2 hit Resident 1 twice on the face, then walked away. Resident 3 further stated Resident 1 was screaming and blood was coming out of her nose. Resident 3 denied hearing Resident 1 cursing at Resident 2.On 7/7/25 at 0939 hours, an interview was conducted with Resident 4 (who had the capacity to understand and make decisions based on the H&P examination dated 1/15/25). Resident 4 verified she was in the patio when the altercation between Residents 1 and 2 happened. Resident 4 stated the residents were sitting in the patio talking and having a good time when suddenly Resident 2 stood up, raised both hands, and hit Resident 1 for no reason. Resident 4 further stated Residents 1 and 2 did not have an argument and did not know why Resident 2 had hit Resident 1.On 7/7/25 at 0956 hours, an interview was conducted with Resident 5 (who was alert and orient to person, place and time based on the H&P examination dated 6/3/25). Resident 5 verified he was at the patio when the altercation between Residents 1 and 2 happened. Resident 5 stated Resident 2 looked mean and pounded on the table several times. Resident 5 stated Resident 2 stood up, went around the table, started hitting Resident 1 four to five times in the face, and then walked away. Resident 5 further stated Resident 2 tried to come back, but he pulled Resident 2 away.On 7/8/25 at 1039 hours, a telephone interview was conducted with Resident 2. Resident 2 was asked to describe the physical altercation between himself and Resident 1 on 6/24/25. Resident 2 stated he remembered he was in the patio talking to Resident 1 about pain management. Resident 2 stated Resident 1 was being rude and used foul language towards him. Resident 2 stated he got upset, then got up, and slapped Resident 1 twice on the face. Resident 2 stated the staff did come immediately and took him out of the patio.On 7/8/25 at 1056 hours, a telephone interview was conducted with Resident 1. Resident 1 was asked to describe the physical altercation between herself and Resident 2 on 6/24/25. Resident 1 stated after lunch, she was sitting with the other residents at a table in the patio, and Resident 2 came and sat down with them. Resident 1 stated Resident 2 said he had to be in the facility for 180 days, then Resident 1 said, aren't you new here for 3 days? Resident 1 then observed Resident 2 got

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 2) who was receiving aripiprazole (antipsychotic-class of medications that treat mental illness) was monitored for its side effects. This failure had the potential for increased risk of medication adverse reactions to be undetected.Findings: Review of the facility's P&P titled Antipsychotic Medication Use revised 12/2015 showed the nursing staff shall monitor for and report the side effects of antipsychotic medications to the attending physician. Medical record review for Resident 2 was initiated on 7/8/25. Resident 2 was admitted to the facility on [DATE].Review of Resident 2's H&P examination dated 6/24/25, showed Resident 2 had fluctuating capacity to understand and make decisions. The resident had a diagnosis of psychosis. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 was cognitively intact. Further review of the MDS assessment showed Resident 2 had no behavioral symptoms exhibited such as physical behavioral symptoms directed toward others (for example-hitting, pushing, scratching, grabbing, or abusing others sexually) and verbal behavioral symptoms directed toward others (for example-threatening others, screaming at others, or cursing at others).Review of Resident 2's Baseline Care Plan initiated on 6/19/25, showed Resident 2 was on antipsychotic medication with interventions included to monitor for the adverse effect, monitor the behavior manifestation and notify the medical doctor as needed. Review of Resident 2's Physician Order Summary dated 7/8/25, showed there was an order on 6/20/25, for aripiprazole (medication used to manage various mental health conditions) 5 mg by mouth two times a day for psychosis as manifested by striking out. On 7/9/25 at 1115 hours, a review of Resident 2's MAR for June 2025 and concurrent interview was conducted with the DON. Resident 2's MAR showed the resident had taken aripiprazole as ordered; however, there was no evidence to show the monitoring of the aripiprazole medication side effects were documented. The DON verified and acknowledged the above findings.