

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 08/05/2025
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)		
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for two of five sampled residents (Residents 1 and 5). * The facility failed to develop a care plan to address Resident 1's laceration to the right temporal area. * The facility failed to develop a care plan to address Resident 5's skin tear to the left forearm. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 12/2016 showed a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. Closed medical record review for Resident 1 was initiated on 7/16/25. Resident 1 was readmitted to the facility on [DATE], and discharged on 6/19/25. Review of Resident 1's H&P examination dated 2/27/25, showed the resident had no capacity to understand and make decisions. Review of Resident 1's SBAR Communication Form - General dated 3/11/25, showed the resident had an unwitnessed fall and had a laceration to the right temporal area. Review of Resident 1's plan of care failed to show a care plan was developed to address the resident's laceration to the right temporal area. On 8/1/25 at 1453 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 was not able to show a care plan was developed to address Resident 1's laceration to the right temporal area. RN 2 stated the licensed nurse should have made a care plan for Resident 1's fall because it was a change of condition. On 8/5/25 at 1400 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified Resident 1 had unwitnessed fall with laceration to the right temporal area on 3/11/25, however there was no care plan to address the resident's laceration to the right temporal area. The DON stated Resident 1 was transferred out to acute care hospital for further evaluation and the licensed nurse did not do the care plan. The DON stated the care plan should have been initiated to reflect the interventions provided prior to Resident 1's transfer to the acute care hospital. 2. Medical record review for Resident 5 was initiated on 7/17/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 4/26/25, showed the resident had no capacity to make decisions. Review of Resident 5's SBAR Communication Form - General dated 7/1/25, showed the resident had unwitnessed fall with skin tear on the left forearm. Review of Resident 5's plan of care failed to show a care plan to address the resident's skin tear to the left forearm. On 8/1/25 at 1128 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified there was no care plan for Resident 5's skin tear on the left forearm. LVN 3 stated the licensed nurse should have initiated the care plan after doing the SBAR. On 8/5/25 at 1339 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 5 had left forearm skin tear from an unwitnessed fall on 7/1/25, and there was no care plan to address the resident's left forearm skin tear. The DON stated the licensed nurse who identified the change of condition should have initiated the care plan for Resident 5.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Braden scale assessment was performed for one of the three sampled residents (Resident 1) reviewed for the pressure injury. This failure had the potential to result in a delay in interventions being put in place to prevent further decline. Findings: Review of the facility's P&P titled Pressure Injury/Ulcer Risk Assessment revised 3/2024 showed the purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries or pressure ulcers. The General Guidelines section showed to repeat the risk assessment/Braden scale assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. Closed medical record review for Resident 1 was initiated on 7/16/25. Resident 1 was readmitted to the facility on [DATE], and discharged on 6/19/25. Review of Resident 1's H&P examination dated 2/27/25, showed the resident had no capacity to understand and make decisions. Review of Resident 1's Pressure Ulcer Assessment - V 4 dated 4/2/25, showed the initial identified wound to the coccyx Stage 1 pressure injury declined to Stage 2 pressure injury. Review of Resident 1's SBAR Communication Form - General dated 4/2/25, showed the resident's coccyx Stage 1 pressure injury declined to Stage 2 pressure injury. Review of Resident 1's Pressure Ulcer Assessment - V 4 dated 5/29/25, showed the wound to the coccyx area was re-classified to Stage 3 but was smaller in size. Review of Resident 1's SBAR Communication Form - General dated 5/29/25, showed Resident 1 had wound to the coccyx area was re-classified to sacrococcyx Stage 3 pressure injury. Further review of Resident 1's closed medical record failed to show documented evidence Resident 1 received repeated risk assessments or Braden scale assessments for Stage 2 and Stage 3 pressure injury. On 8/1/25 at 1153 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 verified Resident 1's Stage 2 pressure injury was developed on 4/2/25, and the risk assessment or Braden scale assessment for the Stage 2 pressure injury was not performed. In addition, LVN 2 verified Resident 1's Stage 3 pressure injury was developed on 5/29/25, and the risk assessment or Braden scale assessment for the Stage 3 pressure injury was not performed. LVN 2 stated the licensed nurse performed the Braden scale on the residents' admission to the facility but did not perform the Braden scale for a change of condition on the wound. LVN stated she would verify with the DON if the licensed nurse needed to perform the Braden scale for a change of condition on the wound. On 8/5/25 at 1400 hours, an interview and concurrent closed medical record review was conducted with the DON. The SBAR Communication Form - General showed Resident 1 had a Stage 2 pressure injury on 4/2/25, and a Stage 3 pressure injury on 5/29/25. The DON verified Resident 1 had change of condition of pressure injuries on 4/2 and 5/29/25, and the Braden Scale assessments were not done. The DON stated there was a change in Resident 1's skin and the Braden scale assessment should have been completed by the licensed nurse who identified the changes in the resident's skin condition.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurate for one of three sampled residents (Resident 4). This failure posed the risk for Resident 4 not to receive the accurate and necessary care. Findings: Review of the facility's P&P titled Fall Risk Assessment copyright 2001 showed the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. Review of the facility's P&P titled Charting and Documentation revised 7/2017 under the Policy Interpretation and Implementation section showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 4 was initiated on 7/17/25. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 3/25/25, showed the resident could make his needs known and medical decisions. Review of Resident 4's SBAR Communication Form - General dated 4/5/25, showed the resident had unwitnessed fall and no changes was observed. However, review of Resident 4's Fall Risk Assessment - V 2 dated 4/5/25, showed the resident had no falls in the past three months. On 8/1/25 at 1433 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 4 fell on 4/5/25, and the Fall Risk assessment dated [DATE], showed Resident 4 had no falls in the past three months. RN 2 stated it should have been marked as one to two falls in the past three months because Resident 4 fell. On 8/5/25 at 1318 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the Fall Risk Assessment was inaccurate. The DON acknowledged Resident 4 had an unwitnessed fall on 4/5/25, however the Fall Risk Assessment showed no falls in the past three months. The DON stated the licensed nurse should have clicked one to two falls in the past three months instead of no falls in the past three months.</p>		