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	11/13/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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, and facility P&P review, the facility failed to ensure an allegation of abuse was immediately reported to the CDPH, L&C Program, Ombudsman Office, and local law enforcement agency for one of four sampled residents (Resident 1). * Resident 1 alleged CNA 1 shook the resident's shower chair, pulled and yanked their hands, and kicked them. This failure had the potential for Resident 1 to be vulnerable to further abuse and emotional distress.Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 4/2024 showed all the reports of resident abuse, neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by the facility management. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. Immediately is defined as: a. within two hours of an allegation involving abuse or result in physical harm/serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in physician harm/serious bodily injury. Further review of the facility's P&P showed the administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:a. The state licensing. certification agency responsible for surveying/licensing the facility;b. The local/state ombudsman;c. The resident's representative;d. Adult protective services (where state law provides jurisdiction in long-term care);e. Law enforcement officials;f. The resident's attending physician; andg. The facility medical director. On 11/10/25, the CDPH, L&C Program received an SOC 341 report regarding Resident 1. The report showed Resident 1 alleged experiencing physical abuse at the facility about three months ago (August 2025). Resident 1 reported CNA 1 was showering with the resident, lathering her, and causing her not to be able to breathe. Resident 1 said CNA 1 took offense to something that was said and then started shaking the resident's shower chair, pulling, yanking my hands back, and kicking me. Resident 1 stated she reported this to the other CNAs and one nurse practitioner. Closed medical record review for Resident 1 was initiated on 11/12/25. Resident 1 was admitted to the facility on [DATE], readmitted on [DATE], and discharged on 10/20/25. Review of Resident 1's H&P examination dated 8/15/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderately impaired cognition. Review of Resident 1's medical record failed to show any documentation of Resident 1's allegation of abuse by CNA 1. On 11/12/25 at 1035 hours, an interview was conducted with the Administrator and DON. The Administrator and DON stated they were not aware of any abuse allegation for Resident 1. On 11/12/25 at 1315 hours, a telephone interview was conducted with CNA 1. CNA 1 stated she had been assigned as Resident 1's CNA in the past and had only given Resident 1 one shower. CNA 1 stated she was unable to recall the exact date. CNA 1 stated during the shower, Resident 1 became upset when CNA 1 was going to use the washcloth to clean Resident 1's body. CNA 1 stated Resident 1 said no and told CNA 1 not to use towels on her body. CNA 1 stated from that time, Resident 1 acted like CNA 1 was her enemy. CNA 1 stated after that shower incident, Resident 1 was telling other facility staff that CNA 1 was trying to kill her with the washcloth and soap. CNA 1 stated the next time she was assigned to give Resident 1 a shower, Resident 1 had refused the shower. On 11/13/25 at 0835 hours, a follow-up telephone interview was conducted with CNA 1. CNA 1 stated on another date following the shower incident, CNA 1 was in Resident 1's room, providing care to Resident 2 (Resident 1's roommate) when CNA 1 heard Resident 1 had refused her shower with her assigned CNA that day. CNA 1 stated she heard the CNA ask Resident 1 why she did not want her shower. CNA 1 stated she heard Resident 1 tell the CNA she did not want to have a shower because CNA 1 tried to kill her with the washcloth in the shower. CNA 1 was asked about the facility's abuse protocol and CNA 1 stated any allegation of abuse should be reported to the abuse coordinator, the Administrator. CNA 1 was asked if she reported Resident 1's allegation of abuse and CNA 1 stated the allegation was not true and CNA 1 did not attempt to kill Resident 1 with the washcloth. CNA 1 stated she did not report Resident 1's allegation of abuse and she should have reported it. On 11/13/25 at 1300 hours, an interview was conducted with the DON. The DON stated all the facility staff were mandated reporters and should report any allegation of abuse to the abuse coordinator immediately. On 11/13/25 at 1630 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON were informed and acknowledged the above

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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)

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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 0684 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 document review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 1) was provided quality care. * The facility failed to conduct a skin assessment following a newly observed skin impairment for Resident 1. In addition, the facility failed to document and monitor Resident 1's bilateral lower extremities wounds. These failures had the potential for delay in providing the necessary care and services to Resident 1.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed the facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injury or an unknown source. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition. Closed medical record review for Resident 1 was initiated on 11/12/25. Resident 1 was admitted to the facility on [DATE], readmitted on [DATE], and discharged on 10/20/25. Review of Resident 1's Skin Supplemental assessment dated [DATE], showed Resident 1 was admitted to the facility and a skin assessment was completed. Resident 1 was noted with scattered redness to the face and scar tissue to the bilateral lower extremities due to old wounds. The scar tissue appeared with hyperpigmentation. Review of Resident 1's H&P examination dated 8/15/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's Weekly Summary dated 8/17/25, showed under the Integumentary section, the licensed nurses documented Resident 1 had no skin breakdown. Review of Resident 1's Physician Progress Notes dated 8/20/25 at 1443 hours, showed Nurse Practitioner 1 documented Resident 1 had trace erythema in the right lower extremity with blister. Review of Resident 1's Weekly Summary dated 8/24/25, showed under the Integumentary section, the licensed nurses documented Resident 1 had no skin breakdown. Review of the facility document titled CNA Daily Body Check for Resident 1 dated 8/26/25, showed the CNA circled the areas of Resident 1's right and left lower extremities extending to both feet. Further review of the CNA Daily Body Check showed the licensed nurse signed the Daily Body Check on 8/26/25. Review of Resident 1's Physician Progress Notes dated 9/4/25 at 1608 hours, showed Nurse Practitioner 1 documented Resident 1 had trace erythema in the right lower extremity with blister. Review of Resident 1's Weekly Summary dated 9/7/25, showed under the Integumentary section, the licensed nurses documented Resident 1 had no skin breakdown. Review of Resident 1's Weekly Summary dated 9/14/25, showed under the Integumentary section, the licensed nurses documented Resident 1 had no skin breakdown. Review of Resident 1's Physician Progress Note dated 9/18/25 at 1151 hours, showed Nurse Practitioner 1 documented Resident 1 had trace erythema in the right lower extremity with blister.Review of Resident 1's TAR from 8/2025 to 10/2025 failed to show any treatment or monitoring of Resident 1's bilateral lower extremities. Review of Resident 1's medical record failed to show documentation the licensed nurse assessed Resident 1's bilateral lower extremities following the CNA's documentation on the CNA Daily Body Check on 8/26/25. Further review of Resident 1's medical record failed to show a care plan problem was initiated for the documented blister on Resident 1's right lower extremity. On 11/12/25 at 1620 hours, an interview was conducted with CNA 5. CNA 5 stated for the residents scheduled for showers, while in the shower, the CNAs checked the resident's skin for any new skin problems. If any new skin problems were observed, the CNA would document on the CNA shower sheet and inform the charge nurse or treatment nurse. CNA 5 stated at the end of the shift, the licensed nurse checked and signed the CNA shower sheets. On 11/13/25 at 1145 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with LVN 2. LVN 2 stated when new skin impairments were noted during care, the CNAs would inform the treatment nurse or the charge nurse. LVN 2 stated upon notification by the CNA of any new skin impairments, the licensed nurse would assess the resident's skin and document the findings, as well as notify the physician and initiate a change of condition. LVN 2 reviewed Resident 1's medical record and stated Resident 1 was readmitted to the facility with healed bilateral lower extremity wounds. LVN 2 further stated there were no physician's orders to administer treatment or monitor any skin impairments to Resident 1's bilateral lower legs. On 11/13/25 at 1300 hours, an interview and