STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055653	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Coast Post Acute	1030 W Warner Ave Santa Ana, CA 92707

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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32179

Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to promote dignity and respect for four nonsampled residents (Residents A, B, C and D)

* The facility failed to ensure the resident's call lights were answered in a timely manner for Residents A, B, C and D.

These failures posed the risk to negatively affect the residents' physical and emotional well-being.

Findings:

Review of the facility's P&P titled Call Light/Bell revised 9/2022 showed answer the resident call system immediately. If the resident needs assistance, indicate the approximate time it will take for you to respond. If the president's request requires another staff member, notify the individual. If resident's request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether a request can be fulfilled, or if you cannot fulfill resident's request, ask the nurse supervisor for assistance.

1. On 5/20/24 at 0910 hours, a concurrent observation and interview was conducted with Resident A. Resident A was observed sitting upright in the bed. Resident A stated she needed the staff's assistance with hygiene and diaper change. Resident A further stated the facility staff usually took more than 45 minutes to respond to her call light. When asked how she knew how long it took, Resident A stated she looked at the clock in front of her to check the time. Resident A further stated in the evening, the staff told her they were busy. Resident A stated she felt uncomfortable to wait for the staff for hours on a wet diaper.

Medical record review for Resident A was initiated on 5/20/24. Resident A was admitted to the facility on [DATE] and readmitted on [DATE].

Review of Resident A's History and Physical examination dated 12/4/23, showed Resident A had the capacity to understand and make decisions.

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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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NAME OF PROVIDER OR SUPPLIER South Coast Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1030 W Warner Ave Santa Ana, CA 92707	

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of Resident A's care plan dated 3/13/2024, addressing the resident's risk for occurrence of skin breakdown related to bladder incontinence, bowel incontinence, impaired bed mobility, aspirin use, admitted with pressure injuries, dx of colitis (inflammation of the inner lining of the colon) showed the interventions included to keep skin clean and dry at all times.

2. On 5/20/24 at 0935 hours, a concurrent observation and interview was conducted with Resident B. Resident B was observed lying in the bed with the head of bed at 60 degrees. Resident B stated the facility staff took more than an hour to respond to her call light during change of shift or in the evenings. Resident B stated she waited for a long time when she need assistance for transferring her from wheelchair to the bed. The staff told her they were busy and needed to look for a working and fully charged Hoyer lift. Resident B stated she felt uncomfortable sitting in long periods in her wheelchair, especially when she needs to have bowel movement after taking a laxative medicine. Resident B stated the issue was brought to resident council but was still ongoing.

Medical record review for Resident B was initiated on 5/20/24. Resident B was admitted to the facility on [DATE].

Review of Resident B's History and Physical examination dated 3/21/24, showed Resident B had capacity to understand and make decisions.

Review of Resident B's care plan dated 3/21/2024, showed the resident required assistance in the following areas: bathing, bed mobility, dressing, locomotion off unit, locomotion on unit, personal hygiene, toilet use, transfers secondary to diagnoses of left tibial plateau (knee to ankle) fracture, right knee fracture, osteoporosis (loss bone of density) and history of falling. The care plan interventions included to assist the resident with transfers as needed.

3. On 5/20/24 at 1110 hours, a concurrent observation and interview was conducted with Resident C. Resident C was observed laying on her back in app mattress bed. Resident C stated sometimes during the evening shift, she pressed the call light for assistance for diaper change, but the staff would take a long time. Resident 3 stated she would have to wait for more than 30 minutes or more than one hour during a change of shift or evening. The staff informed the resident that they were very busy.

Medical record review for Resident C was initiated on 5/20/24. Resident C was admitted to the facility on [DATE].

Review of Resident C's History and Physical examination dated 2/2/23, showed Resident C had capacity to understand and make decisions.

Review of Resident C's care plan dated 3/23/24, addressing the resident with bladder/bowel incontinence and at risk for UTI (urinary tract infection) and skin breakdown showed the interventions included to conduct the incontinent pads check and change when wet as needed.

4. On 12/28/23 at 0930 hours, a concurrent observation and interview was conducted with Resident D. Resident D was observed sitting up in wheelchair. Resident D stated sometimes during the night shift, she waits more than one hour after pressing the call light for assistance. Resident Dfelt upset about it and stated she needed assistance to be cleaned after a bowel movement in colostomy or to empty the bowel movement in colostomy bag.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident D was initiated on 5/21/24. Resident D was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident D's care plan dated 5/17/24, addressing the resident with alteration in bowel elimination pattern secondary to colostomy (opening the intestine draining to collection bowel movement bag) with bowel movement in rectum showed the interventions included to provide colostomy care as ordered. Review of the Resident Council Meeting Minutes dated 4/18/24, showed the residents had concerns with the staff taking longer than 30 minutes in between shifts to answer call lights. On 5/20/24 at 1600 hours, an interview was conducted with CNA 1. CNA 1 stated she had a lot of residents who needed total care assistance such as diaper change, showering, eating assistance, toileting, and hygiene. If there were a couple of residents requesting help at the same time, it was challenging to attend all the needs. CNA 1 verified the findings. On 5/20/24 at 1645 hours, an interview was conducted with LVN 1. LVN 1 stated he did not have any assignments yet for the residents and sometimes both him and the CNAs received their assignments late. LVN 1 stated it was challenging to answer the call lights at the same time when he was busy with the medication administration. On 5/20/24 at 1650 hours, an interview was conducted with the DSD. The DSD stated the staff coordinator usually made the schedule, but the schedules for the 3 pm to 11 pm shifts were missing from the binder located at nursing station. The DSD stated he did not know who took it and the staff coordinator was off. The DSD verified the findings. On 5/21/24 at 1025 hours, an interview and concurrent review of the resident council minutes dated 4/18/24, was conducted with the Director of Activity. The Director of Activity stated during the last resident council meeting, the residents had brought up concerns regarding the call light delay. The Director of Activity stated an in-service was given to the nurses and non-nursing staff to assist with answering the call lights. When asked if anyone had followed up with the concerns with the call lights, the Director of Activities was unsure and not able to provide documentation on the follow up. The Director of Activities verified the call light issues were ongoing and verified the finding. On 5/21/24 at 1300 hours, an interview was conducted with RN 1. RN 1 stated sometimes the staff made a copy of their schedules and did not put it back to the binder. RN 1 further stated the next shift staff might not have the schedules and the RN on duty must help to make the schedules again. RN 1 stated it didtake time and possibly delay care. On 5/21/24 at 1540 hours, an interview was conducted with CNAs 3, 4, and 5. CNAs 3 and 4 stated they got their assignments in two different stations. CNA 4 stated she could not see the call lights in other stations when she was busy with her assigned residents. CNAs 3, 4, and 5 stated the non-nursing staff did not help with answering the call lights even if those were the non-nursing simple tasks. Additionally, some of the charge nurses did not assist with answering the call lights. They also received their assignments late, so they did not know which residents they needed to care for.