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	12/18/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941 Based on interview, medical record review, and facility document review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse by another resident for one of five sampled residents (Resident 1). * Resident 2 punched Resident 1 in the face because Resident 1 would not be quiet. This failure caused Resident 1 to have a broken nose, bruising to his left eye, and bruising to the area around the left eye. Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure dated 2/23/21, showed the facility prohibits the abuse of all residents. Review of the SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 11/19/24, showed Resident 1 alleged Resident 2 hit Resident 1 on the face. Both Residents 1 and 2 were separated, and Resident 2 denied hitting Resident 1. a. Closed medical record review for Resident 1 was initiated on 12/3/24. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 11/18/24. Review of Resident 1's H&P examination dated 11/22/24, showed Resident 1 had the capacity to understand and make medical decisions. Review of Residents 1's MDS dated [DATE], showed Resident 1 was cognitively intact. Review of Resident 1's CIC evaluation dated 11/18/24, showed at 2300 hours, the staff heard Resident 1 yelling from his room. The CNA noted the resident lying in bed with discoloration, swelling on his face. Resident 1 stated Resident 2 hit him in the face. Resident 1 was seen with open skin on the bridge of the nose. Resident 1 stated he had throbbing pain and headache. Resident 1 was given a pain medication as ordered. Resident 1 also received the anticoagulant mediations. The CIC further showed Resident 1 was sent to the acute care hospital for further evaluation via 911 ambulance. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's acute care hospital CT scan report dated 11/19/24 at 0050 hours, showed Resident 1's nasal bones had been broken into multiple small pieces. Review of Resident 1's acute care hospital records also showed the first CT scan electronically signed by the physician on 11/19/24 at 0122 hours, with no acute intracranial abnormally. A repeated CT scan dated 11/19/24 at 0941 hours, showing acute right frontal probable subdural hematoma (a collection of blood that accumulates between the inner layer of the skull and the surface of the brain) with associated adjacent small petechial hemorrhages (tiny spots of bleeding). b. Closed medical record review for Resident 2 was initiated on 12/3/24. Resident 2 was admitted to the facility on [DATE], and discharged to the acute psychiatric hospital on 11/18/24. Review of Residents 2's MDS dated [DATE], showed Resident 2 was cognitively intact. Review of Resident 2's H&P examination dated 9/24/24, showed Resident 2 had the capacity to understand and make medical decisions. Review of Resident 2's CIC dated 10/9/24 showed at 0400 hours, Resident 2 was noted sitting in bed with a 1 cm (length) by 1.5 cm (width) skin tear to the lateral left hand. Resident 2 stated he got out of bed by himself and punched his roommate's electric wheelchair on the back of the wheelchair multiple times with fist closed. Resident 2 stated he did not think to hit his roommate and took his frustration out on the empty wheelchair. Resident 2 apologized and stated he would not do anything like this again. The interventions included to monitor the resident and redirect when needed. Resident 2's behavior assessment showed the resident had physical and verbal aggression. Review of Residents 2's CIC dated 11/18/24, showed at 2300 hours, the staff was alerted to the resident's room because Resident 1 had accused Resided 2 of hitting him in the face. Resident 2 was calm and lying in his bed. When the staff asked him what happened, Resident 2 did not respond and smiled. Resident 2 was separated from Resident 1. Resident 2 was noted with blood on his right knuckles and bed. Resident 2 denied a body check, but the staff noticed scant blood on his right knuckles and noted it was not Resident 2's blood. Resident 2 denied hitting Resident 1. The staff remained with Resident 2 until he was transferred to the acute psychiatric hospital. The CIC also showed when Resident 2 was asked if he had hit his roommate, he denied it. Additionally, the CIC showed Resident 2 had blood on his knuckles and on his bed. Review of Resident 2's care plan dated 11/18/24, for the resident-to-resident altercation showed Resident 2 was noted to be physically abusive as evidenced by hitting roommate (Resident 1). On 12/3/24 at 0920 hours an interview was conducted with RN 2. RN 2 stated he was requested to go to Resident 1's room by the nursing staff on the evening of 11/18/24. RN 2 stated he assessed Resident 1 and observed Resident 1's face was swollen, and there was a cut on his nose. RN 2 stated when he asked Resident 1 what happened, Resident 1 pointed at Resident 2 and stated Resident 2 hit him. RN 2 stated he asked Resident 2 if he had hit Resident 1, and Resident 2 denied it. RN 2 stated he observed blood on Resident 2's knuckles and bed. RN 2 stated the third roommate (Resident 5) was not in the room at that time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 0946 hours, an interview was conducted with Resident 5. Resident 5 stated when he returned to his room on the night of 11/18/24, Resident 2 was in the room acting weird. Resident 5 stated he asked Resident 2 why he hit Resident 1. Resident 5 stated Resident 2 told him it was because Resident 1 would not shut up. Resident 5 stated Resident 1 would scream sometimes. On 12/18/24 at 1210 hours, a concurrent interview and closed medical record review for Residents 1 and 2was conducted with the DON, Administrator, and Administrative Assistant. The DON and Administrator confirmed the above findings.