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	06/06/2025

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** Based on observation, interview, medical record review,facility document review, and facility P&P review, the facility failed to ensure one of 10 sampled residents (Resident 8) was free from abuse. * Resident 8 accidently bumped into Resident 7. In response, Resident 7 got upset and pushed Resident 8 into the wall, causing an abrasion to Resident 8's forehead and a laceration to Resident 8's left eyelid. This failure resulted in Resident 8 sustaining multiple injuries as a result of the altercation, which had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure dated 2/23/21, showed the following: 1. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm injury, or mental anguish. 2. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, will include: a. Providing patients, families, and staff with information on how and to whom they may report concerns, incidents, and grievances without fear of retribution and provide feedback regarding the concerns that have been expressed; b. identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of a patient property is more likely to occur; and c. establishing a safe environment that supports, to the extent possible, a patient's consensual sexual relationship. 3. Staff will identify events-such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse-and determine the direction of the investigation. This also includes patient-to-patient abuse. a. The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) Or designee and other officials in accordance with state law. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. If the patient if the patient/resident sustained serious bodily injury the employee who informs the suspicion or witnesses the incident must report no later than (2) hours after forming the suspicion. c. All reports of suspected abuse must be reported to the patient's family and attending physician. 4. If the suspected abuse is resident-resident, the resident who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. a. The Center will provide adequate supervision when the risks of resident-resident altercation is suspected. b. The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. c. The family and physician will be notified and any follow up recommended will be completed (e.g. psychiatric evaluation). d. Options for room changes will be provided based on the situation e. the Center should seek alternative placement for the patient exhibiting the abusive behavior if warranted. 5. The investigation will be thoroughly documented. Ensure that documentation of witnessed interviews is included. 6. The Center will protect patients from further harm during an investigation. a. Provide the patient with a safe environment by identifying persons with whom he/she feel safe and conditions that would feel safe. Assign a representative from social services or designee to observe the patient's feelings concerning the incident, as well as the patient's involvement in the investigation. 7. If the suspected abuse is resident-to-resident, the resident who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. a. Options for room changes will be provided based on the situation. b. The Center should see alternative placement for the patient exhibiting the abusive behavior, if warranted. 8. Initiate an investigation within two hours of an allegation of abuse that focuses on: a. whether abuse or neglect occurred and to what extent; b. clinical examination for signs of injuries, if indicated; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. causative factors; and d. interventions to prevent further injury. On 6/3/25 at 1519 hours, the CDPH, L&C Program received an SOC 341 from the facility showing at approximately 1320 hours, Resident 8 accidently bumped into Resident 7 in the hallway. Resident 7 reacted by pushing Resident 8, which caused Resident 8 to fall and sustain an abrasion on the forehead. Both residents were separated, and Resident 7 was placed on close supervision. Both the residents were contracted for safety. a. Medical record review for Resident 7 was initiated on 6/5/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 7 had diagnoses including schizoaffective disorder bipolar type and schizophrenia. Review of Resident 7's Progress Note from the resident's previous facility dated 5/10/25, showed the prior facility received a report that Resident 7 was walking the hallway when he saw another male peer walking in the opposite direction. For no reason, Resident 7 pushed the male peer on the floor. Further review of the progress note showed Resident 7 stated he would continue to make assaults toward that male peer if he continued to bump into him. Review of Resident 7's admission Summary Psychiatric Progress Note dated 5/21/25, showed Resident 7 was admitted from a facility with multiple disruptive behaviors, including assaulting a male peer due to paranoia, pushing a male peer without provocation, pulling a male peer in the room and assaulting him. Resident 7 was continuing to make assaults towards peer if the peer kept bumping into him. Resident 7 was placed on a 1:1 supervision (one nurse to supervise one resident) to monitor for safety. The rationale for continued hospitalization section showed Resident 7 remained at high risk for danger to others and was gravely disabled due to the severity for their psychiatric symptoms and required continued hospitalization. Review of Resident 7's care plan for aggressive and assaultive behaviors created 5/20/25, and initiated 5/26/25, showed at Resident 7's previous facility, Resident 7 had assaulted a male peer and pushed him down on the floor. Resident 7 had pulled a different male peer out of his room and assaulted him. Resident 7 had threated to assault another male peer and was placed on a 1:1 supervision for safety. Review of Resident 7's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15, indicating the resident had an intact cognitive response. Review of Resident 7's Behavioral Progress Note dated 6/3/25 at 1400 hours, showed the resident was walking through hallway. Resident 8 bumped into Resident 7 who then pushed Resident 8 down to the ground and into the wall. Resident 7 then moved away from the area, and Resident 8 was assessed, and treated. Further review of the Behavioral Progress Note showed Resident 7 stated Resident 8 had been bumping into him all day and called him racial slurs. Resident 7 confirmed pushing Resident 8 down and then pushed him into the wall. Resident 7's Behavioral Progress Note further showed the resident stated, I told you guys this is not the best unit for me to be on. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's Psychiatric Progress Note dated 6/3/25 at 2305 hours, showed Resident 7 assaulted Resident 8 today. Further review of the Psychiatric Progress Note showed Resident 7 reported slamming into Resident 8, stating he slammed Resident 8 last night and again today. Resident 7 asked the social worker for a change of unit due to wanting to slam Resident 8 because Resident 8 bumped into him. Resident 7 acknowledged the psychiatrist had previously informed him that he should walk away if the bumping continued as Resident 8 had a disorganized behavior of bumping into people indiscriminately but did not do so. The note further showed under the assessment section, Resident 7 continued to be at high risk of violence and assault and assaulted peer due to small quarters and Resident 8 bumping into him. The rationale for continued hospitalization section showed Resident 7 remained at high risk for danger to others and was gravely disabled due to the severity for their psychiatric symptoms and required continued hospitalization. Review of Resident 7's care plan for aggressive and assaultive behavior revised 6/4/25, showed Resident 7 pushed male peer. Review of Resident 7's Social Service Progress Note dated 6/4/25, showed Resident 7 asked the Social Worker why is he still here, he bugs I'm going to break his neck. The document further showed the social worker informed Resident 7 not to do anything and stay calm. On 6/5/25 at 1036 hours, an interview was conducted with Resident 7. Resident 7 stated Resident 8 bumped into me and I slammed him on 6/3/25. On 6/5/25 at 1333 hours, a follow-up interview was conducted with Resident 7. Resident 7 stated he had previously slammed Resident 8 the night before the incident on 6/3/25. Resident 7 stated he grabbed Resident 8's neck and slammed him. Resident 7 further stated he did it because Resident 8 kept bumping into him as if he was trying to start a fight. Resident 7 stated during the first incident, Resident 8's head bumped off the pavement. Resident 7 stated there were six to seven people, including MHW 4 present during the first incident. Resident 7 stated he purposefully slammed into Resident 8. Resident 7 further stated, hell yeah, he got a dirty shirt, slobbery, and bumps into you with his shirt like he's sliming you . When asked if Resident 7 was separated from Resident 8 after the first incident, Resident 7 stated, hell no. Resident 7 stated the only reason he got mad was because Resident 8's shirt kept touching him, and he could only tolerate so many bumps. Resident 7 stated he spoke to the Social Worker and told him he would seriously hurt Resident 8 if he kept bumping into him. Resident 7 told the Social Worker either he or Resident 8 needed to change units. Resident 7 further stated he informed the Social Worker an incident like this happened at the last facility he was at and stated, I'm going to get in trouble for hurting this [NAME] then slammed his head into the wall and ripped open his face. Resident 7 stated the facility stated they will talk to Resident 8 after the first incident occurred on 6/2/25, but nothing had happened. b. Medical record review for Resident 8 was initiated on 6/5/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 8 had diagnoses including schizoaffective disorder bipolar type, and schizophrenia. Review of Resident 8's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's Nurse Progress Note dated 6/3/25, showedat 1511 hours, showed Resident 8 was walking through the hallway and bumped into Resident 7. Resident 7 pushed Resident 8 down to the ground and into the wall. There was approximately a six-inch hole was put in the wall. Resident 8 was assessed and sustained an abrasion to the forehead and a laceration to the left eyelid. The on-call physician was notified and gave order to send the resident to the acute care for further evaluation and clearance. Review of Resident 8's Medical Consultation and Report dated 6/3/25, the reason for consultation showed was to reevaluate for face abrasions. Resident 8 was sent to the acute care hospital emergency room for medical clearance. Review of Resident 8's Visit Record from the acute care hospital dated 6/3/25, showed Resident 8 had imaging done to the face and cervical spine regions, and was noted with a C3-C4 (vertebrae in the cervical spine located in the neck) 2 mm focal posterior disc bulge with minimal spinal stenosis. Review of Resident 8's Psychiatric Progress Noted dated 6/3/25 at 1658 hours, showed the altercation led Resident 8 to be transferred to the local emergency room. Resident 8's family member wanted to take him home because he did not feel Resident 8 would be safe on the unit. Review of Resident 8's Nurse Progress Note dated 6/3/25, showed at 1842 hours, Resident 8 returned from the acute care hospital. Resident 8 had multiple facial abrasions and wounds with a two mm focal posterior C3-4 bulge with minimal spinal stenosis. Review of Resident 8's Progress Note dated 6/4/25 at 1251 hours, showed received an order to transfer the resident to a different unit at 1630 hours. On 6/5/25 at 1047 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed with multiple linear purple and red markings across his entire forehead and a linear dried scab under his left eyebrow. When asked what happened, Resident 8 stated he was attacked, and it had happened two times. On 6/5/25 at 1056 hours, during an interview with the DON, the DON was made aware Resident 8 stated he was attacked two times. The DON acknowledged the findings and stated they would have to report it. On 6/5/25 at 1058 hours, and interview was conducted with MHW 3. MHW 3 stated on 6/3/25, he heard a loud noise and Resident 8 yelling for help. MHW 3 stated Resident 8 was on the ground stating Resident 7 slammed me. MHW 3 further stated Resident 7 stated he did it because Resident 8 bumped into me, and I told him to stop bumping into me and made a racial slur towards Resident 7. MHW 3 stated he witnessed Resident 8 was bleeding, and his head was in the drywall, with pieces of drywall and paint chips on his head. MHW 3 stated when he saw the wall busted he was confused where Resident 8's head was coming out from, and realized it was the dry wall. MHW 3 stated Resident 8 had called his father crying until he was sent out to the acute care facility. MHW 3 stated Resident 8 bumping into Resident 7 was not intentional, however, Resident 7 stated he pushed Resident 8 and hurt himon purpose. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 1111 hours, an interview was conducted with LVN 1. LVN 1 stated she did not witness what happened; however, she saw Resident 8 was still on the ground. LVN 1 stated she assisted Resident 8 to the medication room to clean him up. LVN 1 stated there was a significant dent in the wall, the wall was in pieces in the shape of a head. LVN 1 stated Resident 8 had cuts on his face, was bloody, acting hysterical, and was unable to decipher what Resident 8 was stating. On 6/5/25 at 1310 hours, an interview was conducted with Resident B. Resident B stated during the first incident, Resident 7 got frustrated with Resident 8 continuing to bump into him. Resident 7 grabbed Resident 8 and did a WWE (World Wrestling Entertainment) move on him. Resident 7 grabbed Resident 8 from the head and brought him down. When asked if Resident 8 hit his head on the wall, Resident B stated no. Resident B could not recall the exact date this occurred, however, Resident B stated he heard the commotion of the second incident while he was in the shower. Resident B stated he saw the hole in the wall when Resident 8 hit his head. When asked if anyone else had witnessed the first incident, Resident B stated himself, and another staff (unknown names). On 6/5/25 at 1412 hours, an interview was conducted with the Social Worker. The Social Worker stated he spoke to Resident 7 regarding his request to transfer to another unit due to people bugging me, however, the Social Worker stated they did not have the availability at the time. The Social Worker stated since he was a new admission, they needed to stabilize him and work with the program first. The Social Worker stated the incident on 6/3/25, could have been prevented if either resident was moved to another unit. The Social Worker stated Resident 7 did not state who was bugging him, before the incident on 6/3/25 occurred. The Social Worker stated he did not follow up on Resident 7's request to move units or who Resident 7 was referring to when he stated someone was bugging him. On 6/6/25 at 1002 hours, a telephone interview was conducted with MHW 4. MHW 4 stated on 6/2/25 around 1930 hours, he saw Residents 7 and 8 standing and staring at each other in the hallway but did not witness what happened. MHW 4 stated he separated both residents, asked Resident 8 if he was hurt, and assisted Resident 8 to the quiet room. On 6/6/25 at 1022 hours a telephone interview was conducted with MHW 5. MHW 5 stated he heard a commotion on 6/2/25 around 1930-2000 hours, when he saw Residents 7 and 8 in the hallway. MHW 5 stated he asked Resident 7 what happened. MHW 5 stated Resident 7 was angry at Resident 8 and mentioned Resident 8 could not keep bumping into him. MHW 5 stated he notified RN 1. On 6/6/25 at 1022 hours, a telephone interview was conducted with RN 1. RN 1 stated there was no commotion on 6/2/25, and no one informed her Resident 7 complained of Resident 8 bumping into him. RN 1 stated if she were made aware, she would report to the charge nurse, assess both residents, and notify the physician. On 6/6/25 at 1056 hours, an interview was conducted with the DON. The DON acknowledged Residents 7 and 8 stated the altercation happened twice. The DON stated his expectations for an altercation was to maintain safety, separate the residents, assess for injuries, notify the physician, and dedicate a staff to stay with the resident for one hour to further determine if a 1:1 is needed. On 6/6/25 at 1430 hours, the Administrator and DON acknowledged the above findings.

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 the reporting of a reasonable suspicion of a crime was completed in a timely manner for four of 10 sampled residents (Residents 1, 2, 7, and 8). * The facility failed to ensure Resident 1's physical abuse allegation by MHW 1 was reported timely to the CDPH L&C Program and local law enforcement agency. * The facility failed to ensure Resident 2's verbal abuse allegation by MHW 5 was reported timely to the CDPH L&C Program and local law enforcement agency. * The facility failed to report a resident-to-resident altercation of physical abuse when Resident 7 admitted to assaulting Resident 8 on two different occasions. These failures had the potential for abuse and injury of unknown origin allegations to go unreported and uninvestigated timely. Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure dated 2/23/21, showed upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the CED (Center Executive Director) will perform the following. Report allegations involving abuse (physical, verbal, sexual, or mental) not later than two (2) hours after the allegation is made. Further review of the P&P showed to notify local law enforcement, ombudsman, licensing district office, licensing boards, registries and other agencies as required. 1. On 6/2/25 at 1409 hours, the CDPH, L&C Program received a complaint alleging Resident 1 had been assaulted by MHW 1. Resident 1 was choked to the ground following a request for water on the patio area. Resident 1 experienced severe retaliation from initial requests previously during the week. The complaint further alleged MHW 1 smashed Resident 1's face into the concrete several times. Medical record review for Resident 1 was initiated on 5/30/25. Resident 1 was admitted to the facility on [DATE]. On 6/3/25 at 0949 hours, the DON was informed and acknowledged there was an allegation of assault to Resident 1 by MHW 1. The DON stated there was an incident that occurred on 5/31/25, where Resident 1 claimed MHW 1 slammed his face on the pavement. The DON stated Family Member 1 visited Resident 1 and stated Resident 1 had bruises on his face and neck and wanted to press charges against MHW 1. The DON stated the police were called, and Resident 1 was seen by the nurse practitioner along with an x-ray imaging done to Resident 1's nose. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 1011 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed with a purple and blue color to the right undereye, linear pink scratch on forehead, two small circular purple, red areas on left neck, across the nose bridge was blue and purple, the tip of the nose present with a scratch. Resident 1 stated when out in the patio attempting to get water, MHW 1 took him down to the floor, choked him, and smashed his head into the ground. On 6/4/25 at 1714 hours, the CDPH, L&C Program received an SOC 341 from the facility showing, on 5/31/25 at 0930 hours, Resident 1 pushed MHW 1 during snack break. Resident 1 tackled Adjunctive Therapist 1 (AT 1) and both Resident 1 and AT 1 fell to the pavement. As Resident 1 continue to struggle and during the de-escalation process Resident 1 sustained a scratch mark on his forehead and nasal bridge. On 6/4/25 at 1528 hours, an interview was conducted with the Administrator and DON. The Administrator stated the reporting timeframe for abuse was two hours. The Administrator stated he would report the abuse allegation for Resident 1 and acknowledged the reporting and investigation would be considered late. 2. On 5/30/25 at 1532 hours, an interview was conducted with Resident 2. Resident 2 stated a male staff made fun of him and his stutter, and another staff member called him gay. Resident 2 stated the comments made him feel bad and hurt his feelings. Resident 2 stated MHW 5 made fun of his stutter. Review of Resident 2's medical record was initiated on 5/30/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/30/25 at 1542 hours, an interview was conducted with the DON. The DON was made aware of Resident 2's allegation MHW 5 was mocking his stutter, and other staff members were stating Resident 2 was gay. The DON stated this behavior from staff was not acceptable, and he would have to conduct an in-service to the facility staff. On 6/4/25 at 1528 hours, an interview was conducted with the Administrator and the DON. The Administrator stated the reporting timeframe for abuse was two hours. The Administrator stated he would report the abuse allegation for Resident 2 and acknowledged the reporting and investigation would be considered late. On 6/4/25 at 1639 hours, the CDPH, L&C Program received an SOC 341 from the facility showing on 5/31/25, Resident 2 alleged MHW 5 was making fun of him when he speaks and stutters. 3. On 6/3/25 at 1519 hours, the CDPH, L&C Program received an SOC 341 from the facility showing, at approximately 1320 hours, Resident 8 accidently bumped into Resident 7 in the hallway. Resident 7 reacted by pushing Resident 8, which caused Resident 8 to fall and sustain an abrasion on the forehead. Both residents were separated, and Resident 7 was placed on close supervision. Both the residents were contracted for safety. Further review did not show an SOC 341 form was received for the first physical abuse allegation. a. Medical record review for Resident 7 was initiated on 6/5/25. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7 had diagnoses including schizoaffective disorder bipolar type, and schizophrenia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15. b. Medical record review for Resident 8 was initiated on 6/5/25. Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 8 had diagnoses including schizoaffective disorder bipolar type, and schizophrenia. Review of Resident 8's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15. On 6/5/25 at 1047 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed with multiple linear purple and red markings across his entire forehead, and a linear dried scab under his left eyebrow. When asked what happened, Resident 7 stated he was attacked, and it had happened two times. On 6/5/25 at 1056 hours, during an interview with the DON, the DON was made aware Resident 8 stated he was attacked two times. The DON acknowledged the finding and stated they will have to report it. On 6/5/25 at 1310 hours, an interview was conducted with Resident B. Resident B stated during the first incident, Resident 7 got frustrated with Resident 8 continuing to bump into him. Resident 7 grabbed Resident 8 and did a WWE (World Wrestling Entertainment) move on him. Resident 7 grabbed Resident 8 from the head and brought him down. When asked if Resident 8 hit his head on the wall, Resident B stated no. Resident B could not recall the exact date this occurred, however, Resident B stated he heard the commotion of the second incident while he was in the shower. Resident B stated he saw the hole in the wall when Resident 8 hit his head. When asked if anyone else had witnessed the first incident, Resident B stated himself, and another facility staff (unknown names). On 6/5/25 at 1333 hours, an interview was conducted with Resident 7. Resident 7 stated he had previously slammed Resident 8 the night before the incident on 6/3/25. Resident 7 stated he grabbed Resident 8's neck and slammed him. Resident 7 further stated he did it because Resident 8 kept bumping into him as if he was trying to start a fight. Resident 7 stated during the first incident, Resident 8's head bumped off the pavement. Resident 7 stated there were six to seven people, including MHW 4, present during the first incident. Resident 7 stated he purposefully slammed into Resident 8. Resident 7 further stated, hell yeah, he got a dirty shirt, slobbery, and bumps into you with his shirt like he's sliming you. When asked ifResident 7 was separated from Resident 8 after the first incident, Resident 7 stated, hell no. Resident 7 stated he spoke to the Social Worker and told him he would seriously hurt Resident 8 if he kept bumping into him. Resident 7 stated the facility stated they will talk to Resident 8 after the first incident occurred on 6/2/25, but nothing had happened. On 6/6/25 at 1440 hours, the Administrator and DON acknowledged the above findings. Cross references to F600 and F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 implement their P&P for abuse investigation for four of 10 sampled residents (Residents 1, 2, 7, and 8). * The facility failed to immediately remove MHW 1 from duty pending an abuse investigation for Resident 1. * The facility failed to conduct a thorough investigation for Resident 1's abuse allegation against MHW 1 when the resident witnesses were not interviewed regarding the incident. * The facility failed to begin an investigation within two hours following Resident 2's verbal abuse allegation against MHW 5. * The facility failed to implement their P&P to conduct a thorough investigation when Residents 7 and 8 verbalized Resident 7 assaulted Resident 8 on two different occasions. Additionally, the facility failed to separate the residents until the investigation was completed. These failures had the potential for the abuse allegation going unreported and uninvestigated. Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure dated 2/23/21, showed upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the CED (Center Executive Director) will perform the following. Report allegations involving abuse (physical, verbal, sexual, or mental) not later than two (2) hours after the allegation is made, and initiate an investigation within two hours of an allegation of abuse that focuses on: whether abuse or neglect occurred and to what extent, clinical examination for signs of injuries, if indicated, causative factors, and interventions to prevent further injury. 1. On 6/2/25 at 1409 hours, the CDPH, L&C Program received a complaint alleging Resident 1 had been assaulted by MHW 1. Resident 1 was choked to the ground following a request for water on the patio area. Resident 1 experienced severe retaliation from initial requests previously during the week. The complaint further alleged MHW 1 smashed Resident 1's face into the concrete several times. Medical record review for Resident 1 was initiated on 5/30/25. Resident 1 was admitted to the facility on [DATE]. Review of the facility's Staffing Schedule dated 5/31/25 and 6/1/25, showed MHW 1 was on duty in the same unit as Resident 1. (continued on next page)

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	06/06/2025

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South Coast Post Acute	1030 W Warner Ave Santa Ana, CA 92707

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 0949 hours, the DON was informed and acknowledged there was an allegation of assault to Resident 1 by MHW 1. The DON stated there was an incident that occurred on 5/31/25, where Resident 1 claimed MHW 1 slammed his face on the pavement. The DON stated Family Member 1 visited Resident 1 and stated Resident 1 had bruises on his face and neck and wanted to press charges against MHW 1. The DON stated the police were called, and Resident 1 was seen by the nurse practitioner along with x-ray imaging done to Resident 1's nose. When asked if MHW 1 was suspended, the DON stated he was not suspended, and there was no investigation since it was a witnessed incident, and Resident 1 was making false allegations. The DON further stated other residents who witnessed the incident were not interviewed. On 6/3/25 at 1011 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed with a purple and blue color to the right undereye, linear pink scratch on forehead, two small circular purple, red areas on left neck, across the nose bridge was blue and purple, the tip of the nose present with a scratch. Resident 1 stated when out in the patio attempting to get water, MHW 1 took him down to the floor, choked him, and smashed his head into the ground. Resident 1 stated there were other resident witnesses during the incident. 2. On 5/30/25 at 1532 hours, an interview was conducted with Resident 2. Resident 2 stated a male staff makes fun of him and his stutter, and another staff member calls him gay. Resident 2 stated the comments make him felt bad and hurts his feelings. Resident 2 stated MHW 5 made fun of his stutter. Review of Resident 2's medical record was initiated on 5/30/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/30/25 at 1542 hours, an interview was conducted with the DON. The DON was made aware of Resident 2's allegation MHW 5 was mocking his stutter, and other staff members were stating Resident 2 was gay. The DON stated this behavior from staff was not acceptable, and he would have to conduct an in-service to the facility staff. On 6/4/25 at 1528 hours, an interview was conducted with the Administrator and DON. The Administrator stated the reporting timeframe for abuse was two hours. The Administrator stated he would report the abuse allegation for Resident 2 and acknowledged the reporting and investigation would be considered late. On 6/4/25 at 1639 hours, the CDPH, L&C Program received an SOC 341 from the facility showing on 5/31/25 Resident 2 alleged that MHW 5 was making fun of him when he speaks and stutters. 3. On 6/3/25 at 1519 hours, the CDPH, L&C Program received an SOC 341 from the facility showing, at approximately 1320 hours, Resident 8 accidently bumped into Resident 7 in the hallway. Resident 7 reacted by pushing Resident 8, which caused Resident 8 to fall and sustain an abrasion on the forehead. Both residents were separated, and Resident 7 was placed on close supervision. Both residents were contracted for safety. Further review did not show an SOC 341 form was received for the first physical abuse allegation. a. Medical record review for Resident 7 was initiated on 6/5/25. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7 had diagnoses including schizoaffective disorder bipolar type, and schizophrenia. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15. b. Medical record review for Resident 8 was initiated on 6/5/25. Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 8 had diagnoses including schizoaffective disorder bipolar type, and schizophrenia. Review of Resident 8's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15. On 6/5/25 at 1047 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed with multiple linear purple and red markings across his entire forehead, and a linear dried scab under his left eyebrow. When asked what happened, Resident 7 stated he was attacked, and it had happened two times. On 6/5/25 at 1056 hours, during an interview with the DON, the DON was made aware Resident 8 stated he was attacked two times. The DON acknowledged the finding and stated they would have to report it. On 6/5/25 at 1310 hours, an interview was conducted with Resident B. Resident B stated during the first incident, Resident 7 got frustrated with Resident 8 continuing to bump into him. Resident 7 grabbed Resident 8 and did a WWE (World Wrestling Entertainment) move on him. Resident 7 grabbed Resident 8 from the head and brought him down. When asked if Resident 8 hit his head on the wall, Resident B stated no. Resident B could not recall the exact date this occurred, however, Resident B stated he heard the commotion of the second incident while he was in the shower. Resident B stated he saw the hole in the wall when Resident 8 hit his head. When asked if anyone else had witnessed the first incident, Resident B stated himself, and another staff (unknown names). On 6/5/25 at 1333 hours, an interview was conducted with Resident 7. Resident 7 stated he had previously slammed Resident 8 the night before the incident on 6/3/25. Resident 7 stated he grabbed Resident 8's neck and slammed him. Resident 7 further stated he did it because Resident 8 kept bumping into him as if he was trying to start a fight. Resident 7 stated during the first incident, Resident 8's head bumped off the pavement. Resident 7 stated there were six to seven people, including MHW 4, present during the first incident. Resident 7 stated he purposefully slammed into Resident 8. Resident 7 further stated, hell yeah, he got a dirty shirt, slobbery, and bumps into you with his shirt like he's sliming you. When asked ifResident 7 was separated from Resident 8 after the first incident, Resident 7 stated, hell no. Resident 7 stated he spoke to the Social Worker and told him he would seriously hurt Resident 8 if he kept bumping into him. Resident 7 stated the facility stated they would talk to Resident 8 after the first incident occurred on 6/2/25, but nothing had happened. On 6/5/25 at 1412 hours, an interview was conducted with the Social Worker. The Social Worker stated he spoke to Resident 7 regarding his request to transfer to another unit due to people bugging me , however, the Social Worker stated they did not have the availability at the time. The Social Worker stated since he was a new admission, they needed to stabilize him and work with the program first. The Social Worker stated the incident on 6/3/25, could have been prevented if either resident was moved to another unit. The Social Worker stated Resident 7 did not state who was bugging him before the incident on 6/3/25 occurred. The Social Worker stated he did not follow up on Resident 7's request to move units or who Resident 7 was referring to when he stated someone was bugging him. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 1002 hours, a telephone interview was conducted with MHW 4. MHW 4 stated on 6/2/25 around 1930 hours, he saw Residents 7 and 8 standing and staring at each other in the hallway but did not witness what happened. MHW 4 stated he separated both residents, asked Resident 8 if he was hurt, and assisted Resident 8 to the quiet room. On 6/6/25 at 1022 hours a telephone interview was conducted with MHW 5. MHW 5 stated he heard a commotion on 6/2/25 around 1930-2000 hours, when he saw Residents 7 and 8 in the hallway. MHW 5 stated he asked Resident 7 what happened. MHW 5 stated Resident 7 was angry at Resident 8, and mentioned Resident 8 could not keep bumping into him. MHW 5 stated he notified RN 1. On 6/6/25 at 1022 hours, a telephone interview was conducted with RN 1. RN 1 stated there was no commotion on 6/2/25, and no one had informed her Resident 7 complained of Resident 8 bumping into him. RN 1 stated if she were made aware, she would report to the charge nurse, assess both residents, and notify the physician. On 6/6/25 at 1056 hours, an interview was conducted with the DON. The DON acknowledged Residents 7 and 8 stated the altercation happened twice. The DON stated his expectations for an altercation is to maintain safety, separate the residents, assess for injuries, notify the physician, and dedicate a staff to stay with the resident for one hour to further determine if a 1:1 is needed. On 6/6/25 at 1430 hours, the Administrator and DON acknowledged the above findings. Cross references F600 and F609.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 comprehensive care plans were developed and revised for three of 10 residents (Residents 4, 6, and 8). * The facility failed to revise a plan of care for Resident 4's bilateral floor mats for fall prevention. * The facility failed to develop a plan of care for Resident 6's weight loss. * The facility failed to develop the plan of care for Resident 8's facial abrasion following an injury after a physical altercation occurred. These failures had the potential to place the residents at risk of their care needs not being met. Findings: Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed the following: 1. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident's condition change; 2. the interdisciplinary team is responsible for evaluation and updating the care plans: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been re-admitted to the facility from a hospital stay; and d. at least quarterly. 1. Medical record review for Resident 4 was initiated on 6/4/25. Resident 4 was admitted to the facility on [DATE]. Resident 4 had diagnoses including abnormalities of gait and mobility. Review of Resident 4's care plan dated 2/11/25, showed Resident 4 was at risk for falls. The care plan did not show for the bilateral floor mats as a fall risk preventative intervention. Review of Resident 4's eINTERACT Change in Condition Evaluation form dated 2/27/25, showed Resident 4 had an unwitnessed fall. Review of Resident 4's eINTERACT Change in Condition Evaluation form dated 3/13/25, showed Resident 4 was observed sitting on the floor next to his bed. Resident 4's roommate stated Resident 4 slipped off the side of the bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's Order Summary Report showed a physician's order dated 3/12/25, for bilateral floor mats. On 6/4/25 at 1410 hours, during an observation, Resident 4 was lying in bed and bilateral floor mats present. On 6/6/25 at 1515 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged and verified Resident 4 had no intervention in the care plan for the bilateral floor mats. 2. Review of the facility's P&P titled Weight Management (undated) showed in the event of a patterned or significant, unplanned weight loss/gain of at least 2% in a week, 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, the following interventions would be carried out. Medical record review for Resident 6 was initiated on 5/30/25. Resident 6 was admitted to the facility on [DATE], and discharged on 5/30/25. Review of Resident 6's Weights and Vitals Summary showed the following: - dated 2/28/25, 130 lbs. - dated 3/11/25, 134 lbs. - dated 3/26/25 127 lbs. - dated 4/4/25, 126 lbs. - dated 4/8/25, 127 lbs. - dated 4/16/25, 123 lbs. - dated 4/22/25, 124 lbs. - dated 4/29/25 120 lbs. - dated 5/13/25, 118 lbs. - dated 5/19/25, 115 lbs. - dated 5/27/25, 110 lbs. Further review of Resident 6's Weights and Vital Summary showed Resident 6 had a total weight loss of 24 lbs from 3/11/25-5/27/25 (17.91%) indicating severe weight loss. Review of Resident 6's care plan dated 3/3/25, showed Resident 6 had a nutritional problem or potential nutritional problem. Further review of Resident 6's care plans failed to show documented evidence the weight loss was addressed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 1207 hours, an interview and concurrent medical record was conducted with the Registered Dietician (RD). The RD acknowledged and verified Resident 6 had severe weight loss and the current care plan did not include her weight loss. The RD stated when there was a change of condition, the care plan for weight loss should have been initiated by the licensed nurse. On 6/6/25 at 1341 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged Resident 6 had no care plan initiated for the weight loss. 3. Medical record review for Resident 8 was initiated on 6/5/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed the resident was cognitively intact with a BIMS score of 15. On 6/5/25 at 1047 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed with multiple linear purple and red markings across his entire forehead, and a linear dried scab under his left eyebrow. When asked what had happened, Resident 7 stated he was attacked, and it had happened two times. Review of Resident 8's care plan dated 6/4/25, showed Resident 8 was a victim of assault. There was no care plan for Resident 8's facial injuries. Review of Resident 8's Progress Note dated 6/4/25, showed the resident sustained a facial abrasion, assess resident for bleeding, or swelling in face. On 6/5/25 at 1540 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 8 did not have a care plan or interventions for his facial abrasions. When asked if his injuries would indicate a change in condition, the DON stated yes. On 6/6/25 at 1430 hours, the Administrator and the DON acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 prevent Resident 1 from injury. * The facility failed ensure Resident 1 was free from injury during the facility's de-escalation process. This failure resulted in Resident 1 sustaining facial and neck bruising, which had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Chapter 5- Why Restrain dated 9/2021 showed in every instance, the facility wants to use the least restrictive method to resolve the situation. Restraint is reserved to contain acute episodes of dangerous behavior. Manual restraint is placing of hands on an individual thereby restricting their ability to move. This can range from two staff members holding an individual's arm to four staff members holding a limb. It may include escorting a patient to a different location or can result in containment on the ground. Medical record review for Resident 1 was initiated on 5/30/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Medical Consultation and Report dated 6/2/25, showed the following physician's physical examination findings: - small bruises on the top of left eyebrow smaller than 0.5 cm x 0.5 cm - three small bruises on left side of the neck, smaller than 0.5 cm x 0.5 cm - bruising around nose bridge, swelling, and tender to touch On 6/3/25 at 1011 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed with a purple and blue color to the right undereye, linear pink scratch on forehead, two small circular purple, red areas on left neck, across the nose bridge was blue and purple, the tip of the nose present with a scratch. Resident 1 stated he when out in the patio attempting to get water,MHW 1 took him down to the floor, choked him, and smashed his head into the ground. Resident 1 stated there were other resident witnesses during the incident. On 6/3/25 at 1022 hours, a concurrent observation and interview was conducted with the DON and Resident 1. The DON verified Resident 1 had bruising to the bridge of the nose, bruising to the right periorbital (around the eye) area, scratch on his forehead, and three dots to the left side of his neck. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 0856 hours, an interview was conducted with MHW 1. MHW 1 stated on 5/31/25, the incident started in the patio with Resident 1 requesting water, and became demanding, was verbally aggressive, and began pouring out the community water jug. During the process of preventing Resident 1 to pour out the water, Resident 1 began stating, what are you going to do about it, and MHW 1 attempted to intervene with therapeutic communication techniques which were unsuccessful. MHW 1 stated Resident 1 pushed MHW 1 and Adjunctive Therapist 1 to the pavement, and they both fell to the ground. MHW 1 stated Resident 1 began fighting more and stated as a last resort, they had to manually restrain him. On 6/4/25 at 1107 hours, a telephone interview was conducted with MHW 2. MHW 2 stated he responded to an incident that occurred out in the patio on 5/31/25. MHW 2 stated he witnessed Resident 1 was on the ground, and he was thrashing around, kicking his arms, legs and head back and forth as he attacked a staff over water. MHW 2 stated the staff were present holding Resident 1's limbs until the resident had calmed down. On 6/5/25 at 0912 hours, an interview was conducted with the DON. The DON stated the bruising on Resident 1 face and neck occurred while there was a struggle out on the patio on 5/31/25. The DON stated injuries were not present upon admission to the facility and was an intentional act. On 6/6/25 at 1430 hours, the Administrator and DON acknowledged the above findings.