

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2025
NAME OF PROVIDER OR SUPPLIER  South Coast Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed ensure the residents were free from the abuse for two of five sampled residents (Resident 4 and 5). This failures resulted in Residents 4 and 5 having a physical altercation, which had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&amp;P titled Abuse Prohibition effective 2/23/21, showed the program facility staff will do everything in their control to prevent occurrences of abuse. Prevention tactics include understanding behavior symptoms of residents that may increase the risk of abuse and how to respond, and identifying, correcting and intervening in situations in which abuse is more likely to occur. Review of the facility's Conclusion Letters to CDPH dated 6/26/25, showed on 6/24/25 around 1030 hours, an unwitnessed altercation between Residents 4 and 5 occurred in their shared room. Both residents alleged they were hit first and they hit their roommate in the face in self-defense. Both residents were assessed by the staff, and Resident 4 was observed to have a small abrasion on the lip and Resident 5 was observed to have a swollen lip. a. Medical record review for Resident 4 was initiated on 7/10/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's Care Plan Report showed a focus for the resident being physically aggressive/assaultive created on 3/24/25, and last revised on 7/2/25. The care plan showed the following:-On 4/18/25, the resident verbally threatened someone.-On 5/17/25, the resident swung at staff.-On 5/8/25, the resident punched the wall.-On 5/15/25, the resident punched the wall.-On 5/25/25, the resident struck a resident on the back of the head.-On 5/26/25, the resident swung at staff.-On 6/24/25, the resident hit his roommate.-On 7/2/25, the resident hit facility staff. b. Medical record review for Resident 5 was initiated on 7/10/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Care Plan Report showed a focus for the resident's aggressive behavior created on 6/7/25, and last revised on 6/30/25. The care plan showed the following:-On 6/11/25, the resident was agitated, responding to internal stimuli, and pounding on the wall.-On 6/12/25, the resident was threatening to stab staff with a pen and was experiencing auditory hallucinations.-On 6/13/25, the resident was responding to internal stimuli, punched and banged on the wall.-On 6/14/25, the resident was punching/banging on plexiglass.-On 6/18/25, the resident was banging on the plexiglass.-On 6/19/25, the resident punched a cabinet on the patio.-On 6/22/25, the resident banged on the plexiglass and was yelling.-On 6/24/25, the resident punched his roommate.-On 6/26/25, the resident punched the wall in the hallway.-On 6/30/25, the resident screamed and punched the plexiglass. On 7/10/25 at 1205 hours, an interview was conducted with the TRC DON. The TRC DON stated Resident 5 experiences command hallucinations, in which the internal stimuli commands him to do things. The TRC DON stated one of Resident 4's antipsychotic medications had to be discontinued due to the side effects, and his behaviors escalated after discontinuing the medication. The TRC DON stated for the altercation between Residents 4 and 5 on 6/24/25, both residents alleged the other resident hit first, but both acknowledged they hit each other. On 7/10/25 at 1235 hours, an interview was conducted with Resident 5. Resident 5 stated he had an altercation with his prior roommate that his roommate hit him first and he hit his roommate back in self-defense.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure the medical record was accurate for one of five sampled residents (Resident 1). This failure had the potential to negatively impact the resident's care as the medical information was inaccurate. Findings: Closed medical record review for Resident 1 was initiated on 7/10/25. Resident 1 was readmitted to the facility on [DATE], and discharged to the acute care hospital on 7/5/25. Review of Resident 1's EHR failed to show a signed copy of the residents admission physician's orders. On 7/10/25 at 0955 hours, the HIM stated once the paper medical records were scanned into the EHR, they were shredded. The HIM stated Resident 1's signed Order Summary Report should be in the EHR. The HIM verified the signed Order Summary Report was not located in the resident's EHR. On 7/10/25 at 1043 hours, the Medical Records Clerk provided a copy of Resident 1's signed Order Summary Report with the signature dated 7/8/25. Review of Resident 1's Order Summary Report showed at the bottom of the last page, I have approved these orders for Resident 1. Below was Physician 1's name and 7/8/25 hand written, as well as a signature. On 7/10/25 at 1058 hours, an interview and concurrent record review was conducted with Physician 1. Physician 1 stated he signed Resident 1's Physician Order Summary earlier that morning. When asked about the handwritten date of 7/8/25, next to his signature, the physician stated it was already dated when he signed the Order Summary Report.</p>		