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	08/07/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 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 a safe and coordinated discharge for one of four sampled residents (Resident 1). * The facility initiated a Discharge AMA (Against Medical Advice) when Resident 1 returned to the facility after being out on pass (on the same day) without a planned place to stay. In addition, Resident 1's Out on Pass Log was incomplete. This failure had the potential to result in an unsafe discharge when Resident 1 experienced a panic attack and was transported to the emergency room. Findings: Review of the facility's P&P titled Discharge AMA dated 3/2022 showed the following:AMA discharges will be processed in accordance with the Resident's/resident representative's request to arrange for a safe and appropriate discharge. Documentation will be completed as applicable. Referral to Adult Protective Services will be made when appropriate.Efforts would be made to make referrals to community resources and agencies to the extent time permits.Documentation will be made in the medical record with details of the discharge to include: - persons and agencies notified; - statement of reason for discharge (if known); - explanation of benefits of remaining in the facility; - explanation of the potential complications, risk, and consequences of leaving the facility against the advice of the physician; - date and time of discharge, mode of transportation, and by whom. Review of the facility's P&P titled Out on Pass (undated) showed the facility is committed to providing the residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning. It is the policy of the facility to meet the residents' physical and psychosocial needs when going out on pass. As such, the facility will make reasonable efforts to ensure the resident safety and uphold resident rights. If the resident's physician determines that the resident may participate in activities outside the facility, the physician will write/give an order for a resident to go out on pass. The resident/responsible person will verbally notify a licensed nurse prior to going out on pass and will sign out and back in on the Resident Out on Pass Log. The resident/responsible person will return to the facility at the agreed-upon time, or else notify the facility of any unexpected delay in return to the facility. Review of the P&P titled Abuse Prohibition dated 2/2021 showed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental or psychosocial well-being: Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation, and Neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress Closed medical record review for Resident 1 was initiated on 8/5/25. Resident 1 was readmitted to the facility on [DATE], and discharged AMA on 7/20/25. Resident 1 was a custodial resident with diagnoses including cirrhosis of the liver (scarring in liver tissue), cardiomegaly (enlarged heart), essential hypertension (high blood pressure), and depression. Review of Resident 1's Physician Order Summary Report showed an order dated 10/3/24, Resident 1 may go out on pass with a family or friend for no more than four hours for therapeutic activities. Review of Resident 1's Care Plan Report showed the following care plans:- dated 3/7/24, resident requires assist in the following areas: bathing, bed mobility, locomotion off unit, locomotion on unit, personal hygiene, toilet use, and transfers.- dated 3/8/24, Resident 1 will be long-term with minimal/no possibility to be discharged to lower level of care due to medical status, and lack of support system (family and/or community). Review of Resident 1's MDS assessment dated [DATE], section GG Functional Abilities showed the following:- for shower/bath self, lower body dressing, and putting on/taking off footwear, 2 (indicating the resident needed substantial/maximal assistance);- for upper body dressing, personal hygiene, roll left to right, sit to lying, lying to sitting on side of bed, chair/bed to chair transfer, and tub/shower transfer, 3 (indicating the resident needed partial/moderate assistance); and- for walk 150 feet- 4 (indicating the resident needed supervision or touching assistance) Further review of Resident 1's MDS assessment showed substantial/maximal assistance was defined as, helper does more than half the effort, helper lifts, or holds trunk or limbs and provides more than half the effort. Partial/moderate assistance was defined as helper does less than half the effort. Helper lifts, holds, or support trunk or limbs, but provides less than half the effort. Supervision or touching assistance was defined as helper provides verbal cues, and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Review of Resident

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 Out on Pass Log was accurately and completely filled out for two of four sampled residents (Residents 1 and 4). * Resident 1 and 4's Resident Out on Pass Log did not include the time when the resident went out of the facility, had returned to the facility, and the nurse's initials. These failures had the potential for the residents' care needs to not be met.Findings: Review of the facilities P&P titled Nursing Documentation dated 6/2022 showed nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the residents/patients (hereinafter patient) condition, situation, and complexity. Documentation for subsequent and or routine care and procedures may be completed by exception or the use of a checklist, flow charts, or other documentation tools. Clinical judgment is used to determine the need for additional data collection and/or more frequent documentation.- Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patients outcomes, and responses to nursing care. - Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures- All resident information will be documented, scanned, or entered in the appropriate section of the clinical record following established guidelines. Review of the P&P titled Out on Pass (undated) showed the facility is committed to providing residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning. It is the policy of the facility to meet the residents' physical and psychosocial needs when going out on pass. As such, the facility will make reasonable efforts to ensure the resident safety and uphold resident rights. If the resident's physician determines that the resident may participate in activities outside the facility, the physician will write/give an order for a resident to go out on pass. The resident/responsible person will verbally notify a licensed nurse prior to going out on pass and will sign out and back in on the Resident Out on Pass Log. The resident/responsible person will return to the facility at the agreed-upon time, or else notify the facility of any unexpected delay in return to the facility. 1. Closed medical record review for Resident 1 was initiated on 8/5/25. Resident 1 was readmitted to the facility on [DATE], and discharged AMA on 7/20/25. Review of the facility's document titled Resident Out On Pass Log showed the following for Resident 1:- dated 6/2/25, no entry on the time the resident returned and no nurses initials.- dated 6/21/25, no entry on the time the resident returned and no nurses initials.- dated 6/26/25, no entry on the time the resident returned and no nurses initials.- dated 7/8/25, no entry on the time the resident returned and no nurses initials.- dated 7/18/25, no entry when the resident went out, returned to the facility and no nurses initials.- undated, no entry when the resident went out, returned to the facility and no nurses initials. Cross Reference F627. 2. Medical record review for Resident 4 was initiated on 8/7/25. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility document titled Resident Out On Pass Log showed the following for Resident 4:- dated 6/17/25, no entry when the resident went out and no nurses initials.- dated 6/26/25, no entry when the resident went out, returned to the facility and no nurses initials.- dated 7/4/25, no entry when the resident went out, returned to the facility and no nurses initials. On 8/6/25 at 1554 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the Out on Pass Log for Residents 1 and 4 had blank entries and stated ideally the nurses were supposed to sign the entries. On 8/8/25 at 1312 hours, the Administrator and DON acknowledged the findings.