| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055653 | A. Building<br>B. Wing | 09/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| South Coast Post Acute | 1030 W Warner Ave<br>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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 the abuse allegations were thoroughly investigated for two of five sampled residents (Residents 1 and 3). * The facility failed to conduct a thorough investigation for Resident 1's abuse allegation against Resident 2 when the resident's roommate was not interviewed regarding the incident. * The facility failed to conduct a thorough investigation for Resident 3's abuse allegation against Resident 4 when witnesses were not interviewed regarding the incident. These failures had the potential for the residents to be vulnerable for further abuse, mistreatment, and injury.Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure dated 2/23/21, showed health care centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. The Process section showed investigation will be thoroughly documented. Ensure that documentation of witnessed interviews is included. 1. Review of the facility's SOC 341 form dated 9/9/25, showed Resident 1 alleged he was struck on the face by Resident 2. Both residents were separated. Resident 2 was placed on close monitoring and Resident 1 was given first aid. Medical record review for Resident 1 was initiated on 9/23/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed the resident's cognition was intact. Review of Resident 1's Nurse Progress Note dated 9/9/25 at 2119 hours, showed Resident 1 was interviewed and assessed by the facility staff. Review of the Daily Census dated 9/9/25, showed Resident 1 had a roommate (Resident A). Review of Resident 1's medical record showed the resident was in the room by the door and Resident 2 was outside of Resident 1's room. Further review of Resident 1's medical record and investigation report failed to show documented evidence Resident A (who possibly witnessed the incident) was interviewed in relation to the incident. There was no documentation to explain why Resident A was not interviewed regarding the incident. On 9/23/25 at 1605 hours, an interview was conducted with MHW (Mental Health Worker) 1. MHW 1 stated she observed Resident 2 punch someone with his right arm and closed fist. MHW 1 stated she did not know at that time who was the one that Resident 2 punched. MHW 1 stated she immediately ran down the hall and shouted for staff help. MHW 1 further stated Resident 2 stepped back and listened to redirection from the facility staff. MHW 1 stated she saw Resident 1's both hands on his nose and there was bleeding. On 9/24/25 at 1537 hours, an interview and concurrent medical record and facility document review was conducted with the DON. The DON verified Resident 1's roommate (Resident A) was not interviewed. The DON stated he did not know if Resident 1's roommate (Resident A) was in the room at the time of the incident. The DON stated Resident A should have been interviewed because the resident could have potentially seen the incident as a witness. The DON stated the alleged victim and alleged perpetrator were both alert and interviewable. 2. Review of the facility's SOC 341 form dated 9/12/25, showed Resident 4 struck Resident 3 on the back of the neck, unprovoked, while in the patio. Both residents were separated. Resident 4 was placed on close monitoring and contracted for safety. Resident 3 was given first aid. Medical record review for Resident 3 was initiated on 9/23/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 was cognitively intact. Review of Resident 3's Behavior Progress Note dated 9/12/25 at 2145 hours, showed Resident 3 was in the patio waiting for dinner at approximately 1740 hours on 9/12/25. Resident 4 approached Resident 3 and struck her at the back of her neck. The facility staff immediately intervened and separated the two residents. Resident 4 was escorted to the quiet room and Resident 3 was assessed for pain and injuries. Further review of Resident 3's medical record and investigation report failed to show documented evidence other residents who possibly witnessed the incident were interviewed. On 9/23/25 at 1039 hours, an interview was conducted with Resident 5. Resident 5 stated she saw Resident 4 behind Resident 3. Resident 5 further stated Resident 4 smacked his hand on the back of the head of Resident 3. Resident 5 stated Resident 4 took off immediately after the incident. On 9/24/25 at 1550 hours, an interview and concurrent medical record and facility document review was conducted with the DON. The DON verified the other residents who were in the patio waiting for dinner on the time of Resident 3's alleged abuse were not interviewed. The DON stated the facility staff did not interview other residents because Resident 3's alleged abuse was witnessed by the two facility staff. On 9/24/25 at 1645 hours, the Administrator and DON were informed and acknowledged the above findings. |