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	06/04/2026

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, and facility P&P review, the facility failed to protect the resident's right to be free from physical abuse for one of six sampled residents (Resident 3). * Resident 4 pushed and kicked Resident 3 in the abdomen, causing Resident 3 to experience pain and fall to the floor. This failure resulted in Resident 3 experiencing physical pain and potential for psychosocial harm.Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure revised 2/23/21, showed the facility prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The facility will implement an abuse prohibition program through prevention of occurrences and identification of possible incidents or allegations which need investigation. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Physical Abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, will include providing patients, families, and staff with information on how and to whom they may report concerns, incidents, and grievances without fear of retribution and providefeedback regarding the concerns that have been expressed; identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur; and establishing a safe environment that supports, to the extent possible, a patient's consensual sexual relationship. Review of the facility's P&P titled Resident Care Levels of Observation (undated) showed the facility intends to provide a safe and therapeutic milieu for all residents. During the course or their treatment, some residents may experience periods of depression, anger, confusion, or altered mental status that impairs their judgment. For those residents that are felt to be at risk for behaviors that could cause self-injury, harm to others, significant physical damage to the facility, or are sexually inappropriate, three types of observation may be instituted to protect the rights and well-being of the resident and/or their peers. These observations levels are termed: every 15-minute checks, one-to-one observations, and shadowing. Every 15-minute checks were written to require staff to check on the patient at least every 15 minutes for various types of behaviors. Nursing staff can be instructed to chart every fifteen minutes or can give a summation of their checks in a note at the end of the shift. Review of the facility's SOC 341 dated 5/18/26, showed at approximately 2115 hours, Resident 4 was observed pushing Resident 3 with open hands and feet. Resident 3 landed on her buttocks. a. Review of Resident 3's medical record was initiated on 6/3/26. Resident 3 was admitted on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident's BIMS score was 15, indicating the resident had functional cognition. Review of Resident 3's Nurses Progress Notes dated 5/18/26, showed at 2312 hours, Resident 3 was observed being pushed by Resident 4. Resident 3 landed on her buttocks. b. Review of Resident 4's medical record was initiated on 6/3/26. Resident 4 was admitted (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	on [DATE], and was readmitted on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed the resident's BIMS score was 15, indicating the resident had functional cognition. Review of Resident 4's plan of care dated 5/3/25, showed a care plan for labile mood and pushed a peer in the patio. Further review of Resident 4's plan of care failed to show a care plan was developed for Resident 4's child-like behavior, horseplaying and poor boundaries. Review of Resident 4's Behavior Progress Note dated 5/7/26, showed at 1450 hours, resident got easily upset and agitated due to not being able to go to the store. Resident 4 had multiple red cards due to horse playing and poor boundaries. Review of Resident 4's Social Service Progress Note dated 5/12/26, showed at 1126 hours, resident was disruptive and difficult to redirect at times. Resident 4 had poor insight into mental illness and poor judgement. Review of Resident 4's Behavior Progress Note dated 5/12/26, showed at 1532 hours, resident had poor boundaries, horseplaying, child-like behavior, testing limits and close contact with a female peer. Review of Resident 4's Psychiatric Progress Notes dated 5/14/26, showed at 1111 hours, resident still horseplaying with peers. Resident worried he would get in a fight. Review of Resident 4's Nurses Progress Notes dated 5/18/26, showed on 2115 hours, Resident 4 was observed pushing Resident 3 with open hands and one foot. Resident 3 landed on her buttocks. Review of Resident 4's Every 15 Minute Check Order showed a physician's order dated 5/18/26 at 0800 hours, to continue every 15 minute checks for unusual behavior. Review of Resident 4's Every 15 Minute Monitoring: Unpredictable Behavior, Aggressive/ Assaultive Behavior Follow Up Question Report Awake or Asleep dated 5/18/26, showed:- on 5/18/26 at 1545 hours, Is the Resident Awake or Asleep? Response Not Required- on 5/18/26 at 1614 hours, Is the Resident Awake or Asleep? Response Not Required- on 5/18/26 at 1844 hours, Is the Resident Awake or Asleep? Response Not Required- on 5/18/26 at 1915 hours, Is the Resident Awake or Asleep? Response Not Required- on 5/18/26 at 2048 hours, Is the Resident Wake or Asleep? Response Not Required- on 5/18/26 at 2117 hours, Is the Resident Wake or Asleep? Response Not Required Review of Resident 4's Every 15 Minute Monitoring: Unpredictable Behavior, Aggressive/ Assaultive Behavior Follow Up Question Location dated 5/18/26, showed:- on 5/18/26 at 1545 hours, Verify Location Response Hallway- on 5/18/26 at 1614 hours, Verify Location Response Hallway- on 5/18/26 at 1844 hours, Verify Location Response Hallway- on 5/18/26 at 1915 hours, Verify Location Response Hallway- on 5/18/26 at 2048 hours, Verify Location Response Hallway- on 5/18/26 at 2117 hours, Verify Location Quiet Room Review of Resident 4's Every 15 Minute Monitoring: Unpredictable Behavior, Aggressive/ Assaultive Behavior Follow Up Question Report Room Number dated 5/18/26, showed:- on 5/18/26 at 1545 hours, Room Number Response Not Required- on 5/18/26 at 1614 hours, Room Number Response Not Required- on 5/18/26 at 1844 hours, Room Number Response Not Required- on 5/18/26 at 1915 hours, Room Number Response Not Required- on 5/18/26 at 2048 hours, Room Number Response Not Required- on 5/18/26 at 2117 hours, Room Number Response Not Required Further review or Resident 4's Every 15 Minute Monitoring: Unpredictable Behavior, Aggressive/ Assaultive Behavior dated 5/18/26, failed to show any documentation for resident's every 15 minute as ordered by the physician on the following times: - on 5/18/26 at 1600 hours.- on 5/18/26 at 1900 hours.- on 5/18/26 at 2100 hours. c. Review of Resident A's medical record was initiated on 6/3/26. Resident A was admitted on [DATE], and was readmitted on [DATE]. Review of Resident A's MDS assessment dated [DATE], showed the resident's BIMS score was 15, indicating the resident had functional cognition. On 6/3/26 at 0850 hours, an observation and concurrent interview was conducted with Resident 4. Resident 4 was observed in his room laying on his bed. Resident 4 walked to the patio, had a flat affect and was guarded. Resident 4 stated he did not want to talk about the incident that happened on the night of 5/18/26, between him and Resident 3. On 6/3/26 at 0905 hours, an interview was conducted with Resident 3. Resident 3 stated on the night of 5/18/26, she saw Resident 4 was roughly horse playing with Resident A. Resident 3 tried to help Resident A and ask Resident 4 to stop horseplaying roughly. Resident 3 further stated Resident 4 got loud and angry, then had told her what was it for her and what she would do about it. Resident 3 stated Resident 4 pushed (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and kicked her on her abdomen and she fell on the floor. Resident 3 further stated her abdomen hurt for a short while but was alright afterwards. Resident 3 stated sometimes she feared Resident 4 would do it again. On 6/3/26 at 0920 hours an interview was conducted with Resident A. Resident A stated Resident 4 was horseplaying with him, however Resident 3 did not like how Resident 4 was horseplaying. Resident A further stated Resident 3 told Resident 4 to stop, then Residents 3 and 4 started to have an exchange of words and argued. Resident A stated he saw Resident 4 push and kick Resident 3, and she landed on the floor. Resident A further stated the facility staff came after Resident 3, who was already on the floor. On 6/30/26 at 0939 hours, an interview was conducted with LVN 1. LVN 1 stated she was at the nursing station when she heard a noise from the hallway. LVN 1 stated she saw Resident 4 with open hands and kick Resident 3, then Resident 3 landed on her buttocks on the floor. LVN 1 stated one MHW was making rounds and the other MHW assigned in the hallway went to the TV room to assist other residents to change the channel. On 6/3/26 at 1424 hours, a phone interview was conducted with MHW 1. MHW 1 stated she assisted other residents to change the channel of the TV. MHW 1 further stated she heard the noise and saw Resident 3 was already sitting on the floor. MHW 1 stated someone should be watching the hallway. On 6/3/26 at 1440 hours, a telephone interview was conducted with MHW 4. MHW 4 stated he was in the nursing station when he heard the commotion. MHW 4 stated he went out of the nursing station he saw both residents were already separated by LVN 1 and MHW 5. On 6/3/26 at 1501 hours, an interview was conducted with MHW 3. MHW 3 stated he was at the north part of the hallway and heard a commotion from the Residents 3 and 4 at the south part of the hallway. MHW 3 stated he tried to ran towards the residents to stop them however when he came to the location, Resident 3 was already on the floor. On 6/3/26 at 1600 hours, an interview was conducted with MHW 5. MHW 5 stated she went outside of the nursing station because she heard a noise from the hallway. MHW 5 stated she assisted Resident 3 from the floor to go to the room. On 6/4/26 at 1121 hours, an interview was conducted with the DON. The DON stated the incident on 5/18/26 at 2115 hours, was triggered by horseplaying of Resident A and Resident 4. On 6/4/26 at 1545 hours, an interview and a concurrent medical record review for Resident 4 was conducted with the DON. The DON verified Resident 4 had a physician's order for every 15 minutes check due to unpredictable behavior, aggressive/ assaultive behavior. The DON stated the every 15 minutes check should be done by the MHW every 15 minutes and should be documented. The DON stated the MHW checks the resident and documents timely as reflected on the resident's record. The DON verified the above findings and stated the expectation was for the MHW to complete every 15 minutes check and document as they check each resident. The DON verified Resident 4 had history of no boundaries, child-like behavior and horseplaying however, Resident 4's care plan did not reflect a plan of care for the behavior was initiated. The DON stated a care plan should have been implemented. On 6/4/26 at 1645 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above. Cross reference F656.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 ensure the comprehensive care plan was developed and implemented to reflect the individual care needs for one of six sampled residents (Residents 4). * The facility failed to develop a care plan problem to address Resident 4's childlike behavior, horseplaying and poor boundaries. This failure had the potential for the resident to not be provided with appropriate, consistent, and individualized care.Findings: Review of Resident 4's medical record was initiated on 6/3/26. Resident 4 was admitted on [DATE], and was readmitted on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed the resident's BIMS score was 15, indicating the resident had functional cognition. Review of Resident 4's Behavior Progress Note dated 5/7/26, showed at 1450 hours, resident got easily upset and agitated due to not being able to go to the store. Resident 4 had multiple red cards due to horse playing and poor boundaries. Review of Resident 4's Social Service Progress Note dated 5/12/26, showed at 1126 hours, resident was disruptive and difficult to redirect at times. Resident 4 had poor insight into mental illness and poor judgement. Review of Resident 4's Behavior Progress Note dated 5/12/26, showed at 1532 hours, resident had poor boundaries, horseplaying, child-like behavior, testing limits and close contact with a female peer. Review of Resident 4's Psychiatric Progress Note dated 5/14/26, showed at 1111 hours, resident still horseplaying with peers. Resident worried he would get in a fight. Review of Resident 4's Nurses Progress Note dated 5/18/26, showed on 2115 hours, Resident 4 was observed pushing Resident 3 with open hands and one foot. Resident 3 landed on her buttocks. Review of Resident 4's care plans failed to show a care plan was developed for Resident 4's childlike behavior, horseplaying and poor boundaries. On 6/4/26 at 1545 hours, an interview and a concurrent medical record review for Resident 4 was conducted with the DON. The DON stated Resident 4 had a history of no boundaries, child-like behavior and horseplaying, however, Resident 4's care plan did not reflect a plan of care for the behavior was initiated. The DON stated a care plan should have been created. On 6/4/26 at 1645 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above. Cross reference F600.