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	06/10/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide the safe and sanitary environment were implemented for two of seven sampled residents (Residents 5 and 6). * The facility failed to ensure CNA 1 performed proper hand hygiene and handling of clean linens when providing care for Resident 5. * The facility failed to ensure LVN 1 performed disinfection of the call light after picking it up from the floor before placing it on Resident 6's lap. In addition, proper hand hygiene must be performed by LVN 1 after handling the call light from the floor. These failures posed the risk for transmission of disease-causing microorganisms and infections.Findings: Review of the facility's P&P titled Standard Precaution Infection Control (undated) showed the following:- hand hygiene is performed with alcohol-based hand rub (ABHR) or soap and water before and after contact with the resident, performing an aseptic task, before moving from work on a soiled body site to a clean body site on the same resident, after removing gloves;- hands are washed with soap and water when visibly soiled with dirt, blood or body fluids, after contact with blood, body fluids, or contaminated surfaces;- environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces are appropriately cleaned; and- linen soiled with blood, body fluids, secretions are handled and processed in manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments. 1. On 6/8/26 at 0937 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 was observed holding clean linens and entered Resident 5's room. CNA 1 picked up Resident 5's tube syringe on the bedside table and dropped it on the floor. CNA 1 picked Resident 5's tube syringe from the floor with bare hands and held it against the clean linen then placed tube syringe back on the bedside table. CNA 1 failed to dispose of the tube syringe that was picked up from the floor. In addition, CNA 1 failed to perform proper handwashing and disinfection of Resident 5's bedside table. CNA 1 verified the findings. CNA 1 stated anything on the floor is considered dirty and must be thrown away. Furthermore, CNA 1 stated the negative outcome of not following infection prevention and proper hand hygiene is the spread of infection. Medical record review for Resident 5 was initiated on 6/10/26. Resident 5 was admitted to the facility on [DATE], readmitted on [DATE]. Review of Resident 5's Order Summary Report dated 6/10/25, showed physician's order for EBP related to GT. 2. On 6/8/26 at 1009 hours, an observation and concurrent interview was conducted with LVN 1 and the MDS Assistant. LVN 1 was observed picking up Resident 6's call light from the floor and placed it on Resident 6's lap. LVN 1 did not sanitize the call light and did not perform hand hygiene. LVN 1 verified the call light was dirty since she picked it up from the floor and failed to perform hand hygiene. In addition, LVN 1 verified she did not disinfect the call light prior to placing it on Resident 6's lap. The MDS Assistant stated all nurses must disinfect the call light prior to placing it on Resident 6 then perform proper hand hygiene or handwashing. On 6/8/26 at 1517 hours, an interview was conducted with LVN 1. LVN 1 stated the call light found on the floor needed to be disinfected prior to giving the call light to Resident 6. LVN 1 stated the negative outcome of not following infection control was the spread of infection to any residents and staff. On 6/10/26 at 1420 hours, an interview was conducted (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the IP. The IP stated anything on the floor was considered dirty or contaminated and must be disposed unless it can be disinfected. The IP stated all the staff must perform proper handwashing or hand hygiene before and after providing care to the residents and handling or touching any soiled or contaminated linens, surfaces, or equipment. Furthermore, the IP stated the negative outcome was the risk of infection. On 6/10/26 at 1705 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.