

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 02/28/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the informed consents were obtained for the use of psychotropic medications for one of five final sampled residents (Resident 147) reviewed for informed consents (Resident 147).</p> <p>* There were no informal consents prior to administering olanzapine (antipsychotic medication), quetiapine (antipsychotic medication), and valproic acid (mood stabilizer medication) to Resident 147. This failure had the potential for the resident to be unaware of the risks associated with the medications which could have adverse side effects detrimental to the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed the following:</p> <ul style="list-style-type: none"> - The informed consent will be obtained by the Prescriber prior to initiation of psychotropic medication; and - The facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. <p>Medical record review for Resident 147 was initiated on 2/27/25. Resident 147 was readmitted to the facility on [DATE].</p> <p>Review of Resident 147's H&P examination dated 1/15/25, showed the resident had no capacity to understand and make decisions.</p> <p>Review of Resident 147's Order Summary Report dated 2/27/25, showed the following:</p> <ul style="list-style-type: none"> - olanzapine oral tablet 10 mg one tablet via GT every 12 hours for psychosis manifested by hallucinations/striking out for no apparent reason; - quetiapine fumarate tablet 100 mg one tablet via GT every 12 hours for psychosis manifested by constant yelling for no apparent reason causing distress; and - valproic acid oral solution 500 mg/10 ml 10 ml via GT two times a day for mood lability manifested by sudden angry outburst. <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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/27/25 at 1112 hours, a concurrent interview and medical record review was conducted with LVN 12. LVN 12 reviewed Resident 147's medical record and verified there were no informed consents obtained for the use of the olanzapine, quetiapine, and valproic acid medications upon Resident 147's readmission on 1/14/25. LVN 12 stated the informed consents were kept in the medical record or scanned and uploaded to the EHR.</p> <p>On 2/27/25 at 1320 hours, a concurrent interview and medical record review was conducted with the Health Information Manager. The Health Information Manager reviewed Resident 147's medical record and verified there were no informed consents obtained for the olanzapine, quetiapine and valproic acid medications upon Resident 147's readmission on 1/14/25. The Health Information Manager stated if the resident was readmitted to the facility after a week from the acute care hospital, new orders, and informed consents must be obtained.</p> <p>On 2/27/25 at 1341 hours, an interview was conducted with DON 1. DON 1 stated the facility must get an informed consent for each psychotropic medication prior to initiating the medications. DON 1 was informed and acknowledged the above findings.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to maintain a copy of an advance directive in the medical record for one of five final sampled residents (Resident 184) reviewed for advance directives. This failure had the potential for Resident 184's decisions regarding his healthcare and treatment options to not be honored.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Advance Directive dated 3/23/22, showed at the time of admission, the Admission Staff or designee will inquire about the existence of an Advance Directive. A copy of the Advance Directive is maintained as part of the resident's medical record. Further review of the P&P showed if the resident has an Advanced Directive, admission staff or designee will place a copy or scan of the Advanced Directive in the residence medical record and will notify the director of social services of the existence of the Advanced Directive.</p> <p>Medical record review for Resident 184 was initiated on 2/25/25. Resident 184 was readmitted to the facility on [DATE].</p> <p>Review of Resident 184's POLST dated 7/23/24, showed Resident 184 had an advance directive.</p> <p>Review of Resident 184's H&P examination dated 2/17/25, showed Resident 184 had no capacity to understand and make decisions.</p> <p>Review of Resident 184's Social Service assessment dated [DATE], showed Resident 184 had an advance directive and the facility did not have a copy of the Advance Directive in the medical record.</p> <p>Review of Resident 184's medical record failed to show a copy of the advance directive was maintained in Resident 184's medical record. Further review of Resident 184's medical record failed to show documented evidence if the copy of the Advance Directive was requested from Resident 184 or the resident's representative.</p> <p>On 2/26/25 at 1421 hours, an interview and concurrent medical record review for Resident 184 was conducted with the SSA. The SSA verified there was no copy of Resident 184's advance directive in the medical record nor was it uploaded to Resident 184's EHR. The SSA stated she was not able to find documentation the residents and/or the resident's family member or representative were asked to bring a copy of the Advance Directive. The SSA stated if the resident had an advance directive, the facility would ask for a copy of the advance directive; and the social services would have to follow up right away if the resident or resident's representative could not provide a copy of the advance directive. The SSA stated they would have to document any follow up done by the facility regarding Resident 184's advance directives. The SSA could not provide documentation for following up on Resident 184's advance directive.</p> <p>On 2/27/25 at 1005 hours, DON 1 was informed and acknowledged the above findings.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the PASRR Level 1 (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment was coded accurately for two of four final sampled residents (Residents 132 and 147) reviewed for PASRR. This failure posed the risk of the residents not receiving specialized care and services appropriate for their condition.</p> <p>Findings:</p> <p>Review of the facility's P&P titled PASRR Completion Policy dated 9/30/24, showed the center will make sure that all admissions have the appropriate Patient Assessment and Resident Review completed. Further review of the P&P showed the facility will follow the State specific guidelines for completion.</p> <p>1. Medical record review for Resident 132 was initiated on 2/25/25. Resident 132 was admitted to the facility on [DATE].</p> <p>Review of Resident 132's PASRR Level 1 Screening Form dated 12/20/24, showed Resident 132 had no serious mental illness and no prescribed psychotropic medications for mental illness.</p> <p>Review of Resident 132's Admission Record dated 2/26/25, showed Resident 132 had diagnoses which included major depressive disorder (persistent low mood and loss of interest in activities), and schizoaffective disorder.</p> <p>Further review the resident's medical record showed Resident 132's Order Summary Report dated 2/27/25, with the following physician's orders:</p> <ul style="list-style-type: none"> - dated 12/30/24, to administer quetiapine 25 mg by mouth two times a day for schizoaffective disorder (mental health condition that affects a person's thoughts, emotions, and behaviors) manifested by physical agitation without a valid reason; and , - dated 2/26/25, to administer lorazepam (antianxiety) 0.5 mg one tablet by mouth every 12 hours as needed for anxiety, manifested by inability to relax for 14 days. <p>2. Medical Record review for Resident 147 was initiated on 2/25/25. Resident 147 was admitted to the facility on [DATE].</p> <p>Review of the Resident 147's PASRR Level 1 Screening Form dated 12/20/24, showed Resident 147 had no serious mental illness and no prescribed psychotropic medications for mental illness.</p> <p>Review of Resident 147's Admission Record dated 2/26/25, showed Resident 147 had diagnoses which included mood disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), and psychosis.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Furthermore, review of Resident 132's Order Summary Report dated 2/27/25, showed Resident 147 had the following physician's orders:</p> <ul style="list-style-type: none"> - dated 1/15/25, for quetiapine 100 mg via GT every 12 hours, for psychosis manifested by constant yelling for no apparent reason causing distress. - dated 1/15/25, for olanzapine oral tablet 10 mg one tablet via GT every 12 hours for psychosis manifested by hallucination and striking out for no apparent reason. <p>On 2/26/25 at 1451 hours, an interview and concurrent medical record review for Residents 132 and 147 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated there was an error in completing the PASRR Level 1 assessment for Residents 132 and 147. The MDS Coordinator further stated if the PASRR Level 1 was not accurately completed, the facility must do the screening again and refer accordingly. The MDS Coordinator verified Residents 132 and 147 had diagnoses of serious mental illness and had been receiving psychotropic medications. The MDS Coordinator stated Residents 132 and 147's PASRR Level 1 were not accurately completed.</p> <p>On 2/27/25 at 1005 hours, DON 1 was informed and acknowledged the above findings.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the individualized and ongoing activity program to meet the needs and interests for one of one final sampled resident (Resident 147) reviewed for activities. This failure had the potential to affect the residents' psychosocial well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Activities and Social Services (undated) showed the residents are encouraged to choose the types of recreational, cultural, and religious activities and social events in which they prefer to participate. The Interdisciplinary Care Team will evaluate the individual's personal history and preferences and will consider his or her medical condition and prognosis in identifying relevant recreational and cultural activities. When the care planning team develops the residents' activity and social care plans the residents will be given an opportunity to choose when, where, and how he or she will participate in activities and social events. As much as possible the facility will provide activities social events and schedule that are compatible with the residents' interest, physical and mental assessment, and overall plan of care.</p> <p>On 2/25/25 at 0956 hours, 2/26/25 at 1441 hours, and 2/27/25 at 0849 hours and 1349 hours, Resident 147 was observed lying awake in bed and staring at the wall. The television on the nightstand at the right side of Resident 147's bed was turned off.</p> <p>Medical record review for Resident 147 was initiated on 2/25/25. Resident 147 was admitted to the facility on [DATE].</p> <p>Review of Resident 147's H&P examination dated 1/15/25, showed Resident 147 had no capacity to understand and make decisions.</p> <p>Review of Resident 147's MDS dated [DATE], showed Resident 147 had a memory problem and severely impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 147 was dependent on the staff for his activities of daily living.</p> <p>Review of Resident 147's Recreation Comprehensive assessment dated [DATE], showed it was very important for Resident 147 to watch or listen to the TV, and for the opportunity to engage in daily routines that are meaningful relative to his preference. Further review of the Recreation Comprehensive Assessment showed the section for Preference/Identify Intervention showed it was important for Resident 147 to engage in his favorite activities, such as watching TV/movies, exercising, listening to music, and spending time with the family.</p> <p>Review of Resident 147's Care Plan revised 1/16/25, showed it was important for Resident 147 to have the opportunity to engage in daily routines that meaningful relative to his preferences and would receive one to one activity due to his cognitive status. The goal was to engage Resident 147 in one-to-one activities three times a week. The interventions included Resident 147's preferences such as watching TV/movies by himself in his bedroom.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 147's Participation Record dated February 2025 showed Resident 147 was mostly provided with exercise/physical activity/walking, movies/TV, manicure/aroma therapy/massage/painting nails/salon on 2/3, 2/5, 2/7, 2/10, 2/12, 2/14, 2/17, 2/19, 2/21, 2/24, and 2/26/25. Further review of the Participation Record for February 2025 did not show if Resident 147 was provided with any activity on 2/1, 2/2, 2/4, 2/6, 2/8, 2/9, 2/11, 2/13, 2/15, 2/16, 2/18, 2/20, 2/22, 2/23, 2/25, and 2/27/25.</p> <p>On 2/27/25 at 1428 hours, an observation and concurrent interview was conducted with the Activity Director. Resident 147 was observed lying in bed awake and staring at the wall, television was observed not being on, nor any in-room sensory stimulation was observed. The Activity Director verified the observation. The Activity Director stated Resident 147 required daily activities and the preferred activity should have been provided to Resident 147 as identified in the Recreation Comprehensive Assessment. The Activity Director further stated the facility did not have enough activity staff to provide the daily activities to the residents, so he scheduled room visits three times a week for Resident 147. When the Activity Director was asked what kind of activities were provided to Resident 147 when room visits were not scheduled, he was not able to answer.</p> <p>On 2/28/25 at 0806 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 147 was dependent on the facility's staff for his activities of the daily living. CNA 3 was asked if the facility provided any activities to Resident 147. CNA 3 stated Resident 147 was not able to go to the activity room and she had not seen the facility provided activities to Resident 147 in his room.</p> <p>On 2/28/25 at 1430 hours, DON 1 and the Administrator were informed and acknowledged the above findings.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for one of three final sampled residents (Resident 735).</p> <p>* The facility failed to ensure Resident 735's GT was checked for placement before administration of the medications and water. In addition, the facility failed to administer each medication and water flushes via gravity. These failures had the potential for the resident to develop complications related to the GT care and management, including tube dislodgement, delayed nutritional feeding, and trauma.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Enteral Tube Medication Administration dated 10/2017 showed the following procedures to verify the tube placement:</p> <ul style="list-style-type: none"> - Insert a small amount of air into the tube with the syringe and listen to the stomach with the stethoscope for gurgling sounds; - Aspirate the stomach contents with syringe to check for residual feeding.; - Remove the plunger from the syringe and connect the syringe to the tubing; - Flush the tube with at least 15 ml of water prior to medication administration; and - Allow medication to flow down the tube via gravity. <p>Medical record review for Resident 735 was initiated on 2/25/25. Resident 735 was admitted to the facility on [DATE].</p> <p>Review of Resident 735's H&P examination dated 2/8/25, showed Resident 735 had no capacity to understand and make decisions.</p> <p>Review of Resident 735's MDS dated [DATE], showed Resident 735's BIMS score was 1, indicating the resident had severely impaired cognition.</p> <p>Review of Resident 735's Order Summary Report dated 2/25/25, showed an order to check the tube placement prior to each feeding, flush, or medication administration every shift.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/25/25 at 0848 hours, a concurrent medication administration observation and interview was conducted with LVN 3. LVN 3 connected the syringe to Resident 735's GT and aspirated for residual; however, LVN 3 did not check the GT placement. LVN 3 verified she did not check the GT placement and stated she would check it later. LVN 3 continued to administer each of the medication, water flushes into the GT by pushing the syringe's plunger, and not via gravity. LVN 3 verified she should have administered the medications and water flushes via gravity and should not have pushed them with the syringe's plunger.</p> <p>On 2/27/25 at 1438 hours, an interview was conducted with DON 1. DON 1 was informed and acknowledged the above findings.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on interview, and medical record review, the facility failed to provide the necessary care and services to maintain the intravenous accesses and properly provide IV care for three of three final sampled residents (Residents 184, 733, and 983) and one nonsampled resident (Resident 932).</p> <p>* The facility failed to ensure Resident 932's IV tubing was free from air bubbles prior to administration.</p> <p>* The facility failed to ensure Resident 184's midline (a long, thin, flexible tube inserted into a large vein in the upper arm used to deliver fluids and medications into the bloodstream) dressing was dated and labeled. In addition, the facility failed to ensure Resident 184's midline was maintained to prevent possible complications.</p> <p>* The facility failed to discontinue Resident 983's PIV line after the antibiotic therapy was completed. In addition, the facility failed to ensure there were physician's orders for the PIV maintenance.</p> <p>* The facility failed to ensure Resident 733's PIV site was dated and labeled.</p> <p>These failures posed the risk to develop complications to the residents related to the use of the peripheral IV catheter.</p> <p>Findings:</p> <p>1. Review of the National Institutes of Health, Chapter 23.5 Checklist for Primary IV Solution Administration dated 11/11/21, showed the following:</p> <p>- Once primed, clamp the IV tubing and check the entire length of the tubing for air bubbles. Tap the tubing gently to remove any air.</p> <p>Medical record review for Resident 932 was initiated on 2/25/25. Resident 932 was admitted to the facility on [DATE].</p> <p>Review of Resident 932's Order Listing Report dated 2/25/24, showed an order for piperacillin sodium-tazobactam (antibiotic medication) Solution Reconstituted 3-0.375 gm 3.375 gm intravenously every eight hours for UTI until 2/26/25.</p> <p>Review of Resident 932's H&P examination dated 2/28/25, showed Resident 932 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/25/25 at 1452 hours, a concurrent medication administration observation and interview was conducted with RN 1. RN 1 prepared the Zosyn (brand name for piperacillin sodium-tazobactam) IV antibiotic medication and primed the IV tubing. After RN 1 primed the IV tubing, multiple air bubbles were observed in the tubing. RN 1 stated she was ready to administer the Zosyn IV and entered Resident 932's room. RN 1 was requested to come out of Resident 932's room with the Zosyn IV medication. RN 1 was informed there were multiple air bubbles in the IV tubing. RN 1 verified the findings. RN 1 was asked what her next step would be after knowing there were multiple air bubbles in the IV tubing. RN 1 stated she could remove the air by priming the tubing, however it would waste the medication in the tubing. RN 1 attempted to prime the tubing to remove multiple air bubbles. Furthermore, RN 1 stated she would call another staff for assistance.</p> <p>On 2/25/25 at 1457 hours, a concurrent observation and interview was conducted with the QA RN. The QA RN was informed of the multiple air bubbles in the resident's IV tubing and verified the findings. The QA RN was observed tapping the IV tubing to move the air bubbles, however she was not able to remove the air bubbles. The QA RN consulted with DON 1. The QA RN stated DON 1 recommended to change the current IV tubing to a new IV tubing. The QA RN informed RN 1 and RN 1 had agreed.</p> <p>On 2/27/25 at 1438 hours, an interview was conducted with DON 1. DON 1 was informed and acknowledged the above findings.</p> <p>44175</p> <p>2. Review of the facility's P&P titled Midline Dressing Changes (undated) showed the purpose of the P&P is to prevent catheter- related infections associated with contaminated, loosened or soiled catheter-site dressing. Further review of the P&P showed to change midline catheter dressing 24 hours after insertion, every five to seven days, or if it is wet, dirty, not intact, or compromised in any way.</p> <p>On 2/25/25 at 0930 hours, Resident 184 was observed lying on his bed and receiving an IV medication through the midline. There was no label and date observed on the dressing of the midline site.</p> <p>Medical record review for Resident 184 was initiated on 2/25/25. Resident 184 was readmitted to the facility on [DATE].</p> <p>Review of Resident 184's Progress Note dated 2/16/25 at 1919 hours, showed Resident 184 was readmitted to the facility and had a midline in the right upper arm.</p> <p>Review of Resident 184's H&P examination dated 2/17/25, showed Resident 184 had no capacity to understand and make decisions.</p> <p>Review of Resident 184's Physician Order Summary dated 2/28/25, showed a physician's order dated 2/17/25, for piperacillin-tazobactam in dextrose intravenous solution 3-0.375 gm per 50 ml intravenously every eight hours for foot infection.</p> <p>Further review of Resident 184's medical record failed to show if the midline site was monitored to maintain its patency, and possible complications including displacement and infection.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/25/25 at 0933 hours, an observation, interview, and concurrent medical record review for Resident 184 was conducted with RN 1. RN 1 verified the above observation and stated midline site for Resident 184 should have been labeled with the date and time when the dressing at the midline IV site was last changed. RN 1 stated she was not able to find the documentation if the midline dressing was changed after Resident 184 got readmitted to the facility on [DATE]. RN 1 further stated Resident 184 required a physician's order to flush the midline to maintain its patency, monitor arm circumference and external length of the catheter to ensure the placement, and to monitor the signs of infection of the midline site. RN 1 verified she was not able to find the documented evidence if midline site was being flushed to maintain its patency, and monitored for possible complication including displacement and infection.</p> <p>On 2/27/25 at 1005 hours, DON 1 was informed and acknowledged the above findings.</p> <p>47476</p> <p>3. Review of the facility's P&P titled General Policies for IV Therapy dated 3/2023 showed the IV peripheral sites will be rotated when clinically indicated (eg, unresolved complication, discontinuation of infusion therapy, or when no longer necessary for the plan of care).</p> <p>Review of the facility's P&P titled Peripheral Catheter Flushing dated 3/2023 showed a physician's order is required to flush a peripheral catheter.</p> <p>On 2/25/25 at 0925 hours and 2/26/25 at 1153 hours, Resident 983 was observed in bed with a left forearm PIV in place.</p> <p>Medical record review for Resident 983 was initiated on 2/25/25. Resident 983 was admitted to the facility on [DATE].</p> <p>Review of Resident 983's Order Summary Report dated 2/26/25, showed a physician's order dated 2/11/25, for cefepime HCl (antibiotic) intravenous solution 1 gm/50 ml 1 gm intravenously every 12 hours for infection.</p> <p>Further review of Resident 983's medical record failed to show a physician's order regarding Resident 983's PIV line maintenance flushes.</p> <p>Review of Resident 983's IV MAR for February 2025 showed the cefepime HCl medication was administered to Resident 983 from 2/11/25 through 2/21/25.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25 at 1200 hours, an interview, observation, and concurrent medical record review was conducted with RN 1. RN 1 stated the indication for a PIV line was for infections treated with antibiotics and fluids if needed. RN 1 stated the PIV line was changed only when indicated. RN 1 was asked about the maintenance for the PIV line. RN 1 stated they would administer saline flushes before and after the IV medication, and per shift when not in use if they did not have an IV medication that day. RN 1 verified Resident 983 had the previous order for the cefepime HCl medication and stated the medication order was discontinued on 2/21/25. RN 1 stated the PIV line was usually discontinued after a day or two days after the order was discontinued. RN 1 verified there was no order for the maintenance saline flushes for Resident 983's PIV line. RN 1 was then brought to Resident 983's room at 1213 hours, and verified Resident 983 had a left forearm PIV in place. RN 1 stated she would discontinue the PIV line immediately.</p> <p>47474</p> <p>4. Medical record review for Resident 733 was initiated on 2/25/25. Resident 733 was admitted to the facility on [DATE].</p> <p>Review of Resident 733's Order Summary Report for February 2025 showed a physician's order dated 2/25/25, for ceftriaxone (antibiotic) 1 gm IV once daily for urosepsis (a urine infection that spreads to the bloodstream) until 2/28/25.</p> <p>On 2/25/25 at 0919 hours, during an observation, Resident 733 was in his room with a single-lumen PIV line to the right hand with an undated and unlabeled dressing.</p> <p>On 2/25/25 at 1030 hours, a concurrent observation and interview was conducted with RN 1 in Resident 733's room. RN 1 verified Resident 733's PIV line dressing was not dated or labeled. RN 1 stated the PIV sites should be dated and labeled to ensure the PIV sites were changed weekly or as needed and for infection control.</p> <p>On 2/28/25 at 1430 hours, an interview with the Administrator and DON 1 was conducted. The Administrator and DON 1 acknowledged and verified all of the above findings.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure two of three final sampled residents (Residents 96 and 161) reviewed for respiratory care were provided the appropriate respiratory care.</p> <p>* The facility failed to ensure Resident 96's humidifier was labeled and dated and the resident had the physician's order for oxygen use as per the facility's P&P.</p> <p>* The facility failed to ensure Resident 161's oxygen order was carried out as ordered by the physician.</p> <p>These failures had the potential to affect the respiratory health and well-being of the residents in the facility.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Oxygen Administration (undated) showed to review the physician's orders or facility protocol for oxygen administration. The P&P further showed oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter.</p> <p>1. Medical record review for Resident 96 was initiated on 2/25/25. Resident 96 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].</p> <p>Review of Resident 96's Admission MDS dated [DATE], showed Resident 96 had a BIMS score of 12, indicating moderate impairment.</p> <p>On 2/25/25 at 1000 hours, during an observation, Resident 96 was in his room with an oxygen bag dated 2/21/25, and a humidifier not dated or labeled.</p> <p>On 2/25/25 at 1007 hours, an observation, interview, and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 96's humidifier was not dated or labeled. LVN 8 acknowledged the humidifier should be dated and labeled. LVN 8 verified review of Resident 96's physician's orders showed no documented evidence for the oxygen orders. LVN 8 stated Resident 96 used oxygen as needed and acknowledged the observations of Resident 96 on oxygen while in his room. LVN 8 further stated the oxygen orders that were administered continuously or as needed to a resident required a physician's order.</p> <p>On 2/25/25 at 1024 hours, an interview with Resident 96 was conducted with LVN 8 present. When the resident was asked if he used an oxygen, Resident 96 verified he used the oxygen when he feels short of breath.</p> <p>On 2/28/25 at 1430 hours, an interview was conducted with the Administrator and DON 1. The Administrator and DON 1 acknowledged and verified all of the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Medical record review for Resident 161 was initiated on 2/25/25. Resident 161 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE].</p> <p>Review of Resident 161's Order Summary Report for February 2025 showed a physician's order dated 10/13/24, for oxygen at 2 liters per minute via nasal cannula continuously, may titrate up to 3 liters per minute every shift.</p> <p>Review of Resident 161's MAR for February 2025 showed the resident was receiving an oxygen at two liters per minute via nasal cannula continuously with order to may titrate up to 3 liters per minute on 2/25/25.</p> <p>On 2/25/25 at 0837 hours, during an observation, Resident 161 was observed in her room wearing a nasal cannula and receiving oxygen at 5 liters per minute.</p> <p>On 2/25/25 at 1520 hours, an observation and concurrent medical record review for Resident 161 was conducted with IP 1. IP 1 verified Resident 161 was on oxygen at 5 liters per minute; however, the physician's order was to administer the oxygen at 2 liters per minute via nasal cannula continuously, may titrate up to 3 liters per minute every shift.</p> <p>On 2/28/25 at 1414 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged all the above findings.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure accurate reconciliation of the controlled medications for three of 35 final sampled residents (Residents 27 and 40) and one of six medication carts (Medication Cart A). In addition, the facility failed to provide the medications and/or biologicals, as ordered by the prescriber, to meet the needs of one of 35 final sampled residents (Resident 735).</p> <p>* The facility failed to ensure the administration of the controlled medications for Residents 40 were accurately reconciled and documented in the MAR.</p> <p>* The facility failed to ensure the apical pulse for Resident 735 was obtained before administration of Digoxin medication (a cardiac glycoside medication used to control some heart problems, such as irregular heartbeats including atrial fibrillation) as per the physician's order.</p> <p>* The facility failed to ensure the Narcotic Shift Count/IV/PO/E-kit Log for Medication Cart A was completed every shift.</p> <p>* Resident 27's oxycodone HCl (a Schedule II controlled medication) controlled medication count sheet was not maintained accurately for medication reconciliation.</p> <p>These failures posed the risk for diversion of controlled medications resulting in poor residents' outcome.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Controlled Medications dated 4/2008 showed the following:</p> <p>- When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR):</p> <ol style="list-style-type: none"> Date and time of administration; Amount administered; Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply; and Initials of the nurse administering the dose on the MAR after the medication is administered. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to facility policy in the presence of two licensed nurses and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules.</p> <p>Review of the facility's P&P titled Controlled Medication Disposal dated 1/2013 showed the following:</p> <p>- Medications included in the Drug Enforcement Administration (DEA) classifications as controlled substance are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.</p> <p>1. Medical record review for Resident 40 was initiated on 2/28/25. Resident 40 was readmitted to the facility on [DATE].</p> <p>Review of Resident 40's H&P examination dated 10/9/24, showed Resident 40 had the capacity to understand and make decisions.</p> <p>Review of Resident 40's Order Summary Report showed a physician's order dated 10/25/24, to administer oxycodone-acetaminophen (a narcotic medication to treat pain) oral tablet 5-325 mg one tablet by mouth every four hours as needed for moderate to severe pain.</p> <p>Review of Resident 40's MDS dated [DATE], showed Resident 40's BIMS score was 13, indicating the resident was cognitively intact.</p> <p>On 2/26/25 1140 at hours, a controlled medication reconciliation for Resident 40 was conducted with LVN 4. Review of Resident 40's Antibiotic or Controlled Drug Record showed the oxycodone-acetaminophen tablet 5-325 mg medication was signed out on the following dates:</p> <ul style="list-style-type: none"> - 2/5/25 at 0040 hours; - 2/8/25 marked error; - 2/14/25 at 1000 hour; - 2/18/25 at 2350 hours; - 2/19/25 marked error; and - 2/19/25 at 1900 and 2300 hours. <p>However, review of Resident 40's electronic MAR for February 2025 failed to show documented evidence the oxycodone-acetaminophen tablet 5-325 mg medication was administered to Resident 40 on the dates mentioned above, as shown in the Antibiotic or Controlled drug Record. LVN 4 verified the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/28/25 at hours, a concurrent interview and medical record review was conducted with DON 1. DON 1 verified the above findings. DON 1 stated when the licensed nurses administered the controlled medications, they must document on the controlled drug record and the MAR. DON 1 stated LVN 14 was assigned to Resident 40 on 2/8 and 2/19/25, with unaccounted controlled medications. Furthermore, the DON 1 stated an investigation was initiated and a summary of investigation would be provided to California Department of Public Health (CDPH) Orange County District Office.</p> <p>2. Medical record review for Resident 735 was initiated on 2/25/25. Resident 735 was admitted to the facility on [DATE].</p> <p>Review of Resident 735's H&P examination dated 2/8/25, showed Resident 735 had no capacity to understand and make decisions.</p> <p>Review of Resident 735's MDS dated [DATE], showed Resident 735's BIMS score was 1, indicating the resident had severe impaired cognition.</p> <p>Review of Resident 735's Order Summary Report dated 2/25/25, showed a physician's order to administer digoxin tablet 125 mcg via GT one time a day for heart failure prophylaxis, hold if the apical pulse rate less than 60 beats per minute.</p> <p>On 2/25/25 at 0820 hours, an observation was conducted with LVN 3. LVN 3 entered Resident 735's room with the vital signs machine and obtained Resident 735's blood pressure and heart rate using the machine. LVN 3 did not obtain Resident 735's apical pulse.</p> <p>On 2/25/25 at 0848 hours, a medication administration observation for Resident 735 and concurrent interview was conducted with LVN 3. LVN 3 administered the digoxin medication; however, LVN 3 did not obtain Resident 735's apical pulse. LVN 3 verified the above findings.</p> <p>3. On 2/26/25 at 1214 hours, a controlled medication reconciliation for Medication Cart A and concurrent interview was conducted with LVN 10. Medication Cart A's Narcotic Shift Count Log was observed with one missing signature from the licensed nurse for the following date and shift:</p> <p>- dated 2/26/25, on-coming nurse for 11-7 shift (2300-0700 hours).</p> <p>LVN 10 verified the above findings.</p> <p>On 2/27/25 at 1438 hours, an interview was conducted with DON 1. DON 1 was informed and acknowledged the above findings.</p> <p>39683</p> <p>3. Review of the facility's P&P titled Disposal of Medications and Medication- Related Supplies effective 2/2013 showed after removing a controlled medication from the supply, the unused portion is destroyed in the presence of two licensed nurses and documented on the record.</p> <p>Medical record review for Resident 27 was initiated on 2/25/25. Resident 27 was readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 27's MAR for January 2025 showed the following ordered medications:</p> <ul style="list-style-type: none"> - dated 12/10/24, for oxycodone HCl 30 mg by mouth every six hours for moderate pain, and discontinued on 1/3/25. - dated 1/5/25, for oxycodone HCl 15 mg by mouth every six hours for moderate pain. <p>Review of Resident 27's Antibiotic or Controlled Drug Record showed with a pharmacy label for oxycodone HCl 30 mg tablets with the last entry showing tablet #20 was removed on 1/2/25 at 1800 hours. The remaining 19 tablets were not signed out. The document had old page handwritten on the top of the page.</p> <p>Review of Resident 27's Controlled Medication Count Sheet showed handwritten oxycodone 0.5 mg was crossed out, and then 1 mg was written. The count started at 19 tablets. The following was documented:</p> <ul style="list-style-type: none"> - dated 1/6/25, tablet #19 had two administration times at 1306 and 1707 hours, with one staff's initials. - dated 1/7/25, tablet #18 had two administration times at 0000 and 0500 hours, with one staff's initials. - dated 1/7/25 at 1200 hours, tablet #17 was removed, with 15 mg written. There was no co-signature for the wasted portion. - dated 1/7/25 at 1800 hours, tablet #16 was removed, there was no record to show 15 mg tablet was wasted. - dated 1/8/25, tablet #15 had two administration times at 0000 and 0600 hours, with one staff's initials. - dated 1/8/25 at 1200 hours, tablet #15 was removed, with 0.5 mg written. There was no co-signature for the wasted portion of the tablet. - dated 1/9/25 at 0000 hours, tablet #13 was removed, 0.5 mg wasted written. There was no co-signature for the wasted portion of the tablet. <p>One 2/28/25 at 0908 hours, an interview and concurrent record review was conducted with DON 1. DON 1 stated Resident 27 was receiving oxycodone HCl 30 mg routinely before the resident was transferred to the acute care hospital on 1/2/25. DON 1 further stated when the resident returned to the facility from the acute care hospital on 1/5/25, the ordered dose of the oxycodone HCl was decreased to 15 mg tablet. DON 1 reviewed the controlled medication count sheets and stated the nursing staff must have handwritten a new count sheet for the lower 15 mg dose of the medication when the resident returned to the facility. DON 1 verified the handwritten count sheet had the wrong tablet strength of 1 mg tablets instead of 30 mg tablets. DON 1 stated when the 30 mg tablets were cut in half, two nurses should have wasted the other half, instead of saving it until the next scheduled dose administration. DON 1 verified the record failed to show two nurses had signed the medication wastage for the above dates and times.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 146 and 147) reviewed for unnecessary medications were monitored for the use of psychotropic medications.</p> <p>* The facility failed to ensure Resident 146's orthostatic blood pressure related to the use of an antipsychotic medication was monitored as ordered by the physician .</p> <p>* The facility failed to ensure non-pharmacological interventions were provided prior to the administration of quetiapine for Resident 147. In addition, the facility failed to ensure Resident 147's behavior for the use of quetiapine medication was monitored and the AIMS assessment was completed.</p> <p>These failures had the potential to negatively impact the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Psychotropic Medication Use dated 6/2021 showed the following:</p> <ul style="list-style-type: none"> - Psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use; and - Facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for the residents receiving psychotropic medication for the Behavioral or Psychological Symptoms of Dementia (BPSD). <p>1. Medical record review for Resident 147 was initiated on 2/27/25. Resident 147 was readmitted to the facility on [DATE].</p> <p>Review of Resident 147's H&P examination dated 1/15/25, showed Resident 147 had no capacity to understand and make decisions.</p> <p>Review of Resident 147's Order Summary Report dated 2/27/25, did not show non-pharmacological interventions and behavioral monitoring for the use of the quetiapine medication. In addition, the AIMS assessment was not completed after Resident 147's readmission on 1/14/25.</p> <p>On 2/27/25 at 1047 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 reviewed Resident 147's orders and verified the above findings. LVN 4 stated the resident's physician's orders did not show non-pharmacological interventions and behavioral monitoring for the quetiapine medication.</p> <p>On 2/28/25 at 1216 hours, a concurrent interview and medical record review was conducted with DON 1. DON 1 reviewed Resident 147's EHR and verified there was no AIMS assessment completed upon readmission or after 1/14/25. The DON verified the above findings.</p> <p>(continued on next page)</p>		

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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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47476</p> <p>2. Review of the FDA Prescribing Information for quetiapine fumarate (antipsychotic) showed the most common adverse reactions are dry mouth, constipation, dyspepsia (indigestion), sedation, somnolence, dizziness, and orthostatic hypotension.</p> <p>Review of the facility's P&P titled Blood Pressure, Measuring revised 9/2010 showed the steps for the blood pressure reading procedure as follows:</p> <ul style="list-style-type: none"> - Close the valve on the air pump - With your second and third finger of one hand, locate the brachial pulse at the bend in the elbow. - When you locate the pulsation, place the diaphragm of the stethoscope firmly against the skin. Hold the diaphragm in place with your hand. - With your free hand, pump air into the cuff by squeezing the bulb until you can no longer hear the pulsation. (Note: You must be watching the mercury level on the manometer while you are pumping the air in the cuff.) - When you hear the last pulsation sound, loosen the thumbscrew slowly to let the air out. Watch the mercury reading on the manometer. Listen for the first sound. Note the number. This will be the top (systolic) reading. - Continue to listen for the pulsation sound and watch the mercury reading on the manometer. When you hear the last should, note the number. This will be the lower (diastolic) reading. - Record the blood pressure on the paper. - To measure orthostatic blood pressure, repeat steps eight through 14 immediately after helping the resident to a standing position. Not the changes in both the systolic and diastolic measurements compared to the reading while the resident was in a seated position. <p>Medical record review for Resident 146 was initiated on 2/25/25. Resident 146 was readmitted to the facility on [DATE].</p> <p>Review of Resident 146's Order Summary Report dated 2/26/25, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 10/25/24, to administer quetiapine fumarate oral tablet 50 mg one tablet via GT two times a day for psychosis manifested by yelling out for no apparent reason. - dated 1/19/25, to monitor the orthostatic blood pressure while (lying/sitting) every evening shift every Saturday for lying; and to notify the MD for a decline of greater than 19 mmHg in systolic blood pressure or greater than 9 mmHg in diastolic blood pressure after at least three minutes of change in position. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 1/19/25, to monitor the orthostatic blood pressure while (lying/sitting) every evening shift every Saturday for sitting. Notify the MD for decline of greater than 19 mmHg in systolic blood pressure or greater than 9 mmHg in diastolic blood pressure after at least three minutes of change in position.</p> <p>Review of Resident 146's MAR for February 2025 showed Resident 146 was administered quetiapine fumarate 50 mg two times a day from 2/1/25 through 2/25/25.</p> <p>Review of Resident 146's MAR for January 2025 and February 2025 showed the orthostatic blood pressures (lying and sitting) were scheduled to be monitored every Saturday. However, the blood pressure readings were documented as follows:</p> <ul style="list-style-type: none"> - dated 1/4/25, the blood pressure readings were recorded as 108/51 mmHg for the lying and sitting positions; - dated 1/11/25, the blood pressure readings were recorded as 157/70 mmHg for the lying and sitting positions; - dated 1/18/25, the blood pressure readings were recorded as 118/63 mmHg for the lying and sitting positions; - dated 1/25/25, the blood pressure readings were recorded as 134/71 mmHg for the lying and sitting positions; - dated 2/1/25, the blood pressure readings were recorded as 105/61 mmHg for the lying and sitting positions; - dated 2/8/25, the blood pressure readings were recorded as 128/70 mmHg for the lying and sitting positions; and - dated 2/15/25, the blood pressure readings were recorded as 148/64 mmHg for the lying and sitting positions. <p>On 2/27/25 at 1055 hours, an interview and concurrent medical record review for Resident 146 was conducted with LVN 13. LVN 13 verified Resident 146 was being administered quetiapine fumarate medication and monitored for orthostatic hypotension for the use of the quetiapine fumarate medication. LVN 13 stated the process for taking the orthostatic blood pressures reading was to check the blood pressures when lying and sitting, and would check for a significant drop in the systolic blood pressure. LVN 13 stated it was not very likely the numbers would be identical, and the numbers should not match from lying to sitting. LVN 13 reviewed the medical record for Resident 146 and verified the above findings. LVN 13 stated the numbers should never match and there should be some type of change in the numbers. LVN 13 stated the numbers looked incorrect and verified there was no documented evidence to tell if Resident 146 had orthostatic hypotension or not.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 25.93%. Two of four licensed nurses (LVN 3 and RN 1) observed during the medication administration were found to have made errors.</p> <p>* LVN 3 failed to ensure the correct dosage of the medication was administered to Resident 735 when residue was observed in each medication cup after administration. In addition, LVN 3 failed to administer the correct physician's order dosage form for one medication to Resident 735.</p> <p>* RN 1 failed to ensure the correct dosage of medication was administered to Resident 932.</p> <p>These failures had the potential to negatively affect the residents' health conditions.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration General Guidelines dated 10/2017 showed the following:</p> <ul style="list-style-type: none"> - Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule; and - Medications are administered in accordance with the written orders of the attending physician. <p>On 2/25/24 at 0848 hours, a medication administration observation was conducted with LVN 3. LVN 3 stated Resident 735's medications had to be administered via the GT. LVN 3 prepared the following medications for Resident 735:</p> <ul style="list-style-type: none"> - 5 ml of vitamin C (supplement) 500 mg; - one tablet of digoxin (antiarrhythmic) 125 mcg; - 10 ml of docusate sodium (stool softener) liquid 50 mg/5 ml; - one tablet of eliquis (anticoagulant) 5 mg; - 5 ml of Keppra (anticonvulsant) 500 mg/5 ml solution; - one tablet of multivitamin with minerals (supplement); - a packet of omeprazole (a medication used to treat excess stomach acid) and sodium bicarbonate (antacid) 20 mg 1680 mg powder; <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- one tablet of vitamin D (supplement) 25 mcg; and</p> <p>- one tablet of metoprolol tartrate (antihypertensive) 50 mg.</p> <p>The following was identified during the medication administration observation with a concurrent interview with LVN 3:</p> <p>a. LVN 3 administered the crushed metoprolol tartrate, multivitamin with minerals, eliquis, vitamin D, and docusate sodium via GT. There was medication residue observed inside each of the medication cup after the administration was completed. LVN 3 verified the above findings.</p> <p>b. Review of Resident 735's Order Summary Report showed a physician's order dated 2/8/25, to administer Keppra 500 mg one tablet via GT two time as day for seizure prophylaxis. LVN 3 failed to administer the correct ordered physician's dosage form for Keppra when LVN 3 administered Keppra solution instead of Keppra tablet via GT to Resident 735.</p> <p>On 2/25/25 at 1223 hours, an interview was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated she was supposed to update the order in EHR upon receiving a different medication form from the pharmacy.</p> <p>2. Medical record review for Resident 932 was initiated on 2/25/25. Resident 932 was admitted to the facility on [DATE].</p> <p>Review of Resident 932's H&P examination dated 2/28/25, showed Resident 932 had the capacity to understand and make decisions.</p> <p>Review of Resident 932's Order Listing Report dated 2/25/24, showed an order for piperacillin sodium-tazobactam (Zosyn, antibiotic) Solution Reconstituted 3-0.375 gm 3.375 gm intravenously every eight hours for UTI until 2/26/25.</p> <p>On 2/25/25 at 1452 hours, a concurrent medication administration observation and interview was conducted with RN 1. RN 1 prepared the Zosyn IV antibiotic medication and primed the IV tubing. After RN 1 primed the IV tubing, multiple air bubbles were observed in the tubing. RN 1 stated she was ready to administer the Zosyn IV medication and entered Resident 932's room. RN 1 was requested to come out of Resident 932's room with the Zosyn IV medication. RN 1 was informed there were multiple air bubbles in the resident's IV tubing. RN 1 verified the findings. RN 1 was asked what her next step would be after knowing there were multiple air bubbles in the IV tubing. RN 1 stated she could remove the air by priming the tubing, however it would waste the medication in the tubing. RN 1 attempted to prime the tubing to remove multiple air bubbles. Furthermore, RN 1 stated she would call another staff for assistance.</p> <p>On 2/25/25 at 1457 hours, a concurrent observation and interview was conducted with the QA RN. The QA RN was informed of the multiple air bubbles in the resident's IV tubing and verified the findings. The QA RN was observed tapping the IV tubing to move the air bubbles; however, she was not able to remove the air bubbles. The QA RN consulted with DON 1. The QA RN stated DON 1 recommended to change the current IV tubing to a new IV tubing. The QA RN informed RN 1 and RN 1 had agreed.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/25/25 at 1505 hours, a concurrent medication administration observation and interview was conducted with RN 1. RN 1 stated she would change the primed IV tubing of Zosyn to a new tubing. RN 1 was observed disposing the primed IV tubing of Zosyn and replaced the medication with new tubing. RN 1 then administered the Zosyn IV medication to Resident 935.</p> <p>On 2/25/25 at 1526 hours, an interview was conducted with RN 1. RN 1 was informed of the above findings. RN 1 stated she could have prepared and administered a new Zosyn and tubing to prevent medication error.</p> <p>On 2/27/25 at 1438 hours, an interview was conducted with DON 1. DON 1 was informed and acknowledged the above findings.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967</p> <p>Surveyor: Colorado, Star [NAME]</p> <p>Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of the medications.</p> <p>* The facility failed to ensure the expired medications in Medication Room A's refrigerator were discarded. In addition, the medication refrigerator's temperature was not maintained within the recommended temperature.</p> <p>* The facility failed to ensure the expired oral and external administered medications were discarded in Medication Room C.</p> <p>* The facility failed to ensure the expired oral administered medication was discarded in Medication Cart B.</p> <p>* The facility failed to ensure the expired medication and culture swab kit were removed from the current treatment supply in Treatment Cart A. In addition, the last drawer of Treatment Cart A was not kept clean.</p> <p>* The facility failed to ensure the expired medication were removed from the current treatment supply in Treatment Cart B. In addition, the last drawer of Treatment Cart B was not kept clean.</p> <p>These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Storage in the Facility (undated) showed the following:</p> <ul style="list-style-type: none"> - Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye medications are stored separately per facility policy; - Outdated contaminated, or deteriorated medications, and those in containers that are cracked, soiled, or without closures are immediately removed from inventory, disposed of according to procedures for medication disposal and reordered from the pharmacy. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity; and <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Medications requiring refrigeration are kept in a refrigerator at temperatures between two degrees Celsius (36 degrees Fahrenheit) and eight degrees Celsius (46 degrees Fahrenheit) with a thermometer to allow temperature monitoring.</p> <p>1. On 2/26/25 at 0834 hours, an inspection of Medication Room A was conducted with LVN 6. The following was observed:</p> <ul style="list-style-type: none"> - two bags of vancomycin (antibiotic) 2 gm/D5W (dextrose 5% in water) IV inside the refrigerator, with an expiration date of 12/18/24; - an open box of six bisacodyl suppositories (laxative) were stored inside the cabinet, with expiration date of 4/2024 and no open date; and - the medication refrigerator's temperature was 26 degrees Fahrenheit. <p>Review of the refrigerator temperature log dated 2/2025 showed the temperature must be within the normal range of 40 degrees Fahrenheit.</p> <p>LVN 6 verified the above findings.</p> <p>2. On 2/26/25 at 1057 hours, an inspection of Medication Room C was conducted with LVN 9. The following was observed:</p> <ul style="list-style-type: none"> - a tube of clotrimazole (antifungal) vaginal cream 2%, with expiration date of 12/2024; - a box of Complete Lice Treatment kit, with an expiration date of 10/2024; - a bottle of vitamin D 10 mcg, with an expiration date of 11/2024; - a bottle of thiamine vitamin B-1 100 mg, with an expiration date of 12/2024; - a bottle of geri-kot (medication to treat constipation) 8.6 mg, with an expiration date of 11/2024; - two bottles of vitamin E 90 mg, with an expiration date of 6/2024; and - one bottle of Oyster Shell Calcium 500 mg, with an expiration date of 5/2024. <p>LVN 9 verified the above findings.</p> <p>3. On 2/26/25 at 1118 hours, an inspection of Medication Cart B was conducted with LVN 4. The following was observed:</p> <ul style="list-style-type: none"> - a bottle of vitamin C liquid 500 mg, with an expiration date of 12/2024. <p>LVN 4 verified the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. On 2/26/25 at 0952 hours, an inspection of Treatment Cart A was conducted with LVN 8. The following were observed:</p> <ul style="list-style-type: none"> - an opened bottle of sterile 0.9% normal saline, with an open date of 2/25/25; - an opened sterile medi-strips (single use), with 1.5 strips remained; - a bottle of antifungal powder with Miconazole nitrate (antifungal) 2%, with an expiration date of 1/2025; - two BBL culture swabs (a swab-based system used to collect and transport specimens for bacterial and fungal cultures), with an expiration date of 1/3/2025; - three BBL culture swabs, with an expiration date of 2/2/25; and - brownish residues next to the povidine-iodine solution (antiseptic). <p>LVN 8 verified the above findings.</p> <p>5. On 2/26/25 at 0934 hours, an inspection of Treatment Cart B was conducted with LVN 7. The following was observed:</p> <ul style="list-style-type: none"> - a bottle of antidandruff shampoo, with an expiration date of 1/2025; and - a bottle of antifungal powder with Miconazole nitrate (antifungal) 2%, with an expiration date of 1/2025; and - brownish residues on the last drawer. <p>LVN 7 verified the above findings.</p> <p>On 2/27/25 at 1438 hours, an interview was conducted with DON 1. DON 1 was informed and acknowledged the above findings.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed as evidenced by:</p> <ul style="list-style-type: none"> * There were white pieces of plastic trash found on the floor, in the sink area of the pots and pans, and in the main food preparation hallway floor area. Additionally, a pair of gloves and dietary menu forms were found in clean serving areas. * The top clean surface of the soup machine had three unwashed cabbages, cooking mittens, two basins, and a cutting board. * Vegetables in a plastic bag fell on to the floor and was picked up and placed on the food cart by the Dietary Assistant Manager. * There were two fryers baskets with brown residue and a serving utensil used as a scooper was found with food residue. Additionally, a can opener had brownish orange residues. * The microwaves used by the residents in Stations 1, 2, 3, and 4 had food residues. * The Station 4 refrigerator had food residue and a dried brown liquid spill on the bottom shelf. Additionally, the freezer had brown food residues. <p>- There was no air gap in the kitchen sink.</p> <p>- Personal food items stored in the residents' rooms were unlabeled and dated for Residents 205, 222 and 133.</p> <p>These failures posed the risk for food borne illnesses for the residents who consumed food prepared in the kitchen.</p> <p>Findings:</p> <p>Review of the facility's Matrix dated 2/25/25, showed 235 of 240 residents who resided in the facility consumed food prepared in the kitchen.</p> <p>1. Review of the facility's P&P titled Sanitization revised on 11/2022 showed the food service area is maintained in a clean and sanitary manner. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. All the utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corruptions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. On 2/25/25 at 0811 hours, an initial kitchen tour and concurrent interview was conducted with the Dietary Assistant Manager. There were pieces of white plastic trash found on the floor, sink area near the pots and pans, and main food preparation area. The Dietary Assistant Manager stated it should be clean and anyone from the kitchen staff should clean it.</p> <p>b. On 2/25/25 at 1216 hours, a lunch observation and concurrent interview was conducted with the Dietary Assistant Manager. A pair of gloves were found at a corner where the clean plates were served, and multiple dietary menu forms were observed on clean serving trays in the serving area. The Dietary Assistant Manager stated the gloves and forms should not be there and the serving area should be clean.</p> <p>2. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food -Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES AND UTENSILS shall be clean to sight and touch. (C) NonFOOD -CONTACT SURFACES OF EQUIPMENT shall be kept free of an accumulation of dust, dirt, food residue and other debris.</p> <p>Review of the facility's P&P titled Sanitization revised on 11/2022 showed all the utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair.</p> <p>On 2/25/25 at 0814 hours, an initial kitchen tour and concurrent interview was conducted with the Dietary Assistant Manager. The top clean surface of the soup equipment machine had three unwashed cabbages, cooking mittens, two basins and a cutting board. The Dietary Assistant Manager verified the clean surface of the soup machine should be cleared.</p> <p>3. Review of the facility's P&P titled Food Preparation and Service revised on 11/2022 showed food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness.</p> <p>On 2/25/25 at 0817 hours, an initial kitchen tour and concurrent interview was conducted with the Dietary Assistant Manager. A plastic bag containing vegetables fell to the ground. The Dietary Assistant Manager picked up the vegetables and placed them next to the clean vegetables on the food cart. The Dietary Assistant Manager did not clean the vegetables. The Dietary Assistant Manager verified the vegetables should have been cleaned before placing it with the other clean vegetables.</p> <p>4. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food -Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES AND UTENSILS shall be clean to sight and touch.</p> <p>Review of the facility's P&P titled Food Preparation and Service revised on 11/2022 showed all the equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.</p> <p>Review of the facility's P&P titled Sanitization revised on 11/2022 showed all utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. On 2/25/25 at 0828 hours, an initial kitchen tour and concurrent interview was conducted with the Dietary Assistant Manager. Two fryer baskets were observed to have brown residue. The Dietary Assistant Manager verified the baskets should be cleaned and not have brown residue.</p> <p>b. On 2/25/25 at 1204 hours, a lunch observation and concurrent interview was conducted with the Dietary Assistant Manager. A serving utensil used as a scooper was noted to have food residue. The Dietary Assistant Manager verified the serving utensil should have been cleaned before being used to serve food.</p> <p>c. On 2/26/25 at 1131 hours, an observation of the kitchen and concurrent interview was conducted with the Registered Dietitian. The kitchen staff were preparing juice in the drinks preparation area. A can opener was observed with brownish orange residue. The Registered Dietitian verified the findings.</p> <p>d. On 2/26/25 at 0852 hours, an observation of the Station 1 microwave and concurrent interview was conducted with RN Supervisor 1. RN Supervisor 1 verified the microwave was used by the residents and had dried food residue on the roof surface. The RN supervisor verified it should have been cleaned.</p> <p>e. On 2/26/25 at 0856 hours, an observation of the Station 2 microwave and concurrent interview was conducted with CNA 1. CNA 1 verified the microwave was used by the residents and had dried food residue all over the surface. CNA 1 verified the microwave should have been cleaned.</p> <p>f. On 2/26/25 at 0859 hours, an observation of the Station 3 microwave and concurrent interview was conducted with CNA 2. CNA 2 verified the microwave was used by the residents and had dried food residue on the bottom surface. CNA 2 verified the microwave should have been cleaned.</p> <p>g. On 2/26/25 at 0904 hours, an observation of the Station 4 microwave and concurrent interview was conducted with CNA 3. CNA 3 verified the microwave was used by the residents and had food residue on the bottom surface. CNA 3 verified the microwave should have been cleaned.</p> <p>On 2/26/25 at 0913 hours, an interview was conducted with the RN supervisor. The RN supervisor verified all of the above findings.</p> <p>5. Review of the facility's P&P titled Food Brought by Family/Visitors revised on 3/28/24, showed the refrigerator/freezer for storage of foods brought in by visitors will be properly maintained and (d) cleaned daily.</p> <p>On 2/27/25 at 0910 hours, an observation of the Station 4 refrigerator and concurrent interview was conducted with CNA 3. CNA 3 verified the freezer door of the refrigerator had brown food residue and the bottom area of the refrigerator had dried brown liquid residue. CNA 3 verified the refrigerator should have been cleaned.</p> <p>On 2/27/25 at 0922 hours, an interview was conducted with the Maintenance Director. The Maintenance Director verified the refrigerator in Station D should have been cleaned for infection prevention and control.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. According to the USDA Food Code 2022, Section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed.</p> <p>On 2/26/25 at 0923 hours, an observation of the puree food preparation and concurrent interview was conducted with the Dietary Assistant Manager. The sink did not have an air gap and the sink pipe drained directly into the wall. The Dietary Assistant Manager acknowledged there was no air gap and was not familiar about the sink drainage guidelines.</p> <p>7. Review of the facility's P&P titled Food Brought by Family/Visitors revised on 3/28/24, showed all the food brought in for a resident will be checked by a licensed nurse or speech therapist for appropriate diet texture. When the food items are intended for later consumption, the responsible staff member will: Ensure that foods are in a sealed container to prevent cross contamination. Label foods with resident's name, and the current date and use by date.</p> <p>a. On 2/26/25 at 1109 hours, Resident 133's bedside drawer was observed to have three bananas, three apples, six oranges, a bag of pita bread, and a box of dried fruit. All of the food items were not labeled with the name, date brought, and use by date.</p> <p>Medical record review for Resident 133 was initiated on 2/26/25. Resident 133 was admitted to the facility on [DATE].</p> <p>Review of Resident 133's H&P examination dated 9/27/24, showed Resident 133 was not able to make decisions about her medication needs or treatment.</p> <p>Review of Resident 133's Physician Order Summary dated 10/7/24, showed the resident's diet order was a regular diet, regular texture, and regular/thin liquids.</p> <p>On 2/26/25 at 1223 hours, an observation and concurrent interview was conducted with CNA 5. CNA 5 stated the resident's family member usually brought food to the resident. CNA 5 verified all foods should have been labeled and dated.</p> <p>b. On 2/28/25 at 1008 hours, an observation in Resident 205's room and concurrent interview was conducted with CNA 6. Resident 205 had an unlabeled and undated banana with various brown spots placed in a clear ziplock bag. CNA 6 verified the food should have been labeled and dated to prevent food contamination.</p> <p>Medical record review for Resident 205 was initiated on 2/27/25. Resident 205 was admitted to the facility on [DATE].</p> <p>Review of Resident 205's H&P examination dated 10/28/24, showed Resident 205 had limited capacity make decisions .</p> <p>Review of Resident 205's Physician Order Summary dated 10/30/24, showed a diet order of carbohydrate controlled regular/thin liquids.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. On 2/28/25 at 1008 hours, an observation in Resident 222's room and concurrent interview was conducted with CNA 6. Resident 222 had an unlabeled and undated can of prunes. CNA 6 verified the food brought by the resident's family member or visitors should always be labeled with the name, current date when it was brought and use by date to prevent food contamination and pest control.</p> <p>Medical record review for Resident 222 was initiated on 2/28/25. Resident 222 was admitted to the facility on [DATE].</p> <p>Review of Resident 222's MDS for cognitive pattern dated 1/31/25, showed the BIMS score of 15, indicating a person's cognition is intact.</p> <p>Review of Resident 222's Physician Order Summary dated 1/26/25, showed a diet order of regular, no added salt, regular texture, and thin consistency.</p> <p>On 2/28/25 at 1039 hours, an interview was conducted with the QA RN. The QA RN verified all foods brought by the resident's family member and/or visitor should be labeled with the name and date.</p> <p>On 2/28/25 at 1605 hours, an interview was conducted with DON 1. DON 1 verified the above findings.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>49324</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the safe handling and collection of regular waste.</p> <p>* There was scattered food residues on the ground next to the food waste dumpster and the open space storage area had trash such as disposable cups with orange liquid, tortilla plastic container, and piles of leaves.</p> <p>* Two of the six soiled linen barrels were observed with trash inside of them, uncovered, and without a lid; one barrel was overfilled with trash bags and the other barrel contained two bags of trash, with a milky substance spilled at the bottom of the barrel.</p> <p>These failures posed the risk for safety and pest contamination.</p> <p>Findings:</p> <p>According to the USDA Food Code 2022 Section 5-501.110. Storing refuse, recyclables and returnables, shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.</p> <p>According to the USDA Food Code 2022 Section 5-502.11. Frequency. refuse, recyclable and returnables, shall be removed from the premises at a frequency that will minimize the development of objectionable order and other conditions that attract or harbor insects and rodents.</p> <p>According to the USDA Food Section 2022 Section 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment.</p> <p>On 2/26/25 at 1026 hours, an observation of the dumpster area and storage area for the parking cones, and concurrent interview was conducted with the Maintenance Director. There was scattered food residues on the ground next to the food waste dumpster. The open space storage area used for storage of the parking cones were found with trash such as disposable cups with orange liquid, tortilla plastic container, and piles of leaves. The Maintenance Director verified the findings and stated the surrounding areas of the dumpster should be clear of trash to avoid the insects, pests and rodents.</p> <p>On 2/28/25 at 1603 hours, an interview was conducted with DON 1. DON 1 verified the above findings.</p> <p>47476</p> <p>2. According to the FDA Food Code 2022, 5-501.113, Covering Receptacles, receptacle and waste handling units for refuse, recyclables, and returnables shall be kept covered with tight-fitting lids or doors if kept outside the food establishment.</p> <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's P&P titled Food-Related Garbage and Refuse Disposal revised 10/2017 showed all the garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests.</p> <p>On 2/27/25 at 0814 hours, a concurrent observation and interview was conducted with the Maintenance Director. There were six barrels labeled for soiled linen outside and adjacent to the laundry room. Two of the six soiled linen barrels were observed with trash inside them, uncovered, and without a lid; one barrel was overfilled with trash bags and the other barrel contained two bags of trash, with a milky substance spilled at the bottom of the barrel. The Maintenance Director stated the two barrels were for trash only and the staff would put the trash in the barrels, then brought them to the dumpster when they were full. The Maintenance Director stated the barrels were not covered because the trash was placed in a plastic bag.</p> <p>On 2/27/25 at 1620 hours, the Administrator and DON 2 acknowledged the above findings. The Administrator stated he would get covers for the barrels.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for two of 35 final sampled residents (Residents 132 and 184) were complete.</p> <p>* The facility failed to document the administration of the piperacillin-tazobactam medication for Resident 184.</p> <p>* Resident 132's MAR had missing documentation on 1/13/25, for the evening shift.</p> <p>These failures had the potential for the residents' care needs not being met as the clinical information was not complete.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Medication Administration - General Guidelines dated 10/2017 showed under the section for Documentation, the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of the medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administer the medication report off-duty without first recording the administration of any medication.</p> <p>Medical record review for Resident 184 was initiated on 2/25/25. Resident 184 was readmitted to the facility on [DATE].</p> <p>Review of Resident 184's Progress Note dated 2/16/25 at 1919 hours, showed Resident 184 was readmitted to the facility on [DATE] at 1610 hours, and would be on piperacillin- tazobactam until 3/29/25.</p> <p>Review of Resident 184's Physician Order Summary dated 2/28/25, showed an order dated 2/17/25, for piperacillin- tazobactam in dextrose (glucose) IV solution 3-0.375 gm/50 ml intravenously every eight hours for foot infection.</p> <p>Review of Resident 184's MAR for February 2025 showed the order for the piperacillin- tazobactam in dextrose IV solution 3-0.375 gm/50 ml intravenously every eight hours for foot infection until 3/29/25, to run over 4 hours with a start date of 2/16/25 at 2200 hours. Further review of Resident 184's MAR showed no entry if the medication was administered on 2/16/25 at 2200 hours, 2/17/25 at 0600 and 2200 hours, 2/18/25 at 2200 hours, and 2/26/25 at 1400 hours.</p> <p>Further review of Resident 184's medical record failed to show the reason why the above medications were not documented as administered.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 2/27/25 at 0856 hours, an interview and concurrent medical record review for Resident 184 was conducted with RN 1. RN 1 verified the above findings and stated on 2/26/25 at 1400 hours, she administered the piperacillin- tazobactam medication; however, she missed to document the medication administration. RN 1 further stated she should have documented immediately after the administration of the medication. RN 1 stated she was not able to find the documentation why the piperacillin- tazobactam medication was not documented on 2/16/25 at 2200 hours, 2/17/25 at 0600 and 2200 hours, and 2/18/25 at 2200 hours.</p> <p>On 2/28/25 at 1207 hours, an observation of IV Cart A and concurrent interview was conducted with RN 1. RN 1 verified eight doses of the medication piperacillin- tazobactam for Resident 184 were left in the cart.</p> <p>On 2/28/25 at 1328 hours, a telephone interview was conducted with the Pharmacist. The Pharmacist stated there should be eight doses of the medication piperacillin- tazobactam left in the IV medication cart for Resident 184 if the medication was administered as ordered by the physician.</p> <p>On 2/28/25 at 1430 hours, DON 1 and the Administrator were informed and acknowledged the above findings.</p> <p>49324</p> <p>2. Review of the facility's P&P titled Documentation of Medication Administration revised on 11/2022 showed a medication administration record is used to document all medications administered to each resident on the resident's medication administration record (MAR). Administration of the medication is documented immediately after it is given. Documentation of medication administration includes, as minimum: a. resident's name; b. name and strength of the drug; c. dosage; d. route of administration; e. date and time of administration; f. reason(s) why a medication was withheld, not administered, or refused (as applicable); g. initials, signature and title of the person administering the medication; i. resident response to the medication, if applicable(e.g. PRN, pain medication, etc).</p> <p>Medical record review for Resident 132 was initiated on 2/27/25. Resident 132 was admitted to the facility on [DATE].</p> <p>Review of Resident 132's MAR for January 2025 showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 12/28/24, to monitor the antipsychotic side effects related to quetiapine (antipsychotic) use: dry mouth, constipation, blurry vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea and vomiting, lethargy, drooling, extra pyramidal symptoms (tremors, gait issues, involuntary movement of mouth/tongue), weight gain, loss of appetite every shift - dated 12/30/24, to monitor the episodes of schizoaffective disorder manifested by physical agitation without valid reason for quetiapine use every shift and tally by hashmarks. To document non pharmacological use as follows: <ol style="list-style-type: none"> 1. remove patient from environment 2. redirected by engagement in alternative activity <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 3. Listen to patient, attempted to calm familiarize patient with belongings/surrounding 4. Toileted patient 5. Ambulated patient 6. Escorted patient to room for reduced stimuli 7. Provided patient with food/drink as per physician's order <p>Further review of the MAR failed to show documentation the resident was monitored for the above orders on 1/13/25, for the evening shift.</p> <p>On 2/27/25 at 0835 hours, an interview and concurrent medical record review was conducted with RN Supervisor 1. RN Supervisor 1 verified all the missing documentation and stated it was performed but the licensed missed to document in the MAR.</p> <p>On 2/28/25 at 1605 hours, an interview was conducted with DON 1. DON 1 verified the above findings.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>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 35 final sampled residents (Resident 184 and 735) and four nonsampled residents (Residents 64, 118, 151, and 932)</p> <p>* The facility failed to ensure LVN 2 wore proper PPE when administering medication for Resident 184 who had a midline catheter.</p> <p>* The facility failed to ensure proper hand hygiene was performed during medication administration to Resident 151.</p> <p>* The facility failed to ensure proper hand hygiene was performed during medication administration to Resident 735.</p> <p>* The facility failed to ensure the Zosyn (antibiotic) vial's septum was disinfected before connecting to the normal saline mini-bag IV solution for Resident 932.</p> <p>* Residents 64 and 118's shared restroom had a strong foul odor and the toilet rim had dried yellow urine.</p> <p>These failures posed the risk for transmission of disease-causing microorganisms and infections and incorrect notification of infection control practices.</p> <p>Findings:</p> <p>Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24, and effective 4/1/24, showed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed EBP recommendations now include use of EBP for the residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.</p> <p>Review of the facility's P&P titled Enhanced Standard/ Barrier Precautions revised 2/21/25, showed it is the policy of the facility to implement Enhanced Barrier Precautions for the prevention of transmission of multi drug -resistant organism. The P&P showed EBP refer to an infection control intervention designed to reduce transmission of multi drug resistant organisms that employs targeted gown and gloves used during high contact resident care activities. Further review of the P&P showed the residents that will benefit with EBP were those with the indwelling medical devices (e.g. central lines, urinary catheter, feeding tubes .midline catheter {a long, thin, flexible tube that's inserted into a large vein in the upper arm. It's used to deliver fluids and medications into the bloodstream}) even if the resident is not known to be infected or colonized with MDRO.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. a. On 2/25/25 at 0930 hours, Resident 184 was observed lying in his bed and receiving IV medication through his midline catheter. There was no EBP sign observed outside the room.</p> <p>On 2/27/25 at 1358 hours, during an observation, LVN 12 performed hand hygiene and entered Resident 184's room with medication in her hand. LVN 12 administered the oral medication to Resident 184. LVN 12 touched Resident 184 and his bed during the administration of the medication. LVN 2 was not observed wearing gloves and gown before administration of the medication to Resident 184. There was no EBP sign observed outside the room.</p> <p>On 2/27/25 at 1400 hours, an interview was conducted with LVN 12. LVN 12 verified the above observation and verified Resident 184 had a midline catheter. LVN 12 and acknowledged Resident 184 required Enhanced Barrier Precaution while providing direct care. LVN 12 stated she should have worn the gown and gloves before administering medication to the Resident 184.</p> <p>Medical record review for Resident 184 was initiated on 2/25/25. Resident 184 was readmitted to the facility on [DATE].</p> <p>Review of Resident 184's H&P examination dated 2/17/25, showed Resident 184 had no capacity to understand and make decisions.</p> <p>Review of Resident 184's Physician Order Summary dated 2/27/25, showed an order for the intravenous site management as needed when clinically indicated and every night shift and every seven days as follows: to change the catheter site with transparent dressing, indicate the external catheter length and upper arm circumference (10 cm above antecubital), and to notify if the external length has changed since the last measurement.</p> <p>Review of Resident 184's Progress Note dated 2/16/25 at 1919 hours, showed Resident 184 was readmitted to the facility and had a midline in the right upper arm.</p> <p>On 2/27/25 at 1455 hours, an interview was conducted with IP 2. IP 2 was informed of the above findings. IP 2 acknowledged the above findings and stated Resident 184 had a midline which required to be in EBP and use of gloves and gown before providing direct care activities such as administering the medications.</p> <p>On 2/28/25 at 0756 hours, DON 1 was informed and acknowledged the above findings.</p> <p>50967</p> <p>2. On 2/25/25 at 1004 hours, a medication administration observation and concurrent interview was conducted with LVN 5 for Resident 151. LVN 5 did not perform hand hygiene before donning new gloves for eye medication administration. In addition, LVN 5 did not perform hand hygiene after doffing her gloves. LVN 5 verified the above findings.</p> <p>3. On 2/25/25 at 0824 hours, a medication administration observation and concurrent interview was conducted with LVN 3 for Resident 735. LVN 3 sanitized the used blood pressure cuff and vital sign machine. LVN 3 doffed her gloves and prepared the medication cups without performing hand hygiene. LVN 3 verified the above findings.</p> <p>(continued on next page)</p>		

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 02/28/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. On 2/25/25 at 1452 hours, an IV medication administration observation and concurrent interview was conducted with RN 1. RN 1 prepared the Zosyn antibiotic medication vial and removed the cap. RN 1 connected the normal saline bag to the Zosyn vial, then mixed the medication. RN 1 did not disinfect or sanitize the septum of the Zosyn vial prior to connecting it to the normal saline bag. RN 1 verified the above findings.</p> <p>On 2/27/25 at 1438 hours, an interview was conducted with DON 1. DON 1 was informed and acknowledged the above findings.</p> <p>49324</p> <p>5. On 2/25/25 at 0925 hours, an observation of Residents 64 and 118's shared restroom and concurrent interview was conducted with DSD 2. The restroom had a strong foul urine odor and the toilet rim was lost its white [NAME] in color and had dried yellow color urine and with white tape on the side. DSD 2 stated it should have been cleaned for infection prevention and color.</p> <p>On 2/27/25 at 0922 hours, an observation of Resident 64 and 118's shared restroom and concurrent interview was conducted with Maintenance Director. The Maintenance Director verified the toilet rim would be changed immediately and should always be maintained for cleanliness and infection prevention and control.</p> <p>On 2/28/25 at 1605 hours, an interview was conducted with DON 1. DON 1 verified the above findings.</p>		