

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/31/2026
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)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the option to formulate an advance directive for five of seven final sampled residents (Residents 10, 158, 163, 169, and 213) reviewed for advance directives. * Residents 10, 158, 163, 169, and 213 were not given the option to formulate an advance directive. These failures had the potential to prevent Residents 10, 158, 163, 169, and 213 healthcare and treatment decisions from being honored. Findings: Review of the facility's P&P titled Advanced Directive dated 3/2022 showed the purpose of the advance directive was to provide residents the opportunity to make decisions regarding their healthcare. The facility will honor the residents' advance directives and will provide the resident with information related to advance directives upon admission. If no advance directive exists, the facility will provide the resident with an opportunity to complete the advance directive form upon resident request. 1. Medical record review for Resident 213 was initiated on 7/27/26. Resident 213 was admitted to the facility on [DATE]. Review of Resident 213's Advanced Directive Acknowledgement dated 4/3/26, showed Resident 213 was informed of the right to develop an advanced directive. However, further record review did not show the facility provided Resident 213 the option to formulate an advance directive while at the facility. Review of Resident 213's Social Services Psychosocial Unit 2 & 3 Note dated 4/6/26, showed Resident 213 had a full LPS conservatorship status. Review of Resident 213's MDS assessment dated [DATE], showed Resident 213 was cognitively intact. Resident 104 had a diagnosis of schizoaffective disorder. Further review of Resident 213's medical record did not show the facility provided Resident 213 or responsible party the opportunity to formulate an advance directive. 2. Medical record review for Resident 169 was initiated on 7/27/26. Resident 169 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 169's Social Services Psychosocial Unit 2 & 3 Note dated 7/24/25, showed Resident 169 had a full LPS conservatorship status. Review of Resident 169's Advanced Directive Acknowledgement dated 7/27/25, showed Resident 169 was informed of the right to develop an advanced directive. However, further record review did not show the facility provided Resident 169 the option to formulate an advance directive while at the facility. Review of Resident 169's MDS assessment dated [DATE], showed Resident 169 was cognitively intact. Resident 169 had a diagnosis of schizoaffective disorder. Further review of Resident 169's medical record did not show the facility provided Resident 169 or responsible party the opportunity to formulate an advance directive. 3. Medical record review for Resident 158 was initiated on 7/27/26. Resident 158 was admitted to the facility on [DATE]. Review of Resident 158's Advanced Directive Acknowledgement dated 4/10/26, showed Resident 158 refused to sign the document. Review of Resident 158's Social Services Psychosocial Unit 2 & 3 Note dated 4/13/26, showed Resident 158 had a full LPS conservatorship status. Review of Resident 158's MDS assessment dated [DATE], showed Resident 158 was cognitively intact. Resident 158 had a diagnosis of schizoaffective disorder. Further review of Resident 158's medical record did not show the facility provided Resident 158 or responsible party the opportunity to formulate an advance directive. On 7/29/26 at 1411 hours, an interview was conducted with Resident 158. Resident 158 stated the facility did not provide information or the option to form an advance directive. 4. Medical record review for Resident 163 was initiated on 7/27/26. Resident 163 was admitted to the facility on [DATE], readmitted on [DATE]. Review of Resident 163's Advanced Directive Acknowledgement dated 7/14/25, showed Resident 163 was informed of the right to develop an advanced directive. However, further record review did not show the facility provided Resident 163 the option to formulate an advance directive while at the facility. Review of Resident 163's Social Services Psychosocial Unit 2 & 3 Note dated 7/21/26, showed Resident 163 had a full LPS conservatorship status. Review of Resident 163's MDS assessment dated [DATE], showed Resident 163 was cognitively intact. Resident 163 had a diagnosis of schizoaffective disorder. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 163's medical record did not show the facility provided Resident 163 or responsible party the opportunity to formulate an advance directive. On 7/29/26 at 1416 hours, an interview was conducted with Resident 163. Resident 163 stated the facility did not provide information or the option to form an advance directive. On 7/29/26 at 1607 hours, an interview and concurrent medical record review for Residents 158, 163, 169, and 213 was conducted with the SSD-STP. The SSD-STP stated advance directives were presented to residents upon admission; however, the residents in the STP unit did not have organized thinking to formulate an advanced directive, so the facility does not provide the option to formulate one. When asked whether the facility would follow up with residents if their thinking stabilized, the SSD-STP stated the social services team could communicate with the responsible party, conservator, or public guardian. The SSD-STP verified and acknowledged the above findings. The SSD-STP further stated the Advanced Directive Acknowledgement form should document whether the option to formulate an advance directive was offered to the residents. On 7/31/26 at 1157 hours, an interview was conducted with the Administrator and DON-STP. The Administrator and DON-STP were informed and acknowledged the above findings. 5. Medical record review for Resident 10 was initiated on 7/27/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 7/8/26, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Social Services Assessment and Documentation &dash; V1 dated 7/8/26, showed an advance directive was not in place, the opportunity to complete advance directive was not offered, and no educational materials, including state form were provided. On 7/29/26 at 1414 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD stated an advance directive was offered to the residents who have the capacity to understand and make decisions according to the physician's evaluation. The SSD verified Resident 10 had capacity to understand and make decisions. The SSD verified Resident 10's medical record documentation showing Resident 10 did not receive information about completing an advanced directive. The SSD stated Resident 10 was not offered and received information on completing an advance directive. The SSD further stated it was important to provide information about advance directives to know the wishes of the residents. On 7/31/26 at 1135 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the findings.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, facility record review, the facility failed to ensure comfortable water temperatures for seven nonsampled residents (Residents 49, 64, 73, 107, 114, 144, and 184) with the rooms in Hallway A.* Residents 49, 64, and 114 stated their showers were not provided with enough warm water temperatures.* Residents 73, 107, 144, and 184 stated the water temperature in their rooms' adjoining restroom sinks were cold at night. These failures resulted in the residents not being provided water at a comfortable temperature for bathing, hand hygiene, and incontinent cares. Findings: 1. On 7/28/26 at 1029 hours, an interview was conducted with Resident 49. Resident 49 stated his room is Resident Room A and the shower temperature in Shower Room A was too cold. On 7/29/26 at 0744 hours, an observation of Shower Room A and concurrent interview was conducted with the Maintenance Director. The temperatures for Showers 2 and 3, located in Shower Room A, were taken by the Maintenance Director. The Maintenance Director turned on the water for Shower 2 to the hottest setting and stated it takes a while for the water to get warm because this area is the furthest from the boiler. The Maintenance Director used the facility's digital thermometer and obtained the following temperatures the water temperature was 97.2 F and increased until it reached a maximum temperature of 100.1 F. The water temperature felt lukewarm. The Maintenance Director stated the temperature should be at least 104 F. The Maintenance Director turned on the water for Shower 3 to the hottest setting. A digital thermometer showed a temperature of 100.2 F which quickly increased to 106.7 F. The Maintenance Director stated Shower 2's temperature should be hotter, but Shower 3's temperature was appropriate. On 7/29/26 at 1043 hours, an interview was conducted with Resident 114 in Resident Room B. Resident 114 stated the water temperature was too cool, and she would like it warmer. On 7/29/26 at 1056 hours, an interview was conducted with CNA 4. CNA 4 stated recently when she showered Resident 49, the resident asked for the water temperature to be hotter. CNA 4 stated the shower lever was turned all the way to hot, but it would not get hot. CNA 4 stated she asked the resident if he still wanted a shower and he said yes. On 7/32/26 at 0808 hours, an interview was conducted with Resident 64 in Resident Room E. Resident 64 stated she has not had her scheduled shower yet, but the shower temperature has been cooled for a few weeks. All the above residents' rooms were located on Hallway A where Shower Room A was located. 2. On 7/29/26 at 1044 hours, an interview was conducted with Resident 114 in Resident Room C. Resident 114 stated at night, between approximately 2300 to 0500 hours, there is no hot water in her room's adjoining restroom sink. She stated the CNAs would turn on the hot water faucet and leave it on to get hot, but it did not get hot. Resident 114 stated the CNAs must use cold water at night when they clean her after having a bowel movement. On 7/29/26 at 1046 hours, an interview was conducted with Resident 184 in Resident Room D. Resident 184 stated at a certain time at night they turn off the hot water. When asked why she thought the hot water was turned off, Resident 184 stated because no matter how long you leave the restroom sink's hot water on, it stays cold. Resident 184 stated the cold water starts sometime between 2130 hours and midnight. On 7/30/26 at 0416 hours, an interview was conducted with CNA 5. CNA 5 stated she usually worked from 2300 to 0700 hours. CNA 5 stated on Hallway A, there was usually no hot water on her shift until at around 0500 hours. CNA 5 stated she needed to use water to clean residents after they are incontinent during her shift. She turns on the hot water faucet for 10 to 15 minutes, but it did not get warm. When CNA 5 did her first rounds, she had to clean the residents with cold water. On 7/30/26 at 0426 hours, an interview was conducted with CNA 6 in Hallway A. CNA 6 stated she usually worked from 2300 to 0700 hours. CNA 6 (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the water was always cold at the beginning of her shift and would not get warm until at around 0500 hours. When CNA 6 cleaned up her residents, she had to use cold water because there was no other option. CNA 6 stated she knew it was not right and she would not like to be treated like that. On 7/30/26 at 0437 hours, an interview was conducted with LVN 11. LVN 11 stated the plumbing is old, and the water had to be run for a while in order to get warm. LVN 11 stated it took maybe five minutes to get warm. When asked what she used the water for, LVN 11 replied she used it to wash her hands. LVN 11 then clarified, so I guess I really don't know how long it takes for the water to get warm because the water is always cold when I washed my hands. On 7/31/26 at 0810 hours, an interview was conducted with Resident 107 in Resident Room F. Resident 107 stated she only got cold water at night in her restroom sink. Resident 107 stated the CNAs used the water to clean her up after incontinent episodes. On 7/31/26 at 0817 hours, an interview was conducted with Resident 73 in Resident Room G. Resident 73 stated he did not use the restroom in his room, but the CNAs used the water from there to clean him up at night, and it was always cold. Resident 73 stated he would like them to use warm water. All the above residents' rooms were located in Hallway A.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pain management care and services for three of 35 final sampled residents (Residents 4, 6, and 222) and one of one nonsampled resident (Resident 248). * The facility failed to provide nonpharmacological interventions prior to administration of acetaminophen (a prescription medication used to manage mild pain) to Resident 248. In addition, the acetaminophen medication was administered when the resident's pain level did not meet the ordered parameters for moderate pain. * The facility failed to administer the hydrocodone-acetaminophen (narcotic pain medication) according to the physician's orders for Residents 4 and 222. * Resident 6 did not have a physician's order for a PRN pain medication for pain levels of 5 to 7, out a 0 to 10 pain scale. These failures had the potential to place Residents 4, 6, 222, and 248 at risk for ineffective pain management, increased discomfort, and potential adverse effects from unnecessary or inappropriate pain medication use. Findings: Review of the facility's P&P titled Pain Management dated 8/25/21, showed pain management consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences is provided to residents who require such services. An individualized, interdisciplinary care plan will be developed and include addressing/ treating underlying causes of pain to the extent possible; nonpharmacological and pharmacological approaches; and using specific strategies for preventing or minimizing different levels or sources of pain or pain related symptoms. Residents receiving intervention for pain will be monitored for the effectiveness and side effects (e.g., constipation, sedation) in providing pain relief. To document nonpharmacological interventions and effectiveness, effectiveness of PRN medications, ineffectiveness of routine or PRN medications including interventions, follow-up and physician notification. The care plan will be evaluated for effectiveness until satisfactory pain management is achieved. Contact the physician to report findings and obtain revised treatment orders, if indicated and to review the nonpharmacological approaches for effectiveness. 1. On 7/28/26 at 0803 hours, a medication administration observation was conducted with LVN 9. Resident 248 was observed sitting in the wheelchair on the left side of his bed. Resident 248 was observed asking LVN 9 if he could get the Tylenol (acetaminophen/analgesic) medication. LVN 9 asked the resident if he was having pain and asked to describe the location and intensity of his pain. Resident 248 reported generalized pain with a pain level of 6 [on a 0&ndash;10 pain scale (0 = no pain, 10 = worst possible pain)]. LVN 9 administered two tablets of the acetaminophen 325 mg tablet. LVN 9 was not observed offering or providing any nonpharmacological pain interventions before administering the medication. Medical record review for Resident 248 was initiated on 7/28/26. Resident 248 was admitted to the facility on [DATE]. Review of Resident 248's Order Summary Report showed an order dated 7/15/26, for acetaminophen tablet 325 mg to give two tablets by mouth every four hours as needed for mild pain, and to not three grams/day and document nonpharmacological interventions. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 248's MAR for July 2026 showed an active physician's order dated 7/15/26, for acetaminophen 325 mg, to give two tablets by mouth every four hours as needed for mild pain (pain level 1-4). Further review of the MAR showed on 7/28/26 at 0820 hours, the medication was administered for a reported pain level of 6, which exceeded the parameters of the physician's order. Further review of the MAR did not show if nonpharmacological interventions were provided before administration of the acetaminophen. Review of Resident 248's H&P examination dated 7/17/26, showed Resident 248 had the capacity to make his own medical decisions. On 7/28/26 at 1515 hours, an interview and concurrent medial record review for Resident 248 was conducted with LVN 9. LVN 9 verified he did not provide any nonpharmacological interventions before administering pain medication to Resident 248 and should have. LVN 9 verified he administered two tablets of the acetaminophen 325 mg tablet to Resident 248 on 7/28/26 at 0820 hours, when the resident complained of pain 6 out of 10. LVN 9 verified he administered the pain medication outside the ordered parameter and did not notify the physician. On 7/31/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 4 was initiated on 7/27/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's Order Summary Report showed the following orders: - dated 4/3/26 (discontinued 6/27/26), to administer hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for moderate pain (a pain level from 5 to 7 out of 10, using a pain scale of 0=no pain and 10=worst pain); and - dated 6/30/26, to administer hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for severe pain (a pain level from 8 to 10 out of 10). Review of Resident 4's MAR for June 2026 showed Resident 4 was administered the hydrocodone-acetaminophen 5-325 mg pain medication when the pain level was outside of the ordered pain parameters of moderate pain (pain level from 5 to 7). For example: - on 6/1/26 at 1644 hours, for a pain level of 8; - on 6/2/26 at 0600 hours, for a pain level of 8; - on 6/3/26 at 1050 hours, for a pain level of 8; - on 6/8/26 at 1835 hours, for a pain level of 8; - on 6/11/26 at 0950 and 1647 hours, for a pain level of 8; (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 6/14/26 at 0629 hours, for a pain level of 9; and - on 6/15/26 at 1039 hours, for a pain level of 8. Review of Resident 4's MAR for July 2026 showed Resident 4 was administered the hydrocodone-acetaminophen 5-325 mg pain medication when the pain level was outside of the ordered pain parameters of severe pain (pain level from 8 to 10) on the following dates and times: - on 7/5/26 at 0432 hours, for a pain level of 7; and - on 7/8/26 at 0623 hours, for a pain level of 7. On 7/28/26 at 1420 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 stated when the resident complained of pain, the licensed nurse would assess the pain and implement the nonpharmacological pain interventions. LVN 1 stated if the nonpharmacological interventions were not effective, then the PRN pain medication would be administered as ordered by the physician and within the ordered pain parameters. LVN 1 reviewed Resident 4's MAR for June and July 2026 and verified the above finding. On 7/30/26 at 1004 hours, an interview was conducted with the DON. The DON stated when the resident complained of pain, nonpharmacological interventions should be provided. The DON stated if the nonpharmacological interventions were ineffective, the licensed nurse should reassess the resident's pain and administer the pain medication as per the physician's order. The DON stated if the resident did not have the pain medication prescribed for a certain pain level, the licensed nurse should call the physician and clarify/obtain orders. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Review of the facility's P&P titled Medication Administration effective date 10/2017 showed the medication must be administered in accordance with the written orders of the attending physician. Medical record review for Resident 222 was initiated on 7/29/26. Resident 222 was admitted to the facility 9/21/25, and readmitted on [DATE]. Review of Resident 222's H&P examination dated 7/13/26, showed Resident 222 had capacity to understand and make decisions. Review of Resident 222's Order Summary Report showed an order dated 7/24/26, to administer hydrocodone-acetaminophen oral tablet 10-325 mg, give one tablet by mouth every four hours as needed for a pain scale of 5-10, ok to give within four hours of another administration. Review of Resident 222's MAR for July 2026 showed on 7/28/26 at 1204 hours, Resident 222 was administered the hydrocodone-acetaminophen medication for a pain level of 4, which was not within the ordered pain parameters (pain 5-10). (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/26 hours, an interview and concurrent medical record review for Resident 222 was conducted with the QA Nurse. The QA Nurse stated for the residents who reported pain, the licensed nurse would assess the resident pain level prior to the administration of the pain medications. The QA Nurse further stated the pain medication would be administered as per the physician's order and within the ordered parameters. The QA Nurse stated for the pain level of 4, the licensed nurse should not give hydrocodone-acetaminophen medication because the order for the hydrocodone-acetaminophen medication was for a pain level of 5-10. The QA Nurse reviewed Resident 222's MAR for July 2026 and verified the above findings. On 7/30/26 at 1414 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to accurately document the resident's pain level and give pain medication as per the physician's ordered. The DON was informed and acknowledged above findings. 4. Review of the NIH's Newsletter article titled Managing Pain - Moving Beyond Opioids dated 10/2018 showed opioid based medications can be very effective for pain, however they can lead to addiction and long-term use can result in tolerance. Review of the PubMed article titled Management of Chronic Pain in Nursing Homes: Navigating Challenges to Improve Person-Centered Care dated 1/23/21, showed nonopioid medications should be added for moderate to severe pain with opioid based medications being used as a last resort. Medical record review for Resident 6 was initiated on 7/24/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Order Summary showed the following physicians' orders:- dated 6/22/26, for acetaminophen 750 mg by mouth ever four hours PRN for mild pain. On a pain level of 1 to 4, on a 0 through 10 pain scale with 0 being no pain, and 10 being the worst pain; and- dated 6/22/26, for hydrocodone-acetaminophen 5-325 mg by mouth ever four hours PRN for severe pain. On a pain level of 8 to 10, on a 0 through 10 pain scale. Further review of the Order Summary failed to show a physician's order for a pain level of 5 to 7, on a 0 through 10 pain scale. Review of Resident 6's PMNR Physician Progress Note dated 7/3/26, showed the resident received pain management for generalized pain and lower back pain. Review of Resident 6's MAR for July 2026 showed the resident received hydrocodone-acetaminophen 5-325 mg 23 times PRN for pain levels of 8 and 9. The MAR also showed the resident did not receive any acetaminophen 750 mg PRN for mild pain. On 7/30/26 at 0813 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON stated all the residents should have orders to treat all the pain levels. However, if the medication was not used for 30 days, it may be discontinued. The DON reviewed Resident 6's physicians' orders and verified there was no order for pain level of 5 to 7, and there should have been. The DON checked the resident's discontinued orders and stated there was never an order for pain levels of 5 to 7.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility P&P review, the facility failed to ensure the food prepared for the residents was cooked to preserve nutritive value for 233 of 237 residents receiving food prepared in the kitchen. * The vegetables were cooked more than one hour prior to meal service and held in the steamer with a temperature set on 212 to 220 degrees Fahrenheit. This failure had the potential to affect the nutritive content of the food, and the amount of food the residents consume, potentially resulting in a decrease in residents' food intake leading to poor nutrition and health outcomes. Findings: Review of the facility's Diet Type Report dated 7/27/26, showed 233 of 237 residents consumed food prepared in the kitchen. Review of the professional reference titled https://www.healthline.com/nutrition/cooking-nutrient-content dated 11/7/2019, showed in part, The following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxine (B6), folic acid (B9), and cobalamin (B12), fat-soluble vitamins: vitamins A, D, E, and K, and minerals: primarily potassium, magnesium, sodium, and calcium. [NAME] peas contained vitamin C, which is water-soluble and sensitive to heat therefore storing it in the oven at high temperatures for hours likely led to reduced vitamin C content. Review of the Journal of Food Composition and Analysis dated June 2006 showed processing and cooking conditions cause variable losses of vitamins. Losses vary widely according to cooking method and type of food. Degradation of vitamins depends on specific conditions during the culinary process, e.g., temperature, presence of oxygen, light, moisture, pH, and, of course, duration of heat treatment. The molecular structure of vitamins makes them easily degradable under various conditions such as temperature. Review of the facility's P&P titled Food Preparation and Service (undated) showed, fresh, frozen or canned fruits and vegetables are cooked to a holding temperature of 140 degrees Fahrenheit. On 7/28/26 at 0936 hours, an interview was conducted with the Dietary Manager. The Dietary Manager stated puree preparation has been completed by the cook and tray line starts at 1030 hours. The Dietary Manager verified the vegetables were prepared more than one hour prior to meal service. On 7/28/26 at 1040 hours, an observation of the steam table and concurrent interview was conducted with the Assistant Cook. The steam table had serving pans covered with foil of cream of rice, pureed pork and tortilla taco, pureed chicken and pureed green peas vegetables. The Assistant [NAME] acknowledged the findings and stated the puree preparation was started when he comes back from his lunch break at 0900 hours. The Assistant [NAME] stated he had everything prepared already and would do the puree preparation. The Assistant [NAME] stated the pureed green peas were kept on the steamer with a temperature set on 212 to 220 degrees Fahrenheit.		

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 07/31/2026
NAME OF PROVIDER OR SUPPLIER South Coast Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1030 W Warner Ave Santa Ana, CA 92707	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the microwave utilized to warm up the residents' food was in a sanitary condition. * The facility failed to ensure the heavy-duty blender used for puree preparation and clear pitchers were air dried prior to storage. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the kitchen utensils had smooth, cleanable surfaces and were maintained in good repair. * The facility failed to ensure the cutting boards were maintained in sanitary condition and had smooth, cleanable surfaces. These failures had the potential to cause cross-contamination and/or foodborne illness for the residents consuming the food prepared in the kitchen. Findings: Review of the facility's Diet Type Report dated 7/27/26, showed 233 of 237 residents consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Sanitization (undated) showed all kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 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 of proper cleaning. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non-Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 7/27/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. The kitchen microwave on a countertop shelf was observed dirty with dry, crusted food residue in the microwave door and had dry food splatters inside the microwave. The Dietary Manager verified the findings and stated the microwave was used to warm up the resident's food. 2. Review of the facility's P&P titled Sanitization (undated) showed food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 7/27/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. One heavy-duty blender used for puree preparation stored on the countertop shelf and four clear pitchers stored on the top shelf were observed wet with visible water inside. The Dietary Manager verified the findings and stated the blender and pitchers should have been air dried. 3. Review of the facility's P&P titled Sanitization (undated) showed all kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. According to the USDA (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 7/27/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. The following was observed: - one stainless steel spatula with wooden handle was dirty with dry, crusted residue, had dry watermarks and fuzzy films;- one stainless steel spatula with white handle was dirty with dry, crusted residue, had dry watermarks and fuzzy films;- one stainless steel scoop with green handle used for food portioning was dirty with dry, crusted residue and had fuzzy films;- two stainless steel scoops with white handles used for food portioning had fuzzy films;- three stainless steel scoops with gray handles used for food portioning had fuzzy films;- two stainless steel scoops with blue handles used for food portioning had fuzzy films;- one stainless steel dough cutter with white handle had dry watermarks and fuzzy films;- three stainless steel knives with white handles had fuzzy films and dry watermarks; and- one stainless steel knife with black handle had fuzzy films and dry watermarks. The Dietary Manager verified the findings and stated all dirty kitchen utensils and kitchenware should have been rewashed and cleaned for infection control purposes. 4. Review of the facility's P&P titled Sanitization (undated) showed all 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 of proper cleaning. Seals, hinges, and fasteners are kept in good repair. Plastic ware, China, and glassware that cannot be sanitized or are hazardous because of chips, cracks, or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 7/27/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. The following was observed: - one stainless steel whisk with gray-greenish handle was partially cracked;- one stainless steel knife with white handle was partially melted; and- one rubber spatula with red handle had chipped and cracked edges. The Dietary Manager verified the findings and stated all worn-out kitchen utensils and kitchenware should have been discarded. 5. Review of the facility's P&P titled Sanitization (undated) showed cutting boards are washed and sanitized between uses. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 7/27/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. Two green, three yellow, two white and one red cutting boards were observed fuzzy, heavily marred and had deep grooves and pits. The Dietary Manager verified the findings.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were complete and accurate for four of 35 final sampled residents (Residents 8, 178, 189, and 205) and one of three sampled residents (Resident 242) reviewed for closed records were accurate. * The facility failed to ensure Section D of the POLST and the Advance Directive Acknowledgement form were completed accurately for Resident 8. * The facility failed to ensure Resident 178's MAR was complete for the administration of the ertapenem (antibiotic medication) on 7/24/26. * The facility failed to ensure Resident 189's POLST contained the information of Resident 189's healthcare agent as per the resident's advance directive. * The facility failed to ensure accurate and consistent documentation for the monitoring of Resident 205 for opioid overdose. * The facility failed to ensure Resident 242's Physician's Progress Note dated 7/7/26 was accurate. The resident was transferred to the acute care hospital on 6/30/26. These failures had the potential for the residents' care needs not being met as their medical information were inaccurate. Findings: Review of the facility's P&P titled Charting and Documentation dated 7/28/26, showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. Documentation in the medical record will be objective, complete, and accurate. 1. Medical record review for Resident 189 was initiated on 7/27/26. Resident 189 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 189's Advanced Health Care Directive dated 4/19/18, showed Resident 189 selected Responsible Party 1 to be her designated agent for health care decisions. Review of Resident 189's POLST dated 5/14/25, showed documentation Resident 189's Advanced Directive dated 4/19/18, was available and reviewed. However, further review of the POLST, showed the section for the Health Care Agent (if named in the Advance Directive) was blank. Review of Resident 189's H&P examination dated 7/1/26, showed Resident 189 had fluctuating capacity to understand and make decisions. On 7/29/26 at 1046 hours, an interview and concurrent medical record review for Resident 189 was conducted with the SSA. The SSA stated the POLST contained information related to the resident's healthcare directives as per their Advance Directive. The SSA stated the information on the resident's POLST and Advance Directive should match. The SSA further stated if the resident designated a Health Care Agent in their Advance Directive, the individual's name and contact information should be listed on the POLST. The SSA reviewed Resident 189's Advance Directive and POLST and verified the above findings. On 7/30/26 at 1004 hours, an interview was conducted with the DON. The DON stated all the residents' records should be accurate. The DON stated if the resident had an advance directive and (continued on next page)		

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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	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had designated a Health Care Agent, then Health Care Agent should be listed on the POLST to ensure the appropriate care measures were implemented and the Health Care Agent contacted for further medical interventions. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 205 was initiated on 7/27/26. Resident 205 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 205's Order Summary Report showed physician's orders dated 10/12/24 and 11/13/25, to monitor Resident 205 for opioid overdose symptoms/side effects every shift. The symptoms/side effects included constricted and pinpoint pupils, falling asleep or losing consciousness, slow, weak or no breathing, choking or gurgling sounds, limp body, cold and/or clammy skin, discolored skin (especially in lips and nails). To document N if monitored and none of the above were observed or Y if monitored and any of the above was observed. Review of Resident 205's MAR for July 2026 showed the following licensed nurses' documentation for the monitoring of Resident 205 for opioid overdose symptoms/side effects: * For the monitoring order dated 10/12/24: - from 7/1 to 7/4, 7/7 to 7/9, 7/13 to 7/16, 7/18 to 7/21, and 7/26 to 7/28, during the 0700 to 1500 hours shift, the licensed nurse (LVN 7) documented YES, and - on 7/4, 7/18, and from 7/26 to 7/28, during the 1500 to 2300 shift, the licensed nurse (LVN 7) documented YES. * For the monitoring order dated 11/13/25: - from 7/23 to 7/25, during the evening shift (1500 to 2300 hours), the licensed nurse documented Y and - on 7/23/26, during the day shift (0700 to 1500 hours), the licensed nurse documented Y. On 7/29/26 at 1426 hours, an interview and concurrent medical record review for Resident 205 was conducted with LVN 6. LVN 6 stated the monitoring for opioid overdose/side effects was done by the licensed nurse every shift and documented in the MAR. LVN 6 further stated the documentation of Y or YES meant the resident was monitored for opioid overdose and symptoms were present, and the N or no meant the resident was monitored and the symptoms were not present. LVN 6 stated if the resident presented with opioid overdose, the licensed nurse would check the residents' vitals and initiate a change in condition evaluation. LVN 6 reviewed Resident 205's MAR for July 2026 and verified the above findings. On 7/30/26 at 0440 hours, an interview was conducted with the DON. The DON stated she spoke with (continued on next page)		

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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	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 7 regarding her documentation of yes for the monitoring of Resident 205 for opioid overdose. The DON stated LVN 7 informed her she thought yes meant she documented she monitored the resident for opioid overdose. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 8 was initiated on 7/27/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's POLST dated 3/3/26, showed the following check box was checked under Section D - Information and Signatures: Advance Directive not available. Review of Resident 8's H&P examination dated 3/4/26, showed the resident had the capacity to understand and make decisions. Review of Resident 8's Social Services assessment dated [DATE], showed the resident did not have an advance directive and declined to formulate an advance directive at this time. On 7/28/26 at 0923 hours, an interview and concurrent medical record review for Resident 8 was conducted with the SSD. The SSD stated the social services was responsible to review the POLST for completion and accuracy. The SSD review the POLST dated 3/3/26, and the social services assessment notes on 3/4/26, and verified section D on the POLST was not accurate. The SSD stated it was important to have the POLST filled out accurately, so facility could follow the plan of care according to the residents needs and wishes. On 7/30/26 at 1406 hours, an interview was conducted with the DON in the conference room. The DON was informed and acknowledged the above findings. 4. Medical record review for Resident 178 was initiated on 7/27/26. Resident 178 was admitted to the facility 2/2/23. Review of Resident 178's H&P dated 9/16/25, showed Resident 178 had fluctuating capacity to understand and make decisions. Review of Resident 178's Physician Order dated 7/19/26, showed ertapenem sodium (antibiotic) injection solution reconstituted 1 gram, to give 1 gram IV one time a day for UTI for 10 days. Review of Resident 178's IV Administration Record for July 2026 showed the ertapenem sodium medication was scheduled to be administered at 1000 hours daily for 10 days, with a start date of 7/19/26. Further review of the IV Administration Record did not show whether the IV medication was administered on 7/24/26. On 7/29/26 at 1412 hours, an observation, interview, and concurrent medical record review for Resident 178 was conducted with RN 1. RN 1 verified the physician's order for the ertapenem sodium (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication to be administered daily starting 7/19/26 for 10 days. RN 1 confirmed on 7/24/26 at 1000 hours, the IV Administration Record did not indicate whether the medication was administered. RN 1 stated the pharmacy delivered 10 doses of the medication to the facility, and the facility stored the medication in Medication Cart A. Medication Cart A was observed with RN 1, which showed no remaining doses of the ertapenem sodium medication in the cart. Medication Storage Room A was observed with RN 1, and did not show any doses of ertapenem, including in the discontinued medications. RN 1 stated staff should have documented the medication ertapenem administered to Resident 178 on 7/24/26. On 7/31/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Closed medical record review for Resident 242 was initiated on 7/28/26. Resident 242 was initially admitted to the facility on [DATE], readmitted on [DATE], and discharged on 7/7/26. Review of Resident 242's eINTERACT SBAR Summary for Providers evaluation dated 6/30/26 at 0815 hours, showed the resident had productive cough with a change in lung sounds, and an oxygen saturation of 86% on room air. The physician was notified and instructed the resident to be sent out to the ED via 911. Review of Resident 242's Nurses Progress Note dated 6/30/26 at 1300 hours, showed the ED informed the facility staff the resident was admitted to the acute care hospital. Review of Resident 242's Order Summary Report showed a physician's order dated 6/30/26, to send the resident out via 911, and to start a bed hold for seven days. Review of Resident 242's EHR Census List showed the following:- On 6/30/26, the resident was transferred to the acute care hospital, and was placed on a hospital leave; and - On 7/7/26, the acute care hospital leave ended and billing for the resident's bed hold stopped. The resident had not returned to the facility. Review of the PMNR's Physicians Progress Note dated 7/7/26, showed the resident was observed resting in bed watching TV. The note was dated seven days after the resident transferred out from the facility. On 7/28/26 at 1405 hours, an interview and concurrent medical record review for Resident 242 was conducted with the HIM. The HIM reviewed Resident 242 medical and verified the resident was transferred and subsequently admitted to the acute care hospital on 6/30/26, and billing stopped on 7/7/26, once the resident's bed hold was completed. The HIM stated the resident did not return to the facility. The HIM reviewed the Physicians Progress Note dated 7/7/26, and verified the note showed an inaccurate date.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain infection control practices to help prevent the development and transmission of diseases and infection. * The facility failed to ensure the decorative water fountain was monitored and maintained to minimize the growth and spread of waterborne pathogens and other contaminants. * Two out of four washing machines were not maintained in a clean and sanitary condition. * The facility failed to ensure the shower room caulking was clean and free from black residue for one of one shower rooms (Shower Room A). * The facility failed to ensure the staff sanitized glucometer before and after checking Resident 64's blood glucose level and before placing it back into the medication cart. These failures posed the risk for transmission of disease causing microorganisms and infections. Findings: 1. Review of the facility's Legionella Water Management Program (undated) showed under control points, areas to be monitored and tested monthly.no hot tubs or decorative water fountains were found at this location. In the event a hot tub or decorative water fountain is installed, monthly control measures must be implemented. Further review showed each time a control point is checked, the date and time should be entered in a log sheet. Monitoring to include testing for legionella bacteria and the monitoring for preventive measures. On 7/31/26 at 0944 hours, a decorative water fountain on the wall was observed at the entrance of the facility. The right-side border of the decorative water fountain was observed with green built-up residue behind the plexiglass. On 7/31/26 at 1030 hours, an interview and concurrent facility document review was conducted with the MD and Housekeeping Staff 1. The MD stated the facility water management program was implemented since 12/2023. The MD verified the facility had a running decorative water fountain on the wall immediately upon entrance to the facility. When asked what monthly control measures were being implemented to the decorative water fountain, Housekeeping Staff 1 stated he drops three tablets of MaxBlue Tabs (sanitizing product) into the decorative water fountain every three months. Housekeeping Staff 1 stated he did not keep the documentation on when he checks the decorative water fountain and when he puts MaxBlue Tabs into the decorative water fountain. The MaxBlue Tabs container's label showed to add two eight-ounce tablets per 10, 000 gallons of pool water every week, and ensure a free available chlorine level of 1 - 4 ppm. Housekeeping Staff 1 stated he did not conduct testing of the water to know if three tablets of MaxBlue Tabs every three months was enough to prevent the growth of waterborne pathogens and other contaminants. On 7/31/26 at 1151 hours, an observation of the decorative water fountain and interview was conducted with the Administrator. The Administrator verified the built-up green residue behind the plexiglass was on the right-side border of the decorative water fountain. The Administrator acknowledged the findings above. 2. On 7/30/26 at 0814 hours, an observation of the laundry room and concurrent interview was (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with the Maintenance Director. Two out of four washers were observed with residue in the interior of the washing machine. Washing Machine #2 was observed with whitish-gray residue lining the interior of the washer door. Washing machine #4 was observed with brown and white residue on the interior of the washing machine between the washer drum and door. The Maintenance Director verified and acknowledged the findings. The Maintenance Directors states he expected the laundry staff members to clean and disinfect the washing machines after every use. On 7/31/26 at 1157 hours, an interview was conducted with the Administrator and DON-STP. The Administrator and DON-STP were informed and acknowledged the above findings. 3. On 7/29/26 at 0744 hours, an observation of Shower Room A and concurrent interview was conducted with the Maintenance Director. Showers 2 and 3 were located inside Shower Room A. There were areas of black residue observed on the vertical line of white caulking on the corners where the walls met. Upon wiping the caulking with a clean paper towel, a black substance was observed on the towel. The Maintenance Director verified the findings and stated the caulking needed to be cleaned. 4. Review of the facility's P&P titled Glucometer (undated) showed all the glucometers will be cleaned and disinfected using disinfectant wipes. All glucometers that will be shared by multiple residents will be thoroughly wiped with disinfectant and allowed to air dry after every use and between every patient. On 7/28/26 at 1552 hours, during a medication administration observation for Resident 64, LVN 10 was observed preparing the glucometer to obtain the patient's blood glucose level. LVN 10 donned gloves and entered Resident 64's room, however, the glucometer was not sanitized prior to use. After completing the blood glucose check, LVN 10 exited the room, placed the glucometer on top of the medication cart, removed the gloves, and returned the glucometer to the medication cart without sanitizing. On 7/28/26 at 1610 hours, an interview was conducted with LVN 10. LVN 10 verified the findings observed during the medication administration observation. LVN 10 verified she did not sanitize the glucometer before and after checking Resident 64's blood glucose level before placing it back into the medication cart. LVN 10 acknowledged she should have disinfected the glucometer after checking Resident 64's blood glucose level and prior to storing them in the medication cart. On 7/29/26 at 0938 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the residents and/or resident representatives were provided with the right to self-determination for two of five sampled residents reviewed for unnecessary medications (Residents 6 and 10). * The facility failed to ensure the informed consent for the quetiapine (antipsychotic), sertraline (antidepressant), Ativan (antianxiety), and risperidone (antipsychotic) psychotropic medications for Resident 10 included the reason for the use of medications including diagnosis and manifested behavior specific to the resident. * Resident 6's informed consent forms for the lurasidone (antipsychotic) HCl (hydrochloride) and fluoxetine (antidepressant) HCl, failed to include the reason for the use of the psychotherapeutic medications. These failures placed the residents at risk for not receiving adequate information to make informed decisions regarding the risks and benefits of the psychotropic medications and for not being fully included in the treatment decisions. Findings: Review of the AFL 25-27 titled AB 48 & Nursing Facility Resident Informed Consent Protection Act of 2023 dated 10/7/25, showed the prescriber must share the material information a reasonable person in the resident's condition and circumstances would consider necessary for the resident or representative to make a decision about the treatment. Material information that the provider shall provide includes but is not limited to how the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects. The AFL also showed the facility must check the medical record for proper informed consent prior to an initial administration. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by 1/1/26, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and earning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug. Review of facility's P&P titled Informed Consent for Psychotropic Drugs (undated) showed informed consent meant disclosure of material information (e.g., reasons for use, benefits, risks including black box warning, alternatives including non-pharmacological approaches) to the resident or their representative/surrogate, allowing them to accept, refuse, or revoke consent. Consent must be obtained prior to initiation or increase. Further review of the P&P showed to obtain informed consent for all psychotropic medications prior to initiation or dose increase. (continued on next page)		

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 07/31/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical record review for Resident 10 was initiated on 7/27/26. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 5/18/2026, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Order Summary Report Showed the following physician orders: - dated 5/17/26, for Ativan oral tablet 0.5 mg, to give by mouth every six hours for anxiety as manifested by restlessness and inability to relax. - dated 5/17/26, for quetiapine fumarate 100 mg oral tablet, to give 100 mg by mouth at bed time for bipolar disorder as manifested by episode of striking out. - dated 5/17/26, for risperidone oral tablet 2 mg to give one tablet by mouth two times a day for psychosis as manifested by angry outburst without apparent reason - dated 5/17/26, for sertraline oral tablet 50 mg, to give one tablet by mouth in the evening for depression as manifested by reduced social interaction. a. Review of Resident 10's Psychotropic Medication Administration Disclosure (Anti-anxiety) showed for Ativan 0.5 mg to administer one tablet by mouth every six hours. The disclosure form showed Resident 10 was informed on 5/17/26. Under the section for Reason for Use and Benefits of the document showed these drugs alleviate manifestation of anxiety such as nervousness, overconcern, restlessness, insomnia (inability to sleep), sleeplessness, tension, and tremors. Further review of the form did not show Resident 10's diagnosis and manifested behavior specific to Resident 10 for which the Ativan medication was prescribed. b. Review of Resident 10's Psychotropic Medication Administration Disclosure (Anti-psychotic) showed for quetiapine fumarate 100 mg oral tablet to administer by mouth at bed time. The disclosure form showed Resident 10 was informed on 5/17/26. Under the section Reason for Use and Benefits of the document showed these drugs alleviate manifestation of psychosis such as paranoia, disorganized behavior thinking and speech, hitting, kicking, scratching, grabbing, causing damage to surroundings, injuring self, and others, yelling, screaming, insomnia, restlessness, undressing self, hallucinations, delusions, interference with care, throwing objects, and fearful distress. Further review of the form did not show Resident 10's diagnosis and manifested behavior specific to Resident 10 for which the quetiapine medication was prescribed. c. Review of Resident 10's Psychotropic Medication Administration Disclosure (Anti-psychotic) showed for risperidone 2 mg oral tablet to administer by mouth two times a day. The disclosure form showed Resident 10 was informed on 5/17/26. Under the section for Reason for Use and Benefits of the document showed these drugs alleviate manifestation of psychosis such as paranoia, disorganized behavior thinking and speech, hitting, kicking, scratching, grabbing, causing damage to surroundings, injuring self, and others, yelling, screaming, insomnia, restlessness, undressing self, hallucinations, delusions, interference with care, throwing objects, and fearful distress. Further (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the form did not show Resident 10's diagnosis and manifested behavior specific to Resident 10 for which the risperidone medication was prescribed. d. Review of Resident 10's Psychotropic Medication Administration Disclosure (Anti-depressant) for sertraline 50 mg to administer by mouth one time a day. The disclosure form showed Resident 10 was informed on 5/17/26. Under the section for Reason for Use and Benefits of the document showed these drugs alleviate manifestations of depression such as sleeplessness, self-pity, weight loss, unhappiness, loss of appetite, poor grooming, being withdrawn, crying, feeling rejected, not socializing, wishing to die, and anhedonia (reduced ability or inability to feel pleasure or joy from things you usually enjoy). Further review of the form did not show Resident 10's diagnosis and manifested behavior specific to Resident 10 for which the sertraline medication was prescribed. On 7/29/26 at 1443 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 8. LVN 8 verified Resident 10 had been receiving the Ativan, quetiapine, risperidone, and sertraline psychotropic medications. LVN 8 verified the informed consents for Ativan, quetiapine, risperidone, and sertraline medications for Resident 10 did not specify the reason for use including diagnosis and manifested behavior for which the medications were prescribed. On 7/31/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 6 was initiated on 7/24/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 7/1/26, showed the resident was diagnosed with bipolar disorder and major depressive disorder. a. Review of Resident 6's Order Summary showed a physician's order dated 6/22/26, for lurasidone HCl administer 60 mg by mouth at bedtime for bipolar disorder manifested by mood swings. Review of Resident 6's Psychotropic Medication Administration Disclosure (Anti-Psychotic) informed consent for lurasidone HCl dated 6/22/26, failed to show the reason for use of the psychotropic medication. b. Review of Resident 6's Order Summary showed a physician's order dated 6/22/26, for fluoxetine HCl administer 40 mg by mouth at bedtime for depression, manifested by verbalization of feeling sad. Review of Resident 6's Psychotropic Medication Administration Disclosure (Anti-Depressant) informed consent for fluoxetine HCl dated 6/22/26, failed to show the reason for use of the psychotropic medication. On 7/30/26 at 0813 hours, an interview and concurrent record review for Resident 6 was conducted with the DON. The DON verified Resident 6 had active physician's orders for the lurasidone HCl and fluoxetine HCl medications. The DON reviewed Resident 6's informed consents and verified both consents for the lurasidone HCl and fluoxetine HCl medications failed to show the reason for their use, and they should.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to protect the residents' right to be free from physical abuse for two of six final sampled residents (Residents 33 and 204) reviewed for abuse. * Resident 33 was using the facility's telephone when Resident 24 approached and struck Resident 33. * Resident 204 was struck on the head by Resident 104. Mental Health Workers 3 and 4 stated they witnessed the physical altercation involving Residents 104 and 204. These failures to prevent physical abuse had the potential to result in serious injury and/or psychosocial harm to the residents. Findings: Review of the facility's P&P titled Abuse Prohibition dated 2/23/21, showed the facility prohibits abuse for all the residents. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes hitting, slapping, pinching, or kicking. 1. a. Medical record review for Resident 104 was initiated on 7/28/26. Resident 104 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 104's MDS assessment dated [DATE], showed Resident 104 was cognitively intact. Resident 104 had a diagnosis of schizoaffective disorder. Review of Resident 104's eINTERACT Change of Condition Evaluation - V 5.2 dated 7/11/26, showed Resident 104 struck a male peer (another resident). Review of Resident 104's Nurses Progress Note dated 7/11/26 at 2030 hours, showed Resident 104 approached Resident 204 and engaged in horseplay by hugging him from behind. In response, Resident 204 yelled at Resident 104. Resident 104 then struck Resident 204 on the head. On 7/29/26 at 1023 hours, an interview was conducted with Resident 33. Resident 33 stated he witnessed Resident 104 strike Resident 204 on the left side of his head on 7/11/26. On 7/30/26 at 1407 hours, a telephone interview was conducted with Mental Health Worker 4. Mental Health Worker 4 stated he saw Resident 104 strike Resident 204. Mental Health Worker 4 further stated Resident 104 stated he struck Resident 204 because Resident 204 did not want to play and Resident 104 thought it was disrespectful. On 7/31/26 at 0907 hours, a telephone interview was conducted with Mental Health Worker 3. Mental Health Worker 3 stated he saw Resident 104 start to horseplay with Resident 204. Resident 204 did not want to horseplay with Resident 104. MHW 3 stated he witnessed Resident 104 then hit Resident 204 on his head. MHW 3 stated he separated Residents 104 and 204. b. Medical record review for Resident 204 was initiated on 7/28/26. Resident 204 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 204's MDS assessment dated [DATE], showed Resident 204 was cognitively intact. Resident 204 had a diagnosis of schizoaffective disorder. Review of Resident 204's Mental Health Worker Progress Note dated 7/11/26 at 2250 hours, showed Residents 104 and 204 were on the patio, when Resident 104 approached Resident 204 and attempted to horseplay. Resident 204 declined to interact with Resident 104, Resident 104 became upset as a result and swung at Resident 204. Review of Resident 204's Nurses Progress Note dated 7/11/26 at 2303 hours, showed Resident 104 was agitated and struck Resident 204 on the head because Resident 204 did not want to horseplay with him. The staff members intervened and separated Residents 104 and 204. On 7/29/26 at 1045 hours, an interview was conducted with Resident 204. Resident 204 stated Resident 104 was horseplaying with him. Resident 204 told him to let go of him, then Resident 104 struck the left side of his head. 2. a. Medical record review for Resident 24 was initiated on 7/28/26. Resident 24 was admitted to the facility on (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], and readmitted on [DATE]. Review of Resident 24's MDS assessment dated [DATE], showed Resident 24 was cognitively intact. Resident 24 had a diagnosis of schizophrenia. Review of Resident 24's eINTERACT Change in Condition Evaluation - V 5.2 dated 7/16/26, showed Resident 24 struck a male peer with an open hand due to paranoia. Review of Resident 24's Behavior Progress Note dated 7/16/26 at 1200 hours, showed Resident 24 struck Resident 33 on the face with an open hand while he was using a telephone. A staff member stated Resident 24 stated she believed Resident 33 was talking about her over the telephone. On 7/29/26 at 0943 hours, an interview was conducted with RN 2. RN 2 stated he saw Resident 24 slapped Resident 33 on the face while Resident 33 was on the telephone. On 7/29/26 at 0956 hours, an interview was conducted with LVN 2. LVN 2 stated he saw Resident 24 randomly struck Resident 33 with an open hand on the left side of his face. LVN 2 then stated he intervened and separated Residents 24 and 33. On 7/30/26 at 0945 hours, an interview was conducted with Mental Health Worker 2. Mental Health Worker 2 stated Resident 24 told her on 7/11/26, after the incident she was paranoid and believed Resident 33 was talking about her over the telephone. b. Medical record review for Resident 33 was initiated on 7/28/26. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's MDS assessment dated [DATE], showed Resident 33 was cognitively intact. Resident 33 had a diagnosis of schizophrenia. Review of Resident 33's progress note dated 7/16/26 at 1200 hours, showed Resident 33 was on the telephone when Resident 24 struck him on his face with an open hand. On 7/29/26 at 1023 hours, an interview was conducted with Resident 33. Resident 33 was asked to describe the physical altercation between Resident 24. Resident 33 stated he was on the telephone, when Resident 24 slapped the left side of his face on 7/16/26. On 7/31/26 at 1157 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 6 and 10) reviewed for the unnecessary medications were free from the unnecessary psychotropic medications. * Resident 6's monthly behavior summary for the lurasidone (antipsychotic) HCl (hydrochloride) and fluoxetine (antidepressant) HCl medications were inaccurate for June 2026. In addition, the facility failed to complete the weekly orthostatic blood pressure monitoring for the antipsychotic medication use. * The facility failed to ensure the monthly summary of behaviors targeted for the use of the Ativan (antianxiety), quetiapine (antipsychotic), risperidone (antipsychotic), and sertraline (antidepressant) medications were completed for Resident 10. These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of the psychotropic medications prescribed. Findings: Review of the facility P&P titled Psychotropic Medication Use (undated) showed the facility should comply with psychopharmacologic dosage guidelines created for Medicare and Medicaid services (CMS), and all other applicable laws relating to the use of psychopharmacologic medication including gradual dose reduction. The facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behavior. The facility staff should monitor behavioral triggers, episodes, and symptoms. The facility staff to document the number and/or intensity of symptoms and the resident's response to staff interventions. 1. Medical record review for Resident 10 was initiated on 7/27/26. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 5/18/2026, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Order Summary Report Showed the following physician orders dated 5/17/26: - Ativan oral tablet 0.5 mg, to give by mouth every six hours for anxiety as manifested by restlessness and inability to relax; - quetiapine fumarate 100 mg oral tablet, to give 100 mg by mouth at bedtime for bipolar disorder as manifested by episode of striking out; - risperidone oral tablet 2 mg to give one tablet by mouth two times a day for psychosis as manifested by angry outburst without apparent reason; (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- sertraline oral tablet 50 mg to give one tablet by mouth in the evening for depression as manifested by reduced social interaction; - Monitoring orders for antianxiety medication related to episodes of restlessness and inability to relax - Monitoring orders for antidepressant medication related to episodes of reduced social interaction (sertraline); - Monitoring orders for antipsychotic medication related to bipolar disorder and episodes of striking out (quetiapine); and - Monitoring orders for antipsychotic medication related to bipolar disorder and sudden angry outbursts (risperidone). Review of Resident 10's MAR dated 7/1 to 7/31/26, showed all listed medications were active and the staff were monitoring the episodes of behaviors related to each medication use. However, further review of Resident 10's medical record did not show the monthly behavioral summaries for the Ativan, quetiapine, risperidone, and sertraline medications were completed or available for physician review. On 7/30/26 at 1103 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD verified Resident 10 had been receiving Ativan, quetiapine, risperidone, and sertraline medications. The SSD stated the social services department was responsible for completing the monthly behavior summaries for all the residents prescribed with the psychotropic medications. The SSD confirmed he was unable to locate the documentation showing the monthly behavior summaries were completed for Resident 10 for these medications. On 7/31/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's undated P&P titled Blood Pressure, Measuring, showed after obtaining a baseline BP with the resident in a sitting position (or lying as ordered), assist the resident to a standing position (or sitting as ordered) and immediately recheck the BP. Note the changes in both the SBP and DBP compared to the baseline BP. Medical record review for Resident 6 was initiated on 7/24/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 7/1/26, showed the resident was diagnosed with bipolar disorder and major depressive disorder. a. Review of Resident 6's Order Summary Report showed the following physician's orders:- order dated 6/22/26, for lurasidone HCl administer 60 mg by mouth at bedtime for bipolar disorder (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manifested by mood swings. - order dated 6/22/26, to monitor and document the resident for mood episodes of bipolar disorder manifested by mood swings every shift. Review of Resident 6's MAR for June 2026 showed the resident had five mood swing episodes. Review of Resident 6's OBRA Chemical Reduction and Behavior Management Meeting form dated 7/17/26, showed the resident had no episodes of mood swings. b. Review of Resident 6's Order Summary showed the following physician's order: - dated 6/22/26, for fluoxetine HCl (antidepressant) administer 40 mg by mouth at bedtime for depression manifested by verbalization of feeling sad. - dated 6/22/26, to monitor and document the resident for mood episodes of depression manifested by verbalization of feeling sad every shift. Review of Resident 6's MAR for June 2026 showed the resident had five episodes of verbalized feelings of sadness. Review of Resident 6's OBRA Chemical Reduction and Behavior Management Meeting form dated 7/17/26, showed the resident had no episodes of feeling sad. On 7/30/26 at 0855 hours, an interview and concurrent record review for Resident 6 was conducted with the SSD. The SSD stated the monthly behavior monitoring was tracked on the OBRA Chemical Reduction and Behavior Management Meeting form and presented monthly to the IDT for psychotropic medication review. The SSD stated the behavior episodes documented on the MAR were added up and entered on the form kept in a binder. Review of the binder failed to show Resident 6's monthly behavior summaries. The SSD stated he would try and locate the form. On 7/30/26 at 1001 hours, a follow-up interview and concurrent medical record review for Resident 6 was conducted with the SSD. The SSD provided Resident 6's OBRA Chemical Reduction and Behavior Management Meeting form dated 7/17/26. The form showed a column with July and underneath it had a zero for episodes of verbalization of feeling sad, and a zero for episodes of mood swings. The SSD stated the month should be for June, not July, and stated there were no episodes of mood swings or feeling sad. The SSD stated the data on the form was presented to the IDT for psychotropic medications, which included a psychiatric-mental health nurse practitioner as part of the team. The SSD reviewed Resident 6's MAR for June 2026 and verified the MAR showed the resident had five episodes of verbalized feelings of sadness, and five for episodes of mood swings. The SSD verified the monthly behavior summary presented to the IDT was incorrect based on the MAR. c. Review of Resident 6's Order Summary showed the following physicians' orders:- dated 6/22/26, to monitor for orthostatic hypotension every Saturday while lying and sitting. Notify the physician for a decreased SBP of more than 19 mmHg, or a decreased DBP of more than 9 mmHg, after at least three minutes of position change. Review of Resident 6's MAR for July 2026 showed the resident's documented blood pressure for orthostatic monitoring as follows:- On 7/11/26, with a BP of 123/86 mmHg while lying- On 7/18/26, (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a BP of 112/86 mmHg while lying- On 7/25/26, with a BP of 97/50 mmHg while lying Review of the MAR failed to show the resident's BP was also obtained while sitting, to monitor for the orthostatic hypotension. Review of Resident 6's Weights and Vitals Summary blood pressure log showed the following:- On 7/11/26 at 1916 hours , a BP of 123/86 mmHg while lying down, which matched the BP documented in the MAR.- On 7/11/26 at 2257 hours, a BP of 126/75 mmHg while lying down.- On 7/18/26 at 1745 hours, a BP of 112/86 mmHg while lying down, which matched the BP documented in the MAR. - On 7/18/26 at 1927 hours, a BP of 109/81 mmHg while sitting. - On 7/25/26 at 1729 hours, a BP of 97/50 mmHg while lying down, which matched the BP documented in the MAR.- On 7/25/26 at 1729 hours, a BP of 97/80 mmHg while lying down. On 7/30/26 at 0813 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON verified Resident 6 had active physician's orders for the lurasidone HCl medication and for monitoring the orthostatic hypotension. The DON stated the orthostatic hypotension monitoring was for all the residents with antipsychotic medications. The DON reviewed Resident 6's medical record and verified the above findings. The DON stated the following: - For the BP on 7/11/26 at 2257 hours, it was not done in the sitting position, and even if it was, too much time had passed (three hours and 41 minutes) from the initial blood pressure to accurately monitor orthostatic hypotension. - For the BP on 7/18/26 at 1927 hours, too much time (one hour and 42 minutes) had passed to accurately monitor orthostatic hypotension. - For BP on 7/25/26 at 1729 hours, the BP was taken at the same time while in the same position, and was likely a recheck of the previous abnormal BP, or the prior BP was entered in error. The DON continued to review Resident 6's EHR and verified she was unable to find record of the blood pressures while in the sitting position within the appropriate time frame for appropriate orthostatic hypotension monitoring.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to complete the MDS assessments accurately for two of 35 final sampled residents (Residents 4 and 189). * Resident 4 received oxygen and PRN hydrocodone-acetaminophen (opioid medication). The facility failed to code the use of oxygen and administration of opioid medication in the quarterly MDS assessment dated [DATE]. * Resident 189 had a weight loss of 7.97% (more than 5% in one month). The facility failed to accurately code the weight loss in the MDS assessment dated [DATE]. These failures posed the risk of the residents not receiving the individualized plans of care based on the residents' specific needs. Findings: 1. Medical record review for Resident 4 was initiated on 7/27/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. a. On 7/27/26 at 0938 hours, during the initial tour of the facility, Resident 4 was observed in bed and receiving continuous oxygen at two LPM via nasal canula. Review of Resident 4's Order Summary Report showed a physician's orders dated 6/30/26, to administer continuous oxygen at two LPM via nasal canula for hypoxia every shift. Review of Resident 4's MAR for June 2026 showed the licensed nurses documented Resident 4 was administered the continuous oxygen at two LPM via nasal canula on 6/30/26 for the day, evening, and night shift. b. Review of Resident 4's Order Summary Report showed a physician's order dated 6/30/26, to administer hydrocodone-acetaminophen (narcotic opioid medication) 5-325 mg, one tablet by mouth every four hours as needed for severe pain (a pain level from 8 to 10 out of 10, with 0=no pain and 10= worst pain). Review of Resident 4's MAR for June 2026 showed Resident 4 was administered the hydrocodone-acetaminophen 5-325 mg pain medication on 6/30/26 at 0640 hours. Review of Resident 4's quarterly MDS assessment dated [DATE], showed the ARD (assessment reference date) of 6/30/26. Further review of the MDS assessment showed the administration of the oxygen therapy and opioid medication were not coded. On 7/28/26 at 1429 hours, an interview and concurrent medical record review for Resident 4 was conducted with the MDS Coordinator. The MDS Coordinator stated when completing the MDS assessments, the assessment reference date was the last day of the observation period, to include the assessment data until 2359 hours of that day. The MDS Coordinator reviewed Resident 4's medical record and verified the above findings. The MDS Coordinator stated the MDS assessment was inaccurate. 2. Medical record review for Resident 189 was initiated on 7/27/26. Resident 189 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 189's Weights and Vitals Summary from 6/1/26 to 7/31/26 showed the following weights:- dated 6/1/26, Resident 189 weighed 138 pounds; and- dated 6/30/26, Resident 189 weighed 127 pounds, an 11-pound (-7.97 %) weight loss in one month. Review of Resident 189's MDS assessment dated [DATE], showed under Section K, Resident 189 was coded for the weight-loss of 5% or more in one month and Resident 189 was on a weight-loss regimen. Review of Resident 189's H&P examination dated 7/1/26, showed Resident 189 had fluctuating capacity to understand and make decisions. Review of Resident 189's medical record failed to show documented evidence Resident 189 was on a weight-loss regimen. On 7/29/26 at 0958 hours, an interview and concurrent medical record review for Resident 189 was conducted with the MDS Assistant. The MDS Assistant stated there should be a physician's order for the residents who were on a weight-loss regimen. The MDS Assistant reviewed Resident 189's medical records and verified Resident 189 had a weight loss of 7.97% in one month from 6/1 to 6/30/26. The MDS Assistant was asked if there was a physician's order for Resident 189 to be on a weight-loss regimen. The MDS Assistant reviewed the medical record and verified Resident 189 did not have a physician's order for a weight loss regimen. (continued on next page)		

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 07/31/2026
NAME OF PROVIDER OR SUPPLIER South Coast Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1030 W Warner Ave Santa Ana, CA 92707	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS Assistant reviewed Resident 189's MDS assessment and verified the assessment was coded inaccurately. On 7/30/26 at 1004 hours, an interview was conducted with the DON. The DON stated the MDS nurses were responsible for reviewing the residents' records and coding the MDS assessments. The DON further stated the MDS assessments should be accurate. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to comply with the requirements of DHCS as part of the PASRR process for one of two final sampled residents (Resident 10) reviewed for PASRR. * The facility did not complete a Resident Review (Status Change) screening following a diagnosis of schizophrenia for Resident 10. This failure had the potential for Resident 10 to not receive appropriate care and services due to serious mental illness or intellectual disability not being properly identified and evaluated. Findings: Review of PASRR screening background statement showed The Federal Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) and 42 Code of Federal Regulations Sections 483.100 through-483.138 requires each individual, including, but not limited to, an applicant and resident, regardless of payment source, applying for admission to, or residing in, a Medicaid-certified Nursing Facility (NF) be screened and evaluated for serious mental illness and intellectual disability, developmental disability and related condition(s). Federal law prohibits payment for Nursing Facility services until the PASRR screening has been completed. Medical record review for Resident 10 was initiated on 7/27/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's admission Record dated 6/23/26, showed diagnosis information with undifferentiated schizophrenia. Review of Resident 10's H&P examination dated 7/8/26, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's MDS assessment dated [DATE] showed Resident 10 had diagnosis of schizophrenia. Further review of Resident 10's medical record did not show documented evidence the facility completed a resident review or status change to PASRR. On 7/30/26 at 1427 hours, an interview and concurrent medical record review for Resident 10 was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 10 did not have the diagnosis of schizophrenia from admission until the physician updated Resident 10's diagnosis information on 6/2026 to include schizophrenia. The MDS Coordinator further stated a resident review or status change should have been submitted to PASRR for a change in diagnosis related to serious mental illness. The MDS Coordinator verified Resident 10's medical records did not show any documentation that resident review or status change was submitted to PASRR after updating Resident 10's diagnosis information for schizophrenia. On 7/31/26 at 1135 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the findings above.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 35 final sampled residents (Resident 224) was revised to reflect the resident's current care needs and interventions. * Resident 224's care plan for significant weight change was not revised to address the weight interventions as ordered by the physician. This failure posed the risk of not providing the resident with individualized and person-centered care. Findings: Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed assessments of the residents are ongoing and care plans are revised as the information about the resident and the resident's condition change. The Interdisciplinary Team (IDT) is responsible for evaluation and updating the care plans when there has been a significant change in the resident's condition. Medical record review for Resident 224 was initiated on 7/27/26. Resident 224 was admitted to the facility on [DATE]. Review of Resident 224's Order Summary Report showed the following physician's orders:- dated 5/14/26, to offer Glucerna (nutritional shake) if refuses meals three times a day for weight management; and- dated 6/8/26, to provide carbohydrate controlled diet regular texture with thin liquid consistency and to add diabetic snacks at snack times three times a day. Review of Resident 224's care plan for significant weight loss dated 5/14/26, failed to show documented evidence the interventions included weight management per the physician's order. On 7/29/26 at 1027 hours, an interview and concurrent medical record review for Resident 224 was conducted with RN 4. RN 4 verified the resident had a physician's order for a therapeutic diet, and verified the significant weight loss care plan failed to show any interventions documented. On 7/30/26 at 0959 hours, an interview and concurrent medical record review for Resident 224 was conducted with the DON-STP. The DON-STP was informed and verified the above findings.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for three of 35 final sampled residents (Residents 30, 130, and 224). * The facility failed to ensure the physician was informed when Resident 30 refused her complete blood count (CBC) labs for June 2026. * The facility failed to ensure a skin assessment was conducted for Resident 130 when admitted to the facility. Resident 130 had a skin lesion and the facility failed to provide prompt care and interventions. * The facility failed to ensure the insulin (medication that regulates the amount of sugar level in the bloodstream) injection sites were rotated as ordered by the physician for Resident 224. These failures had the potential to result in ineffective treatment, worsening skin conditions, impaired insulin absorption, tissue damage, and monitoring of the laboratory results which could lead to negative resident outcomes. Findings: 1. Review of the facility's P&P titled Skin Integrity Management dated 5/26/21, showed the complete comprehensive evaluation of the resident upon admission to the facility should be conducted. Identify the resident's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. Medical record review for Resident 130 was initiated on 7/27/26. Resident 130 was admitted to the facility on [DATE]. Review of Resident 130's H&P examination dated 7/18/26, showed Resident 130 had herpes simplex virus (HSV) blisters and lesions in the right buttocks. Review of Resident 130's Order Summary Report dated 7/29/26, showed the following physician's order: - dated 7/18/26, to administer Acyclovir (Antiviral medication) oral tablet 400 mg by mouth three times a day for HSV for 10 Days - dated 7/28/26, to apply Acyclovir (Antiviral medication) external ointment to right gluteal lesion topically six times a day for HSV for seven days. Review of Resident 130's admission assessment dated [DATE], showed the resident was compliant with admission. However, the admission assessment showed Resident 130 refused the skin assessment on the back and buttocks. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/26 at 1357 hours, an interview and concurrent medical record review for Resident 130 was conducted with LVN 5. LVN 5 verified Resident 130 was on antiviral medication for Herpes Simplex Virus, took the medication well, monitored for side effects, and no adverse effect was noted. LVN 5 was asked if there was an assessment done by the licensed nurse on the skin lesion documented upon admission to the facility. LVN 5 verified and acknowledged there was no assessment documented and the resident refused to have a body check when admitted . On 7/29/26 at 1416 hours, an interview and concurrent medical record review for Resident 130 was conducted with the IP-STP. The IP-STP verified Resident 130 was on antiviral medication. The IP-STP was asked if they assessed the resident when she was admitted to the facility and did a body assessment, and why Resident 130 was prescribed an antiviral medication two days after the resident was admitted to the facility. The IP-STP stated Resident 130 sometimes refused to have a body check and the nurses were not able to do the skin assessment. The IP-STP verified there was no skin assessment documented when the resident was admitted to the facility. 2. Review of the facility's P&P titled Insulin Administration (undated) showed the facility should provide a safe administration of insulin. The general guidelines included the insulin injections sites are routinely rotated and documented the injection sites for the presence or absence of any bruising, pain, redness, swelling or unusual marks on or near the injection sites. According to Taylor's Clinical Nursing Skills, seventh edition, the various sites used for subcutaneous injections are the outer aspect of the upper arm, the abdomen (from below the costal margin to the iliac crest), the anterior aspect of the thigh, the upper back, and the upper ventral (upper front) or [NAME]-gluteal area (buttocks). It is necessary to rotate sites or areas for injections to prevent buildup of fibrous tissue and permit complete absorption of the medication. Medical record review for Resident 224 was initiated on 7/27/26. Resident 224 was admitted to the facility on [DATE]. Review of Resident 224's Order Summary Report dated 7/29/26, showed the following physician's orders: - dated 4/2/26, to administer insulin glargine (a long-acting insulin designed to manage high blood sugar levels) 10 units subcutaneously two times a day; and - dated 4/2/26, to administer Humulin R (a short-acting insulin designed to manage high blood sugar levels) as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime. Review of Resident 224's Location of Administration Report for July 2026 showed the Humulin R insulin was administered consecutively on the same injection sites on the following dates and times: (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/4 at 1623 hours and 7/5/26 at 1634 hours, Humulin R insulin was administered to the RUQ (right upper quadrant) of the abdomen, - on 7/7 at 1631 hours and 7/8/26 at 2053 hours, Humulin R insulin was administered to the LLQ (left lower quadrant) of the abdomen, - on 7/20 at 1138 hours, at 2030 hours and 7/21/26 at 1619 hours, Humulin R insulin was administered to the LLQ of the abdomen, and - on 7/22 at 2035 hours, 7/23 at 1626 hours and 7/24/26 at 1626 hours, Humulin R insulin was administered to the LLQ of the abdomen. On 7/29/26 at 1027 hours, an interview and concurrent medical record review for Resident 224 was conducted with RN 4. RN 4 verified Resident 130's physician order for the insulin. RN 4 was asked for the administration of insulin injections sites. RN 4 verified the location of injections for July 2026 was documented. RN 4 was asked for the significance as to why the injection sites needed to be rotated. RN 4 stated to prevent any complications on administration of insulin injection sites. RN 4 verified the insulin injection sites were not rotated. On 7/30/26 at 0959 hours, an interview and concurrent medical record review for Residents 130 and 224 was conducted with the DON-STP. The DON-STP was informed and verified the above findings. 3. Review of the facility's P&P titled Lab and Diagnostic Test Results &ndash; Clinical (undated) showed the physician will identify and order diagnostic and laboratory testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record. Review of the facility's P&P titled Physician Orders dated 3/22/22, showed the laboratory orders will include the name of the test desired, the frequency and reason for the test and associated diagnosis. Documentation pertaining to the physician orders will be maintained in the resident's medical record. Medical record review for Resident 30 was initiated on 7/27/26. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's MDS assessment dated [DATE], showed Resident 30 had moderately impaired cognitive skills for daily decision making. Review of Resident 30's Order Summary Report dated 7/29/26, showed a physician's order dated 5/6/26, for monthly CBC (complete blood count) and BMP (basic metabolic panel) blood laboratory tests. Review of Resident 30's medical record failed to show documented evidence Resident 30 had the CBC (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laboratory test done in June 2026. Review of the untitled facility document showed documentation Resident 30 refused the CBC and BMP laboratory tests for the laboratory collection dates on 6/4 and 6/5/26. Review of Resident 30's medical record failed to show the documentation the physician was informed of Resident 30's refusal for the ordered CBC laboratory test. On 7/29/26 at 1447 hours, an interview and concurrent medical record review for Resident 30 was conducted with RN 1. RN 1 reviewed Resident 30's medical record and verified the CBC laboratory results were not available for June 2026. RN 1 reviewed the laboratory portal and stated Resident 30 had the CBC laboratory test scheduled on 6/5/26, however the documentation showed the request was cancelled. When asked as to why the CBC laboratory test was cancelled, RN 1 stated there was no documentation in the resident's medical record why the laboratory test was cancelled. On 7/30/26 at 0930 hours, a follow-up interview and concurrent medical record review for Resident 30 was conducted with RN 1. RN 1 stated the laboratory requisitions for Resident 30 on 6/4 and 6/5/26, showed the resident refused the laboratory tests. RN 1 stated if the resident refused the laboratory test, the licensed nurse should inform the physician and document the notification. RN 1 verified there was no documentation the physician was informed of Resident 30's refusal for the laboratory tests on 6/4 or 6/5/26. On 7/30/26 at 1004 hours, an interview was conducted with the DON. The DON stated if the resident refused the ordered laboratory test, the licensed nurse should explain the risks and benefits and if the resident still refused, the physician should be informed. The DON further stated if the laboratory test was rescheduled and the resident refused again, the physician should be notified and the licensed nurse should document the notification. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide RNA services as ordered by the physician for one of one final sampled resident (Resident 178) reviewed for ROM. * The facility failed to provide documented evidence that the splint for Resident 178 was applied for up to three hours per day as ordered by the physician. This failure had the potential to result in the decline in Resident 178's ROM which could lead to further deterioration in the resident's physical well- being. Findings: Review of the facility's P&P titled Restorative Nursing Services (undated) showed the residents will receive restorative nursing care as needed to help promote optimal safety and independence. Review of the facility P&P titled Resident Mobility and Range of Motion (undated) showed the resident with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. On 7/27/26 at 0904 hours, Resident 178 was observed laying in her bed. A splint was observed on the bed side drawer and not on Resident 178's hand. On 7/30/26 at 0859 hours, Resident 178 was observed sitting on a wheelchair on the right side of her bed. Resident 178 was not observed with the splint on her hand. Medical record review for Resident 178 was initiated on 7/27/26. Resident 178 was admitted to the facility 2/2/23. Review of Resident 178's H&P examination dated 9/16/25, showed Resident 178 had fluctuating capacity to understand and make decisions. Review of Resident 178's Order Summary Report showed a physician order dated 3/13/26, for RNA to apply resting hand splint to right hand for up to three hours every day for five times a week as tolerated with skin checks and to premedicate if indicated. Review of Resident 178's MDS assessment dated [DATE], showed Resident 178 had moderate cognitive impairment and had impairment on one side of upper and lower extremity. Review of Resident 178's Restorative Nursing weekly/monthly Progress report dated 7/16, 7/23, and 7/30/26, showed applied right-hand splint 5 times a week, average wear time was four hours, and skin check was completed. Review of Resident 178's documentation for RNA services for July 2026 showed the splint was applied five days a week under the task to apply resting hand splint to right hand for up to three hours daily, five days a week, with skin checks and pre-medication if indicated. Further review of the document did not show when the splint was applied, when it was removed, or how long the resident tolerated the splint on her right hand each day, even though the physician's order required the splint to be applied for up to three hours a day as tolerated for five days a week. On 7/30/26 at 0924 hours, an interview and medical record review for Resident 178 was conducted with RNA 1. RNA 1 stated Resident 178 had been receiving RNA services, which included the application of a splint to her right hand. When asked how long the splint was applied each day, RNA 1 stated he applied it for approximately four hours each day. However, RNA 1 was unable to provide documented evidence showing when the splint was applied, when it was removed, and how long the resident tolerated the splint on her right hand each day. RNA 1 stated he did not document the times the splint was applied or removed, nor the duration of the resident's tolerance of the splint each day. On 7/31/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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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	
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary GT care and services for one of four final sampled residents (Resident 9) reviewed for tube feeding. * The facility failed to ensure Resident 9 was positioned safely at 30 to 45 degrees during the enteral feeding via GT. Additionally, the facility failed to ensure Resident 9's water flush connected via feeding pump was labeled. These failures posed the risk for developing complications related to the resident's GT. Findings: On 7/27/26 at 0937 hours, an observation was conducted of Resident 9 inside her room. Resident 9 was observed lying flat in bed with her head resting on one pillow. Resident 9 was receiving an enteral feeding and water via feeding pump. The feeding pump was on, and the water bag connected to the feeding pump was not labeled with the date and time when it was connected to Resident 9. Medical record review for Resident 9 was initiated on 6/27/26. Resident 9 was admitted to the facility on [DATE], with diagnoses including encounter for attention to gastrotomy and oral phase dysphagia. Review of Resident 9's Order Summary Report showed the following physician's orders:- dated 5/4/26, to elevate head of bed at least 30 degrees during feeding and for one hour after feeding;- dated 5/6/26, to administer Glucerna (enteral feeding formula) 1.2 at 60 ml per hour via the enteral pump to provide 1200 ml/1440 calories in 20 hours; and- dated 5/27/26, to administer H2O (water) at 20 ml per hour for 20 hours to provide goal of 400 ml. Review of Resident 9's H&P examination dated 5/15/26, showed Resident 9 lacks capacity to understand and make medical decisions. Review of Resident 9's care plan for enteral feeding tube initiated on 5/15/26, showed Resident 9 had an enteral feeding tube to meet nutritional needs failure to thrive, Parkinson's disease and dysphagia. Interventions included to keep the head of bed elevated to 30-40 degrees during feeding. On 7/27/26 at 1010 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 stated Resident 9 had been lying flat in bed since she arrived at work at 0700 hours. Resident 9 continued to be observed lying flat in bed with her head resting on one pillow. The enteral feeding and water bag via feeding pump were connected to Resident 9 and the feeding pump was observed on. On 7/27/26 at 1045 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 stated the enteral feeding set up were changed daily with a new feeding formula, new enteral tubing, new water bag, and new syringe. LVN 4 further stated the water bag should be labeled with the resident's name, date, and time when the water bag was changed. LVN 4 verified Resident 9 water bag was not labeled with name, date, and time it was changed. LVN 4 verified Resident 9 was lying flat in bed with her head resting on one pillow while Resident 9 was receiving enteral feeding and water. LVN 4 stated Resident 9's head of bed should be elevated at least 40 degrees to prevent aspiration. On 7/31/26 at 1135 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the findings above.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to ensure one of two final sampled residents (Resident 4) reviewed for respiratory care were provided the appropriate respiratory care. * The facility failed to ensure Resident 4's nasal canula tubing (dated 7/2/26) was changed weekly as per the physician's order. This failure had the potential to affect the respiratory health and well-being of Resident 4. Findings: Review of the facility's P&P titled Oxygen Administration (undated) showed to verify there is a physician's order for the procedure. To review the physician's order or facility protocol for oxygen administration. On 7/27/26 at 0938 hours, during the initial tour of the facility. Resident 4 was observed in bed and receiving continuous oxygen at two liters per minute via nasal canula. The nasal canula tubing was observed labeled with the date of 7/2/26. Medical record review for Resident 4 was initiated on 7/27/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's Order Summary Report dated 7/28/26, showed the following physician's orders dated 6/30/26:- To administer continuous oxygen at two liters per minute via nasal canula for hypoxia (low levels of oxygen in the body tissues) every shift, and- To change the oxygen tubing weekly. On 7/27/26 at 1114 hours, an interview and concurrent observation was conducted with LVN 1 for Resident 4. LVN 1 stated the oxygen tubing should be changed at least once a week. A concurrent observation was conducted at Resident 4's bedside and LVN 1 verified Resident 4's nasal canula tubing was dated 7/2/26. LVN 1 stated the nasal canula tubing should have been discarded and changed. On 7/28/26 tat 1440 hours, a follow-up interview and concurrent medical record review for Resident 4 was conducted with LVN 4. LVN 4 reviewed Resident 4's medical records and verified the above findings. On 7/30/26 at 1004 hours, an interview was conducted with the DON. The DON stated the oxygen tubing should be changed every seven days and as needed. The DON further stated the oxygen tubing should be labeled with the date so the staff would know when the oxygen tubing should be changed for infection control purposes. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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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	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to follow pharmaceutical procedures for two of 35 final sampled residents (Residents 4 and 6). * Resident 6's Insulin Glargine (a long-acting insulin) was not administered as ordered by the physician. * Resident 4's controlled medication administration was not appropriately reconciled and documented on the MAR. These failures had the potential for Resident 6 to experience undesirable negative outcomes related to BS levels and resulted in inaccurate controlled medication reconciliation records for Resident 4, with the potential for a controlled medication diversion. Findings: 1. Review of the facility's P&P titled Medication Administration General Guidelines effective 10/2017 showed medications are administered in accordance with the physicians' orders. Medical record review for Resident 6 was initiated on 7/24/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Order Summary showed the following physicians' orders:- dated 6/22/26, for insulin glargine 27 units to be administered subcutaneously at bedtime for diabetes mellitus; and- dated 6/22/26, for regular human insulin (a short-acting insulin) to be administered per the sliding scale subcutaneously before meals and at bedtime. The sliding scale showed the following: - for a BS of 0-150 mg/dL, no regular insulin coverage is needed; - for a BS of 151 &ndash; 200 mg/dL, administer 2 units of regular insulin; - for a BS of 201 &ndash; 250 mg/dL, administer 4 units of regular insulin; - for a BS of 251 &ndash; 300 mg/dL, administer 6 units of regular insulin; - for a BS of 301 &ndash; 350 mg/dL, administer 8 units of regular insulin; - for a BS of 351 &ndash; 400 mg/dL, administer 10 units of regular insulin; and- for a BS of 491 mg/dL or more, administer 12 units of regular insulin, and to call the physician if the resident's BS is less than 70 mg/dL or greater than 400 mg/dL. Further review of Resident 6's Order Summary failed to show ordered parameters to hold the insulin glargine medication. Review of Resident 6's MAR for July 2026 showed insulin glargine 27 units was held for the following dates:- dated 7/3/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed;- dated 7/5/26 at 2100 hours, the chart code showed the parameters were out of the ordered range and the medication was not given;- dated 7/8/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed;- dated 7/9/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed;- dated 7/13/26 at 2100 hours, the chart code showed the resident's BS was within range and no (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coverage was needed;- dated 7/18/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed;- dated 7/21/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed;- dated 7/24/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed;- dated 7/25/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed; and- dated 7/26/26 at 2100 hours, the chart code showed the resident's BS was within range and no coverage was needed. Review of Resident 6's MAR for July 2026 showed regular human insulin was held appropriately per the ordered sliding scale on the same dates as the scheduled insulin glargine for the following dates:- dated 7/3/26 at 2100 hours, for a BS of 123 mg/dL;- dated 7/5/26 at 2100 hours, for a BS of 90 mg/dL;- dated 7/8/26 at 2100 hours, for a BS of 142 mg/dL;- dated 7/9/26 at 2100 hours, for a BS of 89 mg/dL;- dated 7/13/26 at 2100 hours, for a BS of 97 mg/dL;- dated 7/18/26 at 2100 hours, for a BS of 150 mg/dL;- dated 7/21/26 at 2100 hours, for a BS of 144 mg/dL;- dated 7/24/26 at 2100 hours, for a BS of 140 mg/dL;- dated 7/25/26 at 2100 hours, for a BS of 97 mg/dL; and- dated 7/26/26 at 2100 hours, for a BS of 122 mg/dL. On 7/30/26 at 0813 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON stated Resident 6's insulin glargine was administered routinely at bedtime, and there were no ordered hold parameters. The DON reviewed Resident 6's MAR for July 2026 and verified the above doses of the insulin glargine showed they were held. However, the DON stated the insulin glargine doses have been administered as ordered. 2. Review of facility's P&P titled Controlled Medications effective date 4/2008 showed under procedures Section C, when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 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 the initials of the nurse administering the dose on the MAR after the medication is administered. Medical record review for Resident 4 was initiated on 7/28/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 6/30/26, to give hydrocodone-acetaminophen (Norco, controlled pain medication) 5-325 mg one tablet by mouth every four hours as needed for severe pain level of 8-10 (using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain), not to exceed 3 g/24 hours from all the sources. Review of Resident 4's H&P examination dated 7/8/26 showed Resident 4 had the capacity to understand and make decisions. Review of Resident 4's Antibiotic or Controlled Drug Record (undated) showed Norco 5-325 mg one tablet was dispensed and signed out on 7/28/28 at 0016 hours. Review of Resident 4's MAR for July 2026 failed to show documentation of the administration for (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydrocodone-acetaminophen 5-325 mg one tablet on 7/28/26 at 0016 hours. On 7/28/26 at 1142 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. LVN 1 verified the above findings. On 7/30/26 at 1348 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON verified one tablet of hydrocodone-acetaminophen 5/325 mg was pulled on 7/28/26 at 0016 hours. The DON verified there was no documented evidence on the MAR. The DON further stated the process when a resident required pain medication was for the licensed nurse to assess the resident, check the order, pull the medication, sign it on the individual narcotic record, administer to the resident, then document on the MAR. The DON was informed and acknowledged the above findings.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services for two of five medication carts (Medication Carts C and E) to ensure proper storage of the medications. * The facility failed to ensure the orally administered medications were stored separate from the externally used medications in Medication Cart C. * The facility failed to ensure medications brought in from home were labeled and not stored in Medication Cart E. In addition, the facility failed to ensure a multidose insulin vial was labeled when it was opened. These failures had the potential to have negative impact on the residents' well-being, and the potential for the medications to be contaminated, losing the stability and effectiveness. Findings: 1. Review of the facility's P&P title Storage of Medications revised dated 1/2025 showed orally administered medications are kept separate from external used medication, such as suppositories, liquids, and lotions. On 7/28/26 at 1052 hours, a medication cart inspection for Medication Cart C was conducted with LVN 1. The following was observed: - two boxes of Alendronate Sodium (medication use to treat or prevent thinning of the bone) 70 mg tablet oral medication were stored with five bottles of Artificial Tears lubricant eye drops in the same compartment in the first drawer of Medication Cart C; and - one box of Pradaxa (blood thinner), one bottle of Alkums Antacid tablet (medication reduce acid in stomach) oral medication, one Enoxaparin Sodium (blood thinner medication) injection, one box of Lidocaine Patch 5% (medication to treat pain), and one tube of Diclofenac Sodium topical gel (medication to treat pain) were all stored in the same compartment in the fourth drawer of Medication Cart C. LVN 1 verified the above findings. LVN 1 stated internal and external medications should not be stored in the same compartment because the medications were administered via different routes and could cause medication errors and contamination. On 7/30/26 at 1348 hours, an interview was conducted with the DON. The DON was informed and acknowledged of the above findings. The DON further stated that external medication and internal medications should be stored separately to prevent contamination and potential medication error. 2. Review of the facility P&P titled Medication Storage in the Facility (undated) showed medications and biologicals are stored safely, securely, and properly, following manufacturers recommendation are those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reorder from the pharmacy if a current order exist. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/26 at 1402 hours, an observation of Medication Cart E and concurrent interview was conducted with LVN 9. The following was observed: - three eye drop medications, including dorzolamide hydrochloride/timolol maleate (used to lower eye pressure for certain people with glaucoma or high eye pressure), latanoprost ophthalmic solution (prescription medications used to lower high fluid pressure inside the eye), and one unlabeled eye drop bottle, were found stored inside an unlabeled Ziplock bag. LVN 9 verified the medications belonged to a recently admitted resident and acknowledged the medications should have been labeled with the resident's name and stored in the designated medication storage area while awaiting family pick-up; and - two opened multidose insulin vials were observed stored inside a plastic bottle labeled to discard after 31 days once opened; however, the vials did not contain any open dates. LVN 9 confirmed the vials were not dated upon opening and stated he was unable to determine how long they had been opened or whether they were safe to administer. On 7/31/26 at 0834 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and facility P&P review, the facility failed to maintain staffing documentation of the education regarding the risks and benefits and the offering of the COVID-19 vaccine. * CNA 1 was not provided education regarding the risks, benefits and not offered the COVID-19 vaccine. In addition, the facility failed to ensure accurate tracking of CNA 1's vaccination status as per the facility's P&P. This failure placed the residents and staff members at risk for increased risk of infection and transmission of COVID-19. Findings: Review of the facility's P&P titled Coronavirus Disease (COVID-19) - Vaccination of Staff revised 2/16/23, showed before offering the COVID-19 vaccine, the staff member is provided with education regarding the benefits and risks, and potential side effects associated with the vaccine. Booster vaccine doses are encouraged/provided in accordance with current CDC guidance. Under the section Documentation and Reporting showed: 1. The infection preventionist maintains a tracking worksheet of staff members and their vaccination status. 2. The tracking worksheet provides the most current vaccination status of all staff who provide any care, treatment, and other services for the facility and/or its residents. The worksheet includes: g. The vaccination status including the specific vaccine received, dates of each dose, date of the next schedule dose (for a [NAME]-dose vaccine), and any booster dates. 3. The facility maintains documentation related to staff COVID-19 vaccination that includes, at a minimum, the following (if applicable): a. That staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; b. That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; c. A copy of the informed consent; and d. Verification of vaccination or documentation of exemption/delay. On 7/30/26 at 0646 hours, an interview was conducted with the IP. The IP stated the COVID-19 vaccine was offered yearly to the staff. The IP stated she was responsible for tracking the staff members' COVID-19 immunization status on a log. On 7/30/26 at 0933 hours, a follow-up interview and concurrent facility document review was conducted with the IP. The IP stated she kept a log of the COVID-19 vaccination status of the staff members in the facility. The IP stated the COVID-19 vaccination log contained information on the staff members who received the COVID-19 vaccine and the staff members who declined the COVID-19 vaccine. The IP stated the vaccination log of the staff members' vaccination status included the staff members' previous to the most current COVID-19 vaccinations. Review of the facility's untitled document (undated) showed the name of the staff members and the staff members' COVID-19 vaccine type and vaccination date. The IP reviewed CNA 1's COVID-19 Vaccination Record and verified the record showed CNA 1 received the third COVID-19 dose on 10/27/21. However, further review of the facility's untitled document showed CNA 1 refused and blank under the COVID-19 vaccination date. When asked about the IP's process for the offering of and the education on the COVID-19 vaccine to the staff, the IP stated the facility only had the documentation for the staff members who consented and received the COVID-19 vaccine. The IP verified the facility did not keep documentation of the offering of COVID-19 vaccine and the education on the risks and benefits of the COVID-19 vaccine for the staff members who declined the vaccine. The IP verified the facility did not have any documentation the COVID-19 vaccine was offered and the education about the risks and benefits of the COVID-19 vaccine for CNA 1. On 7/30/26 at 1004 hours, an interview was conducted with the DON. The DON stated the IP was responsible for the screening and tracking of COVID-19 vaccine for the residents and staff members. The DON stated (continued on next page)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility should have the documentation of the education provided on the risks and benefits of the COVID-19 vaccine and each staff members' vaccination status to document whether the current COVID-19 vaccine was received or declined. On 7/30/26 at 1121 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to ensure one of three glucometers (Glucometer A) was calibrated and the quality control was performed as scheduled. * The facility failed to ensure Glucometer A was calibrated and quality control was performed on 7/27/26. This failure had the potential for residents requiring blood glucose checks to have inaccurate readings. Findings: Review of the facility's document title EvenCare G2 User's Guide showed the purpose of the control solution testing is to make sure that the EvenCare G2 Meter and the EvenCare G2 Test Strips are working properly. Review of the facility's document titled Quality Control Record dated 7/2026 for Medication Cart D, showed no documented evidence the glucometer with serial number 48072751 was calibrated, had quality control check and the log was blank for 7/27/26. On 7/28/26 at 1230 hours, a concurrent inspection of Medication Cart D and interview with LVN 7 was conducted. LVN 7 verified the above findings. LVN 7 stated the licensed nurses on the 11-7 shift (2300 to 0700 hours) calibrated the glucometer and performed the quality control. LVN 7 further stated the glucometers and quality controls were checked nightly to ensure the facility had accurate blood sugar level check for the residents. On 7/30/26 at 1404 hours, an interview was conducted with the DON . The DON verified the above findings. The DON further stated the glucometer quality control performance testing should be done on a daily basis on 11-7 shift to ensure accurate blood sugar reading.		