

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Mesa Verde Post Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 661 Center Street Costa Mesa, CA 92627	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 report and investigate a resident-to-resident altercation to the State Survey Agency in accordance with the state law established procedures for two of five sampled residents (Residents 1 and 4). * Resident 1 stated a male resident (Resident 4) walked into her room unsupervised, screamed and threatened her. The incident was not reported to the appropriate parties (CDPH, the Ombudsman, the residents' responsible parties, the MD and the police department) nor was an investigation initiated. This failure had the potential to negatively impact the well-being of the resident of the facility. Findings: Review of the facility's P&P titled Abuse Prevention and Management revised 5/2024 showed the facility will report all allegation of abuse, and criminal activity as required by law and regulations to the appropriate agencies. The P&P also stated to address the health, safety, welfare, dignity and respect of residents, the reports of resident abuse, mistreatment, neglect, exploitation, injuries of an unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated. Review of the facility's P&P titled Unusual Occurrence Reporting revised 5/2024 showed the facility will follow all applicable, state and federal laws and regulations regarding the reporting of unusual occurrences. On 8/16/25 at 0930 hours, the CDPH L&C Program received a complaint alleging Resident 1 stated a male resident walked into her room unsupervised on 8/16/25. Resident 1 alleged the male resident screamed and threatened her, making her feel very unsafe. Resident 1 called her family member to pick her up and take her home. On 8/29/25 at 0638 hours, an interview was conducted with RN 1. RN 1 stated Residents 1 and 3 were roommates. RN 1 further stated Resident 3's Family Member informed him Resident 4 wandered to Residents 1 and 3's bedroom. RN 1 stated Resident 1 did not feel comfortable and went home that evening. a. Closed medical record review for Resident 1 was initiated on 8/29/25. Resident 1 was admitted to the facility on [DATE], and discharged on the same day. Resident 1 was alert, and oriented to time, place and persons by the admitting nurse. Review of Resident 1's medical record failed to show documented evidence of the incident. In addition, there was no documentation the incident was reported to the CDPH, Ombudsman, residents' responsible parties, MD, and the police department were notified. b. Medical record review for Resident 4 was initiated on 8/29/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed a BIMS score of 3 (meaning severe cognitive impairment.) Further review of Resident 4's medical record failed to show documented evidence of the incident with Resident 1. There was no documentation of the resident's wandering episode and verbal outbursts towards Resident 1 on 8/16/25. On 8/29/25 at 0824 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated she witnessed Resident 4 enter Resident 1's room. RN 2 stated she redirected and reoriented Resident 4 out of the room. RN 2 further stated Resident 1 requested to be discharged AMA after the incident. RN 2 informed the Administrator of Resident 1's request to discharge AMA, and of Resident 4's wandering episode to Resident 1's room. RN 2 verified, there was no written documentation of the incident in either Residents 1 and 4's medical records to address Resident 4's wandering behavior to Resident 1's room and Resident 1's response to Resident 4's wandering to her room. RN 2 verified she should have documented the incident. On 8/29/25 at 1101 hours, a telephone interview was conducted with Resident 1. Resident 1 stated on the day of admission, 8/16/25, a man in a wheelchair (later identified as Resident 4) suddenly entered her room, yelled and screamed toward Resident 1's direction. Resident 1 stated Resident 4 was screaming I'm gonna kill someone. she's raping my wife and what is she doing here. Resident 1 stated a nurse immediately entered and redirected the resident back to his room. However, Resident 4 reportedly returned to Resident 1's room three times in 20 minutes, toppled over the overbed table by Resident 1's bedside and continued to scream at Resident 1. Resident 1 further stated I was shaking and hysterically crying. Resident 1 stated she didn't trust the facility when she was offered another room by nurse. Resident 1 further stated Resident 3's Family Member assisted the staff in removing Resident 4 out of the room. Resident 1 decided to discharge from the facility AMA that same evening. On 8/29/25 at 1142 hours, an interview and concurrent medical record review for Resident 1 was conducted with the MDS Coordinator. The MDS Coordinator verified the resident-to-resident altercation on 8/16/25, was not documented, nor was there an incident report. On 8/29/25 at 1215 hours, an interview was conducted with Resident 3 and Family Member 1. Resident 3 and Family Member 1 stated Resident 4 came into their room in his wheelchair and yelled I wanna kill somebody</p>		