STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555093	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Edna Subacute and Rehabilitation Center	1929 N. Fairview Street Santa Ana, CA 92706

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, facility record review, and facility P&P review, the facility failed to protect the resident's right to be free from physical abuse by a resident for one of two sampled residents (final sampled resident, Resident 113) reviewed for abuse. * Resident 113 was hit in the face with a rehabilitation dowel by another resident (Resident 86). This failure resulted in Resident 113 suffering pain to the left side of his face and experiencing feelings of anger. Findings: Review of the facility's P&P titled Alleged or Suspected Abuse and Crime Reporting revised 10/2022 showed each resident has the right to be free from abuse. Physical abuse includes, but is not limited to, hitting, slapping, pinching and kicking. The facility will implement policies and procedures to prevent and prohibit all types of abuse. Medical record review for Resident 113 was initiated on 5/7/25. Resident 113 was admitted to the facility on [DATE]. Review of Resident 113's BIMS dated 5/5/25, showed Resident 113 was cognitively intact. On 5/7/25 at 0903 hours, an interview was conducted with Resident 113. Resident 113 was asked to describe the physical altercation between himself and his roommate (Resident 86). Resident 113 stated on 5/4/25 at approximately 2030 hours, he was lying in bed watching television. Resident 113 stated his roommate (Resident 86) started cursing at him and told him to turn off his television. Resident 113 stated he then lowered the volume of his television. Resident 113 stated Resident 86 then walked over to his bed and hit him in the face with a pole (later identified as a rehabilitation dowel). Resident 113 stated the dowel was solid and when it struck his face it hurt, causing pain to his face. Resident 113 stated before Resident 86 could hit him again, he grabbed the dowel, preventing Resident 86 from striking him again. Resident 113 stated the incident made him feel angry. Resident 113 stated he felt pain to his jaw and felt swelling to his face. Resident 113 stated he had difficulty chewing after the incident and informed the dietary staff and would prefer a soft diet. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 113's Nursing Note dated 5/4/25, showed at 1945 hours, RN 3 responded to Resident 113's room. Residents 86 and 113 had a resident-to-resident altercation. Resident 113 was hit with a dowel by Resident 86 because Resident 113 refused to turn off his television when asked by Resident 86. Also, a water pitcher full of water was thrown on Resident 113's bed. Resident 113 was assessed and noted with redness to the left side of his face. Resident 113 complained of pain on the left side of his face and was given Tylenol for pain. A cold compress was also applied to Resident 113's face. Review of Resident 113's SBAR dated 5/4/25 at 2247 hours, showed at 1945 hours, Resident 113 had an altercation and physical abuse happen to him. Resident 113 was being monitored for emotional distress due to a resident-to-resident altercation. Review of Resident 86's Nursing Note dated 5/4/25 at 2012 hours, showed on 5/4/25 at approximately 1945 hours, the CNA responded to Residents 113 and Resident 86's room. The CNA saw both residents holding onto a dowel. Resident 113 was lying in his bed and Resident 86 was standing in front of him. As per Resident 113, Resident 86 came to his bed and hit him with the dowel on the left side of his face. When Resident 86 was asked why he tried to hit Resident 113, Resident 86 stated he got mad when he asked Resident 113 to turn off/lower the television volume and Resident 113 just ignored him. Review of Resident 86's care plan titled Potential Behavioral Disturbance related to diagnosis of schizoaffective disorder initiated 11/9/23, showed Resident 86 had behavior of physical aggressiveness/combativeness (per Resident 86's family). Interventions included to monitor Resident 86 for behavior of physical aggression/combativeness. On 5/7/25 at 1436 hours, an interview was conducted with CNA 11. CNA 11 stated on 5/4/25 in the evening, she heard screaming coming from Residents 113 and 86's room. CNA 11 stated when she entered the room, she saw Resident 113 lying on his bed and Resident 86 standing next to Resident 113's bed. CNA 11 stated the residents were struggling to gain control of a dowel. CNA 11 stated she was able to gain possession of the dowel and confiscated the dowel. CNA 11 stated Resident 113 told her that he was struck on the head with the dowel and then grabbed the dowel in an attempt to prevent Resident 86 from hitting him again. CNA 11 stated Resident 113 told her that he did not do anything wrong to cause Resident 86 to hit him. CNA 11 sated Resident 113 complained of pain to his face. CNA 11 stated Resident 86 told her that Resident 113 had his TV too loud. On 5/8/25 at 1033 hours, an interview was conducted with OT 1. OT 1 stated Resident 113 currently had no orders for PT or OT services. OT 1 stated Resident 113 had no orders for the use of a dowel. OT 1 stated no residents at the facility should be in possession of a dowel without staff present, to ensure the residents' safety. OT 1 stated she did not know how Resident 113 gained possession of the dowel. On 5/8/25 at 1603 hours, a concurrent interview, medical record review, and facility photograph review was conducted with the DON. The DON stated on the evening of 5/4/25, an incident occurred involving Residents 86 and 113. The DON stated Resident 113 told her the following information specific to the incident. Resident 113 was lying in bed watching television and Resident 86 asked him to turn off his TV. Resident 86 then walked over to Resident 113's bed and hit him on the let side of the face with a dowel. Resident 113 then grabbed the dowel, and both residents struggled to gain control of the dowel. CNA 11 had entered the room and was able to separate the residents and obtain possession of the dowel. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON verified Resident 86's care plan titled Potential Behavioral Disturbance related to diagnosis of schizoaffective disorder initiated 11/9/23, showed Resident 86 had behavior of physical aggressiveness/combativeness (per Resident 86's family). The DON stated Resident 86 should not have possessed a dowel without a staff supervision, to ensure for resident safety. The DON provided a photograph of the confiscated dowel which was identified by a serial number on this side of the dowel. * The dowel was obtained from the rehabilitation department. The Maintenance Supervisor subsequently measured and weighed the dowel. On 5/8/25 at 1555 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor measured and weighed the dowel. The Maintenance Supervisor stated the dowel was constructed of a PVC pipe. The dowel measured 31.5 inches in length, 3 quarter inches in width, had a circumference of 1 1/4 inches, and weighed 1.4 pounds. On 5/8/25 at 1243 hours, an interview and concurrent facility record review was conducted with the Administrator. Review of the facility's Verification of Incident Investigation Administrative Summary dated 5/8/25, showed the facility conducted an investigation specific to the incident involving Residents 86 and 113. The Administrative Summary showed the facility had substantiated the incident because Resident 113 was actually struck. The Administrator stated he substantiated Resident 113 was struck with the dowel and Resident 113 had redness to his face consistent with where Resident 113 stated he was struck with the dowel.