STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Hills Health and Rehabilitation Center	24452 Health Center Drive Laguna Hills, CA 92653

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 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** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the need for one of nine sampled residents (Resident 3). * The facility failed to ensure Resident 3's scheduled medications for the morning shift were administered within 60 minutes of the scheduled time as per the facility's P&P. This failure had the potential to negatively impact Resident 3's health outcomes. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the medications are administered within one hour of their prescribed time unless otherwise specified (for example, before and after meal orders). During the initial tour of the facility on 9/18/24 at 0815 hours, an interview was conducted with Resident 3. Resident 3 stated a staff took his blood pressure reading at around 0738 hours and his blood pressure was higher than 175 mmHg. Resident 3 stated the nurse did not administer his morning medications yet. Resident 3 was upset and had to call the nurse to give his scheduled medications and the nurse was late on administering his medications. On 9/18/24 at 0950 hours, an observation was conducted with CNA 1 for Resident 3. Resident 3 pressed his call light button and CNA 1 came into Resident 3's room. When CNA 1 asked what Resident 3 needed, Resident 3 asked for his nurse to give his morning medication. On 9/18/24 at 0957 hours, an observation was conducted with LVN 1 for Resident 3. LVN 1 came into Resident 3's room and Resident 3 asked for his morning medications. On 9/18/24 at 1023 hours, an observation and concurrent interview was conducted with LVN 1 for Resident 3. LVN 1 went into Resident 3's room and took his blood pressure reading using a digital machine which showed a blood pressure reading of 179/110 mmHg. After, LVN 1 took Resident 3's blood pressure reading using a manual blood pressure cuff. LVN 1 stated Resident 3's blood pressure reading was 164/84 mmHg. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 1039 hours, a medication administration observation was conducted with LVN 1 for Resident 3. LVN 1 administered the following medications to Resident 3: - losartan (medication to lower blood pressure) 50 mg one tablet; - aspirin EC (antiplatelet medication) 81 mg one tablet; and - Voltaren (pain mediation) gel two grams. Medical record review for Resident 3 was initiated on 9/18/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/13/24, showed Resident 3 had the capacity to make medical decisions. Review of Resident 3's Order Summary Report for September 2024, showed the following physician's orders: - dated 2/13/24, to administer aspirin EC low dose tablet 81 mg one tablet by mouth one time a day for CVA prophylaxis. - dated 4/5/24, to administer losartan 50 mg by mouth one tablet one time a day for hypertension (high blood pressure), hold if SBP less than 110 mmHg. - dated 7/3/24, to apply diclofenac sodium external gel 1% topically to the affected site three times a day for pain. Review of Resident 3's Medication Administration Audit Report for September 2024 showed LVN 1 administered the losartan, aspirin, and Voltaren gel medications on 9/18/24 at 1044 hours. On 9/18/24 at 1105 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above finding. LVN 1 stated she had one hour before and one hour after the scheduled medication time to administer Resident 3's medications. LVN 1 stated she had many distractions, which was why she gave Resident 3's medication more than 60 minutes of the scheduled administered time. On 9/20/24 at 0910 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the above finding.