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	01/03/2025

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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, and medical record review, the facility failed to provide the reasonable accommodations to meet the care needs for one of 10 sampled residents (Resident 7). * The facility failed to ensure Residents 7's call light was kept within the resident's reach. This failure had the potential to negatively impact the resident's psychosocial well-being or result in a delay to provide care and services to the resident. Findings: Medical record review for Resident 7 was initiated on 12/19/24. Resident 7 was admitted to the facility on [DATE] andreadmitted on [DATE]. Review of Resident 7's MDS dated [DATE], showed under Section B, Resident 7 usually made self-understood and usually understood others. On 12/20/24 at 0848 hours, Resident 7 was observed screaming and asking for someone to give him sugar. LVN 6 was observed standing by the medication cart next to Resident 7's room. On 12/20/24 at 0855 hours, Resident 7 was observed lying on her bed with the head of the bed elevated and the breakfast tray was on the bedside table in front of him. Resident 7's call light was observed clipped to the head of the bed on the left side corner of the bed mattress. On 12/20/24 at 0905 hours, an interview was conducted with Resident 7. Resident 7 stated it was hard to get help in the facility. Resident 7 stated he could not find his call light, which made him feel frustrated. Resident 7 stated he needed to yell out for help, but no staff ever came to help him most of the time. Resident 7 then asked to get him sugar. On 12/20/24 at 0907 hours, an interview was conducted with LVN 6. LVN 6 stated Resident 7 was usually able to use call light to get help. LVN 6 verified Resident 7's call light was not within the resident's reach and clipped on the corner of Resident 7's bed mattress. LVN 6 was then observed placing Resident 7's call light within reach and instructed the resident to use the call light when he needed help.

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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(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 - Potential for minimal harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to report the allegation of staff-to-resident abuse timely as per the facility's P&P for one of 10 sampled residents (Resident 4). This failure had the potential for a resident abuse not being identified and reported at a facility with a highly vulnerable resident population and posed the risk of continued abuse of the residents. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting revised July 2017 showed an alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: (a) Two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or (b) 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. Closed medical record review for Resident 4 was initiated on 12/6/24. Resident 4 was admitted to the facility on [DATE]. Review of the SOC 341 - Report of Suspected Dependent/Elder Abuse dated 11/23/24, showed the facility had reported an allegation of abuse to the CDPH, L&C Program on 11/27/24 at 1942 hours, Resident 4 as the alleged victim and LVN 3 as the alleged suspected abuser. Further review of the SOC 341 form showed under Section E (Incident Information), the date and time of the incident was on 11/22/24 around 2300 hours. On 12/5/24 at 1605 hours, a telephone interview was conducted with Resident 4. Resident 4 stated the alleged abuse incident with LVN 3 occurred on 11/22/24. Resident 4 further stated he notified RN 1 of the incident on 11/22/24. On 12/19/24 at 1041 hours, a telephone interview was conducted with LVN 3. LVN 3 verified the alleged abuse incident occurred on 11/22/24, and was reported to the Administrator, DON, and RN 1 on 11/22/24 (the same date of the incident). On 12/19/24 at 1430 hours, a telephone interview was conducted with RN 1. RN 1 verified the alleged abuse incident occurred on 11/22/24, and stated the DON and Administrator were informed. On 1/2/24 at 1543 hours, an interview was conducted with DON 1. DON 1 verified the alleged abuse incident occurred on 11/22/24, and she was informed by LVN 3 and RN 1. DON 1 verified she had faxed the SOC 341 form to the CDPH, LC& Program on 11/27/24, five days after the incident occurrence. (continued on next page)

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F 0609 Level of Harm - Potential for minimal harm Residents Affected - Some	On 1/3/25 at 1200 hours, an interview was conducted with Administrator 2. Administrator 2was 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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for oneof 10 sampled residents (Resident 8) to help attain and maintain their highest practicable physical well-being. * The facility failed to notify the physician of the resident's three-pound weight loss in one week as care planned. This failure had the potential to negatively affect the resident's health and well-being. Findings: Medical record review for Resident 8 was initiated on 12/31/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 12/18/24, showed Resident 8 had fluctuating capacity to understand and make decisions. Review of Resident 8's MDS dated [DATE], showed under Section B, Resident 8 was rarely or never made self-understood and usually understood others. The MDS also showed under Section GG, Resident 8 had limitation in range of motion to one side of the upper and lower extremities and dependent with eating. Review of Resident 8's Weight and Vitals summary showed the following: On 12/22/24 at 1154 hours, 143 lbs. On 12/23/24 at 1047 hours, 143 lbs. On 12/30/24 at 1059 hours, 140 lbs. (three pounds weight loss in a week) Review of Resident 8's plan of care showed a care plan problem dated 12/24/24, addressing the resident'snutritional problem and risk for unavoidable weight loss related to Resident 8's therapeutic and/or altered texture diet. The interventions included to monitor, record, and report to the MD as needed for signs and symptoms of malnutrition: emaciation, muscle wasting, and significant weight loss (three lbs. in one week, greater than 5% in one month, greater than 7.5% in three months and/or greater than 10% in six months). Further review of Resident 8's medical record failed to show the physician was notified of Resident 8's weight loss of three lbs. in one week from 12/23 to 12/30/24, as care planned. On 1/2/24 at 1014 hours, an interview was conducted with LVN 8. LVN 8 verified Resident 8's physician was not notified of the resident's three-pound weight loss from 12/23 to 12/30/24. (continued on next page)

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	On 1/3/25 at 0934 hours, an interview was conducted with RN 5. RN 5 verified Resident 8 had episodes of poor oral intake and lost three lbs. in one week from 12/23 to 12/30/24. RN 5 stated Resident 8's physician should have been notified of the weight loss as per the resident's care plan intervention. On 1/3/25 at 1200 hours, an interview was conducted with DON 2. DON 2 was informed and acknowledged the above findings.