

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Laguna Hills Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 implement their P&P to ensure timely reporting of a reasonable suspicion of a crime related to injuries of unknown source in accordance with Section 1150B of the Act for one of six sampled residents (Resident 4). * The facility failed to report timely to the CDPH, L&C Program, Long-Term Care Ombudsman office, and local law enforcement agency when Resident 4 was discovered with a discoloration to her right eyebrow region. This failure had the potential to compromise or impede the protection of Resident 4 and the other residents at the facility. Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Report and Investigating revised 9/2022 showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations). If a resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the SOC 341 - Report of Suspected Dependent/Elder Abuse dated 9/10/25, showed the facility had reported an allegation of abuse to the CDPH, L&C Program on 9/10/25 at 1357 hours, regarding the discoloration around the eye of Resident 4. The document showed Resident 4 was visited by Family Member 1 on 9/10/25, and Family Member 1 reported to the Administrator that he would like an investigation done. Medical record review for Resident 4 was initiated on 9/11/25. Resident 4 was readmitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 had severely impaired cognition and was dependent on the facility staff for mobility. Review of Resident 4's Change in Condition Evaluation dated 9/8/25 at 2245 hours, written by LVN 2, showed Resident 4 was found with a coin-sized skin discoloration to the right eyebrow region. Resident 4's provider and resident representative were notified. Review of Resident 4's Skin/Wound Note dated 9/9/25 at 1153 hours, showed a skin assessment was done for Resident 4. The licensed nurse noted a purple discoloration around the right eye area measuring 5 cm x 1.5 cm and the skin was intact. The documentation showed Resident 4 had no complaints of pain, nor discomfort during the skin assessment and no other skin issues were noted. On 9/11/25 at 0940 hours, an interview was conducted with Family Member 1. Family Member 1 stated Resident 4 required total assistance from the facility staff for activities of daily living and mobility. Family Member 1 stated he was notified about a discoloration to Resident 4's right eye on 9/8/25 between 2230 to 2300 hours. Family Member 1 stated he visited Resident 4 on 9/10/25, noticed she was bruised around her right eye, and had spoken with the Administrator to tell him he thought the bruising was caused by abuse to Resident 4. On 9/11/25 at 1528 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated CNA 2 had reported Resident 4 had a skin discoloration to her right eyebrow on 9/8/25 around 2100 to 2200 hours. LVN 2 stated he went to assess Resident 4 and Resident 4 had a coin-sized dark red in color discoloration to her right eyebrow. LVN 2 stated he was not sure where the discoloration came from and stated he and CNA 2 did not witness when Resident 4 developed the discoloration. LVN 2 further stated he attempted to ask Resident 4 what had happened; however, Resident 4 did not answer any questions at that time. On 9/11/25 at 1607 hours, an interview and medical record review was conducted with the DON. The DON was informed and acknowledged the findings. The DON stated Family Member 1 was notified at the time the discoloration was discovered, had visited Resident 4 on 9/10/25. The DON added Family Member 1 wanted the facility to investigate Resident 4's skin discoloration. The DON stated the facility did not know how Resident 4 got the skin discoloration and verified Resident 4 was unable to verbalize how she had gotten the skin discoloration. The DON stated the facility did not know the source of the injury until after the facility had conducted their investigation. On 9/15/25 at 1305 hours, an interview was conducted with the Administrator. The Administrator verified he was the facility's abuse coordinator and stated when someone reported an abuse, he would send the SOC 341 to the CDPH, L&C Program, ombudsman, and law enforcement if he was available. The Administrator stated he reported Resident 4's skin discoloration to her right eye because Family Member 1 wanted the facility to investigate. The Administrator stated Resident 4 did not remember how the skin discoloration happened and there were no witnesses. The Administrator stated it was unknown how Resident 4 got the skin discoloration</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</p>

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<p>F 0627</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 and closed medical record review, the facility failed to provide one of six sampled residents (Resident 1) sufficient preparation and orientation to ensure a safe discharge from the facility. * The facility failed to inform Resident 1 her insurance would not cover the cost of her physician ordered DME (a hospital bed and wheelchair), prior to her discharge from the facility. This failure had the potential to compromise Resident 1's ability to make an informed decision regarding her discharge plan of care, potentially leading to financial hardship, physical and psychosocial distress. Findings: On 9/10/25 at 0919 hours, a telephone interview was conducted with Resident 1. Resident 1 stated she was supposed to receive a hospital bed upon her discharge to home from the facility, however, she did not receive it. Resident 1 stated she was using her recliner chair, was unable to care for herself, had a lot of issues with her mobility, and only had a walker to assist with ambulation. Closed medical record review for Resident 1 was initiated on 9/10/25. Resident 1 was admitted to the facility on [DATE], with diagnoses including cellulitis (infection of the skin) of the right and left lower limbs, and lymphedema (chronic swelling in the soft tissues, most frequently in the arms or legs). Resident 1 was discharged from the facility on 8/27/25. Review of Resident 1's H&P examination dated 6/30/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's Order Summary Report dated 9/11/25, showed the following physician's orders:- dated 8/26/25, to discharge home on 8/27/25, per the resident's request with home health RN for safety, PT, OT, bath aide, and wound care; and- dated 8/27/25, for DME: hospital bed and ultralight wheelchair for safety and bed mobility. Review of Resident 1's Discharge Instruction Form/Recapitulation of Stay dated 8/27/25, showed Resident 1 had medical equipment arrangements upon discharge, however, the discharge instructions did not state the information about what DME was arranged, the company to contact, or when the DME would be provided. Further review of Resident 1's medical record failed to show documented evidence Resident 1's DME arrangements were set up by the facility prior to the resident's discharge. On 9/10/25 at 1505 hours, an interview and concurrent closed medical record review was conducted with the SS Staff. The SS Staff stated she assisted with arranging the home health, caregiver resources, transportation, and DME upon discharge of a resident. The SS Staff stated she would obtain the order for the DME from the physician and contact the DME company before the resident discharged, if the resident was able to receive the DME. The SS Staff stated if the resident requested to leave the day before the discharge, she sometimes would not receive a response from the DME company right away but would contact the resident the day after the discharge. The SS Staff stated Resident 1 discharged to her home on 8/27/25, and had physician's orders to discharge with a hospital bed and wheelchair. The SS Staff stated she was made aware Resident 1 was not eligible for her insurance to cover the DME on 8/27/25, and communicated this information to the SSD at around 1100 hours. The SS Staff stated she was not working on 8/27/25, and was not sure if the SSD communicated this information to Resident 1. The SS Staff verified she did not inform Resident 1 regarding her ineligibility for the DME prior to her discharge. On 9/10/25 at 1615 hours, an interview and concurrent closed medical record review was conducted with the SSD. The SSD stated if there was a physician's order for the DME, she expected her staff to inform the resident if their insurance or DME company could not provide the DME and a progress note to document the conversation had occurred with the resident. The SSD stated the SS Staff had made the referral for Resident 1's DME and knew Resident 1 would discharge on [DATE]. The SSD stated if the facility staff knew it was not possible to have the DME in place prior to the resident's discharge, she expected her staff to educate the resident about the timeframe for the services to be set-up. The SSD stated she did not communicate to Resident 1 the information regarding Resident 1's ineligibility for the DME. The SSD verified there was no documented evidence Resident 1 was notified regarding her DME services prior to or after her discharge from the facility. On 9/15/25 at 1343 hours, an interview was conducted with the Administrator. The Administrator acknowledged the above findings.</p>		

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<p>F 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure a notice of transfer/discharge was provided to the resident or the resident's responsible party for one of six sampled residents (Resident 2) prior to the resident's discharge from the facility. * The facility failed to provide the written notice of transfer/discharge to Resident 2 or the resident's responsible party prior to the resident's discharge from the facility. In addition, the facility failed to ensure a copy of Resident 2's notice of transfer/discharge was provided to the State Long-Term Care Ombudsman prior to the planned discharge date. This failure had the potential to violate Resident 1's rights to appeal their discharge. Findings: Review of the facility's P&P titled Transfer or Discharge, Facility-Initiated dated 10/2022 showed under the section notice of transfer or discharge (planned), showed the resident and his or her representative are given a thirty day advance written notice of an impending transfer or discharge from this facility. A copy of this notice is sent to the office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. Under the section notice of transfer or discharge (emergent or therapeutic leave), showed under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge if the resident's health improves sufficiently to allow a more immediate transfer or discharge. Closed medical record review for Resident 2 was initiated on 9/10/25. Resident 2 was readmitted to the facility on [DATE], and discharged on 8/27/25. Review of Resident 2's medical record failed to show a notice of transfer/discharge was provided to Resident 2, Resident 2's representative, or to the LTC Ombudsman on or prior to his discharge on [DATE]. On 9/10/25 at 1505 hours, an interview and concurrent closed medical record review was conducted with the SS Staff. The SS staff stated she would provide the notice of transfer/discharge two days prior to the resident's discharge date or when the resident stated they wanted to go home. The SS staff stated Resident 2 was discharged on 8/27/25, per his wife's request. The SS Staff verified there was no documented evidence a notice of transfer/discharge was provided to Resident 2 or Resident 2's representative. On 9/11/25 at 1341 hours, an interview and concurrent closed medical record review was conducted with the SSD. The SSD stated the social services department was responsible for providing the notice of transfer/discharge. The SSD stated if the resident had requested to be discharged, the facility would provide the notice on the date the resident requested to be discharged. The SSD stated Resident 2's wife had requested Resident 2 to be discharged, and the discharge order was placed on 8/26/25, for him to discharge on [DATE]. The SSD verified there was no documented evidence a notice of transfer/discharge was provided to Resident 2, Resident 2's representative, or to the LTC ombudsman prior to his discharge from the facility.</p>		