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	04/07/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed record review, and facility P&P review, the facility failed to ensure the discharge information and assessments were completed for one of seven sampled residents (Resident 1). * The facility failed to ensure the information in Resident 1's Discharge Instruction Form/Recapitulation of Stay was complete. In addition, the facility failed to provide documentation to show Resident 1 was given the instructions and medications upon discharge. These failures had the potential for Resident 1 to not receive a complete discharge information, instructions, and medications which could potentially affect the resident's health. Findings: Review of the facility's P&P titled Discharging the Resident revised 12/2016 showed the following:- If the resident is being discharged home, ensure the resident and/or responsible party receive teaching and discharge instructions; and- Assess and document resident's condition at discharge, including skin assessment, if medical condition allows. Closed medical record review for Resident 1 was initiated on 3/24/26. Review of Resident 1's Facesheet dated 3/25/26, showed Resident 1 was readmitted to the facility on [DATE], and discharged on 3/20/26. The document also showed Resident 1 had a history of compression fracture (occurs when a spinal bone collapses, typically causing sudden, sharp back pain) of T7-T8 (seventh and eighth vertebra located in mid-back), and hypertension (high blood pressure) and muscle weakness. Review of Resident 1's H&P examination dated 3/12/26, showed Resident 1 had the capacity to make medical decision. Review of Resident 1's Physician's Order Summary showed the following physician's order:- dated 3/5/26, alendronate sodium (a medication used to treat/prevent osteoporosis - bone disease characterized by decreased bone mass and density, making bones fragile and prone to fracture) oral tablet 70 mg, in the morning every Saturday;- dated 3/5/26, amlodipine besylate (blood pressure medication) oral tablet 5 mg, one tablet one time a day for hypertension (high blood pressure);- dated 3/5/26, calcium citrate plus 315-5 mg-mcg (calcium citrate-vitamin D - supplement) two tablets two times a day;- dated 3/5/26, apixaban (blood thinner) oral tablet 5 mg, give one tablet by mouth every 12 hours for atrial fibrillation (rapid heart beat);- dated 3/5/26, for the back surgical incision, to keep a dry gauze bandage over the sutures/staples for two weeks post operation (surgery date 3/2/26). If the gauze/ bandage becomes soiled or falls off, replace until two weeks post op, every shift until 3/16/26; - dated 3/6/26, physical therapy QD, five times per week for 60 days with therEx, therAct, gait training, neuro re-ed, group therapy and occupational therapy QD, five times per week for 60 days with therEx, therAct, neuro re-ed, group therapy, and self-care management due to muscle weakness. Further review of Resident 1's physician's order dated 3/17/26, showed the last covered day of the the resident in the facility was on 3/16/26, and to discharge on [DATE] back to prior living arrangements/hotel, home health registered nurse for medical management, and home health physical therapy for safety evaluation. Review of Resident 1's Discharge Instruction Form/Recapitulation of Stay dated 3/20/26, showed blank entries on the following sections:- Therapy services received while in SNF (Skilled Nursing Facility);- Medication Education - medication reconciliation of medications, provided current list of reconciled medications list to the subsequent/next provider, and the name of the next provider;- Social Services & Activities - dental condition, vision, hearing, speech, (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition and activities;- Emergency - contact information for urgent problems of if your symptoms get worse;- Current Medical Diagnoses - relevant medical condition;- Functional Status;- Discharge Day Status - skin assessed and condition on discharge, lung sounds, and the abdomen, bowel and urinary status. Further review of Resident 1's discharge instruction form showed a check mark to indicate a Discharge Information/Recap of Stay and Pharmacy Discharge Medication Summary were sent with Resident 1. However, the facility failed to show the documentation or the copy of form which contained the current medication list and what medications Resident 1 was discharged with, considering Resident 1 was on high blood pressure and blood thinner medications. On 4/2/26 at 1513 hours, an interview and concurrent closed record review for Resident 1 was conducted with the DON. The DON verified Resident 1's discharge instruction form information and assessments were incomplete and verified there was no documentation to show the current medication list and what medications Resident 1 was discharged with.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and the facility P&P review, the facility failed to provide the necessary services to maintain the resident's highest practicable well-being for one of seven sampled residents (Resident 3). * The facility failed to initiate a change of condition assessment and notify the physician when Resident 3 had a second fall on 3/29/26. In addition, the facility failed to update Resident 3's care plan with the interventions to prevent injury and further fall. These failures had the potential for Resident 3 to not receive the appropriate care and interventions which could negatively affect the resident's health and well-being.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status dated 2/2021 showed the nurse will notify the resident's attending physician or physician on a call when there has been a (an): (a) accident or incident involving the resident.(i) specific instruction to notify of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting);b. impacts more than one area of the resident's health status;c. requires interdisciplinary review and/or revision to the care plan. The P&P further showed prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. Review of the facility's P&P titled Falls - Clinical Protocol revised 3/2018 showed the following:- The physician will help identify individuals with a history of falls and risk factors for falling. (a) Staff will ask the resident and the caregiver or family about a history of falling. (b) The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days). (c) While many falls are isolated individual incidents a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause.- The staff will evaluate and document falls that occur while the individual is in the facility; for example when and where they happen, any observations of the events, etc. The Fall P&P's Cause Identification showed for an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall and under the section for Monitoring and Follow-up showed the following:- The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls.b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented;- If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. Medical record review for Resident 3 was initiated on 4/1/26. Review of Resident 3's Facesheet dated 4/6/26, showed Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's eINTERACT Change in Condition Evaluation form dated 3/29/26 at 0635 hours, showed Resident 3 had a fall on 3/29/26. The form further showed during routine morning medication pass at 0635 hours, Resident 3 was found in her room next to her bed laying down on the floor. Review of Resident 3's Progress Note Dated 3/29/26 showed the following:- at 1900 hours, showed Resident 3 was noted laying on the floor on her left side with her head laying on the pillow, no complaints of pain or discomfort;- at 2314 hours, the LVN spoke to Resident 3's family member. On 4/1/26 at 1158 hours, an interview was conducted with Family Member 1. Family Member 1 stated Resident 3 had fallen on the previous night. On 4/3/26 at 1518 hours, an interview was conducted with LVN 1. LVN 1 stated she received a report Resident 3 had sustained a fall. When asked how many falls Resident 3 had, LVN 1 stated two or three. Further review of Resident 3's medical record failed to show a post fall assessment was completed or the physician was notified (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when Resident 3 had another fall incident. Review of resident 3's Care Plan Report dated 3/30/26, showed a care plan problem showing during routine morning medication passed at 0635 hours patient was found in her room next to her bed laying down on the floor. Further review of the care plan failed to show for revised interventions to help prevent injuries and recurrence of fall. On 4/7/26 at 1511 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. RN 1 verified Resident 3 had two falls on the same day on 3/29/26 at 0635 hours and 1900 hours. When asked if a COC was initiated for the second fall, RN 1 stated I don't see one. When asked if a second fall process would include a COC, RN 1 stated that's my understanding. RN 1 verified there was no documentation to show if the physician was notified of the second fall. When asked if the physician should have been notified, RN 1 stated of course, yes. On 4/7/26 at 1702 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.