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	05/26/2026

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility P&P, the facility failed to ensure the necessary care and services were provided to prevent the development and worsening of the pressure ulcer for one of three sampled residents (Resident 1). * The facility failed to provide the necessary skin treatment when Resident 1 was admitted to the facility with MASD to the perineum and the buttocks on 4/29/26, and when Resident 1 was readmitted with pressure injury. In addition, the facility failed to assess Resident 1's pressure injury, obtain an order for the pressure injury, and ensure Resident 1's low air loss mattress setting was correct. These failures had the potential for the resident's existing pressure injury to worsen and developed additional wounds.Findings: Review of the facility's P&P titled admission Assessment and Follow Up: Role of the Nurse revised 9/2012 showed the purpose of this procedure is to gather information about the residents physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing the required assessment instruments, including the MDS. Review of the facility's P&P titled Resident Examination and Assessment revised 2/2014 showed the purpose of this procedure is to examine and assess the resident for any abnormalities in health status which provides a basis for the care plan. The preparation included the following: 1. Review the resident's admission assessment and/or preliminary care plan to assess for any special situations regarding their residents care;2. Assemble equipment and supplies as needed Review of the facility's P&P titled Prevention of Pressure Injuries revised 4/2020 showed the following:Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment as indicated according to the residents risk factors, and prior to discharge2. During the skin assessment, inspect:a) presence of erythema;b) Temperature of skin and soft tissue: and;c) Edema3. Inspect the skin on a daily basis when performing or assisting with personal care or ADL's.a) Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency;b) Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.)c) Wash the skin after any episodes of incontinence, using pH balanced skin cleanser;d) Moisturize dry skin daily, and;e) Reposition resident as indicated on the care plan.Monitoring:1. Evaluate, report and document potential changes in the skin; and2. Review the interventions and strategies for effectiveness on an ongoing basis; Medical record review for Resident 1 was initiated on 5/21/26. Resident 1 was admitted to the facility on [DATE], transferred to the acute care hospital on 5/3/26, and readmitted on [DATE]. Review of Resident 1's H&P examination dated 5/14/26, showed Resident 1 had the capacity to make decisions. a. Review of Resident 1's Admission/readmission Data Tool effective date 4/29/26, showed Resident 1 had MASD in the perineum and buttocks. Review of Resident 1's Care Plan Report dated 4/30/26, showed a care plan problem addressing the resident is at risk for pressure sore or the potential for pressure ulcer development related to disease process. Review of Resident 1's medical records failed show the wound care orders for Resident 1's MASD and if the skin was monitored for MASD. On 5/26/26 at 1121 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. When asked what wounds Resident 1 was (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted with on 4/29/26, the DON stated Resident 1 had MASD on the peri area and buttocks. When asked what interventions were implemented, the DON verified there were no treatment orders or any treatments rendered for Resident 1 prior to her discharge to the acute hospital on 5/13/25. b. Review of Resident 1's Wound Care RN Assessment and Recommendation from the acute care hospital dated 5/8/26, showed Wound 5/3/26 Pressure Injury Coccyx. The note showed the date and time it was first assessed was 5/3/26 at 2200 hours. The section for Present on Original Admission, indicated yes. The note further showed Resident 1 had coccyx Stage 2 pressure injury. Review of Resident 1's Admission/readmission Data Tool dated 5/13/26 showed, Resident 1 had healing Stage 3 pressure injury on the coccyx, bruise on back to abdomen, and a dressing on the upper back. Review of Resident 1's Progress Notes dated 5/14/26 at 0834 hours, showed Resident 1 had scattered discolorations throughout BUE/BLE/trunk/back, dark purple in color with intact skin.no further skin issues noted. Review of Resident 1's document titled SNF admission Note dated 5/14/26, with the physician's progress notes showed the following active problems:- Deep tissue pressure injury of sacrum. There is a community acquired pressure-related deep tissue injury in the sacrum which was discovered during admission on [DATE]. Wound care consult.- Pressure ulcer of sacrum Stage 3. Diagnosis present and considered in the overall care of this resident. Review of Resident 1's medical records failed to show the wound care orders or monitoring for Resident 1's pressure injury. On 5/21/26 at 1630 hours, a telephone interview was conducted with LVN 1. LVN 1 stated the process for admissions would include reviewing medications, ensuring medications were correct, and performing an assessment which includes a skin assessment. LVN 1 stated the major skin assessment would occur the following morning. On 5/22/26 at 0850 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 2. LVN 2 stated the process for admissions would be for the treatment nurse to assess the resident's skin the following day of admissions. When asked of Resident 1's skin was reassessed by a treatment nurse after 4/29/26, LVN 2 verified there were no other skin assessments after 4/29/26. When asked if Resident 1's skin was assessed upon transfer to the acute care facility on 5/3/26, LVN 2 verified the skin assessment were left blank, since the resident was transferred out as an emergency transfer. On 5/22/26 at 0913 hours, an observation was conducted of CNA 1 providing bladder and bowel care and changing Resident 1's gown. CNA 1 called for LVN 3 to join to assess Resident 1's skin. Resident 1 was observed to be wearing adult briefs and lying on a LAL (low air loss) mattress. When CNA 1 removed the adult briefs, it was observed Resident 1 had bright pink/redness in her perineal area with spots or broken skin, redness in the bilateral groin, and redness on her sacrum with an open spot. LVN 3 stated she would do a change of condition and wait for the physician's orders before providing any treatment. On 5/22/26 at 1038 hours, a wound care observation for Resident 1and concurrent interview was conducted with LVN 3. LVN 3 was observed providing Resident 1's wound care treatment. LVN 3 stated she received the new physician's orders for Resident 1's Stage 1 pressure injury to the sacrococcyx, and perineal MASD. Review of Resident 1's TAR for May 2026 showed a physician's order dated 5/22/26, for perineal MASD; cleanse with NS (normal saline), pat dry, apply zinc oxide (wound treatment) ointment with antifungal ointment (Miconazole 2%) to the affected area and leave open to air daily and as needed for 30 days, and sacrococcyx pressure injury (Stage 1), cleanse with NS, pat dry, apply zinc oxide ointment (Miconazole 2%) to the affected area and cover with foam dressing daily and as needed for 30 days then reassess. On 5/22/26 at 1129 hours, a follow up interview and concurrent medical record review for Resident 1 was conducted with LVN 2. LVN 2 stated on 5/14/26, Resident 1's skin assessment showed she had a healing Stage 3 pressure injury. When asked if there were any treatments rendered for her healing Stage 3 pressure injury, LVN 2 stated she did not see anything until 5/22/26. c. On 5/22/26 at 0930 hours, an observation of Resident 1's low air loss mattress setting and concurrent interview was conducted with LVN 3. Resident 1's LAL mattress setting was beyond the 320 pounds indicator. When asked how to set the LAL mattress setting, LVN 3 stated the setting was according to the resident's weight. When asked if (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 weighed more than 300 pounds, LVN 3 stated no. LVN 3 was observed turning the LAL mattress setting down to the 160 pounds indicator. On 5/22/26 at 1129 hours, a follow up interview and concurrent medical record review for Resident 1 was conducted with LVN 2. When asked how the LAL mattresses were set, LVN 2 stated based on the resident's weight and comfort. When asked how to identify if the resident was comfortable, LVN 2 stated ask the resident. When asked if Resident 1 was over 300 lbs., LVN 2 stated no. LVN 2 verified Resident 1 only weighed 113 lbs. LVN 2 was made aware of the observation when the LAL setting was at 230 and 160 lbs. LVN 2 acknowledge the LAL mattress settings were inaccurate.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure three of three nursing staff (CNAs 2 and 3, and LVN 4) interviewed demonstrated the competencies and skill sets needed to provide safe nursing care to the residents who were on anticoagulant medication. * CNAs 2 and 3 failed to explain failed to explain how to handle and care for residents that are on anticoagulant medication. * LVN 4 failed to explain what the main side effects to monitor for when the residents were on an anticoagulant medication. These failures had the potential for the residents to receive inadequate care and posed the residents at risk for adverse consequences.Findings: Review of the facility's document titled Certified Nurse Assistant (undated) showed the essential duties and responsibilities include:- making residents comfortable (putting them in bed, bringing them water, etc.);- helping residents with their daily grooming, shower or sponge bath;- proper lifting and transitioning residents from wheelchair to bed, bed to chair, etc.;- helping residents sit, stand and walk;- transporting residents to dining area (for meals and activities) and returning them to their room; and- timely report of change in residents condition to the nurse supervisor. Review of the facility's P&P titled Anticoagulation-Clinical Protocol revised 11/2018 showed the staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.If any individual in anticoagulation therapy shows signs of excessive bruising, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. Medical record review for Resident 1 was initiated on 5/21/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Admission/readmission Data Tool effective date 4/29/26, showed Resident 1 had scattered discoloration to the upper extremities, abdominal area, and the right lower extremity. Review of Resident 1's Order Summary Report showed a discontinued physician's order dated 4/29/26, to monitor for ecchymosis (bruising, abnormal bleeding, bloody stool, coffee ground emesis, vomitus, nosebleed, and skin tears. Report to physician promptly every shift (anticoagulant use). Review of Resident 1's Order Summary Report dated 5/13/26, showed Pradaxa (blood thinner medication used to prevent and treat blood clots) oral capsule 110 mg, give one capsule by mouth every 12 hours for atrial fibrillation. Review of Resident 1's MAR for 2026, showed Resident 1 was administered with Pradaxa medication on the following dates and times:- dated 5/14/26 at 1700 hours;- dated 5/15/26 at 1700 hours;- dated 5/16/26 at 0900 hours;- dated 5/17/26 at 0900 hours, and 2100 hours;- dated 5/18/26 at 0900 hours, and 2100 hours;- dated 5/19/26 at 0900 hours, and 2100 hours;- dated 5/20/26 at 0900 hours, and 2100 hours;- dated 5/21/26 at 0900 hours, and 2100 hours; and- dated 5/22/26 at 0900 hours. a. Review of the facility document titled Nursing Staffing Assignment and Sign in sheet dated 5/2/26 at 2200-0700 hours, showed CNA 3 was assigned to Resident 1. On 5/21/26 at 1517 hours, an interview was conducted with CNA 3. When asked how residents who were at risk for bruising and bleeding easily cared for, CNA 3 apologized and could not answer the question. When asked if Resident 1 was observed with any bruising, CNA 3 stated he could not remember. When asked if CNA 3 knew what bruising was, CNA 3 stated he did not. After explaining what bruising was, CNA 3 was asked what the process was if he noticed any bruising on the resident, CNA 3 stated he would provide pericare, apply zinc cream, and if there's an infection to inform the charge nurse. b. Review of the facility document titled Nursing Staffing Assignment and Sign in sheet dated 5/3/26 at 0700-1500 hours, showed CNA 2 was assigned to Resident 1. On 5/21/26 at 1435 hours, an interview was conducted with CNA 2. CNA 2 verified she was assigned to Resident 1 on 5/3/26. When asked how residents were handled during care when the residents were taking blood thinners and have the risk of bleeding and bruising easily. CNA 2 stated to wear a gown and gloves. When asked how residents were handled during bladder and bowel care, showering and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repositioning if they bruise and bleed easily, CNA 2 stated, ask for help. c. On 5/22/26 at 1510 hours, an interview was conducted with LVN 4. When asked if he had worked with Resident 1, LVN 4 stated he has since her recent admission. When asked what the process was if a resident was on anticoagulant medication, LVN 4 stated they were high risk for bleeding, and they were monitored for bleeding. When asked if they were only monitored for bleeding, LVN 4 stated that I know of. When asked where the monitoring was documented, the LVN stated in the MAR. When asked how and what to monitor on the residents who were on anticoagulant medications, LVN 4 stated he would have to check, and that he was aware they are at high risk for bleeding. On 5/21/26 at 1601 hours, an interview was conducted with the DSD. The DSD stated her role as the DSD was to provide onboard training, staffing education, and help with staffing. When asked if CNAs were educated on what it means to be on a blood thinning medication, the DSD stated they knew to report any changes of conditions. The DSD verified there were no in-service training provided to the staff on how to care for the residents on anticoagulant medications. On 5/22/26 at 0913 hours, an observation was made of CNA 1 providing bladder and bowel care and changing the residents gown. CNA 1 called for LVN 3 to join to assess Resident 1's skin. Resident 1 was observed to have bruising on her left and right arm, and discoloration under her left breast. On 5/26/26 at 1121 hours, an interview was conducted with the DON. The DON was made aware about the staff interviews and acknowledged the findings. Cross reference to F757.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility P&P review, the facility failed to provide the necessary care and service for one of three sampled residents (Resident 1) who was on anticoagulant medication. * The facility failed to ensure Resident 1 was monitored for the side effects of anticoagulant medication use. This failure had the potential delay in the identification of the side effects due to anticoagulant medication use and for the resident to receive necessary care and interventions.Findings: Review of the facility's P&P (Policies and Procedures) titled Anticoagulation-Clinical Protocol revised 11/2018 showed the staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems If any individual in anticoagulation therapy shows signs of excessive bruising, hematuria (presence of blood in urine), hemoptysis (coughing or exportation of blood or blood -tinged mucus), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. Medical record review for Resident 1 was initiated on 5/21/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed a discontinued physician's order dated 4/29/26, to monitor for ecchymosis (bruising, abnormal bleeding, bloody stool, coffee ground emesis, vomitus, nosebleed, and skin tears. Report to physician promptly (anticoagulant use) every shift. Further review of the physician's order failed to show the monitoring for anticoagulant use was not ordered when Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Admission/readmission Data Tool dated 5/13/26, showed healing Stage 3 on the coccyx, bruise on back to abdomen, and a dressing on upper back.Review of Resident 1's Order Summary Report dated 5/13/26, showed Pradaxa (blood thinner medication used to prevent and treat blood clots) oral capsule 110 mg (milligrams), give one capsule by mouth every 12 hours for atrial fibrillation (an irregular and often very rapid heart rhythm). Review of Resident 1's MAR (Medication Administration Summary) for dated May 2026 showed Resident 1 was administered Pradaxa medication on the following dated and times:- dated 5/14/26 at 1700 hours;- dated 5/15/26 at 1700 hours;- dated 5/16/26 at 0900 hours;- dated 5/17/26 at 0900 hours, and 2100 hours;- dated 5/18/26 at 0900 hours, and 2100 hours;- dated 5/19/26 at 0900 hours, and 2100 hours;- dated 5/20/26 at 0900 hours, and 2100 hours;- dated 5/21/26 at 0900 hours, and 2100 hours; and- dated 5/22/26 at 0900 hours. On 5/22/26 at 0913 hours, an observation was conducted for Resident 1. Resident 1 was observed lying in bed with bruising on her left upper arm. On 5/22/26 at 1129 hours, an interview and concurrent medical record review was conducted with LVN 2. When asked if Resident 1 was taking any anticoagulant medications, LVN 2 stated, yes Pradaxa. When asked what were the side effects of taking an anticoagulant medication, LVN 2 stated skin discoloration, bleeding, ecchymosis and bleeding gums. LVN 2 verified Resident 1 was not monitored for side effects while taking an anticoagulant medication. On 5/26/26 at 1121 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified Resident 1 had scattered discoloration to upper and lower extremities, and skin discoloration to the abdomen. When asked what would be the process for the residents that were taking anticoagulants, the DON stated to monitor for bruising, bleeding, and discoloration. The DON verified Resident 1 was not monitored for anticoagulant side effects. Cross reference F726.