

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/03/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **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 inform the residents' responsible parties of a change of condition for two of nine sampled residents (Residents 5 and 6). * The facility failed to notify Resident 5 and 6's responsible parties when the residents had fall incidents. These failures resulted in the responsible parties not being informed timely of the residents' change of condition. Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised 2/2021 showed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). In addition, the P&P showed the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. a. Closed medical record review for Resident 5 was initiated on 7/2/26. Resident 5 was admitted to the facility on [DATE], and was discharged on 6/17/26. Review of Resident 5's Advance Health Care Directive dated 10/14/24, showed Family Member 1 was the designated individual of Resident 5 as her agent to make health care decisions. Review of Resident 5's H&P examination dated 6/6/26, showed the resident had no capacity to understand and make decisions. Review of Resident 5's eInteract Change in Condition Evaluation - V 5.1 dated 6/7/26 at 0000 hours, showed the resident was on the floor lying on a thick comforter. The document further showed under the Resident Representative Notification, Resident 5 was notified of the incident on 6/7/26 at 0010 hours. Review of Resident 5's Multidisciplinary Care Conference V2 dated 6/9/26 at 1430 hours, showed a care conference was conducted. There was no documented evidence to show Family Member 1 was notified of the fall incident during the care conference 6/7/26. On 7/3/26 at 1018 hours, an interview and concurrent closed medical record review for Resident 5 was conducted with the SSD. The SSD stated part of the admission process was to verify if there was a responsible party for the resident. The SSD verified Resident 5's facesheet showed the resident was self-responsible. On 7/3/26 at 1046 hours, an interview was conducted with the SSD. The SSD stated Resident 5's daughter attended the care conference on 6/9/26, with the resident. The daughter who attended care conference was Family Member 1. The SSD stated Family Member 1 provided a copy of the Advance Health Care Directive. On 7/3/26 at 1059 hours, a follow-up interview was conducted with the SSD. The SSD verified Resident 5's fall incident on 6/7/26, was not discussed with Family Member 1, after Family Member 1 provided a copy of the Advance Health Care Directive which showed she was the resident's responsible party. b. Medical record review for Resident 6 was initiated on 7/3/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's admission Record (undated) showed his daughter was listed as his responsible party. Review of Resident 6's eInteract COC - V 5.1 dated 7/1/26 at 0130 hours, (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed Resident 6 had a fall. Resident 6 was sitting next to his bed after trying to sit into his wheelchair to go to the bathroom. Resident 6's call light was within reach but was not initiated by the resident. The document further showed under the Resident Representative Notification, Resident 6 was self-responsible. Review of Resident 6's eInteract COC - V 5.1 dated 7/1/26 at 1500 hours, showed Resident 6 had a fall when he was found lying on the floor on the left side next to bed. Resident 6 stated he was trying to transfer himself back into bed without calling for help. The document further showed under the Resident Representative Notification, Resident 6 was self-responsible. On 7/3/26 at 1317 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 1. RN 1 verified Resident 6's daughter was listed as his responsible party, and stated the resident's daughter should have been notified of the fall incidents. On 7/3/26 at 1515 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were notified and acknowledged the above findings.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 provide the necessary care and services to one of nine sampled residents (Resident 8). * The facility failed to ensure a root cause analysis for Resident 8's right humeral fracture was completed. Additionally, there was no documented evidence to show how to provide care for Resident 8's fracture. This failure posed the risk of staff not providing appropriate care for Resident 8. Findings: Medical record review for Resident 8 was initiated on 7/3/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Progress Note H&P examination dated 2/1/26, showed Resident 8 was initially admitted to the facility with generalized weakness, and fall with right knee tibial plateau fracture. Review of Resident 8's eInteract Change in Condition Evaluation dated 4/24/26, showed Resident 8 complained of right shoulder pain which started on 4/3/26. Further review of the document showed the physician recommended a right shoulder x-ray. Review of Resident 8's eInteract Change in Condition Evaluation dated 4/25/26, showed Resident 8 was found with right humeral fracture with the physician recommendation to be sent out to the acute care hospital. Review of Resident 8's After Visit Summary from the acute care hospital dated 4/25/26, showed the resident was diagnosed with an upper arm bone humerus fracture, and to use splint or immobilizer. However, further review of Resident 8's medical record failed to show documented evidence of a root cause analysis to address how Resident 8 sustained the right humeral fracture. Additionally, there was no documented evidence to show how staff could provide care for Resident 8's right humeral fracture. On 7/3/16 at 1130 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 4. LVN 4 stated he did not know how Resident 8 sustained a right humeral fracture. LVN 4 stated they manage Resident 8's right humeral fracture by providing pain medication when she asks for it. LVN 4 was unsure if Resident 8 used a sling or immobilizer. On 7/3/26 at 1330, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON was informed and acknowledged the above findings.		