

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Trabuco Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 25652 Old Trabuco Road Lake Forest, CA 92630	

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)
<p>F 0553</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 2) was provided the opportunity to participate in the care plan conferences. This failure had the potential for Resident 2 to not be able to choose treatment options and make decisions in care planning.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Care Planning-Resident Participation revised 12/2022 showed the facility will inform the resident, in a language he or she can understand of his or her rights regarding planning and implementing care, including the right to be informed of his and her total health status. The facility will honor requests for care plan meetings and acknowledge requests for revision to the person-centered plan of care.</p> <p>During the initial tour of the facility on 4/25/24 at 0840 hours, Resident 2 stated she had not been invited to attend a care plan conference to discuss her care concerns. Resident 2 stated she had met the members of the IDT one by one. However, Resident 2 stated she requested to have a care plan meeting twice, and no staff had offered or set to schedule a day when to conduct a care plan meeting with her. Resident 2 stated she wanted to be informed about her laboratory results due to being susceptible to blood clots; she wanted to do therapy twice a day but she was only treated once a day; and she wanted to get all her medications settled such as the dosage for her Effexor (antidepressant medication). Resident 2 stated it would have been great to get her care settled so she could work better with goals in mind.</p> <p>Medical record review for Resident 2 was initiated on 4/25/24. Resident 2 was admitted to the facility on [DATE].</p> <p>Review of Resident 2's H&P examination dated 4/19/24, showed Resident 2 was alert, oriented, and able to provide the detailed history.</p> <p>Review of Resident 2's Brief Interview for Mental Status (BIMS) Evaluation dated 4/24/24, showed a BIMS score of 15 which indicated Resident 2 had intact cognitive response.</p> <p>Review of Resident 2's Social Services assessment dated [DATE], did not show documented evidence Resident 2 was offered to participate in a care plan conference.</p> <p>(continued on next page)</p>

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)		
<p>F 0553</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident 2's medical record did not show documented evidence Resident 2 was offered to participate in a care plan conference.</p> <p>However, after an interview with Resident 2, review of the Social Services Progress Notes dated 4/25/24 at 0931 hours, showed the SSA talked to Resident 2 about discharge planning and set up the IDT meeting to discuss Resident 2's discharge planning and updates on 5/3/24 at 1100 hours.</p> <p>On 4/25/24 at 1637 hours, an interview and concurrent medical record review was conducted with the SSA. The SSA verified the above findings. The SSA stated she did not work Thursday and Friday of last week due to sickness. The SSA stated another social services Assistant completed the social service's assessment to discuss Resident 2's discharge plan. The SSA stated she met the resident in the morning and set up an appointment for 5/3/24. The SSA stated the care plan meeting for residents should be completed within two weeks of their admitted . The SSA verified there was no documentation to show Resident 2 was invited to attend a care plan conference to discuss her care with the IDT before she spoke to Resident 2 in the morning.</p> <p>On 4/26/24 at 1027 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the care plan conference was scheduled during the baseline care plan meet and greet of the IDT to the resident. The social services staff or case manager would notify the IDT when a care conference was scheduled to be conducted. The DON stated the SSA saw Resident 2 after she was interviewed by the health facilities evaluator nurse. The DON verified there was no documentation to show a care plan meeting was scheduled for Resident 2.</p>		