STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trabuco Hills Post Acute	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)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive person-centered care plan for one of four discharged sampled residents (Resident 828). This failure had the potential to negatively impact the health of the resident. Findings: Review of the facility's P&P titled Comprehensive Care Plans reviewed/revised 12/19/22, showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Closed medical record review for Resident 828 was initiated on 10/8/24. Resident 828 was admitted to the facility on [DATE], and transferred to an acute hospital on 9/4/24. Review of Resident 828's H&P examination dated 9/3/24, showed the resident was unable to make decisions. Review of Resident 828's Fall Risk -V4 assessment dated [DATE], showed a fall risk score of 11 which meant Resident 828 was at risk for falls. Review of the Interdisciplinary Care Conference (IDT)-V 4, Section GG2b for indoor mobility (Ambulation) dated 9/2/24, showed Resident 828 was independent. Section GG2d for functional cognition showed Resident 828 was independent. Section GG3c showed Resident 828 used a walker. Review of Resident 828's Baseline Care Plan and Summary dated 8/31/24, showed the resident was alert and cognitively intact and required the physical assistance of one person with toileting and transferring from the chair to the bed and vice versa. (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

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 10/11/2024
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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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 8282's eINTERACT Change in Condition (COC) Evaluation - v5.1 dated 9/4/24, showed a CNA assisted Resident 828 from the bed to the bathroom using a walker. Once in the restroom, Resident 828 stated she felt light-headed. The CNA tried to assist Resident 828 to sit on the toilet, but the resident stated her legs were giving out. The CNA stated she could not hold Resident 828's full weight and assisted Resident 828 to the bathroom floor. Resident 828's legs got caught in her walker and a large skin tear to the lower right leg and small skin tear to the left hand occurred. Review of Resident 828's Plan of Care failed to show a care plan was developed to address Resident 828's risk for falls based on the fall score of 11 based on the fall risk assessment conducted on 8/31/24. Further review of Resident 828's Plan of Care showed a care plan problem was initiated on 9/4/24, when Resident 828 had an actual fall due to poor balance and unsteady gait and sustained skin tears to the right lower leg and top of the left hand. On 10/10/24 at 1319 hours, an interview for Resident 828 was conducted with RN 2. RN 2 verified the residents at risk for falls were expected to have a risk for falls care plan with interventions such as close monitoring, call light within reach, and maintaining the bed in the lowest position. On 10/10/24 at 1419 hours, an interview and concurrent medical record review for Resident 828 was conducted with RN 1. RN 1 verified Resident 828 had a care plan for the actual fall on 9/4/24; however, no care plan was developed to address the risk for falls.

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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 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 51352

Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure two of four discharged residents (Residents 731 and 828) attained and maintained their highest practicable physical well being when:

* The facility failed to provide documented evidence a follow-up call was made to the physician when Resident 828 felt light-headed and had an assisted fall and sustained skin tear on the right lower leg. In addtion, the facility failed to ensure the treatment order obtained from the physician was consistent with Resident 828's injury status post fall.

* The facility failed to ensure Resident 731's urine sample was collected in a timely manner and failed to ensure Resident 731's urinalysis result was promptly reported to Resident 731's physician.

Findings:

Review of the facility's P&P titled Notification of Changes reviewed/revised 12/19/22, showed the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.

Review of the facility's P&P titled Documentation of Wound Treatments reviewed/revised 9/12/23, showed the facility completes completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and change in treatment.

Review of the facility's P&P titled Documentation in Medical Record reviewed/revised 12/19/22, showed each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress.

1. Closed medical record review for Resident 828 was initiated on 10/8/24. Resident 828 was admitted to the facility on [DATE], and transferred to an acute care hospital on 9/4/24.

Review of Resident 828's H&P examination dated 9/3/24, showed the resident was unable to make decisions.

Review of Resident 828's Fall Risk -V4 assessment dated [DATE], showed a fall risk score of 11 which meant Resident 828 was at risk for falls.

Review of the Interdisciplinary Care Conference (IDT)-V 4, Section GG2b for indoor mobility (Ambulation) dated 9/2/24, showed Resident 828 was independent. Section GG2d for functional cognition showed Resident 828 was independent. Section GG3c showed Resident 828 used a walker.

Review of Resident 828's Baseline Care Plan and Summary dated 8/31/24, showed the resident was alert and cognitively intact and required the physical assistance of one person with toileting and transferring from the chair to the bed and vice versa.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8282's eINTERACT Change in Condition (COC) Evaluation - v5.1 dated 9/4/24, showed a CNA assisted Resident 828 from bed to the bathroom with her walker. Once in the restroom, Resident 828 stated she felt light-headed. The CNA tried to assist Resident 828 to sit on the toilet, but the resident stated her legs were giving out. The CNA stated she could not hold Resident 828's full weight and she assisted Resident 828 to the bathroom floor. Resident 828's legs got caught in her walker and a large skin tear to the lower right leg and small skin tear to the left hand occurred. The COC showed Resident 828 had the following vital signs: pulse of 89 beats per minute, blood pressure of 101/61 mmHg, respiratory rate of 18 breaths per minute, oxygen saturation level of 99% on room air, and temperature of 98.8 degrees F. Further review of the eINTERACT COC dated 9/4/24, showed Resident 828's COC started on 9/3/24, during the night shift and Resident 828's primary care physician was notified on 9/4/24 at 0000 hours, awaiting response. However, further review of Resident 828's medical record failed to show a follow-up notification was made to the resident's physician by the facility's licensed nurses to inform of the resident's episode of feeling light-headed, her legs giving out, and the CNA assisting Resident 828 to the floor, until a physician's order was obtained on 9/4/24 at 0956 hours, for the injury post fall. Further review of Resident 828's medical record showed on 9/4/24 at 0956 hours, a treatment order was obtained for the left lower leg skin tear as follows: cleanse with NS (normal saline) pat dry, apply xeroform cover with calcium alginate, and secure with film dressing every three days and PRN if soiled or dislodged x 21 days every day shift. However, Resident 828's injury sustained from the fall was the right lower leg skin tear. On 10/10/24 at 1419 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 828 was at risk for falls. RN 1 verified Resident 828's medical record did not show the exact time her fall occurred. RN 1 stated the time of a fall should be documented in the resident's medical record. RN 1 also verified the treatment orders ordered by the physician for Resident 828's skin tear was inconsistent with the location of the skin tear in the COC documentation regarding Resident 828's fall. On 10/10/24 at 1548 hours, an interview and concurrent closed medical record review for Resident 828 was conducted with the DON. The DON stated Resident 828's fall occurred on 9/3/24, close to midnight, around the time her vital signs were taken and documented in the COC form. The DON verified the actual time of the fall should have been documented on the COC form. When asked how often the licensed nurse checked on the resident when identified with complain of feeling weak and dizzy, the DON stated the licensed nurses were doing Q shift charting; unless the resident was on medications which required other monitoring, then the licensed would document as well in the medical record. The DON verified Resident 828's physician was notified on 9/4/24 at 0000 hours, post fall, and showed documentation in the COC as awaiting response from the physician; however, there was no documentation to show a follow up was made regarding Resident 828's fall and injuries sustained post fall. The physician notification was noted on 9/4/24 at 0956 hours, when the treatment orders were obtained for the left lower leg skin tear, which was not consistent with Resident 828's skin tear on the right lower leg. The DON also verified the findings and stated the licensed nurse probably made a mistake. 49644 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review or the facility's P&P titled Urine Sample Collection revised 12/19/22, showed to promote accurate diagnosis and treatment of a resident's medical conditions, staff shall obtain urine samples in accordance with established standards of practice. The policy explanation and compliance guidelines section showed to notify physician of results, and file results in the resident's medical record. Review or the facility's P&P titled Laboratory Services and Reporting revised 12/19/22, showed the facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The policy explanation and compliance guidelines section showed the facility is responsible for the timeliness of the services. Promptly notify the ordering physician, physician assistant nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range. a. Closed medical record review for Resident 731 was initiated on 10/9/24. Resident 731 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 731's Order Summary Report for October 2024 showed a physician's order dated 10/1/24, to send UA with C&S one time only for admission labs for three days. Review of Resident 731's Lab Results Report dated 10/5/24, showed the following urinalysis report information: - Collection date: 10/5/24 at 0000 hours - Received date: 10/5/24 at 1453 hours - Reported date: 10/5/24 at 2355 hours On 10/10/24 at 1323 hours, an interview and concurrent closed medical record review was conducted with LVN 3. LVN 3 verified Resident 731's UA C&S was ordered on 10/1/24, and the urine sample for urinalysis was collected on 10/5/24. LVN 3 stated the licensed nurse who received the physician's order should have collected Resident 731's urine sample. LVN 3 stated the charge nurse would collect the urine sample most of the time. On 10/11/24 at 1731 hours, an interview was conducted with the DON. The DON stated the staff should try to collect the urine within 24 hours. If it was more than 24 hours, the staff should notify the physician and ask for a straight catheter order to collect the urine sample. b. On 10/10/24 at 1323 hours, an interview and concurrent closed medical record review was conducted with LVN 3. LVN 3 stated Resident 731's family member approached him on 10/7/24. LVN 3 further stated the resident's family member told him that she already spoke to three different staff regarding Resident 731's urinalysis result. LVN 3 stated he looked for the urinalysis result and called Resident 731's physician. LVN 3 verified the Resident 731's urinalysis result reported date was 10/5/24, and he called the physician to report the urinalysis result on 10/7/24. LVN 3 stated Resident 731's urinalysis result should have been followed up and the staff should have checked if there was a urinalysis result. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 1731 hours, an interview was conducted with the DON. The DON stated once the staff received the result of the urinalysis, the expectation was to call the resident's physician right away especially if there was an abnormal result. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure 19 of 20 final sampled residents (Residents 1, 13, 16, 22, 26, 29, 71, 72, 83, 84, 95, 97, 100, 101, 111, 116, 728, 928, and 931) reviewed for side rail use remained free from the accident hazards associated with the use of elevated side rails. * The facility failed to ensure the accurate and complete assessments and evaluations for the side rails use for Residents 1, 13, 16, 26, 71, 83, 84, 95, 97, 100, 101, 116, 928, and 931. * The facility failed to attempt the alternatives prior to installation of the bed rails for Residents 1, 13, 16, 22, 26, 65, 71, 84, 95, 97, 111, 116, 928, and 931. * The facility failed to obtain the informed consent for the side rails prior to the installation of the grab bars for Residents 83, 101, and 928. * The facility failed to ensure the size of the side rails whether 1/4 or 1/2 side rails were not added after the informed consent for grab bars were obtained from the residents or their responsible parties for Residents 16 and 72. * The facility failed to ensure the informed consents related to the use of side rails were accurate for Resident 95 and Resident 29. * The facility failed to ensure Resident 728's informed consent was specific to the physician's order. Resident 728's physician ordered 1/4 side rails, but the informed consent was both for grab bars and 1/4 side rails. * The facility failed to ensure the alternatives measures were provided prior to installation of bilateral 1/4 side rails as enabler to aid bed mobility, positioning, and ADL functioning for Residents 29 and 95. In addition, the physician order did not specify bilateral side rails for Resident 95 and no physician order for bilateral side rails for Resident 29. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Informed Consent revised 3/25/24, showed the following: - It is the policy of the facility to uphold the rights of residents to participate to the planning and decision-making process concerning their care and treatment. When situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, the prolonged use of a device that may lead to inability to regain use of a normal body function and for transfer and discharge; and - Prior to initiating the administration of a device, licensed nursing staff shall verify with the resident or surrogate decision maker that he/ she has given informed consent for the proposed device to the prescriber. Review of the facility's P&P titled Proper Use of Bed Rails dated on 12/19/22, showed the following: - The resident assessment must include an evaluation of the alternatives that were attempted prior to installation or use of a bedrails and how this alternative failed to meet the resident's assessed needs. - The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rails itself. - A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rails. This policy to reduce entrapment with the use of siderails has been developed utilizing the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. 1. Medical record review for Resident 83 was initiated on 10/8/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's MDS dated [DATE], showed the resident's cognitive skills for daily decision making was severely impaired. Review of Resident 83's Order Summary Report dated 10/10/24, showed a physician order dated 10/9/24, for may have one fourth side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 83's Physician Documentation of Informed Consent dated 9/10/24, showed prolonged use of device order for grab bars as enablers for bed mobility (one fourth). Review of Resident 83's Bed Rails assessment dated [DATE], showed N/A for alternatives attempted prior to installation of bedrails. On 10/8/24 at 1029 hours, during the initial tour of the facility, an observation for Resident 83 was conducted. Resident 83 was observed lying in bed with bilateral side rails up. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 0752 hours, an observation and concurrent interview for Resident 83 was conducted with LVN 1. LVN 1 stated Resident 83 had bilateral side rails and was using it for bed positioning. On 10/10/24 at 0843 hours, an interview and concurrent medical record review for Resident 83 was conducted with RN 1. RN 1 verified the resident's order was for one fourth side rails as enabler and consent was for grab bars as enablers. 2. Medical record review for Resident 100 was initiated on 10/8/24. Resident 100 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 100's H&P examination dated 3/29/24, showed Resident 100 did not have the capacity to make medical decisions. Review of Resident 100's Order Summary Report dated 10/10/24, showed a physician's order dated 3/6/24, for may have grab bars as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 100's Physician Documentation of Informed Consent dated 10/4/24, showed prolonged use of device order for bilateral grab bars as enablers for bed mobility (one fourth). Review of Resident 100's Bed Rails assessment dated [DATE], showed indication for use bed rails/transfer bar was for mobility/transfer purposes and the resident demonstrated ability to use equipment as an enabler. Further review of Bed Rails Assessment recommendation note showed the following: - Positioning/side of bed rails bilateral, type of bedrails left side showed assist bar/grab bar, and type of bed rails right side showed one fourth rails. On 10/8/24 at 0952 hours, during the initial tour of the facility, an observation for Resident 100 was conducted. Resident 100 was sitting in her bed with bilateral side rails up. On 10/9/24 at 0757 hours, an observation and concurrent interview for Resident 100 was conducted. Resident 100 stated she was using the side rails to pull up herself for positioning and turning. On 10/10/24 at 1342 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS coordinator verified the side rails assessment should be done upon admission and quarterly. 3. Medical record review for Resident 101 was initiated on 10/8/24. Resident 101 was admitted to the facility on [DATE]. Review of Resident 101's MDS dated [DATE], showed BIMS score of 7 (meaning severe cognitive impairment). Review of Resident 101's Order Summary Report dated 10/10/24, showed a physician's order dated 10/9/24, for may have one fourth side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 101's Physician Documentation of Informed Consent dated 10/4/24, showed prolonged use of device order for bilateral grab bars as enablers for bed mobility (one fourth). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 101's Bed Rails assessment dated [DATE], showed alternatives that were attempted prior to installation of bedrails was documented as N/A, no bed rails. Further review of the Bed Rails Assessment recommendations notes showed N/A, no bedrails. On 10/8/24 at 0952 hours, during the initial tour of the facility, an observation for Resident 101 was conducted. Resident 101 was observed lying in her bed with bilateral side rails up. On 10/9/24 at 0818 hours, an observation and concurrent interview for Resident 101 was conducted with LVN 1. LVN 1 stated Resident 101 had bilateral side rails up and was using it for bed positioning. On 10/10/24 at 0843 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 101's physician order was for 1/4 siderails as enabler, and the consent was for bilateral grab bars as enabler. On 10/10/24 at 1342 hours, an interview and concurrent medical record review for Resident 101 was conducted with the MDS Coordinator. The MDS coordinator verified the side rails assessment should be done upon admission and quarterly. On 10/11/24 at 1458 hours, an interview was conducted with the DON. The DON was informed of the above findings and acknowledged the findings. 39453 4.a. On 10/8/24 at 0910 hours, 10/9/24 at 1250 hours, 10/10/24 at 0757, 0835, and 1351 hours, and 10/11/24 at 0921 hours, Resident 16 was observed in bed with the bilateral 1/2 (half) side rails elevated. Medical record review for Resident 16 was initiated on 10/8/24. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's MDS dated [DATE], showed the resident had moderate cognitive impairment, an impairment on one side of upper and lower extremities, and dependent with the staff assistance on bed mobility. Review of Resident 16's Bed Rails - V2 dated 8/21/24, showed no documented evidence of the alternatives attempted prior to the installation of the side rails. Review of Resident 16's PT Evaluation and Plan of Treatment dated 8/23/24, showed the bilateral bed grab bars indicated as enablers for bed mobility, not as restraints. Review of Resident 16's Order Summary Report dated 10/10/24, showed a physician's order dated 10/8/24, for the 1/2 side rails as enabler to aide bed mobility, positioning, and ADL functions. Further review of Resident 16's medical record showed no documented evidence of the least restrictive alternatives attempted prior to the installation of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident 16's Physician Documentation of Informed Consent dated 6/18/24, showed the box for prolonged use of device order was checked off, and a handwritten note grab bars for ADLs (1/2). 5.a. On 10/8/24 at 0947 hours, during the initial tour of the facility, Resident 928 was observed awake and lying in bed. There were no side rails observed on the bed. Resident 928 stated, I know I cannot have bed railings because of the gaps and all that. On 10/10/24 at 0920 hours, a facility staff was observed installing grab rails to Resident 928's bed. On 10/10/24 at 0921 hours, an interview was conducted with LVN 9. LVN 9 verified the facility staff just installed the grab bars to Resident 928's bed. On 10/10/24 at 0934 and 1353 hours, and 10/11/24 at 0922 hours, Resident 928 was observed in bed with the bilateral grab bars elevated. Medical record review for Resident 928 was initiated on 10/8/24. Resident 928 was admitted to the facility on [DATE]. Review of Resident 928's H&P examination dated 9/27/24, showed Resident 928 had the capacity to make medical decisions. Review of Resident 928's MDS dated [DATE], showed Resident 928 had moderate cognitive impairment, with no impairment on upper extremities, and dependent with the staff on bed mobility. Review of Resident 928's Bed Rails - V2 dated 9/26/24, showed no documented evidence of the alternatives attempted prior to the installation of the bed rails. Review of Resident 928's OT Evaluation and Plan of Treatment dated 9/27/24, showed the bilateral bed bars indicated to aid resident in self-positioning and mobility, and not as restraint. Review of Resident 928's Order Summary Report showed a physician's order dated 9/26/24, for grab bars as enabler to aid in bed mobility, positioning, and ADL functions. Further review of Resident 928's medical record showed no documented evidence of the least restrictive alternatives attempted prior to the installation of side rails. b. Resident 928's medical record did not show documented evidence the informed consent related to the use of side rails was obtained. On 10/10/24 at 1317, an interview and concurrent medical record review for Resident 928 was conducted with RN 1. RN 1 verified the above findings. When asked about the informed consent for bed rail use, RN 1 verified the informed consent for bed rail use was not obtained from Resident 928 prior to the installation of the side rails. 6. On 10/8/24 1215 hours, and on 10/10/24 at 0745 and 1359 hours, Resident 931 was observed in bed with bilateral grab bars elevated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Trabuco Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 25652 Old Trabuco Road Lake Forest, CA 92630	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 931 was initiated on 10/8/24. Resident 931 was readmitted to the facility on [DATE]. Review of Resident 931's MDS dated [DATE], showed Resident 931 was cognitively intact, with no impairment on upper extremities, and dependent with the staff on bed mobility. Review of Resident 931's Bed Rails - V2 dated 9/25/24, showed no documented evidence of the least restrictive alternatives attempted prior to installation of bed rails. Review of Resident 931's PT Evaluation and Plan of Treatment dated 9/26/24, showed bilateral bed grab bars indicated as enablers for bed mobility, not as restraints. Review of Resident 931's Order Summary Report showed a physician's order dated 10/8/24, for grab bars as enabler to aid in bed mobility, positioning, and ADL functions. Further review of Resident 931's medical record showed no documented evidence of the least restrictive alternatives attempted prior to the installation of side rails. On 10/11/24 at 1345 hours, a concurrent interview and medical record review for Residents 16, 928, and 931. The DON verified the above findings. The DON stated the least restrictive alternatives should be attempted prior to the installation of side rails. 7. On 10/10/24 at 1110 hours, 10/9/24 at 1308 hours, 10/10/24 at 0750, 0813 and 1350 hours, and 10/11/24 at 0919 hours, Resident 72 was observed in bed with bilateral 1/4 side rails elevated. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Progress Note H&P examination dated 9/26/24, showed Resident 72 needed assistance with decision-making capabilities. Review of Resident 72's Order Summary Report dated 10/10/24, showed a physician's order dated 10/8/24, for 1/4 side rails as enabler to aide bed mobility, positioning, and ADL functions. Review of Resident 72's Physician Documentation of Informed Consent dated 9/6/24, showed the box for prolonged use of device order was checked off, and a handwritten note grab bars for ADLs (1/4). On 10/10/24 at 1322 hours, a concurrent interview and medical record review for Residents 16 and 72 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the informed consents were obtained from the residents upon admission. RN 1 stated the licensed nurses wrote grab bars for all the informed consents for side rails use. RN 1 acknowledged the size of the side rails, whether 1/4 or 1/2 side rails, were added after the informed consent for grab bars were obtained from the residents or their responsible parties. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 1320 hours, a concurrent interview and medical record review for Residents 16, 72, and 928 was conducted with the DON. The DON verified the above findings. The DON stated the informed consent for side rails should be obtained prior to the installation of side rails. The DON stated the side rails should coincide to what the PT/OT recommended, informed consent, and physician's order. 49324 8. On 10/9/24 at 0801 hours, an initial room observation of Resident 97 was conducted. Resident 97 was asleep on the left side lying position in a low position bed, and the floor mat observed on the left side of bed but no floor mat on the right side of bed. Medical record review for Resident 97 was initiated on 10/10/24. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Fall Risk assessment dated [DATE], showed the resident was at risk for falls. Review of Resident 97's Order Summary Report showed a physician's order dated 6/30/24, may have grab bars as enabler to aid mobility, positioning, and ADL functions. Review of Resident 97's Bed Rails assessment dated [DATE], showed the alternatives attempted was not specified and the indication for use was also not specified. On 10/10/24 at 0943 hours, a concurrent medical record review and interview was conducted with RN 2. RN 2 stated there were no alternatives tried for use of the grab bar. On 10/11/24 at 1620 hours, an interview was conducted with DON. The DON verified the findings. 9. On 10/10/24 at 0854 hours, an observation was conducted on Resident 71's room. Resident 71 was asleep on a side lying position, with the bilateral 1/4 side rail elevated. Medical record review for Resident 71 was initiated on 10/10/24. Resident 71 was admitted to the facility on [DATE]. Review of Resident 71's Order Summary Report showed a physician's order dated 10/9/24, may have 1/4 side rails in bed to aid mobility and ADL functions. Further review of Resident 71's medical record failed to show alternative measures were attempted prior to the use of the quarter side rails. On 10/10/24 at 0917 hours, an observation and concurrent interview was conducted with RN 2. RN 2 acknowledged no alternative measures were provided before the physician's order dated 10/9/24, for the 1/4 side rails. On 10/11/24 at 1620 hours, the DON verified no alternative measures were provided for the use of 1/4 side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44175 10.a. On 10/8/24 at 1203 hours, and 10/10/24 at 0816 and 1027 hours, Resident 95 was observed lying in the bed with bilateral 1/4th side rails elevated. Medical record review for Resident 95's was initiated on 10/8/24. Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 7/23/24, showed Resident 95 may make her own medical decisions. Review of Resident 95's MDS dated [DATE], showed Resident 95 had severe cognitive impairment. Further review of the MDS showed Resident 95 had no impairment in range of motion to the bilateral upper and lower extremities and required maximum to total staff assistance for ADL. Review of Resident 95's Physician Order Summary showed an order dated 10/8/24, for 1/4th side rails as enabler to aid bed mobility, positioning, and ADL functioning. Further review of the physician order did not specify one or bilateral side rail. Review of Resident 95's Bed Rails-v 2 dated 7/23/24 showed visually checked the bed, mattress, and rail to ensure its appropriateness for the resident's dimension. Under the section for alternatives attempted showed not applicable. b. Review of the Resident 95's Physician Document of Informed Consent dated 10/4/24, showed a consent for the bilateral 1/4 grab bars as enabler for mobility. Further review of the document did not show for an informed consent for the use of bilateral 1/4 side rails. 11.a. On 10/8/24 at 0952 and 1315 hours, and 10/10/24 at 0814 hours, Resident 29 was observed lying in bed, bilateral 1/4 side rails were observed elevated. Medical record review for Resident 29 was initiated on 10/8/24. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's MDS dated [DATE], showed Resident 29 had severe cognitive impairment. Further review of the MDS showed Resident 29 had impairment on bilateral upper and lower extremities and required total staff assistance for her ADL. Review of the Resident 29's Physician Order Summary showed an order dated 2/2/24, for grab bars as enablers to aid bed mobility, positioning, and ADL functions. Further review of the physician's order did not show an order for bilateral 1/4 side rails. Review of Resident 29's Care Plan dated 8/1/24, showed a care plan problem addressing Resident 29's at risk for fall related to incontinence, poor communication, and comprehension. Review of Resident 29's Bed Rails-v 2 dated 7/24/24 showed visually checked the bed, mattress, and rail to ensure its appropriateness for the resident's dimension. Under the section for alternatives attempted showed bed rails not applicable. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of the Resident 29's Facility Verification of Informed Consent dated 7/27/23, showed a consent for the grab bars and 1/4 side rails. In addition, review of the document dated 2/2/24, showed a consent for the grab bars as enabler to aid bed mobility, positioning, and ADL function. Further review of the document failed to show a consent for the use of bilateral 1/4 side rails. On 10/10/24 at 1518 hours, a concurrent observation and interview was conducted with LVN 5. LVN 5 verified the observation and stated Residents 29 and 95 had bilateral 1/4 side rails elevated. On 10/10/24 at 1528 hours, a concurrent interview and medical record review for Residents 29 and 95 was conducted with RN 6. RN 6 was informed and verified the above findings. RN 6 stated the bed rails alternatives should have been attempted for Residents 29 and 95. RN 6 verified the physician's order for Resident 95 did not specify bilateral side rails and there was no physician's order for bilateral side rails for Resident 29. RN 6 further stated Resident 29 had the physician's order for grab bars; however, she was not able to find the physician's order for bilateral side rails for Resident 29. On 10/11/24 at 1456 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. 49644 12. On 10/8/24 at 0848 hours, a concurrent observation and interview was conducted with Resident 116. Resident 116 was observed lying in bed and holding her cellphone. Resident 116's bed had bilateral 1/4 side rails elevated. Resident 116 stated she used the bilateral 1/4 side rails to get up and turn. Medical record review for Resident 116 was initiated on 10/8/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's MDS dated [DATE], showed Resident 116's cognition was intact. Review of Resident 116's Order Summary Report for October 2023 showed a physician's order dated 8/26/24, may have grab bars as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 116's Bed Rails - V2 dated 8/26/24, showed no documented evidence of the alternatives attempted prior to the installation of bed rails. On 10/10/24 at 0851 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 verified Resident 116 had bilateral 1/4 side rails elevated. CNA 6 stated Resident 116 used the bilateral 1/4 side rails all the time to reposition. On 10/11/24 at 0923 hours, a concurrent observation, interview, and medical record review was conducted with RN 1. RN 1 verified Resident 116's 1/4 side rails were elevated. RN 1 stated the facility had no specification of what was available for the resident and the staff told the residents that it was an enabler. RN 1 acknowledged the Bed Rail - V2 form showed there was no alternative prior to the installation of Resident 116's bed rails. RN 1 stated she would check the Rehabilitation Department if they had the assessment, and she would provide the copy. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 1415 hours, a follow-up interview was conducted with RN 1. RN 1 stated the Rehabilitation Department had no copy of the alternatives attempted prior to installation of Resident 116's bed rails. On 10/11/24 at 1722 hours, an interview was conducted with the DON. The DON stated the bed rail assessment was initially done by the admission nurse. The DON further stated the staff from the Rehabilitation Department did the assessment and recommendation for the use of grab bar or side rails. The staff from the Rehabilitation Department would communicate to the nursing and maintenance to install the recommended grab bar or side rail. 13. On 10/8/24 at 0828 hours, a concurrent observation and interview was conducted with Resident 728. Resident 728 was observed lying in bed with bilateral 1/4 siderails elevated. Resident 728 stated she used the bilateral side rails when she tried to get up from bed. Review of Resident 728's Order Summary Report for October 2024, showed a physician's order dated 10/8/24, may have 1/4 side rails as enabler to aid bed mobility, positioning, and ADL (activities of daily living) functions. Review of Resident 728's Physician Documentation of Informed Consent dated 10/6/24, showed the prolonged use of device order - grab bars as enabler to aid bed mobility, positioning, and ADL (1/4). On 10/11/24 at 0822 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 verified Resident 728 had bilateral 1/4 side rails elevated. CNA 6 stated Resident 728 used the side rails to move side to side and to sit. On 10/11/24 at 0914 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified Resident 728's Physician Documentation of Informed Consent form included both the grab bar and 1/4 side rail. RN 1 stated the facility had no specification of what was available for the resident and the staff told the residents it was an enabler. On 10/11/24 at 1722 hours, an interview was conducted with the DON. The DON stated the assigned nurse to update the informed consent only updated it as grab bars. The DON further stated the facility failed to double check the informed consent. The DON stated the unit managers added 1/4 side rail to the informed consent. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 35346 14. On 10/11/24, at 0904 hours, concurrent observation of Resident 1's side rails and interview was conducted with CNA 15. When asked about Resident 1's side rails, CNA 15 stated Resident 1 held on to his side rails when he was being changed. Medical record review for Resident 1 was initiated on 10/9/24. Resident 1 was readmitted to the facility on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's H&P examination dated 7/25/24 showed Resident 1's diagnoses included left side paralysis, anxiety, and depression. Review of Resident 1's informed consent dated 10/7/24 showed, Resident 1's device order was grab bars as enabler for mobility (1/4). Review of Resident 1's bed rail assessment dated [DATE], failed to show a reason why alternatives to Resident 1's bed rails were ineffective. 15. On 10/8/24 at 1000 hours, during an observation, Resident 13 was observed with her 1/4 mid bed rails elevated. Medical record review for Resident 13 was initiated on 10/8/24. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's physician progress note dated 8/7/24 showed, Resident 13's diagnoses included dementia with behaviors and depression. Review of Resident 13's informed consent dated 10/4/24 showed, Resident 13's device order was grab bars as enabler for mobility (1/4). Review of Resident 13's bed rail assessment dated [DATE] failed to show a reason why alternatives to Resident 13's bed rails were ineffective. 16. On 10/11/24, at 0904 hours, a concurrent observation and interview was conducted with CNA 15. When asked about Resident 22's side rails, CNA 15 stated she did not know why Resident 22's bilateral 1/2 side rails were elevated Medical record review for Resident 22 was initiated on 10/11/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 10/11/23 showed, Resident 22's diagnoses included depression. Resident 22 was cognitively impaired. Review of Resident 22's informed consent dated 10/4/24, showed Resident 22's device order was grab bars as enabler for mobility (1/4). Review of Resident 22's bed rail assessment dated [DATE], showed a reason why alternatives to Resident 22's bed rails were ineffective was the bed rails not applicable. 17. On 10/08/24 at 0945 hours, during an observation, Resident 26 was observed in bed with his bilateral upper 1/4 bed rails elevated. Medical record review for Resident 26 was initiated on 10/11/24. Resident 26 was readmitted to the facility on [DATE]. Review of Resident 26's H&P examination dated 2/16/24, showed Resident 26's diagnoses included left side paralysis, dementia, and depression. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26's informed consent dated 10/4/24, showed Resident 26's device order was grab bars as enabler for mobility (1/4). Review of Resident 26's bed rail assessment dated [DATE], showed a reason why alternatives to Resident 26's bed rails were ineffective was the bed rails not applicable. 18.a. On 10/09/24 at 1010 hours, during an observation, Resident 84 was observed in bed, with his 1/8 bed rails elevated. Medical record review for Resident 84 was initiated on 10/9/24. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's physician progress note dated 6/5/24, showed Resident 84 did not have capacity to make medical decisions. Resident 84's diagnoses included dementia and post status torn rotator cuff. Review of Resident 84's bed rail assessment dated [DATE], showed a reason why the alternatives to Resident 84's bed rails were ineffective was the bed rails not applicable. b. Review of Resident 84's informed consent dated 10/4/24, showed Resident 84's device order was grab bars as enabler for mobility. On 10/11/24 at 2000 hours, during an interview with the DON, the DON verified the side rails did not match what Resident 84 had consented for the grab bars. 19. On 10/09/24 at 1024 hours, during an observation, Resident 111 was observed in bed with her bilateral 1/4 bed rails elevated. Medical record review for Resident 111 was initiated on 10/9/24. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's H&P examination 9/17/24, dated showed Resident 111's diagnoses included cognitive impairment. Review of Resident 111's informed consent dated 10/6/24, showed Resident 111's device order was grab bars as enabler for mobility (1/4). Review of Resident 111's bed rail assessment dated [DATE], failed to show a reason why alternatives to Resident 111's bed rails were ineffective. On 10/11/24 at 2000 hours, the above findings were verified with the DON.

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F 0757 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 68) reviewed for urinary tract infection was monitored for the side effects of Bactrim (medication used to treat infections) medication. This failure had the potential to negatively impact Resident 68's well-being. Findings: Review of the facility's P&P titled Medication Monitoring revised 12/19/22, showed this facility takes collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences. Medical record review for Resident 68 was initiated on 10/8/24. Resident 68 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's Order Summary Report for October 2024 showed a physician's order dated 10/7/24, to administer Bactrim DS (double strength) oral tablet 800-160 mg one tablet by mouth every 12 hours for UTI for seven days. Review of Resident 68's medical record failed to show Resident 68 was monitored for the side effects of Bactrim. On 10/11/24 at 1001 hours, a concurrent interview and medical record review for Resident 68 was conducted with RN 1. RN 1 stated Resident 68 was taking Bactrim for her urinary tract infection. RN 1 verified Resident 68 had no monitoring for the side effects of Bactrim. RN 1 stated the monitoring of side effects for Resident 68 was on her care plan. RN 1 further stated the staff only monitored a resident if there was an adverse effect. RN 1 stated the staff would document in the progress note if there was an adverse effect. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for one of 28 final sampled residents (Resident 69) and one closed record (Resident 731) were complete and accurately documented. * The facility failed to ensure Resident 69's POLST Section D information and signatures were documented. * The facility failed to ensure the AMA form was maintained in the resident's medical records. These failures had the potential for the residents' care needs not being met as their medical information was incomplete and inaccurate Findings: Review of the facility's P&P titled Documentation in Medical Record revised 12/19/24, showed documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 1. Medical record review for Resident 69 was initiated on 10/9/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's POLST dated 8/724, failed to show the completed documentation on Section D. Section D was completely blank. On 10/9/24 at 0959 hours, a concurrent medical record review and interview was conducted with LVN 2. LVN 2 verified Section D of the POLST was blank. On 10/9/24 at 1019 hours, a concurrent medical record review and interview was conducted with RN 2. RN 2 verified Section D was blank. On 10/11/24 at 1620 hours, the DON verified Section D of the POLST was blank. 49644 2. Closed medical record review for Resident 731 was initiated on 10/9/24. Resident 731 was admitted to the facility on [DATE]. Review of Resident 731's Progress Notes for October 2024, showed the nurses' progress note dated 10/7/24, the family of Resident 731 had signed the AMA form. Review of Resident 731's medical record failed to show a signed AMA form. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 10/10/24 at 1357 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 731's nurses progress note showed Resident 731's family signed the AMA form. LVN 8 stated to ask the medical records for the copy of the AMA form. On 10/11/24 at 1355 hours, an interview was conducted with the Medical Records Director. The Medical Records Director stated she looked at Resident 731's medical record and was not able to find the signed AMA form. The Medical Records Director stated the DON told her she was not able to find Resident 731's signed AMA form. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.