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	08/08/2025

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 0554 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of six sampled residents (Residents 2 and 4) were assessed for safe self-administration of medications. * Resident 2 was observed with a full and uncovered 16 ounces tub of zinc oxide (a medicated cream used as a protective barrier for the affected skin areas) inside his restroom. * Resident 4 was observed with Halls cough drops on the bedside table. These failures had the potential for Residents 2 and 4 to administer the medications inaccurately and may negatively impact the health and safety of the residents.Findings: Review of the facility's P&P titled Resident Self-Administration of Medication revised 12/19/22, showed a resident may only self-administer medications after the facility’s interdisciplinary team has determined which medications may be self-administered safely. The results of the interdisciplinary team assessment are recorded on the electronic health record. The care plan must reflect resident self-administration and storage arrangements for such medications. 1. Medical record review for Resident 2 was initiated on 8/7/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed a BIMS score of 14, which meant the resident was cognitively intact. On 8/7/25 at 1015 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 stated he has been applying the zinc oxide ointment to his buttock and scrotum areas twice a day to prevent redness and skin irritation to areas during restroom use on his own, since he could walk now and help himself to the restroom. Resident 2's restroom was also observed with a full and uncovered 16 ounces tub of zinc oxide cream with a tongue depressor placed inside a large pink basin with other incontinent supplies. When asked who provided the cream, Resident 2 stated a nurse provided it to him and was not able to recall the name of the nurse. On 8/7/25 at 1029 hours, an observation and concurrent interview for Resident 2 was conducted with CNA 1. CNA 1 verified the findings and stated that medicated cream should not be left unattended. Review of Resident 2’s physician’s orders dated 8/7/25, showed a treatment order to apply the zinc oxide ointment every shift for 30 days for maintenance for resolved sacrum Stage 1 pressure ulcer. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Potential for minimal harm Residents Affected - Some	Further review of Resident 2's medical record failed to show documented evidence of the following for Resident 2 to safely self-administer medications including: - a physician's order - self-administration of medication assessment - IDT notes - a care plan addressing Resident 2's self- administration of medication On 8/7/25 at 1457 hours, an interview and concurrent medical record review for Resident 2 was conducted with Treatment Nurse 1. Treatment Nurse 1 verified Resident 2 did not have a physician’s order, assessment, and care plan to address the safe self-administration of the medications, including the medicated cream. On 8/7/25 at 1545 hours, the DON was informed and verified the above findings. 2. On 8/8/25 at 0844 hours, during the tour of the facility, Resident 4 was observed with four pieces of Halls cough drops on the resident’s bedside table. LVN 2 was in the hallway outside the resident’s room and was asked to come inside the resident’s room for an interview. When asked if the Halls cough drops were considered medications, LVN 2 stated he was not sure and would get back with a response. On 8/8/25 at 0852 hours, a follow-up interview was conducted with LVN 2. LVN 2 stated he verified with RN 2 and RN 2 informed him the Halls cough drops were considered candy. On 8/8/25 at 0856 hours, LVN 2 provided the packaging where the Halls came from. The Halls packaging showed Halls Sugar Free to relieve cough, soothes the throat, and cools nasal passages. The Halls packaging also showed Menthol 5.8 mg. LVN 2 verified the findings and stated Resident 4 should not have had the cough drops at her bedside and needed to have permission from the physician, documented in the progress notes and care plan, and self-administration of medications needed to be filled out. LVN 2 verified Resident 4 was not assessed for safe self-administration of medications, no care plan initiated, and no physician’s order was obtained for self-administration of medication. Medical record review for Resident 4 was initiated on 8/8/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4’s H&P examination dated 7/31/25, showed the resident was alert, oriented and cognitively intact. Further review of Resident 4's medical record failed to show documented evidence of the following for Resident 4 to safely self-administer medications including: - a physician's order - self-administration of medication assessment (continued on next page)

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F 0554 Level of Harm - Potential for minimal harm Residents Affected - Some	- IDT notes - a care plan addressing Resident 4’s self- administration of medication On 8/8/25 at 1448 hours, an interview was conducted with Resident 4. Resident 4 stated a friend brought it to her and she took one Halls cough drop every night by herself. Resident 4 further stated she did not inform anyone when she was going to take it. On 8/8/25 at 1545 hours, the Administrator and DON were informed and acknowledged the above findings.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure a care plan was developed to address an incident between Janitor 1 and one of six sampled residents (Resident 6). The Maintenance Director and Janitor 1 failed to notify the charge nurse and the DON timely when Resident 6 had a verbal outburst towards Janitor 1 when she was asked to leave the laundry room for safety reasons. This failure placed the resident at risk for not having individualized interventions to address the resident's behavior. Findings: On 8/8/25 at 0913 hours, during the initial tour of the facility, an interview was conducted with Resident 6. Resident 6 stated Janitor 1 has been stalking her. Resident 6 stated she went down to the laundry room about three months ago because she ran out of clothes. Once in the laundry room, Janitor 1 told Resident 6 to leave, and she could not be down there. Resident 6 then stated Janitor 1 followed her to her room and she told him to leave her alone. Resident 6 stated the stalking happened about two months. Resident 6 stated she was speaking with another resident and claimed Janitor 1 came up and started talking to the other residents she was talking to. Resident 6 stated Janitor 1 has been told to not go near her; however, came into her room on a different occasion. Resident 6 claimed LVN 3 may have known about it. On 8/8/25 at 0951 hours an interview was conducted with the Administrator and DON. The Administrator and DON were notified of the allegation Resident 6 made against Janitor 1. The DON stated she was made aware by the Maintenance Director about a month ago about Resident 6 not being comfortable with Janitor 1 and Janitor 1 was asked not to go inside her room anymore. However, the DON stated she was not aware of the allegation made by Resident 6. When the DON was asked if she was aware of the reason as to why Resident 6 was not comfortable with Janitor 1, the DON stated no. When asked if the facility had documentation of the report received from the Maintenance Director, the DON stated it was all verbal. The DON claimed she was informed by the Maintenance Director about Janitor 1 accidentally went inside the room of Resident 6 to get the trash. On 8/8/25 at 1018 hours, a concurrent interview was conducted with the Maintenance Director, Administrator, and DON. The Maintenance Director stated Janitor 1 informed him a CNA took Resident 6 to the laundry room and left her there. Janitor 1 told Resident 6 she could not be in the laundry room and Resident 6 started cursing at Janitor 1 and telling him she could do what she wanted because she lived there. The Maintenance Director stated the incident happened about a month ago and claimed Janitor 1 reported the incident to him the following day. When asked if the incident was reported to the DON, the Maintenance Director stated he did not recall if he told all the details at the time. The Maintenance Director also stated he informed Janitor 1 to not go to Resident 6's room; however, because Janitor 1's responsibility included taking out the trash from the residents' room, it was a routine for Janitor 1 to go inside the rooms and accidentally walked inside Resident 6's room to take out the trash. Once Janitor 1 walked into Resident 6's room, he left the room and informed the Maintenance Director. The Maintenance Director informed the DON. When asked if Janitor 1 informed the nursing staff, the Maintenance Director stated he did not recall if Janitor 1 reported the incident to anyone else. The Maintenance Director further stated Janitor 1 felt he did not need to escalate the situation to the Administrator or the DON. When the DON was asked if the staff member may leave the residents in the laundry room by themselves, the DON stated the family or residents may go down to the laundry. If the resident was alert, oriented, and ambulatory, the staff may endorse the resident to go in the laundry room if there was also a staff present at the time. When the DON was asked if the facility documented when a concern was brought up, the DON stated the facility was meant to document; however, the DON stated she was not informed by a charge nurse or CNA about an incident between Janitor 1 and Resident 6. Medical record review for Resident 6 was initiated on 8/8/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 2/13/25, showed the resident was alert and oriented times three, had normal cognition, and had the capacity for healthcare decisions. Further review of Resident 6's medical record did not show documentation of the incident between Janitor 1 and Resident 6. There was no documented evidence a care plan was developed to address the incident and Resident 6's behavior episode towards Janitor 1, to include interventions to prevent another incident between Janitor 1 and Resident 6. On 8/8/25 at 1104 hours, an interview was conducted with LVN 3. Resident 6 identified LVN 3 as the staff who may have had knowledge of the incident between her and Janitor 1. When asked if he was made aware Resident 6 went down to the laundry room with a CNA, LVN 3 stated he did not recall hearing about the situation. When asked if he recalled if Resident 6 had an issue with