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	08/21/2025

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 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	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, closed medical record review, and facility P&P review, the facility failed to notify the resident's representative regarding the resident's change in condition for one of four sampled residents (Resident 1). * The facility failed to notify Resident 1's representative when Resident 1 had poor PO (by mouth, oral) intake (refusing meals/fluids), increased weakness, and confusion, and was sleepy on 8/3/25. This failure had the potential to delay of notification of the resident's changes of condition to the resident's responsible party. Findings: Review of the facility's P&P titled Notification of Changes reviewed/revised 12/19/22, showed the purpose of this 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 a notification. Under the Additional considerations section for competent individuals, showed when a resident is mentally competent, such a designated family member must be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident. Closed medical record review for Resident 1 was initiated on 8/19/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/16/25. Review of Resident 1's H&P examination dated 12/7/24, showed the resident had the capacity to make medical decisions. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 8/3/2025, showed the resident had poor PO intake, was refusing meals/fluids, sleepy, and had increased weakness. In addition, the mental status evaluation showed Resident 1 had increased confusion. However, further medical record review for Resident 1 failed to show documented evidence Resident 1's family member and/or resident representative was notified of the resident's changes in condition. On 8/21/25 at 1151 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 verified Resident 1's family member and/or resident representative was not notified of the resident's changes in condition. LVN 2 stated after the resident's change in condition was initiated, the resident's physician and family member should be notified. On 8/21/25 at 1645 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555308	A. Building B. Wing	08/21/2025

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Trabuco Hills Post Acute	25652 Old Trabuco Road Lake Forest, CA 92630

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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. (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 0684 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, closed medical record review, and facility P&P review, the facility failed to provide services to attain or maintain the highest practicable well-being for one of four sampled residents (Resident 1). * The facility failed to ensure the results of Resident 1's CBC (Complete Blood Count), BMP (Basic Metabolic Panel), and urinalysis test were promptly reported to Resident 1's physician. This failure had the potential for the resident not to receive the necessary care and services to maintain their highest physical well-being and potentially delaying necessary care and treatment. Findings: Review or the facility's P&P titled Laboratory Services and Reporting reviewed/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 1 was initiated on 8/19/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/16/25. Review of Resident 1's H&P examination dated 12/7/24, showed the resident had the capacity to make medical decisions. Review of Resident 1's Order Summary Report dated 8/21/25, showed a physician's order dated 8/3/25 at 1830 hours, for stat CBC, BMP , urine analysis with culture and sensitivity. To start IV hydration 60 cc for 48 hours. Review of Resident 1's Lab Results Report dated 8/4/25, showed the following CBC report information: - Collection date: 8/4/25 at 1145 hours;- Received date: 8/4/25 at 1654 hours; and- Reported date: 8/4/25 at 2231 hours.In addition, the report showed Resident 1's WBC (White Blood Count) was 20.3 and the reference range was 4.5-11. However, further closed medical record review for Resident 1 failed to show documented evidence the CBC test results were promptly reported to Resident 1's physician. b. Review or the facility's P&P titled Urine Sample Collection reviewed/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 of Resident 1's Lab Results Report dated 8/5/25, showed the following urinalysis report information: - Collection date: 8/4/25 at 0500 hours;- Received date: 8/5/25 at 1435 hours; and- Reported date: 8/5/25 at 1917 hours.In addition, the report showed Resident 1's urine WBC was 6-10 and the reference range was negative. The report also showed there was moderate bacteria and the reference range was none seen. However, further closed medical record review for Resident 1 failed to show documented evidence the urinalysis test results were promptly reported to Resident 1's physician. c. Review of Resident 1's Lab Results Report dated 8/5/25, showed the following BMP report information: - Collection date: 8/5/25 at 1500 hours;- Received date: 8/5/25 at 1952 hours; and- Reported date: 8/5/25 at 2229 hours. In addition, the report showed Resident 1's BUN was 57 mg/dl and the reference range was 9-23 mg/dl. However, further closed medical record review for Resident 1 failed to show documented evidence the BMP test results were promptly reported to Resident 1's physician. On 8/21/25 at 1203 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 verified Resident 1's CBC, urinalysis and BMP results were not promptly reported to the resident's physician. LVN 2 acknowledged there was no documentation to show Resident 1's physician was informed promptly regarding the resident's abnormal CBC results. LVN 2 verified the resident's urinalysis laboratory results fell outside of the clinical reference range and was not promptly reported to Resident 1's physician. LVN 2 stated the licensed nurse should have called the laboratory right away and reported the abnormal laboratory results to Resident 1's physician. On 8/21/25 at 1353 hours, an interview and concurrent closed medical record review was conducted with RN 1. RN 1 verified there was no documentation to show Resident 1's physician was informed promptly regarding the resident's abnormal CBC results. RN 1 verified the above findings. RN 1 stated the licensed nurse should have called Resident 1's physician right away and document the notification. On 8/21/25 at 1645 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0770 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the laboratory tests for one of four sampled residents (Resident 1) was performed as ordered. * The facility failed to ensure Resident 1's physician's order for stat CBC, urinalysis, and BMP laboratory tests were completed in a timely manner. This failure posed the risk for Resident 1 not receiving the appropriate treatment, which could significantly impact the resident's well-being. Findings: According to the Fundamentals of Nursing 10th edition, under the Types of Orders section, a stat order is also a single order, but it is carried out immediately. 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. 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. Closed medical record review for Resident 1 was initiated on 8/19/25. Resident 1 was admitted to the facility on [DATE], and discharged on 8/16/25. Review of Resident 1's H&P examination dated 12/7/24, showed the resident had the capacity to make medical decisions. Review of Resident 1's Order Summary Report dated 8/21/25, showed a physician's order dated 8/3/25 at 1830 hours, for stat CBC, BMP, and UA with C&S. Review of Resident 1's Lab Results Report dated 8/4/25, showed the CBC collection date and time was on 8/4/25 at 1145 hours. Review of Resident 1's Lab Results Report dated 8/5/25, showed the urinalysis collection date and time was on 8/4/25 at 0500 hours. Review of Resident 1's Lab Results Report dated 8/5/25, showed the BMP collection date and time was on 8/4/25 at 1145 hours. However, further closed medical record review for Resident 1 failed to show documented evidence the stat CBC, urinalysis, and BMP were collected in a timely manner. On 8/21/25 at 1203 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated the licensed nurse should have collected the urine right away or as soon as possible. LVN 2 stated the licensed nurse should have called the laboratory right away because the physician's order for Resident 1's laboratory tests were ordered as a stat order. On 8/21/25 at 1353 hours, an interview and concurrent closed medical record review was conducted with RN 1. RN 1 acknowledged there was no documentation the laboratory was called right away to draw/collect the resident's ordered stat laboratory tests. RN 1 stated the licensed nurse should have endorsed to the next shift if the laboratory was called and to follow up to the laboratory staff. On 8/21/25 at 1645 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.