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	09/09/2025

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 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, closed medical record review, and facility P&P review, the facility failed to provide the necessary treatment and services to maintain the highest practicable well-being for one of five sampled residents (Resident 3). * The facility failed to ensure Resident 3's change in condition of aggressive behavior was monitored every shift for 72 hours. In addition, the facility failed to ensure Resident 3's plan of care was revised to address Resident 3's recent behavioral episode. This failure had the potential to negatively affect Resident 3's health and well-being and the potential risk of not providing Resident 3 with appropriate and individualized care.Findings: Review of the facility's P&P titled Care Plan Revisions Upon Status Change revised 12/19/22, showed the comprehensive care plan will be reviewed and revised as necessary, when a resident experiences a status change. The care plan will be updated with the new or modified interventions. Closed medical record review for Resident 3 was initiated on 9/5/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 3/16/25, showed Resident 3 had the capacity to make medical decisions. a. Review of Resident 3's progress notes dated 6/20/25 at 1930 hours, showed Resident 3 was observed exhibiting aggressive behavior, barricading himself in the room, yelling and posing as a danger to himself and others. The licensed nurse documented the IM (intramuscular) Ativan (antianxiety medication) was being administered as ordered by the physician and the resident would be monitored closely for safety. Review of Resident 3's eINTERACT Change of Condition Report dated 6/20/25 at 2000 hours, showed Resident 3 exhibited physical aggression with episodes of hitting and refusal of the medication. However, further review of Resident 3's medical record failed to show the resident's change in condition was monitored after the resident's initial change in condition was observed. b. Review of Resident 3's plan of care showed a care plan problem dated 3/20/25, addressing Resident 3's mood problem, with the goal for the resident to have improved mood state. However, further review of Resident 3's plan of care failed to show the resident's care plan was revised to include the interventions associated with the resident's change of condition regarding the recent episodes of the physical aggression on 6/20/25. On 9/5/25 at 1612 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 verified Resident 3's care plan was not revised to reflect the new interventions and monitoring of the resident's status related to the recent episodes of the physical aggression on 6/20/25. RN 2 stated for the residents with a change in condition, the residents should be monitored for a minimum of 72 hours and documented in the resident's progress notes. RN 2 verified there was no documented evidence to show Resident 3's condition was monitored for 72 hours, after the resident's initial change in condition was observed and documented. On 9/9/25 at 1500 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were 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	09/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, closed medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services for one of five sampled resident (Resident 3). * The facility failed to ensure Resident 3's antianxiety medication was available for administration as ordered by the physician. In addition, the facility failed to ensure the May and June 2025 narcotic count sheets for Resident 3's clonazepam medication were available and kept in the resident's medical record. This failure had the potential to negatively impact the resident's health conditions and psychosocial well-being.Findings: Review of the facility's P&P titled Ordering and Receiving Controlled Medications revised 01/2025 showed Schedule II controlled medications prescribed for a specific resident are delivered to the facility only if a valid prescription has been received by the pharmacy prior to dispending. In an emergency situation, the provider pharmacy can accept a telephone order. A follow-up valid prescription is sent to the pharmacy by prescriber within seven days. Closed medical record review for Resident 1 was initiated on 9/5/25. Resident 3 was admitted to the facility on [DATE], and with medical history included generalized anxiety disorder. a. Review of Resident 3's Order Summary Report with active orders as of 7/12/25, showed a physician's order dated 4/2/25, to administer clonazepam (antianxiety medication) oral tablet 2 mg one tablet by mouth at bedtime for anxiety manifested by verbalization of anxiousness. Review of Resident's 3 MAR for June 2025 showed Resident 3's clonazepam medication was documented with the chart code 6 (6= absent from facility with meds ineffective) from 6/22 to 6/24/25 and 6/26 to 6/28/25. In addition, on 6/25/25, the MAR for the clonazepam medication was blank. Further review of Resident 3's medical record failed to show documented evidence the physician, facility's pharmacy, and resident's responsible party were informed the clonazepam medication was not administered to the resident as ordered due to the medication not being available. On 9/9/25 at 1100 hours, a telephone interview was conducted with LVN 4. LVN 4 verified Resident 3's clonazepam medication was not available to administer to the resident from 6/22 to 6/28/25. LVN 4 stated he notified the residents' responsible party, facility's pharmacy, and attending physician about the unavailability of the clonazepam medication, however, he failed to document the communication/notification in the resident's medical record. LVN 4 further stated the potential consequences of a suddenly stopping the administration of the clonazepam medication could lead to behavioral problems and withdrawals effects. b. On 9/4/25 at 1406 hours, a telephone interview was conducted with LVN 5. LVN 5 stated Resident 3's family member ordered a 30-day supply of the resident's clonazepam medication on 5/2/25. LVN 5 alleged the facility was supposed to reorder another 30- day supply of the clonazepam medication on 6/2/25, but never did. However, LVN 5 alleged the licensed nurses were signing the resident's medical record to show the clonazepam medication was administered. Review of Resident 3's MAR for May and June 2025 showed Resident 3 received the clonazepam medication as ordered by the physician except from 6/22 to 6/28/25. However, further review of Resident 3's medical record failed to show the May and June 2025 narcotic count sheet for the clonazepam medication. On 9/9/25 at 1415 hours, am interview and concurrent closed medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated she was unaware Resident 3's clonazepam medication was unavailable. In addition, the DON verified Resident 3's May and June 2025 narcotic count sheets for the clonazepam medication were not in the resident's medical record. The DON stated the resident's narcotic count sheets from the previous months were located in an overflow in the medical records department, however, the DON was unable to locate the narcotic count sheets.