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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the medical record was safeguarded to protect the confidential health information for one of 12 sampled residents (Resident 4). * Resident 4's Care Log binder containing personal health information was not secured. This failure had the potential for the resident's personal and health information to be accessed from the unauthorized users.Findings: Review of facility's P&P titled Confidentiality of Personal and Medical Records dated 12/2022 showed keep confidential is defined as safeguarding the content of information including written documentation, video, audio or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative. Medical record review for Resident 4's was initiated on 1/9/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/19/25, showed the resident had no capacity to make medical decisions. On 1/9/26 at 1538 hours, during an observation, Resident 4's Resident Care Log binder was tucked on the railings outside Resident 4's room, in the hallway leading to the front main entrance of the facility. On 1/9/26 at 1541 hours, during an observation, multiple staff and visitors were observed passing by Resident 4's binder in the hallway. On 1/9/26 at 1543 hours, during an observation, a CNA was walking past Resident 4's room. The CNA did not acknowledge the binder. On 1/9/26 at 1547 hours, during an observation, multiple visitors were observed walking out of the room across Resident 4's room, towards the exit. On 1/9/26 at 1549 hours, during an observation, a group of visitors walked past Resident 4's binder, to the front exit. On 1/9/26 at 1550 hours, during an observation, a CNA walked past the binder and did not acknowledge it. On 1/9/26 at 1557 hours, during an observation, a CNA walked in and out of nearby rooms and did not acknowledge the binder. On 1/9/26 at 1609 hours, an interview and concurrent observation was conducted with LVN 1. LVN 1 acknowledged the binder and stated the resident's family liked to have it in the hallway. When asked to open the binder, Resident 4's name, room number and care notes were observed inside the binder. LVN 1 acknowledged there were people walking up and down hallways near front exit. On 1/9/26 at 1634 hours, an interview was conducted with the DON. The DON verified the Resident Care Log binder was not supposed to be in the hallway. The DON stated it should be in the resident's room, and a CNA probably forgot to put it back. The DON acknowledged the Resident Care Log binder had Resident 4's name inside the binder.

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 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **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 one of 13 sampled residents (Resident 1) was assessed in a timely manner. * The facility failed to reassess Resident 1's occipital (back of head) when it was deemed unable to visualize upon admission due to matted hair until 3/27/24 (16 days later). This failure had the potential to negatively impact the resident.Findings: Review of the facility's P&P titled admission of a Resident revised 3/2025 showed to be completed on admission: (1) licensed nursing assessment (2) developing a plan of care. Closed medical record review for Resident 1 was initiated on 12/23/25. Resident 1 was admitted to the facility on [DATE], and discharged on 3/27/24. Review of Resident 1's Nurses Progress Notes dated 3/12/24, showed a late entry note stating hair matted to occipital area not able to have visual of scalp. Review of Resident 1's Nurses Progress Notes dated 3/27/24, showed at 1015 hours, Family Member 1 was working on the resident's matted hair on the occipital area and noticed dry blood. On 1/22/26 at 1100 hours, an interview was conducted with LVN 5. LVN 5 stated upon Resident 1's admission to the facility, the resident was observed with matted hair close to the scalp. LVN 5 stated the facility staff could not observe anything except the matted hair. When asked if Resident 1's occipital was reassessed, LVN 5 stated Family Member 1 wanted to work through the matted hair. LVN 5 stated once she was able to work through the hair she saw the scalp. On 1/23/26 at 1615 hours, an interview was conducted with the Administrator and DON. 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 0686 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 provide the necessary care and services to prevent the development or worsening of pressure injuries (localized damage to skin and underlying tissue, usually over bony prominences) for one of 12 sampled residents (Resident 11). * The facility failed to ensure Resident 11's low air loss mattress setting was properly set in accordance to the resident's weight. This failure had the potential for Resident 11 to develop pressure injuries or worsening of the existing pressure injuries.Findings: Review of facility's P&P titled Pressure Injury Prevention and Management revised 9/2023 showed evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but not limited to redistribute pressure (such as repositioning, protecting, and/or offloading heals, etc.), and provide appropriate pressure-redistributing devices, support surfaces. Review of the Apex Domus 4 Instruction Manual (undated) showed the general operations is according to the weight and height of the resident, adjust the pressure setting to the most comfortable level without bottoming out, then the pressure in mattress will slowly increase to the intended value after the air mattress is ready to use. Medical record review for Resident 11 was initiated on 1/14/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 9/29/25, showed the resident had no capacity to understand and make medical decisions. Review Resident 11's Order Summary Report showed the following physician's orders:- dated 8/26/25, low air loss mattress, for wound management check placement and settings every shift daily; - dated 1/14/26, left elbow unstageable pressure ulcer, cleanse with normal saline, pat dry, apply collagen cover (wound dressing) with silver foam dressing (antimicrobial wound dressing) cover with abdominal pad wrap with kerlix secure (roll gauze) with retention tape daily for 21 days and as needed;- dated 1/14/26, mid lower back stage 4 pressure ulcer, irrigate with acetic acid 0.25% (sterile acidic solution), pat dry, pack with collagen particles (wound treatment powder), cover calcium alginate wound dressing, secure with silicone super absorbent (wound dressing) daily for 21 days and as needed if soiled or dislodged every day shift until 1/29/26; and- dated 1/14/26, right elbow unstageable pressure ulcer, cleanse with normal saline, pat dry, apply collagen cover with silver foam dressing cover with abdominal pad wrap with kerlix secure with retention tape daily for 21 days and as needed every day shift until 2/13/26 On 1/14/26 at 0845 hours, an observation of Resident 11, interview and concurrent medical record review was conducted with LVN 7. Resident 11 was observed on a low air loss mattress, with the setting at 450 psi. LVN 7 verified the resident's current weight was 162 pounds and the setting was incorrect for the resident's weight. When asked how long the setting was set at 450 psi, LVN 7 stated the setting was there for a while. On 1/23/26 at 1615 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interview, closed medical record review, and facility P&P review, the facility failed to provide pharmaceutical services to ensure appropriate medication administration for one of 12 sampled residents (Resident 1). * The facility failed to follow the physician's order for the medication administration of a laxative for Resident 1. This failure had the potential to negatively impact the resident.Findings: Review of facility's P&P titled Medication Administration dated 12/2022 showed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standard of practice, in a manner to prevent contamination or infection. Closed medical record review for Resident 1 was initiated on 12/23/25. Resident 1 was admitted to the facility on [DATE], and discharged on 3/27/24. Review of Resident 1's Order Summary Report showed a physician's order dated 3/11/24, to administer Dulcolax (laxative medication) rectal suppository 10 mg, insert one suppository rectally every 24 hours as needed for constipation; if MOM (Milk of Magnesia, laxative) was ineffective. Review of Resident 1's MAR for March 2024 showed on 3/16/24, Dulcolax was administered. There was no documented evidence to show the MOM medication was administered prior to the Dulcolax suppository administration, as ordered. On 1/22/26 at 1205 hours, an interview was conducted with RN 1. RN 1 verified the Dulcolax suppository was administered on 3/16/24, and the MOM medication was not administered prior to the Dulcolax. RN 1 verified the resident should have received the MOM first, or obtained a one-time order for Dulcolax. On 1/23/26 at 1615 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **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 ensure two of 12 sampled residents (Residents 1 and 2) were free from the unnecessary drugs. * Resident 1 was administered Ativan (antianxiety medication) as needed for inability to relax. The non-pharmacological interventions showed documentation of NA. * Resident 1's Informed Consent form for Cymbalta (antidepressant medication) was not obtained prior to medication administration. * Resident 2 was administered Tramadol (narcotic pain medication) as needed for moderate pain. There was no documentation to show the non-pharmacological interventions were implemented. These failures had the potential for the residents to receive unnecessary drugs with significant side effects.Findings: Review of facility's P&P titled Use of Psychotropic Medication use revised 3/2025 showed it is the intent of this policy to ensure that residents only receive psychotropic medications when other non-pharmacological interventions are clinically contraindicated. Non-pharmacological interventions must be attempted unless clinically contraindicated to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication. Review of facility's P&P titled Pain Management revised 3/2025 showed based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain.Non-pharmacological interventions will include but not limited to:environmental comfort measures (e.g., adjusting room temperature, smoothing liens, comfortable seating, assistive devices or pressure redistributing mattress and positioning)Loosening any constrictive bandage, clothing or device;Applying splinting (e.g., pillow or folded blanket);Physical modalities (e.g., cold compress, warm shower slash bath, massage, turning and repositioning) ;Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility; andCognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain). Review of the facility's P&P titled Use of Psychotropic Medication(s) revised 3/2025 showed the facility will document that the resident or resident representative was informed in advance of the risk, and benefits of the proposed care, the treatment alternatives or other options, and the preferred option to accept or decline in a formal the facility deems to use (e.g., written consent form, narrative note, etc.). 1. Closed medical record review for Resident 1 was initiated on 12/23/25. Resident 1 was admitted to the facility on [DATE], and discharged on 3/27/24. Review of Resident 1's Order Summary Report showed the following physicians orders:- dated 3/14/24, to administer Ativan oral tablet 0.5 mg by mouth every six hours as needed for anxiety manifested by inability to relax;- dated 3/22/24, to administer Cymbalta 40 mg one tablet at bedtime for pain management;- dated 3/11/24, behavior monitoring, Ativan, monitor number of hours of sleep, interventions (1) relaxation, (2) adjust room temperature/lighting, (3) reposition, (4) toileting, (5) music/television (6) snack(s), Outcomes (1) improved, (2) improved, (3) unchanged, (4) worsened, every shift a. Review of Resident 1's MAR for March 2024, showed the Ativan was administered on 3/20/24 at 0300 and 1242 hours, and on 3/25/24 at 1503 hours. Further review of Resident 1's MAR for March 2024 showed the behavior monitoring for Ativan was documented as NA for the non-pharmacological interventions and outcomes for the Ativan on 3/20, and 3/25/24 from 0700 hours-1900 hours. b. Review of Resident 1's MAR for March 2024 showed the Cymbalta was administered on 3/22 at 2100 hours and on 3/26/24 at 2100 hours. Further review of Resident 1's medical record failed to show documented evidence the informed consent was obtained prior to the administration of the (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cymbalta medication. There was no documentation of the informed consent in a narrative note or written consent form on or prior to 3/22/24. 2. Closed medical record review for Resident 2 was initiated on 12/23/25. Resident 2 was admitted to the facility on [DATE], and transferred to an acute care facility on 3/26/25. Review of Resident 2's H&P examination dated 3/25/25, showed the resident had no capacity to make medical decisions. Review of Resident 2's Order Summary Report dated 3/26/25, showed to administer Tramadol 50 mg one tablet by mouth every six hours as needed for moderate pain (4-6/10). Further review of the physician's orders failed to show an order for the non-pharmacological interventions to be attempted prior to administering the medication. Review of Resident 2's MAR for March 2025 showed the Tramadol 50 mg tablet was administered on 3/26/25 at 0021 and 0927 hours. There was no documented evidence the non-pharmacological interventions were performed prior to medication administration. On 1/22/26 at 1205 hours, an interview and concurrent closed medical record review for Residents 1 and Resident 2 were conducted with RN 1. RN 1 verified the above findings for Residents 1 and 2. When asked what the NA documentation meant, RN 1 stated if there were episodes of behaviors, the process would be to indicate the number of episodes and document the outcomes after the non-pharmacological interventions. When asked if the non-pharmacological interventions were needed for the Tramadol medication, RN 1 stated yes, since it was an as needed medication. When asked if there were any non-pharmacological interventions for Resident 2, RN 1 stated no. On 1/23/26 at 1615 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were 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** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the medical record for one of 12 sampled residents (Resident 1) were complete and accurate. * Resident 1's Neurological Flowsheets and the wound care treatment on 3/24/24, showed blank entries. This failure had the potential for Residents 1's care needs not being met as their medical information was incomplete.Findings: Review of facility's P&P titled Documentation in Medical Record revised 12/2022 showed the licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses. Closed medical record review for Resident 1 was initiated on 12/23/25. Resident 1 was admitted to the facility on [DATE], and discharged on 3/27/24. a. Review of Resident 1's Care Plan Report dated 3/20/24, showed the resident had an actual fall with no injury, poor balance. The interventions included to complete neuro-checks. Review of Resident 1's Neurological Flowsheet (undated) showed there were no entries under the every eight hours section for numbers 17 and 18. On 1/21/26 at 1550 hours, an interview and concurrent closed medical record review was conducted with the DON and ADON. The DON verified the above findings and stated the neurological assessment should have been completed. b. Review of Resident 1's Order Summary Report showed the following orders:- dated 3/12/24, right above eyebrow laceration, swab with betadine daily times 21 days.- dated 3/12/24, deep purplish discoloration to the left side of the body, monitor for any skin breakdown daily times 30 days. Review of Resident 1's TAR dated 3/24/24, showed no entries for the right eyebrow laceration treatment, and monitoring of the deep purplish discoloration. On 1/22/26 at 1100 hours, an interview and concurrent closed medical record review was conducted the LVN 5 for Resident 1. When asked what the no entries meant for the TAR dated 3/24/24, LVN 5 stated she would have to investigate it further because she was not sure if she was out of the facility that day. LVN 5 verified the above findings. On 1/23/26 at 1615 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.