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	05/27/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **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 protect the resident's belongings from theft or loss for one of three sampled residents (Resident 1) who were transferred to the acute care hospital. * The facility failed to ensure Resident 1's belongings were accounted for and properly stored after being transferred to the acute care hospital. This failure resulted in the facility being unable to locate and return the resident's personal belongings after being discharged from the facility. Findings: Review of the facility's P&P titled Resident Personal Belongings dated 12/19/22, showed all the residents' personal items will be inventoried at the time of admission, and any additional items brought in after will be added to the personal belonging inventory list. The facility will care for the protection of the resident's property from theft or loss. Following the discharge of a resident, all personal belongings will be given to the resident's representative. On 5/21/26 at 1500 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated Resident 1 was transferred to the acute care hospital on 5/11/26, without his personal belongings. Family Member 1 stated when the facility called her about a bed hold, she informed the facility he would not be coming back and asked about his personal belongings especially Resident 1's cellphone, eyeglasses, and wallet with the driver's license. The facility staff told her she could come in and pick up Resident 1's belongings. Family Member 1 stated she went to the facility and facility staff was unable to locate Resident 1's belongings. Closed medical record review for Resident 1 was initiated on 5/22/26. Resident 1 was admitted to the facility on [DATE], and transferred to an acute care hospital on 5/11/26. Review of Resident 1's Resident's Clothing and Possessions form dated 5/7/26, the section for On Admission showed the resident's clothing, cellphone and eyeglasses. However, the form did not indicate the wallet with the driver's license. The section for On Discharge showed blank entries. Review of Resident 1's eINTERACT Transfer Form V5 dated 5/11/26, showed the resident was transferred to the acute care hospital at 1340 hours. The form showed a section for Personal belongings sent with resident/patient. There were multiple boxes to select on which items to were sent, including a box for other with a space provided to specify. However, there were no check marks on any of the boxes. On 5/22/26 at 1557 hours, an interview was conducted with SSD 3. SSD 3 stated she had been in contact with Resident 1's family about the resident's belongings. SSD 3 stated she was unable to locate any but was still checking around the facility and trying to locate Resident 1's belongings. The SSD stated she informed the resident's family the facility will try and locate the items indicated in the resident's Clothing and Possessions form and would reimburse the resident for any items they were unable to locate. On 5/27/26 at 1252 hours, an interview and concurrent record review was conducted with the DON. The DON stated the facility would reimburse any missing resident belongings that were listed on the inventory list. The DON stated she was aware the SSD was attempting to locate Resident 1's reported missing items.

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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, and facility document review, the facility failed to follow their P&P after one of four sampled residents (Resident 2) made an allegation she was raped by CNA 1. * The Abuse Coordinator was not timely notified of the abuse allegation. * The facility failed to immediately remove CNA 1 from the resident care areas to protect all the residents from potential abuse. * The facility failed to protect Resident 2 from further abuse and negative outcomes when LVN 1 [NAME] CNA 1 back to Resident 2's room to verify if CNA 1 was the CNA the resident stated raped her. These failures had the potential to put the resident at risk for further abuse and resulted in a delay in the facility initiating their abuse investigation.Findings: Review of the facility's P&P titled Abuse, Neglect and Exploitation dated 12/19/22, showed abuse allegations will be immediately investigated. The facility will ensure all residents are protected from abuse during and after the investigation to include responding immediately to protect the alleged victim and integrity of the investigation, room or staffing changes to protect the resident(s) from the alleged perpetrator. Review of the facility's P&P titled Compliance with Reporting Allegations of Abuse/ Neglect/ Exploitation dated 12/19/22, showed when an abuse allegation occurs, the licensed nurse will remove the accused employee from resident care areas and notify the Administrator or designee. The Administrator or designee will obtain statements from staff and suspend the accused employee pending the investigation completion. Review of the facility's SOC 341 dated 5/7/26, showed at around 1600 hours, the facility was made aware Resident 2 made a sexual abuse allegation against CNA 1. Medical record review for Resident 2 was initiated on 5/22/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed the resident had moderate cognitive impairment. On 5/22/26 at 0926 hours, an interview was conducted with CNA 1. CNA 1 stated approximately two weeks ago, LVN 1 came up to him and told him Resident 2 stated he raped Resident 2. CNA 1 stated LVN 1 then grabbed his arm and brought him to Resident 2's bedside and asked the resident to verify if it was him. CNA 1 stated Resident 2 stated yes that he raped the resident and that he beat up her brother and put him in the ICU. CNA 1 stated he stayed quiet and did not say anything to the resident, he left the room and LVN 1 told him not to go back in Resident 2's room. CNA 1 stated he had been trained on the facility's abuse procedure and knew he should not have gone back to the resident's room, but LVN 1 brought him in there and he did not know what to do. CNA 1 stated he went to the first floor to let the DSD know what happened and then he went back to work. On 5/22/26 at 0945 hours, an interview was conducted with LVN 1. LVN 1 stated on the day Resident 2 made the allegation, he went into her room at around 0900 hours, to give her routine morning medications. When he went to the resident, Resident 2 told him CNA 1 assaulted her and she wanted him to call the police. LVN 1 stated he asked the resident if she was sure, because this was serious. LVN 1 stated SSD 1 was already on their unit doing his rounds so he notified him immediately, then continued to finish the rest of his medication administrations. LVN 1 stated he also went downstairs and notified the ADON and Administrator. On 5/22/26 at 1049 hours, an interview was conducted with SSD 1. SSD 1 stated his usual routine was to do rounds on the 2nd floor every morning at around 0900 hours, before he goes downstairs to attend the daily stand-up meeting at 0930 hours, and then he would go directly to the clinical meeting which was also downstairs. SSD 1 stated at around 1600 hours, LVN 1 informed him and the ADON to follow up with Resident 2, and he and the ADON went to Resident 2's room. SSD 1 stated Resident 2 stated a male CNA was in her room but Resident 2 was confused and not able to get more information from the resident. On 5/22/26 at 1157 hours, an interview was conducted with the ADON. The ADON stated she was first made aware of Resident 2's allegation in the afternoon, when SSD 1 informed her of a concern with Resident 2. The ADON stated the SSD was not sure what specifically what Resident 2's concern was, but they went upstairs to speak with the resident. The ADON stated Resident 2 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed her someone may have sexually abused her, and she notified the Administrator who was also the facility's abuse coordinator. On 5/22/26 at 1228 hours, an interview was conducted with the DSD. The DSD stated he did not recall talking to CNA 1 on the day Resident 2 made her allegation. The DSD stated he left before noon that day and he was in a rush to get his tasks done before leaving. On 5/22/26 at 1509 hours, a follow up interview was conducted with LVN 1. LVN1 verified after Resident 2 made the allegation, LVN 1 brought CNA 1 into Resident 2's room and asked the resident if CNA 1 was the CNA she was talking about. LVN 1 stated the resident pointed at the CNA and stated yes, it was him. On 5/22/26 at 1637 hours, an interview was conducted with the Administrator. The Administrator stated in the afternoon of 5/7/26, the ADON and SSD 1 spoke to Resident 2. The Administrator stated the ADON informed him but it was not clear what allegations were being made by Resident 2 and rape had not been mentioned by the resident. The Administrator stated he went upstairs to talk to Resident 2 and her story was not very clear, but she eventually stated CNA 1 raped her. The Administrator stated to his knowledge, that was the first time the resident mentioned being raped. The Administrator stated he was not informed Resident 2 made a rape allegation in the morning.