

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Trabuco Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	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 one of four sampled residents (Resident 4) was assessed for safe self-administration of his medications. * Resident 4 self- administered his testosterone transdermal gel without a prior self-administration of medication evaluation, a physician's order, or a care plan. This failure had the potential for Resident 4 to have a medication administration error. Findings: Review of the facility's P&P titled 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 P&P further showed the care plan must reflect the resident's self-administration for such medications. On 6/11/26 at 0809 hours, a medication pass observation and concurrent interview was conducted with LVN 1. During the administration of the Testosterone Transdermal Gel 1.62 %, LVN 1 put one pump of the Testosterone gel into Resident 4's outstretched, ungloved, right hand. Resident 4 then applied the gel from his right hand onto his left forearm. Resident 4 did not wash his hands after applying the gel. Immediately following the medication pass for Resident 4, LVN 1 stated Resident 4 should have had an order to self-administer the Testosterone gel and Resident 4 should have washed his hands immediately after applying the medication. LVN 1 verified they should not have let Resident 4 self-administer without an assessment and order. Medical record review for Resident 4 was initiated on 6/11/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 6/9/26, showed Resident 4 had the capacity to understand and make medical decisions. Review of Resident 4's Order Summary Report showed a physician's order dated 6/9/26, to administer Testosterone Transdermal Gel 1.62 % (hormone replacement). Apply one pump transdermally one time a day for hormone replacement. Further review of Resident 4's Order Summary Report failed to show a physician's order was created for Resident 4 to self-administer the Testosterone Transdermal Gel. Review of Resident 4's medical record failed to show documented evidence an assessment to self-administer the medication was completed. Additionally, there was no documented evidence a care plan was initiated to address Resident 4's self- administration of the medication. On 6/23/26 at 1230 hours, an interview was conducted with the DON. The DON confirmed 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
--	-------	-----------