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	10/11/2024

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation and interview, the facility failed to ensure two of 28 final sampled residents (Residents 22 and 111) were treated with dignity and respect. This failure posed the risk of the residents' rights not being honored. Findings: 1. On 10/8/24 at 1305 hours, the staff were observed in a hallway outside the residents' rooms, using the word feeders when referring to the residents who needed assistance with eating their meals. On 10/08/24 at 1330 hours, a staff was observed at the door entry of Resident 111's room using the word feeders when referring to Resident 111. On 10/8/24, medical record review for Resident 111 was initiated. Resident 111 was admitted on [DATE]. Review of Resident 111's H&P examination dated 9/17/24, showed Resident 111 had severe cognitive, psychiatric impairment. Resident 111 had episodes of refusing to eat and needed extensive assistance for eating. 2. On 10/09/24 at 1237 hours, an interview with CNA 13 was conducted. When CNA 13 was asked about Resident 22, CNA 13 referred to Resident 22 as a feeder. When asked what the word feeder referred to, CNA 13 stated the word referred to when the residents were not able to fully feed themselves. When asked where she learned to use the word feeder, CNA 13 stated she learned the word in CNA school. On 10/8/24, medical record review for Resident 22 was initiated. Resident 22 was admitted on [DATE]. Review of Resident 22's H&P examination dated 10/11/23, showed Resident 22 had cognitive impairment. Resident 22 was admitted to the facility with diagnoses including malnutrition, quadriplegia, and had aspiration precautions.

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 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** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to assess two nonsampled residents (Residents 113 and 980) for their self-administration of the medications. This failure had the potential to negatively impact the residents' physiological well-being and could administer the medications inaccurately. Findings: Review of the facility's P&P titled Resident Self -Administration of Medication revised 12/19/22, showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The IDT teams should at a minimum consider the following: - The resident's physical capacity to : swallow without difficulty, open medication bottles, administer injections; - The resident's cognitive status, including their ability to correctly name their medication and know what conditions they are taken for; - The resident's capability to follow direction and tell time to know when medication needed to be taken for; - The resident's comprehensions of instruction for the medication they are taking, including dose timing, and signs of side effects, and when to report to facility staff; - The resident's ability to understand what refusal of medication is and appropriate steps taken by staff to educate when this occurs; and, - The resident's ability to ensure that medication is stored safely and securely. Further review of the P&P showed the result of the interdisciplinary team assessment are recorded on the electronic health records and all nurses and aids are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications were to be given to the charge nurse for return to the family or responsible party. The family and responsible parties are reminded of policy and procedures regarding resident's self-administration when necessary. 1. On 10/8/24 at 0952 hours, during a concurrent observation and interview with Resident 113, bottles of medication D-mannose (supplement to prevent urinary tract infection) and [NAME] oil (herbal supplement) were observed at the bed side table on the right side of the Resident 113's bed. Resident 113 stated she had been self-administering the above medication since she was admitted in the facility and the facility staff were aware of it. Medical record review for Resident 113 was initiated on 10/8/24. Resident 113 was admitted to the facility on [DATE]. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 113's H&P examination dated 9/22/24, showed Resident 113 had no capacity; however, Resident 113 was able to make her needs known. Review of Resident 113's MDS dated [DATE], showed Resident 113 had moderate cognitive impairment. Review of Resident 113's Physician Order Summary dated 10/8/24, did not show an order for the above supplements. Review of the medical record failed to show documented evidence Resident 113 was assessed for self-administration of the medication. 2. On 10/8/24 at 0957 hours, a concurrent observation and interview was conducted with Resident 980. Medication carboxymethylcellulose eye drop (eye lubricant) was observed on the bed side table located at the right side of the Resident 980's bed. Resident 980 stated she had been administering this eye drop medication and the facility staffs were aware about the medication at the bed side. Medical record review for Resident 980 was initiated on 10/8/24. Resident 980 was admitted to the facility on [DATE]. Review of Resident 980'S H&P examination dated 9/29/24, showed Resident 980 had the capacity to make the medical decisions. Review of the Resident 980's MDS dated [DATE] showed Resident 980 was cognitively intact. Further review of the medical record failed to show documented evidence to show Resident 980 was assessed for self-administration of the medication. On 10/8/24 at 1044 hours, a concurrent observation, interview, and medical record review for Residents 113 and 980 was conducted with the RN 3. RN 3 verified the above observation of medications at the bedside for Residents 113 and 980. RN 3 stated he was not able to find if the self-administration of medication assessment was completed for Residents 113 and 980. On 10/10/24 at 1302 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs for four of 28 final sampled residents (Residents 1, 16, 22, and 97) and one nonsampled resident (Resident 128). * The facility failed to ensure Resident 16's request for an extension cord for the resident's phone was followed up. * The facility failed to ensure the call light was within reach and accessible for Resident 128. * The facility failed to ensure the call light and bed remote control were within the Resident 97's reach. * The facility failed to ensure the call light was within reach for Residents 1 and 22. These failures had the potential to negatively impact the resident's psychosocial well-being or result in a delay to receive care. 1. On 10/8/24 at 0910 hours, during the initial tour of the facility, Resident 16 was observed awake and lying in bed. Resident 16's landline phone was observed on the bedside table. Resident 16 stated when the staff pulled the bedside table, the landline phone would fall from the table. Resident 16 stated it had been over a week since he requested for an extension cord for his landline phone because the power cord was too short. Medical record review for Resident 16 was initiated on 10/8/24. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 16's MDS dated [DATE], showed Resident 16 had a moderate cognitive impairment, with impairment on one side of upper and lower extremities. On 10/10/24 at 0757 hours, a concurrent follow-up observation and interview was conducted with Resident 16. Resident 16 was observed awake and lying in bed. Resident 16's landline phone was observed on the bedside table, and a brown extension cord was observed connected to the phone power cord. Resident 16 stated his friend brought the brown extension cord since the the staff did not help even if they have been informed about it. On 10/10/24 at 0800 hours, an interview was conducted with CNA 5. When asked about Resident 16's request for an extension cord, CNA 5 stated Resident 16 requested for an extension cord last week, and even asked if he needed to sign something for it. CNA 5 stated she told the maintenance staff about Resident 16's request for extension cord, but the maintenance staff stated he would check first because of safety. CNA 5 stated she also wrote Resident 16's request for extension cord in the maintenance logbook. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 0820 hours, an interview was conducted with the Maintenance Director. When asked about the residents' maintenance requests, the Maintenance Director stated the staff informed the maintenance department by calling the maintenance thru the radio or his cellphone and wrote the residents' maintenance requests in the maintenance logbook. The Maintenance Director stated the maintenance staff checked the maintenance logbook every hour or two hours, and daily, and did the rounds daily. The Maintenance Director stated when a maintenance request was completed, the maintenance staff would write the status of the request, the date when it was completed and who completed it, to which he showed a copy of the Maintenance Request Jobs. When the Maintenance Director was informed about Resident 16's request for an extension cord, the Maintenance Director stated they informed Resident 16 that the facility was not allowed to have any extension cord because of safety issue. Review of the Maintenance Request Jobs dated 10/2/24, showed Resident 16 wants extension cord for phone. The request form showed ok status for this request, and it was completed on 03/24. The Maintenance Director verified the above findings. The Maintenance Director stated he was not sure why the maintenance staff wrote ok for this request when Resident 16 was not allowed to have an extension cord. The Maintenance Director stated it was an extension cord for Resident 16's cellphone. The Maintenance Director was informed the extension cord was for Resident 16's landline phone and not a cellphone, and also informed Resident 16 was observed with a brown extension cord in the room today, the Maintenance Director stated he would have to check. On 10/10/24 at 0835 hours, a concurrent observation for Resident 16 and interview with the Maintenance Director was conducted. Resident 16 was observed awake and lying in bed. Resident 16's landline phone was observed on the bedside table, and a brown extension cord was observed connected to the phone power cord. The Maintenance Director verified the findings. The Maintenance Director stated the landline phone and brown extension cord were brought in by the resident and should have been logged in with the social services department and checked by the maintenance department. 2. Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 12/19/22, showed the staff will ensure the call light is within reach of resident and secured, as needed. On 10/9/24 at 1255 hours, Resident 128 was observed sitting in the wheelchair near the foot of the bed, and on the left side of the bed. Resident 128 stated she needed assistance and could not reach the call light to call the facility staff. The call light was observed near the head of the bed, on the right side of the bed and not within Resident 128's reach. On 10/9/24 at 1301 hours, CNA 10 was asked to assist Resident 128. Resident 128 was observed sitting in the wheelchair near the foot of the bed, and on the left side of the bed. The call light was observed near the head of the bed, on the right side of the bed. CNA 10 verified the call light was not within Resident 128's reach. 49324 3. On 10/10/24 at 0756 hours, an observation of Resident 97's room was conducted. Resident 97 was asleep on a side lying position laying on her left side. The call light and the bed remote control were on the floor and not within reach of Resident 97. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review of Resident 97 was initiated on 10/10/24. Resident 97 was admitted to the facility on [DATE]. Medical record review for Resident 97 was initiated on 8/30/24. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's H&P examination dated 7/1/24, showed Resident 97 had no capacity to make decisions. Review of Resident 97's MDS Section C - Cognitive Patterns dated 7/6/24, showed Resident 97's BIMS Summary score was 7 (meaning with severe cognitive impairment). Review of Resident 97's MDS Section GG - Functional Abilities and Goals dated 7/6/24, showed Resident 97 needed substantial/maximal assistance (meaning Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). Review of Resident 97's plan of care showed a care plan problem revised 9/24/24, addressing the resident at risk for falls. The interventions included place the resident's call light within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. On 10/10/24 at 0952 hours, a concurrent observation of Resident 97's room and interview was conducted with RN 2. RN 2 acknowledged the call light and bed remote control were on the floor and not within the reach of Resident 97. RN 2 proceeded to go in Resident 97's room, disinfected the call light and bed remote control, and placed them within reach of Resident 97. 35346 4.a. On 10/9/24 at 1234 hours, a concurrent observation and interview was conducted with CNA 13 in Resident 1's room. Resident 1's call light was on the nightstand and out of reach of the resident. When asked if Resident 1 was able to use his call light, CNA 13 stated Resident 1 was able to use his call light. When asked where Resident 1's call light was, CNA 13 verified Resident 1's call light was on Resident 1's nightstand, not within reach for the resident. Medical record review for Resident 1 was initiated on 10/9/24. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 7/25/24, showed Resident 1's diagnoses included left side paralysis and wheelchair bound. b. On 10/9/24 at 1237 hours, a concurrent observation and interview was conducted with CNA 13 in Resident 22's room. Resident 22's call light was on the nightstand and out of reach of the resident. When asked if Resident 22 was able to use his call light, CNA 13 stated Resident 22 was able to use his call light. When asked where Resident 22's call light was, CNA 13 verified Resident 22's call light was on Resident 22's nightstand, not within reach for the resident. Medical record review for Resident 22 was initiated on 10/8/24. Resident 22 was admitted on [DATE]. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 22's H&P examination dated 10/11/23, showed Resident 22 had cognitive impairment. Resident 22 was admitted to the facility with diagnoses including quadriplegia.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on interview, medical record review, and facility P&P review, the facility failed to ensure a copy of the advanced directive was obtained for one of 15 final sampled residents (Residents 83) reviewed for advanced directives. This failure had the potential for the resident's decisions regarding his health care and treatments to not be honored. Findings: Review of the facility's P&P titled Resident's Rights Regarding Treatment and Advance Directives revised 12/19/22, showed the following: - On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. - Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Medical record review for Resident 83 was initiated on 10/8/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's MDS dated [DATE], showed the resident's cognitive skills for daily decision making was severely impaired. Review of Resident 83's POLST dated 9/10/24, under Section D Information and Signatures showed the advance directive dated 11/20/23, was available and reviewed. However, further review of Resident 83's medical record failed to show a copy of Resident 83's advance directive for healthcare was obtained. On 10/10/24 at 1445 hours, an interview and concurrent medical record review for Resident 83 was conducted with the SSD. The SSD verified the above findings. The SSD acknowledged she documented Resident 83 had a POA for healthcare authority. When asked if she had followed up with Resident 83 regarding the resident's advance healthcare directive, the SSD stated she did; however, there was no documentation regarding the follow-up to obtain a copy of the advanced directive. On 10/11/24 at 0955 hours, an interview and concurrent medical record review for Resident 83 was conducted with the MRD. T he MRD verified there was no documented evidence a copy of Resident 83's advance directive was obtained. On 10/11/24 at 1458 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	555308	A. Building B. Wing	10/11/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44175 Based on interview, medical record review, and facility document review, the facility failed to ensure the residents' physician was notified when the residents refused laboratory collection of blood for two of five final sampled residents (Residents 16 and 95) reviewed for unnecessary medication. This failure had the potential for Residents 16 and 95 not to receive appropriate treatment and could negatively affect residents' well-being. Findings: 1. Medical record review for Resident 95 was initiated on 10/8/24. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's Physician Order Summary showed an order dated 7/26/24, for potassium chloride (potassium supplement) oral tablet extended release 10 meq two tablets by mouth in the evening for hypokalemia (low potassium level). Review of Resident 95's Consultant Pharmacist Medication Regimen Review from 9/1/24 to 9/16/24, showed to consider obtaining a repeat potassium level to monitor for adverse effect and effectiveness of the potassium medication. In addition, the document showed potassium therapy was started in July, but no follow up lab was done to recheck potassium level. Further review of the Consultant Pharmacist Medication Regimen Review showed per CMS regulation (F757), each residents drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate monitoring. Under the section for follow through showed a check mark. Review of Resident 95's Physician Order dated 9/17/24, showed an order for laboratory potassium level. Review of Resident 95's medical record did not show the result for potassium level ordered on 9/17/24. Review of the Resident 95's Test Request Form dated 9/17/24, showed a request for potassium. Under the section for The Nurse Notification - Submit New Requisition, showed Resident 95 refused blood to be collected on 9/17 and 9/18/24. Further review of the medical record for Resident 95 failed to show documented evidence the physician was informed of Resident 95's refusal for blood to be collected for potassium level. On 10/11/24 at 1000 hours, a concurrent interview and medical record review for Resident 95 was conducted with the DON. The DON verified the above findings. The DON stated facility should have notified the physician when Resident 95 refused the potassium level to be collected. Cross reference to F756. 39453 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 16 was initiated on 10/8/24. Resident 16 was readmitted to the facility on [DATE]. Review of Resident 16's MDS dated [DATE], showed the resident had moderate cognitive impairment. Review of Resident 16's physician's order dated 9/16/24, showed a laboratory order for CBC with differential (complete blood count, measures the number of red blood cells, white blood cells and platelets in the blood), CMP (comprehensive metabolic panel, a routine blood test to measure the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), magnesium (a mineral in the body to help maintain muscles, nerves and bones) and procalcitonin (a protein in the blood to help identify bacterial infection and sepsis) on 9/17/24. Review of Resident 16's medical record did not show the results for the laboratory tests ordered on 9/17/24. On 10/11/24 at 1306 hours, a concurrent interview and medical record review for Resident 16 was conducted with the DON. When asked about the results of the laboratory tests, the DON stated the results were received through the electronic health record or via fax. When asked for the results of Resident 16's laboratory tests on 9/17/24, the DON verified the results were not found on Resident 16's medical record. The DON stated Resident 16 probably refused to have his laboratory drawn, to which she showed a copy of the laboratory request form. Review of Resident 16's laboratory request form dated 9/17/24, showed a request for CBC with differential, CMP, magnesium and procalcitonin. The Nurse Notification - Submit New Requisition section showed Resident 16 refused. Further review of Resident 16's medical records did not show the physician was notified when the resident refused the laboratory tests ordered on 9/17/24. The DON verified the above findings.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the personal privacy was maintained for three of 28 final sampled residents (Residents 26, 72, and 931) and the resident's confidential health information on a computer was not protected for one nonsampled resident (Resident 6). * LVN 4 failed to completely close Resident 26's privacy curtain while the GT medications were being administered. Resident 26's abdomen was exposed during the procedure. * LVN 3 failed to completely close Resident 72's privacy curtain while the GT medications were being administered. Resident 72's abdomen was exposed during the procedure. * LVN 6 failed to log off from the electronic medical record where Resident 6's confidential medical information could be seen on the monitor by unauthorized personnel. These failures had the potential to negatively affect the dignity of the residents and violate the residents' privacy, and had the potential for resident's confidential health information to be accessed from the unauthorized users. Findings: Review of the facility's P&P titled Promoting/Maintaining Resident Dignity dated 12/19/22, showed it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances a resident's quality of life by recognizing each resident's individuality. Compliance Guidelines showed all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Additionally, staff are to maintain resident privacy. Review of the facility's P&P titled Safeguarding of Resident Identifiable Information dated 12/19/22, showed it is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information and to safeguard against destruction or unauthorized release of information and records. Policy Explanation and Compliance Guidelines showed the following: 1. Medical records shall not be left in open area where unauthorized persons could access identifiable resident information. 2. Computer screens showing clinical record information may not be left unattended and readily observable or accessibly by other residents or visitors. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Confidentiality of Personal and Medical Records dated 12/19/22, showed the facility honors the resident's right to secure and confidential personal and medical records. This includes the right confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. Policy Explanation and Compliance Guidelines are as follows: 1. Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated, or other. 2. 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. 1. Medical record review for Resident 26 was initiated on 10/8/24. Resident 26 was admitted to the facility on [DATE]. On 10/8/24 at 0941 hours, a medication administration observation for Resident 26 was conducted with LVN 4 in Resident 26's room. LVN 4 did not pull Resident 26's privacy curtain all the way prior to accessing the resident's GT site for medication administration. Resident 26's door was open and Resident 26's abdomen was exposed during the administration of medications via GT. On 10/8/24 at 1012 hours, an interview was conducted with LVN 4. LVN 4 verified she should have fully closed the privacy curtain prior to the medication administration for Resident 26. 2. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. On 10/8/24 at 0910 hours, a medication administration observation for Resident 72 was conducted with LVN 3. LVN 3 did not pull Resident 72's privacy curtain all the way prior to accessing the resident's GT site for medication administration. Resident 72's door was open and Resident 72's abdomen was exposed during the administration of medications via GT. On 10/8/24 at 1452 hours, an interview was conducted with LVN 3. LVN 3 verified the privacy curtain should have been fully closed when giving the medications via GT to Resident 72. 3. On 10/8/24 at 0834 hours, a medication administration observation for Resident 931 was conducted with LVN 3. Resident 931's room was observed with no privacy curtain and the door was left open during the medication administration observation. Resident 931 was able to be seen in her bed from the hallway through the open door. On 10/09/24 at 1452 hours, an interview was conducted with LVN 3. LVN 3 verified the findings and stated every resident room should have a privacy curtain. LVN 3 stated he should inform the maintenance about Resident 931 not having privacy curtain in her room. When asked if he contacted the maintenance to get a new curtain, LVN 3 stated he did not. 10/10/24 at 0754 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings. (continued on next page)

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	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference to F914, example #3. 4. On 10/11/24 at 1810 hours, one desktop computer monitor at Nursing Station C was observed turned on, unattended, showing confidential resident information for Resident 6. The monitor showed Resident 6's progress notes. The DSD/IP approached Nursing Station C and verified the monitor was left on and unattended. The DSD/IP verified the username was LVN 6. The DSD/IP stated the monitor should not have been left unattended. On 10/11/24 at 1815 hours, an interview was conducted with LVN 6. LVN 6 acknowledged the findings. She stated she should have logged off because the monitor had Resident 6's health information and it could cause a concern regarding resident privacy.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on interview, medical record review, and facility P&P review, the facility failed to failed to send a copy of the notice of transfer/discharge to the representative of the Office of the State Long-Term Care Ombudsman for one of four discharged residents (Resident 125) for closed record reviewed. In addition, the facility failed to provide the notice of transfer/discharge and reasons for the transfer in writing for one of 28 final sampled residents (Resident 25). These failures posed the risk for inappropriate transfers or discharges for Residents 25 and 125 and risk of not providing the residents and their representatives with access to an advocate who could inform them of their options and rights Findings: 1. Review of the facility's P&P titled Transfer and Discharge (including AMA) revised 12/19/22, showed for Non-Emergency Transfers or Discharges, the facility should provide the transfer/discharge notice to the resident/representative and Ombudsman as indicated. Closed medical record review for Resident 125 was initiated on 10/11/24. Resident 125 was admitted to the facility on [DATE], and transferred to the acute care hospital on 7/22/24. Review of Resident 125's H&P examination dated 7/5/24, showed Resident 125 had the capacity to make decision. Review of Resident 125's Order Summary Report showed an order dated 7/22/24, to transfer the resident to an acute care hospital ER with current reconciled medication list from the appointment, and bedhold for 7 days if admitted . Review of Resident 125's closed medical record did not show any documentation for the State LTC Ombudsman notification. On 10/11/24 at 1320 hours, a concurrent closed record review for Resident 125 and interview was conducted with the SSD. The SSD was asked to show any documentation of the Ombudsman notification in the closed medical record of Resident 125 and in the PCC. The SSD acknowledged she could not find any documentation of the Ombudsman notification. On 10/11/24 at 1620 hours, an interview was conducted with the DON. The DON acknowledged there was no Ombudsman notification when Resident 125 was transferred to the acute care hospital. 44175 2. Review of the facility's P&P titled Transfer and Discharge (Including AMA) revised 12/29/22, showed the facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The specific reason and basis for transfer or disorders; - The effective date of transfer or discharge; - The specific location (such as the name of the new provider or description and slash or address if the location is a residence) to which the resident is to be transferred or discharged ; - An explanation of the right to appeal the transfer or discharge to the state; - The name address (mailing and e-mail) and telephone number of the state entity which receives such appeal hearing request; - Information on how to obtain an appeal form; - Information on obtaining assistance in completing and submitting the appeal hearing request; - The name, address (mailing and email), and phone number of the representative of the office of the state long term care ombudsman; - For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name mailing and e-mail address and phone number of the State agency responsible for the protection and advocacy of these populations. Medical record review for Resident 25 was initiated on 10/8/24. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's Physician Order dated 6/29/24, showed an order may transfer to the acute care hospital for further evaluation related to desaturation with high blood pressure and heart rate. Review of Resident 25's Progress Note dated 6/29/24 at 1705 hours, showed Resident 25 was transferred to the acute care hospital for low oxygen saturation, high blood pressure and heart rate. Further review of the medical record for Resident 25 failed to show if the transfer discharge notice was provided in writing to the resident and/or their representative when Resident 25 was transferred to the acute care hospital on 6/29/24. On 10/11/24 at 1616 hours, a concurrent interview and medical record review for Resident 25 was conducted with RN 5. RN 5 verified the above findings and stated he was not able to find the documentation if Resident 25 and/or their representative was provided with written notification of the transfer when Resident 25 was transferred to the acute care hospital on 6/29/24. On 10/11/24 at 1626 hours, a concurrent interview and medical record review for Resident 25 was conducted with the DON. The DON was informed of the above findings and was not able to show documented evidence Resident 25 and/or their representative was provided with the written notification of the transfer when Resident 25 was transferred to the acute care hospital on 6/29/24.

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	555308	A. Building B. Wing	10/11/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, and medical record review, the facility failed to provide the individualized and ongoing activity program to meet the needs and interests of one of three final sampled residents (Resident 83) reviewed for activities. * The facility failed to provide the activities for Residents 83 to meet the resident's identified preference. This failure had the potential for the residents to experience feelings of social isolation. Findings: Medical record review for Resident 83 was initiated on 10/8/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's MDS dated [DATE], showed the resident's cognitive skills for daily decision making was severely impaired. Review of Resident 83's Plan of Care showed a care plan problem (undated) addressing Resident 83's risk for isolation. The care plan problem addressed the potential for social isolation due to disease and condition . The goal was for Resident 83 to participate in activities of choice (one to two times weekly). The interventions included the staff would provide 1:1 room visits to the resident on a regular basis, encourage to be up in geri-chair as tolerated, take to group activities, and place him next to other speaking resident to increase socialization and to increase physical functioning; and monitoring and addressing changes in mood state as needed. Further review of Resident 83's Plan of Care showed a care plan problem (undated) for having adjustment issues to admission. The care plan goal was for Resident 83 to receive daily opportunities for social contact. The care plan intervention was to encourage the resident to participate in activities of choice and to facilitate attendance as required. Review of Resident 83's Activity assessment dated [DATE], showed Resident 83's activity preferences included to listen to music, do things with groups of people, and go outside to get fresh air when the weather was good. On 10/8/24 at 1029 hours, during the initial tour of the facility, Resident 83 was observed lying in bed. The television was observed to be off and there was no other sensory stimulation observed. On 10/9/24 at 0803 hours, Resident 83 was observed awake in bed. The television was observed to be off. On 10/10/24 at 0956 hours, an observation and concurrent interview for Resident 83 was conducted with CNA 1. CNA 1 stated Resident 83 did not attend any activities and only got Resident 83 up when Resident 83's family requested. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 1351 hours, an interview and concurrent medical record review for Resident 83 was conducted with the Activity Director. When asked what activities were provided to Resident 83, the Activity Director stated they provided the room visits. When asked to review any documentation of the activities provided to Resident 83 during the room visits, the Activity Director showed the activity clinical notes. The Activity Director verified there were no activity notes for the week 9/22-9/28/24, to show any activities were provided for Resident 83. Further review of the Activity Notes dated 9/11 through 10/10/24, failed to show documentation room visits were provided for Resident 83 on 10/8 and 10/9/24. The Activity Director verified the findings. On 10/11/24 at 1458 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings.

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	555308	A. Building B. Wing	10/11/2024

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F 0685 Level of Harm - Potential for minimal harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the assistive devices to help with vision was provided for one of 28 final sampled residents (Resident 47). This failure posed the risk of Resident 47 to not maintain his ability to see and perform his daily activities. Findings: Review of the facility's P&P titled Use of Assistive Devices revised 12/19/22, showed the purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. The P&P showed the Policy and Explanation and Compliance Guidelines: h. sensory enhancement (glasses). 2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care. Review of the facility's P&P titled Care of Eyeglasses revised 12/19/22, showed it is the practice of this facility to provide care to resident's eyeglasses to ensure they are clean and protected from loss and breakage when not being worn. The P&P showed the Policy and Explanation and Compliance Guidelines: 5. Missing glasses shall be reported to supervisor and/or Social Services Department. Medical record review for Resident 47 was initiated on 10/9/24. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination date 4/21/24, showed Resident 47 needed assistance on decision making. Review of Resident 47's MDS Section B - Hearing, Speech and Vision dated 8/1/24, showed the resident with impaired vision. Review of Resident 47's Order summary Report showed an order dated 2/10/23, for latanoprost ophthalmic solution instill 1 drop in both eyes at bedtime for glaucoma. Review of Resident 47's care plan dated 2/17/23, showed the resident has impaired visual function related to glaucoma. The interventions included to remind the resident to wear glasses when up, ensure the resident is wearing glasses which are clean free from scratches and in good repair, and report any damage to nurse/family. On 10/9/24 at 1256 hours, an observation of Resident 47 and concurrent interview was conducted with Resident 47. The bulletin board located above Resident 47's headboard was observed to contain print outs on reminders or activities of the day. Resident 47 was asked if he could read the print outs from the bulletin board, the resident stated he could not read anything from the bulletin board. Resident 47 was also asked if he could read the time from the clock placed on the wall near the bathroom door, Resident 47 stated he could not read the time on the clock. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0685 Level of Harm - Potential for minimal harm Residents Affected - Some	On 10/9/24 at 1258 hours, an observation on Resident 47's room and concurrent interview was conducted with CNA 3 and Resident 47. CNA 3 was asked if he could find Resident 47's eyeglasses. CNA 3 looked inside the drawer of Resident 47's bedside table and only found Resident 47's eyeglasses case. CNA 3 also asked Resident 47 if he could see anything from the television, Resident 47 stated he could not see clearly on the television. CNA 3 was asked if he could find any visual assistive devices in Resident 47's room, CNA 3 stated he could not find any. Resident 47 was asked if he was able to locate his urinal. Resident 47 stated he could not see it clearly and would touch and feel in order to locate where his urinal was. On 10/9/24 at 1301 hours, a concurrent Resident 47's room observation and interview with RN 2 was conducted. RN 2 was asked if she could find Resident 47's eyeglasses in the room, RN 2 verified she was not able to find Resident 47's eyeglasses. RN 2 was also asked if there were any visual assistive devices that could help Resident 47 reading the print outs from Resident 47's bulletin board, watching TV, reading the time from the wall clock, and identifying his bathroom door. RN 2 verified she was unable to find any assistive devices in Resident 47's room. RN 2 stated she would help provide a magnifying glasses, help in getting optometrist appointment, print out larger prints for the bulletin board, and provide large print to identify Resident 47's bathroom. On 10/11/24 at 1620 hours, an interview was conducted with the DON. The DON verified the above findings.

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	555308	A. Building B. Wing	10/11/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for one of three final sampled residents (Resident 97) reviewed for accident hazards and in the laundry area. * The facility failed to clean and maintain the heating furnace inside the laundry closet. * The facility failed to implement the bilateral floor mats as per the physician's order and plan of care. These failures had the potential for accidents with serious injuries to occur. Findings: 1. On 10/9/24, during the laundry department inspection, an observation and concurrent interview was conducted with the Laundry Supervisor. The following was observed inside the closet in the laundry area where the heating furnace was located at: - dirty floor with a lot of lint on top of the vent tubes connected to the ceiling, - a stack of linens inside a clear plastic bag stored inside the closet, and - a black discoloration on the insulator foam located on top of the furnace. The Laundry Supervisor verified the above findings. The Laundry Supervisor stated they needed to notify the Maintenance Supervisor for any problem in the laundry department. The Laundry Supervisor stated the laundry closet should have been cleaned and maintained to prevent any fire accidents. On 10/10/24 at 1029 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was informed by the laundry staff about the closet with a furnace inside and verified the closet was dirty, and the foam insulation with black discoloration was dirty. The Maintenance Director stated he asked the housekeeper to clean the closet in the laundry and removed the stacked of linens inside the closet. On 10/10/24 at 1622 hours, an interview was conducted with the Administrator. The Administrator was informed and verified the above findings. 49324 2. On 10/9/24 at 0801 hours, an initial observation was conducted on Resident 97's room. Resident 97 was observed to be asleep on a left side lying position in a low position bed. One floor mat was in place on the left side and no floor mat was observed in place on the right side. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 97 was initiated on 10/10/24. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Fall Risk assessment dated [DATE], showed the resident was at risk for falls. Review of Resident 97's Order Summary Report showed a physician's order dated 7/3/24, to have floor mats next to the bed as appropriate every shift. Review of Resident 97's plan of care showed a care plan problem dated 12/22/21, addressing Resident 97's risk for falls/injury. The interventions included may have floor mats next to bed as appropriate. Another care plan problem addressing the resident had behaviors of intentionally sitting or crawling on the floor. The intervention included may have floor mats or mattress on floor for soft surroundings when the resident had behaviors to sit or crawl on floor. On 10/10/24 at 0943 hours, a concurrent Resident 97's room observation and interview was conducted with RN 2. RN 2 verified the left side of Resident 97's bed was placed with a floor mat and no floor mat was placed on the right side of the bed. RN 2 further stated the housekeeping may have cleaned it and she would get it to place at the right side of Resident 97's bed. On 10/10/24 at 1620 hours, during an interview, the DON acknowledged there should be one mat placed on the right side of the bed.

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	555308	A. Building B. Wing	10/11/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, and facility document review, the facility failed to provide the necessary GT care and services for two of two sampled residents (Residents 26 and 72) reviewed for GT care. * The facility failed to ensure the licensed staff assessed for residuals from Resident 26's GT prior to the administration of medication. * The facility failed to ensure the licensed staff verified the placement of Resident 72's GT prior to the administration of medication. Findings: Review of the facility's P&P titled Preparation and General Guidelines 11A7: Enteral Tube Medication Administration dated August 2014, showed the facility assures the safe and effective administration of enteral formulas and medications via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition in consultation with the physician and dietician. Review of the textbook titled Nursing Skills published 2021 showed prior to the medication administration, tube placement must be verified. Bedside placement is verified by the nurse before every medication pass. Review of the textbook titled Nursing: A Concept Based Approach to Learning Volume I Second Edition published 2015 showed the following steps should be used to confirm tube placement: - Assess the abdomen for distention, bowel sounds, and tenderness using the sequence of inspection, auscultation, percussion, and palpation. - Assess tube condition and placement. - Using a 60 ml syringe, inject 30 ml of air into the feeding tube, then aspirate a small amount of stomach contents and check the pH of the aspirate. 1. Medical record review for Resident 26 was initiated on 10/8/24. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 26's Order Summary Report dated 9/30/24, showed the physician's orders dated 2/14/24, - Check residual volume. Hold if residual exceeds 100ml. Recheck residual in one hour. Notify the physician if residual volum is more than 100 ml on the second check; and - Check GT placement every shift. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 0941 hours, a medication administration observation for Resident 26 was conducted with LVN 4. LVN4 was observed injecting 20 ml air into Resident 26's G-tube while listening over the stomach with a stethoscope to check the GT placement. However, LVN 4 did not aspirate and assess residual (the volume of fluid remaining in the stomach at a point in time) volume prior to the administration of medications via GT. On 10/8/24 at 1012 hours, an interview and concurrent medical record review for Resident 26 was conducted with LVN 4. LVN 4 verified she did not check the residual volume of Resident 26's GT prior to the administration of medications via GT. She verified the residual volume must be checked before administering medications via GT. 2. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Order Summary Report dated 10/8/24, showed the physician's orders dated 9/5/24: - Check residual volume. Hold if residual exceeds 100 ml. Recheck residual in one hour. Notify the physician if residual volum is more than 100 ml on the second check; and - Check for tube feeding placement every shift On 10/8/24 at 0910 hours, a medication administration observation was conducted with LVN 3. LVN 3 was observed to use a syringe to pull back and assess one ml of residual from Resident 72's GT. However, LVN 3 did not use the syringe to inject air into the GT and use a stethoscope to listen to confirm placement. On 10/9/24 at 1452 hours, an interview and concurrent medical record review for Resident 72 was conducted with LVN 3. LVN 3 verified he did not inject air into the GT and listen with the stethoscope to confirm the placement of Resident 72's GT. LVN 3 stated he should have listened for the GT placement. On 10/10/24 at 0754 hours, an interview and concurrent medical record review for Residents 26 and 72 was conducted with the DON. The DON acknowledged and verified the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the physician's order for oxygen therapy was followed for one of two final sampled residents (Resident 95) reviewed for oxygen administration. This failure had the potential to negatively affect the resident's medical conditions. Findings: Review of the facility's P&P titled oxygen administration revised 5/20/24, showed oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and ordered for oxygen are obtained as soon as practicable when the situation is under control. On 10/8/24 at 1211 hours, and 10/10/24 at 0843 and 1044 hours, Resident 95 was observed lying in bed receiving oxygen at 2 liters per minute via nasal cannula. Medical record review for Resident 95 was initiated on 10/8/24. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's Physician Order Summary dated 9/9/24, showed an order for oxygen at 3 liters per minute as needed through nasal cannula to maintain oxygen saturation level greater than or equal to 92% for diagnosis acute respiratory failure. Review of Resident 95's MAR for October 2024 showed no documented evidence if Resident 95 had oxygen saturation level less than 92 % requiring administration of the oxygen. On 10/10/24 at 1044 hours, a concurrent observation, interview, and medical record review for Resident 95 was conducted with RN 4. RN 4 verified the above findings and stated Resident 95 was receiving oxygen at 2 liters per minute through nasal cannula. RN 4 reviewed the medical record and stated there was no documented evidence Resident 95 required administration of the oxygen when the facility administered as needed oxygen to Resident 95. RN 4 acknowledged there should have been documented evidence of the reason requiring oxygen administration. On 10/10/24 at 1247 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed of the above findings. The DON was not able to show documented reason for Resident 95 requiring oxygen administration.

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	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest physical well-being for one of one final sampled residents (Resident 931) reviewed for dialysis care. * The facility failed to ensure the medications scheduled to be administered to Resident 931 on the days the resident had dialysis treatments had a physician's order to be held or were rescheduled. In addition, the facility failed to ensure Resident 931's fluid restriction was monitored by the nursing and dietary departments. These failures posed the risk for possible medical complications for Resident 931. Findings: Review of the facility's P&P titled Hemodialysis revised 6/5/23, showed the following: - The facility will assure that each resident receives care and services for the provision of hemodialysis and/ or peritoneal dialysis consistent with professional standards of practice. This will include ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices; and - The licensed nurse will communicate to the dialysis facility via telephonic communication or written format such as a dialysis communication form or other form, that will include, but not limit itself to timely medication administration (initiated, held, or discontinued) by the nursing home and/ or dialysis facility, and nutritional fluid management including documentation of weights, resident compliance with food/ fluid restrictions or the provision of meals before, during and/ or after dialysis and monitoring intake and output measurements as ordered; and - The facility will communicate with the dialysis facility, attending physician and/ or nephrologist any significant weight changes, nutritional concerns, medication administration or withholding of certain medications prior to the dialysis treatment and document such orders. Medical record review for Resident 931 was initiated on 10/8/24. Resident 931 was readmitted to the facility on [DATE]. Review of Resident 931's Order Summary Report dated 10/10/24, showed the following physician's orders: - dated 9/25/24, to administer midodrine (medication used to treat low blood pressure) 10 mg one tablet by mouth one three times a a day for hypotension. Hold if SBP is greater than 140 mmHg; - dated 9/25/24, to administer insulin lispro (rapid acting insulin) 100 unit/ml as per sliding scale; - dated 9/26/24, for hemodialysis appointments on Mondays, Wednesdays, and Fridays; and (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/26/24, for fluid restriction of 1500 ml/day total for nursing department with 300 ml in daytime, 150 ml in evening, and 150 ml in NOC (2300 to 0700 hours); and 1500 ml/day total for dietary department with 720 ml for breakfast, 240 ml for lunch, and 240 ml for dinner. Review of Resident 931's MAR for September and October 2024 showed the following: - insulin lispro 100 unit/ml as per sliding scale was held and not administered to Resident 931 on 9/27, 9/30, 10/2, 10/4, 10/7, and 10/9/24 at 1130 hours; - midodrine 10 mg tablet was held and not administered to Resident 931 on 9/27, 9/30, 10/2, 10/4, 10/7, and 10/9/24 at 1200 hours. - fluid restriction for the nursing department showed a documentation of Resident 931's fluid intake for the day shift (0700 to 1900 hours) and the night shift (1900 to 0700 hours) but did not show the total amount of the resident's daily fluid intake. Review of Resident 931's POC Response History showed Resident 931's fluid intake from 9/25 to 10/10/24, did not show the total amount of the resident's daily fluid intake. * Further review of Resident 931's medical record did not show a physician's order to hold Resident 931's medications on dialysis days nor a documentation the physician was notified when Resident 931 was not administered the lispro and midodrine medications. * In addition, further review of Resident 931's medical record did not show a monitoring of Resident 931's total daily fluid intake from the nursing and dietary departments. On 10/10/24 at 1255 hours, a concurrent medical record review and interview for Resident 931 was conducted with RN 1. When asked about Resident 931's lispro and midodrine medications, RN 1 verified the lispro and midodrine medications were held and not administered to Resident 931's due to the resident at the dialysis center on Mondays, Wednesdays, and Fridays. RN 1 verified there was no documented evidence the medications were given during the above listed days. RN 1 verified there was no documentation to show the physician was notified Resident 931 was routinely out of the facility when the medications were ordered to be administered. When asked about Resident 931's fluid restriction, RN 1 stated the charge nurses documented Resident 931's fluid intake from the medication administration in the MAR, while the CNAs documented Resident 931's fluid intake from her meal intake in the Task (POC Response History). When asked who monitored Resident 931's daily total fluid intake, RN 1 stated the charge nurses monitored the total daily fluid intake from the documentation in the MAR for nursing department. RN 1 stated she was not sure if the RD monitored the total daily fluid intake from the Task documentation for dietary department. RN 1 verified there was no documented evidence to show the nursing department, nor the dietary department was monitoring Resident 931's total amount of the resident's daily fluid intake.

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure 19 of 20 final sampled residents (Residents 1, 13, 16, 22, 26, 29, 71, 72, 83, 84, 95, 97, 100, 101, 111, 116, 728, 928, and 931) reviewed for side rail use remained free from the accident hazards associated with the use of elevated side rails. * The facility failed to ensure the accurate and complete assessments and evaluations for the side rails use for Residents 1, 13, 16, 26, 71, 83, 84, 95, 97, 100, 101, 116, 928, and 931. * The facility failed to attempt the alternatives prior to installation of the bed rails for Residents 1, 13, 16, 22, 26, 65, 71, 84, 95, 97, 111, 116, 928, and 931. * The facility failed to obtain the informed consent for the side rails prior to the installation of the grab bars for Residents 83, 101, and 928. * The facility failed to ensure the size of the side rails whether 1/4 or 1/2 side rails were not added after the informed consent for grab bars were obtained from the residents or their responsible parties for Residents 16 and 72. * The facility failed to ensure the informed consents related to the use of side rails were accurate for Resident 95 and Resident 29. * The facility failed to ensure Resident 728's informed consent was specific to the physician's order. Resident 728's physician ordered 1/4 side rails, but the informed consent was both for grab bars and 1/4 side rails. * The facility failed to ensure the alternatives measures were provided prior to installation of bilateral 1/4 side rails as enabler to aid bed mobility, positioning, and ADL functioning for Residents 29 and 95. In addition, the physician order did not specify bilateral side rails for Resident 95 and no physician order for bilateral side rails for Resident 29. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's P&P titled Informed Consent revised 3/25/24, showed the following: - It is the policy of the facility to uphold the rights of residents to participate to the planning and decision-making process concerning their care and treatment. When situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, the prolonged use of a device that may lead to inability to regain use of a normal body function and for transfer and discharge; and - Prior to initiating the administration of a device, licensed nursing staff shall verify with the resident or surrogate decision maker that he/ she has given informed consent for the proposed device to the prescriber. Review of the facility's P&P titled Proper Use of Bed Rails dated on 12/19/22, showed the following: - The resident assessment must include an evaluation of the alternatives that were attempted prior to installation or use of a bedrails and how this alternative failed to meet the resident's assessed needs. - The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rails itself. - A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rails. This policy to reduce entrapment with the use of siderails has been developed utilizing the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. 1. Medical record review for Resident 83 was initiated on 10/8/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's MDS dated [DATE], showed the resident's cognitive skills for daily decision making was severely impaired. Review of Resident 83's Order Summary Report dated 10/10/24, showed a physician order dated 10/9/24, for may have one fourth side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 83's Physician Documentation of Informed Consent dated 9/10/24, showed prolonged use of device order for grab bars as enablers for bed mobility (one fourth). Review of Resident 83's Bed Rails assessment dated [DATE], showed N/A for alternatives attempted prior to installation of bedrails. On 10/8/24 at 1029 hours, during the initial tour of the facility, an observation for Resident 83 was conducted. Resident 83 was observed lying in bed with bilateral side rails up. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 0752 hours, an observation and concurrent interview for Resident 83 was conducted with LVN 1. LVN 1 stated Resident 83 had bilateral side rails and was using it for bed positioning. On 10/10/24 at 0843 hours, an interview and concurrent medical record review for Resident 83 was conducted with RN 1. RN 1 verified the resident's order was for one fourth side rails as enabler and consent was for grab bars as enablers. 2. Medical record review for Resident 100 was initiated on 10/8/24. Resident 100 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 100's H&P examination dated 3/29/24, showed Resident 100 did not have the capacity to make medical decisions. Review of Resident 100's Order Summary Report dated 10/10/24, showed a physician's order dated 3/6/24, for may have grab bars as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 100's Physician Documentation of Informed Consent dated 10/4/24, showed prolonged use of device order for bilateral grab bars as enablers for bed mobility (one fourth). Review of Resident 100's Bed Rails assessment dated [DATE], showed indication for use bed rails/transfer bar was for mobility/transfer purposes and the resident demonstrated ability to use equipment as an enabler. Further review of Bed Rails Assessment recommendation note showed the following: - Positioning/side of bed rails bilateral, type of bedrails left side showed assist bar/grab bar, and type of bed rails right side showed one fourth rails. On 10/8/24 at 0952 hours, during the initial tour of the facility, an observation for Resident 100 was conducted. Resident 100 was sitting in her bed with bilateral side rails up. On 10/9/24 at 0757 hours, an observation and concurrent interview for Resident 100 was conducted. Resident 100 stated she was using the side rails to pull up herself for positioning and turning. On 10/10/24 at 1342 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS coordinator verified the side rails assessment should be done upon admission and quarterly. 3. Medical record review for Resident 101 was initiated on 10/8/24. Resident 101 was admitted to the facility on [DATE]. Review of Resident 101's MDS dated [DATE], showed BIMS score of 7 (meaning severe cognitive impairment). Review of Resident 101's Order Summary Report dated 10/10/24, showed a physician's order dated 10/9/24, for may have one fourth side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 101's Physician Documentation of Informed Consent dated 10/4/24, showed prolonged use of device order for bilateral grab bars as enablers for bed mobility (one fourth). (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 101's Bed Rails assessment dated [DATE], showed alternatives that were attempted prior to installation of bedrails was documented as N/A, no bed rails. Further review of the Bed Rails Assessment recommendations notes showed N/A, no bedrails. On 10/8/24 at 0952 hours, during the initial tour of the facility, an observation for Resident 101 was conducted. Resident 101 was observed lying in her bed with bilateral side rails up. On 10/9/24 at 0818 hours, an observation and concurrent interview for Resident 101 was conducted with LVN 1. LVN 1 stated Resident 101 had bilateral side rails up and was using it for bed positioning. On 10/10/24 at 0843 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 101's physician order was for 1/4 siderails as enabler, and the consent was for bilateral grab bars as enabler. On 10/10/24 at 1342 hours, an interview and concurrent medical record review for Resident 101 was conducted with the MDS Coordinator. The MDS coordinator verified the side rails assessment should be done upon admission and quarterly. On 10/11/24 at 1458 hours, an interview was conducted with the DON. The DON was informed of the above findings and acknowledged the findings. 39453 4.a. On 10/8/24 at 0910 hours, 10/9/24 at 1250 hours, 10/10/24 at 0757, 0835, and 1351 hours, and 10/11/24 at 0921 hours, Resident 16 was observed in bed with the bilateral 1/2 (half) side rails elevated. Medical record review for Resident 16 was initiated on 10/8/24. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's MDS dated [DATE], showed the resident had moderate cognitive impairment, an impairment on one side of upper and lower extremities, and dependent with the staff assistance on bed mobility. Review of Resident 16's Bed Rails - V2 dated 8/21/24, showed no documented evidence of the alternatives attempted prior to the installation of the side rails. Review of Resident 16's PT Evaluation and Plan of Treatment dated 8/23/24, showed the bilateral bed grab bars indicated as enablers for bed mobility, not as restraints. Review of Resident 16's Order Summary Report dated 10/10/24, showed a physician's order dated 10/8/24, for the 1/2 side rails as enabler to aide bed mobility, positioning, and ADL functions. Further review of Resident 16's medical record showed no documented evidence of the least restrictive alternatives attempted prior to the installation of side rails. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of Resident 16's Physician Documentation of Informed Consent dated 6/18/24, showed the box for prolonged use of device order was checked off, and a handwritten note grab bars for ADLs (1/2). 5.a. On 10/8/24 at 0947 hours, during the initial tour of the facility, Resident 928 was observed awake and lying in bed. There were no side rails observed on the bed. Resident 928 stated, I know I cannot have bed railings because of the gaps and all that. On 10/10/24 at 0920 hours, a facility staff was observed installing grab rails to Resident 928's bed. On 10/10/24 at 0921 hours, an interview was conducted with LVN 9. LVN 9 verified the facility staff just installed the grab bars to Resident 928's bed. On 10/10/24 at 0934 and 1353 hours, and 10/11/24 at 0922 hours, Resident 928 was observed in bed with the bilateral grab bars elevated. Medical record review for Resident 928 was initiated on 10/8/24. Resident 928 was admitted to the facility on [DATE]. Review of Resident 928's H&P examination dated 9/27/24, showed Resident 928 had the capacity to make medical decisions. Review of Resident 928's MDS dated [DATE], showed Resident 928 had moderate cognitive impairment, with no impairment on upper extremities, and dependent with the staff on bed mobility. Review of Resident 928's Bed Rails - V2 dated 9/26/24, showed no documented evidence of the alternatives attempted prior to the installation of the bed rails. Review of Resident 928's OT Evaluation and Plan of Treatment dated 9/27/24, showed the bilateral bed bars indicated to aid resident in self-positioning and mobility, and not as restraint. Review of Resident 928's Order Summary Report showed a physician's order dated 9/26/24, for grab bars as enabler to aid in bed mobility, positioning, and ADL functions. Further review of Resident 928's medical record showed no documented evidence of the least restrictive alternatives attempted prior to the installation of side rails. b. Resident 928's medical record did not show documented evidence the informed consent related to the use of side rails was obtained. On 10/10/24 at 1317, an interview and concurrent medical record review for Resident 928 was conducted with RN 1. RN 1 verified the above findings. When asked about the informed consent for bed rail use, RN 1 verified the informed consent for bed rail use was not obtained from Resident 928 prior to the installation of the side rails. 6. On 10/8/24 1215 hours, and on 10/10/24 at 0745 and 1359 hours, Resident 931 was observed in bed with bilateral grab bars elevated. (continued on next page)

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	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 931 was initiated on 10/8/24. Resident 931 was readmitted to the facility on [DATE]. Review of Resident 931's MDS dated [DATE], showed Resident 931 was cognitively intact, with no impairment on upper extremities, and dependent with the staff on bed mobility. Review of Resident 931's Bed Rails - V2 dated 9/25/24, showed no documented evidence of the least restrictive alternatives attempted prior to installation of bed rails. Review of Resident 931's PT Evaluation and Plan of Treatment dated 9/26/24, showed bilateral bed grab bars indicated as enablers for bed mobility, not as restraints. Review of Resident 931's Order Summary Report showed a physician's order dated 10/8/24, for grab bars as enabler to aid in bed mobility, positioning, and ADL functions. Further review of Resident 931's medical record showed no documented evidence of the least restrictive alternatives attempted prior to the installation of side rails. On 10/11/24 at 1345 hours, a concurrent interview and medical record review for Residents 16, 928, and 931. The DON verified the above findings. The DON stated the least restrictive alternatives should be attempted prior to the installation of side rails. 7. On 10/10/24 at 1110 hours, 10/9/24 at 1308 hours, 10/10/24 at 0750, 0813 and 1350 hours, and 10/11/24 at 0919 hours, Resident 72 was observed in bed with bilateral 1/4 side rails elevated. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Progress Note H&P examination dated 9/26/24, showed Resident 72 needed assistance with decision-making capabilities. Review of Resident 72's Order Summary Report dated 10/10/24, showed a physician's order dated 10/8/24, for 1/4 side rails as enabler to aide bed mobility, positioning, and ADL functions. Review of Resident 72's Physician Documentation of Informed Consent dated 9/6/24, showed the box for prolonged use of device order was checked off, and a handwritten note grab bars for ADLs (1/4). On 10/10/24 at 1322 hours, a concurrent interview and medical record review for Residents 16 and 72 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the informed consents were obtained from the residents upon admission. RN 1 stated the licensed nurses wrote grab bars for all the informed consents for side rails use. RN 1 acknowledged the size of the side rails, whether 1/4 or 1/2 side rails, were added after the informed consent for grab bars were obtained from the residents or their responsible parties. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 1320 hours, a concurrent interview and medical record review for Residents 16, 72, and 928 was conducted with the DON. The DON verified the above findings. The DON stated the informed consent for side rails should be obtained prior to the installation of side rails. The DON stated the side rails should coincide to what the PT/OT recommended, informed consent, and physician's order. 49324 8. On 10/9/24 at 0801 hours, an initial room observation of Resident 97 was conducted. Resident 97 was asleep on the left side lying position in a low position bed, and the floor mat observed on the left side of bed but no floor mat on the right side of bed. Medical record review for Resident 97 was initiated on 10/10/24. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Fall Risk assessment dated [DATE], showed the resident was at risk for falls. Review of Resident 97's Order Summary Report showed a physician's order dated 6/30/24, may have grab bars as enabler to aid mobility, positioning, and ADL functions. Review of Resident 97's Bed Rails assessment dated [DATE], showed the alternatives attempted was not specified and the indication for use was also not specified. On 10/10/24 at 0943 hours, a concurrent medical record review and interview was conducted with RN 2. RN 2 stated there were no alternatives tried for use of the grab bar. On 10/11/24 at 1620 hours, an interview was conducted with DON. The DON verified the findings. 9. On 10/10/24 at 0854 hours, an observation was conducted on Resident 71's room. Resident 71 was asleep on a side lying position, with the bilateral 1/4 side rail elevated. Medical record review for Resident 71 was initiated on 10/10/24. Resident 71 was admitted to the facility on [DATE]. Review of Resident 71's Order Summary Report showed a physician's order dated 10/9/24, may have 1/4 side rails in bed to aid mobility and ADL functions. Further review of Resident 71's medical record failed to show alternative measures were attempted prior to the use of the quarter side rails. On 10/10/24 at 0917 hours, an observation and concurrent interview was conducted with RN 2. RN 2 acknowledged no alternative measures were provided before the physician's order dated 10/9/24, for the 1/4 side rails. On 10/11/24 at 1620 hours, the DON verified no alternative measures were provided for the use of 1/4 side rails. (continued on next page)

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	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44175 10.a. On 10/8/24 at 1203 hours, and 10/10/24 at 0816 and 1027 hours, Resident 95 was observed lying in the bed with bilateral 1/4th side rails elevated. Medical record review for Resident 95's was initiated on 10/8/24. Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 7/23/24, showed Resident 95 may make her own medical decisions. Review of Resident 95's MDS dated [DATE], showed Resident 95 had severe cognitive impairment. Further review of the MDS showed Resident 95 had no impairment in range of motion to the bilateral upper and lower extremities and required maximum to total staff assistance for ADL. Review of Resident 95's Physician Order Summary showed an order dated 10/8/24, for 1/4th side rails as enabler to aid bed mobility, positioning, and ADL functioning. Further review of the physician order did not specify one or bilateral side rail. Review of Resident 95's Bed Rails-v 2 dated 7/23/24 showed visually checked the bed, mattress, and rail to ensure its appropriateness for the resident's dimension. Under the section for alternatives attempted showed not applicable. b. Review of the Resident 95's Physician Document of Informed Consent dated 10/4/24, showed a consent for the bilateral 1/4 grab bars as enabler for mobility. Further review of the document did not show for an informed consent for the use of bilateral 1/4 side rails. 11.a. On 10/8/24 at 0952 and 1315 hours, and 10/10/24 at 0814 hours, Resident 29 was observed lying in bed, bilateral 1/4 side rails were observed elevated. Medical record review for Resident 29 was initiated on 10/8/24. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's MDS dated [DATE], showed Resident 29 had severe cognitive impairment. Further review of the MDS showed Resident 29 had impairment on bilateral upper and lower extremities and required total staff assistance for her ADL. Review of the Resident 29's Physician Order Summary showed an order dated 2/2/24, for grab bars as enablers to aid bed mobility, positioning, and ADL functions. Further review of the physician's order did not show an order for bilateral 1/4 side rails. Review of Resident 29's Care Plan dated 8/1/24, showed a care plan problem addressing Resident 29's at risk for fall related to incontinence, poor communication, and comprehension. Review of Resident 29's Bed Rails-v 2 dated 7/24/24 showed visually checked the bed, mattress, and rail to ensure its appropriateness for the resident's dimension. Under the section for alternatives attempted showed bed rails not applicable. (continued on next page)

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	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of the Resident 29's Facility Verification of Informed Consent dated 7/27/23, showed a consent for the grab bars and 1/4 side rails. In addition, review of the document dated 2/2/24, showed a consent for the grab bars as enabler to aid bed mobility, positioning, and ADL function. Further review of the document failed to show a consent for the use of bilateral 1/4 side rails. On 10/10/24 at 1518 hours, a concurrent observation and interview was conducted with LVN 5. LVN 5 verified the observation and stated Residents 29 and 95 had bilateral 1/4 side rails elevated. On 10/10/24 at 1528 hours, a concurrent interview and medical record review for Residents 29 and 95 was conducted with RN 6. RN 6 was informed and verified the above findings. RN 6 stated the bed rails alternatives should have been attempted for Residents 29 and 95. RN 6 verified the physician's order for Resident 95 did not specify bilateral side rails and there was no physician's order for bilateral side rails for Resident 29. RN 6 further stated Resident 29 had the physician's order for grab bars; however, she was not able to find the physician's order for bilateral side rails for Resident 29. On 10/11/24 at 1456 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. 49644 12. On 10/8/24 at 0848 hours, a concurrent observation and interview was conducted with Resident 116. Resident 116 was observed lying in bed and holding her cellphone. Resident 116's bed had bilateral 1/4 side rails elevated. Resident 116 stated she used the bilateral 1/4 side rails to get up and turn. Medical record review for Resident 116 was initiated on 10/8/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's MDS dated [DATE], showed Resident 116's cognition was intact. Review of Resident 116's Order Summary Report for October 2023 showed a physician's order dated 8/26/24, may have grab bars as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 116's Bed Rails - V2 dated 8/26/24, showed no documented evidence of the alternatives attempted prior to the installation of bed rails. On 10/10/24 at 0851 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 verified Resident 116 had bilateral 1/4 side rails elevated. CNA 6 stated Resident 116 used the bilateral 1/4 side rails all the time to reposition. On 10/11/24 at 0923 hours, a concurrent observation, interview, and medical record review was conducted with RN 1. RN 1 verified Resident 116's 1/4 side rails were elevated. RN 1 stated the facility had no specification of what was available for the resident and the staff told the residents that it was an enabler. RN 1 acknowledged the Bed Rail - V2 form showed there was no alternative prior to the installation of Resident 116's bed rails. RN 1 stated she would check the Rehabilitation Department if they had the assessment, and she would provide the copy. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 1415 hours, a follow-up interview was conducted with RN 1. RN 1 stated the Rehabilitation Department had no copy of the alternatives attempted prior to installation of Resident 116's bed rails. On 10/11/24 at 1722 hours, an interview was conducted with the DON. The DON stated the bed rail assessment was initially done by the admission nurse. The DON further stated the staff from the Rehabilitation Department did the assessment and recommendation for the use of grab bar or side rails. The staff from the Rehabilitation Department would communicate to the nursing and maintenance to install the recommended grab bar or side rail. 13. On 10/8/24 at 0828 hours, a concurrent observation and interview was conducted with Resident 728. Resident 728 was observed lying in bed with bilateral 1/4 siderails elevated. Resident 728 stated she used the bilateral side rails when she tried to get up from bed. Review of Resident 728's Order Summary Report for October 2024, showed a physician's order dated 10/8/24, may have 1/4 side rails as enabler to aid bed mobility, positioning, and ADL (activities of daily living) functions. Review of Resident 728's Physician Documentation of Informed Consent dated 10/6/24, showed the prolonged use of device order - grab bars as enabler to aid bed mobility, positioning, and ADL (1/4). On 10/11/24 at 0822 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 verified Resident 728 had bilateral 1/4 side rails elevated. CNA 6 stated Resident 728 used the side rails to move side to side and to sit. On 10/11/24 at 0914 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified Resident 728's Physician Documentation of Informed Consent form included both the grab bar and 1/4 side rail. RN 1 stated the facility had no specification of what was available for the resident and the staff told the residents it was an enabler. On 10/11/24 at 1722 hours, an interview was conducted with the DON. The DON stated the assigned nurse to update the informed consent only updated it as grab bars. The DON further stated the facility failed to double check the informed consent. The DON stated the unit managers added 1/4 side rail to the informed consent. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 35346 14. On 10/11/24, at 0904 hours, concurrent observation of Resident 1's side rails and interview was conducted with CNA 15. When asked about Resident 1's side rails, CNA 15 stated Resident 1 held on to his side rails when he was being changed. Medical record review for Resident 1 was initiated on 10/9/24. Resident 1 was readmitted to the facility on [DATE]. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's H&P examination dated 7/25/24 showed Resident 1's diagnoses included left side paralysis, anxiety, and depression. Review of Resident 1's informed consent dated 10/7/24 showed, Resident 1's device order was grab bars as enabler for mobility (1/4). Review of Resident 1's bed rail assessment dated [DATE], failed to show a reason why alternatives to Resident 1's bed rails were ineffective. 15. On 10/8/24 at 1000 hours, during an observation, Resident 13 was observed with her 1/4 mid bed rails elevated. Medical record review for Resident 13 was initiated on 10/8/24. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's physician progress note dated 8/7/24 showed, Resident 13's diagnoses included dementia with behaviors and depression. Review of Resident 13's informed consent dated 10/4/24 showed, Resident 13's device order was grab bars as enabler for mobility (1/4). Review of Resident 13's bed rail assessment dated [DATE] failed to show a reason why alternatives to Resident 13's bed rails were ineffective. 16. On 10/11/24, at 0904 hours, a concurrent observation and interview was conducted with CNA 15. When asked about Resident 22's side rails, CNA 15 stated she did not know why Resident 22's bilateral 1/2 side rails were elevated Medical record review for Resident 22 was initiated on 10/11/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 10/11/23 showed, Resident 22's diagnoses included depression. Resident 22 was cognitively impaired. Review of Resident 22's informed consent dated 10/4/24, showed Resident 22's device order was grab bars as enabler for mobility (1/4). Review of Resident 22's bed rail assessment dated [DATE], showed a reason why alternatives to Resident 22's bed rails were ineffective was the bed rails not applicable. 17. On 10/08/24 at 0945 hours, during an observation, Resident 26 was observed in bed with his bilateral upper 1/4 bed rails elevated. Medical record review for Resident 26 was initiated on 10/11/24. Resident 26 was readmitted to the facility on [DATE]. Review of Resident 26's H&P examination dated 2/16/24, showed Resident 26's diagnoses included left side paralysis, dementia, and depression. (continued on next page)

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	10/11/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26's informed consent dated 10/4/24, showed Resident 26's device order was grab bars as enabler for mobility (1/4). Review of Resident 26's bed rail assessment dated [DATE], showed a reason why alternatives to Resident 26's bed rails were ineffective was the bed rails not applicable. 18.a. On 10/09/24 at 1010 hours, during an observation, Resident 84 was observed in bed, with his 1/8 bed rails elevated. Medical record review for Resident 84 was initiated on 10/9/24. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's physician progress note dated 6/5/24, showed Resident 84 did not have capacity to make medical decisions. Resident 84's diagnoses included dementia and post status torn rotator cuff. Review of Resident 84's bed rail assessment dated [DATE], showed a reason why the alternatives to Resident 84's bed rails were ineffective was the bed rails not applicable. b. Review of Resident 84's informed consent dated 10/4/24, showed Resident 84's device order was grab bars as enabler for mobility. On 10/11/24 at 2000 hours, during an interview with the DON, the DON verified the side rails did not match what Resident 84 had consented for the grab bars. 19. On 10/09/24 at 1024 hours, during an observation, Resident 111 was observed in bed with her bilateral 1/4 bed rails elevated. Medical record review for Resident 111 was initiated on 10/9/24. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's H&P examination 9/17/24, dated showed Resident 111's diagnoses included cognitive impairment. Review of Resident 111's informed consent dated 10/6/24, showed Resident 111's device order was grab bars as enabler for mobility (1/4). Review of Resident 111's bed rail assessment dated [DATE], failed to show a reason why alternatives to Resident 111's bed rails were ineffective. On 10/11/24 at 2000 hours, the above findings were verified with the DON.

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 51352 Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services when: * The facility failed to ensure all controlled medications were accounted for and documented. * The facility failed to ensure the licensed nurses followed the facility's process when opening and dispensing medications from the E-kit (emergency kit). These failures had the potential for drug diversion. Findings: Review of the facility's P&P titled Medication Storage in the Facility ID3: Controlled Medication Storage dated August 2014, showed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. At each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. Review of the facility's Emergency Kit Pharmacy Log showed intructions for all items used from Emergency Kit and for all orders where initial dose(s) were used from the emergency kit as follows: - Call order (including one-time or 'STAT' orders) into pharmacy - Fill out all appropriate areas in log - When completed, place top copy on pharmacy log clipboard - Return yellow copy to pharmacy in Emergency Kit 1.a. On 10/11/24 at 1241 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 2. The form titled Controlled Substances Shift Count Log dated October 2024 had unreadable headings on each section of the column due to the black mark on the background of the form. LVN 2 verified the headings on the Controlled Substances Shift Count Log were unreadable and clarified the column sections as follows: - Column one- Date of the month; - Column two- Off Going Nurse (7p-7a); - Column three- On Coming Nurse (7a-7p) ; (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Column four- Total Number of Cards/Count Sheet; - Column five- Off Going Nurse (7a-7p); - Column six- On Coming Nurse (7p-7a); - Column seven- Total Number of Cards/Count Sheet; and - Column eight- Comments Further review of the Controlled Substances Shift Count log dated 10/1 through 10/11/24, showed the following missing information: - No signatures of the On Coming Nurse for 7a-7p on 10/1, 10/2, 10/3, and 10/6/24. - No total number of cards/count sheet documented from the endorsement between 7p-7a and 7a-7p licensed nurses on 10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/8, 10/9, 10/10, and 10/11/24. - No total number of cards/count sheet documented from the endorsement between 7a-7p and 7p-7a licensed nurses on 10/1, 10/2, 10/3, 10/4, 10/5, 10/6, 10/8, 10/9, and 10/10/24. When asked what the purpose of having the signatures on the Controlled Substances Shift Count was, LVN 2 stated it was to get the key or endorse the key between the oncoming and offgoing licensed nurses, and both licensed nurses needed to make sure all controlled medication counts were correct. LVN 2 verified all the above findings. b. On 10/11/24 at 1814 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 6. The form titled Controlled Substances Shift Count Log dated 10/1-10/11/24, showed the following missing information: - No signatures from the Off Going Nurse (7p-7a) on 10/3, 10/4, and 10/7/24. - No signatures from the Off Going Nurse (7a-7p) on 10/1, 10/3, and 10/6/24. - No documentation for the total number of cards/count sheet from 10/1-10/11/24. LVN 6 verified all the above findings and stated the licensed staff' signatures and narcotic card counts should be completed and documented on the Controlled Substances Shift Count Log every shift. c. On 10/11/24 at 1814 hours, an inspection of Medication Cart C and concurrent count of the controlled medications and interview was conducted with LVN 6. A bubble pack of Resident 62's Morphine Sul ER (Morphine Sulfate Extended release - a pain medication that is slowly released into the body over time) 15 mg tablet showed and verified a total of 17 tablets. However, the Antibiotic or Controlled Drug Record for Resident 62 showed there were 18 tablets remaining. (continued on next page)

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	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 6 verified the number of the remaining Morphine Sul ER 15 mg tablets on Antibiotic or Controlled Drug Record for Resident 62 did not match the number of tablets remaining in the bubble pack. LVN 6 stated the record sheet was incorrect due to Morphine Sul ER 15 mg being administered to Resident 62 on 10/10/24, but not documented on the Antibiotic or Controlled Drug Record. LVN 6 also stated the night shift LVNs had performed the change of shift narcotic card count prior to her starting her shift. LVN 6 verified she should have performed the narcotic card count for Medication Cart C with another licensed staff member upon reporting to the facility for her shift. 2. On 10/11/24 at 1340 hours, an inspection of Medication Room A and concurrent interview was conducted with RN 2. An emergency kit containing oral medications was observed sealed with yellow zip ties on the counter of Medication Room A. RN 2 stated the yellow zip ties meant the emergency kit had been opened. A white form with a yellow form was visible through the clear emergency kit. Review of the Emergency Kit Pharmacy Log in Medication Room A showed the emergency kit was opened 10/5/24 at 1015 hours. On 10/11/2 at 1400 hours, RN 2 opened the emergency kit containing oral medications in Medication Room A. An Emergency Kit Pharmacy Log was observed to be inside the previously sealed (with yellow zip ties) emergency kit. The Emergency Kit Pharmacy Log showed the most recent entry was dated 10/10/24, for Potassium Chloride (supplement) 10 mEq (milliequivalent- unit of measurement used to express the amount of medication in a solution) capsule with directions to give 40 mEq once for Resident 831. RN 2 acknowledged and verified the above findings and stated the white copy of the Emergency Kit Pharmacy Log should have been on the clipboard in Medication Room A and not inside the emergency kit of oral medications. On 10/11/24 at 1638 hours, an interview and concurrent facility document review was conducted with the DON. The DON acknowledged the above findings. The DON also verified the copy of the Emergency Kit Pharmacy Log from the emergency kit for oral medication in Medication Room A was the log that was used to document the removal of medications. The DON verified the instructions written on the Emergency Kit Pharmacy Log was not followed for the use of medication from the emergency kit of oral medications in Medication Room A.

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	555308	A. Building B. Wing	10/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Pharmacy Consultant's recommendations from the drug regimen review were followed through for one of five final sampled residents (Residents 95) reviewed for unnecessary medications. * The Pharmacy Consultant's recommendation for follow up laboratory to recheck the potassium level was not followed through for Resident 95. This failure posed the risk of the resident not receiving the necessary care and services or receiving unnecessary medications. Findings: Review of the facility's P&P tiled Medication Regimen Review dated 12/19/22, showed MRR (Medication Regimen Review) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: - The review of the medical records in order to prevent, identify, report, and resolve medication related problems medication errors or other irregularities. - Collaboration with other members of the interdisciplinary team, including the resident the family and/or resident representative. Further review of the P&P showed pharmacist shall communicate any recommendation and identified irregularities via written communication with in 10 working days of the review. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Medical record review for Resident 95 was initiated on 10/8/24. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's Physician Order Summary showed an order dated 7/26/24, for potassium chloride oral tablet extended release 10 meq two tablets by mouth in the evening for hypokalemia (low potassium level). Review of Resident 95's MAR dated September 2024, showed Resident 95 had been receiving potassium chloride oral tablet extended release 10 meq two tablets by mouth in the evening. Review of Resident 95's Consultant Pharmacist Medication Regimen Review dated 9/1/24, to 9/16/24, showed to consider obtaining repeat potassium level to monitor for adverse effect and effectiveness of the medication potassium. In addition, the document showed potassium therapy was started in July, but no follow up lab was done to recheck potassium. Further review of the MRR showed per CMS regulation (F757), each residents drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate monitoring. Under the section follow through, showed a check mark. (continued on next page)

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	10/11/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 95's Physician Order dated 9/17/24, showed an order for potassium level. Further review showed the order for the potassium level was discontinued on 9/18/24. Review of Resident 95's test request form dated 9/17/24, showed Resident 95 refused lab to be collected on 9/17 and 9/18/24. Further review of Resident 95's medical record did not show the physician was notified regarding Resident 95's refusal for potassium level to be collected. On 10/11/24 at 1000 hours, a concurrent interview and medical record review for Resident 95 was conducted with the DON. The DON verified the above findings. The DON stated the facility should have followed through the recommendation and notified physician when Resident 95 refused the potassium level to be collected. Cross reference to F580, example #1.

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 68) reviewed for urinary tract infection was monitored for the side effects of Bactrim (medication used to treat infections) medication. This failure had the potential to negatively impact Resident 68's well-being. Findings: Review of the facility's P&P titled Medication Monitoring revised 12/19/22, showed this facility takes collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences. Medical record review for Resident 68 was initiated on 10/8/24. Resident 68 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's Order Summary Report for October 2024 showed a physician's order dated 10/7/24, to administer Bactrim DS (double strength) oral tablet 800-160 mg one tablet by mouth every 12 hours for UTI for seven days. Review of Resident 68's medical record failed to show Resident 68 was monitored for the side effects of Bactrim. On 10/11/24 at 1001 hours, a concurrent interview and medical record review for Resident 68 was conducted with RN 1. RN 1 stated Resident 68 was taking Bactrim for her urinary tract infection. RN 1 verified Resident 68 had no monitoring for the side effects of Bactrim. RN 1 stated the monitoring of side effects for Resident 68 was on her care plan. RN 1 further stated the staff only monitored a resident if there was an adverse effect. RN 1 stated the staff would document in the progress note if there was an adverse effect. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	555308	A. Building B. Wing	10/11/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 72) reviewed for unnecessary medications was free from the unnecessary psychotropic medications (medications affecting brain activity). * The facility failed to ensure Resident 72 was monitored for the side effects related to the use of bupropion (antidepressant), escitalopram (antidepressant), and trazodone (antidepressant) medications. In addition, the facility failed to ensure the documentation of the monitoring of side effects related to the use of psychotropic medications for Resident 72 in the MAR did not have two different meanings under the chart codes. These failures had the potential to not identify which medication caused the side effects and would negatively impact Resident 72's well-being. Findings: Review of the facility's P&P titled Use of Psychotropic Drugs reviewed 12/19/22, showed the following: - Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medications is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications; - The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as but not limited to: upon admission (routine and as needed), during the pharmacists monthly medication review, during significant change, and in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care; and - The resident's response to the medication(s), including progress towards goals and presence/ absence of adverse consequences, shall be documented in the resident's medical record. According to https://medlineplus.gov/druginfo/meds/a695033.html, the bupropion medication may cause the following serious side effects: seizures, confusion, hallucinating (seeing things or hearing voices that do not exist), irrational fears, muscle or joint pain, and rapid, pounding, or irregular heartbeat. According to https://medlineplus.gov/druginfo/meds/a603005.html, the escitalopram medication may cause the following serious side effects: unusual excitement, hallucinating, rash, hives or blisters, itching, fever, joint pain, difficulty breathing or swallowing, swelling of the face, throat, tongue, lips, or eyes, fever, sweating, confusion, fast or irregular heartbeat, severe muscle stiffness or twitching, agitation, hallucinations, loss of coordination, nausea, vomiting, or diarrhea, abnormal bleeding or bruising, nose bleeding, headache, unsteadiness, problems with thinking, concentration, or memory, seizures, and difficult or painful urination. (continued on next page)

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	10/11/2024

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to https://medlineplus.gov/druginfo/meds/a681038.html, the trazodone medication may cause the following serious side effects: chest pain, fast, pounding, or irregular heartbeat, loss of consciousness or coma, fever, sweating, confusion, fast or irregular heartbeat, and severe muscle stiffness or twitching, agitation, hallucinations, loss of coordination, nausea, vomiting, or diarrhea, fainting, seizures, shortness of breath, unusual bruising or bleeding, nosebleeds, small red or purple dots on the skin, erection lasting more than six hours, headache, problems with thinking, concentration, or memory, weakness, and problems with coordination. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Order Summary Report dated 10/10/24, showed the following physician's orders dated 9/5/24: - To administer bupropion 150 mg via GT every eight hours for depression manifested by loss of interest in daily activities; - To administer escitalopram 10 mg via GT in the morning for depression manifested by verbalization of sadness; - To administer trazodone 50 mg via GT at bedtime for depression manifested by inability to sleep at night; and - To monitor for side effects related to the use of psychotropic medications. The staff initials indicate absence of signs and symptoms of side effects. Review of Resident 72's MAR for September and October 2024 showed the following: - Resident 72 was administered the bupropion medication on 9/6 to 9/17/24, and 9/25 to 10/10/24 at 0600, 1400, 2200 hours, 9/24/24 at 1400 and 2200 hours, and 10/11/24 at 0600 hours; - Resident 72 was administered the escitalopram medication on 9/6 to 9/17/24, and 9/25 to 10/11/24 at 0600 hours; - Resident 72 was administered the trazodone medication on 9/5 to 9/17/24, and 9/24 to 10/10/24 at 2100 hours; - Resident 72 was monitored for side effects related to the use of psychotropic medications on 9/6 to 9/17/24, and 9/24 to 10/10/24 at 0700 to 1900 hours shift and 1900 to 0700 hours shift, 9/5/24 at 1900 to 0700 hours shift, and 9/23/24 at 1900 to 0700 hours shift; and - The MAR also showed Resident 72 was not monitored for the side effects related to the use of the psychotropic medications on 9/18 to 9/22/24 at 0700 to 1900 hours and 1900 to 0700 shifts, and 9/23/24 at 0700 to 1900 hours shifts. The boxes were marked with a 2, and 3. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 72's MAR for September and October 2024 showed the chart codes had two different meaning. For example: the number 2 meant to hold/see progress notes, and another column showed, 2 meant treatment refused, while the number 3 meant hospitalized , and another column showed 3 meant vitals outside of parameters administration. In addition, further review of Resident 72's medical record did not show the resident was monitored for the specific side effects for each antidepressant medications she was taking. On 10/11/24 at 1320 hours, a concurrent interview and medical record review for Resident 72 was conducted with the DON. The DON verified the above findings. When asked about the monitoring of the side effects related to the use of bupropion, escitalopram, and trazodone medications, the DON acknowledged the monitoring of the side effects was not specific to each of the antidepressant medication. The DON stated it was a company standard to have a monitoring for the side effects for all the psychotropic medications use, and not specific to each psychotropic medication. The DON stated they would monitor the side effects of each of the psychotropic medication only for antipsychotic medications, but not for any other psychotropic medications. When asked about the documentation of the monitoring of the side effects related to the use of the resident's psychotropic medications, the DON verified the MAR showed two different meanings under the chart codes.

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	10/11/2024

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 13.79%. One of three licensed nurses (LVN 1) observed during the medication administration was found to have made errors. * LVN 1 failed to prepare UTI-STAT oral liquid (supplement to reduce the risk of urinary tract infections) and polyethylene glycol 3350 powder (a stool softener to relieve occasional constipation) for one nonsampled resident (Resident 829) as ordered by the physician * LVN 1 failed to assess Resident 829 about her stools or review her medical record for any loose stools prior to the administration of Colace 100 mg (stool softener), as ordered by the physician. * LVN 1 failed to administer hydrocodone-acetaminophen (narcotic pain medication) 10-325 mg to resident 829 as ordered by the physician. These failures had the potential to negatively affect the resident's health conditions. Findings: Review of the facility's P&P titled Preparation and General Guidelines IIA2: Medication Administration - General Guidelines, dated October 2017, showed medications are administered as prescribed in accordance with good nursing principles and practices and only be persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes of the scheduled time (One hour before and one hour after), except before or after meal orders, which are administered based on mealtimes. On 10/9/24 at 0932 hours, a medication administration observation for Resident 829 was conducted with LVN 1. LVN 1 prepared and administered Resident 829's medications which included the following: - One tablet of valsartan 40 mg (medication to treat high blood pressure) - One capsule of duloxetine HCL DR (delayed release) 20 mg (medication to treat depression) - One capsule of gabapentin 300 mg (medication to treat pain or seizures) - One tablet of docusate sodium 100 mg (stool softener) - One tablet of hydrocodone/APAP 10-325 mg Medical record review for Resident 829 was initiated on 10/8/24. Resident 829 was admitted to the facility on [DATE]. Review of Resident 829's Order Summary report dated 10/3/24, showed the following physician's orders dated 10/3/24: (continued on next page)

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	10/11/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- gabapentin Oral Capsule 300 mg by mouth three times a day for neuropathic pain. - UTI-Stat Oral Liquid 30 ml by mouth one time a day for urinary prophylaxis. - valsartan 40 mg by mouth one time a day for HTN, to hold if SBP less than 110 mmHg. - an order dated 10/4/24 for polyethylene glycol 3350 Powder 17 grams by mouth in the morning for bowel management, to hold for loose stool. - an order dated 10/6/24, to administer Colace 100 mg capsule BID for bowel management, to hold for loose stools - an order dated 10/8/24, to administer Cymbalta oral capsule delayed release particles 20 mg by mouth one time a day for pain management - an order dated 10/8/24, to administer Hydrocodone-Acetaminophen oral tablet 10-325 mg one tablet by mouth every four hours for moderate pain (levels of 4-6) or severe pain (levels of 7-10) for 3 days. Review of Resident 829's MAR showed the medication administration times for the hydrocodone-acetaminophen 10-325 mg were for 0000, 0400, 0800, 1200, 1600, and 2000 hours. Review of Resident 829's Antibiotic or Controlled Drug Record showed an entry dated 10/9/24 at 0949 hours, for the hydrocodone-acetaminophen 10-325 mg. During the medication administration observation, LVN 1 did not prepare the UTI-Stat Oral Liquid and polyethylene glycol 3350 powder for Resident 829. LVN 1 did not ask Resident 829 if she recently had loose stools prior to giving the docusate sodium. On 10/09/24 at 1046 hours, an interview and concurrent medical record review for Resident 829 was conducted with LVN 1. LVN 1 verified she did not prepare the UTI-Stat oral liquid and polyethylene glycol 3350 powder for Resident 829. LVN 1 further stated Resident 829 always refused the medication. LVN 1 stated she should have prepared both medications, even if Resident 829 usually refused to take them because the medications were ordered to be given at 0900 hours. LVN 1 also verified the physician's order for Resident 829 for Colace 100 mg showed an instruction to hold for loose stools. In addition, LVN 1 verified she did not assess or ask Resident 829 about her stools or review the resident's medical record for loose stools before administering the medication as per the physician's order. Furthermore, LVN 1 verified the order for hydrocodone-acetaminophen 10-325 mg was ordered every four hours and was scheduled to have been given at 0800 hours. LVN 1 verified the hydrocodone-acetaminophen 10-325 mg was given at 0949 hours, which was administered late, outside the allowed time frame of within 60 minutes before and after the scheduled time.

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	10/11/2024

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51352 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the staff implemented the proper storage, labeling, and disposal of medications and treatment supplies in a safe and secure manner; and failed to ensure the medications were safely stored and accessed by authorized personnel only. * The facility failed to ensure medications were not left unattended. One nonsampled resident (Resident 18's) medications were left unattended on top of the medication cart and on top of her bedside table during a medication administration. * The facility failed to ensure that medications administered orally were stored separately from transdermal and ophthalmic (relating to the eye and it's diseases) medications, subcutaneous injections (SQ - an injection is given in the fatty tissue, just under the skin) were stored separately from ophthalmic medications, and medications given via inhalation were stored separately from nasal and transdermal medications in Medication Cart A. * The facility failed to ensure a bottle of nasal solution was proper labeled in Medication Cart A. * The facility failed to properly monitor and record the room temperature for Medication Storage Room A. * The facility failed to properly dispose of medications in the incineration containers for Medication rooms [ROOM NUMBERS]. * The facility failed to ensure the opened insulin pen in Medication Cart C was properly labeled. * The facility failed to ensure medication container was kept in clean condition * The facility failed to ensure an expired silicone suction tubing connector was removed from Medication Cart D * The facility failed to ensure a tube of Anasept (antimicrobial skin and wound gel) cream, and a medicine cup with a white pasty cream were not left at one of 28 final sampled residents (Resident 928's) bedside. These failures had potential to result in unsafe medication administration, cross-contamination of the medications, and pose the risk for non-licensed staff or unauthorized personnel to have access to the medications. Findings: (continued on next page)

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	10/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Medication Storage in the Facility ID1: Storage of Medications dated [DATE], showed medications and biologicals are to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The P&P further showed the following: A. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. B. Orally administered medications are kept separate from externally used medications such as suppositories,liquids, and lotions. C. Intravenously administered medications are kept separate from orally administered medications. D. Eye medications are kept separate from ear medications. E. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. F. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. G. Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified. Review of the facility's P&P titled Disposal of Medications and Medication-Related Supplies dated [DATE] showed discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed. The P&P further showed the procedure for medication destruction as follows: A. All medications are placed in the proper waste container per facility policy. The facility maintains a contract with a waste disposal company specifying pick-up and disposal procedures. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Controlled substances are retained in a securely locked area using double-lock procedures, with restricted access until destroyed by the facility director of nursing or a registered nurse employed by the facility and a consultant pharmacist. C. Non-controlled medication destruction occurs in the presence of two licensed nurses. 1. Medical record review for Resident 18 was conducted on [DATE]. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. On [DATE] at 0836 hours, a medication administration observation for Resident 18 was conducted with LVN 5. LVN 5 was observed dispensing the following medications into the medicine cups: - One Vitamin C (supplement) 500 mg tablet - One Eliquis (blood thinner) 2.5 mg tablet - One Gentesa (medication to treat overactive bladder) 75 mg tablet - One metformin HCL (medication to treat diabetes-high blood sugar) 850 mg tablet - One One-daily multivitamins with minerals tablet - One Geri-Kot (laxative) 8.6 mg tablet - One metoprolol (medication to treat high blood pressure) 100 mg tablet - One losartan (medication to treat high blood pressure) 25 mg tablet - One diltiazem (medication to treat high blood pressure) 90 mg tablet On [DATE] at 0858 hours, LVN 5 was observed leaving Resident 18's medications unattended on top of the medication cart while he entered the room and attended to a request from Resident 18's roommate, Resident 95. On [DATE] 0904 hours, LVN 5 was observed to begin preparing Tylenol 650 mg for Resident 95, while Resident 18's medications remained on top of the medication cart. On [DATE] at 0904 hours, LVN 5 left Resident 18's medications unattended on the medication cart while he administered medication to Resident 95. On [DATE] at 0910 hours, LVN 5 left Resident 18's medications unattended on her bedside table to remover her breakfast tray from the room. On [DATE] at 1118 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 verified he left the medications for Resident 18 unattended on the medication cart and the bedside table. He stated he should never leave medications unattended on the medication cart or in the resident's room. (continued on next page)

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	10/11/2024

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.a. On [DATE] at 1240 hours, an interview and concurrent inspection of Medication Cart A was conducted with LVN 2. During the Medication Cart A inspection, the following was observed: - The top drawer of Medication Cart A was observed to have an Insulin Lispro (medication to lower blood sugar level) pen was stored with a bottle of nitroglycerine (antiangina) SL and sterile eye drops. Further inspection of the top drawer of Medication Cart A showed a transdermal scopolamine (medication to prevent nausea and vomiting) patch stored with medications administered orally, sterile lubricant eye drops, and six plastic single use Carboxymethycellulose Sodium (medication to relieve eye dryness) 0.5%. LVN 2 verified the findings and stated these medications should not be stored together. b. The bottom drawer of Medication Cart A was observed with azelastice (medication to treat eye itching) HCL Nasal Solution with a smudged, unreadable open date written on the bottle. The box for the medication showed an open date of ,d+[DATE], however, there was no year written on the box. LVN 2 verified the finding and stated the open date should include the year. - Further inspection of the bottom drawer of Medication Cart A showed two medications administered via inhalation ipratropium bromide inhalation solution (medication to control symptoms of lung disease and treat air flow blockage) 0.5 mg/2.5 ml and albuterol sulfate (medications to treat and prevent breathing difficulties caused by lung disease) inhalation aerosol 90 mcg stored with two nasal spray medications (naloxone HCL nasal spray 4 mg and fluticasone 50 mcg nasal spray). In addition, ipratropium bromide and albuterol sulfate inhalation solution were stored with house supply transdermal lidocaine pain reliever gel patches with 4% lidocaine and a Trelegy Ellipta (medication to treat and prevent breathing difficulties caused by lung disease) inhaler in Medication Cart A. LVN 2 verified the findings. 3. On [DATE] at 1340 hours, an inspection of Medication Room A was conducted with RN 2. Review of the Medication Room/Refrigerator & Freezer Temperature Log for Medication Room A for [DATE] showed the log had already been filled out for [DATE], for 7 pm to 7am shift. RN 2 stated RN 4 was the one who filled out the temperature log for Medication Room A. On [DATE] at 1406 hours, an interview and concurrent facility document review was conducted with RN 4. RN 4 verified she signed the Medication room/Refrigerator & Freezer Temperature Log for Medication Room A for the [DATE], for 7 pm to 7 am shift. RN 4 stated she checked the temperatures of the fridge and freezer during the 7 am to 7 pm shift on [DATE]. RN 4 further stated she signed on the night shift slot because the previous RN signed on the 7 am to 7 pm slot for [DATE]. RN 4 verified she should have left the log as it was and made a notation of her temperature check in the comments section of the log. b. During the inspection of Medication Room A, bottles of medications were observed in the incineration bin and accessible in the incineration container inside Medication Room A. RN 2 verified the findings. When asked about the facility's process for the destruction of the medications and putting medications in the incineration bin, RN 2 stated she did not know the process and would find out. (continued on next page)

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	10/11/2024

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1638 hours, an interview was conducted with the DON. The DON verified the findings regarding accessible medication observed in the incineration bin in Medication Room A. She stated the licensed staff should discard all remaining medications from the blister packs and medicine bottles into the incineration container. She further stated the licensed staff should pour water on top of the medications to ensure they were destroyed and not accessible. 4. On [DATE] at 1745 hours, an interview and concurrent inspection of Medication Room C was conducted with LVN 6. The incineration container in Medication Room C was observed to have a bubble pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles (or blisters) containing medications, bottles of medications, eye drops, and whole pills and capsules were observed to be accessible. LVN 6 verified the findings. LVN 6 stated someone with a key to Medication Room C could access the medications in the incineration container. 5. On [DATE] at 1814 hours, an interview and concurrent inspection of Medication Cart C was conducted with LVN 6. During the inspection, the top drawer of Medication Cart C was observed to have an Insulin Lantus (medication to lower blood sugar) pen with an open date of ,d+[DATE]. LVN 6 verified there was no year written on the pen and the full date should be written on all opened medications. During the inspection of Medication Cart C a container of Reguloid 100% Natural Psyllium Husk was observed with a stained label. LVN 6 stated the label was not clean and showed staining. LVN 6 verified the findings. 6. On [DATE] at 0853 hours, an interview and concurrent observation of Medication Cart D was conducted with RN 2. During the observation, a silicone suction tubing connector was observed with an expiration date of [DATE]. RN 2 acknowledged and verified the findings. 39453 7. On [DATE] at 0947 hours, during the initial tour of the facility, Resident 928 was observed awake and lying in bed. A medication cup with a white pasty cream was observed on top of the resident's stand. A tube of Anasept (antimicrobial skin and wound gel) cream was observed inside the drawer of the resident's nightstand. Resident 928 stated the staff used the creams on her since two days ago. On [DATE] at 1016 hours, a concurrent observation and interview for Resident 928 was conducted with LVN 8. A medication cup with a white pasty cream was observed on top of the resident's stand. A tube of Anasept cream was observed inside the drawer of the resident's nightstand. LVN 8 verified the above findings. LVN 8 stated the white pasty cream could be zinc, but not sure what it was, and the creams could be from the treatment cart. Medical record review for Resident 928 was initiated on [DATE]. Resident 928 was admitted to the facility on [DATE]. Review of Resident 928's H&P examination dated [DATE], showed Resident 928 had the capacity to make medical decisions. Review of Resident 928's Order Summary Report dated [DATE], showed a physician's order dated [DATE], to apply clotrimazole (antifungal cream) 1% to sacrum/buttocks MASD (moisture-associated skin damage) topically everyday shift. (continued on next page)

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	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 928's medical record did not show a physician's order to apply Anasept cream. On [DATE] at 1345 hours, a concurrent interview and medical record review for Resident 928 was conducted with the DON. The DON verified the above findings. The DON stated the treatment creams were used as a skin barrier from the treatment cart, but the treatment creams should not be left at the bedside.

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	10/11/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, facility document review, and facility P&P review, the facility failed to follow the menu when preparing food for the residents. * The facility failed to ensure [NAME] 1 followed the recipe when preparing puree roast beef and puree potatoes. * The facility failed to ensure the recipe for fruit plate was followed. Resident 131 was served with a plateful of cantaloupe slices and several pieces of grape when the resident requested for a fruit plate. These failures had the potential of not meeting the residents' nutritional needs which could lead to nutritional related health complications. Findings: 1. Review of the facility document Order Listing Report for dietary dated 10/9/24, showed 15 residents received pureed food prepared from the kitchen. Review of the facility's diet spreadsheet titled Daily Spreadsheet Menus dated 10/9/24, showed the lunch menu including rosemary pot roast, roasted yukon gold mashed potatoes, and fresh brussels sprouts for pureed diet. Review of the facility's P&P titled Puree Food Preparation revised 12/19/24, showed it is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance. Further review of the P&P showed do not use water as an additive to prepare puree foods, and to follow the recipe and spreadsheets for a puree food item. a. On 10/9/24 at 1036 hours, a concurrent observation and interview was conducted with [NAME] 1. [NAME] 1 was preparing puree roast beef. [NAME] 1 was observed holding a pan of roast beef with reserved cooking liquid in it, [NAME] 1 was not observed measuring roast beef and reserved cooking liquid of roast beef. [NAME] 1 stated the facility had around 17 residents on puree diet and he used six pounds of roast beef and three cups of reserved cooking liquid. [NAME] 1 was then observed adding water from the tap (unmeasured) and blended the roast beef. Then, [NAME] 1 was observed adding two ounces of thicker to the puree roast beef for consistency. b. On 10/9/24 at 1047 hours, a concurrent observation and interview was conducted with [NAME] 1. During a puree preparation observation for puree potatoes, [NAME] 1 was observed holding a pan of butter and milk, [NAME] 1 was not observed measuring butter and milk, [NAME] 1 stated he had four ounces of butter and eight ounces of milk in the pan. [NAME] 1 was then observed adding 1/4 spoon of salt and black pepper. [NAME] 1 then proceeded to add hot water without measuring it, then stated he added 3/4 qt of hot water. [NAME] 1 added dry potato mix in the mixture and mixed it in the pan for consistency. [NAME] 1 was observed not measuring dry potato mixture. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1047 hours, a follow-up interview was conducted with [NAME] 1. [NAME] 1 verified the above observation and stated he should follow the recipe while preparing puree diet. When asked [NAME] 1 to show the recipe he used to make puree roast beef and puree potatoes, he was not able to show. On 10/9/24 at 1105 hours, a concurrent interview and facility document review was conducted with the DSS. The DSS was informed of the above observation. When asked the DSS about the recipe for puree roast beef and puree potatoes. The DSS showed the recipe for Pureed Fish/Meat/Poultry, and Pureed Potatoes, Pasta, Rice and other Grains. Review of the facility document titled Pureed Fish/Meat/Poultry dated 10/6/21, showed for 15 serving, to add 2 and 3/4 pounds of meat product, 3 cups of reserved cooking liquid 1 tbsp and 1 and 1/2 tsp thickener. Further review of the document showed the following directions: - Remove required portion amounts from regular prepared recipe, place in food processor. Remember to weigh meet only do not include cooking juice or gravy; - Process until meat is smooth in consistency. Gradually add broth or gravy and thickener to meat while processing. All liquid may not be required depending on texture of the meat. - Scrape down sides of processor with rubber spatula; reprocess for 30 seconds. - Ensure mixture achieves smooth, lump free and extremely thick consistency. Review of the facility's document titled Pureed Potatoes, Pasta, Rice and other Grains dated 11/5/21, showed for 15 residents to add 1qt and 3 and half cup of potatoes cooked and drained, 3 and 3/4 cup of broth or hot 2% milk, margarine 3 tbsp, and food thicker 1 tbsp and 1 and 1/2 tsp. Further review of the document showed the following directions: -Remove portion required from regular prepared recipe and drain, place it in a food processor and process until smooth; - Slowly add hot broth or hot milk and margarine. If needed add thickener and process until smooth in consistency; - Scrape down sides with rubber spatula and reprocess for 30 seconds; and - Ensure mixture achieves smooth, lump free and extremely thick consistency. The DSS stated the cook should have followed the recipe for roast beef and puree potatoes, and should have measured ingredients while preparing puree diet to meet the nutritional needs of the residents. The DSS further stated the cook should not have added water during the preparation of the puree diet. On 10/9/24 at 1105 hours, an interview with the RD was conducted. The RD acknowledged above findings. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 1145 hours, a follow-up interview was conducted with the RD. The RD sated [NAME] 1 was nervous during the puree preparation observation and did not follow the recipe. The RD further stated the facility discarded the puree roast beef and puree potatoes prepared during observation and was repreparing puree roast beef and puree potatoes following the recipe. 39453 2. On 10/9/24 at 1250 hours, Resident 131 was observed in bed, with a lunch tray. Resident 131 stated she had a concern with the fruit plate she ordered, which she ordered from the alternative menu list. Her lunch tray was observed with a plateful of cantaloupe slices and pieces of grape, a dessert, a cup of water, and a fruit cup. Resident 131 stated the fruit cup was from her breakfast tray. Resident 131 stated she was served with the fruit plate for lunch but expecting more of a variety of fruits, and cottage cheese. Resident 131 stated she only ate a couple of grapes. Resident 131 stated she could not eat the fruit plate and would just eat ice cream instead. On 10/9/24 at 1300 hours, RN 5 was asked inside Resident 131's room. Resident 131's lunch tray was observed with a plateful of cantaloupe slices and pieces of grape, a dessert, and a cup of water. RN 5 verified the above findings. RN 5 stated he would get the ice cream from the kitchen. On 10/9/24 at 1305 hours, an observation and concurrent interview was conducted with LVN 9. LVN 9 verified the above findings. LVN 9 stated he was expecting at least slices of strawberries, but today it was just the cantaloupe and grapes. Medical record review for Resident 131 was initiated on 10/8/24. Resident 131 was admitted to the facility on [DATE]. Review of Resident 131's Internal Medicine H&P evaluation/Progress Note dated 10/7/24, showed Resident 131 had the capacity to make medical decisions. Review of Resident 131's Order Summary Report dated 1010/24, showed a physician's order dated 10/6/24, for a regular diet texture, thin consistency, and chopped meals for breakfast, lunch and dinner. On 10/11/24 at 0929 hours, a concurrent facility document review and interview for Resident 131 was conducted with the DSS. When asked about alternative menu, the DSS stated the residents chose from the alternative menu list, which included fruit plate. When asked if the recipes were followed for the alternative menu, the DSS answered yes, and showed the recipe for fruit plate. Review of the facility's recipe for Cottage Cheese and Fruit Plate - 2 ounces dated 10/11/24, showed the recipe included cottage cheese, peach slices, pear halves, pineapple slices, and fresh lettuce leaf with liner. The directions included other canned fruit may be used according to the availability. The DSS verified the above findings. When asked if the fruits listed in the recipe were available, the DSS answered yes. The DSS stated he would find out why Resident 131 was served with a fruit plate with cantaloupe and grapes. On 10/11/24 at 1430 hours, the DSS stated there was another recipe for fruit plate, to which he showed a copy of the chef's choice of seasonal fruit recipe. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's recipe for Chef Choice of Seasonal Fruit (Canned or Fresh) - (Fruit) dated 10/11/24, showed peach slices, golden delicious apples, fresh bananas, fresh strawberries, fresh pineapple, and fresh seedless green grapes. The directions showed the following: - Serve 1/2 cup of desired fruit using #8 scoop. Note: other canned fruits available, drain canned fruit. Applesauce, pineapple, pears, mandarin oranges, fruit cocktail, sliced apples or fresh fruit may include strawberries, grapes, apples, groups, melon, peaches, apricots, bananas, kiwi, pears and nectarines. - Section fruit appropriately; and - Serve #8 scoop of drained canned fruit or appropriate amount of fresh fruit to equal 1/2 cup, per portion. The DSS verified the above findings. When asked if the fruits listed in the recipe were available, the DSS answered yes. When asked why Resident 131 was not served with the fruits and serving size as shown in the recipe, the DSS stated it was the chefs choice recipe which meant the chef can choose what fruits to serve.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44175 Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when: * A bin with multiple pan lids were stored with food crumbs and dirt. * Two blenders, five pink and two brown meal trays were stored wet. * A cutting board with blue colored handle did not have cleanable surface. * A cart with full of dessert in multiple small bowl were unlabeled. * The appropriate hair restraint was not worn by a dietary staff. * The condiments were not stored in sanitary condition. These failures had the potential to result in foodborne illnesses for 134 of 140 residents receiving kitchen services. Findings: 1. According to FDA Food Code 2022, 4-601.11, Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood-contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 10/8/24 at 0758 hours, a concurrent observation and interview was conducted with the DSS. A bin with multiple pan lids ready to use were observed with dust and food crumbs, the DSS verified the observation and stated the bin with the clean pan lids were ready to use should not have food crumbs and dirt. The DSS was observed taking out the bin with the pan lids to the dish washing area for cleaning. 2. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. On 10/8/24 at 0758 hours, a concurrent observation and interview was conducted with the DSS. The following was observed: - two blenders were observed on food preparation area, blenders were observed covered with lids. The DSS opened the lids of the blenders, and the two blenders were observed to be stored wet. The DSS verified the observation and stated the staff should have air dried the blenders before storing. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- five pink and two brown meal trays were observed stored stacked in the clean dish storage area; the meal trays were observed to be stored wet. The DSS verified the observation and stated staff should have air dried the meal trays before stacking for storage. The DSS was observed taking the two blenders and five pink and two brown meal trays to the dish washing area for cleaning. 3. According to FDA Food Code 2022, Section 4-501.12, Cutting Surfaces, surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 10/8/24 at 0758 hours, a concurrent observation and interview was conducted with the DSS. A white cutting board with blue handles was observed to be heavily marred with brownish discoloration. The DSS verified the observation and stated the cutting board needed to be replaced. 4. Review of the facility's P&P titled Date Marking for Food Safety dated 12/29/22, showed the facility to adhere to a date marking system to ensure the safety of ready to eat, time and temperature control for food safety. Further review of the P&P showed the individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. On 10/8/24 at 0758 hours, a concurrent observation and interview was conducted with the DSS. A meal cart full of desert in a multiple small bowl were observed unlabeled in the walk-in refrigerator. The DSS verified the observation and stated those desserts were prepared yesterday; however, the staff should have labeled each dessert with dated and time it was prepared. 5. According to the USDA Food Code 2022, Section 2-402.11 (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils. On 10/9/24 at 1202 hours, a concurrent observation and interview was conducted with the DSS. Dietary Aid 1 was observed in the kitchen around the steam table wearing hat, which was covering half of his scalp, other half of his scalp with hair was observed not restrained and Dietary Aid 1 was not observed wearing hair net. The DSS verified the observation and stated all the kitchen staff and personnel entering the kitchen should restrain their hair. On 10/11/24 at 1405 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings. 51352 6. On 10/8/24 at 1256 hours, an observation and concurrent interview was conducted with LVN 7 in the main dining room. LVN 7 pulled out a drawer containing condiments which included sugar packets, salt packets, and pepper packets. The condiment drawer was observed to have black and white granules spilled inside the drawer. LVN 7 verified the findings and stated the sugar and black pepper had spilled inside the drawer, and the drawer was not clean.

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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** 49324 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for one of 28 final sampled residents (Resident 69) and one closed record (Resident 731) were complete and accurately documented. * The facility failed to ensure Resident 69's POLST Section D information and signatures were documented. * The facility failed to ensure the AMA form was maintained in the resident's medical records. These failures had the potential for the residents' care needs not being met as their medical information was incomplete and inaccurate Findings: Review of the facility's P&P titled Documentation in Medical Record revised 12/19/24, showed documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 1. Medical record review for Resident 69 was initiated on 10/9/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's POLST dated 8/724, failed to show the completed documentation on Section D. Section D was completely blank. On 10/9/24 at 0959 hours, a concurrent medical record review and interview was conducted with LVN 2. LVN 2 verified Section D of the POLST was blank. On 10/9/24 at 1019 hours, a concurrent medical record review and interview was conducted with RN 2. RN 2 verified Section D was blank. On 10/11/24 at 1620 hours, the DON verified Section D of the POLST was blank. 49644 2. Closed medical record review for Resident 731 was initiated on 10/9/24. Resident 731 was admitted to the facility on [DATE]. Review of Resident 731's Progress Notes for October 2024, showed the nurses' progress note dated 10/7/24, the family of Resident 731 had signed the AMA form. Review of Resident 731's medical record failed to show a signed AMA form. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 10/10/24 at 1357 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified Resident 731's nurses progress note showed Resident 731's family signed the AMA form. LVN 8 stated to ask the medical records for the copy of the AMA form. On 10/11/24 at 1355 hours, an interview was conducted with the Medical Records Director. The Medical Records Director stated she looked at Resident 731's medical record and was not able to find the signed AMA form. The Medical Records Director stated the DON told her she was not able to find Resident 731's signed AMA form. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	555308	A. Building B. Wing	10/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their infection control surveillance program in accordance with the facility's P&P and failed to maintain the infection practices to help prevent the development and transmission of diseases and infection. * The facility failed to maintain an accurate infection surveillance program for June, July, August, and September 2024. * Resident 47's urinal was found to be hanging by the trash bin. * LVN 3 wore two pairs of gloves and failed to perform hand hygiene when the top pair of gloves was removed prior to the administration of G-tube medication for Resident 72. * LVN 3 failed to sanitize the stethoscope and blood pressure machine with cuff after using for Resident 931. * LVN 1 failed to perform hand hygiene after removing gloves during medication administration observation for Resident 829 * LVN 4 failed to perform hand hygiene after removing gloves during medication administration observation for Resident 26. These failures posed the risk for not identifying the residents infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility. Findings: 1. Review of the facility's P&P titled Infection Surveillance dated 12/19/22, showed the infection preventionist will conduct an ongoing surveillance and nursing staff will monitor the residents for signs and symptoms that may suggest infection, according to the current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. The facility will collect date to properly identify possible communicable diseases or infections before the spread by identifying the date to be collected, including how often and type of data to be documented the infection site, signs and symptoms, and resident locations, including the summary and analysis of the number of residents who developed infections. The CDC's National Healthcare Safety Network (NHSN) Long Term Care Criteria, updated McGeer criteria or other surveillance criteria will be used to define the infections. Review of the facility's Monthly Infection Control Surveillance Reports for the months of June, July, August, and September 2024 showed the following residents infection surveillance data for Community Acquired Infection (CAI) (an infection presents prior to admission to the facility or developed within 48 hours of admission), Healthcare Acquired Infection (HAI) (an infection developed 48 hours after admission to the facility), and the total number of infections: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- June 2024: 38 CAI, 7 HAI, and 55 total number of infections. - July 2024: 31 CAI, 11 HAI, and 49 total number of infections. - August 2024: 49 CAI, 9 HAI and 64 total number of infections. - September 2024: 49 CAI, 20 HAI and 75 total number of infections. However, there was no documented evidence on the Infection Prevention and Control Surveillance Log if the residents' infections were HAI or CAI. In addition, there was no evidence it met the McGeer's Criteria (a set of specific definitions to identify true infections in long term nursing facilities) and the total number of infections on the surveillance log did not match on the infection control monthly report. a. Review of the Infection Prevention and Control Surveillance Log for September 2024 showed Resident 73 was on levofloxacin 500 mg (an antibiotic medication) for pneumonia (an infection in the lungs caused by a bacteria) for six days. Medical record review for Resident 73 was initiated on 10/10/24. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's Infection Screening Evaluation dated 9/5/24, under evaluation on general findings, the recent CXR (chest x-ray) was marked as no. Under the Infection Analysis section, the section for the criteria was not marked if the resident's infection meets the criteria for true infection or not. Review of Resident 73's Nurses Progress Note dated 9/7/24, showed the report from the acute care hospital, x-ray result showing Resident 73 had PNA (pneumonia) and started on levofloxacin 500 mg daily started 9/6/24, to six more doses at the facility. Further medical record review for Resident 73 did not show documented evidence of a copy of the x-ray result was on the resident's medical record from the acute care hospital was found. b. Review of the Infection Prevention and Control Surveillance Log for September 2024 showed Resident 110 was on Fidaxomicin and Vancomycin (antibiotic medication) for c-diff (clostridium difficille- a bacterial infection in the large intestine that highly contagious). Medical record review for Resident 110 was initiated on 10/10/24. Resident 110 was admitted to the facility on [DATE]. Review of Resident 110's Infection Screening Evaluation dated 9/12/24, showed the resident was admitted with symptoms of diarrhea within 24 hours. The Infection Analysis section showed the resident met the McGeers criteria for true infection. Review of the Nurses Progress Note dated 9/12/24, showed the resident was prescribed with Vancomycin 2. 5 ml four times a day for 39 days. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further medical record review for Resident 110 did not show a copy of the laboratory results from the acute care hospital to confirm the diagnosis of c-diff and if it was a true infection or not. In addition, there was no documented evidence to show the physician was informed that the resident was on two antibiotic therapy. On 10/10/24 at 1501 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP verified the above findings. The DSD/IP confirmed the missing and incomplete Infection Prevention and Surveillance Log and Monthly Infection Control Surveillance. The DSD/IP stated the Monthly Infection Control Surveillance should be completed and accurate because it showed information readily available to report during their monthly and quarterly Quality Assurance meeting. The DSD/IP further stated each resident with infection were included in the Infection Prevention and Surveillance Log should have a McGeer's criteria. The DSD/IP confirmed some of the McGeer Criteria forms were missing and not completed. On 10/10/24 at 1623 hours, an interview was conducted with the Administrator. The Administrator was informed and verified the above findings. Cross reference to F881, examples #1 and #2. 49324 2. On 10/9/24 at 1256 hours, an observation was conducted of Resident 47's room. Resident 47's urinal was found to be hanging by the trash bin. Medical record review for Resident 47 was initiated on 10/10/24. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination date 4/21/24, showed Resident 47 needed assistance on decision making. On 10/10/24 at 1025 hours, a concurrent observation of Resident 47's room and interview was conducted with RN 2. The urinal was still observed hanging by the trash bin. RN 2 verified there could be a risk of infection control. RN2 further stated she would check for urinal holder to hang the urinal by the bed. On 10/11/24 at 1255 hours, a subsequent interview was conducted with RN 2. RN 2 stated Resident 47 told her it was his preference to place the urinal by the trash bin. RN 2 also added risks and benefits and care plan was immediately done after being notified. RN 2 was then asked if from the previous days, Resident 47 was educated about the risks ad benefits of his urinal hanging from the trash bin. RN 2 did not answer the question. On 10/111 at 1620 hours, an interview was conducted with the DON. The DON was informed about the findings. The DON acknowledged the risk of infection control on Resident 47's urinal hanging by the trash bin. 51352 (continued on next page)

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	10/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Progress Note H&P examination dated 9/5/24, showed the resident needed assistance in decision making capabilities. On 10/8/24 at 0909 hours, a medication administration observation for Resident 72 with LVN 3. LVN 3 was observed wearing two pairs of gloves during the medication administration. After accessing Resident 72's GT, LVN 3 was observed removing the top pair of gloves. However, LVN 3 did not perform hand hygiene after removing the pair of gloves and proceeded with the medication administration via GT. On 10/9/24 at 1452 hours, an interview was conducted with LVN 3. LVN 3 verified he wore two pairs of gloves during the medication administration for Resident 72. LVN 3 stated he wore two pairs of gloves because he wanted to make sure the gloves stayed clean. 4. Medical record review for Resident 931 was inititated on 10/8/24. Resident 931 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 931's H&P examination dated 9/28/24, showed Resident 931 was unable to make decisions. On 10/8/24 at 0834 hours, a medication administration observation for Resident 931 was conducted with LVN 3. LVN 3 took stethoscope and blood pressure machine with cuff and used on Resident 931 to take her blood pressure (BP). After leaving Resident 931's room, LVN 3 was observed placing the stethoscope and BP machine with cuff in a white bin on the medication cart without cleaning and sanitizing the equipment. On 10/9/24 at 1452 hours, an interview was conducted with LVN 3. LVN 3 stated all equipment must be cleaned before returning it to the white bin on the medication cart. He stated that he must have cleaned the equipment, because he returned the equipment to the white bin on the medication cart after medication administration for Resident 931. However, LVN 3 was observed to have not cleaned and sanitized the stethoscope and BP machine with cuff upon exiting Resident 931's room. 5. Medical record review for Resident 829 was initiated on 10/8/24. Resident 829 was admitted to the facility on [DATE]. Review of Resident 829's H&P examination, undated, showed the resident had the capacity to understand and make decisions. On 10/9/24 at 0932 hours, a medication administration was observed for Resident 829. LVN 1 removed a BP cuff from the medication cart, donned gloves, and wiped the machine and BP cuff with Super Sani-Cloth. After cleaning the BP machine and cuff, LVN 1 was observed entering Resident 829's room without performing hand hygiene. On 10/9/24 at 1046 hours, an interview was conducted with LVN 1. LVN 1 stated she performed hand hygiene prior to entering Resident 829's room. However, she was observed not performing hand hygiene prior to entering Resident 829's room. (continued on next page)

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	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Medical record review for Resident 26 was initiated on 10/8/24. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 26's H&P examination dated 2/16/24, showed the resident did not have the capacity to understand and make decisions. On 10/8/24 at 0937 hours, a medication administration observation for Resident 26 was conducted with LVN 4. During the medication administration observation, LVN 4 raised Resident 26's bed in a higher position, checked the piston syringe, and removed the syringe from the plastic bag. LVN 4 was observed removing the glove on her right hand and putting on a new glove without performing hand hygiene. On 10/8/24 at 1012 hours, an interview was conducted with LVN 4. LVN 4 verified she did not wash her hands after removing her glove and/or before donning the new glove and stated she should have washed her hands.

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	10/11/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, facility document, and facility P&P review, the facility failed to implement the antibiotic stewardship program. * The facility failed to ensure two nonsampled residents (Residents 73 and 110) were accurately and timely reviewed for the appropriate use of antibiotics. This failure had the potential for inappropriate use and increased risk of drug resistant organisms. Findings: According to the CDC, the antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Antibiotic Stewardship Program revised 12/19/22, showed the Infection Preventionist will review antibiotic utilization as part of the antibiotic stewardship program and identify the specific situations that are not consistent with the appropriate use of antibiotics, including clinical findings which do not indicate continued need for antibiotics. 1. Review of the Infection Prevention and Control Surveillance Log for September 2024 showed Resident 73 was on levofloxacin 500 mg (antibiotic medication) for pneumonia (an infection in the lungs caused by a bacteria) for six days. Medical record review for Resident 73 was initiated on 10/10/24. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's Infection Screening Evaluation dated 9/5/24, under evaluation on the general findings, the recent CXR (chest x-ray) was marked as no. Under the Infection Analysis section, there was no criteria was marked if the resident's infection meets the criteria for true infection or not. Review of Resident 73's Nurses Progress Note dated 9/7/24, showed the report from the acute care hospital's x-ray result, Resident 73 had PNA (pneumonia) and started on levofloxacin 500 mg daily started 9/6/24 to six more doses at the facility. Further medical record review for Resident 73 did not show documented evidence of a copy of the x-ray result was on the resident's medical records from the acute care hospital was found. 2. Review of the Infection Prevention and Control Surveillance Log for September 2024 showed Resident 110 was on Fidaxomicin & Vancomycin (antibiotic medication) for c- diff (clostridium difficille- a bacterial infection in the large intestine that highly contagious). (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 110 was initiated on 10/10/24. Resident 110 was admitted to the facility on [DATE]. Review of Resident 110's Infection Screening Evaluation dated 9/12/24, showed the resident was admitted with symptoms of diarrhea within 24 hours. The Infection Analysis section showed the resident met the McGeers criteria for true infection. Review of the Nurses Progress note dated 9/12/24, showed Resident 110 was prescribed with Vancomycin 2. 5 ml four times a day for 39 days. Further medical record review for Resident 110 did not show a copy of the laboratory results from the acute care hospital to confirm the diagnosis of c-diff and if it was a true infection or not. In addition, there was no documented evidence to show the physician was informed the resident was on two antibiotic therapy. On 10/10/24 at 1501 hours, an interview and concurrent medical record review for Residents 73 and 110 was conducted with the DSD/IP. The DSD/IP verified the above findings. The DSD/IP verified there were no documentation in the residents' medical records to show the evidence of a true infection. The DSD/IP stated they should inform the physician for the antibiotic use of the residents. On 10/10/24 at 1623 hours, an interview was conducted with the Administrator and was informed of the findings. The Administrator verified the above findings. Cross reference to F880, examples #1.a, and #1.b.

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	555308	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 51352 Based on observation, interview and facility P&P review, the facility failed to ensure two of two glucometers (Glucometers A and B) were maintained in safe operating condition. In addition, the facility failed to ensure the three residents' refrigerator (in Stations A, B, and C) frozen storage area were free of ice buildup. These failures had the potential for residents requiring blood glucose checks to have inaccurate reading; and the failure had the potential for the food stored in the freezer area were not kept at the proper temperature. Findings: 1. On 10/11/24 at 12:40 hours, an interview and concurrent inspection of Medication Cart A was conducted with LVN 2. Review of the Daily Quality Control Record log for Medication Cart A dated October 2024 showed the daily Quality Control Record testing was completed with a glucometer with the serial number K008171N5044. However, the serial number of the glucometer stored in the medication cart showed a serial number of K008229N3093. LVN 2 verified there was no other glucometer stored inside the medication cart. Further review of the log showed the glucometer test strips with lot number WDO8MAQAB were opened on 10/6/24. However, the open date written on the test strips was 10/9/24. LVN 2 verified the findings. 2. On 10/11/24 at 1815 hours, an interview and concurrent inspection of Medication Cart C was conducted with LVN 6. Review of the Daily Quality Control Record log for Medication Cart C dated October 2024 did not show the serial number for Glucometer B being used for the Daily Quality Control Record testing. LVN 3 verified the log did not have the serial number for the glucometer and the serial number should be written on the log. In addition, the log for Glucometer B showed test strips with a lot number of WB27MAPCA. However, the test strips stored in Medication Cart C showed a lot number of WD08MAQAB. LVN 3 verified the findings and stated the lot numbers should match. 44175 3. On 10/8/24 at 0909 hours, a concurrent observation and interview was conducted with RN 3. Stations A, B, and C refrigerators for the residents' food was observed with ice buildup in the frozen storage area. RN 3 verified the above observation and stated the above refrigerators needed to be defrosted. On 10/11/24 at 1456 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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	10/11/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to show documented evidence Zone 1 (area of entrapment) measurement was completed for 18 of 20 final sampled residents (Residents 1, 13, 16, 22, 26, 29, 71, 72, 83, 84, 95, 100, 101, 111, 116, 728, 928, and 931) reviewed for side rail use. Also, the facility failed to conduct the monthly entrapment measurements as per the residents' care plans. These failures posed the risk of not ensuring all areas of possible entrapment to be identified. Findings: According to FDA.gov, Zone 1, is one of the seven areas for risk of resident entrapment on beds with bed rails. Zone 1 is identified as the open space within the perimeter of a bed rail. 1. On 10/09/24 at 1237 hours, concurrent observation and interview was conducted with CNA 13. CNA 13 verified Resident 1 had the bilateral 1/4 (quarter) bed rails elevated. On 10/9/24 medical record review for Resident 1 was initiated. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 7/25/24, showed Resident 1's diagnoses included left side paralysis and anxiety. Resident 1 had impaired cognition. Review of Resident 1's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show documented evidence Zone 1 was measured. 2. On 10/08/24 at 1000 hours, Resident 13 was observed in bed with the bilateral mid 1/4 bed rails elevated. On 10/8/24 medical record review for Resident 13 was initiated. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's physician's progress note dated 8/7/24, showed Resident 13 had diagnoses including seizure and dementia with behaviors. Review of Resident 13's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show documented evidence Zone 1 was measured. 3. On 10/11/24 at 0908 hours, Resident 22 was observed in bed with the bilateral 1/2 (half)bed rails elevated. On 10/11/24 medical record review for Resident 22 was initiated. Resident 22 was admitted to the facility on [DATE]. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 22's H&P examination dated 10/11/23 showed Resident 22 had diagnoses including depression. Resident 22 had cognitive impairment. Review of Resident 13's Bed System Measurement Device Test Results Worksheet dated 10/6/24 failed to show documented evidence Zone 1 was measured. 4. On 10/8/24 at 0945 hours, Resident 26 was observed in bed with his bilateral upper 1/4 bed rails elevated. On 10/8/24 medical record review for Resident 26 was initiated. Resident 26 was readmitted to the facility on [DATE]. Review of Resident 26's H&P examination dated 2/16/24, showed Resident 26 had diagnoses including depression, dementia, and left side paralysis. Resident 26 had cognitive impairment. Review of Resident 26's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show documented evidence Zone 1 was measured. 5. On 10/9/24 at 1010 hours, Resident 84 was observed in bed with the bilateral upper bed rails elevated. On 10/9/24 medical record review for Resident 84 was initiated. Resident 84 was readmitted to the facility on [DATE]. Review of Resident 84's physician progress note dated 6/5/24, showed Resident 84 had diagnoses including dementia and post status torn rotator cuff. Resident 84 had congitive impairment. Review of Resident 84's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show documented evidence Zone 1 was measured. 6. On 10/08/24 at 0832 hours, Resident 111 was observed in bed with the bilateral upper 1/4 bed rails elevated. On 10/8/24 medical record review for Resident 111 was initiated. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's H&P examination dated 8/22/24, showed Resident 111 had diagnoses including intracranial hemorrhage. Resident 111 had cognitive impairment. Review of Resident 111's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show documented evidence Zone 1 was measured. On 10/11/24 at 1006 hours, concurrent interview and record review was conducted with the Maintenance Director and Maintenance Assistant. The Maintenance Director verified the check for Zone 1 was not documented on the residents' Bed System Measurement Device Test Results Worksheets for Residents 1, 13, 22, 26, 84, and 111. 50953 (continued on next page)

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	10/11/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Medical record review for Resident 83 was initiated on 10/8/24. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's MDS dated [DATE], showed the cognitive skills for daily decision making was severely impaired. Review of Resident 83's H&P examination dated 9/11/24, showed Resident 83 was unable to make decisions. Review of Resident 83's Order Summary Report dated 10/10/24, showed a physician order dated 10/9/24, may have one fourth side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 83's Plan of Care showed an undated care plan problem for bilateral 1/4 siderails in bed for increase mobility and position. Interventions included for the maintenance to measure entrapment zones monthly and as necessary. On 10/8/24 at 1029 hours, during the initial tour of the facility, an observation was conducted for Resident 83. Resident 83 was observed lying in bed with bilateral siderails up. On 10/10/24 at 0752 hours, an observation and concurrent interview for Resident 83 was conducted with LVN 1. LVN 1 verified Resident 83 had bilateral side rails for bed positioning. On 10/11/24 at 1010 hours, a concurrent interview was conducted with the Maintenance Director and Assistant Maintenance Director regarding the facility's process of measuring the entrapment zones of the bed rails. Both verified the entrapment measurement for Zone 1 was missed and acknowledged the monthly entrapment measurement, per the plan of care intervention, was not done. 8. Medical Record Review for Resident 100 was initiated on 10/8/24. Resident 100 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 100's H&P examination dated 3/29/24, showed Resident 100 did not have the capacity to make medical decisions. Review of Resident 100's Order Summary Report dated 10/10/24, showed a physician's order dated 3/6/24, for may have grab bars as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 100's Plan of Care showed an undated care plan for bilateral grab bars in bed for increase mobility and positioning. The care plan interventions included for maintenance to measure entrapment zones monthly and as necessary. On 10/8/24 at 0952 hours, during the initial tour of the facility, an observation for Resident 100 was conducted. Resident 100 was sitting in her bed with bilateral siderails up. On 10/9/24 at 0757 hours, an observation and concurrent interview was conducted with Resident 100. Resident 100 verified she was using the side rails to help pull herself up, for positioning and turning. (continued on next page)

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	555308	A. Building B. Wing	10/11/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 1010 hours, a concurrent interview was conducted with the Maintenance Director and the Assistant Maintenance Director regarding the facility's process of measuring the entrapment zones of the bed rails. Both verified the entrapment measurement for Zone 1 was missed and acknowledged the monthly entrapment measurement, per the plan of care intervention, was not done. 9. Medical record review for Resident 101 was initiated on 10/8/24. Resident 101 was admitted to the facility on [DATE]. Review of Resident 101's MDS dated [DATE], showed a BIMS score of seven (meaning severe cognitive impairment). Review of Resident 101's Order Summary Report dated 10/10/24, showed a physician's order dated 10/9/24, for may have one fourth side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 101's Plan of Care showed an undated care plan problem for bilateral 1/4 siderails in bed for increase mobility and position. Interventions included for the maintenance to measure entrapment zones monthly and as necessary. On 10/8/24 at 0952 hours, during the initial tour of the facility, an observation was conducted for Resident 101. Resident 101 was observed lying on her bed with bilateral side rails up. On 10/9/24 at 0818 hours, an observation and concurrent interview for Resident 101 was conducted with LVN 1. LVN 1 verified Resident 101 had bilateral side rails up and was using the side rails for bed positioning. On 10/11/24 at 1010 hours, a concurrent interview was conducted with the Maintenance Director and Assistant Maintenance Director regarding the facility's process of measuring the entrapment zones of the bedrails. Both verified the entrapment measurement for Zone 1 was missed and acknowledged the monthly entrapment measurement, per the plan of care intervention, was not done. On 10/11/24 at 1458 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings. 44175 10. On 10/8/24 at 1203 hours, and 10/10/24 at 0816and 1027 hours, Resident 95 was observed lying in bed with the bilateral one forth side rails were observed elevated. Medical record review for Resident 95's was initiated on 10/8/24. Resident 95 was admitted to the facility on [DATE]. Review of Resident 95's MDS dated [DATE], showed Resident 95 had severe cognitive impairment. Further review of the MDS showed Resident 95 had no impairment in range of motion on bilateral upper and lower extremities and required a maximum to total staff assistance for the ADL. Review of Resident 95's Physician Order Summary showed an order dated 10/8/24, for one fourth side rails as enabler to aid bed mobility, positioning, and ADL functioning. (continued on next page)

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	10/11/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident 95's undated Care Plan showed problem addressing the bilateral one fourth side rails in bed for increase mobility and positioning, intervention included maintenance to measure entrapment zones monthly and as necessary. Review of Resident 95's Bed System Measurement Device Test Result Worksheet dated 10/6/24, did not show if Zone 1 for entrapment was measured for Resident 95. Further review of the Resident 95's medical records failed to show if the monthly entrapment measurement for the siderails was conducted as identified in the care plan. 11. On 10/8/24 at 0952 and 1315 hours, and on 10/10/24 at 0814 hours, Resident 29 was observed lying in bed, bilateral one fourth side rails were observed elevated. Medical record review for Resident 29 was initiated on 10/8/24. Resident 29 was admitted to the facility on [DATE] and was readmitted on [DATE]. Further review of the care plan dated 2/2/23, showed a problem addressing grab bars in bed as enabler to aid bed mobility, positioning and ADL functions, the interventions included maintenance to measure entrapment zones monthly and as necessary. Review of the Resident 29's Physician Order Summary showed an order dated 2/2/24, for grab bars as enablers to aid in bed mobility for positioning and for the ADL functions. Review of Resident 29's MDS dated [DATE], showed Resident 29 had severe cognitive impairment. Further review of the MDS showed Resident 29 had impairment on the bilateral upper and lower extremities and required total staff assistance for her ADL. Review of Resident 29's Care Plan dated 8/1/24, showed problem addressing Resident 29's at risk for fall related to incontinence, poor communication, and comprehension. Review of Resident 29's Bed System Measurement Device Test Result Worksheet dated 10/6/24, did not show if Zone 1 for entrapment was measured for Resident 29. Further review of the Resident 29's medical records failed to show if the monthly entrapment measurement for the siderails was conducted as identified in the care plan. On 10/10/24 at 1518 hours, a concurrent observation and interview was conducted with LVN 5. LVN 5 verified the observation and stated Residents 95 and 29 had the bilateral one fourth side rails elevated. On 10/11/24 at 1015 hours, a concurrent interview and the facility document review was conducted with the Maintenance Director. The Maintenance Director verified Zone 1 was not measured for Residents 29 and 95. The Maintenance director further stated he did not measure the monthly entrapment measurement and only performed a visual check of the side rails. On 10/11/24 at 1456 hours, an interview and medical record review for Residents 29 and 95 was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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	10/11/2024

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49644 12. On 10/8/24 at 0848 hours, during the initial tour of the facility, Resident 116 was observed lying in bed and holding her cellphone. Resident 116's bed had bilateral 1/4 siderail elevated. Resident 116 stated she used the bilateral 1/4 side rails to get up and turn. Medical record review for Resident 116 was initiated on 10/8/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's MDS dated [DATE], showed Resident 116's cognition was intact. Review of Resident 116's Order Summary Report for October 2023, showed a physician's order dated 8/26/24, may have grab bars as enabler to aid for the bed mobility, positioning, and ADL functions. Review of Resident 116's Care Plan dated 8/27/24, showed for the bilateral grab bars in bed for increase mobility and positioning. The care plan intervention section showed for the maintenance to measure the entrapment zones monthly and as necessary. Review of Resident 116's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show Zone 1 was measured. On 10/10/24 at 0851 hours, an observation and concurrent interview was conducted with CNA 6. CNA 6 verified Resident 116 had bilateral 1/4 side rails elevated. CNA 6 stated Resident 116 used the bilateral 1/4 side rails all the time to reposition. On 10/11/24 at 1010 hours, an interview was conducted with the Maintenance Staff and the Maintenance Director. The Maintenance Staff stated they knew the resident needed side rail from the Rehabilitation Department. The Maintenance Staff stated he used the Bionix bed system measurement device before putting the side rails. The Maintenance Director acknowledged Zone 1 was not documented on the Bed System Measurement Device Test Results Worksheet. The Maintenance Director stated he was aware of the care plan to measure the entrapment zones monthly and as necessary. However, the Maintenance Director stated they did not measure monthly because the measurement would not change. On 10/11/24 at 1037 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director verified Zone 1 was not documented on the Resident 116's Bed System Measurement Device Test Results Worksheet. The Maintenance Director stated the form only included Zones 2, 3, and 4. The Maintenance Director wrote pass on the headboard and the foot board section. On 10/11/24 at 1320 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director showed the instruction to visually inspect the side rails to ensure proper function order on the Monthly Inspection of Room form. The Maintenance Director verified the monthly entrapment measurement of Resident 116's bed rail was not done. The Maintenance Director stated the instruction was to do visual inspection of the side rail. 13. On 10/8/24 at 0828 hours, during the initial tour of the facility, Resident 728 was observed lying in bed with bilateral 1/4 side rails elevated. Resident 728 stated she used the bilateral 1/4 side rails when she tried to get up from bed. (continued on next page)

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	10/11/2024

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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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 728 was initiated on 10/8/24. Resident 728 was admitted to the facility on [DATE]. Review of Resident 728's H&P examination dated 10/6/24, showed Resident 728's had normal cognition and had capacity for healthcare decisions. Review of Resident 728's Order Summary Report for October 2024 showed a physician's order dated 10/8/24, may have 1/4 side rails as enabler to aid bed mobility, positioning, and ADL functions. Review of Resident 728's Bed Rails - V2 dated 10/5/24, showed the bed rail/transfer bar was indicated for mobility/transfer purposes and resident demonstrated ability to use the equipment as an enabler. Review of Resident 728's Bed System Measurement Device Test Results Worksheet dated 10/6/24, failed to show Zone 1 was measured. On 10/10/24 at 0822 hours, an observation and concurrent interview was conducted with CNA 6. CNA 6 verified Resident 728 had bilateral 1/4 side rails elevated. CNA 6 stated Resident 116 used the bilateral 1/4 side rails to move side to side and when she wanted to sit. On 10/11/24 at 1010 hours, an interview was conducted with the Maintenance Staff and Maintenance Director. The Maintenance Staff stated they knew the resident needed the side rails from the Rehabilitation Department. The Maintenance Staff stated he used the Bionix bed system measurement device before putting the side rails. The Maintenance Director acknowledged Zone 1 was not documented on the Bed System Measurement Device Test Results Worksheet. The Maintenance Director stated he was aware of the care plan to measure the entrapment zones monthly and as necessary. However, the Maintenance Director stated they did not measure monthly because the measurement will not change. On 10/11/24 at 1037 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director verified Zone 1 was not documented on the Resident 728's Bed System Measurement Device Test Results Worksheet. The Maintenance Director stated the form only included Zones 2, 3, and 4. The Maintenance Director wrote pass on the headboard and the foot board section. On 10/11/24 at 1320 hours, an interview and concurrent record review was conducted with the Maintenance Director. The Maintenance Director showed the instruction to visually inspect the side rails to ensure for proper function order on the Monthly Inspection of Room form. The Maintenance Director verified the monthly entrapment measurement of Resident 728's bed rail was not done. The Maintenance Director stated the instruction was to do visual inspection of the side rail. On 10/11/24 at 1757 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 49324 14. On 10/10/24 at 0854 hours, an observation was conducted on Resident 71's room. Resident 71 was asleep on a side lying position, with bilateral 1/4 (quarter) side rail up. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 71 was initiated on 10/10/24. Resident 71 was admitted to the facility on [DATE]. Review of Resident 71's Order Summary Report showed a physician's order dated 10/9/24, may have 1/4 side rails in bed to aid mobility and ADL functions. Review of Resident 71' s Bed Rails assessment dated [DATE], showed alternatives attempted was not specified, indication for use was also not specified. Review of Resident 71's plan of care showed a care plan problem dated 2/2/24 showed may have grab bars in bed as enabler to aid bed mobility, positioning and ADL functions, with goals as will prevent entrapment of limbs, neck and body parts from grab bar. No space gaps between grab bar and mattress, bed in lowest position. The interventions included to maintenance to measure entrapment zones monthly and as necessary. On 10/11/24 at 1010 hours an interview was conducted with Maintenance Director and Maintenance Assistant. The Maintenance Director verified Zone 1 measurement entrapment was missed and acknowledged the monthly entrapment measurement was not done per care plan. On 10/11/24 at 1620 hours, DON verified the findings regarding Zone 1 measurement entrapment was missed and acknowledged monthly entrapment measurement was not done performed. 39453 15. On 10/10/24 at 0934 and 1353 hours, and on 10/11/24 at 0922 hours, Resident 928 was observed in bed with the bilateral grab bars elevated. Medical record review for Resident 928 was initiated on 10/8/24. Resident 928 was admitted to the facility on [DATE]. Review of Resident 928's MDS dated [DATE], showed Resident 928 had moderate cognitive impairment, with no impairment on upper extremities, and dependent with the staff on bed mobility. Review of Resident 928's OT Evaluation and Plan of Treatment dated 9/27/24, showed the bilateral bed bars were indicated to aid the resident in self-positioning and mobility, and not as restraint. Review of Resident 928's Order Summary Report showed a physician's order dated 9/26/24, for the grab bars as enabler to aid in bed mobility, positioning, and for the ADL functions. Review of Resident 928's plan of care showed a care plan problem dated 9/27/24, addressing the use of the bilateral grab bars in bed for increase mobility and positioning. The goal was for the resident to remain from injury, and prevent entrapment of limbs, neck, and body parts from the grab bar. The interventions included the following: - To complete and evaluation for enabler upon admission, readmission, quarterly, and PRN (as needed) for review of necessity; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- To initially obtain informed consent from the resident and/or responsible party, and obtain consent and physician order for enabler use; and - To educate responsible of the following risk associated with the use of enablers, such as entrapment, getting caught in the enablers, getting caught between the mattress and the enablers, injury or death, strangulation, suffocation, bruising, and/or skin tears from hitting against the enabler; and - Maintenance staff to measure entrapment zones monthly and as necessary. On 10/10/24 at 0909 hours, an interview was conducted with CNA 12. CNA 12 stated Resident 928 could move her upper extremities and needed assistance with bed mobility. On 10/10/24 at 0920 hours, a facility staff was observed installing grab rails to Resident 928's bed. On 10/10/24 at 0921 hours, an interview was conducted with LVN 9. LVN 9 verified the facility staff just installed the grab bars to Resident 928's bed. On 10/10/24 at 0934 hours, Resident 928 was observed awake and lying in bed. The bilateral grab bars were observed elevated. LVN 9 verified the above findings. 16. On 10/8/24 1215 hours, and on 10/10/24 at 0745 and 1359 hours, Resident 931 was observed in bed with the bilateral grab bars elevated. Medical record review for Resident 931 was initiated on 10/8/24. Resident 931 was readmitted to the facility on [DATE]. Review of Resident 931's MDS dated [DATE], showed Resident 931 was cognitively intact, with no impairment on upper extremities, and dependent with the staff on bed mobility. Review of Resident 931's Order Summary Report showed a physician's order dated 10/8/24, for the grab bars as enabler to aid in bed mobility, positioning, and for the ADL functions. Review of Resident 931's plan of care showed a care plan problem dated 9/26/24, addressing the use of the bilateral grab bars in bed for increase mobility and positioning. The goal was for the resident to remain from injury, and prevent entrapment of limbs, neck, and body parts from the grab bar. The interventions included the following: - To complete and evaluation for enabler upon admission, readmission, quarterly, and PRN for review of necessity; - To initially obtain informed consent from the resident and/or responsible party, and obtain consent and physician order for enabler use; and (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- To educate responsible of the following risk associated with the use of enablers, such as entrapment, getting caught in the enablers, getting caught between the mattress and the enablers, injury or death, strangulation, suffocation, bruising, and/or skin tears from hitting against the enabler; and - Maintenance staff to measure entrapment zones monthly and as necessary. On 10/10/24 at 0914 hours, an interview was conducted with CNA 11. When asked about Resident 931's use of the bed rails, CNA 11 stated Resident 931 used the grab bars in turning and repositioning. 17. On 10/10/24 at 1110 hours, on 10/9/24 at 1308 hours, on 10/10/24 at 0750, 0813 and 1350 hours, and on 10/11/24 at 0919 hours, Resident 72 was observed in bed with the bilateral 1/4 side rails elevated. Medical record review for Resident 72 was initiated on 10/8/24. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's Progress Note H&P evaluation dated 9/26/24, showed Resident 72 needed assistance with decision-making capabilities. Review of Resident 72's Order Summary Report dated 10/10/24, showed a physician's order dated 10/8/24, for the 1/4 side rails as enabler to aide bed mobility, positioning, and for the ADL functions. Review of Resident 72's plan of care showed a care plan problem revised date 10/8/24, addressing the use of the bilateral 1/4 side rails in bed for increase mobility and positioning. The goal was for the resident to remain from injury, and prevent entrapment of limbs, neck, and body parts from the grab bar. The interventions included the following: - To complete and evaluation for enabler upon admission, readmission, quarterly, and PRN for review of necessity; - To initially obtain informed consent from the resident and/or responsible party, and obtain consent and physician order for enabler use; and - To educate responsible of the following risk associated with the use of enablers, such as entrapment, getting caught in the enablers, getting caught between the mattress and the enablers, injury or death, strangulation, suffocation, bruising, and/or skin tears from hitting against the enabler; and - Maintenance staff to measure entrapment zones monthly and as necessary. On 10/10/24 at 0811 hours, an interview was conducted with CNA 5. When asked about Resident 72's use of the bed rails, CNA 5 stated Resident 72 could not use the side rails by herself so CNA 5 had to guide the resident's hand to hold on to the side rails when turning and repositioning the resident. 18. On 10/8/24 at 0910 hours, 10/9/24 at 1250 hours, 10/10/24 at 0757, 0835, and 1351 hours, and 10/11/24 at 0921 hours, Resident 16 was observed in bed with the bilateral 1/2 side rails elevated. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 16 was initiated on 10/8/24. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's MDS dated [DATE], showed he had moderate cognitive impairment, an impairment on one side of upper and lower extremities, and dependent with the staff on bed mobility. Review of Resident 16's Bed Rails - V2 dated 8/21/24, did not show alternatives were attempted prior to the installation of the side rails. Review of Resident 16's PT Evaluation and Plan of Treatment dated 8/23/24, showed the bilateral bed grab bars were indicated as enablers for bed mobility, not as restraints. Review of Resident 16's Order Summary Report dated 10/10/24, showed a physician's order dated 10/8/24, for 1/2 side rails as enabler to aide bed mobility, positioning, and for the ADL functions. Review of Resident 16's plan of care showed a care plan problem revised date 10/8/24, addressing the use of the bilateral 1/2 side rails in bed for increase mobility and positioning. The goal was for the resident to remain from injury, and prevent entrapment of limbs, neck, and body parts from the grab bar. The interventions included the following: - To complete and evaluation for enabler upon admission, readmission, quarterly, and PRN for review of necessity; - To initially obtain informed consent from the resident and/or responsible party, and obtain consent and physician order for enabler use; and - To educate responsible of the following risk associated with the use of enablers, such as entrapment, getting caught in the enablers, getting caught between the mattress and the enablers, injury or death, strangulation, suffocation, bruising, and/or skin tears from hitting against the enabler; and - Maintenance staff to measure entrapment zones monthly and as necessary. On 10/10/24 at 0800 hours, an interview was conducted with CNA 5. When asked about Resident 16's use of the side rails, CNA 5 stated Resident 16 used the side rails in turning and repositioning. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 1011 hours, a concurrent interview and facility document review for Residents 16, 72, 928, and 931 was conducted with the Maintenance Director and Maintenance Staff. The Maintenance Director stated the maintenance department was responsible for the bed inspection of all the beds in the facility. The Maintenance Director stated the bed inspection including checking the bed control, wiring and making sure the bed was functioning properly was done monthly. The Maintenance Director stated they documented the monthly bed inspection in the Rooms Monthly Inspection log. When asked about the side rails, the Maintenance Director stated the maintenance department was responsible for installing the side rails. The Maintenance Director stated they would get the order from the rehabilitation department via text, or call, or through the maintenance request log. When asked about entrapment assessment, the Maintenance Director showed the Bionix safety measuring device to measure the side rails, the gaps between the gaps in between the mattress, side rails, headboard, and footboard. When asked about the monthly measurement of the entrapment zones per the residents' plan of care, the Maintenance Director stated they did not do a monthly measurement of the entrapment zones because the measurements would be the same. When asked to show the documentation of the results of the entrapment assessment using the safety measuring device, the Maintenance Director showed the Bed System Measurement Device Test Results Worksheet. Review of the facility's document titled Rooms Monthly Inspection dated 9/1/24, showed the following were inspected: overbed lights, bathroom closets, bed controls, outlets, blinds, phone, floor, TV, overbed table, curtain track, wall ceiling, wheelchairs, call light, and bedside rails for each bed in the facility. Review of the facility's document titled Bed System Measurement Device Test Results Worksheet dated 10/6/24, for Residents 16, 72, and 931 showed the entrapment Zones 2, 3, and 4 were marked P, and the headboard and footboard were marked pass. The worksheet did not show Zone 1 was measured for Residents 16, 72, and 931. In addition, review of the facility's document titled Bed System Measurement Device Test Results Worksheet did not show an entrapment assessment was conducted for Resident 928. Further review of the residents' medical records and facility documents failed to show a documented evidence the residents' entrapment assessments were completed, and the measurements were recorded for Zone 1 during the bed inspection to identify areas of possible entrapment with the use of side rails. The Maintenance Director verified the above findings.

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F 0914 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. 51352 Based on observation, interview, and facility P&P review, the facility failed to ensure one of 28 final sampled residents (Resident 931) had the ceiling suspended curtains to provide privacy. This failure had the potential to negatively affect the resident's dignity, privacy, and self-esteem. Findings: Review of the facility's P&P titled Promoting/Maintaining Resident Dignity revised 12/19/22, showed it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances a resident's quality of life by recognizing each resident's individuality. Compliance Guidelines showed all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Additionally, staff are to maintain resident privacy. On 10/8/24 at 0834 hours, a medication administration observation for Resident 931 was conducted with LVN 3. Resident 931's room was observed with no privacy curtain and the door was left open during the medication administration observation. Resident 931 was able to be seen in her bed from the hallway through the open door. On 10/9/24 at 1452 hours, an interview was conducted with LVN 3. LVN 3 verified the findings and stated every resident room should have a privacy curtain. LVN 3 stated he should inform the maintenance staff of Resident 931 not having a privacy curtain in her room. When asked if he contacted the maintenance staff to get a new curtain, LVN 3 stated he did not. On 10/10/24 at 0754 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. Cross reference to F583, example #3.