STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555462	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Valencia Healthcare Center	25000 Calle DE Los Caballeros Laguna Hills, CA 92653

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive plan of care to reflect the individual care needs for two of five sampled residents (Residents 1 and 3). * The facility failed to develop a care plan to address when Resident 1 had an actual fall on 11/26/25. * The facility failed to develop a care plan to address Resident 3's upper back abrasion. These failures had the potential risk of not providing the appropriate, consistent, and individualized care to these residents.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised December 2016 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Policy Interpretation and Implementation section showed the IDT must review and update the care plan when there has been a significant change in the resident's condition. 1. Medical record review for Resident 1 was initiated on 12/24/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 1's eINTERACT Change in Condition Evaluation V5 dated 11/26/25, showed the resident had an unwitnessed fall. Review of Resident 1's plan of care failed to show a care plan was developed to address the resident's actual fall on 11/26/25. On 1/21/26 at 1353 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified there was no care plan to address Resident 1's actual fall on 11/26/25. RN 2 stated the licensed nurse should have created the care plan for the actual fall and placed interventions and goals. On 1/21/26 at 1518 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no care plan for Resident 1's actual fall on 11/26/25. The DON stated the licensed nurse should have developed a care plan. 2. Medical record review for Resident 3 was initiated on 1/20/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 3's Post Fall IDT dated 1/12/26, showed Resident 3 had an upper back abrasion. Review of Resident 3's plan of care failed to show a care plan was developed to address Resident 3's upper back abrasion. On 1/21/26 at 1405 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified there was no care plan to address Resident 3's upper back abrasion. RN 2 stated the licensed nurse should have created a care plan for the upper back abrasion so the interventions would be implemented and to create the goals. On 1/21/26 at 1530 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no care plan to address Resident 3's upper back abrasion. The DON stated the care plan should have been done to address Resident 3's upper back abrasion.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Valencia Healthcare Center	25000 Calle DE Los Caballeros Laguna Hills, CA 92653

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurate for one of five sampled residents (Resident 3). * The facility failed to ensure Resident 3's change in condition documentation was accurate. This failure had the potential for the resident's health care needs not met as the medical record was inaccurate.Findings: Review of the facility's P&P titled Charting and Documentation revised July 2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The Policy Interpretation and Implementation section showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 3 was initiated on 1/20/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had severe cognitive impairment. Review of Resident 3's eINTERACT Change in Condition Evaluation V5 dated 1/12/26, showed the resident had an unwitnessed fall. Under the question whether Resident 3 was on other anticoagulant (direct thrombin inhibitor or platelet inhibitor), showed no. Review of Resident 3's Order Summary Report dated 1/20/26, showed a physician's order dated 12/25/25, to administer clopidogrel bisulfate (antiplatelet medication used to prevent blood clots) oral tablet 75 mg, give one tablet by mouth one time a day for CAD. On 1/21//26 at 1405 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 acknowledged Resident 3 had an unwitnessed fall and was on clopidogrel bisulfate medication. RN 2 stated the licensed nurse should have answered yes on the question because Resident 3 was on anticoagulant and at risk of bleeding. On 1/21/26 at 1530 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 3 was on clopidogrel bisulfate medication stated the licensed nurse should have answered yes on the question for the accuracy of documentation.