

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555763	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER San Juan Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 31741 Rancho Viejo Road San Juan Capistrano, CA 92675	

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)
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was complete and accurately maintained for one of three sampled residents (Resident 1).</p> <p>* Resident 1 had a blood sugar level of 58 mg/dL. There was no documentation a COC was initiated for the blood sugar level of 58 mg/dL. Additionally, there was no documentation the resident's representative was notified of the low blood sugar.</p> <p>* Resident 1's vital signs were documented as taken after the resident had already been discharged from the facility.</p> <p>These failures had the potential for not providing the necessary care and services due to incomplete medical record information.</p> <p>Findings:</p> <p>Review of the facility P&P titled Charting and Documentation revised 7/2017 showed the following:</p> <ol style="list-style-type: none"> 1. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 2. The following information is to be documented in the resident medical record: <ol style="list-style-type: none"> a. Objective observations; b. Medications administered; c. Treatment or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>3. Documentation of procedures and treatments will include care-specific details, including:</p> <ul style="list-style-type: none"> a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting. <p>Review of the facility P&P titled Nursing Care of the Resident with Diabetes Mellitus revised 12/2015 showed approximate reference ranges for hypoglycemia are: mild hypoglycemia 55-70 mg/dL; moderate hypoglycemia 40-55 mg/dL; and severe hypoglycemia < 40 mg/dL.</p> <p>Closed medical record review for Resident 1 was initiated on 5/15/25. Resident 1 was admitted to the facility on [DATE], and discharged to the acute care hospital on 6/17/24.</p> <p>a. Review of Resident 1's Care Plan Report dated 5/31/24 showed the resident was at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diabetes (high blood sugar).</p> <p>Review of Resident 1's Progress Notes showed a late entry note dated 6/7/24, showed in the morning, Resident 1 had a blood sugar level of 58 mg/dL. Resident was alert, oriented, answering the questions appropriately and stating he felt fine. Resident 1 did not have any signs or symptoms of low blood sugars. The vital signs were within normal limits. Resident 1 was given a glass of orange juice with two packets of sugar. The resident's blood sugar was rechecked with a reading of 94 mg/dL.</p> <p>Review of Resident 1's Weights and Vital Summary dated 6/7/24, did not show Resident 1's blood sugar reading of 58 mg/dL.</p> <p>Review of Resident 1's Medication Administration Record for June 2024 did not show Resident 1's blood sugar reading of 58 mg/dL.</p> <p>Review of Resident 1's eINTERACT Version 5.0 did not show Resident 1 had a COC for low blood sugar level of 58 mg/dL.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 5/23/25 at 1028 hours, and interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 stated the process for a COC would be to open the eINTERACT COC form, which included notifying the physician and resident's representative. When asked what the parameters for hypoglycemia would be, LVN 1 stated for the blood sugar levels below 70 mg/dL. When asked if the blood sugar level of 58 mg/dL would require a COC, LVN 1 stated yes definitely, they should have done a COC. When asked if there was a COC for Resident 1's blood sugar level of 58 mg/dL, LVN 1 stated unfortunately no, not even a daily skilled note. LVN 1 verified the findings.</p> <p>On 5/23/25 at 1500 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated a blood sugar level below 70 mg/dL would indicate hypoglycemia. The DON stated the process of a COC was to assess the resident, notify the physician and resident's representative, and monitor the resident after the COC. When asked if a blood sugar level of 58 mg/dL would require a COC, the DON stated it should and that was why they notified the physician. When asked if there was a COC, the DON stated no, but the nurse made a progress note about it. When asked if the resident's representative was notified, the DON was not able to show the resident's representative was notified. The DON verified the above findings.</p> <p>b. Review of Resident 1's SBAR Communication Form dated 6/17/24, showed Resident 1 had a COC for altered level of consciousness, labored breathing, abnormal lung sounds, pulse oximeter (measurement of the saturation of oxygen in the blood) of 88%, blood pressure of 88/58 mmHg (millimeters of mercury), and a heart rate of 38 beats per minute.</p> <p>Review of Resident 1's Progress Notes dated 6/17/24 at 1247 hours, showed Resident 1 was transferred to the acute care hospital. Resident 1 was transferred out at 1247 hours. Further review of the progress notes showed the SBAR with the vital signs taken at the following dates and times:</p> <ul style="list-style-type: none"> - dated 6/17/24 at 1458 hours, blood pressure 85/58 mmHg; - dated 6//17/24 at 1459 hours, pulse rate 38 beats per minute; - dated 6/16/24 at 0624 hours, respiratory rate 17; and -dated 6//17/24 at 1500 hours, pulse oximetry 88%. <p>On 5/23/25 at 1028 hours an interview was conducted with LVN 1. LVN 1 stated when a COC was initiated, a current set of the vital signs would be taken.</p> <p>On 5/23/25 at 1500 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the vital signs above were documented as taken after the resident had already been discharged from the facility. The DON verified the above findings.</p>		