STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555763	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Hills Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to meet the resident's care needs for one of four sampled residents (Resident 2). * The facility failed to complete a Change of Condition (COC) report and corresponding documentation related to Resident 2's new physician's order for the intravenous fluids due to poor oral intake. This failure had the potential for the resident to not receive adequate and timely care.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised on 5/2017 showed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical and/or mental condition and/or status (such as changes in level of care, billing and/or payments, resident rights, etc.). The P&P further showed the nurse will record in the resident's medical record information relative to changes in the resident's medical and/or mental condition or status. Review of the facility's P&P titled General Policies for IV Therapy revised on 3/2023 showed documentation of IV therapy should include but is not limited to: - Intake and ouput;- Vital signs every shift;- IV medication administration; - Response of therapy; and- IV site assessment. Medical record review for Resident 2 was initiated on 5/22/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 2/18/26, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Order Summary Report for May 2026 showed a discontinued physician's order dated 5/15/26, and an active physician's order dated 5/22/26, to administer sodium chloride solution 0.9%, one liter at 50 ml/hr intravenously every shift for poor oral intake. However, review of Resident 2's medical record failed to show a COC report and 72-hour documentation monitoring were completed related to the resident's poor oral intake and IV fluid orders. On 5/2626 at 1348 hours, an interview and concurrent medical record review of Resident 2 was conducted with LVN 4. LVN 4 verified the above findings and stated the resident's new IV fluid orders would be considered a COC. LVN 4 stated there was no documented evidence of a COC or 72-hour monitoring for the COC. On 5/26/26 at 1545 hours, an interview and concurrent medical record review of Resident 2 was conducted with the DON. The DON verified Resident 2 started on IV fluids 5/15/26, and received a new order on 5/22/26. The DON acknowledged there was no COC or 72-hour documentation monitoring completed. The DON stated there should have been a COC to identify the reason for IV fluids and 72-hour monitoring to ensure the interventions were effective. On 5/26/26 at 1625 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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

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

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the DHPPD nurse staffing forms were accurate and posted daily. * The facility failed to ensure the DHPPD staffing information was posted daily on 5/22 and 5/26/26, and failed to complete and obtain required signatures on the forms dated 5/20 and 5/22/26. These failures had the potential to result in inaccurate staffing information provided to the public.Findings: Review of the facility's P&P titled Posting Direct Care Daily Staffing Numbers revised 7/2016 showed the facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The P&P further showed within two hours of the beginning of each shift, the number of licensed Nurses (RNs, LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living (ADLs), performing gastrointestinal feeds, giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notify physicians of changes of condition. Moreover, the P&P showed within two hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the Administrator. Review of the AFL 19-16 dated 4/9/19, showed facilities must use CDPH forms 530 and 612. The facility was responsible for ensuring all entries are accurate and legible. Unacceptable documentation includes, but is not limited to: - Census forms (CDPH Form 612) without the original verifying signature from the Administrator, DON or DON designee. Review of the CDPH 612 form dated 7/2019 showed to verify this form is complete, true, and accurate, the DON or designee must sign this form. Review of the facility's document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) [CDPH 612 form] dated 5/20/26, showed no documented evidence of the Actual Direct Care Service Hours and no documented signature of the DON or assigned designee. Review of the facility's document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) [CDPH 612 form] dated 5/22/26, showed no documented evidence of the Actual Direct Care Service Hours and no documented signature of the DON or assigned designee. On 5/22/26 at 0811 hours, an interview and concurrent facility document review was conducted with LVN 1. LVN 1 verified the DHPPD posting at the nurse's station was not current and dated 5/20/26. LVN 1 stated the Actual Direct Care Nursing Hours should be completed and the form should be signed by the DON or DON designee. On 5/22/26 at 1527 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD verified the DHPPD form dated 5/20/26, did not show the Actual Direct Care Service Hours and did not show the DON or designee's signature. The DSD stated the DON or DSD signed the DHPPD form and it was required to be posted daily. The DSD further stated the DHPPD form informed families or visitors the staffing levels had met the needs of the census. On 5/26/26 at 0730 hours, an interview and concurrent facility document review was conducted with LVN 3. LVN 3 verified the DHPPD form posted at the nurses' station was dated 5/22/26, and was not signed by the DON or designee. LVN 3 further verified the form did not include the Actual Direct Care Service Hours. LVN 3 stated there were no other DHPPD postings from 5/22 through 5/26/26. LVN 3 stated the DSD usually updated the forms daily. On 5/26/26 at 0752 hours, a follow interview and concurrent facility document review was conducted with the DSD. The DSD verified the DHPPD form dated 5/22/26, did not show the Actual Direct Care Service Hours and was not signed by the DON or assigned designee. The DSD further verified there were no DHPPD posted from 5/23 to 5/26/26. The DSD stated the DHPPD form should be posted daily, including weekends. On 5/26/26 at 1625 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure medications were not left unattended at the bedside for one of four sampled residents (Resident 1. * Multiple medications including oral, topical, and subcutaneous medications were left unattended at Resident 1's bedside without authorization for beside storage. This failure had the potential for Resident 1 to inaccurately self-administer the medications.Findings: Review of the facility's P&P titled Storage of Medications revised 4/2007 showed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Review of the facility's P&P titled Self-Administration of Medications dated 4/2008 showed residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a routine basis. a. The resident is instructed in the use of the package, purpose of the medication, reading of the label, and scheduling of medication dose.b. The resident is then requested to read the label on each package and indicate at what time the medication should be taken and any other special instructions for use.c. The resident is asked to demonstrate the removal of the medication from the package and, in the case of nonsolid dosage forms such as an inhaler, to verbalize the steps involved in administration.The results further showed the following conditions are met for bedside storage to occur:-The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. -Notation of each dose self-administered is documented on the MAR The facility's P&P also showed all nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Medical record review for Resident 1 was initiated on 5/22/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/29/26, showed Resident 1 had the capacity to understand and make decisions. On 5/22/26 at 0839 hours, an observation and concurrent interview was conducted with Resident 1, in the resident's room. Multiple medications were observed unattended at Resident 1's bedside table including the following: - One medication cup with two blue and red capsules and half of a white tablet, unlabeled;-One tube of diclofenac sodium gel 1% (pain medication);- One tube of Voltaren topical gel 1% (pain medication), unlabeled;- One bottle Trulance 3mg (bowel management medication); and- One case of Repatha SureClick injection.Resident 1 stated the licensed nurses were aware these medications were kept at bedside and stated she needed assistance applying the diclofenac and Voltaren topical medications to her back area, which she could not reach on her own. Review of Resident 1's medical record failed to show documented evidence an IDT meeting was conducted to determine Resident 1's cognitive, physical, and visual ability to carry out the self-administration of medications and the ability to self-administer medications by means of a skilled assessment conducted on a routine basis as per the facility's P&P. Review of Resident 1's Order Summary Report for May 2026 showed no documented evidence of a physician's order for Repatha SureClick injection (cholesterol medication). On 5/22/26 at 0907 hours, an observation, interview and concurrent medical record review for Resident 1 was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated Resident 1 had an order for supervised self-administration of Trulance but did not have self-administration orders (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the other medications. LVN 1 verified there was no physician's order for Repatha SureClick injection medication. LVN 1 stated there should be a physician's order and the medications should be labeled to ensure the staff knew who the medication belonged to, along with the medication direction and expiration. LVN 1 further stated the licensed nurses should not leave medications unattended at bedside and must observe self-administration when permitted. On 5/22/25 at 1019 hours, an interview was conducted with LVN 2. LVN 2 verified she administered Resident 1's morning medications at 0630 hours and acknowledged she left the Tylenol (pain medication) and famotidine (acid reflux medication) at the bedside. LVN 2 stated medications should not be left unattended to prevent inaccurate dosing and to ensure other residents or visitors do not access them. On 5/26/26 at 1545 hours, an interview and concurrent medical record review of Resident 1 was conducted with the DON. The DON acknowledged the above findings and stated medications should not be kept unattended at bedside and must be stored in the medication carts. The DON stated medications approved for self-administration could be stored inside the resident's bedside drawer. The DON verified Resident 1 had a self-administration assessment completed by the licensed nurse who received the order for the self-administration; however, the DON stated the facility did not conduct an IDT assessment to determine Resident 1's ability to self-administer her medications and conduct a skilled assessment per the facility's P&P. On 5/26/26 at 1625 hours, an interview with was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.