

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/22/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation requirements were met in the kitchen. * The facility failed to ensure the proper labeling and dating of the food items in the main kitchen and satellite kitchen. * The facility failed to ensure the expired food items in the main & satellite kitchen were discarded. * One of one ice machine was not clean. * The facility failed to ensure a dry food storage container was properly sealed. * The facility failed to ensure the food preparation equipment were in good condition. * The facility failed to ensure the cutting board was kept in a sanitary condition. * The kitchen utensils and dishware were not stored in a sanitary condition. * The facility failed to ensure the food preparation equipment were properly air dried prior to storage. * The floor in the walk-in refrigerator was littered with various rubbish of vegetables and fruits. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared from the kitchen. Findings: Review of the facility's Diet Type Report dated 1/20/26, showed 42 of 42 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Food Receiving and Storage revised 10/2017 showed all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Other opened containers must be dated and sealed or covered during storage. All foods belonging to residents must be labeled with the resident's name, the item and the use by date. Review of the facility's P&P titled Food Preparation and Service revised 10/2017 showed potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The Rapid Cooling section showed potentially hazardous foods should be cooled rapidly. This is defined as cooling from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours and then to a temperature of below 41 degrees Fahrenheit within the next 4 hours. The total cooling time between 135 degrees Fahrenheit and below 41 degrees Fahrenheit is not to exceed 6 hours. a. On 1/20/26 at 0750 hours, during the initial tour of the main kitchen, an observation of the walk-in refrigerator and concurrent interview was conducted with the Food Services Director and the Co-Food Services Manager. The following food items were observed:- One opened jar of kalamata pitted olives dated 1/6/26, no use by date;- One opened jar of sweet & sour sauce, labeled with prep date 11/28/25 and opened 12/29/25, no use by date;- One opened jar of mild chunky salsa, the white lid was labeled with 1/9/26, no use by date;- One opened jar of premium sweet pickle relish dated 1/13/26, no use by date;- One opened jar of coleslaw dressing, the red lid was labeled with R 12/16/25, no use by date;- One opened jar of tomato ketchup, not labeled with open and use by date;- One opened jar of heavy duty mayonnaise dated 1/13/26, no use by date;- One pack of cage free peeled hard cooked eggs, the package was left open, and had no open and use by date;- Two trays of sliced cauliflowers covered with plastic wrap dated 1/19/26, no use by date;- One box of pork sausage skinless links dated 1/13/26, no use by date; and- One tray of cooked turkey covered with plastic wrap, not labeled when it was cooked and use by date. The Food Services Director verified the above findings. The Food Services Director stated all food items which were opened or prepared should have been properly labeled with use by date. The Food Services Director stated the opened (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555763
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	package of eggs should also be kept tightly closed as well. The Co-Food Services Manager stated R meant received. The Food Services Director stated no cool down process was recorded for the turkey. b. On 1/20/26 at 0920 hours, during the initial tour of the satellite kitchen, an observation of the refrigerator and concurrent interview was conducted with the Food Services Director. The following food items were observed:- One opened box of thickened lemon flavored water labeled R 12/5/25, no use by date;- One container covered with plastic wrap, containing light green pureed food, no label of what kind of pureed food and no use by date;- One small brown bowl containing cut-up peaches was not labeled with use by date;- One opened jar of tomato ketchup labeled with arrived 11/14, no open & use by date;- One opened bottle of caramel dessert sauce labeled with prep date 11/14, no use by date; and- One quart of open chocolate ice cream labeled with RM [ROOM NUMBER], was not labeled with the resident's name and use by date. The Food Services Director verified the above findings. 2. a. On 1/20/26 at 0750 hours, during the initial tour of the main kitchen, an observation of the walk-in refrigerator and concurrent interview was conducted with the Food Services Director and the Co-Food Services Manager. There was one tray of red berries jam covered with plastic wrap labeled with prep date 1/16/26 and use by date 1/19/26. The Food Services Director stated the expired food should not be kept in the refrigerator and should be disposed. b. On 1/20/26 at 0920 hours, during the initial tour of the satellite kitchen, an observation of the refrigerator and concurrent interview was conducted with the Food Services Director. There was one open bottle of Hershey's chocolate syrup labeled with date 11/14 and use by 11/30. The Food Services Director stated when labeling the food items, the year should be included. 3. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. Review of the facility's P&P titled Sanitization revised 10/2008 showed ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy. Review of the facility document titled Monthly Cleaning Ice Machine showed the ice machine was last cleaned on 1/4/26. On 1/20/26 at 0945 hours, an observation of the ice machine located in the satellite kitchen and concurrent interview was conducted with the Maintenance Director. The Maintenance Director stated there was only one ice machine being used for the SNF residents. The interior of the white water dispenser was observed with slimy yellowish and brownish residue. The Maintenance Director verified the findings. The Maintenance Director stated the maintenance department was responsible for cleaning the ice machine. The Maintenance Director stated they did standard cleaning of the ice machine every month which included wiping the interior and exterior of the machine and cleaning the filters. The Maintenance Director stated the outside vendor would come every six months to perform the chemical cleaning, descaling, and sanitizing of the ice machine. 4. Review of the facility's P&P titled Food Receiving and Storage revised 10/2017 showed the non-refrigerated foods, disposable dishware and napkins will be stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. On 1/20/26 at 0900 hours, an inspection of the dry storage room and concurrent interview was conducted with the Food Services Director. One transparent plastic container with walnut halves was observed partly covered with plastic wrap. The Food Services Director verified the findings and stated it should be covered with closed tight lid. 5. According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. Review of the facility's P&P titled Sanitization revised 10/2008 showed all utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. On (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/20/26 at 0750 hours, during the initial tour of the main kitchen, two scoops with black handles were observed discolored with white sediments and had melted handles. The Food Services Director verified the findings. 6. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, showed surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. On 1/20/26 at 0750 hours, during the initial tour of the main kitchen, one green chopping board was observed heavily marred with knife marks and had black and yellowish stain. The Food Services Director acknowledged the cutting board needed to be replaced. 7. According to the USDA Food Code 2022, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. a. On 1/20/26 at 0750 hours, during the initial tour of the main kitchen, three rectangular containers containing the scoops, spatulas, and other kitchen utensils were observed dirty with food debris, and white and brown substance. The Food Services Director verified the findings. b. On 1/20/26 at 0920 hours, during the initial tour of the satellite kitchen, the following items were observed:- rectangular container 1 containing scoops was dirty with white & brown substance; and- rectangular container 2 containing scoops had a black disposable glove inside. The Food Services Director verified the findings. 8. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air- Drying Required, showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. Review of the facility's P&P titled Sanitization revised 10/2008 showed food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. a. On 1/20/26 at 0750 hours, during the initial tour of the main kitchen, two water jars were observed wet with water visible inside the jars and not completely dried. The Food Services Director verified the findings. b. On 1/20/26 at 0920 hours, during the initial tour of the satellite kitchen, one scoop with white handle was observed wet with water visible inside the scoop. The Food Services Director verified the finding. 9. Review of the facility's P&P titled Sanitization revised 10/2008 showed all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. On 1/20/26 at 0750 hours, during the initial tour of the main kitchen, an observation of the walk-in refrigerator and concurrent interview was conducted with the Food Services Director and the Co-Food Services Manager. The space below the metal rack shelving in the walk-in refrigerator was observed littered with various rubbish of vegetables and fruits. The Food Services Director verified and acknowledged the findings. On 1/21/26 at 1438 hours, an interview was conducted with the Regional RD Consultant and the Food Services Director. The Regional RD Consultant and the Food Services Director were informed and acknowledged the above findings. On 1/22/26 at 1355 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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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** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to implement the infection control surveillance program for the months of January 2025 through August 2025. The facility conducted surveillance of resident infections only when the residents were prescribed antimicrobial medications and/or if the residents were diagnosed with an infection. The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications, or had not been diagnosed with an infection, met the facility's criteria for infection (utilizing McGeer's Criteria). The facility failed to include these residents in the facility's infection control surveillance program. * The facility failed to ensure the clean laundry in the laundry room was stored properly. Additionally, the facility failed to ensure the housekeeping staff did not store their personal items on the resident clean linen sorting counter. * The facility failed to ensure the Hoyer lift was cleaned in between usage for Residents 35 and 81. * The facility failed to ensure LVN 2 performed hand hygiene before administering eye drops to Resident 78. These failures posed the risk of not identifying resident infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program revised 10/2025 showed an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program is coordinated and overseen by the IP. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. The information obtained from infection control surveillance activities is compared with acknowledged standards and used to assess effectiveness of established infection prevention and control practices. Standard criteria (McGeer's and Lobes's Criteria) are used to distinguish CAIs from HAIs. On 1/21/26 at 1007 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's resident infection surveillance program. The IP stated when a resident was prescribed antimicrobial medications or was diagnosed with an infection, the facility would then initiate a McGeer's Criteria and/or Loeb's Criteria form. The IP stated the McGeer's Criteria was utilized to determine if a resident had a true infection. The IP stated the Loeb's Criteria was utilized to determine whether a resident met the minimum criteria for the use of the antibiotics. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2025 through August 2025 showed the following infection surveillance data for HAIs, CAIs, and the residents who did not meet McGeer's Criteria (DNMC): - for 1/2025: HAI &ndash; 31, CAI &ndash; 26, and DNMC &ndash; 0; - for 2/2025: HAI &ndash; 3 , CAI &ndash; 29, and DNMC &ndash; 0; (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- for 3/2025: HAI &dash; 8 , CAI &dash; 18 , and DNMC &dash; 0; - for 4/2025: HAI &dash; 10, CAI &dash; 19, and DNMC &dash; 0; - for 5/2025: HAI - 11 , CAI &dash; 19, and DNMC &dash; 0; - for 6/2025: HAI - 7 , CAI &dash; 16, and DNMC &dash; 0; - for 7/2025: HAI &dash; 7, CAI &dash; 16, and DNMC &dash; 0; and - for 8/2025: HAI - 8, CAI &dash; 0, and DNMC &dash; 0. Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2025 through August 2025 showed that all the residents included in the facility's infection surveillance program were determined to have either a HAI or CAI (with prescribed antimicrobial medications or having been diagnosed with an infection). The Infection Prevention and Control Surveillance logs failed to show any residents that did not meet McGeer's criteria. The IP verified no residents in the facility were classified as having not met the McGeer's Criteria between the months of January 2025 through August 2025. When the IP was asked if the facility included the residents in the facility's infection surveillance program when a resident at the facility exhibited signs and/or symptoms of an infection and was not prescribed antimicrobial medications (or was not diagnosed with an infection) when the facility initiated the McGeer's criteria form, the IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications (or were not diagnosed with an infection). The IP was asked how many residents had met the McGeer's criteria and were not prescribed antimicrobial medications from January 2025 through August 2025 (excluding residents who were diagnosed with an infection). The IP stated she was uncertain, as the facility did not initiate the McGeer's criteria form for those residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications (or had not been diagnosed with an infection). 2. On 1/22/26 at 0908 hours, an observation of the facility's laundry room and concurrent interview was conducted with Housekeeping 1. The counter designated for clean laundry sorting was observed with a facility binder and a used paper cup with a food wrapper stuffed inside of the cup. Additionally, a clean linen cart was observed adjacent to the clean laundry sorting counter. The top shelf of the clean linen cart contained clean resident linens. A stack of facility paperwork was observed on the top shelf of the clean linen cart adjacent to the clean resident linen. Housekeeping 1 verified the findings and stated the facility staff personal cups and food wrappers should not be stored on the clean laundry sorting counter, for infection control purposes. Housekeeping 1 also stated the facility paperwork should not be stored inside of the resident clean linen cart, for infection control purposes. 3. Review of the facility's P&P titled Cleaning and Disinfecting Non-Critical Resident-Care Items revised 6/2011 showed under the General Guidelines section, reusable items are cleaned and disinfected or sterilized between residents (example is the durable medical equipment). On 1/20/26 at 1135 hours, during the initial tour of the facility, CNA 3 was observed transferring Resident 35 from the wheelchair to the bed using the Hoyer lift equipment. CNA 2 came to Resident 35's room and borrowed the Hoyer lift equipment from CNA 3. CNA 3 was then observed bringing the Hoyer lift equipment to Resident 81's room and used it to transfer Resident 81 from the bed to the wheelchair without cleaning the Hoyer lift equipment prior to using it for the resident. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Medical record review for Resident 35 was initiated on 1/20/26. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's MDS assessment dated [DATE], showed Resident 35 had moderate cognitive impairment and dependent with mobility. b. Medical record review for Resident 81 was initiated on 1/20/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's MDS assessment dated [DATE], showed Resident 81 had severe cognitive impairment and dependent with mobility. On 1/20/26 at 1150 hours, an interview was conducted with CNA 2 and LVN 3. CNA 2 verified she did not clean the Hoyer lift equipment prior to using it for Resident 81. CNA 2 stated she should have wiped the lift equipment with the disinfecting wipes prior to using it. LVN 2 stated any reusable equipment like the durable medical equipment the facility staff used for the residents should be cleaned in between use for the residents. LVN 2 further stated the facility used the Sani-Cloth germicidal wipes to clean the equipment used for residents who were not on any isolation precautions and the Sani-Cloth bleach wipes would be used to clean the equipment used for residents who were on isolation precautions. On 1/22/26 at 0907 hours, an interview was conducted with the IP. The IP stated the licensed nurses and CNAs were provided regularly with an in-service training regarding the cleaning of all reusable medical equipment after being used with a resident and which germicidal wipes to use depending on whether the resident was on isolation precautions or not. The IP further stated if the cleaning process was missed, a potential outcome of spreading the infection could occur. The IP was informed and acknowledged the above findings. On 1/22/26 at 1355 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Handwashing/Hand Hygiene dated 10/2017 showed to medications are administered as prescribed in accordance with good nursing principles and practices and only by person authorized to do so. Personnel authorized to administer medication do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions: - medications are administered without unnecessary interruptions; and - hands are washed before and after administration of topical (direct application of medication to a specific body surface, such as the skin), ophthalmic (administration of medications to the eye), optic (direct application of medication into the external ear canal), parenteral (medications administered into the tissues by injection), enteral (medication administered directly into the gastrointestinal system), rectal (through the anus into the rectum) and vaginal medications. Medical record review for Resident 78 was initiated on 1/20/26. Resident 78 was admitted to the facility on [DATE]. On 1/21/26 at 0907 hours, a medication administration observation was conducted with LVN 2 for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 78. LVN 2 was observed preparing the following medications: - one tablet of carvedilol (antihypertensive) 25 mg; -one tablet of doxazosin (antihypertensive) 8 mg; - one tablet of Eliquis (anticoagulant) 5 mg; - one tablet of furosemide (diuretic) 40 mg; - one tablet of hydralazine (antihypertensive) 25 mg; - one tablet of multi-vitamin (supplement); - two tablets of senna (laxative) 8.6 mg; - two tablets of Klor-Con (to treat low potassium) 20 meq; - 30 ml of Milk of Magnesia (relieve constipation); and - bottle of dorzolamide-timolol (prescription eyedrop to lower high eye pressure) one drop to left eye. LVN 2 was observed performing hand hygiene, donning a pair of gloves and administering Resident 78's oral medications. LVN 4 knocked on the door and asked LVN 2 for the key to Medication Cart 1. After administering Resident 78's oral medications, LVN 2 removed his gloves and gave the key to Medication Cart 1 to LVN 4. LVN 2 then donned a pair of gloves and while LVN 2 was explaining the eyedrop to Resident 78, LVN 4 gave the keys for Medication Cart 1 back to LVN 2 and LVN 2 was observed putting the keys in his pocket. LVN 2 was then observed administering the eye drop to Resident 78 left eye. However, LVN 2 was not observed performing hand hygiene. On 1/21/26 at 1236 hours, an interview was conducted with LVN 2. LVN 2 verified he did not perform hand hygiene prior to administering the eyedrop to Resident 78 and after LVN 4 gave back keys for Medication Cart 1. On 1/22/26 at 1318 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one non-sampled resident (Resident 68) was assessed, had a care plan and a physician's order to self-administer the medications. * Resident 68's bedside table had Neosporin (antibiotic medication) ointment. There were no assessment, care plan or physician's order to self-administer this medication. This failure had the potential for the resident to administer the medication inaccurately and negatively impact the residents' physiological well-being. Findings: Review of the facility's P&P titled Self-Administration of Medication revised 12/2016 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.- As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.- Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. During the initial tour of the facility on 1/20/26 at 0833 hours, an observation and concurrent interview was conducted with Resident 68. Resident 68 was sitting on his wheelchair. There was a tube of Neosporin ointment on the resident's bedside table. Resident 68 stated he asked his son to bring the Neosporin ointment for him to apply to his skin tear. Medical record review for Resident 68 was initiated on 1/20/26. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's MDS admission assessment dated [DATE], showed a BIMS score of 12 indicating the resident was cognitively impaired. Review of Resident 68's medical record failed to show documented evidence of the following for Resident 68 to safely self-administer the medication:- a physician's order for Neosporin ointment;- an assessment to self-administer the medications; and- a care plan addressing Resident 68's self- administration of the medication. On 1/20/26 at 0930 hours, an interview and concurrent medical record review for Resident 68 was conducted with LVN 2. LVN 2 verified the Neosporin ointment was on the resident's bedside table. LVN 2 verified Resident 68 did not have an assessment, physician's order or care plan developed to self-administer the medication. LVN 2 stated it was not safe for the resident to keep the medications at bedside. On 1/22/26 at 0948 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON verified Resident 68 did not have an assessment, physician's order or care plan developed to self-administer the Neosporin medication. On 1/22/26 at 1318 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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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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 observation, interview, medical record review, and facility P&P review, the facility failed to develop a resident-centered care plans to reflect the individual care needs for two of 12 final sampled residents (Residents 67 and 72). * The facility failed to develop a comprehensive person-centered care plan to address Resident 67's right upper arm midline catheter and the administration of Dextrose - NaCl solution 5-0.45% (an IV fluid used for hydration and electrolyte replenishment). * The facility failed to develop a comprehensive person-centered care plan to address Resident 72's use of siderails. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents. Findings: Review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered revised 12/2016 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 comprehensive, person-centered care plan would include the following:-include measurable objectives and timeframes;-describe the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. On 1/20/26 at 0827 hours, during the initial tour of the facility, an observation and concurrent interview for Resident 67 was conducted with LVN 1. Resident 67 was lying in bed with a midline catheter to the right upper arm. A one-liter bag of Dextrose & NaCl solution 5-0.45% was hanging and connected to Resident 67's right upper arm midline catheter via IV tubing. The Dextrose solution was infusing at 100 ml/hr. LVN 1 stated Resident 67's right upper arm midline catheter was used for his antibiotic and IV fluids. Medical record review for Resident 67 was initiated on 1/20/26. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's MDS assessment dated [DATE], showed Resident 67 had a BIMS score of 9 indicating the resident was moderately impaired. Review of Resident 67's Order Summary Report showed the following physician's orders:- dated 1/7/26, to change the catheter site dressing every Wednesday; and- dated 1/19/26, to administer Dextrose & NaCl solution 5-0.45% at 100 ml/hr intravenously for poor meal intake times 5 liters. Review of Resident 67's care plans failed to show an individualized care plan was developed to address the resident's right upper arm midline catheter and Dextrose & NaCl solution 5-0.45% administration. On 1/22/26 at 0902 hours, an interview and concurrent medical record review for Resident 67 was conducted with the DON. The DON verified there was no care plan developed to address the resident's right upper arm midline catheter and Dextrose & NaCl solution 5-0.45% administration. On 1/22/26 at 1318 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. (Cross reference to F694) (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled Bed Rails & Safe Use Policy revised 10/2025 showed bed rail use and safety provisions shall be included in resident's care plan. During the initial tour of the facility on 1/20/26 at 1148 hours, Resident 72 was awake and lying in bed with the right upper bed rail elevated. Resident 72 stated he would use the bed rail to grab on when he was being turned or cleaned. On 1/20/26 at 1210 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 72 was dependent on mobility and verified the resident's use of the right upper bed rail while in bed since the resident was admitted to the facility. CNA 3 stated Resident 72 was able to grab the rail during repositioning and cleaning. Medical record review for Resident 72 was initiated on 1/20/26. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 had moderate cognitive impairment and was dependent on mobility. Further review of Resident 72's medical record failed to show a plan of care was formulated or initiated to address the use of right upper bed rail for the resident. On 1/20/26 at 1400 hours, a follow-up observation was conducted with Resident 72. Resident 72 was observed sleeping in bed with the right upper bed rail elevated. On 1/22/26 at 1142 hours, an interview and concurrent medical record review for Resident 72 was conducted with LVN 2. LVN 2 stated Resident 72 had the right upper bed rail which the resident used for grabbing when being repositioned. LVN 2 stated the use of bed rails was determined by the physical therapist's evaluation. LVN 2 stated the use of bed rails could cause entrapment & injuries. LVN 2 stated a care plan for the use of bed rail should have been initiated to establish a plan for care and formulate interventions to avoid injuries caused by using bed rail since it could cause entrapment and risk for fall. On 1/22/26 at 1355 hours, an interview and concurrent medical record review for Resident 72 was conducted with the DON. The DON verified the above findings and acknowledged there was no plan of care formulated for the use of right upper bed rail for Resident 72. Cross reference to F700 and F909, example #1.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 the comprehensive plan of care was revised to reflect the resident's current care needs and interventions for one of 12 final sampled residents (Resident 64). * Resident 64's care plan for alteration in functional mobility and presence of pain related to nondisplaced type III odontoid (neck bone) fracture was not revised to address the use of the neck collar brace as ordered by the physician. This posed the risk of not providing the resident with individualized and person-centered care. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered dated 12/2016 showed the areas of concern are identified during the resident assessment will be evaluated before the interventions are added to the care plan. Interventions are chosen only after careful data gathering, proper sequencing of events, careful considerations of the relationship between the resident's problem areas and their causes, and relevant decision making. The Interdisciplinary team must review and update the care plan. On 1/20/26 at 0926 hours, an observation and concurrent interview was conducted with Resident 64. Resident 64 was observed in bed, alert and verbally responsive wearing a neck collar brace. Resident 64 stated he fell and broke a bone in his neck. Resident 64 stated he needed to wear the neck collar brace at all times except when he showered. Resident 64 stated he had pain in the neck and the pain medication help him a lot. Medical record review for Resident 64 was initiated on 1/21/26. Resident 64 was admitted to the facility on [DATE] with diagnosis of non-displaced fracture. Review of Resident 64's Order Summary Report for January 2026 showed the following physician's orders:- dated 1/8/26, to wear a C collar on for 6 weeks, may remove when showering only every shift;- dated 1/8/26, to monitor for placement of the neck brace every shift. Review of Resident 64's care plan for alteration in functional mobility and presence of pain related to fracture dated 1/7/26, showed the interventions including to administer the prescribed medication for pain, gentle handling of the resident during care, and support fractured site during turning and repositioning. However, the wearing and monitoring of the neck collar brace as ordered by the physician for Resident 64 were not included in the interventions. Review of Resident 64's medical record failed to show the neck collar brace was monitored per the physician's order. On 1/21/26 at 1128 hours, an interview and concurrent medical record review for Resident 64 was conducted with LVN 1. LVN 1 stated Resident 64 was admitted to the facility with a neck collar brace with a physician's order. LVN 1 verified the above findings and stated the care plan should have been revised to reflect Resident 64's most current plan of care. On 1/22/26 at 0948 hours, an interview and concurrent medical record review for Resident 64 was conducted with the DON. The DON stated she expected the plan of care should be comprehensive based on physician's order and the interdisciplinary team input in developing the care plan. The DON was informed and verified the above findings.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **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 for one of one final sampled resident (Residents 67) reviewed for IV care. * The facility failed to ensure Resident 67's parenteral fluids were administered in accordance with the physician's order, and the right upper arm midline catheter was changed as per the facility's P&P. These failures had the potential for Resident 67 to not maintain adequate hydration and/or electrolyte levels and delay the identification of catheter related complications. Findings: Review of the facility's P&P titled Midline Catheter Dressing Change dated 3/2023 showed the catheter dressing changes are to be performed by RNs and IV certified LVNs according to state law and facility policy. Dressing changes using transparent dressings are performed at least weekly. On 1/20/26 at 0827 hours, during the initial tour of the facility, an observation and concurrent interview for Resident 67 was conducted with LVN 1. Resident 67 was observed lying in bed with a midline catheter on the right upper arm with a dressing dated 1/7/26. A one-liter bag of Dextrose - NaCl solution 5-0.45% (an IV fluid used for hydration and electrolyte replenishment) was hanging and connected to Resident 67's right upper arm midline catheter via an IV tubing. The Dextrose solution was infusing at 100 ml/hr. LVN 1 stated Resident 67's right upper arm midline catheter was used for his antibiotic and IV fluids. Medical record review for Resident 67 was initiated on 1/20/26. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's MDS assessment dated [DATE], showed Resident 67 had a BIMS score of 9 indicating the resident's cognition was moderately impaired. Review of Resident 67's Order Summary Report showed the following physician's orders:- dated 1/7/26, to change the catheter site dressing every Wednesday; and- dated 1/19/26, to administer Dextrose - NaCl solution 5-0.45% at 100 ml/hr intravenously for poor meal intake for 5 liters. On 1/20/26 at 1536 hours, an observation, interview and concurrent medical record review for Resident 67 was conducted with RN 1. RN 1 verified there was approximately 400 ml of Dextrose - NaCl solution 5-0.45% solution remaining in the one-liter bag (600 ml was infused). RN 1 stated Dextrose - NaCl solution 5-0.45% solution was supposed to be infused at 100 ml per hour. RN 1 verified the Dextrose - NaCl solution 5-0.45% infusion was started on 1/20/26 at 0700 hours (8 hours had lapsed since the IV bag was hung). RN 1 acknowledged 800 ml of the Dextrose - NaCl solution 5-0.45% should have been infused since the time the bag was hung, but only 600 ml was infused. RN 1 verified there was no documentation or physician's order to hold the Dextrose - NaCl solution 5-0.45% infusion. RN 1 further verified the right upper arm midline dressing was dated 1/7/26 and should have been changed. On 1/22/26 at 1318 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. (Cross reference to F656)		

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the respiratory services for two of two final sampled residents (Residents 12 and 63) reviewed for respiratory care. * The facility failed to ensure Resident 12's nasal cannula tubing was changed as per the facility's P&P. In addition, the facility failed to ensure the nasal cannula tubing was stored in a set-up bag when not in use. * The facility failed to ensure Resident 63's nebulizer tubing and mask were changed every week as per the facility's P&P. These failures posed the risk of complications and negative health outcomes to Resident 12 and 63. Findings: 1. Review of the facility's P&P titled Respiratory Therapy & Prevention of Infection dated 11/15/23, showed the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Change the oxygen cannula and tubing every seven (7) days, or as needed. Keep the oxygen cannula and tubing used as needed in a bag when not in use. On 1/20/26 at 0909 hours, an observation of Resident 12 and concurrent interview was conducted with the DON. Resident 12 was sitting in her bed with an oxygen concentrator and the nasal cannula tubing was in Resident 12's nostrils. There was another portable oxygen concentrator was observed by Resident 12's bedside table with an oxygen tubing dated 12/13/25, hanging on the portable oxygen concentrator. Resident 12 stated that she used the portable oxygen concentrator when she goes out. The DON verified Resident 12's nasal cannula tubing was dated 12/13/25 and was not stored inside the bag. The DON further stated the nasal cannula tubing needed to be inside a bag to prevent dirt and dust contaminating the tubing. Medical record review for Resident 12 was initiated on 1/20/26. Resident 12 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed the following physician's orders: - dated 1/27/24, to change oxygen cannula tubing every Saturday and as needed for soilage; and - dated 8/19/25, for oxygen at a rate of 4-6 LPM via nasal cannula continuously for COPD (chronic obstructive pulmonary disease - a progressive lung disease which blocks air flow making breathing difficult). On 1/22/26 at 1318 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Respiratory Therapy - Prevention of Infection dated 11/15/23, showed to store the nebulizer administration set up in plastic bag, marked with date and resident's name and to change the set up every seven days. During the initial tour of the facility on 1/20/26 at 0922 hours, Resident 63 was observed on her wheelchair and watching on her television set. Resident 63's nebulizer machine was observed on top of the bedside drawer, and the mask and tubing were placed on a clear plastic bag dated 1/3/26. Medical record review for Resident 63 was initiated on 1/20/26. Resident 63 was admitted to the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE]. Review of Resident 63's Order Summary Report showed a physician's order dated 12/23/25, to administer albuterol sulfate (breathing treatment) nebulization solution (2.5 mg/3ml) 0.083% 3 ml inhale orally via nebulizer every four hours as needed for shortness of breath or wheezing. On 1/20/2026 at 1224 hours, an observation and concurrent interview was conducted with LVN 3 at Resident 63's bedside. LVN 3 verified Resident 63 had an order for nebulizer machine use. LVN 3 was asked for the clear plastic bag label where the nebulizer tubing and mask were stored. LVN 3 verified the plastic bag storage was labeled of date 1/3/26. LVN 3 stated the night shift nurses were usually the one responsible for changing the oxygen tubing including the nebulizer tubing and the mask once a week on Saturdays. LVN 3 verified the clear plastic bag was not changed every week and it was last changed more than two weeks ago. On 1/22/2026 at 0952 hours, an interview and concurrent medical record review for Resident 63 was conducted with the DON. The DON was informed and stated she expected the oxygen tubing including the nebulizer mask and tubing to be changed every week or as needed as per the facility's protocol. The DON acknowledged the above findings.		

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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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the monitoring of output and fluid restriction were followed for two of two final sampled residents (Residents 71 and 72) reviewed for dialysis. * The facility failed to ensure the output was properly monitored for Resident 71. * The facility failed to ensure the physician's order for 1500 ml of fluid restriction was followed and carried out accordingly for Resident 72. These failures had the potential of not identifying potential negative outcomes for the dialysis residents. Findings: Review of the facility's P&P titled Intake, Measuring and Recording revised 10/2010 showed the purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. If the resident is medically capable of understanding the procedure, ask him or her to assist you in telling you when he or she drank some fluid and how much he or she drank. Record the fluid intake as soon as possible after the resident has consumed the fluids. At the end of the shift, total the amounts of all liquids the resident consumed. Record the amount noted on the intake side of the intake and output record. Record the time the intake was measured. Review of the facility's P&P titled Output, Measuring and Recording revised 10/2010 showed the purpose of this procedure to accurately determine the amount of urine that a resident excretes in a 24-hour period. Be sure that the intake and output record is available. Record the time the output was measured. Review of the facility's P&P titled Encouraging and Restricting Fluids revised 10/2010 showed the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Follow specific instructions concerning fluid intake or restrictions. Be accurate when recording fluid intake. Be sure an intake and output record is maintained in the resident's room. Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in mls. 1. On 1/21/26 at 0830 hours, an observation and concurrent interview was conducted with Resident 71. Resident 71 stated he had hemodialysis every Tuesday, Thursday, and Saturday. Resident 71 stated he was still producing urine and would use the restroom to void. Resident 71 stated he did not think his urine was being measured. Resident 71 further stated no one had informed him about his urine output needed to be measured. Medical record review for Resident 71 was initiated on 1/22/26. Resident 71 was admitted to the facility on [DATE]. Review of Resident 71's MDS assessment dated [DATE], showed Resident 71 was cognitively intact. Review of Resident 71's plan of care revised on 1/20/26, showed a care plan problem addressing Resident 71's risk for dehydration or potential fluid deficit related to IV fluids received in acute hospital, acute kidney injury on hemodialysis, and variable oral intake. The interventions included monitoring the intake and output. Review of Resident 71's Task: B&B - Bladder Elimination for January 2026 showed only a check mark for continent. Further review of Resident 71's medical record failed to show the urine output was properly monitored. On 1/22/26 at 0931 hours, an interview and concurrent medical record review for Resident 71 was conducted with LVN 1. LVN 1 verified Resident 71 was receiving dialysis. LVN 1 stated Resident 71 still voided and independent with bladder and bowel elimination. LVN 1 stated when the resident had an order for monitoring of the intake and output, they would provide the resident with graduated cup with measurements in order for them to be able to measure exactly how much the resident's intake was. LVN 1 stated for the output, they would just ask the resident how many times the resident voided for the shift. LVN 1 stated for the residents who had renal failure or on dialysis, measuring the intake and output should be more accurate by measuring the exact amount to determine if the resident was retaining fluid, and this could assist them in reporting immediately to the physician as well as the dialysis center for any changes in the condition of the residents. LVN 1 verified the output was not being measured properly by not accurately measuring the exact amount of the urine output for Resident 71. 2. During the initial tour of the facility on 1/20/26 at 1148 hours, Resident 72 was observed awake and lying in bed. Resident 72 stated he had dialysis (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every Monday, Wednesday, and Friday. Resident 72 stated he was drinking water and juice but not a lot although he liked coffee. Medical record review for Resident 72 was initiated on 1/20/26. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 had moderate cognitive impairment Review of Resident 72's Order Summary Report showed a physician's order dated 1/15/26, for fluid restriction of 1500 ml/24 hours as follows:* Nursing to provide 540 ml of fluid: - 200 ml for the AM shift - 200 ml for the PM shift - 140 ml for the NOC shift* Dietary to provide 960 ml of fluid: - 360 ml at breakfast - 360 ml at lunch - 240 ml at dinner Review of Resident 72's MAR for January 2026 showed the fluid restriction record for nursing to provide 540 ml of fluids for 24 hours. The MAR showed:- on 1/15/26 for the NOC shift, the recorded fluid intake was 400 ml;- on 1/16/26 for the NOC shift, the recorded fluid intake was 300 ml;- on 1/18/26 for the NOC shift, the recorded fluid intake was 200 ml; and- on 1/19/26 for the PM shift, the recorded fluid intake was 400 ml. Further review of Resident 72's medical record failed to show documented evidence of the fluid intake from the dietary to provide 960 ml of fluids in 24 hours. On 1/22/26 at 1000 hours, an interview for Resident 72 was conducted with CNA 4. CNA 4 verified Resident 72 had dialysis and a fluid restriction. CNA 4 stated she measured the amount of fluid intake of Resident 72 by the cup they used for hot drinks. CNA 4 stated the cup was approximately 250 ml and she would give a pitcher of water to the resident which was approximately 500 ml. CNA 4 stated she would ask Resident 72 how many cups of fluid he had for breakfast and lunch then she would record it in the CNA's task for nutrition-fluids. On 1/22/26 at 1015 hours, an interview and concurrent medical record review for Resident 72 was conducted with LVN 2. LVN 2 verified Resident 72 was a dialysis resident and on fluid restriction of 1500 ml per day as per the physician's order. LVN 2 stated when documenting the fluid intake of the resident in the MAR, he would refer to the CNA's nutrition-fluids record and add the amount of fluids he provided if he did. LVN 2 was asked about the documentation of fluid intake coming from the dietary. LVN 2 verified and acknowledged there was no fluid intake recorded from the dietary. In addition, LVN 2 verified Resident 72 received more than the fluid restriction as per the physician's order on 1/15, 1/16, 1/18, and 1/19/26. On 1/22/26 at 1355 hours, an interview and concurrent medical record review for Residents 71 and 72 was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Resident 72) reviewed for the use of bed rails remained free from accident hazards associated with the use of elevated bed rails. * The facility failed to ensure the physician's order was obtained for the use of the right upper bed rail for Resident 72. In addition, an IDT assessment was not conducted prior to the use of the right upper bed rail. This failure had the potential to put the resident at risk for serious injuries. Findings: Review of the facility's P&P titled Bed Rails - Safe Use Policy revised 10/2025 showed the following:- when bed rail use is desired/considered, Resident's sleeping environment shall be assessed by the Interdisciplinary Team, considering safety needs, entrapment risks, medical conditions/symptoms, cognitive/behavioral status, functional needs, comfort, freedom of movement, and input from the resident and family regarding previous sleeping habits and bed environment; and- when bed rails are indicated for use, physician will be consulted to establish concurrence/orders. On 1/20/26 at 1148 hours, during the initial tour of the facility, Resident 72 was awake and lying in bed with the right upper bed rail elevated. Resident 72 stated he used the bed rail to grab when he was being turned or cleaned. On 1/20/26 at 1210 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 72 was dependent on mobility and verified the resident's use of the right upper bed rail while in bed since the resident was admitted to the facility. CNA 3 stated Resident 72 was able to grab the rail during repositioning and cleaning. Medical record review for Resident 72 was initiated on 1/20/26. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72's Side Rails Screening Tool V.2 dated 1/9/26, under Section VII. Interdisciplinary Team Recommendation showed the IDT believed that the use of a bilateral assist rail will further enhance the resident's ability to participate in the completion of his activities of daily living (repositioning, transfers and bed mobility). The use of the rail did not limit the resident's freedom of movement. Review of Resident 72's Order Summary Report showed a physician's order dated 1/9/26, for the use of bilateral assist handrail for bed mobility and repositioning and transfers, and with a discontinued date of 1/19/26. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 had moderate cognitive impairment and was dependent on mobility. Review of Resident 72's medical record failed to show a physician's order was obtained for the use of the right upper bed rail and if an IDT assessment was conducted prior to the use of the right upper bed rail. On 1/20/26 at 1400 hours, an observation was conducted of Resident 72. Resident 72 was sleeping in bed with the right upper bed rail elevated. On 1/22/26 at 1142 hours, an interview and concurrent medical record review for Resident 72 was conducted with LVN 2. LVN 2 stated Resident 72 had the right upper bed rail which the resident used for grabbing when being repositioned. LVN 2 stated the use of bed rails was determined by the physical therapist's evaluation. LVN 2 stated prior to the use of the bed rails, a physician's order should be obtained, an informed consent should be obtained, and an assessment using the Side Rails Screening Tool should be completed. LVN 2 stated the screening was done by the IDT. LVN 2 verified there was no physician's order obtained, and no IDT assessment was conducted for the use of right upper bed rail for Resident 72. On 1/22/26 at 1355 hours, an interview and concurrent medical record review for Resident 72 was conducted with the DON. The DON stated Resident 72's bed rails were discontinued on 1/19/26. The DON was informed that during the initial tour of the facility on 1/20/26, Resident 72 was observed with the right upper bed rail and the resident verbalized he used the bed rail during repositioning and cleaning. Furthermore, the DON was informed the facility's staff verified the use of Resident 72's right upper bed rail. The DON acknowledged the above findings for Resident 72. Cross reference to F656 and F909, example #1.		

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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	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food items were served in the appetizing and safe temperatures. * The food temperatures were above the recommended temperature for cold desserts. This failure posed the risk of not providing safe food for the residents receiving a meal tray from the kitchen. Findings: Review of the facility's Diet Type Report dated 1/20/26, showed 42 of 42 residents consumed the food prepared in the kitchen. According to the USDA Food Code 2022 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5 degrees Celsius to 57 degrees Celsius (41 degrees Fahrenheit to 135 degrees Fahrenheit) too long. Maintaining temperature controlled foods under the cold temperature control requirements prescribed in this code will limit the growth of pathogens that may be present in or on the food and may help prevent foodborne illness. Review of the facility's P&P titled Food Preparation and Service revised date 10/2017 showed the danger zone for food temperatures is between 41 degrees Fahrenheit to 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illnesses. On 1/21/26 at 1220 hours, a tray line observation and concurrent interview was conducted with the Food Service Director, Regional RD Consultant, and Dietary Aides 1 and 2. Dietary Aide 1 checked and verified the following temperatures for the following:- first plate of banana pie was 63 degrees Fahrenheit- second plate of banana pie was 54.8 degrees Fahrenheit Dietary Aides 1 and 2 stated the banana pie desserts were transferred to the satellite kitchen from the main kitchen around 1200 hours. The Food Service Director and the Regional RD Consultant stated the banana pie dessert was not holding the cold temperature of below 41 degrees Fahrenheit. The Food Service Director and the Regional RD Consultant acknowledged the dessert temperatures varying from 54.8 to 63 degrees Fahrenheit were above the recommended temperatures for cold food.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment was complete. * The facility failed to ensure the Facility Assessment addressed or included the active involvement of required individuals in developing the Facility Assessment and resources necessary to care for residents including weekends. This failure had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment and the resources necessary to care for the residents including weekends. On 1/22/26 at 1003 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with Administrator. The Administrator verified the Facility Assessment was dated 9/25/25, and acknowledged he was not aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no resources necessary to care for the residents including weekends and emergencies. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were completed and the measurements were recorded during the bed inspection when identifying areas of possible entrapment with the use of side rails for two of three final sampled residents (Residents 72 and 75) reviewed for side rails use. * The facility failed to ensure the entrapment assessment of bed rails were completed for Residents 72 and 75. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is potential for entrapment are:- Zone 1: within the rail;- Zone 2: under the rail, between the rail supports or next to a single rail support;- Zone 3: between the rail and the mattress;- Zone 4: under the rail, at the ends of the rail;- Zone 5: between split bed rails;- Zone 6: between the end of the rail and the side edge of the head or foot board; and- Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Rails - Safe Use Policy revised 10/2025 showed bed rails will be installed, secured, and maintained according to manufacturer instructions and the facility shall assess spaces for unsafe gaps between mattress and bed rails and bed system components to reduce entrapment risks in consideration of resident's size, weight, and behavioral patterns. 1. On 1/20/26 at 1148 hours, during the initial tour of the facility, Resident 72 was observed awake and lying in bed with the right upper bed rail elevated. Resident 72 stated he used the bed rail to grab when he was being turned or cleaned. On 1/20/26 at 1210 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 72 was dependent on mobility and verified the resident's use of the right upper bed rail while in bed since the resident was admitted to the facility. CNA 3 stated Resident 72 was able to grab the rail during repositioning and cleaning. Medical record review for Resident 72 was initiated on 1/20/26. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72's Order Summary Report showed a physician's order dated 1/9/26, for the use of bilateral assist handrail for bed mobility and repositioning and transfers, and with a discontinued date of 1/19/26. Review of Resident 72's Side Rails Screening Tool V.2 dated 1/9/26, under Section III. Alternative Measures showed the bilateral assist handles were recommended at this time. Review of Resident 72's MDS assessment dated [DATE], showed Resident 72 had moderate cognitive impairment and was dependent on mobility. Review of the facility's Bed System Measurement Device Test Results Worksheet Log for January 2026 did not show evidence the entrapment assessment for Resident 72 was completed prior to the use of bed rails. On 1/20/26 at 1400 hours, an observation was conducted for Resident 72. Resident 72 was sleeping in bed with the right upper bed rail elevated. 2. On 1/20/26 at 1307 hours, during the initial tour of the facility, Resident 75 was observed awake and lying in bed with the bilateral upper bed rails elevated. Resident 75 stated he could help with turning in bed and used the bed rails to hold on to. Medical record review for Resident 75 was initiated on 1/20/26. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's Order Summary Report showed a physician's order dated 1/12/26, for the use of bilateral assist handrail for bed mobility and repositioning and transfers. Review of Resident 75's Side Rails Screening Tool V.2 dated 1/12/26, under Section III. Alternative (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Measures showed bilateral assist handles were recommended at this time. Review of Resident 75's MDS assessment dated [DATE], showed Resident 75 had moderate cognitive impairment and needed partial or moderate assistance with mobility. On 1/21/26 at 0907 hours, an observation was conducted for Resident 75. Resident 75 was awake and lying in bed with the bilateral upper bed rails elevated. On 1/22/26 at 1113 hours, an interview was conducted with CNA 5 for Resident 75. CNA 5 stated Resident 75 could turn and get out of bed with supervision. CNA 5 stated Resident 75 used the bilateral upper bed rails to grab during repositioning and transferring. On 1/22/26 at 1142 hours, an interview and concurrent medical record review was conducted with LVN 2 for Residents 72 and 75. LVN 2 stated Resident 72 had the right upper bed rail which the resident used during repositioning. LVN 2 stated Resident 75 used the bilateral upper bed rails during repositioning, transferring and when getting out of bed. LVN 2 stated the use of the bed rails was determined by the physical therapist's evaluation. LVN 2 stated the use of the bed rails could cause entrapment and injuries to the residents. LVN 2 stated he was not familiar with the different zones of entrapment of the bed and measurement. LVN 2 stated the maintenance department was responsible for the bed rail installation but he did not know how the department was notified. On 1/22/26 at 1308 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated the physical therapist determined the resident's need of the use of bed rail(s) and would install it since the bed rails were kept at the resident's room. The Maintenance Director stated the maintenance department then would be notified by the medical records department to inspect the installation of the bed rail(s). The Maintenance Director stated he would complete the entrapment assessment by measuring the bed Zones 1, 2, 3, and 4, and would check the fitment and locking. The Maintenance Director further stated he did weekly check for the bed rails. Reviewed the facility's Bed System Measurement Device Test Results Worksheet Log for January 2026 with the Maintenance Director and the Maintenance Director verified the log did not show evidence the entrapment assessment for Residents 72 and 75 were completed prior to the use of bed rails. On 1/22/26 at 1355 hours, an interview was conducted with the DON. The DON stated if the entrapment assessment was not completed for those residents with the bed rails, then the residents had high risk for injury, like strangulation. The DON was informed and acknowledged the above findings for Residents 72 and 75.		

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F 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **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 reasonable accommodations to meet the needs of one of 12 final sampled residents (Resident 62). * The facility failed to ensure the call light for Residents 62 was within the residents' reach. This failure had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely Response dated 10/2025 showed the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Staff should facilitate call light placement within reach of resident and secure it as needed. Call system should be accessible to Residents while in bed or other sleeping accommodations in room. During the initial tour of the facility on 1/20/26 at 0912 hours, Resident 62 was in bed, awake, and covered with a blanket. Resident 62 did not answer when asked if she knew how to call the nurse. The call light button was observed clipped and the cable was hanging on the wall. The call light was out of Resident 62's reach. On 1/20/26 at 1034 hours, a follow-up observation of Resident 62 and concurrent interview was conducted with CNA 1 at Resident 62's bedside. CNA 1 verified the call light button was clipped and the cable was hanging on the wall, out of Resident 62's reach. Medical record review for Resident 62 was initiated on 1/20/26. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's Face Sheet dated 1/9/26, showed the resident was self-responsible for her care. On 1/22/26 at 0956 hours, an interview was conducted with the DON. The DON stated she expected the residents' call lights to be placed always near the residents so they could call for help right away if they needed assistance. The DON was informed and verified the above findings.		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to dispose and store trash in a sanitary manner. * One of four dumpsters was overflowing with garbage which prevented the lid to be fully closed. This failure posed the risk for the development of odors, attract and harborage or breeding place of insects and rodents, and a possible source of contamination of food, equipment, and utensils. Findings: According to the USDA Food Code 2022, 5-501.113, Covering Receptacles, showed receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: Inside the food establishment if the receptacles and units contain food residue and are not in continuous use; or after they are filled; and with tight-fitting lids or doors if kept outside the food establishment. Review of the facility's P&P titled Food-Related Garbage and Refuse Disposal revised 10/2017 under the Policy Interpretation and Implementation section, showed all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use, garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests, and outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. On 1/20/26 at 1430 hours, an observation of the trash disposal and concurrent interview was conducted with the Maintenance Director. One of the four dumpsters was overfilled with trash, preventing the lid from being closed. The Maintenance Director stated he always reminded the facility staff who deal with the garbage/dumpsters to make sure the lids were completely closed to prevent harboring of rodents or pests. The Maintenance Director verified and acknowledged the above findings. On 1/22/26 at 1355 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		