

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555462		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2025	
NAME OF PROVIDER OR SUPPLIER VILLA VALENCIA HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 25000 CALLE DE LOS CABALLEROS , LAGUNA HILLS, California, 92653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Number: 2626668. The survey team entered the facility on 10/8/25 at 0755 hours. The facility identified the census as 52. The survey sample size was 4. Inspection was limited to the complaint investigated and did not represent the findings of a full inspection of the facility. * FOR COMPLAINT NUMBER: 2626668, DEFICIENCIES WERE IDENTIFIED AND CITED AT F684. IN ADDITION, DURING THE ABBREVIATED SURVEY, ADDITIONAL DEFICIENCIES WERE IDENTIFIED AND CITED AT F558, F656, F880 AND F909. GLOSSARY AND DEFINITIONS: % - percent ADON – Assistant Director of Nursing AHA – American Health Association Anticoagulant – also known as blood thinners, are medications administered to prevent blood clots BIMS - Brief Interview for Mental Status (a standardized assessment tool) BP – blood pressure			F0000			

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 reverse for further 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 <i>Spencer Norbeck</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>10-31-25</i>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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F0000	Continued from page 1 bpm - beats per minute CNA - Certified Nursing Assistant COC - Change of Condition DON - Director of Nursing DSD - Director of Staff Developer EBP - Enhanced Barrier Precautions ER - Emergency Room FDA - Food and Drug Administration H&P - History and Physical IP - Infection Preventionist LVN - Licensed Vocational Nurse MDRO - Multiple Drug-Resistant Organism MDS - Minimum Data Set (a standardized assessment tool) MRD - Medical Records Director mmHg - millimeter(s) of mercury NP - Nurse Practitioner P&P - Policy and Procedure PPE - Personal Protective Equipment (specialized gear like gloves, gowns, masks, and eye protection to create a barrier between healthcare workers and potential hazards to prevent infection and injury) QA - Quality Assurance RN - Registered Nurse SBAR - Situation/Background/Assessment/Recommendation (a communication tool)	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F0558		

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F0558 SS = D	Continued from page 2 other residents. This REQUIREMENT is NOT MET as evidenced by: 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 four sampled residents (Resident 2) reviewed for communication needs. * The facility failed to ensure Resident 2 was provided with the means to communicate her daily needs. This failure had the potential to negatively impact the resident's psychosocial well-being or result in delayed provision of care. Findings: Review of the facility's P&P titled Translation and/or Interpretation of Facility Services revised 5/2017 showed the following: - when encountering LEP (Limited English Proficiency) individuals, staff members will conduct the initial language assessment (e.g., "I Speak Cards") and notify the staff person in charge of the language access program; - the coordinator of this facility's language access program is the Director of Social Services, or his/her designee; - all LEP persons shall receive a written notice in their primary language of their rights to obtain competent oral translation services free of charge. If written notice is not possible, such notice shall be given orally; - this facility shall provide written translation of vital information pertaining to health services, resident rights and facility policy if the LEP population represents at least five (5) percent of the population or 1000 people eligible to be served by the facility (whichever is fewer); - family members and friends shall not be relied upon to provide interpretation services for the resident, unless explicitly requested by the resident. If family or friends are used to interpret, the resident must provide written consent for disclosure of protected			F0558			

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F0558 SS = D	Continued from page 3 health information; - It is understood that providing meaningful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral interpretation services therefore include interpretation from the LEP resident's primary language back to English; and - It is understood that to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual. Review of the facility's P&P titled Resident Rights revised 12/2016 showed the following: - federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to communication with and access to people and services, both inside and outside the facility and exercise his or her rights as a resident of the facility and as a resident or citizen of the United States. Medical record review for Resident 2 was initiated on 10/9/25. Resident 2 was admitted to the facility on 9/14/25, and readmitted on 9/27/25. Review of Resident 2's Admission Screen and Baseline Care Plan dated 9/27/25, showed Resident 2's mental status was alert and oriented to name, place, and time, need or want an interpreter to communicate with a doctor or health care staff, and preferred language is Cantonese. Review of Resident 2's MDS assessment dated 9/30/25, showed Resident 2's Brief Interview for Mental Status (BIMS) score was 12, which meant the resident had moderate cognitive impairment. On 10/8/25 at hours, Resident 2 was observed sitting up in wheelchair awake, alert, and Vietnamese and Cantonese speaking. Resident 2 was able to speak and understand very limited English. Resident 2 was asked how long she has been staying in the facility and the reason for her stay in the facility. Resident 2 gestured with her hand and stated, "No" and was not			F0558			

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F0558 SS = D	Continued from page 4 able to answer. Resident 2 was interviewed with the assistance of the translation services via phone for Vietnamese language. Resident 2 was asked how she communicated her daily needs to the staff and how the staff understood her since Resident 2 spoke mainly Vietnamese and Cantonese. Resident 2 stated there were no Vietnamese or Cantonese speaking staff to translate, communication board provided and available to use in her room, and the facility staff did not use any translator via telephone. In addition, Resident 2 stated since no one can understand, speak, or translate in her language, she had to wait for her family to arrive and communicate her needs. On 10/8/25 at 1132 hours, an observation and concurrent interview for Resident 2 was conducted with LVN 1. LVN 1 was asked which was the preferred language of Resident 2 and how the resident communicated her daily needs. LVN 1 stated Resident 2 spoke Chinese or Korean language and able to express her needs. LVN 1 stated Resident 2's family member visited the resident every day from morning until bedtime, at around 2100 hours. LVN 1 was asked how the facility staff would understand and communicate with Resident 2 when the family member was not around or between the hours of 2200 to 0700 hours. LVN 1 stated if a family member was not present, there were staff from rehabilitation department who can translate, use a communication board, or use the facility's telephone to translate. In addition, LVN 1 was asked to show Resident 2's communication board. LVN 1 was followed to Resident 2's room to look for the communication board consistent with the resident's preferred language; however, LVN 1 failed to show a communication board was present and available for Resident 2 to use to communicate her needs. LVN 1 stated the communication board was not necessary to be available inside Resident 2's room. Furthermore, when LVN 1 was asked how to use the language line using the facility's telephone, LVN 1 was not able to show how to use the language line via facility's telephone and walked away. On 10/8/25 at 1140 hours, an observation and concurrent interview for Resident 2 was conducted with CNA 2. CNA 2 was asked to show the communication board for Resident 2. CNA 2 was observed looking for the communication board inside Resident 2's room. CNA 2 stated she could not find the communication board and was not available inside Resident 2's room. CNA 2 stated if any resident was not able to communicate their needs, the resident's needs might not be met.			F0558			

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F0558 SS = D	Continued from page 5 On 10/8/25 at 1145 hours, an observation and concurrent interview for Resident 2 was conducted with the DSD. The DSD stated the nurses use the language line solutions and there were staff who spoke Korean. The DSD was asked to show the communication board inside Resident 2's room; however, the DSD failed to show the communication board was available for Resident 2 and facility staff to use. On 10/8/25 at 1217 hours, an interview was conducted with Family Member 1. Family Member 1 stated Resident 2 spoke Chinese and Vietnamese language and very limited English. Family Member 1 stated Resident 2's family member visited daily and stayed until 2200 hours so the family member can be there to communicate Resident 2's daily needs because the resident could not understand English. However, during the family's absence or night hours (2300-0700 hours), Family Member 1 stated she was concerned if Resident 2's needs were met because she did not know how the facility staff could understand Resident 2 and vice versa. Family Member 1 was asked how the facility staff communicated with Resident 2, if facility staff have used a communication board or a language line to translate. Family Member 1 stated she has not seen a communication board in Resident 2's preferred language(s) provided and available in the room, nor did the facility staff have used a communication board during Resident 2's stay. In addition, Family Member 1 stated she has not observed any facility staff using the language line translation with Resident 2. On 10/10/25 at 1536 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.			F0558			
F0656 SS = B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			F0656			

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F0656 SS = B	Continued from page 6 (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (II) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (III) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (IV) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plans were developed to reflect the individual care needs for one of four sampled residents (Resident 3) reviewed for care plans. * The facility failed to ensure a care plan was developed for the use of the anticoagulant medication ordered by the physician. This failure had the potential for the resident to not be provided with			F0656			

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F0656 SS = B	Continued from page 7 appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Plans revised 12/2016 showed the following: - 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; and - The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Medical record review for Resident 3 was initiated on 10/10/25. Resident 3 was admitted to the facility on 10/5/25. Review of Resident 3's Order Summary Report dated 10/6/25, showed a physician's order dated 10/5/25, for apixaban (medication to prevent blood clots) oral tablet 2.5 mg, to give one tablet by mouth one time a day for Atrial Fibrillation (a common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly). Review of Resident 3's H&P examination dated 10/7/25, showed the resident had the capacity to understand and make decisions. Further review Resident 3's medical record failed to show a care plan was developed to address the use of the anticoagulant medication. On 10/10/25 at 1007 hours, an interview and concurrent health record review for Resident 3 was conducted with RN 1. RN 1 verified there was a physician's order for the apixaban medication. RN 1 also verified there was no care plan developed for the use of the anticoagulant medication for Resident 3. RN 1 stated she was not responsible for developing care plans for the use of the anticoagulant medication upon admission. In	F0656					

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F0656 SS = B	Continued from page 8 addition, RN 1 stated the DON, ADON, and MRD were responsible for auditing new admissions for completion. On 10/10/25 at 1212 hours, an interview was conducted with LVN 2. LVN 2 was asked about the importance of initiating a care plan for a resident receiving an anticoagulant. LVN 2 stated the anticoagulant medications must have a care plan to show goals and interventions such as monitoring for side effects and re-assess outcomes. On 10/10/25 at 1251 hours, an interview was conducted with the MRD. The MRD stated she would review and audit new admission charts for the completion of medication entries, baseline assessments, and care plans; however, the ADON and MDS Coordinator would be responsible in reviewing and initiating the care plan for medications. On 10/10/25 at 1403 hours, an interview was conducted with the MDS Coordinator. The MDS Coordinator was asked when the care plan for anticoagulant use must be initiated for Resident 3. The MDS Coordinator stated the care plan for the use of anticoagulant must be initiated as soon as possible. The MDS Coordinator verified Resident 3's medical record failed to show a care plan for the use of anticoagulant was developed. On 10/10/25 at 1536 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.	F0656					
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain	F0684					

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F0684 SS = D	Continued from page 9 the highest practicable well-being for one of four sampled residents (Resident 1). * The facility failed to ensure the follow-up assessment, physician notification, and documentation were completed when Resident 1 had low pulse rate and poor oral intakes. These failures posed the risk of the resident not receiving the appropriate care and delay in the provision of care to the resident. Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised on 6/2017 showed the following: - the nurse will notify the resident's Attending Physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition; - a "significant change" of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention and impacts more than one area of the resident's health status; - prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form; and - the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Closed medical record review for Resident 1 was initiated on 10/9/25. Resident 1 was admitted to the facility on 9/5/25. Review of Resident 1's MDS assessment dated 9/9/25, showed Resident 1's BIMS score was 14 (cognitively intact).			F0684			

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F0684 SS = D	Continued from page 10 Review of Resident 1's H&P examination dated 9/10/25, showed Resident 1 had the capacity to understand and make decisions. a. According to AHA (American Heart Association) document titled Bradycardia: Slow Heart Rate revised on 9/25/24, showed bradycardia is a heart rate that is too slow, usually less than 60 beats per minute. Review of Resident 1's Admission and Baseline Care Plan dated 9/5/25, showed a blood pressure of 118/79 mmHg and pulse rate of 76 bpm (beats per minute). Review of Resident 1's Weights and Vital Summary for September 2025 showed the following pulse rate readings: - dated 9/9/25 at 0930 hours, the pulse rate was 55 bpm; - dated 9/9/25 at 1645 hours, the pulse rate was 50 bpm; and - dated 9/13/25 at 2026 hours, the pulse rate was 57 bpm. Review of Resident 1's medical records failed to show documentation if the follow up assessments were done and the physician was notified of the low pulse rate. On 10/9/25 at 1429 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 1's abnormal pulse rates dated 9/9 and 9/13/25, RN 1 verified Resident 1's medical record It failed to show the follow up assessments, interventions, notification of the physician, and documentation when Resident 1 had low pulse rate. RN 1 was asked what she considers a change in condition in a resident and RN 1 stated It could be abnormal vital signs, altered level of consciousness, weakness, skin problems, fall, increased pain, and any changes in resident's condition from his or her baseline. b. Review of Resident 1's Meal Intake from 8/5 to 9/12/25, showed the percentage of the meals eaten by Resident 1 on the following dates: - dated 9/13/25, breakfast = 0 - 25%, lunch = 26-50%,			F0684			

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F0684 SS = D	Continued from page 11 dinner = 26 - 50%; - dated 9/14/25, breakfast = 25 - 50%, lunch = 0-25%, dinner = 0 - 25%; - dated 9/15/25, breakfast = 0 - 25%, lunch = 0-25%, dinner was refused; - dated 9/16/25 breakfast = 0 - 25%, lunch = 0-25%, dinner = 51-75%; and - dated 9/17/25 breakfast = 0 - 25%, lunch = 0 - 25%, dinner = resident not available. On 10/10/25 at 0930 hours, a follow-up interview and concurrent medical record review was conducted with RN 1. Resident 1's meal intakes dated 9/13-9/17/25, was reviewed with RN 1 which showed decreased meal consumption with refusal. RN 1 verified there was no documented evidence if the follow up assessments, physician notification, change of condition evaluation, and care plan was developed when Resident 1 had poor meal intake. Furthermore, RN 1 stated the negative outcome would cause Resident 1's condition to decline because he was not consuming the appropriate nutrients. On 10/10/25 at 1100 hours, an interview and concurrent medical record review were conducted with CNA 1. CNA 1 verified Resident 1's poor meal intakes dated 9/13 to 9/17/25. CNA 1 stated Resident 1 became weaker, refused to participate with activities, and refused to get up in wheelchair after four to five days of admission. CNA 1 stated she reported Resident 1's change of condition including the significant decrease in meal intake to the charge nurses. On 10/10/25 at 1212 hours, a telephone interview was conducted with LVN 2. LVN 2 was asked what she would consider a change of condition, and stated fever, abnormal labs, decline in activities of daily living (ADL), new pain or increase pain, ALOC (altered level of consciousness), abnormal vital signs blood pressure below 100/60 mmHg or pulse rate below 60 bpm or above 90 bpm, and refusal of meals or below 25% meal consumption. LVN 2 stated the assigned licensed nurse must assess the resident, complete the change of condition evaluation, notify the physician, notify responsible party or family, initiate a care plan, add to the alert charting, and document the monitoring every shift for 72 hours. Furthermore, LVN 2 stated the negative outcome would be not being able to provide the	F0684					

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NAME OF PROVIDER OR SUPPLIER VILLA VALENCIA HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 25000 CALLE DE LOS CABALLEROS , LAGUNA HILLS, California, 92653			
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F0684 SS = D	Continued from page 12 appropriate quality care and monitoring for the resident's change of condition and resident's condition could become worse. On 10/10/25 at 1536 hours, an interview was conducted with the DON. The DON stated abnormal vital signs were not a significant change and not considered a COC (Change of Condition). The DON stated she did not expect her licensed nurses to do a follow up entry when there are abnormal vital signs and after providing interventions to reflect resident's current condition. The DON was asked how she would know when the resident's abnormal vital signs (pulse rate) improve if there were no follow up assessments and documentation of the outcome, the DON stated the nurses cannot document every hour since they had a lot of residents. The DON stated she considered a significant COC if the resident's meal intake was 0 - 25% consecutively with refusal for three to four days. The DON was informed and acknowledged the above findings.	F0684					
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880					

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F0880 SS = D	Continued from page 13 (I) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (II) When and to whom possible incidents of communicable disease or infections should be reported; (III) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to			F0880			

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F0880 SS = D	Continued from page 14 provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections for one of four sampled residents (Resident 3). * The facility failed to ensure CNA 3 wore the appropriate PPE when providing high-contact resident care for Resident 3. This failure had the potential to transmit communicable disease to other residents throughout the facility. Findings: Review of the facility's P&P titled EBP dated 6/20/24, showed the following: - EBP used in conjunction with the standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities and in situations of expected exposure to blood, body fluids, skin breakdown, or mucous membranes that provide opportunities for transfer of MDROs to staff hands and clothing reduce transmission; - facility staff shall post a "visual alert" by the resident's door indicating the high-contact resident care activities requiring the use of gowns and gloves for residents with the following criteria for the duration of a resident's stay in the facility or until resolution of the targeted criteria that placed them at higher risk like indwelling medical devices with or without secretions or excretions even if the resident is not known to be infected or colonized with a MDRO such as central lines, urinary catheters, feeding tube, and tracheostomies; - the facility shall provide required PPEs and alcohol-based hand rub (ABHR) readily available, and PPEs may be discreetly accessible to staff to use to help maintain a home-like environment as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities; and - facility staff shall perform hand hygiene and will don gown and gloves before performing the following high-contact resident care activities like dressing, bathing/showering/transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tube, tracheostomy or ventilator, and wound care on chronic wounds requiring a dressing.			F0880			

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NAME OF PROVIDER OR SUPPLIER VILLA VALENCIA HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 25000 CALLE DE LOS CABALLEROS , LAGUNA HILLS, California, 92653			
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F0880 SS = D	Continued from page 15 Medical record review for Resident 3 was initiated on 10/10/25. Resident 3 was admitted to the facility on 10/5/25. Review of Resident 3's Order Summary report showed a physician's order dated 10/6/25, for EBP related to the indwelling devices. Review of Resident 3's H&P examination dated 10/7/25, showed Resident 3 had the capacity to understand and make decisions. On 10/10/25 at 0855 hours, an observation of Resident 3 and concurrent interview was conducted with CNA 3. Resident 3's door had signage indicating the resident's roommate was on EBP. Upon entering Resident 3's room, CNA 3 was observed wearing only gloves and transferred Resident 3 to the wheelchair. CNA 3 stated he assisted Resident 3 with the morning care like brushing his teeth and transferring to the wheelchair in preparation for dialysis pick up. CNA 3 stated he was aware Resident 3 has dialysis and verified he wore only gloves. CNA 3 verified the signage outside the door showed Resident 3's roommate was on EBP and should have worn the proper PPE. On 10/10/25 at 0904 hours, an observation, interview and concurrent medical record review for Resident 3 was conducted with RN 3. RN 3 verified Resident 3 had a physician's order for EBP related to the indwelling device due to having a central line for dialysis access. RN 3 stated the EBP sign outside Resident 3's room should have shown Resident 3 was also on EBP per the physician's order. RN 3 stated the sign must be updated by the DSD because the DSD was responsible for checking and updating residents who have orders for EBP. RN 3 stated all the staff should don gowns and gloves during high-contact resident's care activities like morning care and transfers to prevent the spread of infection. On 10/10/25 at 1350 hours, an interview was conducted with the IP nurse. The IP nurse stated for any residents who have an order for EBP, all staff must wear gloves and gown when providing morning care and transferring the residents. In addition, the IP nurse stated she was responsible for placing the EBP signage and PPE carts with the help of her assistant.			F0880			

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F0880 SS = D	Continued from page 16 Furthermore, the IP nurse stated the negative outcome of the staff not following EBP would be spreading the staff's germs to the residents. On 10/10/25 at 1536 hours, an interview was conducted with the DON. The DON stated it was important for all the staff to follow the EBP to prevent direct caregiver transmission of any infection to the residents. The DON was informed and acknowledged the above findings.			F0880			
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: 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 accurate and complete for one of four sampled residents (Resident 2) and one nonsampled resident (Resident A) reviewed for grab rail use. * The facility failed to ensure the entrapment assessment of the grab rails were accurately completed for Residents 2 and A. This failure had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06, 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,			F0909			

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F0909 SS = D	Continued from page 17 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 Safety revised 12/2007 showed the following: - to try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches like inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks and review that gaps within the bed system are within the dimensions established by the FDA; and - the maintenance department shall provide a copy of inspections to the Administrator and report results to the QA Committee for appropriate action. Copies of the inspection results and QA Committee recommendations shall be maintained by the Administrator and/or Safety Committee. a. Medical record review for Resident 2 was initiated on 10/9/25. Resident 2 was admitted to the facility on 9/14/25, and readmitted on 9/27/25. Review of Resident 2's Order Summary report showed a physician's order dated 9/29/25, for the bilateral grab rail for ease and comfort in bed mobility, transfer, and repositioning as enabler every shift.			F0909			

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F0909 SS = D	Continued from page 18 Review of Resident 2's MDS assessment dated 9/30/25, showed Resident 2's BIMS score was 12, indicating moderate cognitive impairment. On 10/8/25 at 1117 hours, an observation of Resident 2's bed and concurrent interview was conducted with CNA 2. Resident 2 was not present in her room. Resident 2's bed had elevated halo style bilateral grab rails. CNA 2 stated Resident 2 used the bilateral grab rails to transfer. On 10/8/25 at 1125 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was awake, alert, and sitting up in wheelchair in the lobby. Resident 2 stated she used the grab rails from the bed to transfer to the wheelchair. b. Medical record review for Resident A was initiated on 10/10/25. Resident A was admitted to the facility on 9/8/25. Review of Resident A's H&P examination dated 9/10/25, showed Resident A had the capacity to understand and make decisions. Review of Resident A's Order Summary report showed a physician's order dated 9/12/25, for the bilateral grab rail for ease and comfort in bed mobility, transfer, and repositioning as enabler every shift. Review of Resident A's MDS assessment dated 9/14/25, showed Resident A's BIMS score was 15, indicating cognitively intact. On 10/10/25 at 1455 hours, an observation and concurrent interview was conducted with the DON. Resident A's bed had elevated bilateral grab rails. The DON verified the findings and stated Resident A would use the bilateral grab rails for bed mobility and during physical or occupational therapy treatments. On 10/10/25 at 1503 hours, an interview and concurrent facility document review was conducted with the Maintenance Supervisor.	F0909					

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F0909 SS = D	Continued from page 19 - Review of Resident 2's Bed Rail 7 Zones Entrapment Assessment dated 9/15/25, showed Zones 1 through 7 were marked pass. Further review of Resident 2's Bed Rail 7 Zones Entrapment Assessment showed must assess the entrapment for Zones 1, 3, 6, and 7. However, Zones 2, 4, and 5 should have been marked as not applicable (N/A). - Review of Resident A's Bed Rail 7 Zones Entrapment Assessment dated 9/12/25, showed Zones 1 through 7 were marked pass. Further review of Resident A's Bed Rail 7 Zones Entrapment Assessment showed must assess the entrapment for Zones 1, 2, 3, 6, and 7. However, Zones 4 and 5 should have been marked as not applicable (N/A). The Maintenance Supervisor stated he was responsible for completing the entrapment assessments of the grab rails after receiving the physician's order to apply the grab rails from the ADON. The Maintenance Supervisor stated he used the tape measure to measure the zones and referred to the FDA Bed System guide for entrapment. The Maintenance Supervisor was asked to explain how to measure Zone 5 using the facility's guide of Bed Rail 7 Zones Entrapment Assessment guide with photo of the zones. The Maintenance Supervisor stated for Zone 5, he measured from the top of the rail to the top of the mattress. The Maintenance Supervisor was informed the correct and accurate process to measure Zone 5 was to measure the length of between split bed rails, which both Residents 2 and A have bilateral upper grab rails only. The Maintenance Supervisor verified the above findings and stated the entrapment assessments were inaccurate. On 10/10/25 at 1536 hours, an interview was conducted with the DON. The DON was informed of Resident 2 and A's entrapment assessments, which all the zones were marked "pass." The DON stated at least the facility did more than it was supposed to assess. The DON verified the Maintenance Supervisor's assessments were inaccurate and verified the findings.			F0909			

This plan of correction constitutes the licensee's written credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is submitted as part of the statutory requirements set forth in the Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed under Federal and State Law.

F558

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 2 discharged to home on 10/30/2025 without negative impact to psychosocial well-being. Facility provided reasonable accommodation of residents needs with health and safety as a goal. No care issues identified during residents stay at the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 10/24/2025 an audit was conducted by the Director of Nursing (DON) to identify residents whose primary language is not English. These residents were assessed for their ability to communicate their needs and to determine if there is a need for an interpreter, communication boards, or other accommodations. No other residents affected by this deficiency.

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:

On 10/21/2025, the DON and designee re-educated the staff and direct caregivers regarding residents who do not primarily communicate in English to ensure the residents' needs are met via an interpreter, communication board, or other accommodations.

On 10/21/2025 the Administrator re-educated the staff during Monthly All Staff Meeting regarding the availability of translator services in the facility.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The Social Services Director (SSD) or their designee will conduct a weekly audit for the next three months of residents whose primary language is not English to ensure their needs are met, including but not limited to providing communication boards and interpreter services as needed. The SSD or their designee will report any findings at the stand-up meeting. Any issues identified will be corrected. The SSD or their designee will report any trends to the monthly Quality Assurance Performance Improvement Committee Meeting.

Completion Date 10/30/2025

F-656

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 3's care plan initiated on 10/6/2025, was reviewed and updated by the MDS Nurse on 10/17/2025. Apixaban side effect monitoring been ongoing thru Black Box Warning in MAR during daily med pass by Licensed Nurses.

How the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:

On 10/31/2025, MDS Nurse conducted audit of residents on Apixaban to ensure a care plan was in place that addressed the use of the medication. No other residents were affected by the deficient practice.

What measures will be put into place, or what systemic changes will the facility make to ensure that the deficient practice does not recur:

On 10/28/25 and 10/31/2025, the Director of Nursing Services re-educated the licensed nurses and MDS nurses on reviewing and updating care plans, including, but not limited to, the use of Apixaban.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The Medical Records Director (MRD)/designee will audit the care plans for all new admissions daily, Monday to Friday, for the next three months to ensure there is a care plan for Apixaban. The MRD/designee will report any findings to the DON for follow-up. Any issues identified will be corrected. The DON or their designee will report any findings/trends to the monthly Quality Assurance Performance Improvement Committee Meeting.

Completion Date: 10/31/25

F684

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 1 discharged 09/17/25.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 10/27/2025 residents on dialysis were reviewed by DON and ADON to ensure that any changes in condition, such as abnormal vital signs or meal refusals occurring three or more times, were reported to the attending physician. No other resident was affected.

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:

On 10/28/2025 and 10/31/2025, DON provided In Service to Licensed Nurse to re-educate on the following:

- 1) Abnormal Vital Signs(Pulse)- reassess resident for signs and symptoms of any significant decline then initiate a change of condition (COC) to include but not limited to reporting new onset of COC to physician and family AND monitoring of vital sign in a timely manner to include documentation of reassessment in the residents medical record.
- 2) Oral Intake/M meal Consumption- review residents usual meal intake and history of refusal of meals of 3 or more if any then initiate a change of condition (COC) if finding is significant to include but not limited to notification of Physician and family.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The ADON and or Designee with Medical Records will review the 24-hour report for any changes in condition to ensure the physician was notified. Any issues identified will be corrected. The DON or their designee will report any trends to the monthly Quality Assurance Performance Improvement Committee Meeting.

Completion Date: 10/31/25

F880

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 10/10/25, IP Nurse added a visual alert sign of Letter "A" to designate the resident on EBP.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

On 10/10/25, the IP nurse reviewed the surveillance log to ensure that any resident requiring EBP has the appropriate sign on the door. No other issues identified.

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:

On 10/27/2025, the DON re-educated the IP nurse and the nursing staff on EBP, including but not limited to, the residents' conditions that require EBP, and when to don PPEs during contact with residents on EBP and to provide visual alert sign by the door to designate the resident requiring EBP.

On 10/13/2025, the IP nurse provided an InService on Enhanced Barrier Precaution (EBP) to direct care staff especially to C.N.A. including but not limited to proper use of PPE during high contact activity i.e. when providing ADL's.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The IP and/or designee will conduct a random review of five (5) residents who require EBP to ensure the signage is installed correctly. Observation will be conducted weekly for the next three months to ensure staff are donning the appropriate PPE at the right time. Any issues identified will be corrected. The IP and/or designee will report any trends to the monthly Quality Assurance Performance Improvement Committee Meeting.

Completion Date: 10/31/25

F909

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident 2 discharged 10/30/25.

Resident A discharged 10/16/25.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

All residents who use the bedrails are affected. On 10/13/2025 the Maintenance Director (MD) and Designee inspected all residents' beds with bed rails to identify areas of possible entrapment and document the findings accordingly. No other resident affected by this deficiency.

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:

On 10/13/2025, the Administrator re-educated the Maintenance Director (MD) regarding the regular inspection of all bed frames, mattresses, and bed rails, if any, as part of the regular maintenance program to identify areas of possible entrapment. The MD will conduct the bed entrapment measurement/inspection every time a bed rail is installed on the bed. The results of the measurement/inspection will be submitted to the Administrator.

How the facility plans to monitor its performance to make sure that solutions are sustained:

The Administrator or their designee will conduct a random audit of the bed inspection log once a week for the next three months to ensure that bed inspections are performed according to schedule. The Administrator or designee will report any findings to the stand-up meeting. Any issues identified will be corrected. The Administrator or their designee will report any trends to the monthly Quality Assurance Performance Improvement Committee Meeting.

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