STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED survey for COMPLAINT Nos. CA00875821, CA00876545, and CA00876770. Inspection was limited to the specific complaints and did not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 46218, HFEN. FOR COMPLAINT NO. CA00875821: THE DEPARTMENT WAS ABLE TO PARTIALLY SUBSTANTIATE THE COMPLAINT ALLEGATION(S). FINDINGS WERE CITED AT F684 FOR RESIDENT 1. FOR COMPLAINT NO. CA00876545: THE DEPARTMENT WAS UNABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATION(S) AND FOUND NO VIOLATION OF THE REGULATIONS. FOR COMPLAINT NO. CA00876770: THE DEPARTMENT PARTIALLY SUBSTANTIATED THE COMPLAINT ALLEGATION(S) THAT CONSTITUTED NO VIOLATION OF THE REGULATIONS. GLOSSARY OF ABBREVIATIONS AND BRIEF DEFINITIONS: ADON - Assistant Director of Nursing Aspen collar - a device to help heal the neck by supporting the bones of the neck H&P - History and Physical LVN - Licensed Vocational Nurse	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/24/2024

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.

46128, ACCEPTED, 1/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 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
F 000	Continued From page 1 Odontoid fracture - a break in the second bone of the neck RN - Registered Nurse	F 000		
F 684 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 interview, medical record review, and facility document review, the facility failed to ensure one of the two sampled residents (Resident 1) was wearing an aspen collar when discharged to the acute care hospital. This had the potential to negatively affect resident's well-being and placed the resident at risk for further injury. Findings: Closed medical record review for Resident 1 was initiated on 12/27/23. Resident 1 was admitted to the facility on 12/1/23, and discharged to the acute care hospital on 12/19/23. Review of Resident 1's H&P evaluation dated 12/10/23, showed Resident 1 had a mechanical ground level fall resulting in the odontoid fracture. Review of Resident 1's Medicine Discharge	F 684	**How corrective action will be implemented for residents affected by the deficient practice** Resident was discharged from the facility on 12/19/2023. **How the facility will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with orders for an aspen collar had potential to be affected by this deficient practice. On 1/4/24, Medical Records Designee conducted an audit on current residents' records and identified no resident with order for aspen collar. ADON reviewed Medical Records Designee's findings and deemed accurate. LVN 1 and RN 1 were in-serviced by ADON on 1/2/24 regarding proper documentation during discharge process and on ensuring physician orders are being followed. On 1/10/24, all Licensed Nurses were in-serviced on facility's policy and procedures on proper documentation during discharge and transfers including accurate recording of devices such as aspen collar as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 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
F 684	Continued From page 2 Summary from the acute care hospital dated 12/2/23, showed Resident 1 was admitted for the mechanical fall and found to have the odontoid fracture; and the aspen collar was recommended. Resident 1's CT of C Spine without contrast dated 11/28/23, showed the fracture of the base of the odontoid process consistent with type II odontoid fracture; this fracture was considered unstable. Review of Resident 1's Order Summary Report showed a physician's order dated 12/1/23, for the aspen collar to be used on the neck most at all times every shift. Review of Resident 1's Transfer Form dated 12/19/23, Resident 1 was transferred to the acute care hospital for shortness of breath. Further review of Resident 1's Transfer Form did not indicate the resident had any devices, treatment, and risk alerts. Review of Resident 1's Progress Notes date 12/19/23, failed to show documented evidence Resident 1 had the aspen collar in place when discharged to the acute care hospital. Review of Resident 1's Hospitalist Medicine H&P examination dated 12/19/23, showed Resident 1 was just admitted in the acute care hospital after a fall resulting in the odontoid fracture, was placed in the aspen collar, and instructed to remain in the aspen collar. Further review of the document showed Resident 1 arrived without an aspen collar in place. On 12/28/23 at 1415 hours, an interview with LVN 1 was conducted. When asked if Resident 1 was wearing an aspen collar when discharged to the acute care hospital, LVN 1 was unable to recall if	F 684	**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Medical Records Director/Designee will conduct an audit to identify residents with aspen collar weekly for 60 days. ADON or Designee will review identified residents for documentation accuracy weekly for 60 days. Findings will be provided to the DON weekly to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained.** DON will share findings with the QAPI Committee monthly for 60 days. If compliance is not achieved, the QAPI committee will review systems and make appropriate modifications until compliance is met. **Date of Compliance** 1/10/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. BUILDING _____ B. WING _____	C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 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
F 684	Continued From page 3 Resident 1 was wearing an aspen collar when discharged to the acute care hospital. On 1/2/24 at 1133 hours, an interview with RN 1 was conducted. When asked if Resident 1 was wearing an aspen collar when discharged to the acute care hospital, RN 1 was unable to recall if Resident 1 was wearing the aspen collar when discharged to the acute care hospital. RN 1 acknowledged Resident 1 was supposed to have aspen collar all the time. On 1/2/24 at 1555 hours, an interview and concurrent closed record review was conducted with the ADON. The ADON verified Resident 1's closed medical record did not show documentation of Resident 1 wearing an aspen collar when discharged to the acute care hospital. The ADON acknowledged Resident 1 should be wearing an aspen collar when discharged to the acute care hospital.	F 684		