STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45560 Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of three sampled residents (Resident 1) attained and maintained her highest practicable physical well-being. * The facility failed to administer Resident 1's medications as ordered by the physician. This failure had the potential for Resident 1to not receive the appropriate care and services to treat her medical conditions. Findings: On 5/21/24 at 1015 hours, an interview was conducted with Resident 1's family member. Family Member 1 stated Resident 1 was discharged from the facility without aspirin (anti-platelet medication) and Apixaban (blood thinning medication). Medical Record review for Resident 1 was initiated on 5/21/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 1's diagnoses included DM, DVT, and May [NAME] Syndrome (a condition where blood vessels in the pelvis are compressed which disrupts blood flow and can lead to DVT). Review of Resident 1's Skilled Nursing Facility Transfer Orders from the acute care hospital dated 5/1/24, showed the following orders, under the sections titled New Medications and Changed Medications: - aspirin 325 mg tablet, give one tablet (325 mg total) by mouth one time each day - apixaban 2.5 mg tablet, give two tablets (5 mg total) by mouth two times a day a. Review of Resident 1's facility Order Summary Report dated 5/22/24,showed the following: - apixaban oral tablet 5 mg, give one tablet by mouth two times a day for DVT to LLE for seven days with the end date of 5/8/24. Review of Resident 1's MAR for May 2024 showed Resident 1 was administered with apixaban only from 5/1 to 5/8/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	05/21/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of Resident 1's Nursing Facility Transfer Order from the acute care hospital dated 5/1/24, failed to show an order to administer apixaban for seven days only. b. Review of Resident 1's Order Summary Report failed to show documented evidence the order received from the acute care hospital for aspirin 325 mg by mouth daily was entered on Resident 1's Skilled Nursing Facility Transfer Orders dated 5/1/24. Further review of Resident 1's MAR for May 2024 failed to show the resident was administered with aspirin 325 mg tablet while residing in the facility. Further review of Resident 1's medical record failed to show documented evidence to explain the reason why the apixaban had a stop date of seven days and aspirin was discontinued or not carried out. Review of Resident 1's Order Summary dated 5/22/24, showed an order to discharge Resident 1 on 5/10/24, with the current ordered medications. On 5/21/24 at 1510 hours, an interview and concurrentmedical record review was conducted with the DON. The DON acknowledged Resident 1 had an order for aspirin 325 mg tablet and they should have carried out from the acute care hospital list of medications ordered for the SNF admission orders. The DON reviewed the resident's order summary and was unable to locate the order for aspirin 325 mg and acknowledged the medication was not given to Resident 1 as ordered by the physician. On 5/21/24 at 1532 hours, an interview and concurrent medical record review was conducted with the Administrator. The Administrator acknowledged Resident 1's order for aspirin was not carried out and the apixaban was incorrectly entered to only be administered for sevendays when the actual physician's order did not have a timeframe to stop the apixaban medication.