STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43156 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure safeguarding of the controlled medications for Residents 3, 4, 5, and 6. This failure posed the risk for the diversion of the controlled medications. Findings: Review of the facility's P&P titled Medication Storage in the Facility dated 8/2014, under the section for Controlled Medication Storage, showed Schedule 11-V medications and other medications subject to abuse are stored in a separate area under double lock. If a key system is used, the medication nurse on duty maintains possession of the key to controlled medication storage areas. At each shift change, a physical inventory of all controlled medication, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. Review of the facility's Letter dated 8/20/24, showed the facility reported an unusual occurrence on 8/18/24, when the controlled medications were missing. Review of the facility's Conclusion Letter submitted on 8/26/24, showed the following controlled medications were missing: - Pregabalin (a controlled medication to treat nerve and muscle pain) 150 mg medication bubble pack containing two capsules and another Pregabalin bubble pack containing 46 capsules for Resident 6; - temazepam (a controlled medication used to aid sleep) 15 mg capsules medication bubble pack containing three tablets for Resident 3; - temazepam 15 mg capsules medication bubble pack containing one tablet for Resident 5; and - zolpidem tartrate (a controlled medication used to aid sleep) 5 mg medication bubble pack containing six tablets for Resident 4. (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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 0940 hours, a telephone interview was conducted with LVN 1. LVN 1 stated on 8/17/24 at 2345 hours, while LVN 2 was giving the medications using Medication Cart 3, she approached LVN 2 and asked for the keys for Medication Cart 2. LVN 1 stated LVN 2 pointed at Medication Cart 2 in the hallway and LVN 1 observed the keys were hanging from the controlled medication drawer of Medication Cart 2. LVN 1 stated she then proceeded and took a pain medication from Medication Cart 2. When she was done, she returned the keys back to LVN 2. LVN 1 stated she left the keys for Medication Cart 2 on top of Medication Cart 3 because LVN 2 was busy giving the medications and her hands were full. LVN 1 stated she did not borrow the keys for Medication Cart 2 again the rest of the night shift. LVN 1 acknowledged she should not leave the keys unattended and should have handed the keys to LVN 2. LVN 1 further stated on 8/18/24 at 0715 hours, during the shift change, she could not locate some of the residents' controlled medication bubble packs in Medication Cart 2. LVN 1 stated she recounted the controlled medications in Medication Cart 2 with LVN 2 and verified there were controlled medication bubble packs missing for Residents 3, 4, 5, and 6. LVN 1 stated she reported the missing controlled medications to RN 1 (morning shift), and they conducted a facility search. LVN 1 was asked about the facility's process to ensure proper accounting and safeguarding of controlled medications and other medications, LVN 1 stated the medication cart should always be locked. LVN 1 stated controlled medication reconciliation must be done by the incoming and outgoing shift nurses using the Controlled Narcotic Count Book. The licensed nurse failed to secure the key to Medication Cart 2, not leaving it hanging or on top of the medication cart unattended. Further review of the facility's Conclusion Letter submitted on 8/26/24, showed after the facility's thorough review of the inventory records and internal process, the facility unfortunately was unable to reconcile the missing medications from Medication Cart 2 for Residents 3, 4, 5, and 6. On 8/29/24 at 1440 hours, an interview was conducted with the DON. The DON was asked regarding the facility's policy to secure medications, including controlled medications. The DON stated all controlled medications were stored in a double lock drawer inside the medication cart and the medication nurse on duty would keep the key to controlled medication storage. The DON stated accounting of all narcotic and controlled medications must be conducted by two licensed nurses at each shift. The DON verified the facility failed to ensure proper accounting and safeguarding of the controlled medications for Residents 3, 4, 5, and 6.