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	10/17/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the necessary pharmacy services were provided to one of three sampled residents (Residents 1). * The facility failed to ensure the Geodon medication administered to Resident 1 was not from another resident's Geodon medication vial. In addition, the facility failed to ensure the discontinued Geodon medication was kept in the designated area to be disposed. These failures had the potential to cause unsafe administration and handling/storage of the residents' medications. Findings: Review of the facility's P&P titled Storage of Medications dated on 4/2008 showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The P&P further showed except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. Review of the facility's P&P titled Medication Administration - General Guidelines dated 10/2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by the persons legally authorized to do so. Medication supplied for one resident are never administered to another resident. Medical record review for Resident 1 was initiated on 10/16/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/10/24, showed Resident 1 hadthe mental capacity to make medical decisions. Review of Resident 1's IDT Note dated 10/14/24 at 1506 hours, showed a follow-up IDT meeting was conducted. The note showed on 8/31/24 at 2030-2100 hours, the LVN noted Resident 1 was screaming loudly, attempting to go her roommate area, not listening to the staff, and refused to go back to bed. The LVN notified the NP and received an order to administer Geodon IM medication. The note further showed Resident 1 received the Geodon IM medication. (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 1525 hours, an interview with the DON was conducted. The DON acknowledged Resident 1 was administered Geodon IM as a one-time dose ordered by the NP. The DON verified the Geodon medication was not available in the medication e-kit and the Geodon medication administered to Resident 1 was stored in the IP's office, which was originally ordered for another resident and had been discontinued. The DON stated the medications for disposal were kept in the medication room and stated it should not have been kept in the IP's office. On 10/17/24 at 1252 hours, a telephone interview with the IP was conducted. The IP acknowledged she stored one Geodon vial in her office. The IP stated she was supposed to dispose the Geodon vial since the medication was for another resident and had been discontinued; however, the IP stated she forgot to dispose of the medication. The IP stated discontinued medications were disposed in the waste disposal bin that kept in the medication room. The IP verified the Geodon vial should not have been stored in her office and was not properly disposed as per the facility'sP&P. On 10/17/24 at 1700 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Resident 1) was properly monitored as evidenced by: * The facility failed to ensure the order for Resident 1's Geodon (antipsychotic medication) was transcribed and documented after obtaining the verbal order from the NP. * The facility failed to ensure the consent for the use of Geodon medication was obtained from Resident 1's conservator. * The facility failed to ensure the administration of the Geodon medication and the side effects monitoring were documented in Resident 1's MAR. * The facility failed to ensure a care plan was initiated to address Resident 1's Geodon medication use. These failures had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Physician Orders revised 11/2022 showed the licensed nurse receiving the telephone or verbal order will transcribe the order in the resident'smedical record at the time the other order is taken. The P&P further showed the documentation pertaining to the physician's orders will be maintained in the resident's medical record. Review of the facility's P&P titled Medication Administration-General Guidelines dated 10/2017 showed when PRN (as needed) medications are administered, the following documentation is provided: a. Date and time of administration, medication, dose, route of administration (if other than oral), and, if applicable, the injection site. b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication. Medical record review for Resident 1 was initiated on 10/16/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/10/24, showed Resident 1 has the mental capacity to make medical decisions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Face Sheet showed the resident was under the care of a conservator (an appointed guardian or protector assigned by a judge who makes decisions for the person who is unable to). Review of Resident 1's IDT Note dated 10/14/24 at 1506 hours, showed a follow-up IDT meeting was conducted. The note showed on 8/31/24 at 2030-2100 hours, the LVN noted Resident 1 was screaming loudly, attempting to go her roommate area, not listening to the staff, and refusing to go back to bed. The LVN notified the NP and received an order to administer Geodon IM medication. The note further showed Resident 1 received the Geodon IM medication. * Review of Resident 1's Order Summary Report for August and September 2024 showed no documented evidence the Geodon medication was ordered. * Review of Resident 1's medical record failed to show the informed consent was obtained from Resident 1's conservator prior to the administration of the Geodon medication. * Review of Resident 1's MAR for August and September 2024, showed no documented evidence of the Geodon medication administration and medication side effects monitoring post medication administration. * Review of Resident 1's Care Plans and Progress Notes showed no documented evidence a care plan problem was initiated to address Resident 1's new order of Geodon medication On 10/17/24 at 1327 hours, a telephone interview was conducted with LVN 1. LVN 1 stated Resident 1 was able to make her needs known. LVN 1 stated on 9/1/24 during 11-7 shift (2300 to 0700 hours), the RN spoke with the NP and obtained a telephone order for Geodon. LVN 1 verified she did not document the new medication order, side effects monitoring, obtained a consent from the conservator, or initiated a care plan. LVN 1 stated she thought the RN was going to work on it while she continued with the medication pass. LVN 1 stated documentation of the medication use and side effects would allow the staff to monitor for adverse side effects and monitor if the medication was effective or not. LVN 1 further stated Resident 1 had a conservator as her responsible party and medications like Geodon would need a consent prior to administering the medication. On 10/17/24 at 1525 hours, an interview with the DON was conducted. The DON acknowledged Resident 1 was administered Geodon IM as a one-time dose ordered by the NP. The DON verified the staff did not enter the telephone order for Geodon prescribed by the NP. The DON further verified there were no documentation of side effect monitoring, documentation, informed consent, or care plan for the new Geodon medication order. The DON stated he expected the license nurses to transcribe the orders given by the prescriber, document, obtain consent, and initiate care plan. On 10/17/24 at 1542 hours, a telephone interview was conducted with the NP. The NP verified he spoke with a nurse on 9/1/24 during the 11-7 shift and gave a telephone order to administer Geodon 10 mg IM for one time dose for Resident 1. The NP stated he gave the orders and expected the nurses to enter the order and document. On 10/17/24 at 1700 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.