STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055575	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Haven Subacute and Healthcare Center	12072 Trask Ave. Garden Grove, CA 92843

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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, facility document review, and facility P&P review, the facility failed to ensure the RNs were properly trained on the administration and preparation of IV medications, as evidenced by: * The Nursing Skills Competency Skills Checklist for the RNs did not include the reconstitution (process of adding specific amount and type of sterile liquid to a powered medication to create a usable solution for IV administration) of an IV medication. * RN 3 did not receive training on the administration of medications containing amphotericin B (powerful antifungal medication used to treat serious, potentially life-threatening fungal infections). In addition, RN 3 did not research information about the amphotericin B liposomal or Amphotericin B medications, prior to administering the medication for the first time. This failure resulted in a medication error and contributed to the death of Resident 1.Findings: a. Review of the facility's P&P titled Intravenous Therapy dated 2/2020 showed it is the policy of the facility to provide the administration of intravenous fluids and medications according to the physician's orders. Under the Procedures section, it showed to prepare the IV medications or IV fluids according to the pharmacy instructions. Review of the Nursing Comprehensive Clinical Competency Review Skills Checklist for RN 3 dated [DATE], did not show if RN 3 was trained or signed off as competent with the reconstitution of IV medications. In addition, the Nursing Comprehensive Clinical Competency Review Skills Checklist used for the RNs in the facility did not include the reconstitution of IV medications as one of the competencies the RNs must be trained and/or competent with. b. Review of the manufacture's package insert for the amphotericin B (NDC 36822-1055-5; medication delivered by the pharmacy), received from Pharmacy 1, showed to exercise caution to prevent inadvertent amphotericin B for injection overdose, which can result in potentially fatal cardiac or cardiopulmonary arrest. The package insert showed under the Dosage and Administration section: CAUTION: Under no circumstances should a total daily dose of 1.5 mg/kg be exceeded. In addition, the package insert showed amphotericin B should be administered under close clinical observation by medically trained personnel. Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and expired at the facility on [DATE]. Review of Resident 1's Acute Care Hospital Discharge Summary Notes dated [DATE], showed Resident 1 had diagnoses including mucormycosis (severe, invasive fungal infection caused by molds from the mucormycetes group) and respiratory failure. The discharge summary notes also showed the resident had a tracheostomy (surgical procedure that creates an opening in the neck and into the windpipe to allow a tube to be inserted for breathing) and was ventilator dependent (requires mechanical ventilation). Under the Infectious Disease section of the discharge summary notes showed Resident 1 was to receive AmBisome 5 mg/kg medication until [DATE]. Review of Resident 1's Physician's Order dated [DATE] at 1921 hours, showed to administer amphotericin B liposomal (AmBisome - brand name) 350 mg in dextrose (sterile solution used to provide the body with extra water and carbohydrates) 5 % 250 ml IV at 125 ml/hr and to be given over two hours one time for mucormycosis. Review of Pharmacy 1's Proof of Prescription Delivery (undated) showed on [DATE] at 2052 hours, seven vials of amphotericin B 50 mg were received by RN 3. Review of the facility's log of pharmacy deliveries for [DATE] showed on [DATE] at 2052 hours, the amphotericin B 50 mg Vial and dextrose 5 %-water IV solution (solution for the amphotericin medication to be mixed in) was delivered to RN 3. Review of Resident 1's IV MAR for [DATE] showed the amphotericin B liposomal (AmBisome) 350 mg in dextrose 5% 250 ml IV was administered to Resident 1 on [DATE] at 0038 hours, by RN 3. On [DATE] at 1450 hours, an interview and concurrent closed medical record review was conducted with RN 3. When RN 3 was shown Resident 1's physician's order for the amphotericin B liposome (AmBisome) on the IV MAR, RN 3 verified he administered the amphotericin B that was delivered by Pharmacy 1 and not the amphotericin B liposomal (AmBisome) that was ordered by the physician. RN 3 verified this was the first time he had ever given the amphotericin B medication and did not realize there was a difference between the two medications. RN 3 stated the verbiage on the packaging of the amphotericin B he received from Pharmacy 1 did not match the verbiage on the resident's physician's order written on the IV MAR. RN 3 stated the labeling on the outside of the amphotericin B packaging delivered by Pharmacy 1 showed in red font: Amphotericin B should not be given at dosages greater than 1.5mg/kg. Resident 1's weight was 69.5 kg. RN 3 stated he did not double check and compare the dosage warnings on the amphotericin B packaging against the resident's physician's order on the IV MAR. RN 3 stated he did not research the medication prior to administering it to

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F 0755 Level of Harm - 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. (continued on next page)

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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 0755 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to provide the pharmaceutical services to ensure the accurate medication dispensing and administration for one of three sampled residents (Resident 1) as evidenced by: * Pharmacy 1 dispensed 350 mg of amphotericin B (powerful antifungal medication used to treat serious, potentially life-threatening fungal infections), instead of 350 mg of amphotericin B liposome (a different formulation of amphotericin B with different dosing requirements) as ordered by Resident 1's physician. * Pharmacy 1 dispensed a 250 ml bag of D5W (intravenous solution of 5% dextrose in water), which was intended for use with the amphotericin B liposomal (AmBisome). However, amphotericin B was dispensed in error and would have required 3500 ml for the medication to be reconstituted properly to the correct concentration. * Resident 1 received the amphotericin B 350 mg via IV infusion at a rate 2-3 times the recommended rate of administration. These failures resulted in Resident 1 receiving three times the maximum dose of amphotericin B, at a rate 2-3 times the recommended rate of administration, and at a concentration higher than the manufacturer's recommended dosage, which resulted in a medication error and contributed to the death of Resident 1.Findings: Review of the facility's P&P titled Intravenous Therapy dated 2/2020 showed it is the policy of the facility to provide intravenous fluids and medications according to the physician orders. Additionally, the P&P showed to follow the five rights of medication administration. Review of the manufacture's package insert for the amphotericin B (NDC 36822-1055-5; medication delivered by the pharmacy), received from Pharmacy 1, showed to exercise caution to prevent inadvertent amphotericin B for injection overdose, which can result in potentially fatal cardiac or cardiopulmonary arrest. The package insert showed under the Dosage and Administration section: CAUTION: Under no circumstances should a total daily dose of 1.5 mg/kg be exceeded and the intravenous infusion should be given over a period of approximately 2-6 hours. Rapid intravenous infusion has been associated with hypotension (low blood pressure), hypokalemia (low levels of potassium in the blood), arrythmias (abnormal heart rhythm, which could lead to sudden cardiac arrest) and shock (a life-threatening medical condition that occurs when the body's organs and tissues do not receive enough blood flow and oxygen) and should, therefore, be avoided. In addition, the package insert showed that the amphotericin B medication should be administered under close clinical observation by medically trained personnel. On [DATE], CDPH, L&C Program received a complaint from Family Member 1 alleging Pharmacy 1 dispensed the amphotericin B medication that was different from Resident 1's discharge order from Acute Care Hospital 1. Family Member 1 alleged on [DATE], amphotericin B (NDC 39822-1055-05) was ordered by Resident 1's physician and at approximately 2300 hours on [DATE], the amphotericin B medication was delivered to the facility. The licensed nurse then administered the medication to the resident, however, shortly after the infusion began, Resident 1's condition rapidly deteriorated and passed away shortly after. Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and expired at the facility on [DATE]. Review of Resident 1's Acute Care Hospital Discharge Summary Notes dated [DATE], showed Resident 1 had diagnoses including mucormycosis and respiratory failure. The discharge summary notes also showed the resident had a tracheostomy and was ventilator dependent (requires mechanical ventilation). Under the Infectious Disease section of the discharge summary notes showed Resident 1 was to receive the AmBisome 5 mg/kg medication until [DATE]. Review of Resident 1's Physician's Order dated [DATE] at 1921 hours, showed to administer amphotericin B liposomal (AmBisome - brand name) 350 mg in dextrose (sterile solution used to provide the body with extra water and carbohydrates) 5 % 250 ml IV at 125 ml/hr and to be given over two hours one time for mucormycosis. Review of Pharmacy 1's Proof of Prescription Delivery (undated) showed on [DATE] at 2052 hours, seven vials of amphotericin B 50 mg were received by RN 3. Review of the facility's log of pharmacy deliveries for [DATE] showed on [DATE] at 2052 hours, the amphotericin B 50 mg medication and dextrose 5 % water IV solution (solution for the amphotericin medication to be mixed in) was delivered to RN 3. Review of Resident 1's IV MAR for [DATE] showed the amphotericin B liposomal (AmBisome) 350 mg in dextrose 5% 250 ml IV was administered to Resident 1 on [DATE] at 0038 hours, by RN 3. Review of Resident 1's nursing progress notes effective [DATE] at 0420 hours and created on [DATE] at 0648 hours by RN 3, showed the CNA entered Resident 1's room to take the resident's 0400 hours vital signs and found Resident 1 without a palpable pulse. Additionally Resident 1's progress notes showed CPR was initiated, 911 was called, and