STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055984	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Healthcare Center, LLC	501 South Beach Blvd. Anaheim, CA 92804

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** 36872 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident was free from the medication errors for one of five sampled residents (Residents 5). * The facility failed to provide the correct insulin medication to Resident 5 as ordered. This failure had the potential to negatively affect the resident's health. Findings: Review of the facility's P&P titled Medication Errors revised 12/19/22, showed the following: - medication error means the observed or identified preparation or administration of a medication or biologicals which is not in accordance with the physicians' order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication and biological; or accepted professional standards and principles which apply to professionals providing the services - the facility shall ensure medications will be administered as follows: a. according to the physician's orders; b. per manufacturer's specification regarding the preparation, and administration of the drug or biological; and c. in accordance with the accepted standards and principles which apply to professionals providing the services. - to prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. right medication, dose, route, and time of administration; and b. right resident and right documentation. (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: 055984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER: Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 South Beach Blvd. Anaheim, CA 92804	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 1255 hours, an interview was conducted with Resident 5. Resident 5 stated on the morning of 4/29/24 around 0800 hours, the nurse handed her the lispro pen insulin injection instead the glargine pen. Resident 5 stated she checked and noticed it was a wrong insulin pen. Resident 5 stated she asked the nurse, and it seemed like the nurse did not understand, then she asked the nurse to check with the supervisor. Resident 5 further stated a few minutes later, the supervisor and nurse came back with the glargine insulin pen injection. Resident 5 stated what if she was asleep, the nurse might have given her the wrong medication. Medical record review for Resident 5 was initiated on 5/7/24. Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnosis included diabetes. Review of Resident 5's H&P evaluation dated 12/7/23, showed Resident 5 had the capacity to understand and make decisions. Review of Resident 5's Initial Self Administration of Medication evaluation dated 1/26/24, showed Resident 5 was capable of safe self-administration of the medications and the charge nurse was to prepare the medication and the resident was to administer to herself. Review of Resident 5's Annual Self Administration of Medication evaluation dated 4/2/24, showed Resident 5 was capable of self-administration of the medications. Review of Resident 5's MAR for April 2024 showed a physician's order to administer the following medications as scheduled: - insulin glargine (long-acting insulin medication) subcutaneous solution 100 units/ml, inject 62 units subcutaneously daily at 0800 hours; and - insulin lispro (short-acting insulin medication) subcutaneous solution pen-injector 200 units/ml, inject per sliding scale subcutaneously before meals at 0630, 1100, and 1600 hours. Review of Resident 5's SBAR Communication Form dated 4/29/24, showed the charge nurse handed the insulin pen injection to Resident 5 when Resident 5 checked the insulin pen, Resident 5 noticed she was given lispro pen insulin injection instead of the glargine pen. Resident 5 asked the charge nurse to double check the insulin medication. The SBAR form further showed the orders and medication were double checked. Resident 5 was supposed to receive the insulin glargine insulin pen injection. On 5/7/24 at 1130 hours, an interview was conducted with RN 1. RN 1 stated on 4/29/24 around 0800 hours, while preparing the medication for Resident 5 and checking the orders, RN 1 stated she was holding the two insulin pens in her hand. RN 1 stated she did not know how she brought the lispro pen insulin injection instead of glargine pen and handed the lispro pen to Resident 5. RN 1 acknowledged Resident 5 told her it was the lispro pen, a wrong medication. RN 1 stated she notified the supervisor and they both checked the order and explained it to Resident 5. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 0903 hours, an interview and concurrent medical record review was conducted with the RN 2. RN 2 stated on 4/29/24 at around 0830 to 0900 hours, RN 1 reported she handed the wrong insulin pen to Resident 5. RN 2 reviewed Resident 5's physician orders and verified the Resident 5 had an order for insulin glargine (long-acting insulin), to inject 62 units subcutaneously daily and an order for insulin lispro (rapid-acting insulin), to administer 1 to 12 units depending on the sliding scale coverage. RN 2 stated she double checked the insulin orders and went to see Resident 5 with RN 1. RN 2 further stated Resident 5 was upset. On 5/8/24 at 1420 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged RN 1 gave the wrong insulin pen to Resident 5 and the DON stated it should not had happened.