

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2025
NAME OF PROVIDER OR SUPPLIER  Garden Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  12882 Shackelford Lane Garden Grove, CA 92841	

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)
<p>F 0760</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941</b></p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of four sampled residents (Resident 1) was free from the significant medication errors.</p> <p>* The facility failed to administer Resident 1's ketotifen (an antiallergic medication to help prevent asthma attacks) as ordered by Resident 1's physician. This failure had the potential to negatively affect the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Medication Administration revised 4/2025 showed the medications shall be administered as prescribed by the resident's physician.</p> <p>Medical record review for Resident 1 was initiated on 4/15/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 1's MDS assessment dated [DATE], showed the resident was cognitively intact.</p> <p>Review of Resident 1's Order Summary Report showed a physician's order dated 12/6/24, for Resident 1 to have ketotifen 1 mg capsules, give two capsules two times a day for chronic urticaria for five months.</p> <p>Review of Resident 1's MAR for April 2025 showed 9 (other/see progress note) and the nurses' initial for the ketotifen oral capsules administration on 4/14/25 at 0900 and 1700 hours, and 4/15/25 at 0900 hours.</p> <p>On 4/15/25 at 0917 hours, a concurrent interview and medical record review was conducted with the DON and RN 1. RN 1 stated the Ketotifen medication was not re-ordered in time. Review of the MAR showed Resident 1 did not receive the ketotifen medication on 4/14 and 4/15/25. The DON verified the above findings.</p>

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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