STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056145	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Grove Post Acute	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of four sampled residents (Resident1) was free from the unnecessary medications. * Resident 1 was administered Ozempic (medication used to manage type 2 diabetes) one mg subcutaneously (beneath the skin) for DM. However, Resident 1 had no diagnosis of DM. In addition, the facility failed to ensure Resident 1's plan of care addressed the use of the Ozempic medication and monitored the side effects of the medication. * Resident 1 was administered oxycodone (used to relieve severe pain) 10 mg medication when Resident 1's pain level was below the parameters ordered for the medication. These failures had the potential for Resident 1 to receive unnecessary medications and experience adverse effects from the medications. Findings: Review of the facility's P&P titled Medication Administration revised 4/2025 showed it is the policy of the facility that medications for residents be administrated in a safe manner and as prescribed. Medical record review for Resident 1 was initiated on 5/7/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. a. Review of Resident 1's H&P examination dated 1/5/21, showed the resident had no diagnosis of diabetes mellitus (DM). Review of Resident 1's Order Summary Report showed a physician's order dated 1/24/25, to administer Ozempic one mg/dose subcutaneously every evening shift on Wednesdays for DM. Review of Resident 1's MAR for April 2025 showed Resident 1 was administered the Ozempic medication on 4/2, 4/9, 4/16, 4/23, and 4/30/25. Review of Resident 1's General Lab Work dated 4/14/25, showed Resident 1's hemoglobin A1c level was 5. 2, indicating normal or non-diabetic range. (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's medical record failed to show a care plan problem addressing Resident 1's use of the Ozempic medication and the monitoring of the side effects for the use of the medication. On 5/8/25 at 1250 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 1 had no diagnosis of DM and there was no care plan and monitoring for the use of the Ozempic medication. Furthermore, the ADON stated she was not sure if the Ozempic medication was clarified with the resident's physician. b. Review of Resident 1's Order Summary Report showed a physician's order dated 7/8/21, to administer oxycodone 10 mg one tablet as needed for severe pain (equal to the pain level of 7-10 on the pain scale of 0 to 10 with 0 = no pain and 10 = worst pain). Review of Resident 1's MAR for April 2025 showed Resident 1 was administered the oxycodone 10 mg medication on the following dates, times, and pain levels: - On 4/1/25 at 1804 hours, for a pain level of 0. - On 4/7/25 at 1218 hours, for a pain level of 6. - On 4/14/25 at 1345 hours, for a pain level 6. - On 4/22/25 at 1818 hours, for a pain level of 0. - On 4/25/25 at 1115 and 1730 hours, for a pain level of 0. Review of Resident 1's MAR for May 2025 showed Resident 1 was administered the oxycodone 10 mg medication on the following dates, times, and pain levels: - On 5/2/25 at 1703 hours, for a pain level of 6. - On 5/5/25 at 1314 hours, for a pain level of 6 - On 5/6/25 at 1802 hours, for a pain level of 0. On 5/8/25 at 1250 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the above findings. The ADON verified 0 documented in the MAR meant the resident had no pain. The ADON stated the oxycodone medication should not be given when the resident had no pain. Furthermore, the ADON stated the oxycodone medication should be given as prescribed by the physician. On 5/8/25 at 1445 hours, the Administrator was informed and 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 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 48844 Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper safe storage of drugs for one of four sampled residents (Resident 2). * LVN 1 left a medication inside a clear cup unattended on Resident 2's bedside table. This failure posed the risk of other residents, visitors or unauthorized facility staff gaining access to the medication. Findings: Review of the facility's P&P titled Medication Administration revised 4/2025 showed it is the policy of the facility that medications for residents be administrated in a safe manner. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the nurse will continue the medication pass and return later. After completing the medication pass, the nurse will return to the missed resident to administer the medication. On 5/7/25 at 0830 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 2's bedside. A white tablet inside an unlabeled clear cup was observed on top of Resident 2's bedside table. LVN 1 was then observed entering Resident 2's room to administer his medications. LVN 1 verified the white tablet inside the unlabeled clear cup on Resident 2's bedside table. LVN 1 stated the medication should not have been left on the resident's bedside table. Furthermore, LVN 1 stated the resident could not administer the medication himself and she should have taken the medication back and administered it when Resident 2 was ready. On 5/8/25 at 1250 hours, an interview was conducted with the ADON. The ADON was informed of the above findings. The ADON stated the medication should not have been left on the resident's bedside table. If the licensed nurse was unable to administer the medication, the licensed nurse should come back when the resident was ready and administer the medication.