

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Pacific Palms Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Termino Avenue Long Beach, CA 90804	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility did not adequately provide pharmaceutical services to meet the needs of both sampled residents (Resident 1 and Resident 2) by failing to:</p> <p>a. Follow the order as prescribed when the physician discontinued a Hydrocodone-Acetaminophen (used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated) 10-325miligram (mg-unit dose) and ordered 5-325mg dose for Resident 1.</p> <p>b. Follow the facility's policy requiring the controlled substances to be stored in the medication room in a locked container, separate from non-controlled medications. Instead, a bottle of Lorazepam Intensol (knowns as Ativan, is used to treat anxiety disorders) for Resident 2 was found stored unlocked in the refrigerator.</p> <p>c. Properly dispose of the discontinued narcotic medication from the refrigerator for Resident 2.</p> <p>These failures had the potential to result in unmet needs of residents, misuse, or diversion of controlled substances.</p> <p>Findings:</p> <p>a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/13/2025 with diagnoses including low back pain (discomfort in the lower part of your back) and difficulty in walking.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/20/2025, indicated Resident 1 was cognitively (functions your brain uses to think, pay attention, process information, and remember things) intact. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, persona hygiene, maximal assistance (helper does more than half the effort to complete task) with toileting hygiene, showing, upper body dressing, lower body dressing, and was dependent (helper does all of the effort) with putting on/taking off footwear.</p> <p>(continued on next page)</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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Order Summary Report (OSR), as of 6/6/2025, indicated an order to give one tablet of Hydrocodone-Acetaminophen 5-325mg by mouth every six hours as needed for moderate to severe pain 4-10/10(o means no pain and 10 means the worst pain imaginable), hold if respiratory rate is less than 12 per minute(/m), and not to exceed three grams acetaminophen in 24 hours.</p> <p>During a review of Resident 1's narcotic and hypnotic record (narcotic log) for Hydrocodone-Acetaminophen 10-325mg, dated from 5/19/25, to 6/5/2025, it was indicated that a total of 22 doses of Hydrocodone-Acetaminophen 10-325mg were dispensed during this period for Resident 1.</p> <p>During a concurrent observation and interview on 6/6/2025 at 11:55 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that staff retrieved the 10-325mg tablets to administer the ordered dose of Hydrocodone-Acetaminophen 5-325mg. He was uncertain whether the entire 10-325mg tablet was administered or if the tablets were cut, as there was no documentation indicating the tablets were split, nor that the unused portions were properly discarded each time. LVN 2 also mentioned that the medication could not be cut. He stated that there had been a discrepancy between the physician's order and medication available and being pulled for administration for the past few weeks.</p> <p>During an interview on 6/6/2025 at 2:00 p.m. with Resident 1, Resident 1 stated that she had taken the whole table of Hydrocodone-Acetaminophen without cutting it, including the day before the observation.</p> <p>During an interview on 6/6/2025 at 4:12 p.m., the Director of Nursing stated that staff must follow physicians' orders for residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, administering pain medications, revised 10/2010, the P&P indicated that staff have to administer pain medications as ordered, document the following in the resident's medical record: medication and dose. The P&P also indicated that residents are not at risk for addition to narcotic analgesics if used as prescribed for moderate to severe pain.</p> <p>b. During a concurrent observation and interview conducted on 6/6/2025, at 10:35 a.m. with the Assistant Director of Nursing (ADON) in the East medication room, a narcotic container labeled 'Narcotic only' was observed in an unlocked refrigerator. Inside, there was one unopened 30 milliliter (ml-unit dose) bottle of Lorazepam Intensol for Resident 2. The ADON stated that they believed it was unnecessary to lock the narcotic container since the refrigerator itself was locked.</p> <p>During an interview on 6/6/2025 at 2:30 p.m., Licensed Vocational Nurse (LVN) 1 stated that Lorazepam Intensol, a controlled narcotic medication, requires a lock to limit access to assigned staff, preventing theft.</p> <p>During an interview on 6/6/ 2025, at 4:12 p.m. with the Director of Nursing (DON), the DON stated that staff should lock the narcotic medication cart or container because the medications are controlled substances.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 12/2012, the P&P indicated that controlled substances must be stored in the medication room in a locked container separate from containers for any non-controlled medications. This container must always remain locked, except when it is accessed to obtain medications for residents. The P&P also stated that the charge nurse on duty will maintain the keys to controlled substance containers.</p> <p>c. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 2/28/2022 and readmitted on [DATE] with diagnoses including functional quadriplegia (someone is completely unable to move their arms and legs, not because of a spinal cord injury, but because of a severe medical condition that makes it impossible for them to move or control their body) and encounter for palliative care (specialized care that focuses on improving the quality of life for people facing serious illness, both physically and emotionally).</p> <p>During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 5/6/2025, indicated, Resident 2's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was severely impaired. The MDS indicated,</p> <p>Resident 2 was dependent with oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/ taking off footwear and personal hygiene.</p> <p>During a review of Resident 2's Order Summary Report, dated 11/6/2024, the Order Summary Report indicated an order to give Lorazepam oral concentrate 0.25milliliter (ml-unit dose) by mouth every four hours as needed for anxiety manifested by agitation, restlessness for 14 days and the physician discontinued the Lorazepam order on 11/12/2024.</p> <p>During a concurrent observation and interview on 6/6/2025 at 10:35 a.m. with the Assistant Director of Nursing (ADON) in the East Medication room, one unopened 30ml bottle of Lorazepam Intensol was observed in the refrigerator for Resident 2.</p> <p>During a concurrent interview and record review on 6/6/2025 at 2:30 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's Order Summary, as of 6/6/2025 was reviewed. LVN 1 stated that the physician discontinued the lorazepam order in November 2024 and leaving no active order for Resident 2. LVN 1 stated that staff should have removed the lorazepam when it was discontinued six months ago.</p> <p>During an interview on 6/6/2025 at 4:12 p.m. The Director of Nursing (DON) stated that when a narcotic is discontinued, it should be properly removed from the premises to prevent it from being accidentally administered to a resident.</p> <p>During a review of the facility's P&P titled, Discarding and Destroying medications, revised 10/2014, the P&P indicated all unused controlled substances shall be retained in a securely locked are with restricted access until disposed of.</p> <p>During a review of the facility's P&P titled, Disposal of medications, syringes, and needleless, undated, the P&P indicated that unused doses of controlled substances wasted for any reason should be destroyed.</p>		