STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056362	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Verde Post Acute Care Center	661 Center Street Costa Mesa, CA 92627

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the medications were not stored at the bedside for two of two sampled residents (Residents1 and 2) and one nonsampled resident (Resident D). * Resident 2's bubble pack of metformin (medication to treat diabetes) medication was found hidden in Resident 1's closet for 10 days. * Resident D's side table drawer had a medication cup filled with thick white cream and a tongue depressor. These failures had the potential to result in the unauthorized access to the medications and impact the residents' safety. Findings: Review of the facility's P&P review titled Medication Storage in the Facility revised 1/2025 showed the following: a. Medication and biologicals are stored safely, securely, and properly, following manufacture's guidelines or those of the supplier. The medical supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. b. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. 1.a. Medical record review for Resident 1 was initiated on 4/16/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 1 had a diagnosis of DM Type 2. Review of Resident 1's H&P examination dated 8/30/20, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report for April 2025 showed an order dated 2/4/25, for metformin 500 mg oral tablet, give one tablet by mouth two times a day. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	b. Medical record review for Resident 2 was initiated on 4/16/25. Resident 2 was admitted to the facility on [DATE]. Resident 2 had a diagnosis of DM Type 2. Review of Resident 2's Order Summary Report for April 2025 showed an order dated 2/11/25, for metformin 1000 mg oral tablet, give one tablet by mouth two times a day for diabetes. The medication was discontinued on 2/11/25. On 4/30/25 at 1052 hours, an interview was conducted with the Administrator. The Administrator stated on 3/21/25, Resident 2's metformin medication bubble pack was found in Resident 1's closet. The Administrator stated an internal investigation was conducted, and it was discovered CNA 1 had taken the metformin medication from the medication room. The Administrator stated CNA 1 haddiabetes and hid the medication in Resident 1's room to take for himself. On 4/30/25 at 1405 hours, a telephone interview was conducted with CNA 1. CNA 1 stated during one of his shifts (unknown date), he was feeling so terrible as a result of his diabetes. CNA 1 stated he did not have his medications at the time and saw the door of Medication Room A was slightly open. CNA 1 stated he opened the door of Medication Room A, saw and took the metformin bubble pack. CNA 1 went into Resident 1's room to hide the medication to take home later. CNA 1 stated he forgot the medications were in the room until Resident 1's family found the medication hidden under some books inside Resident 1's closet on 3/21/25. 2. Medical record review for Resident D was initiated on 5/1/25. Resident D was admitted to the facility on [DATE]. Review of Resident D's Order Summary Report for April 2025 showed an order dated 4/25/25, to cleanse the pressure injury to coccyx with normal saline, pat dry, and apply zinc oxide (medicated skin cream). On 5/1/25 at 1612 hours, a concurrent observation and interview was conducted with the DON. Resident D's side table drawer had a medication cup filled with thick white cream and a tongue depressor inside the drawer. The DON stated it appeared to be zinc oxide cream, which was a medication and should not have been inside the drawer. On 5/1/25 at 1705 hours, the Administrator and the DON acknowledged the above findings.