

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Palm Terrace Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 24962 Calle Aragon Laguna Hills, CA 92637	

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 - Few</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** 48853</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary pharmacy services were provided to two of two sampled residents (Residents 1 and 2) when the medications were not provided within their prescribed time. This failure had the potential for negative health outcomes for Residents 1 and 2.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration - General Guidelines dated 1/2019 showed medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the care center.</p> <p>Review of the facility's document titled Medication Administration Times, (undated), showed the medications are scheduled to be administered as follows:</p> <ul style="list-style-type: none"> - daily, administer at 0800 hours; - twice a day, administer at 0800 and 1600 hours; - three times a day, administer at 0800, 1200, and 1600 hours; - four times a day, administer at 0800, 1200, 1600, and 2000 hours; - before meals, administer at 0630, 1130, and 1630 hours (approximately); - after meals, administer at 0900 and 1700 hours; - bedtime, administer at 2200 hours for sedative and hypnotics and 2000 hours for all other medications; - every six hours, administer at 0600, 1200, 1800, and 0000 hours; and - every 12 hours, administer at 0800 and 2000 hours. <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 - Few</p>	<p>a. On 8/29/24 at 1550 hours, an interview with Resident 1 was conducted. Resident 1 stated medications were usually received late.</p> <p>On 9/3/24 at 0947 hours, an observation and concurrent interview with LVN 2 was conducted. LVN 2 was observed administering the medications to Resident 1. When LVN 2 was done administering the medications, LVN 2 was asked about the medications administered to Resident 1. LVN 2 confirmed the medications given to Resident 1 were due at 0800 hours. LVN 2 stated he just started the medication administration at 0830 hours because the nurse assigned to administer the medications did not show up today. LVN 2 further stated he still needed to administer the medications scheduled for 0800 hours to other residents at this time.</p> <p>On 9/3/24 at 0954 hours, an observation and concurrent interview with LVN 3 was conducted. LVN 3 was observed wheeling the medication cart back towards Nurses Station A. LVN 3 confirmed she just finished passing the medications scheduled to be administered at 0800 hours.</p> <p>b. Medical record review for Resident 2 was initiated on 9/3/24. Resident 2 was admitted to the facility on [DATE].</p> <p>Review of Resident 2's Order Summary Report dated 09/05/24, showed a physician's order to administer the following:</p> <ul style="list-style-type: none"> - atenolol-chlorthalidone (a medication used to control high blood pressure) 50-25 mg one-half tablet one time a day for hypertension. Hold for systolic blood pressure (SBP) less than 110 mmHg or heart rate less than 55 beats per minute ordered on 8/23/24. - fish oil (omega-3 fatty acids, a supplement) 1000 mg one capsule by mouth one time a day ordered on 3/23/24. - gabapentin (a medication to treat and prevent seizures or treat nerve pain) 600 mg one tablet by mouth three times a day, ordered on 6/26/24. - Prozac (fluoxetine, a medication used for depression) 40 mg by mouth one time a day, ordered on 1/26/24. - Tylenol (a medication used for mild pain and fever) 325 mg two tablets by mouth every four hours as needed for moderate pain, levels 4-6 (on a 0-10 pain scale with 0 = no pain and 10 = worst pain) not to exceed three grams per day of acetaminophen from all sources ordered on 11/14/23. <p>Review of Resident 2's MAR for September 2024 showed the following medications were to be administered at the following times:</p> <ul style="list-style-type: none"> - atenolol-chlorthalidone 50-25 mg, give half tablet one time a day and to hold for systolic blood pressure (SBP) less than 110 mmHg or heart rate less than 55 beats per minute, administer at 0800 hours. - Fish oil 1000 mg give one capsule by mouth one time a day medication, administer at 0800 hours. <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 - Few</p>	<ul style="list-style-type: none"> - gabapentin 600 mg one tablet by mouth three times a day medication, administer at 0800, 1200, and 1600 hours. - Prozac 40 mg by mouth one time a day medication, administer at 0800 hours. - Tylenol 325 mg give two tablets by mouth every four hours as needed for moderate pain (4-6) not to exceed 3 grams per day of acetaminophen from all sources. <p>On 9/3/24 at 1006 hours, a concurrent medication administration observation and interview was conducted with LVN 4. During the medication administration observation, LVN 4 prepared and administered the following medications to Resident 2:</p> <ul style="list-style-type: none"> - atenolol-chlorthalidone 50-25 mg one-half tablet - fish oil 1000 mg one capsule - gabapentin 600 mg one capsule - fluoxetine 40 mg one capsule - Tylenol 325 mg two caplets for complain of pain <p>After the medication administration observation, LVN 4 was asked about the medications administered to Resident 2, LVN 4 confirmed she gave Resident 2 the medications that were supposed to be given at 0800 hours. LVN 4 stated one of her residents had a change of condition and needed to take care of the resident first. LVN 4 further stated she still needed to administer the medications scheduled for 0800 hours, to other residents at this time.</p> <p>c. On 9/3/24 at 0954 hours, an observation and concurrent interview with LVN 3 was conducted. LVN 3 was observed wheeling the medication cart back towards Nurses Station A. LVN 3 confirmed she just finished passing the medications scheduled to be administered at 0800 hours.</p> <p>On 9/3/24 at 1040 hours, a follow-up interview was conducted with LVN 3. LVN 3 confirmed she finished administering the medications scheduled for 0800 hours at 0954 hours. LVN 3 stated she usually finishes the 0800 hours medication administration by a little before 1000 hours most of the time because she made sure the residents swallowed the medications she gave to the residents.</p> <p>On 9/3/24 at 1410 hours, an interview with the DON was conducted. The DON stated the medication administration should not be interrupted. The DON expected the RN supervisor, or the desk nurse to take care of residents with change in condition and should start the medication administration when a licensed nurse scheduled to give the medications did not show up.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on observation, and interview, the facility failed to ensure resident's meals were served at the desired temperatures. This failure had the potential for the undesirable food temperatures to result in decreased oral meal intake and undesirable weight loss for the residents.</p> <p>Findings:</p> <p>a. Medical record review for Resident 3 was initiated on 9/3/24. Resident 3 was admitted to the facility on [DATE].</p> <p>Review of Resident 3's H&P examination dated 8/30/24, showed Resident 3 had the capacity to make decisions.</p> <p>On 8/29/24 at 1505 hours, an interview was conducted with Resident 3. Resident 3 stated the hot food items on the meal tray were not hot enough. Resident 3 stated he would like to at least eat the warm food.</p> <p>b. Medical record review for Resident 4 was initiated on 9/3/24. Resident was admitted to the facility on [DATE].</p> <p>Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 was able to make to make self-understood and understand others. Resident 4's BIMS summary score showed 15 (cognitively intact).</p> <p>On 9/3/24 at 0908 hours, an interview with Resident 4 was conducted. Resident 4 stated the food could be improved. Resident 4 further stated, most of the time the food is already cold.</p> <p>On 9/3/24 at 0748 hours, a test tray was requested to be added to Station 1's meal tray cart.</p> <p>On 9/3/24 at 0806 hours, a meal tray cart with doors containing the test tray and meal trays for the residents was parked by Nurses' Station 1.</p> <p>On 9/3/24 at 0810 hours, the resident's meals trays were passed except for the test tray. The CNAs were observed to close the doors after getting resident's meal trays. The DSS brought the covered test tray in the conference room located across the Nurses' Station 1.</p> <p>On 9/23/24 at 0811 hours, a test tray inspection was conducted with the DSS. The temperatures of the following food items were checked and showed the following readings:</p> <ul style="list-style-type: none"> - egg omelet was at 105.6 degrees Fahrenheit, - bacon was at 86.1 degrees Fahrenheit, - oatmeal was at 108.6 degrees Fahrenheit, - milk was at 51.2 degrees Fahrenheit. <p>(continued on next page)</p>		

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