STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555257	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Terrace Healthcare & Rehabilitation Center	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43156 Based on interview and medical record review the facility failed to ensure one of nine sampled residents (Resident 2) was free from the significant medication errors. * The facility failed to ensure the licensed nurse properly checked and identified the resident prior to administering the medication. This failure had the potential to negatively affect Resident 2's health outcomes. Findings: Review of the facility's P&P titled Medication Administration dated 1/2019 showed the residents are identified before the medication is administered using at least two identifiers. Methods of identification may include checking identification band, checking photograph attached to medical record and if necessary, verify resident identification with other care center personnel. Review of Resident 2's medical record was initiated on 9/30/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 9/7/24, showed Resident 2 had capacity to make decisions. Review of Resident 2's MDS assessment dated [DATE], showed the resident was able to make self-understood and understand others. The resident's BIMS summary score was 14. Review of Resident 2's Change of Condition initiated on 9/25/24, showed the medication error occurred on 9/25/25 at 0500 hours. Resident 2 erroneously received levothyroxine (medication used to treat hypothyroidism) 25 mcg. Resident 2 did not have a history of hypothyroidism. During an interview with Resident 2 on 09/30/24 at 1254 hours, Resident 2 stated on 9/30/24, in the middle of the night (unable to recall specific time), a staff member (LVN 6) had tapped her shoulder and informed her to take a medication. Resident 2 informed LVN 6 that she did not take medications in the early morning. LVN 6 did not respond, continued to administer the medication, and walked away. Resident 2 stated LVN 6 came back after few minutes and told her that she had given her the wrong medication. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 0730 hours, an interview was conducted via phone with LVN 6. LVN 6 stated she was assigned to Resident 2 on 9/25/24. LVN 6 confirmed she erroneously administered levothyroxine 25 mcg to Resident 2 on 9/25/24 at 0500 hours. LVN 6 acknowledged she did not take time to properly check and identify the resident prior to administering the medication. On 10/08/24 at 1545 hours, an interview was conducted with the DON. The DON verified Resident 2 was given the wrong medication, levothyroxine 25 mcg on 9/25/24 at 0500 hours. The DON was asked about the facility's P&P regarding the medications administration. The DON stated the residents were identified before the medication administration using at least two resident identifiers. The DON verified the facility failed to ensure Resident 2 was free from the significant medication errors.