

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: #55267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Palm Terrace Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 24962 CALLE ARAGON , LAGUNA HILLS, California, 92637	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Numbers: 2578863 and 2578864.</p> <p>The survey team entered the facility on 8/11/25 at 1130 hours.</p> <p>The facility identified the census as 92.</p> <p>The survey sample size was 3.</p> <p>Inspection was limited to the complaints investigated and did not represent the findings of a full inspection of the facility.</p> <p>* FOR COMPLAINT NUMBER: 2578863, DEFICIENCIES WERE IDENTIFIED AND CITED AT F 755.</p> <p>* FOR COMPLAINT NUMBER: 2578864, DEFICIENCIES WERE IDENTIFIED AND CITED AT F 756.</p> <p>GLOSSARY AND DEFINITIONS:</p> <p>BIMS - Brief Interview for Mental Status</p> <p>DON - Director of Nursing</p> <p>EHR - Electronic Medical Record</p> <p>EMAR - Electronic Medication Administration Record</p> <p>H&P - History and Physical</p> <p>LVN - Licensed Vocational Nurse</p> <p>MAR - Medication Administration Record</p> <p>MDS - Minimum Data Set (an assessment tool)</p>	F0000	<p>Palm Terrace Healthcare and Rehabilitation Center makes its best effort to operate in full compliance with both State and Federal regulations and any applicable standard of practice. Nothing included in this Plan of Correction is an admission of guilt but is submitted in order to comply with its regulatory obligation and does not waive any objection to the basis, merits and/or form of any obligation contained herein. This Plan of Correction submitted by Palm Terrace Healthcare and Rehabilitation Center is our allegation of compliance.</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 reverse for further 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/CLIA REPRESENTATIVE'S SIGNATURE Griffitts, Kyle Kyle DN: cn=Griffitts, Kyle Date: 2025.08.29 14:42:24	TITLE Excutive Director	(X6) DATE 8/29/2025
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Accepted 8/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 666267	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Palm Terrace Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 24982 CALLE ARAGON , LAGUNA HILLS, California, 92637		
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F0000	Continued from page 1 mcg - microgram(s) mg - milligram(s) P&P - Policy and Procedures RN - Registered Nurse	F0000	F 755 Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45 (a)(b)(1)-(3)	
F0755 SS = D	Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical	F0755	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident 1 no longer resides at facility as of 08/11/25 On 08/13/25, 08/14/25 and 08/15/25, all licensed nurses were in-serviced by DON on medication rights of administration and provided with a copy of the medication administration P&P which states correct administration and documentation – pour, pass, sign. Licensed nurses were also educated on the one-hour medication pass parameter time. 2. Resident 2 no longer resides at facility as of 08/26/25 On 08/13/25, Resident 2 was assessed by DON for adverse reactions related to missed medication. Resident denied any adverse reactions. MD was notified of missed medications by DON immediately, and no new orders were given. On 08/13/25, DON provided 1:1 training to LVN 1 regarding the rights of medication administration, LVN 1 was provided with facility's P&P on medication administration. DON also provided LVN 1 with 1:1 in-service on proper procedure for medication clarification, documentation and monitoring.	

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F0765 SS = D	<p>Continued from page 2 services to two of three sampled residents (Residents 1 and 2).</p> <p>* The facility failed to ensure Resident 1's medication was administered timely as ordered by the physician.</p> <p>* The facility failed to ensure Resident 2's medication was administered as ordered by the physician and accurately documented in the MAR.</p> <p>These failures had the potential for the residents to not receive the medications and posed the risk to negatively affect the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Medication Administration dated 1/2019 showed the following:</p> <ul style="list-style-type: none"> - Medications are administered in accordance with the written orders of the attending physician; - Medications are to be administered at the time they are prepared; - Medications are administered within 60 minutes of schedule time; and - The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. "Pour-Pass-Chart" is the acceptable method for medication preparation, administration, and documentation. <p>1. Medical record review for Resident 1 was initiated on 8/12/25. Resident 1 was admitted to the facility on 7/24/25.</p> <p>Review of Resident 1's H&P examination dated 7/25/25, showed Resident 1 had the capacity to understand and make decisions.</p> <p>Review of Resident 1's MDS assessment dated 7/31/25, showed Resident 1's BIMS score was 12 (moderate cognitive impairment).</p>	F0765	<p>On 08/15/25, Resident 2's medications were revisited and reviewed per physician orders based on Medication Administration Schedule. In addition, a review of resident's chart was conducted by DON.</p> <p>On 08/15/25, Resident 2 was interviewed with daughter at bedside by DON regarding complete medication administration as well as timely medication administration. Resident 2 and daughter validated all medication as well as education was provided, and resident received her medications on time.</p> <p>How the facility will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All current residents with physician order for medication have the potential to be affected by this deficient practice.</p> <p>On 08/13/25, designated licensed nurse conducted a check of all current residents who had received their scheduled morning medications late on 08/13/25. A total of 4 residents out of 91 were affected, attending physicians were notified with orders to monitor for adverse reactions. No adverse reaction noted on 4 residents who were affected by this deficient practice.</p> <p>On 08/13/25, designated licensed nurse conducted an audit on LVN 1's residents with physician's orders for medications. Residents were interviewed by designated licensed nurse, 18 verbal resident stated they received all their medications and were educated on medications administered.</p>	

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F0755 SS = D	<p>Continued from page 3</p> <p>Review of Resident 1's Order Summary Report dated 7/24/25, showed a physician's order dated 7/24/25, for tacrolimus (immunosuppressant medication) 0.5 mg one capsule by mouth one time a day for renal transplant.</p> <p>Review of Resident 1's Medication Administration Audit Report dated 8/13/25, showed for the tacrolimus 0.5 mg one capsule by mouth one time a day was scheduled to be given at 0830 hours. However, the tacrolimus medication was administered and documented on the following dates and times:</p> <ul style="list-style-type: none"> - dated 7/26/25, administered at 1029 hours and documented at 1041 hours; - dated 7/28/25, administered at 1037 hours and documented at 1038 hours; and - dated 7/27/25, administered at 0950 hours and documented at 1051 hours. <p>On 8/13/25 at 1020 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated the licensed nurses must prepare the medications while checking the physician's orders, administer the medications, and document in the MAR right after the medication was administered. RN 1 verified the above findings and stated Resident 1's tacrolimus 0.5 mg morning dose scheduled at 0830 hours were administered late and outside of the one-hour medication pass parameter time. RN 1 further stated it was a medication error since the licensed nurse failed to administer the medication as per the physician's order and could have an adverse effect on Resident 1's health.</p> <p>2. On 8/12/25 at 0835 hours, a medication administration observation was conducted with LVN 1. LVN 1 was observed preparing the following morning medications for Resident 2:</p> <ul style="list-style-type: none"> - cholecalciferol oral (supplement) 50 mcg one tablet; and - ipratropium bromide 0.5mg/albuterol sulfate (anticholinergic/bronchodilator) one unit dose. <p>During the medication administration observation, LVN 1 stated Resident 2's calcium (supplement) 800 mg medication was not available. LVN 1 stated he would not</p>	F0755	<p>On 08/14/25, 08/15/25, 08/18/25, 08/20/25 and 08/22/25, DON, DSD and RN conducted a medication observation for 20 residents to validate pour pass sign, timely medication administration and correct documentation. 20 out of 20 residents received their medication on time, license nurses followed pour pass sign and accurately documented administration.</p> <p>What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not reoccur:</p> <p>On 08/13/25, 08/14/25 and 08/15/25, DON provided in-services to all license nurses regarding rights of medication administration and facility's P&P on medication administration, specifically "pour, pass, sign." Additionally, DON and/or designee will provide in-services will be provided monthly for 4 months and as needed to ensure compliance and competency with P&P.</p> <p>Starting 08/14/25, DON and/or designee will perform a random medication observation of 4 residents per week for 12 weeks and as needed to ensure timely medication administration and accurate documentation. Any deficient findings will be reported to the DON and/or designee for follow up.</p>	

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F0765 SS = D	<p>Continued from page 4 administer the calcium 600 mg medication until he clarified the order with the physician. LVN 1 was observed administering Resident 2's morning medications except the calcium 600 mg medication.</p> <p>Medical record review for Resident 2 was initiated on 8/13/25. Resident 2 was admitted to the facility on 7/8/25.</p> <p>Review of Resident 2's MDS assessment dated 7/31/25, showed Resident 2's BIMS score was 12 (moderate cognitive impairment).</p> <p>Review of Resident 2's H&P examination dated 8/10/25, showed Resident 2 had the capacity to understand and make decisions.</p> <p>Review of Resident 2's Order Summary Report dated 8/13/25, showed physician's order dated 8/5/25, for calcium 600 mg oral tablet, give one tablet by mouth one time a day for supplement.</p> <p>Review of Resident 2's MAR for August 2025 showed the following:</p> <ul style="list-style-type: none"> - dated 8/12/25, the calcium 600 mg to be administered at 0900 hours had a documentation code "7" (other/see nurse notes). Review of the Resident 2' MAR note on 8/12/25 at 0850 hours, for the calcium medication showed "need clarification from MD," and - dated 8/13/25, the calcium 600 mg to be administered at 0900 hours had a check mark to indicate it was given. <p>Review of Resident 2's medical record failed to show the staff had clarified the calcium 600 mg medication order to the resident's physician on 8/12/25, as documented in the MAR. Additionally, review of Resident 2's MAR for August 2025 failed to show the calcium 600 mg medication was administered on 8/12/25.</p> <p>On 8/13/25 at 1150 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no new order for Resident 2's calcium nor a documentation to show the calcium medication was clarified with the physician on 8/12/25.</p>	F0765	<p>How the facility plans to monitor its performance to make sure that solutions are sustained:</p> <p>The DON and/or designee will report to the QA&A Committee monthly for review and recommendations for 3 months until substantial compliance is achieved.</p> <p>Completion Date: 08/27/25</p>	

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NAME OF PROVIDER OR SUPPLIER Palm Terrace Healthcare & Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 24992 CALLE ARAGON , LAGUNA HILLS, California, 92637	
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F0755 SS = D	<p>Continued from page 6</p> <p>RN 1 verified LVN 1 administered the calcium medication on 8/13/25 at 0900 hours. RN 1 stated LVN 1 failed to administer Resident 2's calcium 600 mg on 8/12/25, and it would be considered a medication error. RN 1 stated the licensed nurses must follow the physician's orders and when the medications were not available, the physician must be notified and to obtain an order.</p> <p>On 8/13/25 at 1210 hours, an observation and concurrent interview was conducted with LVN 1. When asked if he administered Resident 2's calcium medication scheduled at 0900 hours, LVN 1 showed the calcium 600 mg scheduled for 0900 hours was checked marked in the MAR to indicate "administered." LVN 1 was asked to show the supply of the calcium 600 mg medication administered. LVN 1 opened the medication cart and showed a bottle of the calcium medication. However, the bottle showed calcium 600 mg with vitamin D. LVN 1 acknowledged the calcium 600 mg medication had vitamin D in it and stated it was the supply of the calcium 600 mg medication the facility currently have. LVN 1 was asked what he had administered to Resident 2 if the facility did not have the calcium 600 mg available. LVN 1 stated he did not administer Resident 2's calcium 600 mg since it was not available. LVN 1 acknowledged he had documented the calcium medication was administered even when Resident 2 did not receive the medication. In addition, LVN 1 was asked if the calcium medication was provided to Resident 2 or if he had clarified the calcium medication with the physician on 8/12/25. LVN 1 stated the calcium 600 mg medication was not administered on 8/12/25. LVN 1 further stated when he called the physician, the physician did not reply. LVN 1 acknowledged there was no documentation to show he attempted to call the physician or had endorsed to the next charge nurse to follow up. LVN 1 stated the medications not given as ordered by the physician could be detrimental to residents' health, the resident was taking the medications for a reason.</p> <p>On 8/13/25 1240 at hours, an interview was conducted with RN 1. RN 1 stated the licensed nurses must not document in the EMAR when the medication was not available and not administered. RN 1 stated the process for the medication administrations must be "pour, pass, and sign." Furthermore, RN 1 stated it was unacceptable to document the medication was administered when the resident did not receive the medication.</p> <p>On 8/13/25 at 1250 hours, an interview was conducted with the DON. The DON stated the medication</p>	F0755		

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F0755 SS = D	<p>Continued from page 6 administration process must be pour, pass, and sign the EMAR immediately for safe and accurate documentation. When asked if an advance documentation on any resident's EHR for care and services including the medication administration is acceptable, the DON stated it was not acceptable. Furthermore, the DON stated any missed medication could greatly affect the resident's health especially depending on the indication of the medication.</p> <p>On 8/13/25 at 1300 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.</p>	F0755		
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