STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055213	A. BUILDING _____ B. WING _____	C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIALTO POST ACUTE CENTER	1471 S RIVERSIDE AVE RIALTO, CA 92376

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F 000	INITIAL COMMENTS	F 000		5/17/2023
	The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00832387 Representing the Department: 46110, HFEN The inspection was limited to the specific complaint does not represent the findings of a full inspection of the facility. One deficiency was identified for the complaint number: CA00832387			
F 755 SS=D	Pharmacy Srvcs/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(g). 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	F 755	5/3/2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE RN/DON | (X6) DATE 5/2/23

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.

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F 755	Continued From page 1	F 755		

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 and record review, the facility failed to ensure licensed nursing staff followed the facility ' s policy and procedure for controlled substances count between shifts for one of four sampled Resident ' s (Resident 1).

This failure resulted in a possible drug diversion that caused Resident 1 a clinically compromised resident to experience unnecessary pain by not receiving her prescribed pain medications.

Findings:

On March 22, 2023 at 10:00 A.M., an unannounced visit was conducted to investigate two possible drug diversions that occurred on March 19, 2023, during the afternoon shift from 3:00 PM to 11:00 PM.

During initial observation and interview with Resident 1 on March 21, 2023, at 3:19 P.M., Resident 1 stated, "I am having pain and getting Norco every four hours, facility did not give me pain medication a day before yesterday."

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F 755	Continued From page 2 During a review of Resident 1 ' s clinical record, the document titled "Admission Record," (contains a resident ' s demographic and medical information) dated March 21, 2023, indicated Resident 1 was admitted to the facility on March 16, 2023, with diagnoses that included malignant neoplasm of brain (cancerous or noncancerous mass or growth of abnormal cells in the brain), and malignant neoplasm of vertebral column (cancerous or noncancerous mass or growth of abnormal cells in the spinal which affects spinal bone or spine). During an interview with the Assistant Director of Nursing, (ADON), on March 22, 2023, at 11:05 A.M., the ADON stated, Licensed Vocational Nurse (LVN 1) reported on March 19, 2023, during the afternoon shift that 37 Norco pills were missing from a card of 40 tablets, and 10 tablets of Norco 5/325 mg were missing from a card of 40 tablets. During a review of Resident 1 ' s physician ' s order titled, "Order Summary Report," dated March 19, 2023, indicated, "Hydrocodone-Acetaminophen oral tablet 5/325 mg give 2 tablets by mouth every 4 hours as needed for moderate pain," and March 18, 2023, indicated, "Hydrocodone-Acetaminophen oral tablet 10/325 mg give 1 tablet by mouth every 4 hours as needed for severe pain." During an interview with LVN 1, on March 22, 2023, at 10:50 AM, he stated, he was working on March 19, 2023, from 3:00 PM to 11:00 PM, when 37 pills of Norco 10/325 tablets mg 10 tablets were missing at the beginning of his shift. LVN 1 also stated that at the beginning of his shift, while he was doing his rounds and before	F 755	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice A new order for pain medication was received, retrieved from the cubix and administered. Evaluated for effectiveness and it was. Investigative search initiated Pharmacy services were notified of new orders and investigative report. Received new medication card License nurse (LN), who did not count and discontinued the controlled substances (narcotic medication) order without the physician authorization was suspended and eventually terminated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Every resident on controlled substances (narcotic medications) has the potential to be affected. A review of residents on controlled substances (narcotic medications) was conducted by the director of nursing (DON) and designee, no other residents were identified. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Inservice training was initiated with License	

	nurses (LNs) focusing on the intent F755. while utilizing the facility's policy and procedure on controlled substances. Such in-service training included but not limited to counting controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON. The DON shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the administrator a written report of such findings. The DON will initiate disciplinary action including but not limited to termination should there be discrepancies with narcotic reconciliation, count and/or order by any nurse.	

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F 755	Continued From page 3 he counted with the out-going nurse, Resident 1 asked for medication for severe pain. He could not find Norco 10/325 mg in the cart and called the pharmacy. Pharmacy informed him for Norco 10/325 mg was discontinued on March 18, 2023. LVN 1 called Resident 1 ' s physician and confirmed the order. Resident 1 ' s physician stated he did not order to discontinue Norco 10/325 mg. LVN 1 called the pharmacy again and was informed 40 tablets of Norco 10/325 mg was sent on March 18, 2023. LVN 1 stated he can only dispense 1 dose through the emergency medication for Resident 1 pending the outcome on what was sent prior. During an interview with the Assistant Director of Nursing (ADON), on March 22, 2023, at 11:10 A.M., the ADON stated, when LVN 1 reported the missing Norco the afternoon shift on March 19, 2023, to the Charge Nurse and to the Director of Nursing, they immediately started their investigation and could not find the missing 37 tablets of Norco 10/325 and 10 tablets of Norco 5/325 mg. She stated on March 19, 2023, a staff was suspended for discontinuing Norco 10/325 mg without a physician ' s order. During a review of Resident 1 ' s Care Plan dated March 17, 2023, titled, "Resident is at risk for pain R/T metastatic bone cancer, brain cancer, Metastatic spine of L3-L4, hx of fall, chronic pain syndrome, muscle spasms...Monitor/document for probable cause of pain episodes, administer pain medication as ordered, evaluate effectiveness of pain interventions and notify MD if additional measures are required ..." A review of the facility' s policy and procedure titled, "Controlled Substances," revised dated	F 755	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; Continuing to educate LNs on the intent of F755 while utilizing the facility's P&P. Weekly review of residents on controlled substances will be conducted by the quality assurance nurse (QA) and/or designee and any discrepancy reported to the DON promptly. Random cart checks to be conducted by the DON and /or designee. Monthly controlled substance review to be conducted by the pharmacist and any discrepancy reported to the DON promptly. Results of such monitoring will be brought to the QA committee by the DON and/or designee for review, oversight and recommendations.	

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F 755	Continued From page 4 December 2012, indicated, " ...controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medications, must count the controlled substance together. Both individuals must sign the designated controlled substance record ...If the count is correct, an individual resident-controlled substance record must be made for each resident who will be receiving a controlled substance ...Controlled substances must be stored in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents ...All keys to controlled substance containers shall be different from any other keys ...Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services ..." During a phone interview with the Director of Nursing (DON), on April 7, 2023, at 10:34 A.M., the DON stated, the missing Norco was reported by LVN 1 on the P.M. shift. She stated, she received the report about the missing narcotics the afternoon of March 19, 2023, during LVN 1 shift and immediately investigated. The DON added that it is the responsibility of the nurses to count the controlled substance together and both individuals must sign the designated counting sheet.	F 755		