STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555804	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA POST ACUTE CARE	654 S. ANZA EL CAJON, CA 92020

(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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for one entity reported incident (ERI). ERI number: CA00533982 Category: Pharmaceutical Services; Resident/Patient/Client Neglect Sub-category: Medications One deficiency was issued; F281 for CA00533982 Representing the California Department of Public Health: 35370, Health Facilities Evaluator Nurse The inspection was limited to the specific ERI investigated and does not represent the findings of a full inspection of the facility.	F 000	Preparation and/or execution of this Plan of Correction (POC) does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusion set forth in the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by provision of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings, we submit the following POC which shall constitute the facility's credible allegation of compliance	
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure physician's orders were transcribed (put into written or printed form) for one resident (1) admitted under hospice (end of life care tailored to the patient's	F 281	Resident 1 is no longer in the facility. No other residents were affected by the alleged deficient practice All residents may be affected by the alleged deficient practice. In-Services were provided to licensed nurses by the Director of Staff Development (DSD) and facility Pharmacy nurse consultant regarding transcribing of physician's orders.	

RECEIVED
CA DEPT OF PUBLIC HEALTH
OCT 26 2018
LICENSING & CERTIFICATION
SAN DIEGO DISTRICT OFFICE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10.25.18

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.

Response accepted 10/29/18

JF

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F 281	Continued From page 1 needs and wishes) care. As a result, the licensed nurse (LN) was not aware of Resident 1's available medications (meds) that were ordered as needed. In addition, this failure had the potential to result in delayed care, miscommunication among caregivers, and affect Resident 1's physical well-being. Findings: Resident 1 was admitted to the facility on 4/28/17 with diagnoses which included malignant neoplasm of unspecified part of bronchus or lung (lung cancer) per the facility's Admission Record. Per physician orders, dated 4/28 and 5/1/17, Resident 1 was admitted under hospice care. An observation was conducted on 5/5/17 at 9:11 A.M. Resident 1 was sitting in a wheelchair in her room. An interview was conducted with LN 2 on 5/5/17 at 11:52 A.M. LN 2 stated that Resident 1 was under hospice care, and that care orders were sent to the facility from hospice. LN 2 stated that on 5/3/17, she placed a call to the hospice nurse (HN) to clarify orders for Resident 1. LN 2 stated that during the conversation with the HN, she was informed that a "comfort pack" (package) was sent to the facility on 4/28/17, for Resident 1. LN 2 stated that she was not aware of the comfort pack that had been sent to the facility for Resident 1. LN 2 stated that the HN faxed a manifest (document with comprehensive detail of contents) and physician's orders dated 5/1/17, for Resident 1. The HN informed LN 2 that the meds listed on the physician's orders were included in the comfort pack that the facility should have already received. LN 2 stated that there were	F 281	Physician orders shall be written on physician order sheets with date and time to ensure and confirm when order was received. Orders will also be transcribed on treatment sheets with date and initial. All orders for new medications are to be added to the 24 hour report and each shift will acknowledge the receipt of medications in nursing notes. DON or designee will ensure compliance. Medical Records, DON and/or Designee will report any findings at facility quarterly QA meeting.	

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F 281	Continued From page 2 meds listed as ordered on 5/1/17, that were not documented as received by the facility. A review of Resident 1's physician's order details from hospice, dated 5/1/17 was conducted. This record included comfort med orders for "Ondansetron (to treat nausea and vomiting) 4 milligrams (mg)... Ativan (to treat anxiety) 0.5 mg... Roxanol (for pain) 0.25 - 0.5 milliliters (ml)... Atropine Sulfate (for secretions)... Ativan 1 mg... Acetaminophen (for fever and pain)..." A concurrent interview and review of the physician's order details from hospice, dated 5/1/17 was conducted with LN 2 on 5/5/17 at 2:20 P.M. LN 2 stated that the orders for Ondansetron, Ativan, Roxanol, Atropine Sulfate, Ativan, and Acetaminophen were not transcribed on to Resident 1's record. LN 2 stated that no orders for the comfort meds had been carried out (administered, implemented, performed) for Resident 1, on 5/1/17, the date the meds were ordered. LN 2 stated that this was the first time the facility had worked with [name of hospice company], and was not familiar with how the physician's orders looked. A review of the facility's hospice service agreement with [name of hospice company], dated 9/2/16 was conducted. This agreement included, "...3.3 Physician Orders. Physician orders for immediate care of a facility patient under hospice care shall be available to ... at the time hospice patient is admitted... 4. Provision of Hospice Services... Hospice shall provide... medications... that are... and necessary for the palliation (comfort care) and management of the terminal illness..."	F 281		

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F 281	Continued From page 3 An interview was conducted on 5/31/17 at 1:32 P.M. with the director of nursing (DON). The DON stated that licensed nurses should know how physician's orders look, and acknowledged that Resident 1's physician's orders from hospice, dated 5/1/17 were not transcribed when the meds were ordered and received, and should have been. According to the Scope of Regulation, excerpt from the Business and Professions Code Division 2, Chapter 6. Article 2, Section 2725, Legislative Intent: Practice of Nursing Defined, of the California Nursing Practice Act, dated 2014, "... (b) The Practice of nursing... including all of the following... (2) direct and indirect patient care services... the administration of medications... necessary to implement a treatment, disease prevention... ordered by and within the scope of licensure of a physician..."	F 281		