STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555771	A. BUILDING _____ B. WING _____	C 06/06/2019

RECEIVED STATE OF CALIF. DEPT OF PUBLIC HEALTH 2019 JUN 10 PM 3:59

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE RIVERWALK SNF (CA)	350 CALLOWAY DRIVE, BUILDING C BAKERSFIELD, CA 93312

LICENSING AND CERTIFICATION BAKERSFIELD DIST. OFFICE

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint Number: 635202 Representing the Department: 40768, HFEN 27137, HFES The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of complaint 635202.	F 000	I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 interview and record review, the facility failed to give one prescribed medication to one of three sampled residents (Resident 1). This had the potential to result in a decline in Resident 1's motor skills (movements and actions of the muscles) and increase muscle tremors. Findings: During an interview with Resident 1's Family	F 658	F 658 How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident 1 was monitored by Licensed Nurses x 72 hours and no adverse effect was noted related to missed medication. SBAR (Situation, Background, Assessment, Request)/COC (Change of Condition) was completed on 4/25/19. Attending Physician and Responsible Party were notified by Licensed Nurse on 4/25/19. Licensed Nurse was re-inserviced by Director of Clinical Services on 5/9/2019 on Carrying out Admission Orders/ Reconciliation of Medication on Admission, Medication Error.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 6/19/19

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.

7-2-19 POC Accepted 28741

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F 658	Continued From page 1 Member (FM 1), on 5/2/19, at 4:53 PM, she stated Resident 1 was admitted to the facility on 4/24/19 around noon. FM 1 stated Resident 1 had been discharged from a local acute care hospital, and had a diagnosis of Parkinson's Disease (a nervous system disorder that causes uncontrollable body movements that affect activities of daily living such as eating, dressing, grooming, walking). FM 1 stated that on the evening of 4/25/19, she asked a facility nurse about Resident 1's evening dose of the medication Carbidopa-Levodopa (a medication commonly given to those with Parkinson's Disease, as it helps control body movements). FM 1 stated the nurse told her that Resident 1 did not have a physician's order for that medication, and therefore had not been receiving it. FM 1 stated the nurse then "eventually found the order," and gave the medication. During a review of the clinical record for Resident 1, the "Transfer Medication List" from the local hospital dated 4/24/19, at 8:50 AM, indicated Resident 1 was prescribed the medication Carbidopa-Levodopa 25 mg - 100 mg (unit of measure) one tablet by mouth four times a day. The document accompanied Resident 1 during her transfer from the acute care hospital to the facility. The facility's "Order Summary Report," dated 4/24/19, at 3:09 PM, indicated Resident 1 was admitted to the facility that day and arrived with a diagnosis of Parkinson's Disease. This facility document was a transcription of the acute care hospital's "Transfer Medication List," but missed the order for Carbidopa-Levodopa. The "Medication Administration Record," dated	F 658	**How will the facility identify other residents having the potential to be affected by same deficient practice?** **The Health Information Specialist conducted a review on 6/18/19 with Residents admitted from 6/10/19 to 6/17/19 Physician order completed and reconcile against referring community orders e.g. Hospital Discharge orders. No other deficient practice was noted.** **What measures will put into place or systematic changes made to ensure that the deficient practice will not recur?** **Licensed Nurses will be re-inserviced by Director of Clinical Services or Designee on Carrying out Admission Orders/ Reconciliation of medication on Admission, Medication Error on 6/21/19.** **Order Summary will be printed for Resident's admission orders. Second License Nurse to verify and reconcile against referring community orders e.g. hospital discharge orders. Second Nurse will sign in OrderSummary Signature Line 2.** **Health Information Specialist or Designee will audit will audit New Admission Records for Transfer Medication List against Physician orders 5x per week. Result of the audit will be communicated to Quality Improvement Team consisting of but not limited to (Director of Clinical Services, Assistant Director of Clinical Services, Resident Assessment Instrument Coordinator during Clinical to oversight correction of any deficiencies.**	

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F 658	Continued From page 2 from 4/1/19 to 4/30/19, indicated Resident 1 had her first dose of Carbidopa-Levodopa on 4/25/19 at 10:25 PM, approximately 31 hours after Resident 1's admission into the facility. Resident 1 missed the following doses: 4/24/19 at 5 PM 4/24/19 at 9 PM 4/25/19 at 9 AM 4/25/19 at 1 PM 4/25/19 at 5 PM During a concurrent interview and record review with Registered Charge Nurse (RCN) on 5/7/19, at 2:40 PM, she verified the findings from Resident 1's clinical record. The RCN stated this was not standard practice, and Resident 1 should have received the Carbidopa-Levodopa medication on admission to the facility. The facility policy and procedure titled "Reconciliation of Medications on Admission/Re-Admission and Monthly Orders," dated 8/14, indicated in part, "The charge nurse will perform medication reconciliation upon admission, readmission or transition of care from prior levels of care, for the purpose of providing an accurate and current medication regimen. Medication reconciliation reduces medication errors and enhances resident safety during the admission/transfer process by: identifying the medications the residents needs and, administering without interruption, the correct dosages and routes. The first charge nurse to verify orders, will gather the information needed to reconcile the medication list: Approved physician's order sheet. . . Medication list from prior level of care as	F 658	**How will the facility monitor its' performance to make sure that solutions are sustained?** **Results of Audits or compliance will be brought to QAPI by Director of Clinical Services or Designee x 3 moths then reassess for any further continuation needed.** **6/28/19**	

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F 658	Continued From page 3 applicable. . . All prescription and supplement information obtained from the resident/legal representative during the medication history. . .List all medications from the medication history. . . Data enter all orders into [the facility's computer]. Review and reconcile the Discharge Summary from the referring community and Order Summary for accuracy."	F 658		