STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555896	A. BUILDING _____ B. WING _____	C 08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARROWHEAD HEALTHCARE CENTER, LLC	4343 N. SIERRA WAY SAN BERNARDINO, CA 92407

(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 a standard abbreviated survey to investigate a complaint. CA00538544 Representing the California Department of Public Health: 35184 The inspection was limited to the specific complaint and does not reflect the findings of a full inspection of the facility. one deficiency was issued for complaint: CA00538544	F 000		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) were free from significant medication errors when Resident 1 did not receive eight medications as ordered by the physician. This had the potential to cause harm and illness. Findings:	F 333	F000 This plan of correction does not constitute admission and/or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared as required by regulation. To remain in compliance with all Federal and State regulations, the center has taken or	9/22/17

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

Electronically Signed — 09/04/2017

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 333	Continued From page 1 During a record review of Resident 1's clinical record, conducted on August 15, 2017, the record revealed, Resident 1 was admitted to the facility on June 2, 2017 at 10:45 PM. Resident 1 was admitted with diagnoses that included chronic obstructive pulmonary disease (COPD - Poor air flow to the lungs), difficulty walking, hypertension (high blood pressure), seizure disorder, type 2 diabetes (high blood sugar). Resident 1 was discharged from the facility on June 7, 2017. During a review of the medication administration record (MAR), the MAR revealed Resident 1 did not receive his medications for the 9:00 AM medication pass on June 3, 2017. Resident 1 did not receive eight medications that included: a. Keppra 1,500 milligram (mg) tablet orally twice a day for seizures. b. Metoprolol Tartrate 50 mg tablet orally twice a day for high blood pressure c. Vimpat 150 mg tablet orally twice a day for seizures d. Metformin HCL 500 mg. tablet orally twice a day for Type 2 diabetes e. Lisinopril 10 mg tablet orally once a day for high blood pressure f. Aspirin EC (enteric Coated) 81 mg. tablet orally once a day for blood circulation. g. Gabapentin 600 mg. tablet orally three times a day for nerve pain h. Famotidine 20 mg. tablet orally every 12 hours	F 333	will take the actions set forth in the following plan of correction. The plan of correction constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F333 Corrective action for residents found to have been affected by this deficiency: Resident 1 s physician was notified and documented of the medications were not administered as ordered on June 2, 2017. Resident 1 is now receiving the following medications as ordered. Keppra 1,500 mg tab orally twice a day for seizures Metopolol Tartrate 50 mg tab orally twice a day for high blood pressure Vimpat 150 mg tab twice a day for seizures Metformin HCL 500mg tab twice a day for Type 2 Diabetes Lisinopril 10mg tab orally once a day for high blood pressure Aspirin EC 81 mg tab orally once a day for blood circulation Gabapentin 600 mg tab orally three times a day for nerve pain Famotidine 20 mg tab orally every 12 hours to GERD Identification of others at risk: On August 15, 2017, DON and Nurse Supervisor reviewed every resident MARs	

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F 333	Continued From page 2 for GERD (gastric reflux disease) During a review of the nursing note dated June 3, 2017 at 3:34 PM, LVN 1 documented that, "Resident 1 has been complaining about his medications all shift." During an interview conducted with LVN 1 on August 15, 2017 at 2:15 PM, LVN 1 stated,"Resident 1 was complaining that his medications weren't here from the pharmacy yet. The Resident was admitted on June 2, at 10:45 PM, and the medication was not here on June 3, 2017." During a concurrent interview with the Director of Nursing (DON) on August 15, 2017, the DON confirmed Resident 1 did not receive eight of the medications, all of the 9:00 AM medications that were ordered by the physician. The DON stated, "Yes he missed the 9:00 AM medications. If it was not documented, it was not done. It usually takes 4-6 hours on admission for the facility to receive the medications for a new admission from the pharmacy. Yes, the physician should have been notified." During an interview with the LVN 1 conducted on August 15, 2017 at 2:57 PM, LVN 1 stated, "I do not recall what time the medication arrived. No, I did not notify the physician." During an interview with the Pharmacy conducted on August 15, 2017 at 3:05 PM, the pharmacist verbalized, I really don't know what time the medication was delivered. The medications should be delivered within 4 hours of receiving the fax for new admissions. The Nurse who received the medication at the facility did not time	F 333	to ensure that all residents had received all medications as ordered by physician. All residents including new admission had received all medications on time as ordered. All residents are potentially affected by the cited deficiency, on 8/15/1, with no further medication errors discovered. Measures that will be put into place to ensure that this deficiency does not recur: DON and Administrator contacted the Pharmacy owner to report of the delay of the delivery of the medications on both new admission and the refill within the acceptable hours of 4-6 hours. The pharmacist must notify the licensed nurse who sent the physician order for the medication if there will be the delay of the delivery and give the licensed nurse when would medication be delivered. The pharmacist must ensure that the delivery slip must be kept with time dispensed and time of delivery to ensure the accountability of pharmacy serv process. On 8/25/17, the DON educated the licensed nurses to ensure to check the medications when delivered. When all ordered medications were checked and accountable for then signed the delivery receipt and keep the signed copy in the pharmacy receiving log book. Licensed nurses must call and follow up after 4 hours period of time when did not receive the ordered medications for the	

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F 333	Continued From page 3 the slip and the driver also failed to time the slip. During a telephone interview with the DON, conducted on August 22, 2017 at 10:54 AM, the DON stated, "Yes, my nurses know they should check the E-Kit (emergency kit for medications)to see if the medications are available to give. I don't know why the LVN 1 didn't give the medication out of the E-Kit." During a review of the facility policy and procedure dated, August, 2016, and titled,"Ordering and receiving medications from [name of pharmacy]," the policy revealed, "The emergency kit shall be used when the resident needs a medication prior to pharmacy delivery."	F 333	resident. The licensed nurse must also document that the medication was delayed if it was not yet delivered. The licensed nurse must notify the attending physician of the delay with accurate documentation. Licensed nurse must report to the nursing supervisor of medication delivery delay to ensure for the follow up of the next shift. Nurse Supervisor will do daily audit if the delay of the pharmacy if occurred. If the deficient practice found the immediate correction must be checked if the licensed nurse has followed the correct step of protocol. The Nurse Supervisor then ensure that the resident must receive the medications as ordered. The findings will be reported to DON for further corrective actions if needed. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The DON will report of the findings on the event that the resident did not receive the medication from pharmacy on time to the QAPI Committee on monthly basis for 3 months beginning September 2017. The Pharmacy Consultant must report of delivery accountability process of the medication delivery to QAPI Committee on quarterly basis for 2 quarters.	