STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555214	A. BUILDING _____ B. WING _____	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL POST ACUTE CENTER	81 PROFESSIONAL CENTER PARKWAY SAN RAFAEL, CA 94903

(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 Recertification Survey conducted from September 16, 2024 to September 19, 2024. The facility was found to be not in compliance with 42 CFR 483.5-483.75 - Subpart B - Requirements for Long Term Care Facilities. Representing the California Department of Public Health: Surveyor: 45849, Health Facility Surveyor Surveyor: 22445, Health Facility Surveyor Surveyor: 29673, Health Facility Surveyor, and Surveyor: 49044, Health Facility Surveyor. The facility census was 91.	F 000		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		9/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/15/2024

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.

POC accepted on 10/15/2024 by Sandra Abayari-Evaristo, HFES. Back in Compliance date is 10/08/2024 per Steven Gardner, Acting DM II.

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F 756	Continued From page 1	F 756		

separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to act upon pharmacy recommendation for 1 (Resident #73) of 6 sampled residents reviewed for unnecessary medications, psychotropic medication, and medication regimen review.

Findings included:

A facility policy titled, "Medication Regimen Review (Monthly Report)," with an effective date of 06/2021, indicated, "The consultant pharmacist performs a comprehensive medication regiment review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident

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F 756	Continued From page 2	F 756		

maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to the medication therapy." The policy directed, "E. Recommendations are acted upon and documented by the facility staff and or the prescriber. 1) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit."

An "Admission Record" revealed the facility admitted Resident #73 on 09/07/2023. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, cerebral infarction due to thrombosis of right middle cerebral artery, muscle weakness, and reduced mobility.

An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2024, revealed Resident #73 had a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident had intact cognition.

Resident #73's care plan, included a focus area revised 05/20/2024, that indicated the resident had hemiplegia/ hemiparesis related to right middle artery infarct. Interventions directed staff to obtain and monitor laboratory/diagnostic work as ordered (initiated 09/08/2023).

Resident #73's "Order Summary Report," revealed an order dated 09/07/2023, for atorvastatin calcium oral tablet 80 milligrams, give one tablet by mouth at bedtime for high cholesterol and an order dated 09/07/2023, for

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F 756	Continued From page 3 clopidogrel bisulfate oral tablet 75 mg, give one tablet by mouth one time a day for blood thinner. The Consultant Pharmacist (CP) recommendation for Resident #73 dated 07/24/2024 and signed by the physician on 08/21/2024, revealed the resident took atorvastatin and clopidogrel, and did not have a recent lipid panel, comprehensive metabolic panel (CMP), complete blood count (CBC) documented in their chart. Per the recommendation, "Please consider monitoring on the next convenient lab [laboratory] day and every 6 months thereafter." During an interview on 09/19/2024 at 8:49 AM, the Registered Nurse (RN) Supervisor stated she did not see any orders for the laboratory work for Resident #73. The RN Supervisor confirmed the CP's recommendations for Resident #73 dated 07/24/2024 had not been implemented. During an interview on 09/19/2024 at 9:11 AM, the Senior Director of Clinical Operations (SDCO) stated the facility acted upon the pharmacy recommendations by placement of the recommendation in the physician's binders for the physician to sign. Per the SDCO, once the physician signed the recommendation, the nurses were to ensure the recommendations were implemented. The SDCO stated she expected the staff to follow through with the pharmacy recommendations. During an interview on 09/19/2024 at 9:27 AM, the Administrator stated she expected staff to follow-up on what the pharmacist recommended or requested.	F 756		

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of 5% or less. There were two medication errors out of 27 opportunities, which yielded a medication error rate of 7.41% for 1 resident (Resident #10) of 4 residents observed for medication administration. Findings included: A facility policy titled, "Administering Medications," revised 04/2023, indicated, "Medication are administered in a safe and timely manner, and as prescribed." Per the policy, "9. The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." An "Admission Record" revealed the facility admitted Resident #10 on 11/05/2015. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified iron deficiency anemia, presence of a right artificial knee joint, contracture of the left knee, and generalized muscle weakness. A quarterly Minimum Data Set (MDS), with an	F 759		

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F 759	Continued From page 5	F 759		

Assessment Reference Date (ARD) of 08/06/2024, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.

Resident #10's care plan included a focus area revised 04/29/2024 that indicated the resident had a history of skin breakdown related, in part, to anemia and osteoarthritis of the knee. Interventions directed the staff to administer medications as ordered. Monitor/document for side effects and effectiveness (initiated 11/06/2015).

Resident #10's "Order Summary Report" that included active orders as of 09/17/2024, revealed an order dated 09/26/2018, for oyster shell calcium D tablet 500-200 milligram (mg) unit, give one tablet by mouth one time a day for supplement and an order dated 02/23/2024, for ferrous fumarate oral tablet, give 325 mg by mouth one time a day for microlytic anemia.

During medication administration observation on 09/17/2024 at 8:32 AM, Licensed Vocational Nurse (LVN) # 1 prepared medications for Resident #10. LVN #1 placed a ferrous sulfate tablet and an oyster shell calcium tablet into the medication cup, along with Resident #10's other scheduled medications, and gave those medications to Resident #10.

In an interview on 09/18/2024 at 11:13 AM, the Consultant Pharmacist (CP) stated the ferrous sulfate the LVN had given to Resident #10 and the physician-ordered ferrous fumarate both contained iron but included a different salt compound. The CP stated it would have been

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F 759	Continued From page 6 better had LVN #1 given Resident #10 what was ordered. The CP stated if he had been observing medication pass he would have counted the exchange of ferrous sulfate for ferrous fumarate as a medication error. The CP stated any medication, not given as ordered by the physician, was considered a medication error. During a concurrent observation and interview on 09/18/2024 at 11:38 AM, LVN #1 removed the ferrous sulfate bottle used to dispense Resident #10's morning medication and compared the bottle with the physician's order. LVN #1 confirmed the physician ordered ferrous fumarate for the resident and stated she had given the resident the ferrous sulfate instead of the ferrous fumarate. LVN #1 stated she had not noticed the medications were not the same and therefore, had not reported the discrepancy to the physician or the medication error to anyone. LVN #1 then removed the calcium from the medication cart that had been given to Resident #10, reviewed the physician's order, and confirmed the order for calcium with Vitamin D. LVN #1 declined to answer why she had not given the correct medication to Resident #10, but acknowledged not giving the right medication was a medication error. In an interview on 09/18/2024 at 1:26 PM, the Senior Director of Clinical Operations (SDCO) stated she expected nurses to follow the rights of medication administration, which included the administration of the right medication to the resident. The SDCO stated if the medication in the medication cart did not match the medication ordered by the physician, she expected the nurse to call the physician for clarification. The SDCO	F 759		

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F 759	Continued From page 7 stated since LVN #1 had not followed the physician's orders, LVN #1 had made a medication error. In an interview on 09/18/2024 at 3:11 PM, the Administrator stated that when nurses gave medications she expected the physician's orders to be followed. The Administrator stated LVN #1 made a medication error because the LVN had not followed the physician's order and had not given Resident #10 the correct medication.	F 759		

Professional Post-Acute Center

October 8, 2024

Re-Licensing Standard Survey

F-756 Drug Regimen Review, report Irregular, Act on

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

All resident who have received Pharmacy recommendation have the potential to be affected by this deficient practice Resident #73 pharmacy recommendation were carried out per pharmacist recommendation. No other residents were found to be affected by this deficient practice.

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.

Facility Nursing Supervisor (NS) reviewed all pharmacy recommendation immediately to assure all other pharmacy recommendation were carried out resident who had Physicians orders. No other resident were found to have been affected by this deficient practice.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Nursing Supervisor (NS) was provided in-service and education by the administrator on 9/18/2024 regarding the importance of reviewing and carrying out all recommendation with follow up need by the Physician to obtain orders for pharmacy recommendations given.

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.

Monitoring will be conducted by the Medical Records and/or Designee through monthly pharmacy recommendation to assure all pharmacy recommendations are carried out as ordered by the physician.. Any pharmacy recommendation found to not have been carried out will be forwarded to the Nursing Supervisor for corrective action to be made immediately.

The plan of correction is integrated into the quality assurance system

Any trends identified will be brought to the QAPI committee by the Medical Records and/or designee where the POC may be modified to ensure threshold is met. The Administrator will review the safety rounds. for 3 months to ensure the facility has met the standard for residents pharmacy recommendations are being carried out as required. When threshold has been met for 3 months without noncompliance, the practice will be removed from QAPI.

Professional Post-Acute Center

Corrective action will be completed- 9/18/2024

F-759 Free of Medication Error Rts 5 Prcnt or More

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice

All resident who receive medication therapy at Professional Post Acute have the potential to be affected by this deficient practice. Resident #10 Medical Doctor (MD) and Responsible Party (RP) were made aware with no adverse reactions and medication orders were changed per MD directive. No other residents were found to be affected by this deficient practice.

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.

Nurse supervisor and regional nurse Consultant did medication on 9/18/2024 AM and PM shift observation on other LN and found No other residents were found to have been affected by this deficient practice.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Regional nurse Consultant (RNC) along with pharmacist initiated an immediate in-service on 9/18/2024 with License Nurses (LN) on the 5 Rights to medication administration and facilities policy on Medication administration.

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.

Monitoring will be conducted by the Director of Staff development and/or Designee through medication administration observation conducted randomly each month for 3 month until found with no discrepancies Any medication errors during medication observation found out compliance will be forwarded to the Director of nursing for corrective action to be made immediately.

The plan of correction is integrated into the quality assurance system

Any trends identified will be brought to the QAPI committee by the Medical Records and/or designee where the POC may be modified to ensure threshold is met. The Administrator will review the medication administration competencies for 3 months to ensure the facility has met the standard and 6 rights to administration for residents as required. When threshold has been met for 3 months without noncompliance, the practice will be removed from QAPI.

Professional Post-Acute Center

Corrective action will be completed- 9/18/2024