

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555247</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/09/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RANCHO MIRAGE HEALTH AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>39950 VISTA DEL SOL</b> <b>RANCHO MIRAGE, CA 92270</b>
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(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
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F 000 INITIAL COMMENTS

F 000

The following reflects the findings of the California Department of Public Health during the investigation of complaint.

Complaint Number: CA00806059.

Representing the Department:

Health Facilities Evaluator Nurse(s): 41422

The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.

Three deficiencies were identified for complaint number CA00806059.

F 684 Quality of Care  
SS=D CFR(s): 483.25

F 684

§ 483.25 Quality of care  
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:

Based on interview, and record review, the facility failed to administer the correct dose of nicotine patch for one of three residents reviewed, (Resident 1). Resident 1 was administered two Nicotine 14 mg patch instead of one patch.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**E.D.**

(X6) DATE

**1-18-23**

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 684	Continued From page 1  This deficient practice had the potential to result in adverse effects from the nicotine patches for Resident 1.  Findings:  On October 17, 2022, at 11:44 a.m., an unannounced visit to the facility was initiated for a complaint investigation.  A review of Resident 1's medical record indicated she was admitted on August 1, 2019, with diagnoses of Behcet's disease, (a rare disorder that causes blood vessel inflammation throughout the body), post-traumatic stress disorder (PTSD - a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world), and major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident 1's history and physical dated June 17, 2022, indicated she has the capacity to understand and make decisions.  On October 17, 2022, at 12:32 p.m., an interview was conducted with Resident 1. Resident 1 stated that she wears a nicotine patch, and the LVN accidentally placed two patches instead of one.  On December 28, 2022, at 12:41 p.m., a telephone interview was conducted with Licensed Vocational Nurse (LVN 1). LVN 1 stated on October 17, 2022, she administered two 14 mg nicotine patches to Resident 1 when she should have administered one 14 mg nicotine patch. LVN	F 684	F 684  Nicotine patch was removed upon discovery from Resident1. MD was notified regarding med error. Resident 1 was monitored for 72 hours for s/s of adverse reaction.  Other residents with nicotine patches were audited, no other residents were noted to be affected by this deficient practice.  LVNs were in-serviced on 1/16/23 and 1/17/23 regarding Medication Administration. DON/Designee will randomly follow Med Pass 2X Weekly and Pharmacy Consultant monthly, for 90 days.  To be monitored by DON/Designee. Any trends in non-compliance will be		1-18-23

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F 684	Continued From page 2  1 stated she thought they were 7 MG., and she should have checked the dosage prior to administering topically.  A record review of Resident 1 ' s "Order Summary" dated October 6, 2022, indicated " ...Nicotine Patch 24 Hour Apply 14 MG transdermally one time a day for smoking cessation for 2 Weeks and remove per schedule ..."  A record review of Resident 1 ' s "SBAR Communication Form" dated October 17, 2022, at 7:37 a.m., indicated " ...Noted 2 nicotine patches on of 14 MG on arm left deltoid ..."  A review of the facility ' s policy titled "Administering Medications" revised April 2019, indicated " ...10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication..."	F 684	brought to the monthly QAPI Committee for further discussion/resolution.		
F 755	Pharmacy Svcs/Procedures/Pharmacist/Records SS=D 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,	F 755			

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F 755	Continued From page 3 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 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 a topical medicated shampoo (Ketokonazole 1%) was provided for one of two residents reviewed (Resident 1), as prescribed by the physician.  This failure had the potential for Resident 1 to suffer severe itching of the scalp.  Findings:  On October 17, 2022, at 11:44 a.m., an unannounced visit to the facility was conducted to investigate quality care issues. A review of Resident 1 's medical record indicated she was admitted on August 1, 2019, with diagnoses of Behcet's disease, (a rare disorder that causes blood vessel inflammation	F 755			
			F755  Keteoconazole cream was located in the bathroom of Resident 1. Resident mat keep at bedside. Refill bottle was provided to Resident 1.  No other Residents were identified as having an MD order for this type of cream.  LVNs were in-serviced on 1/16/23 and 1/17/23 regarding Medication Administration. . DON/Designee will randomly follow Med Pass 2X Weekly and Pharmacy Consultant monthly, for 90 days.  To be monitored by DON/Designee. Any trends in non-compliance will be brought to the monthly QAPI		1-18-23

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F 755	Continued From page 4  throughout the body), post-traumatic stress disorder (PTSD - a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world), and major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident 1's History and Physical dated June 17, 2022, indicated she had the capacity to understand and make decisions.  On October 17, 2022, at 12:32 p.m., an interview was conducted with Resident 1. Resident 1 stated that on October 10, 2022, an order for Ketoconazole shampoo 1% every Tuesday, Thursday, and Saturday was prescribed. She stated she has not receive the shampoo from the facility.  On October 17, 2022, at 2:05 p.m., a concurrent observation and interview was conducted with the Licensed Vocational Nurse, (LVN). The LVN stated that Resident 1 has a physician order for Ketoconazole Shampoo 1 %. The LVN was observed opening the medication cart and Resident 1 ' s Ketoconazole Shampoo 1 % was not in the cart. The LVN stated the medication was not delivered yet, and she would follow up with the pharmacy.  A review of Resident 1 ' s "Physician Orders" dated October 10, 2022, at 9:05 a.m., indicated "Ketoconazole Shampoo 1 %, Apply to head topically in the afternoon every Tue, Thu, Sat for seborrheic condition apply shampoo to head and rise well ..."	F 755	Committee for further discussion/resolution.		

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F 755	Continued From page 5  A review of the facility ' s policy and procedure titled "Medication Administration" revised April 2019, indicated " ...Medications are administered in accordance with prescriber order including any required time frame ..."	F 755		
F 806	Resident Allergies, Preferences, Substitutes SS=D CFR(s): 483.60(d)(4)(5)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;  §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of two residents' (Resident 1) dietary preferences were followed, when Resident 1 was served meatloaf and mashed potatoes with gravy. Resident 1 dislikes gravy.  This failure caused Resident 1 to not eat her meal and had the potential for decreased nutritional intake.  Findings:  On October 17, 2022, at 11:44 a.m., an unannounced visit to the facility was conducted to investigate a quality care issue.  A review of Resident 1 ' s medical record	F 806		

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F 806	Continued From page 6  indicated she was admitted on August 1, 2019, with diagnoses of Behcet's disease, (a rare disorder that causes blood vessel inflammation throughout the body), post-traumatic stress disorder (PTSD - a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world), and major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest). The History and Physical dated June 17, 2022, indicated she had the capacity to understand and make decisions.  On October 17, 2022, at 12:32 p.m., a review of Resident 1 's "Dietary Card" dated October 17, 2022, indicated " ...Feed Instructions: ...NOGRAVY ..."  A review of Resident 1 's "Dietary Assessment" dated August 4, 2022, at 1:46 p.m., indicated " ...dislikes ...gravy ..." On October 17, 2022, at 12:32 p.m., Resident 1 was observed sitting on the side of the bed with her lunch tray on the over-bed table. Her lunch tray had a bowl of chicken noodle soup, a bowl of brussel sprouts, herbal green tea, mashed potatoes with gravy, and meatloaf with gravy.  On October 17, 2022, at 12:32 p.m., an interview was conducted with Resident 1. Resident 1 stated she disliked gravy, and had requested no gravy for three years, but continued to be served gravy. Resident 1 stated she won 't eat the gravy and sends her tray back.  On October 17, 2022, at 1:49 p.m., an interview	F 806	F808  Resident 1 was provided with a substitute tray with items of her choice.  Random checks of other Resident choices revealed no issues.  Dietary Staff was in-serviced on 10/17/23 regarding food preferences. DSS will conduct meal accuracies on a weekly basis for 90 days.  To be monitored by DSS/Designee. Any trends in non-compliance will be brought to the monthly QAPI Committee for further discussion/resolution.		1-18-23

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F 806	Continued From page 7  was conducted with the Certified Nursing Assistant, (CNA). The CNA stated that she assisted with passing out meal trays. The CNA stated Resident 1 ' s tray should not have been served with gravy.  On October 17, 2022, at 2:18 p.m., an interview was conducted with the Dietary Aid, (DA). The DA stated that when he prepared the lunch trays, he checked the dietary preferences. The DA stated if Resident 1 had stated no gravy, then gravy should not have been served on her tray.	F 806		



## Lesson Plan

<b>Facility:</b> RMHC	<b>Date:</b> 01/17/2023
<b>In-service Title:</b> Medication Administration	<b>Time:</b> 0730, 1530
<b>Given by:</b> Virginia Faustino RN, DON	<input type="checkbox"/> Mandatory <input type="checkbox"/> Nursing <input type="checkbox"/> CNA <input type="checkbox"/> Other staff

OBJECTIVES	CONTENT	METHOD OF TEACHING	METHOD OF EVALUATION
Participants will be able to: <ul style="list-style-type: none"> <li>- State the "5 rights of medication administering" and aware to verify 3 times prior to administering medication.</li> <li>- Identify P&amp;P for documenting and reporting medication errors.</li> <li>- Safely administer and document medication administration to residents.</li> </ul>	<p>Discuss the "5 rights of medication administration"</p> <ul style="list-style-type: none"> <li>-right resident</li> <li>-right medication</li> <li>-right dose</li> <li>-right time</li> <li>-right route</li> </ul> <p>Discuss verifying the "5 rights" 3 times with medication label prior to administering medication to resident.</p> <p>Review P&amp;P for medication error.</p> <ul style="list-style-type: none"> <li>-notify supervisor, MD, and responsible party</li> <li>-complete COC/careplan</li> <li>-correct any errors in order and/or with pharmacy</li> </ul>	Handout, Lecture and Group Discussion	Question and Answers.

F755  
F684

# Rancho Mirage Health and Rehabilitation Center

## In-Service Sign In Sheet

Date 11/16/23 Time From: 2:30 To: 6:00

Name Of Lecturer: Virginia Faustino RN

Topic: Medication Administration to ensure medications

Brief Summary of Lecture: are provided to residents per MD orders  
5 rights of medication

administration

1) P+P for documenting & reporting medication error

2) Safety administering & document medication administration  
to residents

Name of Person Attending

Sign Name

Print Name

Title

Shift

J. Taylor

T. Taylor

LUN

AM

M. Bernal

M. Bernal

LUN

AM

M. Leron

M. Leron

trn

AM

Annemarie Barks

Annemarie B

LUN

AM

Vinh Dung

Vinh Dung

LUN

AM

Jael Moreno

Jael Moreno

LUN

AM

Maria Torre

Maria Torre

LUN

AM

Fortunato B. Garcia

FORTUNATO B. Garcia

LUN

PM

Eva Moreno

Eva Moreno

LUN

PM

Brief Evaluation of Response to Lecture: \_\_\_\_\_

Signature of In-Service Director: \_\_\_\_\_

- Erliza Mesias

Erliza Mesias

AM

F755  
F084

Rancho Mirage Health and Rehabilitation Center

In-Service Sign In Sheet

Date: 1/17/23 Time From: 7:45 a.m. To: \_\_\_\_\_



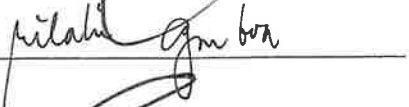

Name Of Lecturer: Virginia Tassler

Topic: Medication Administration to ensure medications

Brief Summary of Lecture: are provided to residents per MD orders  
5 Rights of medication administration

- 2) PEP for documenting & reporting med error
- 3) Safely administering & documenting medication administration to residents

Name of Person Attending

Sign Name	Print Name	Title	Shift
	<u>T. Hennessey</u>	<u>RN</u>	<u>Noc</u>
	<u>Hossaine Cleland</u>	<u>RN</u>	<u>Noc</u>
	<u>Nifali Gramora</u>	<u>W</u>	<u>Noc</u>
	<u>Cherry Zastrow</u>	<u>W</u>	<u>Noc</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brief Evaluation of Response to Lecture: \_\_\_\_\_

Signature of In-Service Director: \_\_\_\_\_

F755  
F054

Rancho Mirage Health and Rehabilitation Center

In-Service Sign In Sheet

Date 1/11/13 Time From: 3:45 pm To: 4:15 pm

Name Of Lecturer: Virginia Fausto

Topic: Medication Administration because medications are

provided to residents per M.D. orders  
Brief Summary of Lecture: 1) 5 rights of medication administration

2) P+P for documenting, reporting medication error

3) Safely administering & documenting medication

administration to residents

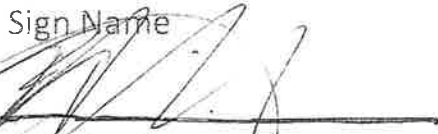
Name of Person Attending

Sign Name

Print Name

Title

Shift



Manny Trujillo LVN AM



Maria Lema lvn AM



Araceli Trujillo LVN AM



Maria Bernal LVN AM



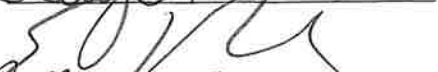
Mario Garcia LVN PM



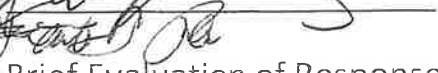
Maria Torres LVN AM



T. Taylor LVN AM



Eud Mino LVN PM



FORTUNATO PELAEZ LVN PM

Brief Evaluation of Response to Lecture: \_\_\_\_\_

Signature of In-Service Director: \_\_\_\_\_

Richard K - RN

[Signature]

RN

PM/NOC

Andrea Verde LVN - ADDN

[Signature]

LVN

PM/NOC/AM

Signature of In-Service Director: \_\_\_\_\_

## Rancho Mirage Health and Rehabilitation Center

## In-Service Sign In Sheet

Date 1/17/28 Time From: 8:15 a.m. To: \_\_\_\_\_Name Of Lecturer: Virginia Fawcett RNTopic: Food Preferences + Checking meal traysBrief Summary of Lecture: prior to serving resident1) Food preferences2) LM to check meal trays prior to CNA'sserving to residents

Name of Person Attending

Sign Name

Print Name

Title

Shift

T. HesterLorraine ClevelandLorraine ClevelandRNNocNitah GambaNitah GambaLUNNocMary ZatorremdNoc

Brief Evaluation of Response to Lecture: \_\_\_\_\_

Signature of In-Service Director: \_\_\_\_\_

## Rancho Mirage Health and Rehabilitation Center

## In-Service Sign In Sheet

Date 11/16/23 Time From: 3:00 To: \_\_\_\_\_Name Of Lecturer: Virginia FaustinoTopic: Food preferences + checking meal trays prior toBrief Summary of Lecture: 2018 residents LN to check meal traysprior to serving residents

Name of Person Attending

Sign Name	Print Name	Title	Shift
<u>J Taylor</u>	<u>J Taylor</u>	<u>LVN</u>	<u>AM</u>
<u>Maria Bernal</u>	<u>Maria Bernal</u>	<u>CNA</u>	<u>AM</u>
<u>Mame Herman</u>	<u>Mame Herman</u>	<u>LVN</u>	<u>AM</u>
<u>Vinh Dong</u>	<u>Vinh Dong</u>	<u>LVN</u>	<u>AM</u>
<u>Annemarie Bates</u>	<u>Annemarie B.</u>	<u>LVN</u>	<u>AM</u>
<u>Maria Torres</u>	<u>Maria Torres</u>	<u>LVN</u>	<u>AM</u>
<u>Joel Moreno</u>	<u>Joel Moreno</u>	<u>LVN</u>	<u>AM</u>
<u>Fortunato Polio</u>	<u>Fortunato Polio</u>	<u>LVN</u>	<u>PM</u>
<u>Eva Munoz Garcia</u>	<u>Eva Munoz Garcia</u>	<u>LVN</u>	<u>PM</u>

Brief Evaluation of Response to Lecture: \_\_\_\_\_

Signature of In-Service Director: \_\_\_\_\_

Enliza Mesian

Enliza Mesian

AM

## Rancho Mirage Health and Rehabilitation Center

## In-Service Sign In Sheet

Date 1/17/66 Time From: 4:15 To: \_\_\_\_\_Name Of Lecturer: Virginia FarnhamTopic: Food preferences & checking meal traysBrief Summary of Lecture: 1) Food preferences2) LUN to check meal trays prior to CNAs  
serving & residents

Name of Person Attending

Sign Name	Print Name	Title	Shift
	Manny Trujillo	LUN	AM
	Mary Loma	LN	AM
	Araceli Trujillo	LUN	N
	Maria Bernal	LUN	AM
	Mario Garcia	LUN	PM
	Maria Torres	LUN	AM
	T. Taylor	LUN	AM
	Eva Munoz	LUN	PM
	FORTUNATO PELTRE	LUN	PM
	Kim	LUN	PM

Brief Evaluation of Response to Lecture: \_\_\_\_\_

Signature of In-Service Director: \_\_\_\_\_



Richard K - RN

*[Handwritten signature]*

Rw

PM/NO C

Andrea Verde LVN -ADON

Her

LVP

PM / NOC / AM

Signature of In-Service Director: \_\_\_\_\_

# INSERVICE MEETING MINUTES

## BRIEF SUMMARY OF LECTURE & TRAINER

Dietary staff were in serviced about the importance of honoring the residents food preferences, dietary staff were instructed to read all meal tickets carefully during trayline.

[illegible]