STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055612	A. BUILDING _____ B. WING _____	C 09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADOWBROOK POST ACUTE	1 GILMORE LANE OROVILLE, CA 95966

(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 complaint. Complaint Number: 769498 The survey was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 23083, Health Facilities Evaluator Nurse A deficiency was issued for complaint 769498 at F755.	F 000	How corrective Action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 is no longer a resident at the facility. DON performed a medication cross match on resident # 2 on 9/29/2022 to ensure compliance. 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: All residents with daily routine medication orders have the potential to be affected by this practice. Pharmacy consultation done on monthly basis with med pass administration visual assessment with licensed nurses done quarterly by nurse pharmacy consultant. Clarification obtained from consulted pharmacy that all "urgent" and other medications not delivered timely will be satellited to a local 24-hour pharmacy. No other residents affected by deficient practice. received date: 10/3/22 approved date: 10/7/22 completion date: 10/3/22 approved by: FM	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records 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, 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-	F 755		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/3/22

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 755	Continued From page 1 §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 interview and record review, the facility failed to ensure timely acquiring, receiving, dispensing and administering of medications to meet the needs of two sampled residents (Resident 1 and 2) when: 1. Resident1 missed two doses of prescribed Symbicort inhaler (used to treat restricted upper airways). 2. Resident 2's prescribed Prednisone (anti-inflammatory medication) order was not administered for three days. These failures resulted in a delay of prescribed medications being administered and the potential for worsening symptoms and negative outcomes that could affect residents' health and well-being. Findings: On 1/18/22, the California Department of Public Health (CDPH) received a complaint that the facility failed to have medications available in a	F 755	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: In-servicing of licensed staff to be completed by 10/07/2022 educating on the procedure to follow for all medications not delivered on the first delivery following medication order to include: 1. Notifying pharmacy of medication(s) ordered and 2. Requesting medication(s) be satellited to a local pharmacy, and 3. Notify MD of any medication delays. New licensed staff and agency licensed staff will be in-serviced of this policy and procedure during facility orientation. How the facility plans to monitor its performance to make sure that solutions are sustained: The DON will do a medication cross match on a resident sampling of 5 residents per week for 3 months to ensure compliance beginning 10/03/2022. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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timely manner to administer to residents in the red zone (isolation area designated for resident's who tested positive with the COVID-19).

1. Resident 1 was admitted to the facility on 1/7/22 with diagnoses that included positive for the Coronavirus (COVID-19), heart failure and dementia (a progressive brain disorder that effects memory and daily functioning).

A review of a 1/7/22 physician order prescribed Symbicort inhaler (used to open restricted upper airways) Aerosol medication 80-4.5 micrograms two inhalations two times a day to Resident 1 for COVID -19.

A review of Resident 1's 1/22 Medication Administration Record (MAR) indicated the Symbicort medication was to be started on 1/8/22 but was not available and the licensed nurses documented they were waiting for the pharmacy to deliver the medication.

A handwritten entry on the back of the MAR dated 1/8/22 at 9 am indicated the facility was waiting for the pharmacy to deliver the Symbacort, and the physician was aware. The next entry on the same day at 7 pm also indicated the medication was still not available from the pharmacy. Resident 1 missed 2 doses, one at 9 am and the next at 5 pm on 1/8/22.

During a concurrent interview and record review with the Director of Nurses (DON) on 9/9/22 at 10:30 am, she stated a medication error occurred as the Symbicort for Resident 1 was not delivered timely from the pharmacy or administered as the physician prescribed.
The DON stated the licensed nurses should have

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contacted the pharmacy and obtained a physician's order to administer the medication when available.

2. Resident 2 was admitted to the facility on 5/11/21 with diagnoses that included heart and lung disease, and dementia.

Resident 2 was transferred to the facility red zone on 1/13/22 for testing positive with the COVID-19 virus.

A review of Resident 2's 1/22 physicians orders prescribed Prednisone 10 milligrams one time a day for COVID- 19 for seven days and to begin on 1/15/22.

A review of Resident 2's 1/22 MAR indicated the Prednisone was not administered at 9 am for three days (1/15, 1/16 and 1/17/22).

Documentation on the reverse side of the MAR showed a handwritten statements indicating on 1/15 and 1/16/22 the Prednisone medication had not arrived from the pharmacy. Another handwritten entry dated 1/17/22 at 9 am, indicated the physician and pharmacy were then notified and aware.

Further review of the same MAR indicated that Resident 2 received her first dose of 10 mg of Prednisone on 1/17/22 at 9 pm.

A review of a clarification order written 1/17/22 at 11:40 am indicated the physician was made aware of the prednisone medication not being delivered from the pharmacy, and new orders received to start this day.

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During a concurrent interview and record review with the DON on 9/9/22 at 11 am, she stated the late Prednisone was a medication error as the physician's orders were not followed.

A review of a 2017 revised, "Medication Administration," policy instructed medications are to be administered by licensed nurses as ordered by the physician. The policy additionally instructed medications are to be administered within 60 minutes prior to or after scheduled times unless ordered by the physician. If the medications are unavailable the pharmacy and the physician should be notified.

A review of the facility's policy titled, "Medication Ordering and Receiving from Pharmacy," revised 10/23/15, indicated that medications are received timely from the dispensing pharmacy. New medication orders are entered in the facility electronic medical record and transmitted electronically or written on a medication order form and transmitted to the pharmacy. Medications which are urgent and can not wait until the next scheduled delivery date can be filled at a satellite pharmacy (after hours and other than usual pharmacy). The nurse or the facility or the medication staff person who orders the medication is responsible for notifying the pharmacy of changes.

During an interview with the DON on 9/13/22 at 3:30 pm, she stated she had no further documentation as to why Resident 1 and 2's above medications failed to arrive timely from the pharmacy.