STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055481	A. BUILDING _____ B. WING _____	C 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIENNA NURSING AND REHABILITATION CENTER	800 SO. HAM LANE LODI, CA 95242

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of complaint #CA00839504. Representing the Department of Public Health: Health Facilities Evaluator Nurse, 42813 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	Received 5/19/23 approved 5/23/23 BIC 5/21/23.	
F 755 SS=D	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- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	1. On 5/5/23 the order for Tramadol was clarified by the attending physician and sent to the Pharmacy via electronic prescription and was delivered to the facility that night. Resident received the first dose on 5/6/23. 2. At the time of a new admission and if the orders arrive without a triplicate for narcotics, or with DC orders that are unclear, the nurse will obtain clarification from the MD, input the order in PCC and fax the new order to the pharmacy. The admission nurse will ensure that the MD has communicated with the pharmacy and the order is authorized. If the medication is needed immediately, get a release from the pharmacy to obtain the medication from the CUBEX machine for as many needed doses until the resident supply arrives from the pharmacy. The following morning during recap of orders, the nurses will assure that there is a triplicate for all narcotics and that either the medication has been delivered or has a release for the CUBEX machine as needed. 3. If there is any delay in the attending MD providing authorization for narcotics,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/18/23

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 755	Continued From page 1 §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 supply Tramadol (generic name; a controlled drug used to treat moderate to severe pain) to one of three residents (Resident 1) as ordered for 57 days since Resident 1's admission to the facility. This failure had the potential to cause Resident 1 discomfort, pain, and inability to sleep. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in March of 2023 with diagnoses including urinary tract infection (infection which affects the passageway of urine). A review of Resident 1's Hospital Discharge Summary, dated March 9, 2023, indicated Tramadol 50 mg (milligrams, a unit of measurement) four tablets was part of the 13 medications ordered by the provider for the skilled nursing facility. A review of Resident 1's Order Summary Report indicated Resident 1 had orders for "Tramadol HCL (hydrochloride) Oral tablet 50 mg. Give 1 tablet by mouth every 6 hours as needed for	F 755	the nurse will notify the facility Medical Director to obtain the order to prevent delay in treatment. The nursing staff will be in-serviced on May 22, 2023 on the POC. 4. Every Sunday each shift (2nurses) will verify the medications against the orders to affirm that all medication are the correct dosage and are all available. Each of the 2 nurses will sign the cart check form. The QA nurse will check the forms on each Monday to ensure compliance. The QA nurse will report to the next QAA Committee meeting the results of the Monday reviews of the weekly medication cart check forms.	5/22/2023

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F 755	Continued From page 2 moderate-severe pain, dated 3/9/2023. " A review of Resident 1's Nursing Progress Note, dated 3/9/2023 at 8:01 p.m., indicated "Resident c/o (complain of) pain to the left upper arm with a pain scale: 8/10 (numeric pain scale; 10 being the highest number for the worst pain). Notified [name of medical doctor; MD 1] with T.O. [telephone order] Tramadol 50 mg, 1 tab po [per os; by mouth] q [every] 6 hours for moderate-severe pain ... " A review of Resident 1's Medication Order, dated 3/9/2023 at 7:57 p.m., indicated MD 1 ordered Tramadol 50 mg via telephone order. A review of Resident 1's Nursing Progress notes indicated: 4/23/23 at 2:28 p.m.: "Placed call to [name of pharmacy], regarding clarification on resident's [Resident 1] Tramadol delivery status ...Medication was never delivered due to invalid order, no quantity was listed on order by primary provider, MD notified. " 4/29/2023 at 10:27 a.m.: "Placed a call to ... regarding the delivery status for Tramadol ...there is currently no E-script [electronic medication prescription signed by a medical provider] sent at this time. MD notified." 4/30/2023 at 1:01 p.m.: "Placed a call to...regarding the delivery status for Tramadol...there is currently no E-script sent at this time. MD notified." A review of Resident 1's Medication Administration Record for the months of March,	F 755		

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F 755	Continued From page 3 April, May 2023 indicated Tramadol had not been given to Resident 1 since her admission in March of 2023. A review of Resident 1's History & Physical, dated 5/2/2023 at 10:09 a.m., by MD 2 indicated Tramadol was one of the six medications prescribed for Resident 1. During a concurrent observation, interview, and record review on 5/5/2023 at 1:25 p.m. with Licensed Nurse 1 (LN 1), the narcotic medication cart was reviewed with LN 1. The cart contained six packs of narcotic medications for various residents and no Tramadol packs for Resident 1. LN 1 stated she called both the pharmacy and MD 1 regarding the medication order for Tramadol on the following dates: 4/21, 4/29, and 4/30. LN 1 stated there was no Tramadol pack for Resident 1 but there were Tramadol packs for Resident 2 and Resident 3. During an interview with Resident 1 on 5/5/2023 at 3 p.m., Resident 1 stated that she could not sleep at night due to pain in her legs. Resident 1 stated that she had restless leg syndrome (a long term disorder that causes a strong urge to move one's legs, which is aching, tingling, or crawling in nature). Resident 1 also stated that she took Tramadol regularly at home but did not know if the staff had given her Tramadol for her pain. During a concurrent interview with LN 2 on 5/5/23 at 3:48 p.m., LN 2 stated that Tramadol was ordered for Resident 1 for moderate to severe pain, but Resident 1 had to ask for pain medication. During an interview with the Administrator (ADM)	F 755		

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F 756	Continued From page 4 on 5/5/23 at 3:52 p.m., the ADM stated MD 1 "was a very busy physician." The ADM stated the Medical Director (MD 3) was supposed to write the e-script when they did not get a response from MD 1. During an interview with Pharmacy Director (PD) of [name of contracted Pharmacy] on 5/8/23 at 9:38 a.m., PD stated that Resident 1 was admitted with a Tramadol order for pain. PD also stated that pharmacy was not able to supply Tramadol for Resident 1 because they had not received the prescriber's valid prescription for Tramadol. The facility faxed an invalid prescription to the pharmacy on 4/11/2023.The PD stated there had been various correspondence and phone calls regarding the delivery of Tramadol and phone calls to the prescriber. PD also stated that nurses could have escalated the delivery of this medicine if they requested the pharmacist to help them call the MD for the signature. The PD stated the request was not made by the nurses. When the nurses called, they only asked if the Tramadol had been delivered. A review of a facility policy titled, "Medication Orders," revised on 5/15/2018, indicated, "Before a controlled drug can be dispensed, the pharmacy must be in receipt of a valid prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled medication...If the prescriber issues a chart order, he/she must also provide the pharmacy with a valid prescription. " A review of a facility policy titled, "Medication Ordering and Receiving from Pharmacy, " revised 5/15/2018, indicated, "Controlled	F 755		

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F 755	Continued From page 5 substances prescribed for a specific resident are delivered to the facility only if a valid prescription has been received by the pharmacy prior to dispensing. "	F 755		