STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 04/17/2023

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for two complaints and one facility reported incident. Complaint Numbers: CA00832617 and CA00833852 Facility Reported Incident Numbers: CA00832246 Representing the Department: Health Facilities Evaluator Nurse(s): #45978 and #47883 The inspection was limited to the specific facility reported incident and complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number: CA00833852 (F760).	F 000	**This Plan of Correction (POC) serve as our Credible allegation of Compliance. The facility will in substantial compliance on or before 05/07/23. This plan of correction does not admit guilt to any of the alleged violations nor does this interfere with the right to contest or appeal the alleged violation.** F 760 Residents are Free of Significant Med Errors 1. Upon notification of the alleged deficient practice on 4/3/2023, Residents 5, 7, 8 and 9 was assessed by the DON and/or ADON for late administration of cardiac meds for BP and HR (atrial fibrillation). Residents 5, 7, 8 and 9 did not exhibit any hypotensive or hypertensive situation and have stable baseline heart rates. Resident 9 was further assessed for s/s of hyper/hypoglycemia complications. Resident 9's FSBS was within her baseline blood sugar values. Resident 9 has always been on laboratory monitoring of HbA1c and CMP (glucose) Q3 months and as needed. Historically, Resident 9 has been with fluctuations and has been referred to an endocrinologist for blood sugar management since 12/2022. She went to	05-07-23
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure four of five sampled residents (Resident 5, Resident 7, Resident 8, and Resident 9) were free of any significant medication errors (administration of medications which was not in accordance with accepted professional standards and principles).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 5/4/23

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 760	Continued From page 1 This deficient practice had the potential to result in the residents' blood pressure, heart rate, and blood sugar to increase and place the residents' health and safety at risk. Findings: A. A review of Resident 5 ' s Admission Record indicated the facility admitted the resident on 8/16/21 with diagnoses including intellectual development disorder (a type of disorder when individual have trouble with learning, communicating, thinking rationally, making judgments, and planning), tachycardia (rapid beating of the heart), ileostomy and colostomy (openings in the belly to create an opening from an area inside the body to outside). A review of Resident 5 ' s History and Physical (H&P), dated 12/28/2022, indicated that the resident lacked the capacity to make decisions. A review of Resident 5 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/23/2023, indicated the resident had severe impaired cognition (when person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS further indicated the resident required supervision with eating, two-person assistance with mobility and transferring, one person assistance with dressing and toileting and personal hygiene and bathing. A review of Resident 5 ' s Order Summary, dated 12/7/2022, indicated to give Metoprolol Tartare Tablet 25 milligrams (mg/a unit of measurement) by mouth in the morning for high HR (heart rate), hold medication for HR below 60 or SBP (Systolic	F 760	her scheduled appointment on 4/26/2023 and returned with new insulin management orders. LVN 1 was counseled 1:1 regarding delayed administration of medications and was redirected to request for assistance from DON and/or ADON if she anticipates that her med pass will be delayed. Residents 5, 7, 8 and 9's respective primary physicians were made aware of delayed medication administration of BP meds and insulin and no new orders were received. 2. All residents with scheduled medication administration may be affected by this alleged deficient practice. On 4/4/23, 4/5/23 and 4/6/23, Medical Records, Unit Managers and ADON reviewed medication administration via PCC EMAR navigation. DON and/or ADON made clinical rounds on 4/4/23, 4/5/23 and 4/6/23 during medication pass observation. Findings were referred to the PCP and DON, ADON and or designee for evaluation and needed interventions. 3. a. Licensed nurses were in-serviced on 4/4/23, 4/5/23 and 4/6/23 by the DON on timely administration of medications within acceptable timeframe and to adhere to the 1-hour window prior and	05/07/23

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

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F 760	Continued From page 2 Blood Pressure) less than 110 and administer with meal. On 4/3/2023 at 12:27 p.m., during a concurrent medication administration observation and interview, Licensed Vocational Nurse (LVN)1 took Resident 5 ' s BP (blood pressure) with measurement of 112/72 and a pulse 93. LVN 1 administered Metoprolol 25 mg by mouth to Resident 5. LVN 1 stated she was administering the medication scheduled for 9 a.m. late because the facility was short of staff today. LVN 1verified she came in late to help administer medication. LVN 1further stated she regularly works as MDS nurse. B. A review of Resident 7 ' s Admission Record indicated the facility admitted the resident on 2/7/2023 with diagnoses of essential hypertension(a condition in which the blood vessels have persistently raised pressure), congestive heart failure(a condition that develops when your heart does not pump enough blood for your body ' s needs), and seizures (a condition a burst of uncontrolled electrical activity between brain cells that caused temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness). A review of Resident 7 ' s H & P, dated 1/11/2023, indicated Resident 7 had the capacity to understand and make decisions. A review of Resident 7 ' s MDS, dated 1/16/2023, indicated Resident 7 required supervision with eating, required two-person extensive assistance with bed mobility, walking and transferring, required one-person assistance with dressing, toileting, personal hygiene, and bathing.	F 760	after scheduled administration time. They were also in-serviced and instructed to seek for assistance from DON and/or ADON, when they anticipate that their medication administration will be delayed or late. b. Medical Records will report in stand-up meeting any inconsistencies in delayed medication administration and for corrective action by DON and/or ADON. Weekend review of PCC EMAR will be done by the RN Supervisor to be included in their shift report. c. Pharmaceutical Nurse Consultants will conduct quality compliance on medication administration with licensed nurses during their scheduled monthly visit. 4. Findings will be reported by the DON and/or designee to the QA committee monthly x 3 months for review and recommendations. 5. Completion Date: May 7, 2023	05/07/23

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F 760	Continued From page 3 A review of Resident 7 ' s Order summary, dated 1/10/2023, indicated Amlodipine Besylate Oral Tablet 10 mg by mouth one time a day related to essential hypertension. The order further indicated to hold for SBP less than 110 or pulse less than 60. A review of Resident 7 ' s medication administration record (MAR), dated 3/28/2023, indicated that Amlodipine Besylate scheduled at 9 a.m. was administered to resident at 11:30 a.m. A review of Resident 7 ' s MAR, dated 4/3/2023, indicated Amlodipine Besylate scheduled at 9 a.m. and administered to resident at 11:51 a.m. C. A review of Resident 8's Admission Record indicated the facility admitted the resident on 1/26/2023 with diagnoses including cerebral infarction (a type of stroke that occurs when the supply of blood to the brain is reduced or blocked completely), essential hypertension, type 2 diabetes mellitus. A review of Resident 8's H & P, dated 1/26/2023, indicated Resident 8 had fluctuating capacity to understand and make decisions. A review of Resident 8's MDS, dated 2/1/2023 indicated the Resident 8 was unable to walk, required supervision for eating, and two-person extensive assistance with bed mobility and, transfer. A review of Resident 8's order summary, dated 1/26/2023, indicted to give Lisinopril Oral Tablet 20 mg by mouth one time a day related to essential hypertension. Hold for SBP less than 110 or pulse less than 60.	F 760		

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F 760	Continued From page 4 A review of Resident 8's MAR, dated 4/1/2023, indicated Lisinopril 20 mg was scheduled for administration at 9 a.m. and was administered at 11:41a.m. A review of Resident 8's MAR, dated 4/03/2023, indicated Lisinopril 20 mg was scheduled for administration at 9 a.m. and was administered at 2:11 p.m. D. A review of Resident 9 ' s Admission Record, indicated the facility admitted the resident on 5/17/2021 with diagnosis including type 2 diabetes mellitus, atrial fibrillation (an irregular heartbeat that occurs when the electric signals in the atria (the two upper chamber of the heart) fire rapidly at the same time), and muscle weakness (a lack of strength in the muscles). A review of H&P, dated 1/17/2023, indicated Resident 9 had fluctuating capacity to understand and make decisions. A review of Resident 9 ' s MDS, dated 1/15/2023, indicated Resident 9 was unable to walk, required supervision with eating, and extensive 2-person assistance with transferring. A review of Resident 9 ' s Order Summary from 1/9/2023, indicated order for Amiodarone HCL give 100 mg by mouth one time a day related to atrial fibrillation, hold for pulse less than 60. A review of Resident 9 ' s MAR, dated 3/28/2023, indicated Amiodarone HCL was scheduled at 9 a.m. and administered to Resident 9 at 10:19 p.m. A review of Resident 9 ' s MAR, dated 3/31/2023,	F 760		

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F 760	Continued From page 5 indicated Amiodarone HCL was scheduled at 9 a.m. and administered to Resident 9 at 10:32 p.m. A review of Resident 9 ' s MAR. dated 3/31/2023, indicated Amiodarone HCL was scheduled at 9 a.am. and administered to Resident 9 at 12:05 p.m. A review of Resident 9 ' s Order Summary on 3/7/2023, indicated to inject Humulin 70/30 10 units subcutaneously two times a day related to type 2 diabetes mellitus, to give with meal, and rotate sites. A review of Resident 9 ' s MAR, dated 3/28/2023, indicated 10 units of Humulin70/30 scheduled at 9 a.m. and 5 p.m. administered at 10:24 a.m. and 6:42 p.m. The MAR further indicated a blood sugar reading of 457 at 10:24 a.m. and 352 at 6:42 p.m. A review of Resident 9 ' s MAR, dated 4/03/2023, indicated 10 units of Humulin 70/30 scheduled at 9 a.m. and 5 p.m. and was administered at 12:05 p.m. and 8:55 p.m. On 4/4/2023 at 11:19 a.m., during an interview, LVN 2 stated that according to Policy and Procedure the medication should be administered within one hour of scheduled time. LVN 2 stated Nurse should prioritize administration of medication for residents in pain, antibiotics, and high blood pressure medication. LVN 2 stated late administration of medications can potentially affect residents' outcome and compromise residents' health. On 4/4/2023 at 11:49 a.m., during an interview,	F 760		

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F 760	Continued From page 6 Licensed Vocational Nurse (LVN)3 stated scheduled medications can be administered 30 minutes before or after scheduled time. LVN stated, it was not acceptable to administer blood pressure medications late because of risk of stroke to the resident. On 4/4/2023 at 2:47 p.m., during an interview and concurrent record review, the Director of Nursing (DON) stated medications can be administered within one hour of schedule, nurses should prioritize administration of insulins, blood pressure medications, antibiotics, and pain medications. DON stated late administration of medications has a potential for interactions with next scheduled medications and may lead to change in residents' condition. A review of the facility ' s policy and procedure titled, "Medication administration," reviewed on 7/28/2022, indicated, "Medications are to be administered within one (1) hour before or one (1) after the prescribed time."	F 760		