STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055632	A. BUILDING _____ B. WING _____	C 12/15/2022

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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 the investigation of a complaint. Complaint Number: CA00811459 Category: Quality care/Treatment deficiencies. Representing the Department: Health Facilities Evaluator Nurse 28183. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was written for complaint number CA00811459.	F 000	This document will serve as a credible allegation of our intent to correct deficient practices identified. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code.	
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	F 755	A. Resident #1 is no longer residing at the facility. B. All residents have the potential to be affected. An in-service with the facility nursing staff reviewing the proper medication administration procedures was conducted by the Pharmacist Consultant on 11/21/22. A one on one skills review was completed with the Licensed Nurse #1 with the Pharmacist Consultant on 11/21/22. C. New hire and annual skills reviews have been updated to include a more extensive skills check of the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katherine A

TITLE: ADMINISTRATOR

(X6) DATE: 12-19-22

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 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 interview and record review, the facility failed to ensure nursing staff administered medications according to physician's orders and facility policy for one of one sampled resident (Resident 1). As a result, a Licensed Nurse (LN) administered medications to the wrong resident (Resident 1). Resident 1 was transferred to a hospital and admitted to the ICU. During an interview on 11/16/22 at 9:35 A.M., the Assistant Director of Nursing (ADON) stated that she was notified the morning of 11/10/22 of an incident where LN 1 administered medications around 8:05 A.M., on 11/10/22 to the wrong resident. LN 1 had given Resident 1 the roommate's (Resident 2) medications. According to the ADON, LN 1 recognized the error immediately after it occurred and notified Resident 1's physician (MD 1). MD 1 ordered a bolus of IV fluids to be given to the resident and	F 755	medication administration protocol. D. Pharmacy nurse consultant will perform medication administration audits for our licensed nurses through a random sample each month. Results of the audits will be forwarded to the QA Committee for 3 months. E. 3/31/23	

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F 755	Continued From page 2	F 755		

to monitor closely. After lunch, Resident 1 became more sleepy and her heart rate went down to 44, so 911 was called. The resident was administered Narcan (an opioid reversal medication) before transferring to the hospital.

When interviewed on 11/16/22 at 9:55 A.M., LN 1 stated she was the medication nurse on 11/10/22. According to LN 1, it was a busy morning with many residents asking for pain medication after breakfast. LN 1 was then informed that Resident 1 was requesting a pain medication. LN 1 stated, "There was a lot of distraction. I thought I saw her name," since both Resident 1 and 2's last names start with the same letter. LN 1 stated when she went back to the medication cart to get Resident 2's medications, "I realized I gave her [Resident 1] the roommates meds."

According to LN 1, she immediately notified the physician, Resident 1's family member, and the DON. The resident was alert and talking at the time. Then after lunch, the resident became more sleepy, and her blood pressure and heart rate dropped. MD 1 was in the facility and assessed the resident. MD 1 then decided to send the resident to the hospital. The resident received a dose of Narcan prior to going to the hospital.

LN 1 acknowledged she did not verify the resident's identity prior to administering the medications to Resident 1. LN 1 stated, "What I missed was checking with the patient when giving. I didn't check her wristband beforehand."

Resident 1's clinical record was reviewed on 11/16/22. Resident 1 was admitted to the facility on 11/4/22 with diagnoses that included diabetes, atrial fibrillation, and intestinal obstruction, per the

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F 755	Continued From page 3 resident's Admission Record. According to the nurses notes, dated 11/10/22, LN 1 documented that around 8:30 A.M., LN 1 noticed that the wrong medications were given to the resident. Per the note, the medications inadvertently given to Resident 1 included amlodipine (a blood pressure medication), gabapentin (used to treat nerve pain), venlafaxine (an antidepressant), rifampin (an antibiotic), and oxycodone (a narcotic pain medication). The note further indicated that around 1:30 P.M., Resident 1's vital signs were: 94/48 blood pressure, and pulse 46, and the resident was "having a difficult time staying awake." MD 1 was made aware and ordered Narcan to be given. According to Resident 2's physician's orders for November 2022, the following were prescribed for Resident 2 but given to Resident 1: amlodipine 5 mg; give 1 tablet once a day ascorbic acid (vitamin C) 500 mg; give 1 tablet once a day aspirin 81 mg; give 2 tablets once a day ferrous sulfate (iron) 325 mg; give 1 tablet once a day gabapentin 300 mg give 1 capsule twice a day venlafaxine 150 mg give 2 capsules once a day oxycodone 5 mg give 1 tablet every four hours as needed for moderate pain rifampin 300 mg give 2 capsules once a day Resident 1's physicians orders for November 2022 were reviewed. The resident was not prescribed amlodipine, gabapentin, rifampin, oxycodone, iron, or vitamin C supplements. The hospital records were reviewed on 11/17/22. According to the ED Note, dated 11/10/22, the	F 755		

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F 755	Continued From page 4	F 755		

resident was, "accidentally given her roommates medications around 8 or 8:30 this morning by staff at the nursing home. These medications include gabapentin and Norco [oxycodone] which are both known to be sedating."

The ED note further indicated the resident had several episodes of apnea (cessation of breathing) in the ED that required Narcan administration, and " ...given the need for constant monitoring of her respiratory status, patient was upgraded to the ICU."

The hospital records indicated that the resident subsequently improved and was transferred to the stepdown unit on 11/11/22 at 10:40 P.M.

According to the Discharge Summary, dated, 11/14/22, "Patient did extremely well in the ICU and her symptoms completely resolved within 24 to 48 hours." The note further indicated, " ...there has been no significant consequence of the medication error that occurred in the nursing home." Per the Discharge Summary, the resident returned to normal baseline self and was discharged to another skilled nursing facility on 11/14/22.

According to the facility's nursing policy and procedure, titled Six Rights of Medication Administration, revised 2/2018, "The six rights of medication administration are as follows in order to ensure safety and accuracy of administration. 1. Right Resident - Resident is identified prior to medication administration ..."

According to the facility's undated Medication Administration policy and procedure, "Identification of the resident must be made prior

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F 755	Continued From page 5 to administering medications to the resident."	F 755		